

## FROM A SIMULATED PATIENT INTERVIEW TO A CASE PRESENTATION

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**Abstract:** *Medical communication skills are learned during undergraduate studies and residency programmes by future doctors through case presentations, medical interviews, and healthcare staff interactions. Approaches like peer tutoring, simulation-based education, and blended learning enhance these skills. Our study aims to draw attention to the significance of doctor-patient and doctor-doctor scenarios by presenting a course that facilitates sociopragmatic, pragmalinguistic, and code-switching skills that medical students need to successfully employ in future healthcare settings. We consider patient information, case presenting, and interviewing skills, as well as profound knowledge of medical language equally important elements. While highlighting the essential components of the doctor-patient discourse and revealing the students' development of code-switching abilities, this article shares the results of a feedback survey completed by participants in a course entitled 'History taking with actors; simulation practices in the mediskillslab'. We can see the gradual improvement in using medical terms, and the growing confidence of students presenting cases. The programme's assessment approach, which provides constructive feedback from three perspectives—clinician, simulated patient, and communication instructor—helps the students pinpoint their areas for enhancement. Most students report no major difficulties in taking medical history by employing a simplified 'patient-friendly' language understandable to laypeople. However, when they intentionally choose a different code for reporting on their patients by using medical terms, younger students face challenges in creating a brief medical text. The most demanding task for senior participants proved to be delivering bad news; both emotionally and code-switch wise. Our study identifies these difficulties from history-taking simulations to case reports to raise awareness of levels of medical communication. As a conclusion, we believe that an early onset and gradual introduction of activities including history taking, case presentation, and breaking bad news should be incorporated into medical curricula to assist in the acquisition of highly professional, assertive, and empathetic communication skills by graduation.*

**Keywords:** simulation; medical communication; code-switching skills; bad news; case report

### 1. Introduction

Effective doctor-patient communication is a major component of clinical skills in building a therapeutic relationship (Ferreira-Padilla et al., 2015). Since the eighties of the previous century numerous publications (Brown, 2008; Novack et al., 1993;

Richards, 1990) have emphasized the necessity of clear, effective and sensitive communication with the patient, therefore communication courses have emerged in medical education. However, the barriers of communication and the ways to overcome them have been underexplored. Our study intends to highlight those components and skills that, gaining adequate attention and practice, could help students achieve the optimal level of communication skills.

Medical terminology is one of them, significantly contributing to communication problems between doctors and patients. It might be difficult for lay patients to interact with a clinician who utilizes medical jargon since patients do not refer to their body parts in medical terms, neither do they define functional issues, potential therapies, or discuss drugs in a scientific manner. Doctors have, at some point in their careers, however, also been patients of other specialists, with whom they were able to discuss their own symptoms in a less scientific manner, particularly when they worked in two different fields of medicine. Simmons (1998) claimed that doctors who can empathize with both patients and doctors had the ability to alter doctor-patient communication. Medical experts use a variety of layers of specialized vocabulary for their work, according to Duganová (2019), including technical vocabulary (Latin and English medical terms written in scientific papers), semi-technical vocabulary (used in doctor-to-doctor conversations), and non-technical vocabulary (lower level medical English used by doctors in doctor-patient communication with non-medically educated lay people).

Even if medical terminology shifts from Latin and Greek to a medical language containing English and international medical terms, patients will have trouble comprehending it unless code-switching is used. All across the world, premedical programmes and medical schools offer elective courses in terminology, allowing students to learn various levels of medical jargon. Similar to that, no mandatory case presentation classes are to be taken, therefore case presenting abilities also vary. Clinical staff frequently present cases, and professionals think it can take months or years to become proficient. To enhance students' abilities for medical conversational engagements, it therefore seemed appropriate to include medical terminology and case presenting activities in a simulation-based medical communication course. Speaking, as a productive language skill is especially useful for learning medical terminology, according to Dobrevá and Popov (2013).

## **1.1. Effective Communication Skills –Literature Review**

### **1.1.1. Code-switching**

Mishler (1984) used a particular method for conducting medical interviews. He used the idea of voices to describe how doctors and patients interact: the "voice of medicine" and the "voice of the life world." He thought that both may be used by patients and physicians. The voice of medicine is utilized by both patients and doctors during medical examinations, while the voice of the real world is employed to give the patient's medical situation a more personal touch. In his analysis of medical interviews, Mishler discovered that not all doctors switch to the speech of the living world in his analysis of medical interviews. We believe, he discusses a type of code switching incorporating thematic and structural features without specifically referring to voices as codes. When a person's lifestyle changes, attention is given to life situational issues and clinicians focus on the voice of the

outside world. The issue might then suggest the appropriate voice or code. The language used can also indicate the subject (technical medical or personal).

According to Simmons (1998), the ability to move between the patient's and the doctor's languages is available to the doctor but not to the lay patient. The doctor may code-switch between a highly medical language and a more common phrase depending on the conversational partners (other medical staff or the patient's relatives). Even though the healthcare professional is successful in switching between the two codes, the conversation could only take place in the patient's code if it followed the same structure as a typical conversation. On the doctor's prominent role in code-switching, Mishler and Simmons mainly concurred: doctors who are proficient in employing both the voice of medicine and the speech of the real world can code switch with assurance. The doctor can acknowledge the topic by entering that code of the life world, even if the patient brings up the subject. They discovered that group membership was a significant determinant of language choice when they looked for the reason why doctors do not utilize "patient talk." This group membership of doctors is enacted temporarily in positioning the self, related to others (Kim and Angouri, 2020).

Students practise code-switching techniques and learn medical language use through simulated scenarios. By simplifying medical jargon for the patient and their loved ones, they unavoidably activate or gain prior knowledge of medical terminology from their junior years of study. It is also crucial in case presentations where the student is required to provide a concise summary of the pertinent data in medical terminology.

### **1.1.2. Sociopragmatic and pragmalinguistic skills**

Code-switching carries placed meanings in encounters, according to Auer (1998). By characterising sociopragmatic and pragmalinguistic skills as necessary tools for the development of code-switching, his concept can be further developed. According to Holmes and Riddiford (2011), "Sociopragmatic skills relate to the cultural values and expectations underpinning and driving interactions in particular cultural contexts, including workplace contexts." Pragmalinguistic abilities, instead, are the speaker's comprehension and appropriate application of language resources to their goals (Dahm and Yates, 2013).

The majority of medical environments do not meet the necessary standards for understanding sociopragmatic workplace and cultural norms and implementing pragmalinguistic interpersonal communication principles. In a scenario, where immigrant healthcare workers in Canada failed to address mental health because it is viewed as taboo, Derwing and Waugh (2012) wrote about a sociopragmatic failure. The same situation might also be viewed as a pragmalinguistic failure since immigrant healthcare professionals gave off the sense that they can be very cruel or even obnoxious if they want to discuss mental health. The "pragmalinguistic features of specialized medical discourse should be viewed as embedded within the broader cultural context as well as in the specific (sociopragmatic) settings that exist for communication in everyday and workplace contexts within a particular culture," according to the study. The communicative values of a culture – i.e., the values to which interactants focus when they speak – will therefore reflect broadly held cultural attitudes, according to Derwing and Waugh (2012).

Using informal language is one approach to successfully employing pragmalinguistic skills, and to achieving effective doctor-patient communication. It

can reduce social distance and make it easier for medical professionals to establish rapport with patients through relatable language. In order to reduce misconceptions and perhaps increase patient compliance, doctors word their medical explanations in a way that patients can understand. Applying softening strategies may help to reduce the power/knowledge gap between the interactants, enabling patients to actively participate in medical communication and decision-making as more equal conversational partners. Informal, patient-friendly language reduces face-threatening behaviours, makes difficult, uncomfortable topics bearable, and allows clinicians to appear approachable while also building strong relationships with their patients (Dahm and Yates, 2013).

An Indian study examined patient's compliance and barriers to screening for diabetic retinopathy. Patients had a basic awareness of diabetes, but little knowledge about diabetic retinopathy and its implications. The absence of symptoms, doctor-patient communication issues, and the tediousness of follow-up treatment were some of the main barriers against obtaining therapy that patients described. Healthcare professionals noted that the inability to effectively explain diabetic retinopathy to patients who were less literate, intense work demands, and the disease's quiet progression were the main obstacles that patients seeking follow-up care came across (Kumar et al., 2020).

Tongue asserted (2005:655) that it is crucial for medical personnel to explain everything to patients in a simple, intelligible language and to refrain from using medical jargon. Even if the patient nodded after each statement made by the doctor, quick summaries, pausing, and asking questions may be the required language techniques to ensure that they are understood and that the patient followed along. The tone of voice is also crucial. Building rapport with the patient can be done in an honest, sympathetic, and timely manner. The best pragmalinguistic techniques could be to briefly state and explain what happened while pausing frequently to ensure understanding. In a doctor-doctor communication, technical vocabulary and medical jargon should be employed, but not in a doctor-patient encounter.

Wickers et al. (2015) concentrated on the code-switching co-construction procedures, where the participation framework is co-constructed by the participants, allowing input to be weighted. The beginning participant (the doctor) uses the patient-code to let the conversational partner (the patient) participate in the co-construction of the medical interview. The same principle applies to doctor-doctor interactions; the chosen code will specify the framework for participation, and the language used will influence how much of a contribution a resident doctor makes while reporting on a patient to a specialist. Code-switching here functions as qualification of a message (Almelhi,2020). In order to highlight the importance of appropriate language use, let us consider that professionals in all fields of science and technology must present their works in English in order to be understood and acknowledged. The reason is the fact that English is both the lingua franca and also an essential means of transmitting scientific knowledge. As a result, producing good medical case report discourse in English is a crucial requirement for the global distribution and advancement of medical knowledge (Lysanets et al, 2017).

## **1.2. Objective**

The main goal of the current report is to present a course that will give medical

students the sociopragmatic, pragmalinguistic, and code-switching abilities they need to succeed in future professional conversational scenarios in healthcare settings. These encounters call for highly developed skills in patient information gathering, case presenting, and interviewing, as well as a strong foundation in medical language. Our investigation intends to answer the following research questions: What role did previous case presentations and terminology courses, and regular code-switching tasks have in improving effective communication skills? What tools helped students the most in awareness raising to choose the right pragmalinguistic approach in doctor-patient, and doctor-doctor encounters?

## **2. Methods**

### **2.1. Site and participants**

Our current LSP study utilized a feedback survey method based on students' output from our course, "Taking Medical History with Actors: Simulation Practices in the MediSkillsLab," at the University of Pécs in Hungary, which was completed at the end of the term. Questions were grouped into six main fields: preliminary oral case presentation courses, the significance of simulation practices in activation or acquisition of terminology, improvement: self-evaluated, tools applied (written case report samples, clinicians' feedback, course instructor's comment on code-switching, good classmates), the role of diverse specialists, and innovative ideas. As this course is offered in the English programme, international students participate in it; in the spring semester 2019 thirteen students from Norway, Canada, Iran, India, Japan, Korea, America, and Holland, and in the online fall semester in 2020, fourteen international students from Norway, Iran, Korea, South-Africa and Canada attended the course. Medical students could play medical doctors' roles with actors serving as their simulated patients during the seminars, which used real medical cases gathered by the invited physicians as the foundation for simulation scenarios (10–14 per semester) (Eklicsné et al., 2016). Our programme helps students build sociopragmatic and pragmalinguistic skills in addition to professional and psychological skills. Students are observed by an invited clinician and the communication instructor as they take part in the role-plays. After the scenario is over, students receive feedback on how they performed, highlighting both their accomplishments and the areas in which they still need to improve. Students are helped to learn to employ code-switching deliberately and with confidence via three-dimensional assessment (actor-patient, clinician, and teacher) (Eklics et al., 2019). Prompt feedbacks have the advantage of supporting positive behavioural and language patterns of highlighting areas for future improvement. To get the greatest outcomes, the course combines many teaching strategies, including case-based, simulation-based, co-teaching, and feedback-based methods.

In addition to its primary goal of enhancing history-taking abilities, the course aims to raise awareness of code-switching in medical contacts (between doctor-patient and doctor-doctor conversations). We provide students with films and written materials on taking a history at the very beginning of the course, and additional sample scenarios starring actors and physicians are presented to highlight the course's requirements: taking a history and reporting on medical situations to colleagues. It is then openly stated that we do distinguish between two language

codes: one that concentrates on the patient and the other that is packed with medical jargon and provides the means of communication among medical experts. In this way, two unique text styles are introduced.

## **2.2. Activities**

There are three major activities in the course that also served as research tools; history taking, case presentation and delivering bad news.

During *history taking* students elicit information about the specific diseases, diagnostic techniques, surgical interventions that the patient underwent (for example: When was your diabetes diagnosed? Have you ever been in hospital? Do you have a major health condition?). *Delivering bad news* can mean informing patients about the severe conditions that were diagnosed (like I'm afraid your youngster has an illness known as tonsillitis, an inflammation of the tonsils, or Unfortunately, your CT scan showed something suspicious in your lung). The doctor-patient interactions involve the simplicity and elucidation of medical knowledge. There may be a small number of medical words in those works, but they are always defined in common English. After history taking the student is asked to meet the clinician and role-play *reporting* on the patient based on the questions about prior illnesses, medications, social environment (marital status, employment, living conditions), risk factors (alcohol, smoking, drug use, stress), and family history (diseases that run in the family, cause of death of the parents). Case report is introduced gradually, from sample case presentations by a clinician, through written case reports, followed by their own first case presentation (feedback from a clinician, communication and terminology instructor), then mastering it for weeks. The language code will then be entirely different: a summary of the patient's medically pertinent facts using Latin and Greek medical words. (E.g.: a 57-year-old female patient was admitted to the clinic with gastralgia, confined to the peri-umbilical area, with intensity 9 /10. 2 days prior to admission, intense exercise had triggered the pain.) Although lay patients are likely unable to understand this code, clinicians will have no trouble understanding it. We stress the significance of deliberate code-switching when choosing who to talk to during medical contacts.

Our course is an elective one, so students can sign up for it in most of their academic years. However, we advise starting it in year three as that is when they begin their clinical practice and our standards will be in line with what is expected in the practical Internal Medicine classes (seeing real patients at the clinic, obtaining their history, and reporting on the cases). As a result, history collection and reporting, two therapeutic skills connected to communication, can be practised, verified, and internalized.

Each semester, students in their third, fourth, and fifth years enrol in the course, giving junior and senior students the opportunity to practise peer-learning and peer-tutoring. What a third-year student would find challenging will be simple for a fifth-year student. According to our theory, patients' interviews require more practice for students than reports to clinicians.

One of the standards is for each person to deliver bad news to a patient in 10-15 minutes. Before the midterm, students are required to select a condition that is fatal (such as a terminal malignant tumour) or one that has a profound impact on the patient's life (such as infertility or Multiple Sclerosis) and get ready for a simulated scenario with an actor. They should read up on these illnesses' warning signs and

symptoms, diagnostic imaging methods, available treatments, and prognosis. Senior students have the advantage of making decisions based on a strong medical foundation following pathophysiological studies, but junior students must look further for the medically correct information. Timing is carefully planned. Early in the semester, the six-step SPIKES model (Baile et al. 2000) and other protocols of breaking bad news are discussed (Jalali et al.,2023; Kumar V. and Sharkhel S.,2023), and we also suggest watching and analysing movies (like Wit) for positive and negative instances.

The patient is prepared by the student for the role before the scenario begins, the latter will be playing the part of a doctor or specialist in the scene ("You visited me with symptoms of headache, blurry vision, and dizziness, and we carried out several examinations, and now I received the results of CT and MRI"). When the student applies the SPIKES protocol and has developed empathy, raised awareness, and self-assured code-breaking abilities, the true scene unfolds.

### **2.3. Formative assessment of the participants**

In the autumn semester of 2020 we had online classes because of the Covid 19 pandemics, making the already difficult duty of breaking bad news to laypeople considerably more difficult because students could only see their patients from chest above on the computer screen. The simulated conversation has altered in accordance with this, placing more emphasis on verbal abilities, paraverbal communication (such as tone, intonation, and pause), and facial, nonverbal communication. We urged students to pay closer attention to controlling their own brow furrowing and intonation during the feedback session. Many gifted fifth-year students had trouble with the clarifying procedures; there were several instances of embedded code-switching. They were eager to provide the patient with the essential information, using language that was appropriate for a clinical setting.

#### **2.3.1. Constructive feedback on code-switching**

The students were given ideas for additional code-switching examples, after the scenario, during the feedback session, as it was mentioned above. When medical term-loaded definitions were not understood, based on the patient's response, we suggested paraphrase. Student: "You developed amyotrophic lateral sclerosis, or ALS, which is a disease of the nerve cells in the brain, brain stem, and spinal cord that control voluntary muscle movement." The actor-patient, the invited clinician, and the communication instructor recommended that this definition be interpreted as follows: "You have a severe neurological disorder that will paralyze you because it affects your muscles." Third-year students found it more challenging to report about the patient in a clinically acceptable, condensed, and medically relevant fashion, whereas fifth-year students saw providing information to patients as a stressful job. According to the patient, "I feel as if someone would sit on my chest, and my heart beats way faster than usual." the accurate summary would be: The patient experienced tachycardia and a sharp pressing chest pain. Redundancy occurs in the first half of the semester, like: 'When I asked the patient, he stated that he was experiencing pressing chest pain and an unusually quick heartbeat'. The necessary code-switch for a case report can only be executed by the student after a few weeks (The patient reported chest pain and tachycardia).

### **2.3.2. Constructive feedback of sociopragmatic and pragmalinguistic skills**

We emphasize that the terms used to describe the patient's condition should be patient-friendly, simplified if necessary, and at the very least, the organ or system impacted should be clear. The symptoms may next be described in further detail, but, this time, by using common language. Shaking would therefore sound better than tremor, and ataxia should be defined as a lack of muscle control or coordination. The first-year medical terminology studies are to be activated here. As a result, we advise the students to focus on the patient and take note of the symptoms. Nonverbal cues like raised shoulders, raised eyebrows, and frowning alert students regarding the need for clarification after a miscommunication. The learner is also better able to complete cooperative face-work or face damage repair with conscious and assured code-switch. The nonverbal cues listed above could indicate that a face-threatening act was committed, necessitating rapid repair in order to preserve positive doctor-patient relationship (for a discussion of face-work tactics see Merkin, 2006). Missing this chance to learn from the patient's nonverbal cues could result in misinformation, a lack of comprehension, a breakdown in rapport, and uncertain results for the condition.

The course is structured as stated above; up to the midterm, the emphasis is on case studies and taking histories, and the second half of the seminar includes breaking bad news.

Therefore, in order to prevent actual harm, we must enhance awareness about the selection of the appropriate code during medical training and possibly with an actor patient.

Students, who participated in the feedback survey, commented on previous case presentation courses, the value of simulated medical interviews in triggering terminology, their own growth, the use of a variety of tools (written case report samples, videos, clinicians' feedback, the course instructor's comment on code-switching, good classmates), their difficulties with code-switching, as well as the necessity of involving various specialists in the programme.

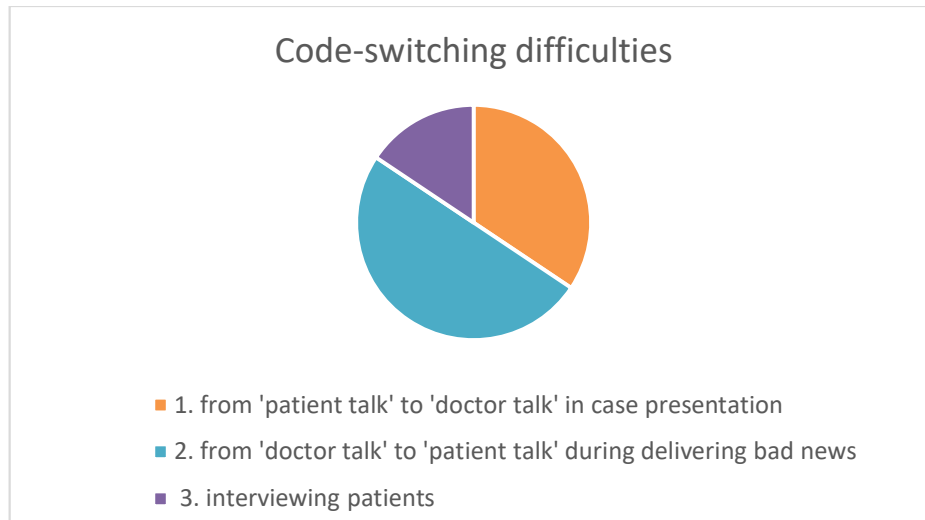
### **3. Results**

Only four out of the 27 students who answered the questions about oral case presentation studies (14% of the total) had taken introductory case presentation courses, meaning that the majority had little to no knowledge of the structural and linguistic components of oral case reports. All participants in the simulation-based history-taking course found this was a great way to practise and deepen their understanding of medical terminology. 22 students claimed they had made significant progress, becoming more self-assured and aware. Those who did not agree attributed their lack of practice opportunities to the course's online style.

Each participant underlined how the clinicians' genuine input on the case presentations and their support helped them get ready for the clinical work they could expect in the future. Students had a choice of more than one response when evaluating the instruments that had been used. Significantly more students than those who voted for using written samples alone (6) or learning from their peers (7) thought that the course instructor's advice on code-switching (17) and the clinicians' advice on proper reporting (18) could effectively develop case presentation skills.

Figure 1 below illustrates the code-switching challenges.





**Figure 1: Code-switching challenges**

When giving bad news, switching from a technical code to a non-technical one was more difficult for half of the participants. The majority were fifth-year students with strong clinical and medical backgrounds (having spent two years in clinical settings with frequent reporting responsibilities), who struggled to transition from their active medical jargon to an accessible language. Only five of the participants, mostly third-year students, said that interviewing a patient is challenging. Eleven participants, mostly third-year students, found case presentation to a medical professional quite demanding immediately after taking the patient's history.

Although the table 1 above shows code-switching difficulties, an important result is related to the socio-pragmatic and pragmalinguistic skills there. Students, who found it challenging to break bad news to patients, not only complained on failing to find a patient-friendly vocabulary, but the right tone, personal space, understanding the cues of the patient's non-verbal communication and situation-specific behaviours too. They could not use pause and silence effectively, sometimes rushed through the information part without considering the emotional needs of the patient.

One of the critical viewpoints mentioned the lack of time to adequately prepare for the situations as well as technical concerns with the online semester, such as wifi problems, hazy screens, and jumbled speech. It presents a challenge for us because, based on prior feedback from 2018, we intentionally focused on giving clear and precise information and instructions prior to the scenes, even though it is true that students had a little more time to discuss the history taking structures and to plan group work accordingly in on-site than in online classes.

#### **4. Conclusion**

Our study has showed that learning technical terms did not ensure effective doctor-

patient communication. The option for the students to study medical history with careful use of medical language was made possible by the deliberate selection of the appropriate pragmalinguistic norms in the cultural environment.

We conclude that simulation exercises – history taking, delivering bad news, and case presentations – can raise awareness of code-switching and generally improve medical communication skills, however, we are aware that delivering bad news to a patient requires more than just code-switching prowess; it also requires taking the effort and time to talk and listen to the patient empathetically. Thus, it can never be practised enough. The results allow us to revise and update the course design and make sure that participants frequently participate in mini-scenarios where emotionally and professionally difficult information should be given to patients (e.g., precautions before interventions, no visiting due to virus). In a similar vein, we should aim to minimize time- and technical-related issues with future online work.

We must emphasize the small number of participants as one of the survey report's limitations. In the following years, more thorough feedback questionnaires and ongoing research could help produce a more representative study. We intend to introduce history-taking, case-presentation activities, and breaking bad news to patients more gradually. These activities will include small verbal interaction tasks that may encourage conscious code-switching when breaking bad news, in addition to written case report samples and some real-world oral case presentations by clinicians.

Additionally, the current multicultural medical environment compels us to frequently discuss taboo subjects (such as religious and sexual issues) as well as intercultural situations (such as language-challenged immigrant patients, immigrant doctors of colour, gender-biased medical staff, uncertain power relations among medical experts, and low-income vs. high-income patients). Courses like ours in medical school English programmes, particularly in a non-native environment, should clarify the reference points so as to enable students to thoroughly understand the context (often facing extreme beliefs in stereotypes even in professional settings), and only then can they effectively improve sociopragmatic skills.

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