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DEVELOPING MEDICAL STUDENTS' COMMUNICATIVE COMPETENCE THROUGH SIMULATION-BASED LEARNING IN ENGLISH LANGUAGE TEACHING

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Abstract
Communicative competence is a central outcome of English language teaching in medical universities, because future physicians must exchange information accurately, show empathy and work in teams within an international professional environment. Traditional lecture-based language classes often fail to provide enough realistic speaking practice. This article examines simulation-based learning as a pedagogical approach that places students in controlled, clinically authentic situations in which they have to use English purposefully. Drawing on communicative language teaching theory and the literature on experiential learning, the paper describes the main types of simulation suitable for English classes, proposes a three-stage instructional model (pre-briefing, simulation and debriefing), and outlines a rubric for assessing the linguistic, pragmatic and professional dimensions of student performance. The article concludes with practical recommendations for teachers who work in settings with limited technological resources.

Keywords: Communicative competence, simulation-based learning, medical English, role-play, debriefing, English for specific purposes, clinical communication.

Introduction

Medicine is one of the most internationalised professions of the modern world. Clinical guidelines, research articles, conference presentations and professional networks operate largely in English, and graduates increasingly work with foreign colleagues, international patients and global digital platforms. For this reason, foreign language proficiency has been treated as a strategic priority in the education system of Uzbekistan, and the state has repeatedly stressed the need to improve the quality of foreign language teaching at all levels [7]. Medical universities therefore face a double task: they must prepare graduates who can read specialised literature and, at the same time, graduates who can speak, listen and interact confidently in professional situations.

In practice, many medical students master long lists of anatomical and clinical terms and perform well in grammar exercises, yet they hesitate when they have to take a patient's history, explain a diagnosis in plain language, or report a patient's condition to a colleague. This gap between knowing about a language and using it is exactly the gap that the communicative approach to language teaching aims to close [1; 2]. A student who can define "hypertension"

but cannot reassure an anxious patient, ask a follow-up question or check understanding has not yet reached the level of communicative competence that the profession requires.

Simulation has long been used in medical education to train clinical and procedural skills in a safe environment. Its potential for developing communicative competence in a foreign language is less systematically described, although it combines several features that language teachers value: authentic context, a real communicative purpose, interaction between participants and immediate feedback. The aim of this article is to analyse the pedagogical value of simulation-based learning in English classes for medical students and to propose a practical model for its implementation. The tasks of the study are to clarify the concept of communicative competence in the medical context, to classify the types of simulation that can be used in language teaching, to describe the stages of a simulation lesson, and to suggest criteria for assessment.

The notion of communicative competence emerged as a response to purely grammatical views of language knowledge. Hymes argued that a speaker must know not only whether an utterance is grammatically correct, but also whether it is appropriate, feasible and actually used in a particular context. Later, Canale and Swain described communicative competence as a combination of grammatical, sociolinguistic, discourse and strategic competences. For medical students, these components acquire a specific professional meaning. Grammatical competence includes accurate use of medical terminology and the structures needed for questions, instructions and explanations. Sociolinguistic competence concerns the choice of register: a doctor speaks differently to a colleague, to a child and to a worried relative. Discourse competence involves organising a consultation or a case presentation logically, while strategic competence helps the speaker to clarify, paraphrase and recover from misunderstanding.

Uzbek methodologists emphasise that the main goal of foreign language teaching is the formation of practical speech skills, and that this goal can be achieved only when learning is organised around communicative tasks rather than around the memorisation of rules [1; 2]. This view is fully consistent with the needs of medical education, where language is a working tool and not an academic subject in itself. In addition to the four traditional skills, medical communication requires empathy, active listening, the ability to give bad news sensitively and the ability to work in a team. These professional communication skills are developed more effectively through practice than through explanation.

Simulation-based learning rests on the principles of experiential and social learning. Learners acquire knowledge by taking part in a concrete experience, reflecting on it, drawing conclusions and applying them in the next attempt. From the sociocultural perspective, language develops through interaction, and the teacher's task is to provide scaffolding that gradually becomes unnecessary. The theory of pedagogical technology adds a further argument: a lesson becomes more predictable and more effective when it is designed as a system with clear objectives, a defined procedure and measurable results [3; 4]. A well-planned simulation corresponds to this logic, because it has a specified learning outcome, a structured sequence of actions and an opportunity for objective evaluation. Interactive methods of this kind also increase learners' motivation and responsibility for their own progress [5; 8].

Simulation in a language class does not necessarily require expensive equipment. Depending on the level of realism, which is usually called fidelity, teachers can choose from several formats that suit their conditions. The most common ones are the following.

- **Peer role-play.** Students work in pairs, one acting as the doctor and the other as the patient, using role cards that contain the patient's complaints, concerns and personality. It is the simplest format and requires only printed materials.
- **Simulated-patient encounters.** A trained senior student, a colleague or the teacher plays the patient and responds spontaneously, which makes the interaction less predictable and closer to real practice.
- **Team-based case simulations.** Groups of three or four students represent a ward team, discuss a case, distribute roles and make decisions together. This format develops interprofessional communication, turn-taking and the language of negotiation.
- **Telephone and digital simulations.** Students conduct a teleconsultation, leave a voice message for a colleague or communicate results by phone. The absence of visual cues forces learners to rely on precise language and to check understanding verbally.
- **Emergency simulations with manikins.** When a training centre is available, students manage a deteriorating patient while giving short, clear commands and confirming them by repeating them back, a technique known as closed-loop communication.
- **Conference and case-presentation simulations.** Students present a clinical case to "international colleagues" and answer unexpected questions, which develops academic and professional speaking skills.

Research and teaching experience suggest that high fidelity is not always necessary for language development. What matters more is the psychological realism of the task: the student must feel that there is a real communicative problem to solve, such as a patient who does not understand the instructions or a colleague who needs urgent information.

To make simulations effective, it is useful to organise each lesson around three consecutive stages: pre-briefing, simulation and debriefing.

Pre-briefing. At this stage the teacher states the learning objectives in both clinical and linguistic terms, for example "to take a focused history of chest pain and to use open and closed questions appropriately". Students receive the necessary language input: functional phrases for opening a consultation, signposting, asking about symptoms, expressing empathy and summarising. For handover situations, a structured framework such as SBAR (situation, background, assessment, recommendation) can be taught. The teacher also sets ground rules for a psychologically safe atmosphere, in which mistakes are treated as material for learning and not as grounds for criticism. Observers are given checklists so that they have a clear task during the performance.

Simulation. The scenario usually lasts between eight and fifteen minutes. The teacher intervenes as little as possible and only when the interaction breaks down completely. With the participants' consent, the performance can be recorded on a smartphone, which provides valuable evidence for later analysis. The main principle at this stage is that students should solve the communicative problem themselves, using the language resources they have.

Debriefing. Debriefing is the most important part of the lesson, and in simulation literature it is generally recommended that it should be at least as long as the scenario itself. A productive discussion begins with participants' own reactions ("How did you feel?"), continues with a description of what actually happened, moves to analysis ("Why did the patient look confused at that moment?") and ends with application ("What will you do differently next time?"). In a language class, the teacher also directs attention to linguistic features: unclear explanations, overuse of technical terms, inappropriate register, missing empathy markers and recurring grammatical errors. Fragments of the recording can be replayed and corrected collectively. A particularly effective technique is to repeat the scenario with a different pair, or with the same pair after reformulation, so that students can immediately apply the feedback and notice their own progress.

The table below presents three scenarios that can be adapted to different levels of language proficiency and different stages of medical training.

Scenario	Communicative focus	Target language
Taking a history from a patient with abdominal pain	Open and closed questions, active listening, empathy	Could you describe the pain? How long has it lasted? I understand this must be worrying.
Explaining a diagnosis and treatment plan	Plain language instead of jargon, checking understanding	In simple terms, this means… Let me make sure I have explained it clearly.
Handing over a patient at shift change	Structured and concise reporting, SBAR	The situation is… Her background is… My recommendation is…

Assessment of simulation activities should be primarily formative, since its main purpose is to help students improve. A rubric that is shared with students in advance makes expectations transparent and encourages self-assessment. It is reasonable to evaluate performance in the following dimensions.

- **Language accuracy and range:** correct use of grammar and terminology and variety of expressions.
- **Fluency and interaction:** ability to maintain the conversation, respond to unexpected input and repair misunderstandings.
- **Pragmatic appropriateness:** suitable register, politeness and expression of empathy.
- **Organisation of clinical discourse:** logical structure of the consultation, signposting and summarising.
- **Patient-centredness and professionalism:** attention to the patient's concerns, clarity of explanation and respect for confidentiality.

Each dimension can be described at three or four levels, and the final feedback should combine self-assessment, peer assessment and the teacher's comments. Over a semester, a portfolio of recordings and reflective notes allows both the teacher and the student to follow progress in a concrete and motivating way.

The analysis of the approach shows that simulation influences language development in several complementary ways. First, it creates a real need to communicate. In a traditional exercise the student knows that the teacher already has the correct answer, whereas in a simulation the "patient" has information that the "doctor" must obtain through questions, and the "doctor" has information that the "patient" must understand. This information gap is a classical condition for meaningful interaction and stimulates the use of negotiation of meaning: students ask for repetition, paraphrase, confirm and correct one another.

Second, simulation reduces the distance between classroom English and clinical practice. When students rehearse a consultation or a handover in advance, they accumulate a repertoire of ready-to-use phrases and discourse patterns that they can later transfer to hospital placements, international internships and professional examinations. Because the scenarios are connected with the content of clinical subjects, language learning also reinforces professional knowledge, and clinical reasoning in turn provides a meaningful context for language use. This integration of content and language is particularly valuable in English for specific purposes, where learners' motivation depends on the perceived relevance of the course to their future career.

Third, the reflective stage develops metacognitive awareness. Students learn to observe their own communication, to recognise habits such as speaking too fast, using unexplained terminology or interrupting the patient, and to set personal goals for improvement. Observers also benefit, because evaluating the performance of peers with the help of a checklist sharpens their understanding of what effective communication looks like. At the same time, it should be acknowledged that simulation is not a universal solution. Its results depend on the quality of scenario design, on the skill of the facilitator in leading the debriefing and on a sufficient number of repeated sessions; a single simulation per semester is unlikely to produce a noticeable change. For this reason, simulation is best regarded as a regular component of the course that complements, and does not replace, systematic work on vocabulary, grammar, reading and writing.

The introduction of simulation faces several practical difficulties. Large groups make it hard to give every student enough speaking time. This problem can be reduced by organising parallel stations, rotating the roles of doctor, patient and observer, and using the observer's checklist as an active learning task. Teachers of English often lack clinical expertise, so close cooperation with clinical departments is advisable: physicians can help to design realistic cases and verify their medical accuracy, while language teachers focus on communication. Some students feel anxious about performing in front of peers, therefore it is wise to begin with low-stakes pair work and to move gradually to team and public simulations. Finally, ethical considerations should not be overlooked: recordings require consent, cases must be fictional or anonymised, and the emotional sensitivity of topics such as serious illness should be respected. The experience of modern pedagogy also shows that any innovative method requires systematic preparation of the teacher and regular reflection on results [4; 9].

Simulation-based learning provides an effective way to link the study of English with the real communicative needs of future physicians. By placing students in realistic situations, it integrates language, professional knowledge and interpersonal skills, and it gives learners the opportunity to practise, receive feedback and try again in a safe environment. The three-stage model of pre-briefing, simulation and debriefing, supported by clear assessment criteria, offers

teachers a flexible framework that can be applied even with modest resources. Further research could examine the long-term effect of regular simulation work on students' performance in clinical placements and international examinations, and compare different formats of debriefing in the context of Uzbek medical universities.

References

1. Jalolov, J.J. (2012). Methodology of Teaching Foreign Languages: A Textbook for Students of Foreign Language Universities (Faculties) [Chet til o'qitish metodikasi]. Tashkent: O'qituvchi. 432 p. (in Uzbek)
2. Hoshimov, O'., & Yoqubov, I. (2003). Methodology of Teaching English: A Study Guide [Ingliz tili o'qitish metodikasi]. Tashkent: Sharq. (in Uzbek)
3. Yo'ldoshev, J.G'., & Usmonov, S.A. (2004). Fundamentals of Pedagogical Technology [Pedagogik texnologiya asoslari]. Tashkent: O'qituvchi. (in Uzbek)
4. Yo'ldoshev, J.G'., & Usmonov, S.A. (2008). Implementing Modern Pedagogical Technologies in Practice [Zamonaviy pedagogik texnologiyalarni amaliyotga joriy qilish]. Tashkent: Fan va texnologiya. (in Uzbek)
5. Ishmuhamedov, R., & Yo'ldoshev, M. (2013). Innovative Pedagogical Technologies in Education and Upbringing [Ta'lim va tarbiyada innovatsion pedagogik texnologiyalar]. Tashkent: Nihol. (in Uzbek)
6. Musurmonova, O. (2020). General Pedagogy [Umumiy pedagogika]. Tashkent: Yoshlar. 376 p. (in Uzbek)
7. Decree of the President of the Republic of Uzbekistan No. PQ-1875 of 10 December 2012, "On Measures to Further Improve the System of Learning Foreign Languages" [Chet tillarni o'rganish tizimini yanada takomillashtirish chora-tadbirlari to'g'risida]. Xalq so'zi, 12 December 2012. (in Uzbek)
8. Xoldorova, M., Farziyeva, N., & Rixsitillayeva, F. (2005). Using Auxiliary Aids in Teaching Foreign Languages [Chet tilini o'qitishda yordamchi vositalardan foydalanish]. Tashkent: Nizami Tashkent State Pedagogical University. (in Uzbek)
9. Pedagogy: Encyclopedia (2015). Vol. 1 [Pedagogika: ensiklopediya. I jild]. Tashkent: State Scientific Publishing House "National Encyclopedia of Uzbekistan". (in Uzbek)