Breaking Bad News in Medical English

Anișoara POP
GE Palade University of Medicine, Pharmacy,
Science, and Technology of Târgu Mureș

Abstract. *Giving serious or bad news is one of the most challenging aspects of medical communication for which training never seems enough (Fallowfield 312). This paper provides a customizable model of CLIL-based (content and language integrated learning) and genre-based approach (exposure, deconstruction of configurations and "grammar," and reflection) to a module of giving bad news in Medical English (ME). The module underlines the importance of medical students' humanistic formation and the opportunity to consolidate it through ME communication classes, its goal being to raise the students' awareness about empathetic doctor-patient communication while helping them form their communication styles. The content included online resources by specialists in the form of candid diaries or "doctors as patients" (reading) and tutorials (listening) while the language learning part focused on genre deconstruction through three movie clips (Aftermath, Temple Grandin, and Wit) followed by asynchronous reflective speaking. Different variables related to breaking bad news together with their theoretical underpinnings were included in the learning process and are briefly presented here, such as linguistic and pragmatic aspects of politeness, euphemisms, the degree of disclosure, conveyor type, cultural aspects, and compassionate communication. The novelty of the design rests in blending asynchronous language-integrated content to breaking bad news and classroom ME practice, with evident positive outcomes.*

Keywords*: CLIL, doctor-patient communication, empathy, giving bad news, integrated Medical English learning, asynchronous speaking, positive semantics*

Introduction

The elements that make doctor-patient communication in general and communication of serious/bad news effective are encapsulated in the acronym EMPATHY (Eye contact, Muscles of facial expression, Posture, Affect, Tone of voice, Hearing the whole patient, Your response) (Riess 1108). Effective communication of bad news within the healthcare context is, for one thing, challenging because the patients are suffering, oftentimes hypersensitive, and frail, hoping for the good news of remission and recovery, while doctors may suddenly become bearers of sad, bad, or difficult news related to their conditions. Moreover, this relational competence occurs with patients with whom doctors may have formed no previous relationship, or on the contrary, when there is a close relationship between them, or even more dramatically when the patient is a child. Interestingly, this unexpected,

unwanted, and possibly dismissed news has a tremendously negative and distressing effect on both the bearer and the recipient rather than just on the latter, rendering it one of the most difficult and uncomfortable encounters in healthcare communication for which training never seems enough (Ranjan JE01-4).

Until recent decades, medical education has placed more value on technical proficiency than communication skills, leaving physicians barely prepared for the communication complexity and emotional intensity of breaking bad news (Lenkiewicz 2622). General abilities in doctor-patient communication and delivery of bad news focus on avoidance of medical jargon, understanding non-verbal language, reflecting and validating ideas, and, above all, demonstrating empathy (E) and congruence with the patients so that the latter feel understood and cared for, to mention just a few of the stages and mnemonics such as SPIKES (setting, perception, invitation, knowledge, emotions/empathy, and strategy/summary) (Baile 302), NURSE (Name the emotion, Understand, Respect the patient, Support, Explore) (Back 164), I PREPARE (Paranzino 37) or PACIENTE (Pereira 43).

Giving bad news has been defined as an ability that is based on a series of complex learned skills, involving the patient both cognitively and affectively and the physician affectively, the latter experiencing feelings of guilt, sorrow, remorse, and even shame, as Sophocles said, "No one loves the messenger who brings bad news". Moreover, the patient's motivation to continue or discontinue the treatment correlates with the doctor's ability, attitude, and behavior while delivering the bad news (Lenkiewicz, 2622). Given the high stakes involved, the psychophysical burden, powerlessness over emotional distress, and the vulnerability of the participants, the act of breaking bad news becomes the gold measure of empathetic communication, a form of therapy all by itself for the patients.

How bad is bad news?

"Giving", "breaking", and "disclosing" versus "confirming*"* are the action terms employed in connection with bad news in the medical communication literature, not interchangeably though, as "confirming" is a strategy in itself, even deemed easier and more effective in the patient-centered healthcare than that of breaking bad news since the former elicits what the patient already knows/suspects to be the bleak truth, and the doctor only needs to validate (Schmauch 186).

But what is bad news? It has been defined as "any information that produces a negative alteration to a person's expectations about their present and future" (Fallowfield, 312-19). Nonetheless, the "bad" in news as the adjective itself, may have different stages, meaning different things to different patients and involving various aspects such as social relationships

(e.g., termination of employment), physical and emotional trauma (e.g., diagnosis of a child's autism for a mother), or death of a loved one. Telling a housewife that she has gallstones that can be laparoscopically removed, or that she has been diagnosed with a chronic condition (diabetes, hypertension) is not the same as telling a diabetic driver that his leg will be amputated, albeit in both cases, the serious news can be subjectively accepted in the superlative rather than relative meaning. Other pieces of news are universally perceived as bad such as that of a stillborn baby, where natural previous anticipations have been for a healthy newborn baby, but the doctors unexpectedly contradict this positive anticipation. Unfavorable diagnoses – irreversible (brain damage), untreatable, non-stoppable diseases, disease recurrence or spread of disease, late-to-treat stages of cancer, and death are generally accepted as bad. Despite remarkable progress in medicine, many diagnosis results can be unfavorable. It is in such situations that doctors have to handle the patient's escalating disbelief, sadness, recrimination, and even violence by using language appropriately and manifesting empathy. If, for instance, when one's house is on fire, language becomes a straight shooter, with no room for sensitivity, it is unacceptable to use direct language or bald on-the-record politeness to achieve a communicative purpose in medicine.

Medical students need to be made aware of probable subjective perceptions of less serious news as bad, of the role language plays in its delivery, and that language should necessarily exude empathy and dignity. Most probably with this last aspect in mind, the term "bad" in "bad news" has been replaced by more refined and compassionate designations such as "sad", and "serious" news. James A. Tulsky, professor of medicine at Harvard Medical School, clearly advises trainees to avoid the phrase "bad news" altogether and refer to the news as "serious" (Cherny 267–276). Not least important is the fact that while communicating, most people focus solely on the verbal component ignoring the nonverbal (rapport, position), paraverbal (tone, pitch, pacing, emphasis, interruptions) (D'Agostino 563), and cultural components of communication, which are not to be underestimated in the medical field.

Giving bad news as culture-bound

Cultural awareness plays a crucial role in medical communication where barriers related to the patient's language, religion, values, customs, and habits may interfere (Rollins 21). Depending on the patient's culture, which can be more individualistic or collectivist, the doctor-patient communication will follow a more direct or indirect approach with either rapport presence or rapport avoidance and a specific degree of disclosure regarding their illness (e.g., Euro-Americans prefer total disclosure versus Korean and Mexican Americans). Acceptance of treatment only from a specific gender, eye

contact or employment of words associated with parts of the human body, abortion, fertilization, pregnancy and birth are similarly culture-specific and are considered unacceptable by a particular ethnicity or religion such as Muslims and Hindus. In terms of involvement of family members in the act of receiving bad news, 81% of the American patients do not want to involve family members whereas most Japanese prefer to be told bad news in the presence of a family member. Sensitization of medical students to culture-bound aspects of communicating bad news is, therefore, advisable as they are expected to function in a multicultural context and an increasingly interconnected world (Brooks 383).

More effective Medical English communication through breaking bad news

Medical English communication classes have represented an effective springboard for future doctors' humanistic formation (Tseligka (b) 50-62). Doctor-patient communication techniques such as teach-me-back, reflection and validation (Pop (c) 304-313), case presentations (Pop (a) 515-522), and soft skills including conference and paper presentations (Pop (b) 41-52), reflection and empathy (Tseligka (a) 32-53), even cross-cultural communication skills (Bakić-Mirić 44) are illustrated in the literature as successfully reinforced and refined paradigms through Medical English practice.

This paper will present a model of giving bad news in Medical English (ME) where the topic of bad news functions as a motivational learning trigger (Triff 657-662). Its goal was to raise the students' awareness about empathetic communication and pragma-linguistic prerequisites of delivering bad news while consolidating their ME vocabulary, reflection ability, and communication styles.

Participants in the experiential learning paradigm are a group of second-year general medicine students at UMPhST Târgu Mureș, during the academic year 2021-2022. The module extended over 4 contact hours with much content being flipped for autonomous asynchronous learning and formative self-evaluation as recorded reflections, thus saving time for quality class discussions on strategies of breaking bad news empathically.

Didactically, the ME module on giving bad news follows the CLIL-based approach (i.e., content and language-integrated learning), streamlined by the students' level of competence in English (most of them B2-C1). The content of bad news communication is authentic as it includes online medical interviews, tutorials, movies, and doctors' diaries, able to transpose students to real-life communication situations. In addition, by applying a genre-based approach, students detected special configurations and conveyor types,

language patterns and functions through deconstruction, followed by reflection.

The medical language learning encompassed all activities, was integrated (listening, reading, speaking, and meta-reflections) and covered linguistic and pragmatic aspects of politeness, euphemisms, the degree of disclosure, conveyor type, and empathetic, compassionate communication. Results, as evident from the final "Metareflections" in the form of asynchronous video clips created by students, demonstrate involvement, motivation, and acquisition/application by students of diverse aspects of empathetic communication.

CLIL-ing the bad news scenario

Through galvanizing different perspectives from the arts (movie clips), candid diaries of doctors as patients, Vimeo tutorials by physicians and specialists in communication, and yes/no YouTube tutorials, the bad news-related content was CLIL-ed and transformed into a meaningful integrated activity in ME without actually teaching content. The module scenario with types/content of activities in a logical progression, materials, student input and learning outcomes showcased below is interspersed with pragma-linguistic theoretical considerations (on euphemisms, medical jargon, prosody, grammar of bad news, positive semantics) that may be exploited as teaching handouts or awareness-raising discussion points in class.

Activity 1 – Lead-in brainstorming and predicting. In pairs, students roleplayed breaking bad news to assigned clients/patients with different profiles, predicting appropriate language (language adaptation), direct versus framed communication, and other contextual elements, thinking critically, sharing findings, and evaluating ideas with the other group members (Table 1):

> *Roleplay 1: You are a PR airline officer. Prepare to tell one of your customers' next of kin that the plane in which their wife and daughter were flying has crashed. How will you start? What terms will you use? How will you show empathy? Other aspects you will say/do.*
> *Roleplay 2: You are a paediatrician. You need to tell a mother that her 4-year-old girl who hasn't talked so far is autistic and that she will probably remain nonverbal. How will you start? What terms will you use? How will you show empathy? Other aspects you will say/do.*
> *Roleplay 3: You are an OB/Gyn professor. Prepare to break the bad news of metastatic ovarian cancer in stage III to a middle-aged female patient who is a university professor. How will you show empathy? Other aspects you will say/do.*

Predicting language	*I'm sorry to tell you….*

	I'm afraid I have to tell you some bad news……
Direct communication *versus*	*You have cancer! You have ovarian metastatic cancer!*
Framing the bad news	*I need to tell you something bad: you have cancer* *I know this isn't what you want to hear but…* *I really don't know how to say it, but …*
Deductive reasoning	*Polite, indirect, empathetic language*

Table 1. Predicting the language of bad news. Author's contribution

Activity 2 – Case-based listening, filling the knowledge gap and mind-mapping ideas

To benchmark their conclusions (Table 1), students watched three video clips on situations overlapping with the role-plays in Activity 1: Case study 1 - *Aftermath* (plane crash), Case study 2 - *Temple Grandin* (autism), and Case study 3 - *Wit* (metastatic ovarian cancer). Worksheets (Table 2) required students to assess what they already knew/used in Activity 1 against the real situation in the video clips, thus bridging the knowledge gap through the zone of proximal development (Vygotsky 21–34).

Question	Case/movie clip	Answers
1. Was your approach/language different/similar? If different, which do you think is more effective? Give reasons	*1.Aftermath* (plane crash)	
	2.Temple Grandin (autism)	
2. Detect behavioral aspects: a) type of conveyor, and other mechanics of giving bad news b) privacy, c) clarity, directness/indirectness of the message, d) tone of voice, e) attitude, f) empathetic language	*3.Wit* (metastatic ovarian cancer)	a)….. b)….. c)…. d)…. e)…. f)….

Table 2. The listening handout – Benchmarking and filling the knowledge gap. Author's contribution

Activity 3 Group discussion and incubation of ideas – type of conveyor, mechanics, and behavioral aspects in bad news delivery

Students identified different lexical, pragmatic (polite disagreement), empathetic as well as contextual variables of bad news delivery (behavior, venue), which were synthesized and then mind-mapped (Fig. 1 below). In terms of the *Mechanics of delivering bad news, the following values were identified*: privacy, attitude, clarity of the message, a separate room, a bottle of water, sitting down and talking at an equal level, and offering ample time

to process the information. It was observed that specifically, the location should be quiet, comfortable, and private.

As far as the *Behavioral aspects are* concerned, students identified and compared different types of conveyors of bad news:

- Case study 1- the *Aftermath* conveyor introduces herself, is tactful, benevolent, empathetic, and professional, speaking at a low pace, using pre-announcement: "the worst news that one will ever receive",
- Case study 2 - the doctor in *Temple Grandin* (*The consultation*) is benevolent, shows concern and care and employs polite language signaled through hedges ("It's been suggested that there *may be* a lack of bonding with the mother"; "She will *probably* never speak", "*I'm afraid* there's no course of treatment…"). He is, however, tactless and gender-biased when asking if he could talk with her husband instead.
- Case study 3 – the professor in *Wit* is a rough expert, glacial, and knowledge-focused ("advanced metastatic ovarian cancer*"; "*an insidious adenocarcinoma that unfortunately went undetected in stages one, two, and three*").* Although he makes frequent breaks, these are only to mechanically check if he is being followed in his peroration – an enthusiastic tally of professional conundrums, passion about treatment, cancer stages, and side effects – barely acknowledging their effect on the patient.

Linguistic deconstruction - The grammar of giving bad news

Laura-Jane Smith agrees that in breaking bad/serious news, one has to choose the words carefully. "What I have realized from having spoken to patients is that they never forget that conversation, and quite often they don't forget the specific words that you use," she says (*BBC. How do you tell someone that they are dying?*). Several pragma-linguistic aspects pertaining to the "grammar" of communicating bad news were crystallized in the activities above and they include: the role of direct versus polite assertions, expressing empathy, impact mitigation through hedging, medical jargon, euphemisms, and the degree of disclosure (Fig. 1).

MEDICAL JARGON	***Autistic – I 'm not sure.... = disbelief*** ***Understands the term but requires more complete disclosure: infantile schizophrenic***		
POLITENESS **PASSIVE MODALITY**	*I'm afraid, there is no course of treatment* *I'm sorry* Indirectness: ***It's been suggested*** *that there* ***may be*** *a lack of bonding with the mother.....*	COURTESY	**Tact:** *I'm not sure you'd understand...perhaps if you'd have your husband call me* banter
EUPHEMISMS	***institutionalisation***	*I'm not sure I'd like that, I'll probably miss her first word*	*She* ***probably*** *will never speak*
EMPATHY (encouragement of patients to share thoughts, feelings,	**Conveyor: benevolent but tactless:**	*+ allows time for patient to express opinions,*	

Fig. 1 The grammar of giving bad news – Source: Author's compilation, replies from the three movie clips/case studies above

Medical jargon. From the pragmatic point of view, using a medical denomination (jargon) such as *adenocarcinoma* instead of a common descriptive/explanatory term such as *lump* is vague, flouting the maxim of manner, (un)intentionally trying to deceive or rather protect the receiver by being obscure. While modern medicine authorizes the employment of direct, unmitigated assertions (*You have cancer*, *You have metastatic ovarian cancer*), politeness through hedging (mostly modal verbs) and expressions of sorrow and empathy represent a gold standard in empathetic communication (Case studies 1 and 2 above).

The degree of disclosure, in linguistic terminology obeying/flouting the maxim of quantity (how much information is given), may vary according to the type of condition, patient preference, and sometimes patient education. During the 1950s – 1970s it was deemed inhumane and detrimental to disclose bad news because of the bleak treatment prospect for cancer but nowadays, full disclosure is endorsed by the development of therapeutic technology, different societal attitudes towards cancer, and the improved rates of survival. Given the patients' rights sanctified through the informed consent, but also to prevent malpractice suits, it is considered unfair and even unethical to withhold information from patients (Naoko 257). According to current research, about 78% of patients prefer an empathetic professional, while doctors seem to give more detailed explanations to patients who are upper middle class, more educated and middle-aged (Naoko 262), which overlaps with our findings in Case study 3. However, this does not imply that honest and truthful disclosure should lack empathy and caution for the

patient's feelings and reactions, which makes it a more difficult task (Narayanan 61-65).

Euphemisms are considered pragmatic barriers to communication since in many instances, hiding behind euphemisms in the desire to buffer or cushion bad news is potentially problematic and deceptive. Defined as delicate language, euphemisms are diplomatic means to convey unpleasant things pleasantly (e.g., *institutionalization* - hospitalization in a mental institution in *Temple Grandin*). In medicine, they are generally employed either for unwanted words or inappropriate ones that are linked with patient hypersensitivity due to age or condition. Patients such as terminally ill adults in hospices or palliative care and child patients and/or conditions such as incurable diseases legitimize the use of compassionate, euphemistic language.

In contrast, a euphemistic term can be misleading and therefore detrimental to the patient's compliance with treatment. The literature mentions how in the case of *heart failure* the use of the medical term itself instead of a euphemistic expression, more easily comprehensible by the patient such as: "Your heart is a bit weaker than it used to be" and "Your heart is not pumping properly" or "Your heart is not working efficiently" made patients believe that their illness had more serious consequences and it would last for longer, it made them more anxious and depressed (Tayler 325).

On the other hand, although common responses to the diagnosis of cancer were shock, anger, fear, and disbelief, open use of the word *cancer* produced a moderate increase in short-term anxiety, but it also reduced the ambivalence of the patient's situation, enabling people to think more clearly about their illness and commit themselves more effectively to its treatment.

Through integrated listening, speaking, writing and debating class activities, the module deconstructed the *grammar* of giving bad news helping students understand the role of euphemisms, medical jargon as absconded language, the impact of using direct versus indirect speech acts and the degree of disclosure. But what do candid diaries by doctors as patients teach about doctor-patient communication and breaking serious and bad news?

I'm a doctor, but also a terminally ill cancer patient – Learning from *Candid Diaries*

Advice on doctor-patient communication that comes from a professional who experiences a terminal disease is insightful and overwhelming and it has a long-term impact. The selected text for the in-class reading comprehension focused on "The doctor as a patient point of view" a case of empathetic compassionate care by 29-year-old terminally ill cancer patient Dr. Kate Granger (https://www.hellomynameis.org.uk/). Students read for gist

#HelloMynameis campaign – for more compassionate care – a short disturbing narration of and by an ex-healthcare professional and her dehumanizing and humiliating experience of being curtly told the bad news of cancer by a junior doctor whom she had never seen before. The bottom line of this in-class reading activity, besides language and communication, was the identification of further core values about communication of bad news: little things like introducing yourself, giving full attention to the patient by maintaining rapport, explaining what you are going to do, holding the patient's hand, sitting beside them instead of standing over them, seeing the person rather than a bed number, a rare disease or a case (a rare form of cancer) – are strongly therapeutic in their own right and contribute to treating a suffering person with empathy and dignity (https://www.gizmodo.com.au/2015/01/how-doctors-learn-to-break-bad-news/).

Moreover, empathetic communication is symmetrical (Samuelson 2), clearly indicating verbally and paraverbally to patients that they matter as individuals beyond and above illness. Doctors who gain a clear understanding of the patients' situation and acknowledge it, without expressing this understanding in a visible and supportive way, have gone only halfway through the process of empathetic communication. Symmetrical communication is a therapeutic relationship that engages patients as partners, involves authentic caring, and careful listening that maximizes the patient's voice and, as dr. Granger demonstrates that, starts with little things which make a connection between two human beings: one who is suffering and vulnerable, and another who wishes to help.

Flipping – Deconstructing strategies for delivering bad news with tutorials

Tutorials and Yes/no scenarios by physicians were flipped to deconstruct the strategies in the genre of giving bad news in parallel with the consolidation of language and communication. Some 10 short Vimeo Videoclips by VitalTalk (tutorials and interview simulations e.g.: *Ask-tell-ask, Don't talk too much, Using I wish*) were uploaded on the students' learning platform Blackboard to be watched at home. Students collaborated on a Google spreadsheet in a joint effort to derive different strategies for giving bad news, synthesized below under the variables of Strategies and interaction, Prosody, and Positive semantics.

Strategies and interaction:

1. Delivery as a sequence of announcements: pre-announcement, announcement, response from patient, elaboration, and assessment; a pre-

announcement forecast: "I have some bad news for you*"*; post-announcement: "This is unfortunately bad news*"* (Maynard 109-131).

2. Ask-tell-ask "What do you think about…", "Here's what the tests show", "Does that make sense…?"
3. Understand what the patient knows and how much they would prefer to find out. Ask, "What do you understand about your condition...? Would you like the full details of your illness?" These questions invite patients to enter a conversation and reveal the level of their understanding.
4. Ask what the patient knows, and what they want to know: "What thoughts have you had since the biopsy? What have other doctors told you about the future?" Arrange adequate time and do advanced preparation about what to say. Turn off cell phones and begin with, "I'm sorry. I have some news." Avoid saying "bad" news.
5. Inform starting with a headline - "The CT scan shows that the cancer has gotten worse". Bluntly telling patients about a grim diagnosis or prognosis can be frightening and traumatic.
6. Give information in small chunks. Encourage questions. This is more comfortable for the doctor and obeys the patient's wishes.
7. Expect the patients' first response to be emotion: tears, disbelief, denial, or silence. Acknowledge the emotion explicitly. Track emotion with "I wish" statements "I wish I had better news".
8. One verbal strategy that doctors can use to mitigate imposition and to be polite is using negations (e.g., "this news is not good") rather than affirmations (e.g., "this news is bad") (Fraenkel 517-540).

Prosody refers to pitch, intonation, loudness, and speech rate. Prosodic devices are employed as devices that propose a particular affective orientation to the news: if some telling displays enjoyment through a faster, lively, even rushed speech rate and increased pitch (associated with good news, eagerness, excitedness), others reflect regrets such as bad news, which is produced with a soothing cast, reduced speech rate and constricted pitch range. The students identified the following prosodic strategy:

9. Some words in the message (cancer) were softened, the pace was slower, and the voice became quieter. *Died/sorry* are loaded words and are recurrently pronounced more quietly than the surrounding talk, with a breathy voice. According to the literature, this conveys the speaker's reluctance or discomfort in using these terms as if the doctor is trying to avoid agency and blame. (Burgers 267-273)

Positive semantics – Therapeutic language. Students observed the predominance of positive words versus negative ones:

10. The language of hope was mind-mapped in class and included: *heal, recover, get better, improve, relieve, alleviate, help, success, good results, positive, beneficial, a significant improvement, recuperate,*

stabilize. This finding is consistent with the guidelines and psychological studies showing that positively framed messages have positive effects on patients' evaluations as compared to negatively framed messages and that every patient feels an additional burden and stress even when only a negative form is used, despite the positive meaning such as "No problem", "No metastases in other organs." (Chapman 105). According to research, in critical, life-threatening situations, the first signal system is activated and a more limited perception of the message takes place mainly in the form, not content, which cautions students to careful selection of positive rather than negative terms (Tacheva1-23).

Metareflections - Asynchronous speaking videoclips

Asynchronous speaking was chosen as a formative learning- and reflection-orientated self-assessment. Students created short cellphone-recorded mini-presentations, reflecting on the content and the linguistic and paralinguistic patterns they detected, including prosody, softening of keywords, controlling the speech rate, making breaks, being compassionate and expressing empathy, listening in order to understand rather than reply, the importance of gaze ("look at the patient and observe"), and positive versus negative semantics.

To this date, the videoclips on different aspects of empathetic communication of bad news, deposited in the ME Facebook group testify to the students' candid learning, involvement, and satisfaction with a motivating yet uncomfortable skill whose meanders they had started to discern while learning Medical English.

Conclusion - From "cure" to "care"

Giving bad news is more than a bullet list or a mnemonic. How we communicate and how the words we use resonate in others' minds and souls are as important as what we are communicating.

The module on giving bad news proposed herein is a novel paradigm that combines freely available online content with medical language practice that can be adopted and adapted with positive results in Medical English classes. The CLIL and genre-based model, besides facilitating more effective communication in English, advances discussion on a deep, controversial topic often involving ethical decisions, and contributes to the students' linguistic awareness and humanistic thinking by highlighting the importance of empathetic communication.

In an era of deterioration of doctors' communication skills, medical students become more aware that if there may not always seem to be something left to do medically, there is always something left for them to do for the patient: compassionate empathetic communication that is as crucial

nowadays as it was in the pre-technology era is likely to make the difference between cure and care.

Works Cited

Back, L. Anthony, Arnold M. Robert, Baile F. Walter, Tulsky A. James, Fryer-Edwards Kelly. "Approaching difficult communication tasks in Oncology." Cancer Journal for Clinicians 55 2005:164–77.

Baile, F.Walter, Buckman Robert, Lenzi Renato, Glober Gary, Beale A. Estela, & Kudelka P. Andrzej. "SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer." The Oncologist 5(4) 2000:302-11.

Bakić-Mirić, Nataša, Gaipov Davronzhon Erkinovich. "The Importance of Teaching Intercultural Competence in English for Specific Purposes Course in European Medical Schools." Teaching English for Specific Purposes in Higher Education 5 Spring 2015:44-50. DOI: https://doi.org/10.13136/2281-4582/2015.i5.267

BBC. How do you tell someone that they are dying: https://www.gizmodo.com.au/2015/01/how-doctors-learn-to-break-bad-news/

Brooks, A. Laura, Manias Elizabeth, Bloomer J. Melissa. "Culturally sensitive communication in healthcare: A concept analysis." Collegian 26 (3) 2019: 383-391. https://doi.org/10.1016/j.colegn.2018.09.007.

Burgers, Christian, Beukeboom J. Camiel, Sparks Lisa. "How the doc should (not) talk: When breaking bad news with negations influences patients' immediate responses and medical adherence intentions." Patient Education and Counseling 89(2) 2012:267-273. https://doi.org/10.1016/j.pec.2012.08.008.

Chapman, W. Wendy, Bridewell Will, Hanbury Paul, Cooper F. Gregory, and Buchanan G. Bruce. "Evaluation of negation phrases in narrative clinical reports." Proceedings of AMIA Symposium 2001:105-109.

Cherny, I. Nathan, et al. "Communication with the patient and family." Oxford Textbook of Palliative Medicine, 6 Ed. Nathan I. Cherny, and others Oxford: Oxford Academic, 2021. 267–276. https://doi.org/10.1093/med/9780198821328.003.0029.

D'Agostino, A. Thomas, Bylund L. Carma. "Nonverbal Accommodation in Health Care Communication." Health Communication 29(6) 2014: 563-573. DOI: 10.1080/10410236.2013.783773.

Fallowfield, Lesley, Jenkins Valerie. "Communicating Bad, Sad, and Difficult News in Medicine." The Lancet 363, January 2004: 312-319.

Fraenkel, Tamar, Schul Yaacov. "The meaning of negated adjectives." Intercultural Pragmatics 5 2008:517-540.

Hello my name is campaign: https://www.hellomynameis.org.uk/ https://www.swselfmanagement.ca/uploads/ResourceDocuments/The%20Power%20of%20Empathy%20and%20Communication%20Symmetry.pdf

Lenkiewicz, Julia, Lenkiewicz Oliwia, Trzciński Marcin, Sobczak Krzysztof, Plenikowski Jan, Przeniosło Julia, Kotłowska Agata. "Delivering Bad News: Self-Assessment and Educational Preferences of Medical Students." International Journal of Environmental Research in Public Health February 19(5) 2022:2622. doi: 10.3390/ijerph19052622.

Maynard, W. Douglas. "On 'Realization' in Everyday Life: The Forecasting of Bad News as a Social Relation." American Sociological Review 61(1) February 1996:109-131.

Naoko, J. Miyaji. "The power of compassion: Truth-telling among American doctors in the care of dying patients." Social Science & Medicine 36(3) 1993:249-264. https://doi.org/10.1016/0277-9536(93)90008-R .

Narayanan, Vijayakumar, Bista Bibek, Koshy Cheriyan. "BREAKS Protocol for Breaking Bad News." Indian Journal of Palliative Care May 16(2) 2010:61-65. doi: 10.4103/0973-1075.68401.

Paranzino, K. Grace, Butterfield Patricia, Nastoff Teresa, Ranger Cherryll. "I PREPARE: development and clinical utility of an environmental exposure history mnemonic." AAOHN Journal 53(1) 2005:37–42.

Pereira, Carolina Rebello, Marco, Calônego Antônio Marchetti, Lemonica Lino, Guilherme Moreira de Barros Antonio. "The PACIENTE Protocol: an instrument for breaking bad news adapted to the Brazilian medical reality." Revista Da Associação Médica Brasileira 63(1) 2017:43–9.

Pop, Anișoara (a). "Alternatives in Assessment: Student-generated Videos and Online Written Case presentations in Medical English." Proceedings of the 15th International Conference on Virtual Learning October 2020:515-522.

Pop, Anișoara, Pascan Aurora (b). "Self-access learning in Medical English (ME). A Two-year Edmodo Project." Acta Universitatis Sapientiae Philologica 9(3) 2017:41-52.

Pop, Anișoara (c). "Adopting Doctor-Patient Interactional Strategies to the Medical English Context, Uniformity and Diversity in Teaching Medical Sciences Today. Part IV Humanistic Sciences and Interdisciplinary Education. Ed. Gr.T.Popa Iasi, 2018. 304-313.

Rajic, Tea. *Euphemisms in Medical Jargon.* Unpublished Dissertation. Josip Juraj Strossmayer University of Osijek: 2014.

Ranjan, Piyush, Kumari Archana, Chakrawarty Avinash. "How can Doctors Improve their Communication Skills?" Journal of Clinical Diagnosis Research March 9(3) 2015:JE01-4. doi: 10.7860/JCDR/2015/12072.5712.

Riess, Helen, Kraft-Todd Gordon. "EMPATHY." Academic Medicine, 89(8) 2014:1108-1112.

Rollins, K. Lisa, Hauck R. Fern. "Delivering Bad News in the Context of Culture: A Patient-Centered Approach." Journal of Clinical Outcomes Management. January 2015:21-26.

Samuelson, Julie. The Power of Empathy & Communication Symmetry. Press Ganey Associates, https://www.swselfmanagement.ca/uploads/ResourceDocuments/The%20Power%20of%20Empathy%20and%20Communication%20Symmetry.pdf.

Schmauch, Natália Ubisse, Pinto Emilia, Rego Francisca, Castro Luísa, Sacarlal Jahit & Rego Guilhermina. "Communication strategies used by medical physicians when delivering bad news at the Maputo Central Hospital, Mozambique: a cross-sectional study." BMC Palliative Care 22 2023:186. https://doi.org/10.1186/s12904-023-01309-y

Tacheva, Violeta. "Communication – the master key to the patient's heart." JAHR 4(1) February 2013:1-23.

Tayler, Michael Ogden Jane. "Doctors' use of euphemisms and their impact on patients' beliefs about health: an experimental study of heart failure." Patient Education and Counseling 57 2005: 321–326.

Triff, Zorica & Triff Dorin. "Utilitatea lecţiilor. Caracteristici individuale ale studenţilor." Buletin științific Fascicula Filologie XXIII 2014:657-662. https://www.ceeol.com/search/article-detail?id=162723.

Tseligka, Theodora (a). "Medical Humanities: the 'Glass Slipper' of Medical English -A Review of Instructional Interventions." International Journal of English for Specific Purposes 4(1) December 2022: 32-53. Available from: https://www.researchgate.net/publication/371279966_Medical_Humanities_the_'Glass_Slipper'_

Tseligka, Theodora, Koik Kätlin. "The Becoming of a Medical Professional: Integrating Humanities-Based Resources in a Medical English Course." ESP Today 9(1), 2021:50-62. doi:10.18485/esptoday.2021.9.1.3

Vygotski, Lev. "Learning and mental development at school age." *Educational psychology in the U. S. S. R.* B. Ed.Simon & J. Simon. London: Routledge & Kegan Paul,1963:21–34.