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EALTHY
European Association of Language Teachers for Healthcare

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PROCEEDINGS SPECIAL

3rd English for Healthcare Conference, S. Golini (2017)

Vital Signs

- *A word or 2 from our new President*
- *5 Qs for Averil Coxhead*
- *6 papers from the 3rd English for Healthcare Conference, 2017*
- *39 pages of medical English research!*

EALTHY
European Association of Language Teachers for Healthcare

DISCOVER THE OCCUPATIONAL ENGLISH TEST (OET)

A PRACTICAL SEMINAR AND WORKSHOP

EALTHY, International House London and SLC are delighted to host a seminar and workshop on the Occupational English Test (OET).

The OET test of English for Healthcare Professionals is now being taken by hundreds of international doctors and nurses every year to demonstrate they have the right language levels to practise safely and effectively in an English-speaking environment.

Come and find out more about the OET – what it consists of, how to prepare for it and where to take it.

Hear from **Cambridge University Hospitals** (Addenbrooke's) about how their European nurses are finding their OET preparation programme.

Get inside the test by participating in Speaking test role plays.

Registration

To register, sign up at www.specialistlanguagecourses.com/OET-seminar

EALTHY members: free

Non-EALTHY members: £15

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Who should attend?

- ✓ Healthcare providers
- ✓ Healthcare recruitment companies
- ✓ Medical English teaching organisations
- ✓ Medical English teachers
- ✓ ELT publishers

When is it?

Friday, May 18th, 1pm to 5pm

Where is it?

International House London,
16 Stukeley St, Covent Garden,
London, WC2B 5LQ

What's happening?

- ✓ **An overview of the OET**: background, objectives, recognition
- ✓ **A practical workshop**: role plays in the OET Speaking test
- ✓ **OET Panel**: Q&A with representatives from Cambridge University Hospitals, OET, International House London & SLC

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contin.

The expressions translated for their final project proved that students could engage in the act of recreating, and by transforming themselves from passive learners into authors, which increased their interest, input and effort and stimulated their thinking. To receive feedback, students were interviewed and comments regarding their learning performance mentioned improvement in learning new vocabulary, compiling glossaries based on etymology, understanding linguistic relations (recognizing combining forms and guessing the meaning of unfamiliar vocabulary based on etymology networks) as well as creating networks or connections within and between linguistic, historical, and scientific domains. They also listed improvement in their historical knowledge about the origin of terms; using terms with better awareness of their meaning, and last, but not least, that they felt an inseparable part of the history of the medical profession and acquired a sense of belonging to the medical society. Another student had reconsidered the place of language in the medical context and communication.

5. Conclusion

When students acquire their identity as doctors, they see their studies differently. They learn more, they are motivated, more interested in how language shapes their communication with books, colleagues (dead or living), their clients and possibly – their future students. For some, etymology is just an interesting fact of knowledge, for others it is a tool to enable them to memorize and explain. For all, however, it is a link and exploration into the origins of meaning and communication.

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The Language of Effective Doctor-Patient Communication: An approach for teaching history taking to medical students in English

Abstract: *Taking a patient history is one of the most important clinical tasks of a doctor. Medical students should be familiar with it, and they should acquire advanced communication skills during their university studies. When taking a medical history, two main elements are involved: the history taking content and the history taking process. History taking content is commonly referred to as information gathering, the 'what' of the medical interview, collecting specific information about the patient's symptoms, from the presenting complaint to the wider context of the patient's social history. The history taking process, however, is the method by which information is elicited, and thus it is more concerned with the 'how' of the interview. A fine balance is needed to combine content and process in order to effectively acquire adequate clinical information without considering either one as an alternative for the other. Evidence suggests that if history taking is done well, it improves patient satisfaction and compliance, and results in better health outcomes. We present the linguistic perspective of the history taking process as the main goal of our course. We also offer a few tips on how medical English teachers can contribute to better communication of their students who are non-native speakers of English coming from a multicultural environment.*

Keywords: doctor-patient communication, ESP course development, history taking, medical role-play, medical terminology

1. Introduction

Apart from providing medical training to Hungarian medical students, the Faculty of Medicine at the University of Szeged is also an English medium university where all lectures and classes are conducted to foreign students in English. The enrolment in the English Programme each year is around 170-200 students. The medical students are selected on the basis of their entrance exam results, their secondary school grades, and B2/C1 level of English (Cambridge or TOEFL examinations).

The students studying in the English Programmme are from all over the world. Although a few students have been educated in English-speaking countries, most of them come from countries where the medium of instruction is other than English with very little exposure to English.

The Department for Medical Communication and Translation runs English for Medical Purposes (EMP) courses and offers them to Hungarian medical students. In the English Programme, we teach Hungarian as a foreign language (both general and medical Hungarian), and we also run a tailored course in English, 'The language of effective doctor–patient communication', specially designed to meet the needs of the students in the English Programme. The idea of introducing a communication course like this was mainly supported by the fact that in our multicultural teaching environment, with students coming from Asian, African and European countries, they have very different cultural norms and values, different perceptions of disease, as well as diverse concepts regarding the role of the doctor, and the doctor-patient encounter. One specific and very important communication skill, for example, is managing patients' concerns. This aspect of communication arguably has its origin in a Western approach to the doctor-patient relationship under the umbrella term 'patient-centred care', and it might be a less prominent feature of medical communication in other cultures (Verma *et al.*, 2016). Furthermore, the students' level of English is not always advanced enough so that they can participate in the interactions adequately; many of them lack the ability to detect cues, address concerns or understand 'patient speak'.

Cultures in different societies and medical education systems affect the way doctors interact with their patients and with each other. Communication that achieves information exchange and negotiation of mutual expectations between the doctor and the patient reassures patients, and it also increases patient adherence (Ohtaki *et al.*, 2003). Communication during history taking or discussion of the management plan has a significant association with the patient outcomes (Keresztes *et al.*, 2017).

The medical interview or clinical history taking is one of the most important clinical tasks performed by clinicians on a daily basis. As part of our medical curriculum, we expect our students to be familiar with this task and acquire advanced communication skills during their university studies.

When taking a medical history, two main elements are involved: history taking content and history taking process. History taking content is commonly referred to as information gathering; it is concerned

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with the 'what' of the medical interview, eliciting specific information about the patient's symptoms, from the presenting complaint to the wider context of the patient's social and occupational history. The history taking process, however, is the method by which information is elicited, and thus is more concerned with the 'how' of the medical interview. A fine balance is needed to combine the content and process in order to effectively acquire adequate clinical information without considering either one as an alternative for the other (Silverman *et al.,* 2013). Evidence suggests that if history taking is done well, it improves patient satisfaction, compliance, symptom relief, and it also results in better health outcomes.

Scientific discoveries and technological innovations of the past few decades have substantially altered the manner in which diseases are diagnosed and managed. In the era of modern medicine, listening to the patient is often overshadowed by the results of imaging studies and laboratory tests. However, an emerging body of literature on the quality and safety in medical care has demonstrated that good communication is highly beneficial, in the way that it improves health outcomes and patient satisfaction.

Numerous models for good doctor-patient communication have been developed. All of them emphasize that quality medical care requires a combination of comprehensive scientific knowledge and sophisticated communication skills (Demeter, 2005).

Several theoretical perspectives fostered the early studies of doctor-patient communication, and from a sociological perspective, the concept of 'power' was a central issue. The 'medical model' elaborated on by Parsons (1958, 1978) and Freidson (1961, 1986) defines a hierarchical relationship between the doctor and the patient. Ten Have (2001) identifies two trends in medical interaction research: one that focuses on physicians' behaviours in the course of performing particular professional communication strategies, and the other focusing on the medical encounter as an activity type or genre. Power, however, remains a significant theme within this tradition.

Psychoanalysis and psychotherapy offer a different point of view. Concepts like therapeutic transference and counter-transference inspired Balint (1957) in his work with small groups of general practitioners. His aim was to make doctors aware of how the complex interaction between them and their patients can be built up over a life-time partnership. Rogers (1957) and his ideas of a therapeutic relationship based on unconditional positive regard required attention for such concepts as empathy and interest, and focused on the importance of non-verbal behaviour. These theoretical approaches, formulated between 1940 and 1970, provide the foundations for the purposes of communication in health care as distinguished by Ong *et al*. (1995), creating a good personal relationship, exchanging information, and making treatment decisions.

While sophisticated technologies may be used for the medical diagnosis and treatment, interpersonal communication is the primary tool by which the physician and the patient exchange information (Street, 1991). Provision of adequate information, eliciting patient worries, and a participatory decision-making style all correlate with improved effectiveness.

Two types of interaction analysis systems can be identified: 'cure' systems which are meant to capture the instrumental (task focused) behaviour, and 'care' systems which are meant to measure affective (socio-emotional) behaviour (Sensing, 1991). These two types of systems reflect the patients' need for cure and care when visiting a doctor: the need to know and understand (cure) and the need to feel known and understood (care).

2. The Integrated Medical Interview

Integrated medical interviewing, which comprises both clinician-centred and patient-centred interview techniques, serves as the backbone for most clinical encounters. This approach also serves our educational purposes the best. The patient-centred part of the interview generally precedes the clinician-centred part. This approach validates the importance of the patient's concerns and allows the patient to feel more comfortable. The chief complaint and history of present illness parts of the interview provide information on the most pertinent symptoms bothering the patient as well as the personal context in which the symptoms occur. This portion of the history is best developed using a patient-centred interviewing approach. The latter portions of the interview, from the past medical history through the review of systems, are most appropriately developed using the clinician-centred techniques. Importantly, patient-centred interviewing should complement traditional clinician-centred interviewing, and not replace it. Several interviewing skills facilitate a patient -centred approach to clinical encounters.

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These skills include open-ended questioning, non-verbal communication skills, such as purposeful silence or non-verbal encouragement, attentive listening, and summarizing or paraphrasing. Effective doctor–patient communication and shared decision-making require the incorporation of these techniques into everyday practice (Lloyd and Bor, 1996). Smith (2002) has proposed a 'Five-Step' model to synthesize patient-centred facilitating skills into sequential steps that can be adopted by any clinical encounter.

3. The Teaching Context, Discourse Focus

In order to develop a history-taking course and enhance the students' performance in this context, we observed authentic video-taped doctor–patient encounters and interviews developed for educational purposes, and we had discussions with medical communication experts from the Department of Behavioural Sciences and practising clinicians from different fields of medicine. In addition, we participated in different hospital study trips in Great Britain (London, Bristol, and Edinburgh) where we had the opportunity to have an insight into history taking in a real life context both in clinical practice and primary care.

Then we analysed the structure, the communicative functions, and the discourse features of the medical interview, and identified the language areas that appeared to be difficult for our medical students being non-native speakers of English.

4. Launching The Course

Based on this analysis and given the needs described above, we launched our two-semester course, *The Language of Effective Doctor–Patient Communication*, for the first time in 2009, as a compulsory elective course. There is a given number of credit points that have to be acquired in compulsory elective subjects in certain modules at our university. One can choose freely from the subjects offered. The students are required to collect 45 credits from the compulsory elective subject category by the end of the 10th semester. Besides our course, students can opt for Basic Biostatistics, Introduction to Aviation and Space Medicine, Microsurgery, Pharmacology Cases, Nuclear Medicine, Clinical Immunology, Social and Health Policy, and Sports Medicine.

Our training course (2 x14 weeks, 2 hours per week) aims to utilize the background professional knowledge of the students (they are in the fourth or fifth year of their professional training), and it focuses on the development of effective communication strategies internalizing the language forms necessary for building up a successful doctor–patient relationship.

In global terms, we try to raise students' awareness through exposure and practice of effective communication strategies. Within this broadly specified aim, we focus on specific discourse features characteristic of effective doctor–patient encounters, such as formulating the opening of the interview, developing awareness of politeness and respect, facilitating, clarifying, signposting, summarizing, checking information, reassuring, and dealing with emotions (McCullagh and Wright, 2008).

5. Elaborating the Curriculum

Based on the previously described needs, the students' special position, and the requirements of their future employers, we have elaborated a complex curriculum focusing not only on language skills but overall communication skills also considering cultural and behavioural aspects.

The main emphasis was put on the communicative aspects of the structure of comprehensive history taking, informing the patient during the physical examination and investigations, and offering explanation on the diagnosis established and management options offered.

Our next step was to identify specific language forms we wanted our students to be familiar with and use actively in the process of transforming their acquired cognitive medical knowledge into applied clinical practice. We noted the importance of the ability to use verb tenses, indirect questions as well as modal auxiliaries accurately when forming the open and closed questions of the medical history.

We designed complex tasks in which we integrated language, discourse function and the required communication skill and relied on the students' background professional knowledge.

After a general introduction and covering the common features of history taking, the time is devoted to discussing the special requirements in the major and minor clinical subjects. Considering the time constraints of the course, we focus on the following clinical areas: Internal medicine: Surgery, Gynaecology and obstetrics, Neurology, Paediatrics, Urology, Dermatology, Pulmonology, ENT, Ophthalmology, Anaesthesiology, Cardiology, Rheumatology, Oncology, Haematology, and Endocrinology. Professional help and guidance from medical specialists were provided throughout the curriculum design and course development.

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6. Publishing the Course Book

The course as well as the curriculum have been refined and improved since the beginning and worksheets were used as teaching material. Finally, by January 2017, we had managed to collect the revised and amended worksheets and compile a course book (publisher: JATE Press, Szeged, Hungary). Part 1 is used in the first semester of the course, and Part 2 is intended to be published in 2018 to be used as course material in the second semester.

Based on the compulsory subjects (clinical specialties) in Years 4 and 5 of the medical studies, Part 1 of the book involves the following chapters: an introduction to taking history, the language of history taking and physical examination in Urology, Neurology, Surgery, Paediatrics, ENT, Ophthalmology, Oncology, and Rheumatology.

6.1 Introduction to the Medical Specialty – Tasks 1 & 2

The structure of each unit is practically the same, beginning with the description of the given clinical field: who/what it deals with, who works there, and the common symptoms and signs, and diseases. For example, "*Urology is a specialty in medicine that deals with the treatment of conditions involving the male and female urinary tract and the male reproductive organs. […] A urologist is a doctor who has specialized knowledge and skills to treat the problems of the male and female urinary tract and the male reproductive organs. As a variety of clinical problems might be encountered, knowledge of internal medicine, paediatrics, gynaecology, and other specialties is required of the urologist*."

Task 1. What common symptoms do patients present with to the Department of Urology? e.g., incontinence, fever/rigors

Some of the possible answers are the following: dysuria, frequency, urgency, nocturia, haematuria, nausea/vomiting (often associated with pyelonephritis), erectile dysfunctions, and bedwetting (mainly children).

Task 2. Make a list of some diseases people visiting the Department of Urology are diagnosed with.

Students may come up with a list of urinary tract infections, urinary retention, urinary incontinence, kidney stones, benign prostatic hyperplasia, and cystitis.

6.2 Developing Medical Terminology – Task 3

Another particular language need is the ability to use technical terms (medical terminology) and their everyday equivalents adequately according to the professional context. The use of appropriate language and the avoidance of medical jargon when the doctor gives information to the patient is of paramount importance in doctor–patient communication. The way in which information is given influences patient satisfaction and compliance with the treatment.

We believe that with language tasks focusing on making connections between everyday and technical terms, we can raise students' awareness of the register required in a specific situation and prepare them for similar situations occurring in real-life contexts.

Every chapter of the course book incorporates a task on terminology of the given field: general and medical terms (conditions, diseases, and interventions) describing the same phenomenon, *e.g.,* urethra = pipe, polyuria = passing excessive amount of water, nephritis = inflammation of the kidney(s), lithotripsy = breaking up of kidney stones.

The manner in which a physician communicates information to a patient is as important as the information being communicated. Patients who understand their doctors are more likely to acknowledge health problems, understand their treatment options, modify their behaviour accordingly, and follow their medication schedules (Stewart, 1995). In fact, research has shown that effective doctor–patient communication can improve a patient's health as quantifiably as many drugs – perhaps providing a partial explanation for the powerful placebo effect seen in clinical trials (Ciechanowski *et al*., 2001; Bull *et al.,* 2002).

6.3 Abbreviations and Acronyms – Task 4

This part of the chapter introduces students to the most common abbreviations and acronyms used in a given medical field. *There is a universal tendency in medical writing (and also in verbal communication) to abridge the utterance when possible, by shortening or omitting words and to abbreviate (Dirckx 1983, 2006). Initialisms, i.e. acronyms and abbreviations are particularly common in clinical documents.* Initialisms are in some cases better known within the profession than their full name. *Initialisms are especially popular for describing names of diseases,* and of diagnostic and therapeutic procedures. Abbreviations can also be ambiguous, the idea that they stand for can vary according to various fields of medicine, *e.g.,* CAT usually stands for either *computer assisted tomography* or *computed axial tomography*, but it can also initialize *cognitive abilities test* or *chronic arsenic toxicity* depending on the medical field or the context.

They can be found mainly in the 'Laboratory results' section in the form of a list and the 'Medications

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section' of the report, but less frequently acronyms are also used when the diagnoses or the past medical history of the patient are described (Keresztes, 2013). Therefore, students should be familiar with the most frequently used acronyms in the field (Figure 1).

Figure 1. Some abbreviations and acronyms taken from the chapter on Urology. The description of the acronym in blue should be given by the students. *The Language of Effective Doctor–Patient Communication*, Chapter 2.

Task 4. Give the meaning of these acronyms and abbreviations used in the field of Urology.

AGN	(acute glomerular nephritis)
ARF	(acute renal failure)
BPH	(benign prostate hyperplasia)
C&S	(culture and sensitivity)
CRF	(chronic renal failure)
CSU	(catheter specimen urine)
DRE	(digital rectal examination)
TURP	(transurethral resection of the prostate)
UA	(urinalysis)
UTI	(urinary tract infection)

6.4 History Taking, Focusing on the Specific Features of the Given Clinical Specialty – Tasks 5 - 7

Students should acquire how to reveal the complex interplay between the patient's current health problem, any chronic health problems, the lifestyle and risk factors, the social and family situation, and how all these affect their health in the long-term. They should pick up verbal and non-verbal cues, and encourage the patient to tell their story. During the consultation, they should take brief notes, and meanwhile, they should deal sensitively with embarrassing or disturbing topics, as well as pain. It is also important to learn to expose only the relevant part of the patient ensuring as much privacy as possible. All these should be done properly from a professional aspect and using appropriate language. It might put an enormous burden on our students as English is not their first language, and during their medical studies in Szeged, history taking is mostly done in Hungarian or in mediated English (*i.e.*, their clinical tutor mediates the history taking between them and the patient).

From a medical point of view, doctors need information to establish the right diagnosis and treatment plan, whereas from the patient's point of view, two requirements have to be met: the requirement of knowing and understanding, and the requirement of feeling known and understood (Ong, 1995).

A doctor's communication and interpersonal skills encompass the ability to gather information in order to facilitate an accurate diagnosis, counsel appropriately, give therapeutic instructions, and establish a caring relationships with patients (Duffy *et al.*, 2004) (Figure 2).

Figure 2. A task for practicing history taking in Urology. *The Language of Effective Doctor–Patient Communication*, Chapter 2.

Task 5b. You work as a doctor at the Department of Urology. A male patient presents to you with hematuria. Make up the questions you would ask him. The subheadings below will guide you in taking the history of present illness.

blood:	
onset:	
number:	
duration:	
other symptoms:	
pain:	
infection:	
stream:	

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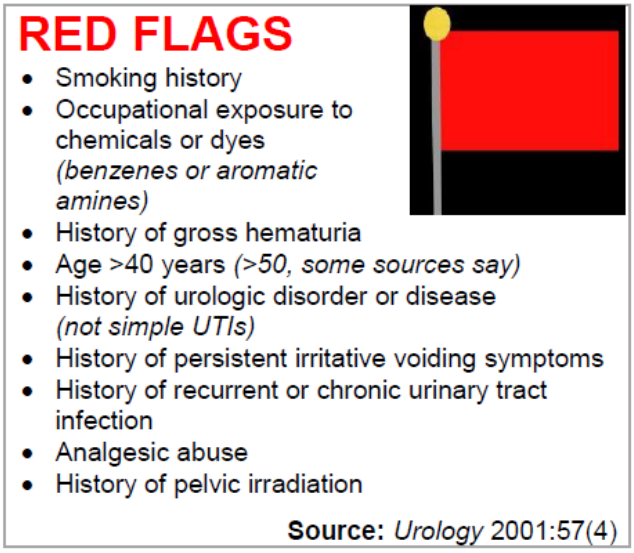

Figure 3. A task for watching history taking and practicing note taking in Urology. *The Language of Effective Doctor–Patient Communication*, Chapter 2.

Task 8. Video-watching. Based on the information in the film, fill in the Patient Notes

PATIENT NOTES		
SURNAME ***Buchanan***		FIRST NAMES ***Maureen***
AGE ***21***	SEX ***F***	MARITAL STATUS ***S***
OCCUPATION ***student***		
CC: ***frequent urination*** HPI ROS PMH FHx SHx		
O/E General Condition T: 100.4 °F GUS GIS CVS BP: ***100/70 mmHg P: 120 bpm*** RS CNS		
INVESTIGATIONS		
DIAGNOSIS		
MANAGEMENT		

6.5 Audio-visual Input and Role play – Tasks 8 & 9

The traditional method of teaching history-taking by instruction and demonstration suffers from the disadvantage that students are mostly passive learners and do not get involved in processing cues and asking supplementary questions. We have concluded that an interactive video system involves students in learning actively and can be used to transmit clinical skills. It can demonstrate knowledge, skill and judgement in patient-consultation including data gathering, data processing and communication. They should acquire how to use concise, clear and easily understood questions and instructions during the doctor–patient interview. They can also learn from the visual cues how to listen attentively, allow the patient to complete the history without being interrupted and while facilitating it non-verbally.

Before giving the students the challenging task of the role-play, we provide them with an audio-visual input, a sample doctor–patient interview from the clinical field they are dealing with. Preceding the role-play, they have to analyse and critique the video from several points of view, *e.g.,* the content aspects and the structure of the interview (commencement of the interview, problem processing, summary, and overall effectiveness), adequate language use, the doctor's behaviour, establishing rapport with the patient, and the communication strategies the doctor used, both verbal and non-verbal. The audio-visual sample interview gives the students a chance to revise what they have learnt on history taking, and more importantly, sets a useful example on how the medical interview is conducted in a Western clinical environment (Figure 3).

The role-play is widely used as an educational method to acquire knowledge, attitude and skills. Role-play is a form of simulation and acknowledges the importance of the social context of learning (Nestel and Tierney, 2007). At the culmination of our history-taking course we design tasks in which our students participate in small group activities practising history taking through role-play. We, the language teachers, act out the role of the simulated patient, and feedback (structured feedback) is provided by group members in discussions following the role-play. The aim of the role-play is to give students an opportunity to rehearse all functions (communicative and language)

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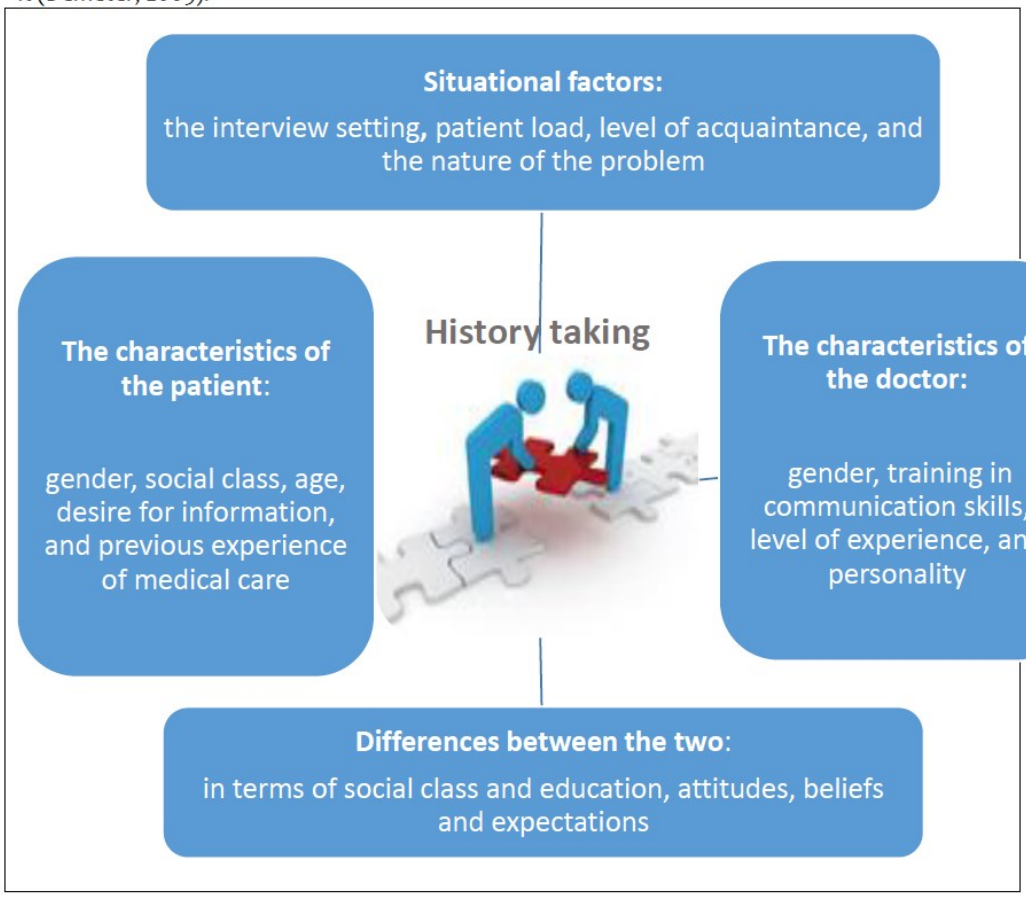
they have previously practised in more controlled contexts. The tasks aim to create, as far as possible, interactions that are authentic replicas of the clinical doctor–patient situations.

The role-play is regarded as an effective and creative means of teaching communication skills by medical students and communication experts, alike. Role-plays can be used beneficially if clear objectives about the roles and tasks are stated and these tasks are related to the broader contexts in which the students are learning. The use of structured feedback on the participants' performance is equally important.

7. Conclusions

Doctors with better communication and interpersonal skills are able to detect problems earlier, can prevent medical crises and expensive interventions, and provide better support to their patients. It may result in higher quality outcomes and better satisfaction on both sides, lower costs of care, better patient understanding of health issues as well as better adherence to the treatment process (Clack *et al.*, 2004) (Figure 4).

Figure 4. The complex task of conducting a medical interview with the various factors influencing it (Demeter, 2005).



Our students, who are non-native speakers of English, need to acquire complex communication skills during their university studies to be able to answer these requirements. Professions and institutions are not neutral culturally; thus, thus should also be considered when medical history taking is performed in various parts of the world. Adequate awareness of the differences and similarities could be used to educate future clinicians about the best approaches to patients from particular cultural backgrounds (Ohtaki *et al.*, 2003). Clinicians who are not prepared for cultural diversity may fail to take into account the impact of divergent beliefs, values and behaviour when patients present. An educational solution is to provide programs that encourage medical students to develop into intercultural speakers by promoting the acquisition of relevant competences (Lu and Corbett, 2012).

Effective doctor–patient communication has a central role in building a therapeutic doctor–patient relationship as "the heart and art" of medicine. Much patient dissatisfaction and many complaints are due to a breakdown in this relationship (Ha and Longnecker, 2010). *The Language of Effective Doctor–Patient Communication* course is expected to expand and bolster our students' knowledge to be able to better fulfil these complex tasks.

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