A framework for designing and evaluating ESP materials for English and communication skills in the doctor-patient interview

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Abstract

Effective medical consultations make an important contribution to positive outcomes for patients. For the large number of international doctors working in English speaking countries, deficits in language and communication skills can be a barrier to this effectiveness. This reflective report evaluates the effectiveness of *Good Practice* (McCullagh and Wright, 2008), a course book and related components, in addressing those deficits. The book filled a gap in the English for Medical Purposes literature, by providing learning materials with a clear focus on communicating in the doctor patient interview. Existing tools for evaluation were limited in their ability to show in detail the types of contribution which these learning materials can make to improving doctors' skills and knowledge.

An evaluative framework to fill this gap was developed, using principles from the literature of materials development and from English for Specific Purposes. By making explicit links between needs analysis as an ESP methodology and the development of principled materials, this framework has filled a gap in the availability of tools for evaluating ESP materials, and made a contribution to the under-researched area of ESP materials development more generally.

In evaluating *Good Practice*, the framework highlighted areas where the materials made a strong contribution to meeting the needs of learners, as well as areas where more support was needed. This demonstrated its usefulness for those developing ESP materials, and for teachers adapting and supplementing existing ESP materials. The report describes the compromises that were made in the writing of the materials and discusses the constraints of writing materials for a coursebook. The report also shows how my published contribution to the literature of materials development underpins the work carried out in this report. Finally, it also sets out opportunities for further refinement of the evaluative framework and for further research and development of its potential.
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Declaration

Whilst registered as a candidate for the Award of Doctor of Philosophy by Publication, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award.

I confirm that I was responsible for 50% of the jointly authored work, as detailed in Appendix 2.

Marie McCullagh
28/04/2015
1.0 Introduction

This reflective report evaluates the effectiveness of *Good Practice* (McCullagh and Wright, 2008), a course book and related components designed to develop the language and communication skills of international doctors for the patient interview. To do so, I have developed an evaluative framework which draws on the literature of ESP and materials development. This fills a gap in materials evaluation since no evaluative framework which links both literatures exists. In developing this framework, I hope to show the ways in which *Good Practice* meets the needs of international doctors and how the framework can be applied to other areas of ESP.

Background to *Good Practice*

As outlined in McCullagh (2011), the foundations for what became *Good Practice* were laid in my MA Materials Development dissertation, which was completed in 2004. It contained many of the innovative features which would feature in *Good Practice*. These included: an early version of the communication jigsaw (pragmatic awareness, cultural awareness, non-verbal communication, active listening and language); an introduction to communication skills, quotations from experts on medical communication, readings taken from doctors' own experiences of communicating with patients and observation tasks to be carried outside the classroom the 'out and about activities'. It also included features which did not make it into *Good Practice* such as: short case studies highlighting aspects of medical communication where difficulties could arise; a detailed focus on different questions types and other aspects of communication skills such as barriers to listening, readings from classical literature which had implications for medical communication (e.g. The Seven Floors by Dino Buzzati); readings which linked broader social issues and medicine (e.g. an article called Crime and Nourishment which discussed links between poor nutrition and crime) and readings from agony aunt columns to expose learners to everyday language used by patients. The range of activities included in the materials was broader than those which featured in *Good Practice*. These included case study discussion in which learners were encouraged to put themselves in the patient’s position, activities which encouraged reflection, for example, through the use of journal entries and activities which focused on intonation.
In 2006, Ros Wright and I wrote a proposal for Cambridge University Press (CUP). Initially it outlined the need for a medical English coursebook which focused on communication skills to help International Medical Graduates pass the language and communication components of the Professional and Linguistics Assessment Board (the UK professional entrance exam). However, as success in the PLAB was measured primarily in terms of making a correct diagnosis, with a reasonable level of linguistic accuracy, the proposal was extended to include a broader range of communication skills which would prepare doctors for working in an English speaking environment. While there were already English for Medical Purposes (EMP) materials which covered the consultation (e.g. Glendinning and Holmström, 2005), they had a lexico-grammatical focus and we felt that there was a gap for materials which would develop a broader range of language and communication skills to reflect the complex nature of the patient interview.

The proposal had two components: a sample unit; and a description of and rationale for the materials. The sample unit drew partly on materials I had developed as part of my MA dissertation. The rationale drew substantially on my MA dissertation, and made the case for a focus on communication, the language used by patients, the use of references from the medical communication literature, a wider range of activities and the need for a video component. We believed that the course should feature a high proportion of authentic material so that learners would be exposed to language used by patients and doctors during the interview, and different cultural issues arising from their interactions. To this end, we planned to include authentic video recordings of doctor patient interviews (in line with the documentary footage I had used when teaching doctors). The description of the materials followed general guidance from CUP in terms of the number and length of units. It envisaged that the materials could be used for self-study or for teaching and would include a student’s book, teacher’s book, audio component and video component, sold together as a complete package.

The proposal was reviewed internally by CUP. In addition, it was also reviewed by six external reviewers, two from the UK, two from the US, one from France and one from Poland. Five of the reviewers were very experienced teachers of medical English and one reviewer was a doctor, who had published widely on communication skills in medicine. In general, all the reviewers were very positive about the materials and felt that the book would make a welcome contribution for teachers and learners. They all agreed that the focus on communication was essential and that the proposed materials were very sound from a medical perspective. Following an initial review process, our proposal was accepted.
by Cambridge University Press without any substantial revisions. A writing schedule was agreed, with an agreed deadline for the delivery of the overall project. As part of this, deadlines were established for the delivery of units, but details of the specific units were left to the authors to decide.

**The writing and review process**

The writing responsibilities were shared between both of us equally (see Appendix 2 for a breakdown). Initially, we planned to write the units jointly in sequence, but this proved impractical because it was too time consuming. We then tried to write the units separately in sequence, but this was also time consuming as it involved a lot of liaison and discussion around changes between what content was planned, and what was actually written. We then divided the book into larger chunks around the core stages of the patient interview and specific contexts such as working with different patient profiles and breaking bad news. This meant that each writer could write a number of integrated chapters, without the need to consider how this would impact on the other writer. Ros focused, for the most part, on the core stages of the patient interview and I mainly on specific contexts in the patient interview. However, we still peer reviewed units on to ensure consistency and continuity.

Each unit when submitted was reviewed by CUP internal reviewers, and also by the six external reviewers. Reviewers were asked to provide their feedback under the following headings provided by CUP: contents, topic, skills, tone, level and organisation and accessibility. The areas which came up most often were: the need for more focus on language, with more vocabulary development and especially informal language used by patients, greater use of roleplays and clearer use of headings. Points raised from specific reviewers included the inclusion of more American equivalents of terminology and a list of abbreviation of medical terms by the reviewer from Poland. In general, there was broad agreement among the reviews, though they differed on two key areas. The first of these was the introductory unit on communication skills. One reviewer felt that learners needed to get to the patient interview immediately, while the other reviewers regarded it as very useful lead-in to the importance of communication. Because the majority were in favour, it was kept. Reviewers were also split on the progress check. One of the units included a progress check at the end of the unit where learners were instructed to rate their progress on the different functions covered. Two reviewers liked this activity because they felt that it provided learners with the opportunity to evaluate their own progress. Although another
reviewer commented that the activity was not helpful, it was retained and became a feature of every unit to provide consistency. The reviewers' comments also strengthened our argument for the need to include a video component, though from the publisher's perspective this would increase production costs significantly. I was in agreement with the outcomes of most of the review process. The main area I disagreed with was the progress check, as I felt that in its current form, it served as a tick box exercise, since learners did not have sufficient input on how to self-evaluate.

**From vision to reality**

Comments from the external reviewers together with those of the editor shaped the direction of the materials. The stage in the consultation we had chosen for our sample unit was, on reflection, not the best choice to give the full flavour of the approach we wanted to use. The stage was examining the patient, which by its nature was the most doctor directed stage of the consultation. As such, while there was some focus on pragmatics (eg using softening devices when giving instructions), there was less emphasis on the interaction between doctor and patient, and more on the language which the doctor needed to provide instructions to the patient. Because of this focus, the unit had a disproportionate number of language focused activities with closed answers. As subsequent units were written which had more emphasis on doctor patient interaction, the suggestions for improvement made by CUP were for the inclusion of more of the activity types in the sample unit. I raised this issue at an early stage, as I was concerned that the more innovative features related to communication would be pushed out. CUP acknowledged the importance of the communication focus, but stressed the need for the book to follow the pattern of other successful EFL/ESP coursebooks, such as the various editions of the *Headway* series (eg Soars. & Soars, 1990) and the *Market Leader Business English* series (eg Cotton, Falvey & Kent, 2000).

In retrospect, this emphasis is understandable. As a commercial product, the materials needed to be presented in a recognisable format with activities that learners and teachers would be familiar with. The advantages of the course book format from CUP's perspective, were that the book could potentially appeal to a much wider market than we had in mind in our initial proposal. This market of more traditional users of course books would include undergraduate medical students, doctors with lower levels of English. It could also appeal to those in other health related professions who want to develop their consultation skills,
such as dentists, pharmacists, nurses and midwives. The limitations of course book format meant the materials also needed to include answer keys for teachers and for self-study, so this required questions which had clear closed-type answers. In addition, there were significant space constraints in the student's book, which meant that texts for the purpose of extensive reading could not be included. Additionally, the activities we developed for the DVD also had to go in the teacher's book. Our original concept, where the CD, DVD and student's book to have been sold as one package, would have given learners access to a greater range of content, but commercial reasoning divided these into separate items.

Compromises made

There were compromises in terms of the focus on communication, which made the book innovative for example, the inclusion of a DVD, snippets of advice from the medical communication literature, personal accounts of doctor patient communication and use of the Calgary Cambridge Guide. However to some extent, these features were shaped so that they fitted into the course book model. For example, space constraints required the DVD activities to go in the teacher's book, gap fill exercises were used to introduce learners to the Calgary Cambridge Guide (rather than for example, noticing type activities). The references to the medical literature were almost an aside, rather than signposting learners to the broader areas of knowledge they would need to acquire, which was the intention of the original course book. Only one text about the personal experiences of a doctor was included in the student's book (Unit 9, A time to Listen). While this was a very powerful text, the nature of the comprehension questions reduced its impact. Other similar texts had to be put in the teacher's book. I also would have liked to include extended pieces of literature, which I used in my MA materials, to achieve a better balance between the transactional and relational aspects of the patient interview. However, space and the open-ended interpretations of literature would not allow this.

Another factor was that once the writing commenced, and CUP began providing feedback on changes they wanted in the materials, the deadlines meant there was very little time to discuss the effect of specific changes on the overall shape of the book. This meant that most of the suggested changes were incorporated with very little discussion. As new writers, Ros and I felt pressure to meet the writing deadlines, rather than debating the overall shape of the book.
Reflections on the process

The section above has been written with the benefit of hindsight, and considerable reflection on how *Good Practice* evolved. I have also reflected on what lessons can be learnt from the process which are relevant to publishers and materials developers. These lessons relate to the course book, and it seems the core functions which it fulfils (providing a structure for classes to follow, providing controlled activities with answers and providing activities for self-study) will continue to be a central part of learning for many students, for many years to come. In the near future, developments in technology make it likely that there will be significant changes in the way the course book is presented to learners. Text can become more interactive, and content such as audio and video can be included more easily and presented in a much more seamless way. There is considerable potential to use this richness in content in innovative ways. However, to do this effectively, materials developers and publishers need to differentiate between innovation which is driven by a desire to show off the technology, and that which is aimed at enhancing the learner experience. This involves both publishers and materials writers developing a structured approach to analysing content and activities. Both publishing and medical education have had a reputation for relying heavily on precedent in their approaches to their work. In recent decades medical education has gone a long way in challenging precedent, and has begun to adopt a more critical approach to the curriculum it delivers and the way it delivers it. One example of this is the inclusion of medical humanities in the UK undergraduate curriculum, to help produce more rounded learners by focusing on the human dimension of the patient. If the bastion of conservatism which medical education represented can change in such a dramatic way, there is surely scope for publishing to take steps in the same direction.

For those materials developers who are considering writing a course book, the most important lesson is the need to work within the restrictions of the course book format, and to adapt innovative developments so they fit within this. When materials in class have worked well with an open type response, they do not convert automatically to a coursebook format because learners and teachers want answers which can be verified. The lesson seems to be that when working with publishers on course books, writers need to recognise that while some parts of the mould can be changed, the overall shape of the mould remains. Rather than viewing this as an imposition on their creativity and innovation, writers have the option of using evaluation tools, such as the one outlined in
this report, to justify why there is a need for their approach, by identifying holes or gaps in existing materials. They can also use the tools to provide a more detailed picture of the shape of the new materials and to describe their likely pedagogical effectiveness. By acting as a point of reference for writer and publisher, a more objective basis for negotiating change can be established.

**Augmenting the initial evaluation**

The final product which emerged as *Good Practice* has sold over 116,000 copies worldwide (personal correspondence from CUP, February 2015) and it retained sufficient innovative features to win the David Riley Inaugural Prize for Innovation in Business and ESP in 2008. In this regard, it is clear that the decision to keep the book in a traditional EFL format was a sound commercial one.

Five years on, teachers have had an opportunity to familiarise themselves with the materials, and to use them more extensively. In addition, my understanding and experience of the context of the doctor-patient interview and of materials development has increased through observation of consultations in a pain clinic, teaching postgraduate doctors on the Foundation Programme in a local hospital and teaching materials development. It therefore seems timely to re-evaluate the book and its effects. To begin this work, I wrote a review of the literature which discusses the role of the course book in ESP (McCullagh, 2015, forthcoming), and a number of findings from this will be incorporated into the development of the evaluative framework.

In creating the framework to carry out this re-evaluation, I will build on the methodological approach in McCullagh (2010), which drew on Maley's (2003) concept of analysing the inputs (raw materials) and processes (activities using the raw materials) used in a set of materials in order to determine their contribution to pedagogical, educational and psychosocial outcomes. The evaluative criteria I used in McCullagh (2010) were designed for situations where end-users and context were fairly well defined (McGrath, 2002, p. 31). However, the results of the research I undertook for McCullagh (2010) showed that the profiles of end-users were more varied than I had anticipated when selecting the evaluative criteria. To compensate for this, the criteria used in this re-evaluation will need to reflect the needs of a varied range of user profiles. By using criteria which reflect the
distinction made by Ur (1996) and Tomlinson (2003) between general (i.e. the essential features of any good teaching learning material) and specific (or context related) criteria, this can more easily be achieved.

The framework will also need to take into account conclusions from McCullagh (2015) which highlight the need for the development of an ESP specific materials evaluation methodology. Chan’s checklist (2009) for evaluating business English materials, though restricted to business in its scope, and having a number of limitations in its approach, makes considerable progress in tackling this challenge. The evaluation tool I have developed, will address these limitations by bringing together methodologies from the literature of materials development and ESP. The use of the tool will also take into account the fact that Good Practice is one of the relatively few published evaluations of coursebooks carried out by authors (another is Watkins, 2010),

**Key questions**

My objectives in this report are to provide answers to the following questions

- What is the theoretical underpinning necessary for an evaluative framework?
- How can the existing literature inform the construction of the evaluative tool?

I will use an evaluation of Good Practice to test the tool and in particular to answer two key questions:

- What do course materials need to achieve to enable international doctors to perform successfully in the doctor-patient interview?
- To what extent does Good Practice contribute to the achievement of these outcomes?

To answer the first set of questions, I will draw on the materials development and ESP literatures to inform the creation of the principled evaluative framework.

To answer the second set of questions, I will carry out a needs analysis to identify the outcomes required for learners and feed this into the evaluative framework. I will use the framework to analyse feedback collected from teachers who have used the book, and to carry out my own evaluation of a unit from the book.
2.0 Materials evaluation and needs analysis in ESP

Needs analysis as a methodology has been described as a “cornerstone of ESP”, (Dudley Evans and St John, 1998, p.122). As a methodology it offers many different tools (Basturkmen, 2011, p.19), but for this report the most useful are Target Situation Analysis (TSA) and Discourse Analysis (DA). TSA identifies the different activities which learners are expected to undertake to perform effectively in a target communicative situation (West, 1997, p.68). From this, the various language functions required to perform these activities can be identified (Hutchinson and Waters, 1987, p.32). Discourse analysis provides detailed information on how language is used for different functions, taking into account the ways it is used in different settings (Basturkmen, 2011). This allows us to identify the distance between where learners are, where they need to be, and how this can be covered, (West, 1997).

The information to support TSA and DA can be gathered directly from the target setting or from secondary sources. Research in the target settings can produce a very detailed description of learners’ needs (e.g. Sullivan and Girginer (2002) on the needs of Turkish air traffic control workers, and Cutting (2012) on the needs of European airport ground staff). Such ethnographic methods (observation, shadowing or interviews) require significant resource and expertise (Anthony, 2011). In addition, gaining access to representative situations in the target setting and recording and identifying representative language can be very difficult (Handford, 2010). In practice, these constraints mean that while primary information is sometimes gathered, much TSA and DA relies on secondary sources only.

There are usually many secondary sources of information available for TSA. These include general descriptions of the work required through job descriptions relating to the target context and various types of guidance (professional and local) on what tasks require. Secondary sources also include richer descriptions such as published written or spoken interviews about working in the target setting, or documentaries which include interactions within the target situation. Taken together, these can provide a good range of sources of information on the tasks which learners are expected to carry out, and the context in which the communication will take place. An increasing amount of literature is available to provide guidance on how this information can be used to determine the language required to carry out the functions TSA identifies (e.g. Basturkmen, 2010; Huhta, Vogt, Tulkki, and Johnson, 2013). However, DA is also required to provide a full description of the type of language required.
TSA can also identify knowledge and skills other than language which are essential for communication in the target setting, and there has been a significant debate in ESP on the extent to which ESP should focus on subject content. To some extent, this is an extension of the specificity debate, and the issue of how specific to contexts, or how generalisable language is. (It is worth noting that a lot of this debate centres around EAP contexts, rather than work-based settings). Dudley Evans and St John (1998, p.11) believe in a more generalist approach to language, with the subject knowledge acting only as a ‘carrier content’ for the ‘real content’ of the language. They give a description from their book ‘Nucleus: General Science’, of a plant growing, which they state acts as carrier content for the ‘real’ language of process, which can be transferred to any context. I believe there are limits on the extent to functional language transfers between domains, which puts me closer to Paltridge whose stance is that the teaching of the language “cannot be divorced from the teaching of the subject itself” (2009, cited in Anthony, 2011, p.6). While ESP can use ‘carrier content’ to provide examples of specific language, this carrier content must be relevant to the target context and of use to the learners (these aspects will be discussed below in relation to evaluation criteria). In general, the teaching of specific aspects of subjects is outside the aims of ESP. An exception to this is where subject content provides guidance on communication within the target situation. I refer to this type of subject content as ‘context specific communication guidance’, and this is discussed more fully below.

2.1 Applying needs analysis to international doctors

While communication skills are embedded in UK medical undergraduate degrees, this varies for international institutions. Many are only beginning to include clinical communication skills on their curriculum (Kennedy, Lilley, Levente, Levente and Harden, 2013). A summary of English language and communication skills requirements, and likely clinical communication training for IMGs, EU doctors and UK trained doctors is provided in the table below.
Figure 1: Overview of English and communication requirements and likely training for IMGs, EU doctors and UK trained doctors

Gap in language and communication skills

The most obvious gap between international doctors and UK medical graduates is their knowledge of English, and the skills to use this language effectively in the consultation. Two assessments are provided to test these. To demonstrate how well they have overcome the gap in language skills, international doctors are required to achieve an overall IELTS score of 7.5 (previously 7.0). When developing Good Practice, we believed that IELTS was a poor indicator of the ability to perform in specific contexts, and that it was unlikely to show how competent doctors would be in the clinical workplace. This stance received considerable support from the work of Berry, O’Sullivan and Rugea (2013), who found that IELTS did not adequately test doctors’ ability to use language in the ‘can do’ requirements they identified in the clinical workplace (see appendix 8), and who recommended the development of a UK specific test tailored to these requirements.

To test IMGs’ competence in clinical and communication skills, the PLAB uses an Objective Structured Clinical Examination (OSCE) format, where doctors are expected to demonstrate their diagnostic skills with a number of simulated patients. The effectiveness of this assessment has also been contested. Recent research (McManus and Wakeford, 2013) indicates that the PLAB does not provide a reliable benchmark for UK level performance, and that the comparison for international doctors is at the level of penultimate year medical undergraduates rather than first year postgraduates. While the OSCE format of the PLAB is common to many other UK assessments of medical competence, there is no mechanism to ensure that it shares the same standards, and
marking criteria for the PLAB are not openly available. However, we do know that PLAB allows doctors to compensate for low communication skills scores with high clinical scores, thus limiting its effectiveness as a test of communication skills. We had already encountered the lack of clarity around the marking schemes, and the limitations on testing communication skills when developing *Good Practice*, and had come to similar conclusions about the limitations of the PLAB in evaluating communication skills. For this reason, we decided to extend the scope of *Good Practice* beyond preparing for the PLAB, and to focus more broadly on helping learners to develop their communication skills for the doctor-patient interview in the clinical workplace.

The section above has shown the lack of training international doctors may have in language and communication skills, and there are other aspects which also need to be addressed. Figure 2 shows the range of factors which UK doctors are likely to cover as part of their clinical communication training, on an undergraduate programme. While the patient is not represented in the figure, they are at the centre, along with the doctor’s respect for others. International doctors may have covered some of these areas in their undergraduate training, but they may not have covered the full range of these, and cultural values underpinning them may differ.

![Diagram of patient communication](image)

*Figure 2. Consensus statement view of patient communication, from Von Fragstein, Silverman, Cushing, Quilligan, Salisbury and Wiskin (2008).*
An example of the extent of these cultural differences is shown by Slowther, Hundt, Taylor and Purkis (2009, p. 45) who quote an international doctor as saying:

“In ‘my country’ the doctor is a kind of king who can do everything that he wants to, so there were no actual dilemmas because I was brought up in a way that whatever was decided was the right thing”.

Becoming familiar with their new cultural settings is a key objective for international doctors and there may well be issues in each of the domains of Figure 2. Partly this will be achieved by acquiring knowledge about these topics directly through study. Partly it will be through ongoing reflection as they begin to see the relevance of cultural knowledge in their interaction with patients and colleagues. This reflection and self-learning should also extend to the development of their language and clinical communication skills. In addition, they will need support to help them develop confidence in their ability to use these language and communication skills effectively in what is a new and challenging working environment.

The patient-centred consultation and the Calgary Cambridge Observation Guide

This discussion on needs highlights that the ESP coursebook does not just need to present medical lexis and practice but also to focus on non-medical specific interpersonal communication, and to understand how interaction must be different in different contexts. This is very apparent in the professional guidelines given to trainee doctors (and therefore also to materials developers and teachers). For the doctor-patient interview, there is a range of this type of guidance. Examples include the Calgary Cambridge Observation Guide (Silverman, Kurtz and Draper, 2005, p.75), and the SPIKES model for breaking bad news (Baile, Buckman, Lenzi, Glober, Beale, and Kudelka, 2000). These guides have emerged from the move from a doctor-centred approach to the consultation, where doctors make the decisions, to a more patient-centred approach (Kramer, Bauer, Dicker, Durusu-Tanriver, Ferreira, Rigby, Roux, Schumm-Draeger, Weidanz, and van Hulsteijn, 2014, p.125).

The Calgary Guide is the standard used in the UK and other English-speaking countries to teach communication skills for the patient interview to medical undergraduates. It is increasingly used abroad. The Guide has five main stages, set out in Figure 3, and the
guidance structures the consultation as well as directing the doctor on how to build a relationship with the patient. Knowledge of the Guide and how to use it are generally seen as essential for effective performance in the consultation.

Figure 3: Summary of the stages of the Calgary-Cambridge Observation Guide (Image from Thomas, 2013)

A key feature of relationship building in the Calgary Guide is guidance to the doctor on how to show empathy to their patients. The Guide does not advise on the type of language which can be used to achieve this or other relationship - building objectives, but it does provide guidance for other aspects of communicating with the patient. This includes chunking and summarising when providing information, and also paying attention to the body language of the patient as well as their own. The implications of these are discussed more fully below.
Language for the consultation

As the needs analysis discussion above shows, Target Situation Analysis (TSA) and Discourse Analysis (DA) can be used to identify the language needed to communicate effectively in a target situation. When developing Good Practice, a range of sources for TSA were available. These included guidance such as the Calgary Guide, literature on clinical communication, personal accounts of doctor-patient interactions and documentary video footage. Because of its central role in the consultation, the Calgary Guide was essential in my TSA and acted as a basis for various central functions: language to elicit patients' views, language to elicit information contributing to diagnosis, language to ask for permission when conducting a physical examination and language to explain conditions.

Resources for DA were very limited, however. The research available on language used in the doctor-patient interview tended to focus on register and grammar, the role of language in power relations in the consultation (see Ferguson (2013), or on very detailed aspects such as the use of first person pronouns (e.g. Skelton, Wearn & Hobbs, 2002; Rees and Monrouxe, 2008). There was also some corpus-based research related to healthcare, which used recordings of non-professional staff offering advice on a telephone helpline (Adolphs, Brown, Carter, Crawford and Sahota, 2004). Because of the scarcity of data on which to base a DA of the language required, I explored ways in which relational aspects could be included with the functional language identified. In doing this, I drew heavily on literature on corpora and relational language which would later be brought together in the work of O’Keeffe, McCarthy and Carter (2007). I identified different types of language involved in conveying politeness, respect and empathy (e.g. modals), as well as paralinguistic features such as “tone, speed of delivery, intonation and pitch” (McCullagh, 2011, p.221).

More studies which can be used to inform DA are now becoming available. The most relevant of these is work by Roberts, Atkins, & Hawthorne (2014), comparing the performance of L1 and L2 candidates in the assessment of interpersonal effectiveness as part of the assessment for membership of the Royal College of General Practitioners. The assessment involves an OSCE type format exam which tests clinical and communication skills in a way similar to that in the PLAB. The work by Roberts et al., (2014) involved corpus and discourse analysis of the language used by candidates who passed and those who failed the assessment. The report found that language skills such as pronunciation were not a significant problem, but that the ability to use language to explain, to clarify and generally control the conversation were. A major factor identified in failure was difficulty for
candidates in demonstrating their understanding of the patients’ position by communication strategies (e.g. showing alignment or empathy). A common reason for this was the explicit use of stock ‘empathy’ phrases in a way which was perceived by examiners as mechanical and insincere.

Roberts et al. (2014) identified a number of techniques which successful candidates used to make stock phrases sound less formulaic. These include using appropriate body language, changing the phrases slightly, using them in slightly different contexts or using “conversationalising strategies, such as vague language and softeners” (2014, p.32). Some good candidates were able to avoid using these phrases by creating a ‘shared emotional tone’ through indirect means such as humour, metaphor and an informal conversational mood based on tone of voice” (2014, p.127). These factors correlate with many aspects of language identified in research on workplace discourse which has recently become available. This work on different aspects of the role of language in building relationships and in achieving objectives within the workplace (e.g. politeness (Schnurr, 2012), turn-taking (Angouri, 2010) and the use of humour (Schnurr, 2009), vague language and paralanguage (Handford 2010; Koester 2010), links with areas referred to by Roberts et al. above. This suggests that some research on workplace discourse can have a role to play in informing DA for the consultation.

Given that the target learners will by definition already possess an IELTS score of 7/7.5 or above, I do not envisage that they will need to develop their general grammar knowledge. I also do not envisage that they will need to develop their knowledge of specialist terms in the medical lexis. Their prime need for vocabulary will relate to their need to understand the language used by their patients (‘patient speak’), and to speak to them using language which they can understand. Learners will also need vocabulary input around relational aspects of language. Skills development in speaking will be needed to develop their ability and confidence in using the lexis, particularly within the context of the Calgary Guide and related guidance. Skills development for listening will be required to help learners with the range of non-standard vocabulary and with the range of accents which they may encounter.
Broader communication skills

I have discussed how TSA can identify knowledge and skills other than language which are required for communicative competence in the target context. The need for knowledge and skills relating to context specific communication guidelines is one of these, which has already been flagged up in terms of ESP needs analysis methodology. The needs analysis around the consultation has also showed, that language features such as tone, speed of delivery, intonation and pitch need to be taken into account. Figure 4, sets out some other areas, mainly taken from the Calgary Guide, which need to be considered as part of the needs analysis. Some of these are communication skills which are carried out within the language function, such as chunking information and checking the patient’s understanding. Other aspects relate to non-verbal communication, such as eye contact and facial expression, integral aspects of communication within the patient consultation. However, the skills in Figure 4 have not been categorised in a way which makes clear what their function is, and what competences they relate to.

<table>
<thead>
<tr>
<th>eye contact</th>
<th>responding to cues (both verbal and non-verbal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>facial expression</td>
<td>summarising</td>
</tr>
<tr>
<td>attentive listening</td>
<td>signposting</td>
</tr>
<tr>
<td>screening</td>
<td>determining the patient’s starting point when giving information</td>
</tr>
<tr>
<td>appropriate balance of open and closed questions</td>
<td>chunking information, and checking the patient’s understanding</td>
</tr>
<tr>
<td>facilitation</td>
<td></td>
</tr>
<tr>
<td>empathic reflection</td>
<td></td>
</tr>
</tbody>
</table>

Figure 4: Skills for consultation from the undergraduate consensus statement on UK medical undergraduate communication skills training (von Fragstein et al., 2008).

As part of the needs analysis for Good Practice, we had already identified many of these skills in the literature. While the literature provided some general categorisation of the skills, it was not done in a way which made clear how they fitted in with broader communication skills. Recognising the importance of categorising the skills in a way which was accessible for learners, I organised them under five headings: verbal communication, voice management, non-verbal communication, active listening and cultural awareness. For greater impact, the skills were visually presented in the form of a colour-coded jigsaw icon, which was featured throughout the book (see Figure 5).
For this evaluation, I have decided to incorporate communicative competences identified by Gilmore (2007, 2012) with the skill areas identified in the jigsaw. This will provide a more systematic and robust tool for integrating language and general communication skills, drawing extensively on the literatures of applied linguistics and communicative competence. Brief descriptions of the five competences identified by Gilmore are set out in Figure 6.

<table>
<thead>
<tr>
<th>Linguistic Competence</th>
<th>Ability to understand and use the literal meaning (locutionary force) of utterances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pragmalinguistic Competence:</td>
<td>Ability to understand or convey communicative intent (illocutionary force) appropriately in a given context.</td>
</tr>
<tr>
<td>Sociopragmatic Competence:</td>
<td>Understanding of what is socially and culturally appropriate in a given speech community, including an appreciation of politeness, social conventions and taboo topics as well as nonverbal factors such as kinesics and proxemics.</td>
</tr>
<tr>
<td>Strategic Competence:</td>
<td>Ability to use verbal or nonverbal strategies to manage the overall communication process and avoid breakdowns.</td>
</tr>
<tr>
<td>Discourse Competence:</td>
<td>Ability to recognise and produce the features of different written and spoken genres which are appropriate to the context.</td>
</tr>
</tbody>
</table>

Figure 6: Communicative competences taken from Gilmore (2011, pp.787-788)
These communicative competences cover many of the areas included in the jigsaw. They can also be used to cover skills which have been identified by the Calgary Guide, such as chunking, repeating and checking. These examples can be said to fall into the category of strategic competence. Other examples already identified such as humour and politeness fall into the pragmalinguistic and sociopragmatic categories. Turn-taking can be seen as relevant to both strategic and discourse competence. While Gilmore's (2007, 2012) categories cover most of the skills included in the jigsaw, cultural awareness can also be considered separately, and this will be referred to in the evaluation.

2.2 What do course materials need to achieve?

What do IMGs need to do to perform successfully in the doctor-patient interview?
The previous sections describe the gap between the knowledge and skills which UK and international doctors are expected to have developed through their training. (I would like to emphasise the 'expected to', as there are considerable variations in knowledge and skills for both groups). In order to perform successfully in the doctor-patient interview, doctors need to be able to integrate three different elements in their performance. They need to be able to understand and follow good practice guidance relating to the doctor-patient interview (e.g. Calgary Guide), to have and be able to use the appropriate language to achieve what the guidance recommends, and to integrate a range of wider communicative competences along with their use of language to achieve the required outcomes. In addition, doctors also need to understand how culture affects communication, and to be aware of the implications of differences in national culture (for example in religion, social class) and in medical culture.

How do we measure what course materials need to achieve?
The descriptions of competence above need to be translated into learning outcomes to make them useful for teaching and learning. Learning outcomes can be seen as the 'building blocks of any learning programme or teaching', but they can also become 'an educational 'straitjacket' (McKimm and Swanwick, 2009, p. 407). The straitjacket focuses only on narrowly pre-determined outcomes and ignores any other type of learning which is taking place. To overcome these restrictions on learning, McKimm and Swanwick suggest that outcomes should provide 'varying levels of detail' (2009, p.407), which allow teachers more scope in identifying what learning is taking place. By including levels of detail in
outcomes, we can help teachers to quantify learners' progression towards competence. This can be very useful for ESP teachers working under time and resource constraints, where they are 'increment(ing) the competences required by the workplace in realistic units' (Huhta et al., 2013, p. 41).

One way to provide greater levels of detail is to differentiate between outcomes for knowledge and for skill. McGrath (2002, p.98) points out that 'knowledge can be 'presented or discovered''; it can also be forgotten. Skill on the other hand, can only be acquired through practice and once acquired is relatively easily maintained'. Miller's (1999) pyramid, in Figure 7 below, identifies four levels which can be used to assess the stage of development of knowledge and skills for any given outcome.

![Miller's Pyramid](image)

Figure 7 – Miller's Pyramid

**Framework for material outcomes**

Amalgamating the three different types of outcome identified in the needs analysis with the outcome levels from Miller (1990) introduces the idea of hierarchy and progression through stages into the evaluation of outcomes. Figure 8 tries to capture both the scope and the dynamic of the evaluation process.
The outcomes matrix provides a conceptual framework for the outcomes of a needs analysis. While it has emerged from my needs analysis for international doctors, it is transferable to other ESP contexts. The next step will be to place the matrix within the context of the overall framework for materials evaluation. This is the focus of the next section.

2.3 Evaluative framework

This section of the report will create an evaluative framework which can be used for ESP coursebooks and course components. It will link the outcomes matrix in Figure 8, with an evaluation grid made up of criteria drawn from the ESP and materials development literature.

Outcomes

In the introduction to this report, I stated that Maley’s (2003) inputs, process and outcomes, outlined in detail in McCullagh (2010), would provide a structure for this evaluative framework. Maley’s pedagogical, educational and psychosocial outcomes dovetail with the different levels already identified in the outcomes matrix. For Maley, pedagogical outcomes describe those that can be tested for during the course and are
contrasted with educational outcomes or the purposes to which learning will be put after the course. Deciding which pedagogical outcomes will be measured in summative and formative assessment, and how well these are aligned with the educational outcomes, are key parts of course design (Widdowson, 1983). However in ESP, where learners are being prepared to communicate in a specific environment, the distinction between the two is less important (Hutchinson and Waters, 1987).

The difference between educational and psychosocial outcomes can best be explained by using the example of confidence, which Maley (2003) includes in both categories. As a pedagogical outcome, confidence in performance can be observed and evaluated. However, this may be simply the appearance of confidence, whereas the extent to which a learner possesses true confidence (which cannot easily be measured), reflects a psychosocial outcome. In line with this, Miller’s (1990) three levels of ‘knows’, ’knows how’ and ‘shows how’, can be seen as similar to pedagogical / educational outcomes, while the ‘does’ can be seen as a type of psychosocial outcome.

Criteria for evaluating the effectiveness of inputs and processes

This section draws on Maley’s (2003) concept of analysing materials by focusing on inputs (raw materials) and processes (activities using the raw materials). It identifies a range of criteria from the ESP and materials development literatures which are suitable for evaluating ESP materials, and then selects a smaller number to create the evaluative grid which will be used in the framework. The criteria for the evaluation of the effectiveness of the inputs and processes in Good Practice come from two sources.

The first source is Tomlinson (2003), whose ‘universal’ and ‘content-specific’ criteria will be used for this evaluation. Universal criteria are derived from principles of language learning (Tomlinson, 1998, 2011) and can be applied to “any language learning materials anywhere for any learners”. Content-specific criteria “relate to the topics and/or teaching points of the materials being evaluated” (Tomlinson, 2003, pp. 27-31); the needs analysis provides a basis for these. Tomlinson also describes local criteria, which measure “the value of the materials for particular learners in particular circumstances” (2003, p.31) and relate to the objectives of a course and the syllabus which is being followed. Because of the nature of this evaluation, local criteria will not form part of the framework, but information about these will emerge from interviews with teachers.
The second source of criteria comes from Dudley Evans and St John (1998) and Hyland (2003, 2006), and were devised to evaluate how well ESP materials fulfil roles for learners and teachers. Figure 9 combines some of their criteria and some of Tomlinson's (2003) universal criteria which are relevant to the present evaluation. It groups the criteria together in terms of role.

Figure 9: Amalgamation of criteria from (1) Tomlinson; (2) Dudley Evans and St John; (3) Hyland (the purpose of the numbers in green is explained below).
By combining Maley’s (2003) inputs and processes with the categories above, and recognising the need to extend outcomes beyond language, I developed three categories for the evaluation grid.

| Inputs as a source of language, communication and meta-language | Processes for supporting learners | Inputs and processes for engagement |

All of the criteria in Figure 9 have merit in the evaluation of ESP materials, but there is a trade-off between the range of what is covered and usability. After careful consideration, I selected the elements in Figure 10 below for the evaluative grid. I feel these represent the best compromise between range and conciseness for my present purposes.

I have included details on why elements were chosen or rejected in appendix 9 (using the green numbers from Figure 9). A key point to note is the amending of the category descriptions to reflect the focus on inputs and processes, in addition to the role headings in Figure 9. A second point is the changes to some of the criteria to reflect the focus on the subject area and the target situation.

In order to make the criteria as transparent as possible, Figure 11 draws on the literature to explain the scope of each, and to provide guidance on their use. This helps to overcome the problem, identified by McGrath (2002:44), that the terms to which the criteria relate, may not be fully understood by those who are using them.

I envisage that the grid can be amended if required, to reflect the judgement of the user. The amendments need to reflect the focus on the inputs and processes which the categories impose, where this is relevant. For some of the criteria in Figure 9, such as the publishing related areas, this many not apply.
<table>
<thead>
<tr>
<th>Inputs as a source of language, communication and meta-language</th>
<th>Processes for supporting learners</th>
<th>Inputs and processes for engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent do the inputs cover the full range that learners require?</td>
<td>To what extent do the tasks draw attention to relevant features of language and communication?</td>
<td>To what extent are inputs and processes likely to be perceived as relevant and useful?</td>
</tr>
<tr>
<td>To what extent do the inputs expose learners to authentic language and communication in use in the target situation?</td>
<td>To what extent do tasks provide opportunities to produce language and communication appropriate for the target situation?</td>
<td>To what extent do inputs and processes encourage aesthetic and emotional involvement?</td>
</tr>
<tr>
<td>To what extent do the inputs provide explanations of the language and communication used (meta-language)?</td>
<td>To what extent do materials provide opportunities for feedback?</td>
<td></td>
</tr>
</tbody>
</table>

Figure 10: Evaluation grid: criteria to evaluate inputs and processes
<table>
<thead>
<tr>
<th>Inputs as a source of language, communication and meta-language</th>
<th>To what extent do the inputs cover the full range that learners require?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In this criterion, the main focus is on the extent to which relevant inputs are provided to achieve the tasks identified in TSA. In this evaluation, this will include: inputs on context specific guidance (e.g. Calgary Guide), on the language required to carry out the functions within the relevant stage of the Calgary Guide, and also any broader communicative competences (Gilmore, 2011), which have been identified. This criterion can also cover the extent to which key subject information is available to support teachers who are less knowledgeable or less confident about the area. (Wu and Badger, 2009).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>To what extent do the inputs expose learners to authentic language and communication in use in the target situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Two aspects of inputs can be considered under this criterion. The first is the extent to which the language and communication inputs provided are authentic. Authenticity has been the subject of much discussion in the materials development literature (e.g. McDonough 1984; Hutchinson &amp; Waters 1987; Guariento and Morley 2001; Mishan, 2005), and can refer to the language used, or the tasks which learners are expected to carry out. My position is that materials should, wherever possible, provide real representations of language and communication in use in the target setting (McCullagh, 2013). However, this type of input can be very difficult to obtain (Handford, 2010). For this reason, inputs which show “fitness to the learning purpose” (Hutchinson and Waters, 1987, p.159) may need to be created by the materials writer. The authenticity of these can be assessed on how well they contribute to the production of language for use in the target situation. The second aspect to consider is the extent to which the inputs show how the language and communication is used in the target communicative situation. This is important both because it allows learners to model the language, but also because it provides learners with input on appropriate contexts in which the language can be used Chan (2009).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>To what extent do the inputs provide explanations of the language and communication used (meta-language)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This criterion draws on Hyland’s (2006, p.95) distinction between materials providing knowledge about language, rather than practice in using the language (my italics). The ‘explanatory precision’ which meta-language provides, can have significant benefits for learners (Hu, 2010, p.66). These include: helping learners make links with their existing knowledge; facilitating communication about language between learners and between learner and teacher, and providing a</td>
</tr>
</tbody>
</table>
means of linking together new concepts which they acquire in the classroom. While much of the literature focuses on the use of meta-language in relation to language, meta-language can also be used for the other areas identified in the needs analysis: context specific guidance and broader communicative competences. This criterion can also consider explanations which use the meta-language to show how inputs and processes contribute to the outcomes.

<table>
<thead>
<tr>
<th>Processes for supporting learners</th>
<th>To what extent do the tasks draw attention to relevant features of language and communication?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Learners’ attention can be explicitly drawn to particular features of language and communication, or they can be allowed to discover them for themselves. For learning to take place, learners need to notice and reflect on the relevant features of language (Ellis, 2008, p.439), and the more that activities enhance ‘noticing’ and ‘consciousness raising’, the more likely that attitudes to learning can be changed for the better (Carter, 2003, p.65). Doctors ‘noticing’ the effect on patients of different features of using language and communication, can be a powerful tool for learning. Part of this process involves drawing the attention of others to their discovery, which is most effective when appropriate meta-language is available to facilitate learner to learner, and learner to teacher communication (Hu, 2010).</td>
</tr>
</tbody>
</table>

|                                                                                        | To what extent do tasks provide opportunities to produce and practice language and communication appropriate for the target setting? |
|                                                                                        | Kurtz, Silverman and Draper (2005, p.70) point to the need for a combination of practice and feedback (in addition to knowledge) in order to develop learners’ clinical communication skills, and the same applies to language skills. The materials therefore, need to provide opportunities to produce and practise the target language and communication skills. Tomlinson’s (2003) criterion states that language should be produced for communicative purposes, and this is echoed by Guarente and Morley’s condition of task authenticity, that ‘real communication takes place’ and that language is ‘used for a genuine purpose’ (2001, p.349). Where appropriate, tasks should be drawn from the target situation. However, they can also be “guided in terms of (their) general orientation by the target situation”, but reflect the needs of the learning environment. (Hutchinson & Waters 1987, p.61) |

|                                                                                        | To what extent do materials provide opportunities for feedback? |
|                                                                                        | This criterion is taken from Tomlinson (2003), and in this evaluation relates to activities which tests learners’ ‘knows’, ‘knows how’ and ‘shows how’ outcomes. |
Feedback is key to a learner’s sense of progression. The nature of the feedback will depend on the type of outcome which is being tested. Cooker (2008, p.114) distinguishes between activities which have a definite answer, and those where various answers are possible. These can be described as requiring fixed or flexible feedback. The ‘knows’ and ‘knows how’ activities are more likely to have fixed answers, which can be provided in the materials. ‘Show how’ outcomes are more likely to require flexible feedback. This is because feedback can be provided on different aspects of the task performance, and the tasks can be performed equally well in different ways. Flexible feedback can be provided via the teacher, but it is also important that learners have access to “self-diagnostic and self-evaluative tools” so that they can begin to monitor themselves and their peers in terms of their levels of proficiency. (Cooker, 2008, p.114). The importance of peer evaluation and peer feedback in developing identities in professional communication is also underlined by Huhta et al. (2013, p.195).

The development of self-evaluation skills links closely to the need for learners to become reflective in thinking about their own learning (Kolb, 1984), and feedback needs to be considered in terms of the development of reflective practices in learners. These self-diagnostic and self-evaluative tools need to cover the different types of outcome identified in the needs analysis. For the purposes of this evaluation, the criteria are that clear guidance should be available to the learners so that they can evaluate their own performance and those of their colleagues. In addition, clear unambiguous guidance should be available to teachers so that they can clarify areas which are unclear.

<table>
<thead>
<tr>
<th>Inputs and processes to engage learners</th>
<th>To what extent are inputs and processes likely to be perceived by learners as relevant and useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learners’ beliefs about the extent to which materials are relevant to them can have a very significant impact on their motivation (Dornych, 1998). Some of this perceived relevance will come from the authenticity of the inputs and processes in the materials. However, the relevance of inputs and processes to meeting the overall objectives also needs to be made explicit in the inputs.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To what extent do inputs and processes encourage aesthetic and emotional involvement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are many ways in which materials can involve learners emotionally. Ensuring variety in inputs and processes provides a foundation for this. Another way, is using activities which draw on learners’ knowledge and experience to make the connection between the course book and ‘the real world which the learners live in’ Tomlinson (2003, p.171). Using literature and real life accounts to replace access to alternative worlds is also powerful (eg Lu and Corbett 2012).</td>
</tr>
</tbody>
</table>
and there is a growing body of literature in the medical humanities which takes this approach. The tone of voice of the materials (part of [6] in Figure 9) is another factor to consider. This needs to be authoritative, but not patronising in order to encourage learners to involve themselves with the inputs and activities. Finally, the medium in which inputs are presented to the learner is also a factor to be considered, with video providing more potential for involvement (McCullagh, 2013).
Final evaluative framework

To create the final evaluative framework, the outcomes matrix will be used in combination with the evaluation criteria. The relationship between the two components (Figure 12) and a worked example of how they are related are shown below.

![Diagram showing levels of outcome and types of outcome]

<table>
<thead>
<tr>
<th>Types of outcome</th>
<th>Inputs as a source of language, communication and meta-language</th>
<th>Processes for supporting learners</th>
<th>Inputs and processes for engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context specific communication guidelines (eg Calgary Guide)</td>
<td>To what extent do the inputs cover the full range that learners require?</td>
<td>To what extent do the task draw attention to relevant features of language and communication?</td>
<td>To what extent are inputs and processes likely to be perceived as relevant and useful?</td>
</tr>
<tr>
<td>Language</td>
<td>To what extent do the inputs expose learners to authentic language and communication in use in the target situation?</td>
<td>To what extent do tasks provide opportunities to produce language and communication appropriate for the target situation?</td>
<td>To what extent do inputs and processes encourage aesthetic and emotional involvement?</td>
</tr>
<tr>
<td>Communicative competences (pragmalinguistic, sociopragmatic, discourse, strategic)</td>
<td>To what extent do the inputs provide explanations of the language and communication used (meta-language)?</td>
<td>To what extent do materials provide opportunities for feedback?</td>
<td></td>
</tr>
</tbody>
</table>

Figure 12: Showing relationships between outcomes matrix and evaluation grid
Using the framework

The table below describes a sequence in which the framework is used. These do not have to be followed in exactly this way. The framework is designed to be flexible and iterative and stages can be used in a way which meets the needs of the materials developer or teacher.

<table>
<thead>
<tr>
<th></th>
<th>Outcomes which the materials need to achieve are identified by the TSA and DA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>The outcomes are categorised under the three types in the outcomes matrix. The materials developer or teacher will need to use their judgement in this process, but the matrix will help to guide their decisions.</td>
</tr>
<tr>
<td>3</td>
<td>Using appropriate-sized sections, inputs and processes in the materials are identified and examined to determine what outcomes they are likely to deliver.</td>
</tr>
<tr>
<td>4</td>
<td>These likely outcomes from the inputs and processes are classified using the matrix in terms of type and level. This provides a very fine-grained picture of what outcomes are likely to result from the section under evaluation.</td>
</tr>
<tr>
<td>5</td>
<td>The evaluation grid can be used with the inputs and processes to determine how effective they are likely to be in achieving their outcomes. This will help the materials developer or teacher identify where the processes used are not fully exploiting rich inputs, and where the inputs do not support the processes used.</td>
</tr>
<tr>
<td>6</td>
<td>The end result of using the framework is an overview of the different inputs, processes and outcomes in a section or unit. This can show the materials developer whether there is a balance in the type of outcomes, or the type of inputs and processes used in sections and units. Repetition of the same type of inputs and processes suggests that the materials are not providing variety to the learners, missing opportunities to make the materials emotionally appealing.</td>
</tr>
</tbody>
</table>
The outcomes matrix can be used to show what outcomes the inputs and processes are likely to deliver. The outcomes can be classified in terms of how many of the three types of outcome are likely to be delivered, and in terms of which of the four different levels it covers. This helps to get an overview of what types of outcomes are being delivered in a section of a course book, both in terms of the focus on guidance, language and communication skills, and the level of 'knows', 'knows how', 'shows how' and 'does'. These can be used to cross-check the types of outcomes the unit is expected to deliver.

2.4 Evaluation of a unit from the coursebook

Selecting content for the evaluation

The next step is to use these tools to evaluate ESP materials. I have chosen for this trial Unit 7 of Good Practice: planning treatment and closing the interview because it makes extensive use of the Calgary Guide. Also it has a DVD component and the planning stage of the consultation involves negotiation between the doctor and patient. The evaluation includes the audio CD as an integral part of the unit (though sold separately), the relevant DVD segment (also sold separately), and relevant additional material from the teacher’s book. A sample page with annotations will be included in the results section.

Section analysis of Unit 7

As a first stage, drawing on TSA and DA carried out earlier, I identified overall outcomes from the materials in terms of the three different types set out in the outcomes matrix. Turning then to the unit, I examined the inputs and processes to determine the detailed outcome(s) they can potentially achieve. This was done using the matrix to identify which of the three types and four levels ('knows', 'knows how', 'shows how', and 'does') the outcomes fit into. I then used criteria from the evaluation grid to assess how effective the inputs and processes are likely to be in achieving the outcomes. The results are presented in a summary format by evaluation criteria and outcome type, and linked to relevant data obtained from the interviews with teachers. Appendix 11 contains a revision of part of Unit 7, which illustrate how the evaluative tool can contribute to improving the materials.

Overall outcomes for Unit 7

The outcomes of Unit 7 are driven by two sections of the Calgary Guide: negotiating treatment and closing the interview. The content of the interaction in these settings will be firstly explaining treatments and options to the patient, describing benefits, side effects and
how lifestyle may be affected. At the second stage, interaction moves to the phase of negotiation where a treatment plan is proposed and discussed. The need here will be for the doctor to elicit opinion from the patient. Finally, the interaction needs to be brought to a timely end but without cutting short input from the patient who may need reassurance or clarification.

At the end of the unit, learners will be expected to know what is covered by the guidance, in this case, two stages of the Calgary Guide. The stages cover: explaining treatments to a patient; discussing options; describing benefits and side effects; advising on lifestyle; proposing possible treatments; checking if the proposal is acceptable; inviting suggestions from the patient and closing the interview. Learners will also be expected to be familiar with key guidance on how they should perform in each of these areas. They should be able to demonstrate in the class setting that that they can follow the guidance in their performance. Finally, they should have the knowledge and motivation to use the guidance in the workplace.

The language outcomes will assess the extent to which learners can carry out the functions identified by TSA, such as the relevant stages of the Calgary Guide (e.g. explaining treatment). These outcomes will also include relational language required to help them achieve relationship-building aspects of the Calgary Guide (e.g. showing empathy, putting the patient at ease). Specific outcomes for each unit will be considered on the ‘knows’, ‘knows how’, ‘shows how’, and ‘does’ continuum.

Some aspects of relational language will overlap with areas covered by the communication jigsaw / communicative competences. These include the use of hedging, humour, metaphor and tone of voice. Together with areas such as appropriate body language, these will be considered in terms of the communicative competences to be achieved. The specific outcomes for each unit will be considered in terms of the four levels.

### 2.5 Data collection from teachers: semi-structured telephone interviews

Following on from my previous research (McCullagh, 2010), I felt that a qualitative approach was the best way of gaining insight into how well the book was meeting teachers' needs. For practical reasons, interviews via Skype or telephone were the most effective way to collect the data. Because respondents were providing information on their
“experience and behaviour, opinions and values, feelings and knowledge” (Patton, cited in Richards, 2009 p.188), the nature of the interview was quite personal. For this reason, I wanted to make it very much "a conversation with a purpose" (Burgess 1984, cited in Richards, 2009 p183), rather than a more formal interview. To help with this, I had identified the key areas for discussion but wanted to “tap into the everyday reality” of the interviewees, and elicit unprompted views as much as possible. (McDonough and McDonough, 1997, p.184). These were tested with colleagues to see how well they worked.

I began the interview with open-ended questions, such as 'can you tell me a little bit about your teaching context' as a warm-up question (Richards, 2009, p.188). This was followed by a small number of event questions, such as ‘when did you start using the book?’ to begin to focus on the book, and on their teaching of English to doctors. Once these questions were out of the way, I asked some very general perspective questions to elicit their views on the book, how they used it, and how useful they found it. Pre-prepared probing questions, (see appendix 3) based on the evaluative framework were used when respondents gave their opinion of certain aspects of the materials (Richards, 2009. p.186). For example, comments about the usefulness of the video would be probed to determine how it contributed to learners’ outcomes. Interviews were scheduled for 30 minutes and usually lasted for that length of time, though the professional commitments of respondents meant they were under significant time pressures. A questionnaire with semi-structured questions, some open-ended and some closed, was used with one teacher who was willing to give me written feedback but who was unable to participate in a telephone interview because of logistical reasons. A copy of the questionnaire is in Appendix 4.

Ideally, I would have liked to research the views of international medical graduates and teachers who have used Good Practice. However, due to time constraints, I decided to focus on teachers who had used the book with international doctors. Cambridge University Press helped me to identify teachers who were using the book with qualified doctors and I also identified some respondents from a medical English conference that I attended in September 2014. I contacted approximately twenty potential respondents, of whom seven eventually took part. I emailed teachers in advance task for their permission to participate in the research and after their agreement, I sent a further email to confirm the time and date of the interview. I decided to make field notes during the interview (Stake, 1995, p.56), rather than recording the conversations in order to reduce any constraints on respondents’ willingness to speak freely.
Summary of teacher profiles

Interviewee 1: Retired GP teaching refugee doctors in UK
Interviewee 2: Medical Manager working as a communication skills trainer working for a Deanery in UK
Interviewee 3: UK ESP teacher teaching English in a Spanish Hospital
Interviewee 4: Communication Consultant teaching on a range of ESP courses in the UK
Interviewee 5: UK Hospital based trainer in an NHS Trust
Interviewee 6: Polish Lecturer based in a Polish university with a medical school
Interviewee 7: US lecturer based in a US university in a medical school

(see appendix 6 for more detail on these profiles)

Figure 13: Summary of teacher profiles

Ethical considerations

A number of ethical considerations (Denscombe, 2010, p.331-334) were taken into account. These were that: participants gave informed consent (see appendix 5 for consent form), participants remained anonymous and participants’ interests were protected.

I also informed the publishers, Cambridge University Press, about the nature of the research I was conducting. They were very supportive of my research as in my previous research.

Analysing data

Data from the teacher interviews were used for two purposes. The first was to provide an additional source of information to the needs analysis in identifying what it is that international doctors need to achieve to perform well in the consultation. The second was to give some indication of how well the section analysis has identified the ways in which Good Practice contributes to meeting these needs. The evaluative framework highlighted the potential contribution of inputs and processes to desired outcomes, and helped identify any gaps. Data gathered from teachers were combined with my findings from the author evaluation of content and both analysed together. In presenting the findings from the interviews, I decided to use quotations which illustrated specific points, and also which gave different perspectives on similar areas (Richards, 2009, p.193).
Limitations

The data collection has a number of limitations. The first of these is the sample size. While the sample represents a cross-section of possible teachers who use the book, the number is small in comparison to the total numbers using the book. The fact that data from one respondent came from a questionnaire, rather than an interview is also a limitation. Another limitation was that all respondents were experienced teachers of medical English. I had hoped to interview some teachers who were new to medical English as I was interested to find out to what extent the teacher’s book provided support to teachers with limited experience of medical English. A final limitation is the fact that teachers were aware that I was the author and, while I stressed the importance of obtaining their true opinions, they may have been less willing to give feedback which is critical of the materials than they might otherwise have.
### Inputs as a source: Do the inputs cover the full range

<table>
<thead>
<tr>
<th>Context specific (e.g., Calgary Guide)</th>
<th>Language</th>
<th>Communicative Competence</th>
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<tr>
<td>The relevant sections of the Calgary Guide are included (negotiating treatment p88 and closing the interview p75), to provide input for the 'knows' outcomes of the unit. Dialogues showing doctors following the guidance provide inputs for the 'knows how' outcomes. Questionnaires from authorities on clinical communication are provided to give more context and authority to the inputs, and these contribute to the 'does' outcomes. &quot;I feel the Calgary guide is really important for teaching clinical communication skills&quot; (Retired GP) &quot;Doctors need input on clinical communication skills like the Calgary Guide&quot; (Polish Lecturer) &quot;Younger doctors have had input on this (the Calgary Guide) during their training, but don't necessarily know how to use it. For the older doctors its new territory&quot; (Spanish Hospital) &quot;I think some guidance around encouraging patients to complete consent forms would have been helpful&quot; (US Lecturer) &quot;My learners know about the Calgary Guide, but they don't have the language they need to use it&quot; (Communication Consultant) &quot;They need to listen to the audio three or four times before they begin to hear what is being said&quot; (Polish Lecturer)</td>
<td>Explicit language input in the form of suggested phrases is provided which covers most of the functions required for the Calgary Guide stages. There are also inputs on patient speak, linked to the Calgary Guide stages. Both contribute to the 'knows how' outcomes for language. Some examples of the language input is used in the dialogues, and additional language is used on the DVD. Both contribute to the 'knows how' outcome. &quot;I think that some learners need more general language to help them with things like conversational English&quot; (Retired GP) &quot;Some doctors lack tenses necessary to carry out tasks&quot; (Medical Manager) &quot;Doctors need more collocations when they are explaining things&quot; (Medical Manager) &quot;I think there is a need for exposure to collocations in language in use&quot; (Polish Lecturer)</td>
<td>The unit includes a number of inputs relevant to communicative competences. Information is provided about skills for summarising and signposting (strategic competences), 'knows how'. The semi-scripted nature of the DVD content exposes learners to a wide range of communicative competences (knows how), and body language and tone of voice (socio-pragmatic). The DVD also provides inputs on a range of these skills in use, especially body language. There is also input (p75) on the importance of cultural awareness. &quot;My students really need more support to help them carry out a general conversation&quot; (Retired GP) &quot;Another thing they need is more familiarity with the conventions of conversational English&quot; (Retired GP) &quot;The doctors really need to learn how to interrupt a patient in an appropriate way&quot; (and the materials don't really cover this) (Retired GP) &quot;There's definitely a need to address areas such as euphemism and formality&quot; (Medical Manager) &quot;The book stands out because of its focus on communication, and area that I believe is neglected&quot; (Spanish Hospital) &quot;A knowledge of cultural issues is really important for good communication with patients, especially with tourists, and my doctors deal with tourists a lot&quot; (Spanish Hospital) &quot;I like that the book gives learners exposure to the nuance of language, because this is something they need. For example, what does &quot;I don't feel great today&quot; really mean.&quot; (Communication Consultant)</td>
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### Inputs as a source: Authentic language in the target situation

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<th>Context specific (e.g., Calgary Guide)</th>
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<tr>
<td>The audio and video components expose learners to the Calgary Guide in use in the target situation, showing examples of good and poor practice. Learners can see language being used to achieve Calgary Guide objectives. &quot;It would be really good if there were examples of communicating with somebody with dementia. It is such a big thing now&quot; (Hospital Trainer)</td>
<td>The explicit inputs of language (phrases) are authentic, as they are used in the consultation. However, not all of these are put in context for the target situation, in the audio or video components. (eg some patients speak &quot;I'll give it a go, is presented in use in the video, but others are not). Language in the audio component is scripted, while language in the video component is semi-scripted and ad-libbed by the doctor and simulated patient, who played the roles.</td>
<td>Because the Calgary Guide is used to structure the consultation, learners are exposed to strategic competence in action. In addition, the DVD provides examples of body language (socio-pragmatic) in use, as well as a wide range of other types of communicative competences.</td>
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"Culture is really important for my context. They're coming in and they don't really know anything about the culture – the culture of the hospital, the culture of living in the UK - there’s so much stuff... Even if they have the English, they can't communicate very well if they don't understand the culture". (Hospital Trainer)

"Other things they need are softeners, word stress and intensifiers". (Retired GP)

### Inputs as a source: Provide explanations and meta-language

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<th>Context specific (Calgary Guide)</th>
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<td>A number of quotations are used to provide background information on the patient centred interview, and on compliance and concordance in order to put the Calgary Guide in context. However, the chapter relies on the introduction to Calgary Guide which is provided in unit 6.</td>
<td>A brief description of the purpose to which the language can be put is provided (eg language for making suggestions). Apart from this, there isn’t any input to provide meta-language for a particular type of language which is being used (eg in exercise 3d, phrasal verbs which can be used by patients are listed. However, an explanation of the way phrasal verbs add informality is not provided, and the term phrasal verb is not used). Overall, very little meta-language is used in the unit. <em>&quot;I think that there is need for more input on how the grammar works and for highlighting some grammar points where they are used. For example this comes up in history taking... more explanation of the use of 'would' and 'should' ...&quot;</em>. (Polish Lecturer)</td>
<td>While inputs are provided (eg box on summarising skills p74) for various aspects of communicative competence, no extended explanation of their purpose is provided. They are situated in the context of the communicative jigsaw, but not in the context of broader communicative competences.</td>
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### Processes for supporting learners: Do the tasks draw attention

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<th>Context specific (Calgary Guide)</th>
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| A lot of attention is given to ensuring that learners identify stages of Calgary Guide, and the type language which is appropriate at the different stages (eg exercise 3a, 3c) | Learners attention is drawn to specific features of language in use, but primarily so they can see how it is appropriate for the functions of the Calgary Guide. Listeners with gap-fill are used to help learners identify the language which is used in negotiating treatment. Learners are encouraged to note relevant and then to use this in their roleplays.

Some learners need to be reminded which tenses they need to use when they’re doing the history taking". (Medical Manager) | Learners’ attention is draw to socio-pragmatic features such as tone of voice, and body language in the DVD question.

*"I love the way the cultural points are highlighted for the learners"* (Hospital Trainer) |
### Processes for supporting learners: Opportunities to produce and practice

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<th>Context specific (Calgary Guide)</th>
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<td>Learners are given opportunities to practice role plays. In one they are explicitly asked to follow the Calgary Guide stages, though can do so in others if they choose.</td>
<td>Learners are given four opportunities to use the appropriate language in role plays (e.g. Exercise 4d – practising language for treating hypertension). “They really need more practice at introducing themselves, getting the patient’s name right, because it makes you very vulnerable if you don’t do it” (Retired GP) “There could be more practice at using a range of broader communicative aspects of language to help learners sound less mechanical.” (Medical Manager) “I’ve noticed that learners really develop in confidence because they are able to show they can use the skills, as well as know what they are supposed to do” (Spanish Hospital) “I think that learners should get more practice in using language in stressful situations. Not all consultations are as routine as the book shows” (Communication Consultant) “Some role plays within the units are repetitive and need to be adapted to be more engaging” (Polish Lecturer) “Learners need to practice writing within the consultation – this is very much part of what they need to do” (Polish Lecturer)</td>
<td>The DVD worksheet contains a number of activities which encourage learners to practice aspects of socio-pragmatic competence. The role plays also provide opportunities to practice.</td>
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### Processes for supporting learners: Opportunities for feedback

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<th>Context specific (Calgary Guide)</th>
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<td>Feedback is provided on closed activities to show learners where the stages have been covered, and which are good and bad examples of the Guide used in practice. Some guidance is provided for teachers to feedback on questions where learners’ opinions or knowledge and experience are used.</td>
<td>Closed exercises provide feedback on whether the answer is correct or not. Where learners are asked to use their judgement (e.g. is the language likely to convince the patient), guidance is provided for teachers in the teachers’ book.</td>
<td>Some feedback is provided in the teacher’s book on the effect of some of the communicative competences used in the DVD. There are also opportunities for peer feedback in the role plays. However, no detailed guidance is provided for learners, especially in the final role play where there is an observer role.</td>
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**Inputs and processes for engagement: Perceived as relevant and useful**

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<th>Context specific (Calgary Guide)</th>
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<td>Authentic inputs and activities (described above) are likely to be perceived as relevant and useful, and 'non-authentic' activities are still relevant because learners can see the link to the final outcomes. Some inputs and activities are studied in nature because of the need to meet 'knows' outcomes for learners (eg Calgary Guide gapfill). “Some activities do not take into account that learners will already know the answer to the questions (eg the seating arrangements which are a listening comprehension question). If doctors already know the answer, then this can be very demotivating as there is no purpose in listening. The activities need to be designed to avoid this possibility” (Medical Manager)</td>
<td>Functional language, patient speak and phrasal verbs all have a role in the patient interview, and are likely to be seen as relevant by learners, though some more variation on the aspects they focus on would be helpful. More explanation could be provided to learners for the use of some inputs and processes (eg on the role of phrasal verbs as softeners).</td>
<td>“You really need to spell out why they are doing specific activities, because otherwise they don’t see the point, which can have a negative effect on the group as a whole” (Medical Manager)</td>
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**Inputs and processes for engagement: Aesthetic and emotional involvement**

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<th>Context specific (Calgary Guide)</th>
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<td>Some use of learner’s experience and knowledge in processes (eg lead in questions – what do you think?), Also using their predictions as inputs – Question One – asking learners if any of their suggestions were included in the listening. Some missed opportunities to link to their own experiences (eg 7a). Quotations from doctor to doctor create a tone of voice for the materials which is non-patronising. They position the teacher as intermediary for the learners, rather than as authorities on clinical communication. This can help overcome issues raised by Wu and Badger (2009). Additional reading inputs from doctors own experiences also encourage positive attitudes to communication supporting ‘does’ outcome. However, there is no use of literature from the medical humanities (eg poetry or short stories related to medicine. This would have contributed to the achievement of outcomes at the ‘does’ level. Seeing ‘simulated reality’ on video is also likely to engage emotional involvement.</td>
<td>“The learners really enjoy using the book, and they see it as being compassionate and humane. That really comes through” (Communication Consultant) “Using Good Practice gives the learners confidence in the language that they are using with patients. They are aware that sometimes they use broken language, and they know that this can have a bad effect on the patient. They compensate by trying to create their own expressions, but they don’t know if they are correct. So they feel the book gives them the appropriate language to use, so they have confidence in it” (Communication Consultant) “The tone is very helpful. It’s pitched right and its not patronising” (Hospital Trainer) “I really enjoy using the book and find the activities stimulating” (Polish Lecturer) The additional readings in the teacher's book are very emotionally involving, but I can only use them with weekend courses because of the time constraints” (Polish Lecturer)</td>
<td>“I really like the way the questions draw on learners’ existing knowledge and experience” (Hospital Trainer) “The book is very adaptable and can be used for multi-cultural groups” (Hospital Trainer) “The Calgary Guide is really important to give a structure to follow in the materials” (Retired GP) “Following the Calgary Guide is good, but I would organise the structure of each chapter differently. I would make the grammar and functions of the language much more explicit at the beginning” (Polish Lecturer) “Possibly there is a need for additional materials on the cultural context in which the consultation takes place” (Polish Lecturer) “The book is very good as a structured course, but it’s also very good to dip into on a 1:1 basis” (American Lecturer)</td>
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3.2 Annotated page from Unit 7

**Outcomes:**
- guidance
- knows

**Input:**
- authentic
- relevant metalanguage

**Process:**
- relevant
- feedback
- involves

**Think about**
- what differences in terms of patient communication you would expect to see between a doctor who follows a concordance-based approach (see panel on left) and one who does not.

**Negotiating a plan of action**

1. Discuss ______.
2. Provide ______ on action or treatment offered.
3. Obtain patient’s ______ of need for action, perceived benefits, barriers, motivation.
4. Elicit patient’s reactions and ______ about plans and treatments.
5. Take patient’s lifestyle, ______, cultural background and abilities into consideration.
6. Encourage patient to be involved in implementing ______.
7. Ask about patient ______ systems; discuss other ______ available.

**Key to abbreviations used**

authentic: uses authentic language and communication in the target situation

guidance: context specific communication guidelines

involves: inputs and processes encourage aesthetic and emotional involvement

metalanguage: provides explanation of the language and communication used (meta-language)

relevant: perceived by learners as relevant and useful
3.3 Teachers’ suggestions for additional for additional topics

Outside the remit

Socialising with colleagues                          Retired GP
Reading papers and writing / presentations          Retired GP
“I use some business English materials to help develop the learners’ skills in negotiation and socialising” Retired GP
Specialist language for case presentations          Spanish Hospital
More specialist lexis to talk with colleagues about patients, rather than to a patient Spanish Hospital
“The learners are not familiar with the English, lifestyle or culture used in American minority cultures. The biggest question from residents is how to deal with this” American Lecturer

Figure 14 – Teacher comments which related to aspects of medical communication outside the doctor patient interview
4.0 Discussion

This section will consider how effective the evaluative framework has been in evaluating Good Practice. The first stage is to see if the data from the teacher interviews on outcomes is in line with the outcomes in the needs analysis I carried out. The second is to look at what the evaluative framework has shown us about the effectiveness of Good Practice. The final stage is to consider what this tells us about the effectiveness of the framework.

4.1 Outcomes for course materials

Overall, as the data in section 4.0 suggests, most of the objectives that teachers identified fitted well within the outcomes identified by the needs analysis. A small number were outside the scope of the doctor-patient interview (e.g. language for case presentations to colleagues - see Figure 13). There was only one which was within the scope of the consultation, but not picked up by the needs analysis and this was a grammar outcome. This was perceived as an issue in relation to history taking by Medical Manager and Polish Lecturer. Both commented that the learners were often not sure which tense they should use in their history taking, and felt that the materials should draw attention to tenses. This was not so surprising where Polish learners was concerned, as they were outside the UK and doctors might not have a high IELTS score. However, Medical Manager's students were doctors working in the UK and would have IELTS scores over 7.0. At this level I would expect learners to have control over these aspects, apart from occasional slippage. This is evidence to support the suggestion by Berry, O’Sullivan and Rugea (2013) that the IELTS level for international doctors should be increased. It is also perhaps, an indicator that linguistic insecurity is a continuing problem and that it remains necessary to build competence and confidence in areas such as tense manipulation.

4.2 How well does Good Practice meet the needs of teachers and learners?

So what does the evaluation show us about how well Good Practice prepares doctors for the consultation in terms of their knowledge of and skill in using relevant communicative guidance, of their competence in the language and of their mastery of the broader communication skills?
The evaluation suggests that *Good Practice* has done reasonably well in helping learners achieve outcomes related to the context specific communicative guidance. In the section analysis, inputs were provided on the Calgary Guide, many of them showing it in use in the target setting. Processes were included which drew learners' attention to the various features of the Guide and provided feedback to learners. There were opportunities to produce the language in activities which were relevant to the target setting, and some flexible feedback was provided to teachers on this. Quotations from authoritative sources on clinical communication provided additional explanations and background for aspects of the guidance, and some processes were used to involve learners emotionally with these. Overall, the inputs and processes supported all four levels of outcome ('knows', 'knows how', 'shows how', 'does').

In terms of language, the evaluation showed that the inputs and processes supported a range of outcomes for the functional language identified in the needs analysis. Authentic input was provided for vocabulary needed to accomplish the different functions which the needs analysis identified. There was a strong emphasis on developing accuracy in listening as an outcome, with a range of comprehension activities to test skills and provide direct feedback. The processes provided opportunities to produce the language in the inputs in role-plays which drew on realistic scenarios with a doctor, patient and observer. However, opportunities for production and practice were relatively limited. Flexible feedback on the roleplays was provided in the teacher's book, but not the student's. The teachers did not make any comments on feedback / answers / suggestions provided in the materials, and I did not pick this up and did not pursue it. It would be interesting to know whether the lack of interest was because this was a feature that was much appreciated and therefore not worthy of comment or whether these experienced teachers felt confident in providing their own feedback.

The evaluation suggested that *Good Practice* needed to provide more support for outcomes in developing relational aspects of language. Some inputs, such as the language for making suggestions, contained relational language in the form of softeners. The processes drew learners attention to the use of this language in appropriate contexts, and gave them opportunities to use these, but it did not draw their attention to the relational aspects specifically. In addition, no input was provided to give an explanation of the importance of theses aspects of language in the consultation, or to give learners' meta-language which they could use to discuss these features.
The evaluation considered many of the relational features of language and communication in terms of the broader communicative competences. This included areas such as tone of voice, paralanguage and non-verbal communication. The examination of the inputs and processes for this area in the section analysis suggests that *Good Practice* does not provide enough opportunity for developing these types of outcomes. The audio inputs contained some aspects of strategic competence such as summarising and checking, but processes were not used to draw attention to these. In addition, some input was provided in communication boxes as advice from the author, but no processes were used to develop these beyond the 'knows' level. No meta-language was provided to describe these aspects. The DVD provided a range of inputs for communicative competences, but the processes developed only limited aspects of these, focusing mainly on the non-verbal aspects of communication. Other aspects paralinguistic and pragmalinguistic (in terms of humour) could also have been exploited.

4.3 Effectiveness of the evaluative framework for ESP materials

The effectiveness of the evaluative framework can be judged in terms of the insights I have gained from using it to evaluate *Good Practice*. Using the evaluative framework here has been revealing. Until I used the framework in this systematic way, I was not conscious of the full extent of the gaps mentioned in the previous section. In fact, all the observations on the quality of inputs and processes made in the analysis of the unit were informed by the evaluative framework and were more robust because of it. Some insights can also come from how likely it is that features requested by teachers would have been included in *Good Practice* by using the framework. However, although I found the evaluative framework an effective tool for assessing the *Good Practice* materials, there were also some key points which need to be considered in the future use and development of the framework.

- Breaking down the content of units and sections into inputs and processes can seem somewhat artificial, due to the inter-dependence of the two in the materials.
- In its current state, the framework may not be so easily used by others. Worked examples from different ESP contexts may help.
- There is a need for developers and teachers to use their own judgement in mapping between the needs analysis (TSA, DA) and the outcomes matrix, particularly in terms of the overlap between language and communicative competence.
When using the evaluation grid initially, it may be necessary to refer to the detail of what is covered by the criteria.

Until one is familiar with the method, a full application of the framework is time-consuming. However, once it has been mastered it becomes an approach rather than a bureaucratic task.

Adapting the evaluative framework for another context can be time consuming. However, this could provide additional benefits, depending on how close the context is to the one examined in this report. The content of the evaluation grid is flexible and appropriate criteria from Figure 9 can be used as required.

In general, the benefits of the approach are the following:

- The three-pronged process in the grid allows the user to see where a rich input is let down by inadequate exploitation in a process, or where good processes suffer from poor quality inputs. One example of this from the Unit 7 evaluation was the identification of the video as a rich input, but with inadequate processes used to exploit it.

- It permits an overview of how effective a unit, or a section within a unit is likely to be, based on the mix of outcomes, inputs and processes.

- It encourages reflection on how processes are broken down. E.g. the process of drawing attention, moving to opportunities to produce and then providing feedback.

A number of shortcomings in Good Practice were identified by teachers, some of which related to features which were already included. One example of these was for euphemisms and softeners. The evaluation showed that while inputs on softeners were provided in Unit 7, they were clustered in one part of the unit. It is likely that had the framework been used in the development of the materials that these would have been distributed more evenly across the unit, and indeed across the book. Another example related to doctors taking notes during the consultation, which was raised by Polish Lecturer. Again, taking notes was included in earlier units in the book, but primarily as a 'knows' and 'knows how' outcome. If the framework had been used, it is likely that it would have been flagged up as a 'shows how' outcome, and repeated more often.

In a slightly different context, Retired GP suggested as an outcome that learners would be more familiar with the general conventions of English conversation. If the framework had been used, it is likely this would have been identified as part of the discourse and strategic aspects of communication, both of which would be covered by the outcomes matrix.
Another example related to communicative competence, came from a comment by Medical Manager on the poor pronunciation skills of some doctors, which she felt made them sound mechanical. The research from Roberts et al. (2014) suggests that sounding mechanical is less likely to be a pronunciation problem and more likely to result from lack of skills in discourse and nonverbal competences. While evidence for this comes from research carried out as part of the needs analysis, the outcomes matrix would act as a check to ensure that this type of coverage is considered.

In terms of insights from the section analysis, three key areas are worth mentioning. The first is the missed opportunities which the evaluation showed for the audio inputs. Even within the limitations imposed on them by being scripted and acted, more features of language identified in the communicative competences could have been included. Using the outcomes matrix would have shown an imbalance in the range of communicative competence outcomes which the inputs supported. This lack in the inputs could then have been addressed, for example by including more features such as vague language, hesitations, overlapping and turn-taking in the scripts. Features of discourse and strategic competence could also have been included. Processes could then be used to draw attention to specific features of language, and to help learners to produce these features in their own communication.

Another area relates to the lack of literature used from the medical humanities. Increasingly, the medical humanities, which include literature, are an integral part of the training that healthcare professionals receive. As Lu and Corbett (2012) point out, literature can help develop the ethical and social awareness of doctors, as well as their ability to empathise with others. A final area relates to the DVD inputs. The evaluation identified these as rich inputs containing many features of communicative competence, but showed that the processes used did not fully exploit this potential. For example, in Unit 7, the processes focused almost completely on drawing attention to features of body language and ignoring other features the input contained, such as humour and back-channelling. While these were opportunities which were missed in the creation of the materials, one of the benefits of the framework is that it can be used by teachers to identify opportunities such as this to adapt and supplement with their own materials.
5.0 Conclusion

This report together with the publications which make up the total submission for this PhD, have identified and begun to fill a gap in the knowledge relating to materials for English language and communications training for doctors. The report has also brought together literature from materials development and from ESP to fill a gap in the availability of evaluation tools for ESP materials.

Contributions to the literature

Each of the research publications listed in this report, have contributed to the literature of materials development in their own way. In addition, this report provided an in-depth evaluation of Good Practice, making a further contribution to the literature. The tools which where used to carry out this evaluation, in themselves also make a contribution to the literature, especially making a link between the needs analysis (as a core methodology in ESP) and the evaluation and development of materials.

The published research has been incorporated into this report, highlighting the contribution which they make to the literature. McCullagh (2010) used the methodologies which have been further developed in this report, and identified some of the characteristics of the two distinct learner profiles using Good Practice. McCullagh (2011) added detail to the rationale and methodologies in McCullagh (2010) and outlines in detail the needs analysis process undertaken for the book. McCullagh (2013) demonstrates how materials development methodologies can be used to develop relational language and communication for specific workplace contexts. Both of these are relevant to this report. Finally, McCullagh (2015) provides a solid foundation of knowledge about the role of the ESP coursebook on which this report builds.

Potential contribution to materials writers and ESP writers

1. The development and use of the evaluative framework described in this report has the potential to make a significant contribution to those creating EFL and ESP materials. The framework provides tools for analysing the inputs and processes in a set of materials, and linking these to a set of outcomes. The outcomes grid component has been developed for ESP materials, where the outcomes are
identified using a needs analysis. However in EFL, where a set syllabus is usually used, there is also scope for its use in its use in analysing outcomes. While the distinctions between knows, knows how, shows how and does are not as central as they are in the ESP context, they can provide a very useful guide to what outcomes can be expected from a set of materials. The professional communicative guidelines may be less relevant to EFL. However, I would argue that there is scope for including the broader communicative competences in EFL, both to help build learner’s confidence in using the language in the classroom, and also when they come to use it in practice. The evaluative grid, which looks at the inputs and processes, can also be used in EFL and ESP materials, though the principled criteria used in this instance are selected for an ESP context. Evaluating inputs and processes alone, can give a materials developer a good insight into how varied their materials are. By using them with the principled evaluative criteria, the developer can begin to get a insight into their quality.

2. There are a number of lessons which I have learnt from working with publishers which have implications for materials writers. The first is that while a writer may have very good innovative ideas, and a clear methodological rationale for their materials, this will need to be weighted against the commercial interests of the publisher. Publishers welcome proposals for innovative materials. However, in practice, these will need to fit in with their existing models, which focus primarily on linguistic competence and on providing activities with closed answers. The extent to which this happens and the compromises which have to be made on the part of the writer needs to be borne in mind by writers when presenting proposals for course books. My experience was that an innovative proposal, which does not exactly fit the model, may be accepted without too much revision. However, the subsequent revisions of individual units will change the materials so that they fit the model more closely. This can be to the point where the innovative features which originally made the proposal so attractive are diluted to fit the established model, and lose their impact. By anticipating this process at the proposal stage, the materials writer can shape their materials so they are more in line with what will eventually be required.

3. While the evaluative framework provides a tool for ESP and EFL materials developers to analyse materials in a more systematic and fine-grained way, its use still relies heavily on the developers knowledge and experience, as well as their
intuition and feel for what they want to achieve. As well as a tool which can help in their analysis of the variety and quality of the materials while writing, it can also help in the planning and proposal stage. This can be really helpful for developers who want to introduce innovative features, as the tools will help them visualise more clearly how their innovations can be integrated into the materials in practice.

4. A final point is that if teachers rely only on a diet of materials following the established EFL model, their expectations of what materials can achieve, and how they can achieve them, are likely to be limited. They are also likely to use a limited set of criteria when evaluating materials. This means that when asked by publishers to provide feedback, the teachers will concentrate on a limited number of areas. The feedback from the teachers for the most part did not identify what I considered to be deficiencies in the materials, and this can be explained in terms of their expectations of what materials should achieve. Developments in ESP needs analysis (eg Basturkmen and Huhta), increasingly highlight the communicative, and to some extent the discourse aspects of language but these do not appear to be reaching teachers in the way that they should. This suggests a need for broader training for teachers, both in needs analysis and in the development of materials to enable them to meet those needs. The training should also cover evaluating, adapting and supplementing materials.

Future Research

In future research, I plan to refine the evaluative framework to increase its usefulness to developers and teachers. One way in which this can be done, is to use the framework to evaluate the effectiveness of Good Practice for use by undergraduates. Another is to examine how effectively it can be used to adapt and supplement ESP materials from other areas. I also look forward to using the framework in the future development of ESP materials in other areas of skills for medical professionals.
6.0 References


Berry, V., O’Sullivan, B., and Rugea, M. (2013). Identifying the appropriate IELTS score levels for IMG applicants to the GMC register.


URL http://eprints.nottingham.ac.uk/11928/ (accessed 3.28.15).


6.1 Appendix 1 Submissions

Submissions

Report


### 6.2 Appendix 2 Breakdown of writing responsibilities

Breakdown of writing responsibilities for *Good Practice: Student's Book and Teacher's Book*

<table>
<thead>
<tr>
<th>Section</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to communication</td>
<td>Marie McCullagh</td>
</tr>
<tr>
<td>Unit 1 Receiving the patient</td>
<td>Ros Wright</td>
</tr>
<tr>
<td>Unit 2 The presenting complaint (DVD)</td>
<td>Ros Wright</td>
</tr>
<tr>
<td>Unit 3 Past medical &amp; family history (DVD)</td>
<td>Ros Wright</td>
</tr>
<tr>
<td>Unit 4 Social history</td>
<td>Ros Wright</td>
</tr>
<tr>
<td>Unit 5 Examining a patient (DVD)</td>
<td>Ros Wright</td>
</tr>
<tr>
<td>Unit 6 Giving results</td>
<td>Marie McCullagh</td>
</tr>
<tr>
<td>Unit 7 Planning treatment &amp; closing the interview (DVD)</td>
<td>Marie McCullagh</td>
</tr>
<tr>
<td>Unit 8 Dealing with sensitive issues</td>
<td>Ros Wright</td>
</tr>
<tr>
<td>Unit 9 Breaking bad news</td>
<td>Marie McCullagh</td>
</tr>
<tr>
<td>Unit 10 Communicating with challenging patients (DVD)</td>
<td>Marie McCullagh</td>
</tr>
<tr>
<td>Unit 11 Communicating with the elderly</td>
<td>Marie McCullagh</td>
</tr>
<tr>
<td>Unit 12 Communicating with children (DVD)</td>
<td>Marie McCullagh</td>
</tr>
</tbody>
</table>
6.3 Appendix 3 Outline of interview structure and questions

Outline of interview structure for teachers of Good Practice

Teaching profile
How long have you been teaching EFL, ESP and EMP? (English for Medical Purposes)
How familiar are you with the subject area?

General questions about your usage of Good Practice
• How many of the components have you used: Student's book, Audio CD, Teacher's book, DVD
• How long have you been using Good Practice?
• What course(s) do you use Good Practice with?
• Can you describe the courses in terms of the following: length & intensity, number of students, repeat or one off, course
• What are the objectives of your learners in following an EMP course (CPD, personal skills development, pass exam etc)
• What are the main reasons you chose to use Good Practice for this/these course(s)?
• Did you consider any alternatives to Good Practice?
• What other materials (if any) do you use with these courses?

Evaluation
• What are the areas that you feel it does well?
• Are there any additional areas you would like to see covered?

Outcomes
• To what extent do the materials match the outcomes your learners need to achieve?

Communication and Language
• Does Good Practice cover the range of language needed for a good consultation?
• How much input did your learners have on clinical communication prior to your course?
• How important is it that Good Practice covers communication as well as language?
• How important is it to include communication guidance such as the Calgary Guide?
• How well do you think Good Practice blends language and communication?
• Does Good Practice cover the range of knowledge and skills needed for a good consultation?
• How well does it develop the knowledge and skills necessary for a good consultation?

Use of the materials
• Have you supplemented or adapted the materials. How and why?
The questions set out in the interviews were designed to provide information on the following areas:

1. the different learning contexts and objectives for learners students
2. the teachers' use of the different components of Good Practice
3. the teachers' existing levels of knowledge / skill in language teaching the teachers' existing levels of knowledge / skill in the subject area
4. how well teachers feel Good Practice meets the needs of their learning context (local criteria)
5. the ways in which teachers use the book
6. how teachers adapt or supplement the book

Pre-determined exploratory questions focused on 3 and 5 and linked to the evaluative framework were used. Examples are:

Respondent says "find the video very useful"
ask why is that and gently probe along the lines of the criteria:

- because the authentic type setting is very engaging?
- because of the language it provides?
- because it shows aspects of communication skills which couldn't easily be explained otherwise

For supplementing with own materials – why – what do their own materials add? Is it because outcomes are not covered, because there is not enough authenticity in Good Practice, or additional language / communication skills are required which are not covered by Good Practice?
6.4 Appendix 4 - Questionnaire

Dear ____________, as I have explained in my previous emails, I am collecting data on Good Practice as part of research on what makes good learning materials. These are some questions about your use of Good Practice to give me an understanding of your particular teaching context. There are also some questions about your experience as an English teacher, and in teaching English for Medical Purposes. These relate to how learning materials support teachers at different levels of experience. I really appreciate that you are taking the time to help with this research and very much value your input.

General

Approximate number of years in EFL teaching ____ / ESP ____ / EMP ______

How long have you been using Good Practice? ____ years ____ months

How many of the components are available / have you used (please circle): Student's book ; Audio CD ; Teacher's book ; DVD

What course(s) (max 3) do you / have you use(d) Good Practice with? ____________________________
_______________________________________
_______________________________________
_______________________________________

Can you describe the courses in terms of the following (copy and paste this section for each course);
Type of learners __________________________
Average number of learners in class ___
Length of course ___ days / ___ weeks / ___ months
___ hours per day / ___ hours per week
Is course repeated or one off? (please circle)

What are the course objectives for learners? (please circle): Continuing Professional Development ; Own interest ; PLAB ; Professional exam; Other ____________________________
_______________________________________
_______________________________________

What are/were the main reasons you chose to use Good Practice for this/these course(s)?
_______________________________________
_______________________________________
_______________________________________
What other materials (if any) do you use with these courses?

How do you use the book? (please underline)
Use specific chapters / Use parts of chapters / Work through the whole book

Have you adapted or supplemented Good Practice to meet the needs of your learners? If so, how?

What outcomes does your course have in terms of knowledge of and skills in using the Calgary Guide?

What broader communication skills (eg active listening skills) do you want your learners to acquire by the end of the course (in terms of knowledge and skills)?

What outcomes does your course have in terms of knowledge and skills in using the Calgary Guide?

What outcomes does your course have in terms of broader communication skills?
6.5 Appendix 5 – Informed consent form

Informed consent Form

Thank you for agreeing to participate in this research project. My name is Marie McCullagh and I am the co-author of Good Practice: Communication Skills for the Medical Practitioner (2008, Cambridge University Press).

I would like to investigate how the materials are used in specific contexts with doctors and to what extent they meet the needs of learners.

You will remain anonymous when the findings of the data are reported
You can stop the interview at any stage
You can skip any questions you prefer not to answer in the questionnaire
You can decide not to answer any questions you would prefer not to in the interview
The interviews will take approximately 30 minutes

Participant
Date
6.6 Appendix 6 – Teacher profiles

Brief Summary of teachers’ profiles

Interviewee 1: Retired GP teaching refugee doctors in UK
Interviewee 2: Medical Manager working as a communication skills trainer working for a Deanery in UK
Interviewee 3: UK ESP teacher teaching English in a Spanish Hospital
Interviewee 4: Communication consultant teaching on a range of ESP courses in the UK
Interviewee 5: UK Hospital trainer based in an NHS Trust
Interviewee 6: Polish Lecturer, based in a Polish university with a medical school
Interviewee 7: US lecturer based in a US university in a medical school
<table>
<thead>
<tr>
<th>Name</th>
<th>Ex GP</th>
<th>Medical Manager</th>
<th>Spanish Hospital</th>
<th>Communication Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Male</td>
</tr>
<tr>
<td>Nationality</td>
<td>UK</td>
<td>UK</td>
<td>UK</td>
<td>UK</td>
</tr>
<tr>
<td>Based in</td>
<td>UK</td>
<td>UK</td>
<td>Spain</td>
<td>UK</td>
</tr>
<tr>
<td>Years teaching English</td>
<td>3</td>
<td>20</td>
<td>25</td>
<td>23</td>
</tr>
<tr>
<td>Years teaching EMP</td>
<td>3</td>
<td>20</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>Level of medical knowledge</td>
<td>Very high</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Length of time using Good Practice</td>
<td>2 years</td>
<td>8 years</td>
<td>7 years</td>
<td>7 years</td>
</tr>
<tr>
<td>Components used</td>
<td>Student book only</td>
<td>Student book only</td>
<td>All the components</td>
<td>All the components</td>
</tr>
<tr>
<td>Other books used</td>
<td>English in medicine – Glendinning, Sam McCarter English for Careers - medicine, other US books (unnamed)</td>
<td>None</td>
<td>None</td>
<td>Language in use, Cambridge (grammar)</td>
</tr>
<tr>
<td>Course(s) description</td>
<td>Remedial courses with individual doctors employed by the NHS who have issues with communication. 8 morning sessions over a month, mainly OSCE type scenarios</td>
<td>Interdisciplinary courses for L2 speakers, includes nurses, physiotherapists, radiographers etc. Intensive courses for doctors who are taking several attempts to pass exams or have been told by supervisors to improve their communication. Possible litigation is an issue. Vary in nationalities – European and Asian Totally varied in amount of communication skills training which they have had. No negative attitudes to communication skills after first session.</td>
<td>In-hospital sessions with doctors and trainee doctors for CPD. Focus on using language to present to colleagues, rather than interacting with patients. However, some activities around this.</td>
<td>One week intensive for CPD. Young professional doctors from medical universities in Spain and Czech republic Practising doctors, mainly from Spain</td>
</tr>
<tr>
<td>Name</td>
<td>UK Hospital trainer</td>
<td>US Lecturer</td>
<td>Polish Lecturer</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------</td>
<td>-------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Nationality</td>
<td>UK</td>
<td>USA</td>
<td>Poland</td>
<td></td>
</tr>
<tr>
<td>Based in</td>
<td>UK</td>
<td>USA</td>
<td>Poland</td>
<td></td>
</tr>
<tr>
<td>Years teaching English</td>
<td>10</td>
<td>27</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Years teaching EMP</td>
<td>10</td>
<td>18</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Level of medical knowledge</td>
<td>High (Trained nurse)</td>
<td>Medium</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>Length of time using Good Practice</td>
<td>2 years</td>
<td>5-6 years</td>
<td>5-6 years</td>
<td></td>
</tr>
<tr>
<td>Components used</td>
<td>Student book only</td>
<td>Student book &amp; DVD</td>
<td>All components</td>
<td></td>
</tr>
<tr>
<td>Other books used</td>
<td>Cambridge English for Nursing, Glendening, Hospital English</td>
<td>Medically speaking rules, Medically speaking idioms, Well said. Also uses TED.com and articles from the New York times.</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Course(s) description</td>
<td>Embedded 10 week programme with standalone sessions for 1.5 hours per week. Multi-disciplinary sessions for those who want to improve language and communication skills. Continuing medical development for doctors already in post. Not mandatory after first session. Very wide range of nationalities: Sri Lanka, India, Poland, Bulgaria, Romania, Russia, Italy, Spain Portugal, Philippines.</td>
<td>Teaches practicing doctors on a remedial basis where there are communication issues with patients or colleagues. Classes are 1.1 and can be short term, or extend over one year to three years.</td>
<td>Provides CPD for doctors who want improve their communication skills, so not compulsory and no exams. Courses are 2 hours per week and run over a long period. Occasionally courses are run over weekends.</td>
<td></td>
</tr>
</tbody>
</table>
6.7 Appendix 7 - Roles of ESP materials

Dudley Evans & St John (1998)

**Source of Language** (present real language as it is used, and the full range that learners require)

**Learning Support** (involves learners in thinking about and using the language, stimulates cognitive processes. Provide a sense of progression)

**Stimulation and Motivation** (challenging yet achievable, offers new ideas and information but grounded in learners experience and knowledge, provides reasons to communicate)

**Reference** (for self-study or reference purposes, explanations, examples and practice activities with answer keys)

Hyland (2003, 2006)

**Model** (representative samples which illustrate particular features, structures or functions of the language being studied)

**Scaffolding** (opportunity to discuss, analyse and manipulate language and constructive feedback)

**Stimulus** (provide ideas and contexts that stimulate and promote discussion in writing, encouraging students to make connections to their own experiences, articulate their ideas and interact with others)

**Reference** (information about language, rather than the practice of language).
6.8 Appendix 8 - 'Can do' statements for UK doctors

'Can do' statements for doctors from Berry, O'Sullivan and Rugae (2013)

Reading
Can read and understand handwritten, typed or online:

- Prescriptions
- Labels
- Signs
- Drugs charts
- Dosage regulations/protocol guidelines
- X-rays/radiography
- Laboratory reports
- Blood test results/Results of other investigations
- Emergency procedures/advanced life support algorithms
- Abbreviations (UK, as different in all countries)
- Medical records/patients' clinical notes
- Referrals
- Letters/notes from other doctors/hospitals
- Letters/written communication from patients
- Discharge and clinic letters
- Medical legal reports
- Forms/complaint forms
- Medical journals/textbooks/dictionaries
- The BNF and BNF for Children (British National Formulary)
- Newspapers/leaflets/posters
- Trust policies/procedures/protocols – hard copy and on Intranet
- Contracts outlining their responsibilities
- Documents phrased in regulatory terms
- Hospital management minutes/directives
Can:
- skim long texts quickly for essential information
- understand lengthy, complex instructions including details on conditions and warnings, provided difficult sections can be reread.
- understand in detail a wide range of lengthy, complex texts likely to be encountered in professional life, identifying finer points of detail
- demonstrate comprehensive understanding of personal messages in informal letters, emails etc.
- when working under time pressure, demonstrate broad understanding of texts conveying detailed, new information

**Writing**
Can handwrite, type or dictate into a dictaphone for later transcription clear, concise, accurate and systematic:
- Patients’ records, chronological histories, case notes, ward round notes
- Prescriptions
- Notes to colleagues
- Clear, precise instructions/orders to nurses
- Clear, precise instructions to patients about drug protocols
- Flow charts
- Sick notes to employers/ for benefits
- Forms, death certificates
- Appointments
- Handover of patient care
- Communicate with labs to get results
- Communicate with patients by email
- Translate findings from patient contact into writing
- Referral letters
- Letters/notes to other doctors/hospitals
- Letters/other forms of written communication to patients
- Discharge and clinical letters
- Medical legal reports/statements to lawyers
- Police/coroners/court reports
- Detailed letters to insurance companies
- Letters to management re: red tape
- Letters to PCTs to obtain non-routine medications
- Writing therapy letters (in psychiatry)

Can:
make full and accurate notes and continue to participate in a meeting or consultation
express themselves with clarity and precision in personal correspondence, using language
flexibly and effectively
handle a wide range of routine and non-routine situations in which professional services
are requested from colleagues or external contacts
write a set of instructions with clarity and precision
describe and interpret empirical data on professional topics for a general audience
transfer information from one place to another
interpret what they have read and rewrite it for different audience

**Listening**
Can listen and pick out relevant and important information from:
- Patients: adults/children/elderly/disabled/brain damaged/otherwise impaired/drunken
- Families of patients/carers
- Other doctors /senior and junior colleagues/GPs
- Nurses/Midwives
- Social workers/child protection workers
- Physiotherapists/dieticians/language therapists/paramedics/ radiographers/lab. technicians
- Police/solicitors/coroners
- Pharmacists/drug companies’ representatives
- Management/Admin. staff
- Seminar/conference speakers

Can pick out relevant and important information in:
- Emergency situations while doing other things
- Excitable or stressful situations with considerable background noise
- Handovers/ward rounds/multi-disciplinary meetings/discharge situations
- Seminars/conferences
- Conversations by phone/Skype/videolink/conference calls

Can:
- follow extended, natural speech even when it is not clearly structured
- extract the gist of what is said in informal meetings and discussions involving multiple participants, marked by colloquialisms and overlapping turns
- extract the gist of what is said when conversation is animated and delivered at a fast natural rate in a range of accents
- extract gist, detail, purpose and main points from formal discussions involving detailed information such as facts or definitions related to professional topics
- integrate information from multiple sources and follow detailed instructions to carry out complex tasks involving unfamiliar process or procedures
- understand a wide range of recorded, broadcast and telephone audio material, which includes some non-standard usage, colloquialisms and regional accents
- identify finer points of detail including implicit attitudes and relationships between speakers

**Speaking**
Can use appropriate tone and suitable vocabulary when interacting with:
- Patients: adults/children/elderly/disabled/brain damaged/otherwise
- impaired/drunken
- Families of patients/carers
- Other doctors /senior and junior colleagues/GPs
- Nurses/Midwives
- Social workers/child protection workers
- Physiotherapists/dieticians/language therapists/paramedics/radiographers/lab.
- technicians
- Police/solicitors/coroners
- Pharmacists/drug companies’ representatives
- Management/Admin. staff

Can use appropriate intonation, stress and word choice to:
• Give detailed information at handovers
• Discuss and evaluate the nature and relative merits of particular choices of procedures, courses of action or care packages
• Give instructions on carrying out a series of complex professional procedures
• Frame critical remarks in such a way as to minimize any offence
• Be persuasive
• Deliver bad news
• Request/receive/give results
• Explain complex, technical findings using suitably non-technical words and phrases
• Express sympathy or condolences, enquire into the causes of unhappiness or sadness and offer comfort
• Summarize what the patient is saying
• Deal with emotive circumstances
• Justify what they do (everything to everyone)

• Can:
  pronounce words in a way that is readily comprehensible to those familiar with standard forms of English
  produce clear, smoothly flowing, well-structured speech which helps the hearer to notice and remember significant points
  modify their speech to express degrees of commitment or hesitancy, confidence or uncertainty
  adjust their level of formality and style of speech to suit the social context, formal, informal or colloquial as appropriate
  use appropriate technical terminology when discussing their area of specialisation with other specialists
6.9 Appendix 9 - Rationale for collapsing elements in figure 9

Source of language => Inputs as a source of language and communication

'Language in authentic use' [1] has been changed to reflect the criterion 'real language as it is used' [2] and to cover the use of the language in the target setting. The change also reflects the need to consider aspects of communication beyond language. Because of the importance of covering the needs identified in the needs analysis, the 'full range that learners require' [2] has been used as a separate criterion. 'Maximising learners’ exposure to the language' [3], while important, is difficult to quantify and has not been used.

Supporting the learner => Processes to support learners

There were difficult choices to be made here. Consistency and a recognisable pattern and a sense of progression [4,5] are important criteria and although not mentioned specifically are implicit in the three criteria used in figure 14. Many of the criteria included in 'helping learners feel at ease'[6] are controlled by publishers. Aspects such as the voice of the materials can be included as part of engagement. 'Draw learners’ attention to linguistic features'[7] has been included, with some modification to reflect the broader communicative focus. 'Provide opportunities for outcome feedback'[8] has also been included, given the central nature of feedback in learning. 'Opportunities to use the target language to achieve communicative purposes'[9], has been changed to reflect both the need to use language and communication, and merged with 'exploitation match how the input would be used outside the learning situation'[14].

Provide motivation and stimulation => Inputs and processes to engage learners

'Intellectual, aesthetic and emotional involvement'[10] has been included as a criteria, but for reasons of space the intellectual component will be considered under whether materials are 'perceived as relevant and useful'[11]. The criteria of 'challenging yet achievable'[12] and 'offer new ideas'[13] are important, but they have not been included for reasons of space.

Acting as a source of reference => removed

'Are materials suitable for self-study'[15] is a useful criterion, but because many of the aspects are controlled by the publisher rather than the materials writer, it has not been used. Some aspects of the criterion will be covered by 'providing feedback'[8]. 'Are
materials complete'[16] and 'Do materials list objectives'[17] are both relevant criteria, but publisher controlled so they have been omitted from this grid. Finally, 'materials provide information about language'[18] has been moved to the inputs column, and expanded slightly. As a result, the source of reference column has been removed.
6.10 Appendix 10 – Overview of published research work

Overview of my published research work

McCullagh (2010) provides the basis for this report by carrying out an initial evaluation of Good Practice. Methodologically, it drew on Maley's (2003) inputs, process and outcomes. It used principled criteria in the evaluation, but did not fully take into account the needs of an author post use evaluation. Support for explicit focus on communication skills, though didn't differentiate between specific guidance and more general communication skills. A key finding of the research was the wide range of learners, context and uses of the materials, and the range of needs. Major distinction between needs of post-graduates preparing for the workplace and undergraduate medical students.

McCullagh (2011) is a longer piece of work. It outlines the medical context for which the materials were developed, and provides more detail on the rationale for developing Good Practice and the needs analysis which was undertaken for its development. Methodologically, this work provided more detail on the role of principled criteria in the development of the materials. (These were to: achieve impact, be relevant and useful, have authenticity, promote confidence and provide opportunities for feedback on output). It referred to the importance of the Calgary Guide and related guidance on clinical communication, both for the needs analysis and as in the structuring of the materials. It also provided a rationale for including non-verbal aspects of communication, the role of culture and areas such as para-language in developing learner's language and communication skills for the consultation.

McCullagh (2013) provides a different perspective on relational aspects of language which were discussed in the earlier works in the context of the doctor-patient interview. It describes a case study in which authentic video inputs are used to create materials to develop learners' interpersonal language for working in teams. Tomlinson's text driven approach (1998, 2011) was used to inform the selection of engaging input video texts and to inform the development of engaging activities to exploit the materials. Koester's (2010) discourse approach was used to identify features representative of the target context on which the activities would focus. The discourse approach links closely with the DA used in
ESP needs analysis methodology in this work. In addition the article identified the need to raise learners awareness of the role of the paralinguistic and non-verbal features of communication in interpersonal language, and highlighted the potential of authentic video as an input in achieving this.

McCullagh (2015) focuses directly on the role of the ESP course book, rather than on the development of materials for a particular area. It is wide ranging in its scope and includes the following areas:

- the importance of subject and target context as defining features of ESP
- how subject and course design affect the ways in which the course book is used
- the limitations of existing materials evaluation methodologies for ESP
- assumptions made around the expertise of the ESP teacher
- possibilities which new technologies offer for the ESP course book

The limitations of existing materials evaluation methodologies in fully reflecting the focus on subject and target context in ESP is the gap which this work addresses most directly. The different ways in which course books are used, depending on the subject and course design relates both to the differences between post-graduate and undergraduate use of Good Practice identified in McCullagh (2010), and to decisions by teachers on whether to use as a whole or as individual units or sub-units. This work addresses the assumption that all ESP teachers possess the knowledge and skills required to develop the materials they need by the development of the evaluative framework. Finally, the potential of new technologies is relevant in terms of overcoming some of the limitations which emerged from the evaluation of Good Practice, such as lack of space to fully exploit inputs.
6.11 Appendix 11 – Revision of part of Unit 7

Lead in

*Read the poem A Parallel Universe.* It was written by a junior doctor as part of a project at the University of Bristol medical school.

A Parallel Universe

Just around the corner
There is a parallel universe

A 21 year old man lives there
He’s my age
But his life is worlds away from mine
Abused as a child
A father at 18

I’d cross the road to avoid him in the street

Works at a local garage
Where my car was fixed last year
Our worlds touch, but never meet
Until today

He’s in floods of tears in front of me
In the doctor’s surgery
His mother is being abused
His sister committed suicide
He’s wanted by the police
He’s lost his job
Has a daughter to support

What’s the point in living?
he asks me

What do I say?
He goes back to face his world with some antidepressants
And I go back to my parallel universe
Just around the corner.

[ http://www.putofourheads.net/cooh/handler.php?id=424 ]

.What would you say to this patient ?
.Work in small groups and share your examples.
.Do you have your own example of a parallel universe ?

Think about

Encouraging patients to change unhealthy habits is a significant part of a GP’s role.
Sometimes the habits lead to a lower quality of life or sometimes they can be life
threatening.

• Think about a habit that you [or someone close to you] would like to break or you have
managed to break
• What would motivate/motivated [you /them] to break the habit?
• What difficulties would it/did it cause you?

Explaining treatment

1. Listening [sound only]

You are going to listen to a consultant discussing a plan of treatment with a patient who has a
drink problem.

• Write down a question you would ask a patient who is drinking too much
• Now listen to the consultation
• What words would you use to express how you think the consultant feels at the end of
the consultation ?
• Did the doctor ask the question that you noted?

This activity replaces the Think about exercise in the original unit. The original exercise does
not provide any opportunity for learners to reflect on the challenges they may have had
when trying to break a habit. Reflecting on the challenges may help them to have a better
understanding of the patient's perspective.

Unknown Author
12/08/2015 15:33

This listening replaces the
listening text in the original unit.
This listening text makes a link
to the poem – dealing with a
distressed patient. This text is
also more likely to have greater
impact as it is an authentic
recording. It aims to raise
awareness of the different
perspectives that doctors and
patients have of the interview
and for learners to consider
things from the patient's
perspective.

Unknown Author
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- Has your opinion of the relationship between the doctor and patient changed by watching the video?
- Why do you think the patient is laughing?
- How would you approach this consultation?

2. Language Focus: Questions

Read the transcript of the dialogue you have just listened to.

Transcript
Dr: Ahhm... You're keeping yourself healthy? (1)
P: No
Dr: Why not? (2)
P: (laughs) I've been drinking like a fish
Dr: How much have you been drinking? (3)
P: You won't believe me.
Dr: Tell me.
P: About a pint of vodka a day
Dr: How much? (4)
P: A pint.
Dr: A pint of vodka a day? (5) OK. Was this just on holiday or just everyday? (6)
P: Every day... Basically every single day.
[intercut patient... Sometimes the way how he's talking to me I don't like that ]
Dr: You're telling me you're soaking your liver in alcohol every night, with vodka... a bottle of vodka a day? (7)
[Patient laughs]
Dr... it's not funny

[intercut by patient... I don't like when somebody's pushing me, yeah, like raising voice which he did once, I didn't like that yeah ]

Dr: You're sitting here because you have damage to your liver. We will not be able to treat you full stop if you cannot start to improve your lifestyle with the alcohol ...
[patient laughs]
Dr... you're giggling and laughing at me, what does that mean? (8)
P: No, I'm not laughing...
Dr: Are we going to do this seriously or not? (9)
P: [continues to laugh] Of course...
Dr: But it's not a joke dude
P: I know ...
[voice over from doctor explaining that patients need to take responsibility for their lifestyle choices]
Dr: We have so many patients we put on treatment, we see so many people who need liver transplants, you are 27 years old, I don't ever want to think about that for you. OK. So I'm writing in big letters here, stopping vodka, getting a GP, sorting out life...
[patient leaves]

Identify what kind of questions the doctor asks the patient

1. You're keeping yourself healthy? closed
2. Why not? open
3. How much have you been drinking? closed
4. How much? closed – showing emphasis / surprise
5. A pint of vodka a day? - closed – repeating what has been said

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6. Was this just on holiday or just everyday? closed
7. You're telling me you're soaking your liver in alcohol every night, with vodka... a bottle of vodka a day? closed - getting patient to confirm
8. You're giggling and laughing at me, what does that mean? closed like a tag question - you're laughing at me aren't you?
9. Are we going to do this seriously or not? closed

- What effect do these questions have on the patient?
- Which of these questions would you change?

3. Negotiating a plan of action: Calgary Cambridge Guide

Below are seven stages recommended by the Calgary Cambridge Guide when negotiating a plan of action with a patient.

1 Discuss options
2 Provide information on action or treatment offered
3 Obtain patient's view of need for action, perceived benefits, barriers, motivation
4 Elicits patient's reactions and concerns about plans and treatment
5 Take patient's lifestyle, beliefs, cultural background and abilities into consideration
6 Encourage patient to be involved in implementing plans
7 Ask about patient support systems; discuss other support available

3a Think about the last time you went to the doctor's. How many of these stages did the doctor cover? Were you happy with the outcome?

b Listen to the following consultation. How many of the stages of the Guide does the doctor cover.

c Read the audio script dialogue on p.144 and underline the sections that correspond to the recommended stages of the Calgary Cambridge Guide
4. Language and content

a Work in threes. Go back to transcript 1. Using the guidelines from the Calgary Guide, and the language in the box below, recreate the dialogue to achieve a more satisfactory outcome for both the patient and doctor.

b Now one of you should take the role of the doctor, one the patient and one the observer.

Observer: give feedback to the person playing the role of the doctor
Comment on their use of open and closed questions
How many opportunities the doctor gave the patient to be involved in the treatment plan?

Patient: give feedback to the doctor on how you felt the consultation went
Comment on the effect the questions had on you
How well the doctor was able to respond to your non-verbal language?
How you felt at the end of the consultation. Did you feel there was a positive outcome?

Doctor: tell the other two participants how you feel the consultation went

c Rotate the roles twice more, so each person gets to take each role once.

Language for a collaborative approach to the consultation

Involving patient by making a suggestion rather than a directive
My suggestion for tackling this would be... What do you think?

Encouraging patient to contribute their thoughts
I’d be interested in hearing your thoughts about ways that I could help you stop smoking
What do you think would help?

Negotiating a mutually acceptable plan
What I’ve suggested makes sense to me... but if it isn’t right for you, we’ll need to think again. Tell me what you feel about it
Offering choices: encouraging patient where possible to make choices and decisions
There are several things we might try here, each one as I've said with their own advantages and disadvantages... Do you have any clear preferences?

Check with patient if they accept planning
Now can I just check that you are happy with the plan?
FORM UPR16
Research Ethics Review Checklist

Please include this completed form as an appendix to your thesis (see the Postgraduate Research Student Handbook for more information)

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<tr>
<th>Postgraduate Research Student (PGRS) Information</th>
<th>Student ID: 748357</th>
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<tbody>
<tr>
<td>Candidate Name: Marie McCullagh</td>
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<tr>
<td>Department: SLAS</td>
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<tr>
<td>First Supervisor: Professor Sue Wright</td>
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<tr>
<td>Start Date: 1.02.2014 (or progression date for Prof Doc students)</td>
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Study Mode and Route:
- Part-time [ ]
- Full-time [ ]
- MPhil [ ]
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Title of Thesis: A framework for designing and evaluating ESP materials for English and communication skills in the doctor-patient interview

Thesis Word Count: 11,250 (excluding ancillary data)

If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University's Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study. Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

UKRIO Finished Research Checklist:
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a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame? YES

b) Have all contributions to knowledge been acknowledged? YES

c) Have you complied with all agreements relating to intellectual property, publication and authorship? YES

d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration? YES

e) Does your research comply with all legal, ethical, and contractual requirements? YES

*Delete as appropriate

UPR 16 (2013) – November 2013
Candidate Statement:

I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)

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<th>Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):</th>
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Signed:  
(Student)  
Date:  

If you have not submitted your work for ethical review, and/or you have answered ‘No’ to one or more of questions a) to e), please explain why this is so:

My work is the evaluation of a text book and language course I published. My supervisor and I considered that the ethical dimension did not warrant application to the committee. There are no data that are sensitive, confidential or harmful. The only person who could be affected by the opinions expressed is the author, i.e. myself. The publishers have given their approval for the work.

Signed:  
(Student)  
Date: 7.09.2015