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CLINICAL CASE PRESENTATIONS: AN OVERVIEW OF AN EXEMPLAR MEDICAL SPEECH EVENT

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Abstract. Clinical case presentations are core medical speech events carried out in medical and teaching institutions worldwide among both students and active practitioners. While in most non-English speaking locales these events will usually be communicated in a local language they are also, on set occasions, often performed in English. In order to understand both how and why clinical case presentations are carried out in English in non-English speaking Asian locales, the author visited 8 medical universities and/or affiliated hospitals in 6 Asian countries, observing a total of 36 English clinical case presentations, followed by interviews with 25 different clinical practitioners, teachers, or medical students. The author then analyzed the collected speech event data in terms of Hymes’ (1974) SPEAKING model, augmented by Swales’ (1990) focus upon ‘moves’ in genre analysis, and further informed by Bhatia’s (1994**)** introduction of a socio-cognitive dimension to genre analysis, in order to develop a well-rounded descriptive synoptic model of how this speech event is both perceived and performed in non-English speaking English settings. It is hoped that these insights can be further applied to the development of English for Medical Purposes (EMP) materials or curricula and that this case may serve as an exemplar for other inquiries into professional, situated ESP speech events.

Key words: academic discourse, spoken discourse, genre analysis, clinical case presentations, English for medical purposes (EMP), non-native English speakers.

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МОДЕЛИРОВАНИЕ КЛИНИЧЕСКОГО СЛУЧАЯ КАК РАЗНОВИДНОСТИ КОММУНИКАТИВНОЙ СИТУАЦИИ МЕДИЦИНСКОГО ДИСКУРСА

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Аннотация. В статье описывается коммуникативная модель одного из центральных жанров медицинского дискурса – разбора клинического случая, который широко используется как на консилиумах практикующих докторов, так и при обучении студентов-медиков. Опираясь на собственный опыт, автор отмечает, что в большинстве стран Азии и Дальнего Востока подобные обсуждения проходят не только на местном языке, но и на глобальном английском, что объясняется доминирующей ролью информирования на этом языке в медицинском дискурсе. Материалом исследования стали записи 36 разборов клинических случаев в 8 медицинских университетах с аффилированными госпиталями, сделанные автором статьи в 6 азиатских странах, а также 25 интервью с практикующими докторами, преподавателями и студентами-медиками, посвященные содержанию и структуре этого жанра. При воссоздании (моделировании) коммуникативно-дискурсивной составляющей жанра автор использовал SPEAKING модель Д. Хаймса с выделением стратегических ходов Дж. Суэлса и социокогнитивных особенностей коммуникативной ситуации, что позволило создать полимодусное описание жанра разбора клинического случая, выделить дискурсивные и лингвистические особенности его репрезентации на английском языке в сообществе профессионалов, для которых английский язык

не является родным. В заключении автор отметил, что представленное описание моделирования жанра может быть использовано для разработки программ обучения студентов-медиков на английском языке (EMP) или для моделирования коммуникативных жанров иных профессиональных дискурсов.

Ключевые слова: академический дискурс, устный дискурс, жанровый анализ, обсуждение клинического случая, английский язык для медиков (EMP), английский как неродной язык.

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1. Introduction and background

Clinical case presentations (hereafter CPs) are standardized, formalized, and situated core medical speech events. Such presentations, occasionally termed 'Grand Rounds', are basically oral clinical case reports carried out between healthcare professionals, usually involving, but not limited to, doctors.

It is imperative at the outset to note that the term 'speech' here does not imply simply reading a written case report aloud but rather that the choice of speech mode demands a great deal of emphasis upon editing and selectivity for prioritization, emphasis, and significance. While a written case report is invariably comprehensive and allows the reader to search out those particular items considered to be of greatest importance, CPs, being multimodal, demand selectivity of content such that a narrative flow is created for the listener/viewer, thereby allowing fellow clinicians the greatest opportunity to comprehend the clinical data in a concise, accurate, fashion.

CPs should also not be thought of as being functionally equivalent to oral conference presentations, even though the two may share some extant features (such as when exemplar clinical cases are utilized *within* a conference presentation), but rather serve primarily as means of in-house or interdepartmental education or edification among in-service practitioners. Such sessions are normative within the medical profession worldwide. Every institution in South-East Asia included in this study that the author contacted regarding requests for observations or interviews regularly conducted CPs, not only in the local language but also, at least to a certain degree, English.

In most cases, CPs will be carried out in the native tongue of the participants, although many institutions located outside the Anglosphere also use CPs as an opportunity to enhance their English skills (and, in some locales, *require* it). This is a fairly widespread practice given that most medical research worldwide is conducted in English, that most medical professionals will have some degree of English proficiency, and because a large amount of English medical discourse has already built into the speakers' L1 in the form of specialist medical terminology, often to the extent that standard medical speech encounters between non-native English speaking practitioners invariably involves a certain amount of linguistic code-switching.

It is because of this centrality and ubiquity of these speech events within the domain of medicine that the author chose to analyze CPs at a deeper level. Most discourse and genre analysis of clinical speech has previously focused upon healthcare worker-patient encounters**,** perhaps reflecting the fact that most linguists and language teachers are used to taking the perspective of patients/clients and are thus more inclined to emphasize such 'vertical' discourses, as opposed to more horizontal 'insider-insider' speech events.

By analyzing the characteristics of CPs, it is believed that light can be shed on important interactive speech features used by the medical / academic discourse community, as well as pertinent clinical functions, since such genre analysis represents a starting point for describing how texts are organized [Dudley-Evans, 1993]. As language teachers, knowledge of these forms and features will also allow us to further enable our ESP / EMP learners to participate in the international medical discourse community, particularly in the field of collaborative research, with confidence and skill since genre analysis is directly relevant to the classroom due to the importance of understanding rhetorical text structures [Hyland, 1992]. Or, as Boswood and Marriot state, "Through close engagement with the contexts of communication, ESP practitioners can further develop their ability to contribute positively and directly to the development of their students' abilities and to the

development of their client communities" [Boswood, Marriot, 1994, p. 3]. DudleyEvans likewise emphasizes the pedagogical applicability of genre analysis, noting that it provides, "...a flexible prescription based on analysis that makes suggestions about the layout, ordering and language appropriate to a particular writing or speaking task" [Dudley-Evans, 1987, p. 28].

For readers who operate outside the scope of teaching medical English, I believe that this inquiry into a single speech event within a single genre / domain may also serve as an example that can be applied to those engaged in other academic / professional ESP domains, particularly standardized / formalized speech events carried out between members of any specific discourse community, particularly in light of Bhatia's descriptions of intertextuality (textual devices used beyond the domain of a single academic / professional discipline) in carrying out genre analyses of academic / professional discourses [Bhatia, 1994]. The use of Hymes' SPEAKING model [Hymes, 1974] to frame the structure of CPs also allows for Bhatia's notion of 'interdiscursivity' [Bhatia, 1993] (text-external features of genre analysis) to be utilized – as it is the surrounding spoken text environment that determines much of a spoken text's internal structure.

In the present study, the author aimed to answer two core inquiries: 1) for what purposes do healthcare professionals (HPs) in non-English speaking environments carry out English CPs and 2) in what way or ways are these managed by the participants? These core inquiries further hint at several secondary questions: Is there a set form or structure to CPs that is applied in all or nearly cases? Where variation exists, what are the factors that affect variation and how are these variations most commonly manifested? To what extent and in what manner do non-native speakers of English manage these speech events differently than those who might be classified as 'native or native-like'? The present inquiry builds upon and updates the author's previous research into the structure of clinical case presentations [Guest, 2017] through the application of an established framework (Hymes' SPEAKING model) that allows more a more thorough analyses of the genre. It is hoped that the resulting data and observations arising from this extended inquiry may hereafter serve as templates as well as hinting of good pedagogical practices for others teaching or learning English within healthcare professions.

2. Literature Survey

Hymes' SPEAKING model (1974) has been long established as a framework for the discourse analysis of speech events. The acronym covers the following speech categories:

S- Setting and scene (physical environment and circumstances of speech event)

P- Participants (also including the field or domain of discourse)

E- Ends (purpose or goal of speech event)

A- Acts (order/structure of speech acts or 'moves')

K- Key (tone/tenor of speech)

I- Instrumentalities (mode or modes of speech, including language, dialect, and register)

N- Norms (social rules of, or constraints on, interaction)

G- Genre (type of speech event)

Most of these categories have since been expanded in scope by researchers and commentators to contain further sub-categories, however, for our immediate purposes, it is not necessary to list these. Readers familiar with either discourse or genre analysis may also recognize that, over time, some of these categories have been expanded by subsequent researchers under slightly different nomenclature and/or that some boundaries between categories have become blurred.

It should be noted at the outset that the purpose of the SPEAKING model is not to establish a step-by-step methodology into discourse inquiry but rather to serve as general guidelines in terms of separating discourse categories and/or considerations as a basis for research inquiry into the analysis of speech events. As such, while the Hymes model informed the author's inquiry, particularly in terms of grounding those features crucial to understanding the form and content of specific clinical speech events such as CPs, the author's study was not absolutely beholden to every category during every CP observation.

The most well-known extensions of similar inquiries into spoken discourse, particularly in terms

of application to our present study, are those of Swales' genre analysis [Swales, 1990], particular the analysis of rhetorical 'moves', and Bhatia's (1994) inclusion of socio-cognitive features into the realm of genre analysis (using the term 'interdiscursivity'). These approaches also both served as discourse framing and interpretative sources for the author both before carrying out CP observations as well as in the post-observation analysis of the data. These were not applied in the present study as 'scientific' models per se but rather as qualitative means of describing the categories of Acts and Norms respectively.

What role does genre analysis play in applying Hymes' SPEAKING model to a particular speech event? Swales emphasized the role that genre analysis plays in establishing '...the importance of structuring and ordering' and the 'correlations between cognitive, rhetorical, and linguistic features'. This occurs, he says, because genre allows language to be '...sufficiently conventionalised' allowing one to '...establish pedagogically-employable generalisations that may will capture useful relationships between function and form' [Swales, 1988, p. 212-213]. In other words, in order to understand discourse, one must first understand the context in which the discourse arises [Van Dijk, 1997].

Genre analysis helps to identify communicative purposes and ties these purposes to particular forms or structures. Naturally, this demands that the scope of analysis extends not only beyond the sentential level and supra-sentential levels [Winter, 1977] but also into the meta-textual and macro-structural levels of analysis [Bhatia, 2002; Bhatia V.K., Bhatia A., 2007; Hoey, 1983]. Fairclough describes such discourse as being three-pronged: including the text, the related discursive practice, and the social practice [Fairclough, 1992]. A such, Bhatia (2004) considers them to be cognitive, as opposed to a merely linguistic, structures. Such analyses, including the present study, therefore require interpretation beyond the merely descriptive levels. This would include then, as Bhatia has argued, explanations of the socio-cultural, organisational, and institutionalised or conventionalised constraints and expectations that govern specialized discourse genres, representing broader socio-cognitive factors in that, "…language use in a conventionalised setting, in order to give expression to a specific set of communicative goals of a disciplinary or social institution, which gives rise to stable structural forms by imposing constraints on the use of lexico-grammatical as well as discursive resources" [Bhatia, 1993, p. 23].

It should be noted, however, that this should not imply that genres are static, but simply, "…recognised and sufficiently standardised" [Bhatia, 1993, p. 29] in a manner that most members of the speech community share. Bhatia (2002) later argues that these text-external, extra-linguistic factors also introduce the increased possibility of genre innovation and exploitation, or, as Hart earlier put it, "Genre analysis is pattern seeking rather than pattern imposing" [Hart, 1986, p. 280].

Such structures are conventionalised in 'speech communities' (or 'discourse communities') which share rules for the conduct of speech, allowable patterns of usage, or the appropriacy of utterances [Hymes, 1974]. At professional levels, this includes displaying discourse expertise in terms of the use of a particular lexis, established notions of relevant content, an agreed set of common or public goals, and mechanisms of intercommunication among members, Swales states that, "...exemplars of a genre exhibit various patterns of similarity in terms of structure, style, content and intended audience" and that, "the exemplar will be viewed as prototypical by the parent discourse community" [Swales, 1990, p. 58].

That genres are not dynamic rhetorical structures and therefore allow for manipulation by members, as a form of 'social cognition', has been further pointed out by Berkenkotter and Huckin [Berkenkotter, Huckin, 1995]. And while the implication is that conventional constraints will be placed upon 'allowable' contributions, these constraints can be, "…exploited by expert members of the community to achieve private intentions within the framework of socially recognised purpose" [Bhatia, 1993, p. 13].

Before beginning our analysis, it is also worth noting that Hymes (1974) distinguishes between 'genres' and 'speech events', even though their characteristics often coincide, with 'genre' being the broader term whose properties may be applied beyond a single speech event (although Saville-Troike (1982) significantly

equates genre with 'communicative events'). Couture (1986) makes a further important distinction between genre and register, noting that the former operates at the syntactic / lexical level, whereas the latter operates at the level of discourse. This dichotomy, too, has been incorporated into the author's description.

3. Research background and methods

For the purpose of gathering authentic data on the management and performance of CPs, the author visited 8 clinical institutions (hospitals and/ or medical faculties at universities) in 6 different Asian countries in which English is not used as an official or colonial language nor as a standard language of tertiary instruction. These included: Japan (University of Miyazaki), Vietnam (Can Tho University and Hong Bang International University), Indonesia (Brawijaya University), Myanmar (Yangon Medical University), Taiwan (Cheng Kung University), and Thailand (Thammasat University and Chiang Mai University). These research visit purposes were twofold: to observe actual English CPs and note their generic features and to interview local HPs regarding the role and function of English CPs at the institution, or more widely, across the respective countries.

In total, 36 CPs were observed, connected to 10 different clinical departments: Obstetrics-Gynecology, Surgery, Pediatrics, Family Medicine, Community Medicine, Anesthesiology, Respiratory, Endocrinology, Nursing, and Ophthalmology. During these observations, the investigator / author took case notes based on a self-developed checklist outlining the following features (Fig. 1).

Not all categories listed in Figure 1 below were filled in upon each observation as not all items were addressed in every CP, in which case they were marked n/a. Only 3 of the CPs were recorded due to difficulty in gaining recording consent. In 5 of the observations I was presented with the local standardized English written document used by the speakers in order to formulate the CP.

Follow-up interviews were conducted with full consent of the presenters and/or departmental representatives. These interviews (6 were recorded, the rest notated by hand) generally

External categories:

Date

Location

Clinical Department

Presenter's position / role / status

Text modes (other than speech)

Internal (generic) categories:

Opening framework / management of background

Order of data

Interpretations / Expansion

Adherence to standardized CP forms

Notable Exclusions / Omissions

Special emphases

Novel or local acronyms / abbreviations

Academic formulaic phrases

Notable interactive / narrative/transitional features

Closing framework

Discussion / Follow up points of note

Take home message and/or Investigator's additional comments

Fig 1. Author's Checklist for Investigation of Case Presentation Structure

followed a pattern involving the following pre-established questions (Fig. 2 and 3).

The above line of inquiry was far less concerned with quantifying particular incidences of speech forms or interview responses than it was with spotting developing or significant qualitative trends, which might have more immediate application to understanding the deeper structure and/or the socio-cultural environment of the CP speech event, as well as related ESP/EMP teaching pedagogy. The next section outlines and discusses some of the most compelling features that these observations and interviews unearthed.

4. Findings and discussion

The clinical categories that serve as a synopsis for the majority of CPs, based on the author's observations and interviews, typically included the categories listed below in Figure 3 (updated and revised from [Guest, 2017]). These were the items most regularly noted in performance and, on four occasions corresponded to the particular institution's written worksheets / check sheet used to augment the oral presentation.

Precise nomenclature might vary slightly from setting to setting but, generally speaking, these

1. *Do you perform clinical case presentations in English or in your indigenous / local language? If both, what are the percentages?*
2. *In what situations do doctors carry out English case presentations at your medical / educational institution as opposed to using the local / mother tongue?*
3. *What elements are typically included in a case presentation?*
4. *Is there any formal style or template used for doing case presentations?*
5. *At what points do students usually learn how to do case presentations, mother tongue and/or English?*
6. *How are these taught and/or practiced?*
7. *What aspects of my (attached) model are you familiar or unfamiliar with?*
8. *Do you have any wish or need to upgrade education in this particular area? If so, what or how?*

Fig 2. Author's Interview Questions

- ID (basic patient data)
- Chief Complaint (CC)
- History of Present Illness (HPI): primary and associated symptoms
- Physical Examinations (including palpation; visible manifestations; vital signs; Review of Systems / RoS: e.g. Cardio-Vascular, Respiratory, Central Nervous etc.; HEENT: Head Eyes Ears Nose Throat)
- Current medications / allergies / ongoing treatments /complications
- Past Medical History (PMH / PMx): including surgeries, hospitalizations, underlying conditions, injuries / trauma, treatments / therapies
- Family History (Sx)
- Social History (Sx)
- Investigations (lab tests / imaging / biopsy etc.)
- Summary (e.g., problem list / pertinent findings)
- Post-admission developments
- Initial/Provisional / Differential diagnoses (Dx)
- Assessment and treatment / therapy / management plan
- Follow-up / Outcomes / Operational findings
- Treatment successes / failures / adherence

Fig 3. Synopsis of Clinical Case Presentation Categories or 'Moves'

constituted the core categories used in most CPs, with the presentation of each item within a CP marking a specific generic 'move'.

However, CPs involving a deviation from a standard / synoptic CP form drew particular attention. In practice, many of these moves were circumvented, omitted, or relegated to the speech event periphery. Many of the most significant variations on this canonical form and speculation on the reasons underlying them, which constitutes a central component of the inquiry, are discussed in the Acts section below.

Using Hymes' SPEAKING acronym (with Genre here occupying the primary position due to its fundamental relevance) as a baseline parameter, a synoptic outline of the CP speech event, based upon observations made in this study, are as follows: *genre*, *setting and scene*, *participants*, *ends*, *acts*, *keys*, *instrumentalities*, *norms*.

4.1. Genre – Clinical case oral presentations.

4.2. Setting and scene – *1) Departmental conference rooms at hospitals or medical universities. 2) Standard university classroom settings, both lecture and seminar / tutorial style. 3) During student clerkship rounds in the hospital patient wards.*

CPs were most often performed as departmental sessions in small meeting or study rooms within the hospital, usually in the early morning. Presenters tended to be younger doctors or residents, often those who had recently experienced an 'interesting case' or were actively carrying out research. In some institutions, CPs were performed daily, in others only once every week or two weeks. Bedside teaching sessions were held in the wards with small groups of upper-grade students and an instructor. These were carried out in a much more impromptu fashion than the formalized intra-departmental CDs. Standard teaching seminar rooms within the attached university constituted the third setting, that of interactive discussion CPs.

The CPs observed in the present study did not fall into a single consistent structure. Rather, the extant purpose of the particular presentation determined both the form and structure of the speech event. Some presentations attended were peer-to-peer '*interesting case*' presentations, meant largely to edify and inform peers (particularly residents). Some were evaluative, with senior clinicians present who subsequently critiqued and further advised presenters regarding the presentation contents. Some were bedside teaching sessions held between a clinician and upper-grade medical students, the latter of whom were carrying out case presentations as a part of their rounds in clinical clerkship sessions. Some were actual scheduled teaching classroom scenarios with medical students who had been assigned teacher-chosen case data to report upon in a standard classroom. In four observed CPs, the presentation revolved around the discussion of published research external to the hospital / university. In these sessions, the presenter focused upon recent English research papers for discussion and exposition but with particular emphasis upon the exemplar case(s) that had been presented as evidence in the research paper.

In 12 cases, CPs were performed individually, in 14 cases as pairs / trios, and in 10 cases as fully interactive sessions between a leader (preceptor) and a small number of participants (preceptees).

The speech functions of the CPs ranged from monologues, to elicited dialogues, to team evaluative responses, and group discussion. These factors also drastically affected both the content, order, and structure of the case reports (which further negatively impacted the author's intention to note and classify features and speech moves according to pre-established categories.)

The majority (26) of presenters provided multimodal presentation resources (PowerPoint, lab results, imaging samples, textbook data, online websites, medical documents) to augment their presentations while others, typically those of the interactive discussion type, referred primarily to PowerPoint slides and/or printed data sheets (generally provided to participants in advance). In short, the roles and functions of CPs within university hospitals appear to be multi-faceted.

Once-per-month required English CPs for each department were standard at Thailand's Thammasat University Hospital and Cheng Kung University Hospital in Taiwan. Brawijaya University (Indonesia) and Hanoi Medical University (Vietnam) required that doctors perform all CPs in English, although this standard was not always strictly met. Based on interviews, it appears that the balance between English and

L1 CPs ranged from 10–90%, with the average being approximately 40% delivered in English.

Some institutions required presenters to adhere to an established clinical format based on 'global standards'. Such clinical case presentation formats include all the synoptic categories described earlier but are subsumed under an established discourse superstructure such that the presentation of the data does not necessarily follow the order of the synopsis. Five institutions followed the SOAP format (Subjective Observation Assessment Plan) closely. The SNAPPS presentation model (Summarize, Narrow, Analyze, Probe, Plan, Select) was employed at two of the facilities I visited. Eight CPs followed a locally established format, whereas most others allowed for formal flexibility as determined by the clinician depending upon the type of case. These invariably followed the synoptic form.

4.3. Participants – *1) Young, practicing physicians and residents with peers and seniors present. 2) Established physicians with both students and residents / young doctors present. 3) Small groups (3-5 members) of upper grade medical students with instructors (doctors / professors).*

At a linguistic level, an interesting phenomenon regarding the participants was noted: Due to the fact that in every one of the CPs observed both presenters and 'audience' were non-native English speakers, often, articles, verbal agreement, plurality, and other formal minutiae of English were omitted or rendered in non-standard forms. However, although instructors committed these numerous formal 'errors' in their English speech ('*...if it is infect or not infect*'; '*is there anything vomiting?*'; '*How to assess about X?*'), this use of non-standard forms never notably impeded the discussion nor the intended teaching content or teaching purpose of the presentation session. In many cases, speakers assumed non-standard English forms consistent with emerging English as a Lingua Franca (ELF) speech. This further suggests that formal English accuracy not be confused with communicative or performance English efficacy, even within academic and professional domains. On the rare occasions that clarification was called for, negotiation (often multi-coded) ensued.

4.4. Ends – *1) Informative, for the edification of peers ('Interesting Cases'). 2) Assessment / evaluative. 3) Instructional (for students).*

The most common immediate purpose of performing CPs was said to be that of informing and educating peers regarding interesting or enlightening cases that might be encountered in future clinical practice. CPs were also used as a basis for the assessment of a young / trainee clinician's reasoning skills, with senior members of the staff providing feedback. As such, the CP is considered an integral element of the clinical training of young doctors. When performed during bedside teaching sessions with upper-grade medical students, it was the students' ability to organize, prioritize, and recognize the most pertinent features of a patient / case that were regarded paramount.

The purpose as to why CPs were carried out in English varied significantly according to the interviewed clinicians / presenters, institutions, and even countries. Bedside CPs involving students were said to be due to the students' choice of having entered an English-specialized seminar or program. Departmental peer-to-peer English CP sessions were asked to be utilized largely as staff English brush-up sessions. Only five of the presenters I observed and interviewed, however, spoke of any immediate plan to study / practice abroad, present at an international conference, or engage in an upcoming collaborative task, although, in subsequent interviews, 'preparation for international research / studies' was noted by four department heads as a primary motivation for establishing English CPs as normative.

The notion that performance skills in English should be equated with 'professionalism' and the increasing number of both foreign patients and foreign collaborators / researchers (with whom the lingua franca would be English) were also widely given as reasons for requiring English CPs.

The belief that arranging and performing a CP in English had a positive washback effect on the clinician's holistic reasoning and analytic skills, even on the presenter's L1, was also expressed. This rather interesting purpose for performing CPs was offered during three separate interviews. English was preferred over the local language, it was said, because performing in English required the speaker to be more vigilant about the structure

of the speech event, particularly causal and temporal connections, as well as organization and prioritization. It is *not*, as one interview hastened to add, because English was somehow inherently superior in manifesting these qualities – presumably any foreign language would do – but it was the act of 'languaging' itself, in a foreign tongue, that forced presenters to pay attention to both structure and clinical detail.

4.5. Acts (order / structure or 'moves').

The general synoptic order of moves within the CPs observed has been described earlier (see Fig. 3). However, specific features within each category varied widely, largely depending on whether an established, superstructural format was required to be used or not.

In several CPs, the data arising from the history taking portion was elicited through audience / peer participation and thereby occasionally deviated from the synoptic form (particularly when presenters had to address tangents and extenuating features appearing among the responses). However, in the majority of CPs, the first seven sections listed in the earlier synopsis (Patient ID through Social History) were covered in a span of less than a minute with the bulk of the presentation instead focusing upon the investigations, treatment / management, and follow-up sections.

This unexpected feature may be of particular significance to those EMP instructors whose backgrounds are from outside healthcare fields as they may tend to overemphasize the more layman-friendly history data at the expense of the often more clinically-compelling and pertinent post-history taking sections. Summaries of pertinent findings and related problem lists (the ninth section listed in the synopsis) took up far more presentation time, on average, than the history taking data.

Moves widely used in CPs that had not been previously noted by the author (see: [Guest, 2017]) included the development of 'problem lists', 'post-admission developments', 'pertinent findings', and/or the generating of lists of 'operative approaches', 'operative findings', and 'post-operative findings'. These categories thus merit inclusion in a core synopsis of the CP speech event.

However, the most compelling finding was that of the relative amount of time, emphasis, or prioritization given to the different categories within the synopsis. For example, when the case was presented as part of a bedside learning session (also known as 'preceptor-preceptee' training), much greater focus was placed upon presenting an accurate rendering of the HPI, the interpretation of lab results / imaging, and, in particular, plans regarding the future management of the patient.

Individual clinical department factors also strongly affected the prioritization structure and sequencing of the presentation on several occasions. For example, social and family histories were discussed at length only in the cases of Community Medicine and Nursing. In OBGYN / Pediatrics, day-to-day recent or post-admission developments and active monitoring of the fetus / mother / baby were given priority, as regular updates on the status of the mother and fetus are paramount. In Endocrinology, review of systems and physical examinations were prioritized. In Surgery too, the physical examination, developed as a 'baseline status' of the patient, was discussed more comprehensively. The interpretation of images (whether by the presenter or elicited from participants) was emphasized in all departments, with the notable exceptions of Family and Community Medicine. Respiratory focused particularly on family history and lab investigations. In the Anesthesiology CP, a large section was devoted to listing and explaining interventions, a feature noted otherwise only in Nursing.

According to interviewees, in most standard peer-to-peer CPs, the greatest teaching value to departmental colleagues is thought to be contained within the management (or mismanagement) of such clinical events, whereas history taking tended to be allotted a more central role when students were either present or performing the CP. Therefore, in departmental CPs, the treatment and prognosis section was often presented in thorough detail, whereas categories more fundamental to history taking, such as HPI or PMH, were occasionally moved to the chronological and textual periphery.

Pertinent negative data (i.e., *'There was no sign of X'*) also figured prominently in both past medical history (PMH) and physical examination (PE) / lab report sections, as well as, although to a lesser degree, with imaging. The ruling out or exclusion of certain possible diagnoses was

carried out most noticeably in the interactive teaching-based sessions. As negative data (a negative lab test result or the lack of specific symptoms or history) is often considered highly significant, young clinicians should learn how to assess negative data pertinence and subsequently prioritize such cases. For example, in a case from a respiratory department, the presenter strongly emphasized the negative data (no family history of tuberculosis, negative AFB blood test results) in a suspected case of tuberculosis, which allowed the clinician, at least provisionally, to rule out the initial diagnosis of tuberculosis and posit a more accurate differential diagnosis.

Contraindications were also frequently mentioned when formulating initial or provisional diagnoses (IDx / PDx), a feature that the author had been hitherto unaware of. Occasionally, instructors and/or presenters appeared uncertain as to whether to generate a list of initial or provisional diagnoses at all or to proceed quickly to the differential diagnosis. However, if the emphasis of the case was upon management and follow-up, the latter approach was generally preferred.

Interestingly, overly comprehensive CPs, in which irrelevant or insignificant details were included, were a particular hallmark of trainee or student presenters, who were likely being careful not to omit any item of possible interest, particularly in the presence of their instructors or adjudicators. Unfortunately, however, such an approach often had the upshot of obscuring or inadvertently de-prioritizing the more pertinent data, as was pointed out by adjudicators on several occasions.

4.6. Key (tone / tenor of speech).

4.6.1. Formulaic Academic Phrases.

Bhatia emphasizes the interactive nature of academic discourses by focusing upon set structures in language use that can occur across different fields, which he refers to as 'intertextuality' [Bhatia, 1993]. One of the hybrid features of academic / professional discourse intertextuality is the usage of formulaic academic phrases in set speech events and these were highly evident in every CP the author observed.

Formulaic academic phrases are those set lexical items that fall between general English and specialist terminology [Guest, 2017; 2018]. Although most presenting clinicians used specialist English terminology almost flawlessly, some younger practitioners did appear to have trouble with the appropriate use of English formulaic academic phrases (e.g., '*did* a survey', as opposed to, '*conducted* a survey'; '*We saw X so we thought...*', as opposed to, '*The presence of X indicated...*'). Guest notes two telling examples in which young, inexperienced CP presenters said, *'Because X is there, it means there's more chance that it's because of Y'* and *'He drinks a lot of alcohol but, except for that, his social life is normal.'* [Guest, 2018, p. 74].

The lack of appropriate academic register, conveyed through the bypassing of suitable academic / professional phrases in favour of 'everyday speech', distinguished such CP speakers markedly from the more proficient presenters and hinted at a less advanced degree of professionalism. One prominent example from a student presenter drew an immediate repair response from an instructor, who added the appropriate professional register:

> Student presenter: *...stuff will come out.*
> Instructor: *...foreign agents will be discharged.*

According to interviewees, academic formulaic phrases are not explicitly taught at any of the institutions that the author visited, even though they are a central feature of professional peer discourse and thus should be included in EMP training and represent an area in which might be of particular value to non-Anglophone healthcare instructors and workers.

The marking of temporal expressions (especially the accurate use of the perfect or past perfect tenses) and the occasional failure to use appropriate discourse signals to mark transitions in the speaker's moves, also occasionally lead to confusion regarding the nature of, or connections within, the data on some occasions which required a negotiated (often in both L1 and English) conclusion. EMP teachers might wish to address this potential area of concern.

The CPs observed were also notable for the prevalent usage of formulaic academic / professional phrases used effectively even among those presenters who did not appear to be otherwise wholly proficient in general English. Enabling our learners to speak in the manner of academics and professionals will better allow

them to carry out CPs as well as other peer-to-peer clinical discourses.

4.6.2. The multimodal use of acronyms and abbreviations.

The frequent use of acronyms / abbreviations in CPs was viscerally notable. Among the regularly noted acronyms were *NPO (nothing by mouth)*, *PTA (prior to arrival)*, *GA (gestational age)*, *NS (not significant)*, *PR (peripheral)*, and *CBC (complete blood count)*. Interestingly, these forms were often deployed in speech as well as in written mode.

Other written forms were rendered in full form in speech. For example, *Sx* represents symptoms in written form while *Dx* was generally written for 'diagnosis', with treatment being usually rendered as *Tx*. However, in all cases, the full terms were used in speech.

The visceral importance of acronyms and abbreviations in CPs does not necessarily call for a taxonomic teaching / learning of all such items from EMP teachers, but it should demand learner familiarity with at least the most commonly used abbreviations and acronyms in order to ensure succinct and speedy CP data transmission both as a presenter and as a participant. ESP / EMP teachers and clinicians should also be careful not to assume universal knowledge of certain acronyms and abbreviations as some acronyms are local or highly genre-specific constructions that may not have currency across institutions.

4.7. Instrumentalities (mode or modes of speech / communication).

PowerPoint, white board, lab images, data lists and clinical charts (projected or on handouts), check sheets, and printed assessment forms.

Non-native English speaking clinician presenters and instructors were not always confident with the quality of their own English but, more importantly, were also often uncertain how to manage or balance the language and clinical content when it was conducted as a standard classroom or bedside teaching lesson (in many cases, students had superior English speaking skills). This also affected the number of instances of 'reading aloud' of case notes by presenters in peer-to-peer sessions. In some such cases, English became mixed with the speakers' native language, either leading to or requiring a great degree of linguistic code switching by all participants.

This, however, should not necessarily be considered a problematic feature in non-native English speaker interactions in which participants share the same L1**.** This feature, too, rarely impeded the effective conveyance of clinical data.

4.8. Norms (social rules of, or constraints on, interaction).

Power differentials between speaker and 'audience' were dependant upon the function of the CP. In the case of assessed or instructional CPs, the (invariably) young presenters were highly conscious of maintaining an established CP form or synopsis before listening to commentary and questions from adjudicators. In the peer-to-peer informative sessions, however, the structure of the PC was less formalized and more interactive, with active contributions from participants (particularly when questions or commentary from participants were elicited by the presenter), as authoritative figures in the speech event were not explicitly marked. L1 appeared far more frequently in these latter sessions, often resulting in constant code-switching with English. In bedside or classroom teaching sessions, carried out for instructional purposes, the sessions were wholly directed by the instructor even though the content of the CP itself was the result of teamwork among the students. Students waited for explicit signals from the instructor eliciting their data.

5. Conclusions

In short, CPs are considered a core speech event within many clinical settings and it is therefore imperative that non-Anglophone clinicians master this skill in order to manifest their membership within the international medical discourse community. Hymes' SPEAKING model, despite being forty-five years old at the time of writing, can still help teachers and language researchers to elucidate many generic features of the extant structure of CPs, which further serve to illuminate important and interesting internal discourse features of this speech event. If EMP teachers understand how this speech event is structured and managed, they can better aid in having their clinical learners achieve this goal. Thus, such analyses can prove valuable to both learners and instructors. It is believed by the author that similar analyses of such professional and/or

academic speech events can also be applied to other academic and professional fields, eventually leading to productive insights that might be of value to students within other ESP domains.

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