USING CLINICAL SCENARIO-BASED TASKS TO DEVELOP MEDICAL STUDENTS' PROFESSIONAL COMMUNICATION SKILLS IN ENGLISH

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Abstract

Professional communication in medical English requires learners to obtain information, explain unfamiliar concepts and respond appropriately to patients and colleagues. This conceptual article examines how clinical scenario-based tasks can connect language instruction with these professional purposes. A focused narrative analysis of task-based language teaching, medical role-play, simulation and patient understanding informs an original classroom framework. The framework combines preparation, an information-gap encounter, structured feedback and repeated performance. Practical examples address history taking, explanation of a planned examination and transfer of patient information. An analytic rubric separates comprehensibility, interaction, professional register and task completion. The analysis suggests that realistic tasks are most educationally useful when communication goals are explicit and clinical complexity matches learners' knowledge. The article offers a teaching proposal rather than evidence of measured learning gains. Future classroom research should examine transfer to unfamiliar cases and the reliability of performance assessment.

Keywords: medical English; English for specific purposes; clinical scenarios; professional communication; role-play; task-based learning; formative assessment.

Introduction

A medical student may recognize the English term “dyspnoea” yet struggle to ask a worried patient when breathing became difficult. This difference illustrates a central teaching problem: knowledge of terminology does not automatically provide the ability to conduct an interview. In professional encounters, speakers must select suitable words, organize questions, interpret incomplete answers and check that the other person has understood. Medical English courses therefore need opportunities to practise purposeful interaction alongside vocabulary and reading.

Clinical scenarios can provide such opportunities. A scenario-based task presents a plausible situation, assigns complementary roles and requires a communicative outcome. For example, a student interviewing a simulated patient must produce an accurate symptom summary from information that is initially unavailable. The task creates a reason to listen and ask follow-up questions. A rehearsed dialogue may support initial preparation, but subsequent performance should require learners to respond to information rather than reproduce a fixed script.

Task-based language teaching offers a foundation for connecting classroom language with meaningful outcomes [1]. Medical communication education supplies additional attention to role expectations and patient experience. Nestel and Tierney identify preparation, realistic activities and constructive discussion as important considerations in medical role-play [2]. The present article brings these perspectives together to answer a practical question: how can an English teacher design manageable clinical tasks that elicit professional communication and produce useful evidence for feedback?

Materials and methods

The article uses a focused narrative review and pedagogical design approach. Sources were purposively selected for their relevance to language tasks, medical role-play, simulation design and checking patient understanding. Bibliographic details were checked against publisher or scholarly records. The source set includes one foundational language-teaching monograph and four healthcare education or communication publications [1–5]. It is neither an exhaustive search nor a systematic review, and no pooled effect estimate is calculated.

The analysis considered four design questions: what information learners need to exchange; which professional language functions the encounter requires; what support learners need before speaking; and how performance can be observed. Concepts from the selected literature were translated into a proposed instructional cycle. The classroom timings, sample scenarios and scoring rubric below are original design proposals. No students were recruited, no interviews were recorded and no experimental outcomes are reported.

Theoretical foundations

The principal contribution of task-based teaching is the relationship between language use and a nonlinguistic outcome [1]. In medical English, this outcome might be an agreed account of a symptom, a comprehensible explanation or a concise handover. Grammar remains relevant because tense, negation and modality influence meaning. However, the teacher can address these forms in relation to a specific communicative difficulty, such as an unclear distinction between a past symptom and a continuing one.

Medical role-play research provides a rationale for giving learners clear roles and opportunities to reflect on performance [2]. Its relevance to English instruction is pedagogical rather than proof of second-language effectiveness. A role card should therefore indicate the person’s information and concerns while leaving the wording open. Students acting as patients also need guidance: an exaggerated performance

or an unexpected specialist diagnosis can undermine the intended language objective.

Simulation literature emphasizes feedback, repeated practice and integration within the curriculum [3]. Lateef also describes simulation as a technique that can support guided experiential learning [4]. These ideas support the proposed use of low-cost encounters with written role cards. They do not establish that a classroom role-play produces the same outcomes as high-fidelity clinical simulation. The transferable design principle is that learners need a coherent cycle of performance and revision rather than an isolated activity.

Patient understanding introduces a further requirement. Schillinger and colleagues studied communication that checks comprehension in encounters involving patients with diabetes and low health literacy [5]. For an English classroom, this supports practising explicit comprehension checks while avoiding claims that a language task itself improves clinical outcomes. Learners can practise asking a simulated patient to explain instructions in their own words and then reformulate any unclear information.

Results of the pedagogical analysis

The analysis yields a four-stage instructional framework. Its intended learners are medical students with approximately intermediate English and sufficient background to understand the selected case. The same framework can be simplified for earlier learners by reducing the number of symptoms, providing visual prompts and allowing more preparation. Learning objectives should describe observable acts, such as asking an open question, clarifying a time reference or summarizing the patient’s concern.

Preparation and task design

In preparation, the teacher identifies a single professional situation and a small set of language functions. A history-taking lesson might focus on opening an encounter, establishing symptom duration and confirming the main concern. A short model

exchange can demonstrate these functions. Learners then practise useful expressions without memorizing an entire conversation. The teacher checks that all students understand the role cards and the required final product.

An information gap makes the subsequent encounter purposeful. The interviewer receives the consultation objective, while the patient receives the symptom details, relevant background and one concern. Neither student sees the other card. The patient should provide information naturally when asked rather than recite the card. The interviewer records a brief summary after the encounter. This arrangement allows the teacher to check whether successful interaction produced an accurate shared account.

Interaction and supported repetition

During the first performance, the teacher observes without correcting every error. Immediate interruption is reserved for a misunderstanding that prevents the task from continuing. Notes distinguish language problems from interaction problems: an unclear verb tense requires a different response from repeated interruption of the patient. Students should know that appropriate clarification is an indicator of professional communication, not an admission of failure.

Feedback follows the communicative sequence of the encounter. The simulated patient first identifies something that helped or hindered understanding. An observer then cites one specific example from the checklist. The teacher selects a limited number of priorities, demonstrates a more effective expression and invites a second attempt. In repetition, students exchange roles or receive a related case with altered details. This reduces dependence on memorized wording and creates an opportunity to apply feedback.

A proposed lesson sequence

A 60-minute lesson can allocate 10 minutes to the model and vocabulary, 5 minutes to role preparation, 8 minutes to the first encounter and written summary, 10 minutes to feedback, 8 minutes to a second encounter, and 9 minutes to comparison and

reflection. The remaining 10 minutes can support delayed language correction and an exit task. This allocation is illustrative and should be adapted to class size and proficiency.

For larger classes, groups of three can rotate the roles of interviewer, patient and observer. The observer tracks a short list of behaviours rather than attempting to transcribe the conversation. Role rotation should be planned across successive tasks so that every learner practises speaking and listening. A brief written output gives quieter learners another way to demonstrate what they understood and helps teachers detect inaccurate information transfer.

Illustrative clinical scenarios

History-taking task. A fictional adult patient reports several days of headache and is concerned about its effect on study. The interviewer must establish onset, duration, location and the patient's main concern, then produce a four-sentence summary. Useful prompts include "Could you describe the discomfort?" and "Let me check that I have understood." The task assesses information gathering and clarification; it does not require students to diagnose the condition or recommend treatment.

Explanation task. The learner explains the sequence of a routine examination using a clinician-approved description. The simulated patient asks about an unfamiliar expression and requests clarification. The communicative outcome is a plain-language account that the patient can restate. The observer notes whether the speaker signposts the sequence, invites questions and responds to uncertainty. Any clinical content should match the curriculum and be reviewed by a medical educator before use.

Handover task. One learner receives a short fictional record and transfers its essential information to a colleague. The recipient must identify the current concern and ask about one deliberately omitted detail. The pair then creates a concise agreed summary. Unlike the patient-facing tasks, this encounter permits appropriate professional terminology, giving learners practice in selecting register for a different

audience. Task difficulty can increase through additional information or reduced preparation time.

Assessment of professional communication

Assessment should show what the learner can accomplish in an encounter. The proposed rubric has four dimensions, each scored from 0 to 3: comprehensibility, interaction management, professional register and task completion. For each dimension, 0 indicates that the target behaviour is absent or communication breaks down; 1 indicates frequent support; 2 indicates generally successful performance with occasional support; and 3 indicates independent, consistent performance. The total ranges from 0 to 12 and is a proposed classroom score, not a validated clinical competence measure.

Comprehensibility concerns whether the message can be understood without repeated repair. Interaction management concerns listening, relevant follow-up questions and confirmation. Professional register concerns respectful phrasing and vocabulary appropriate to the recipient. Task completion concerns whether the requested summary or explanation contains the essential information. A learner can therefore receive credit for effective clarification despite minor grammatical errors. Conversely, fluent speech should not compensate for omitted information that defeats the task’s purpose.

Teachers should agree on examples before using the rubric for consequential grading. Two assessors can independently score a small set of practice performances and discuss disagreements. Clinical correctness should be checked separately by a suitably qualified educator when a task involves substantive clinical decisions. A language score alone cannot establish readiness for unsupervised patient care. Learner confidence questionnaires may supplement assessment, but observed performance should remain the main evidence of communication development.

Discussion

The framework offers a practical bridge between terminology learning and situated communication. Its distinctive feature is alignment: the role cards, final product, observation checklist and feedback all address the same communicative objective. Teachers can use this alignment to avoid an activity that is engaging but difficult to evaluate. For example, a lesson targeting clarification must contain an ambiguity that actually requires a follow-up question; a fully scripted dialogue cannot supply equivalent evidence.

Implementation nevertheless requires careful control of difficulty. Learners may struggle because they lack English resources, clinical knowledge or familiarity with the task format. These causes should be separated before interpreting weak performance. A teacher can reduce linguistic demand through a phrase bank, reduce medical demand through a simpler case, or model the task procedure. Support can then be gradually withdrawn. This progression is a proposed instructional strategy rather than a finding from a tested intervention.

The evidence base has limits. The selected literature spans different learner populations and educational aims, and the foundational sources do not directly evaluate this exact framework in a medical English course. The narrative selection may omit relevant studies. Furthermore, improvement during repeated classroom tasks would not by itself demonstrate transfer to real clinical encounters. These limits require restrained conclusions and a local evaluation before wider adoption.

A future study could compare scenario-based instruction with usual teaching over a defined course period. Both groups should complete comparable but unfamiliar speaking tasks before and after instruction, with blinded assessors where feasible. A delayed assessment would examine retention. Analysis should account for baseline proficiency, attendance and assessor agreement. Reporting task materials and scoring criteria would make the study easier to reproduce and help distinguish improved familiarity from transferable communication ability.

Conclusion

Clinical scenario-based tasks provide a coherent way to organize medical English around purposeful professional interaction. The proposed cycle combines clear outcomes, complementary role information, focused feedback and another opportunity to perform. Appropriate assessment considers both understandable language and completion of the communicative task. The framework can guide classroom design, while its effectiveness remains a question for empirical evaluation using unfamiliar cases and reliable performance measures.

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