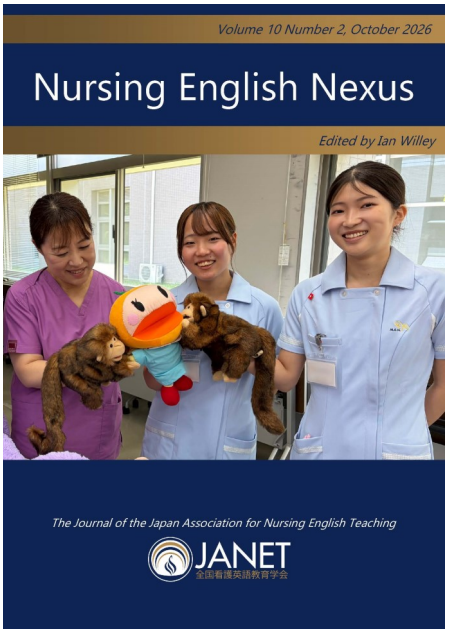
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Clinical Communication Models: A Solution to Teaching at Lower Levels?

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***Abstract**: Internationally educated nurses with lower levels of English proficiency face a dual challenge: acquiring linguistic competence while simultaneously demonstrating safe, patient-centred communication in complex environments. This paper explores how clinical communication models can provide much-needed scaffolding to support these learners in developing their skills in spoken English. It will outline practical classroom applications for nursing contexts, including escalation of care, consultations, and patient education. It will also address common pitfalls and propose strategies to encourage learners to move from formulaic use to authentic interaction. By integrating clinical communication models, trainers can deliver instruction that is both linguistically accessible and professionally credible, preparing nurses and nursing students for real-world practice. This paper will be of particular interest to teachers of English for healthcare, nursing educators, and trainers working with internationally recruited staff at lower proficiency levels.*

Keywords: clinical communication models; English for healthcare; linguistic competence; nursing educators

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Japanese nursing students with lower levels of English proficiency face a dual challenge: the need to acquire linguistic competence while simultaneously demonstrating safe, patient-centred communication in complex environments. In response, this paper explores how the use of clinical communication models in the teaching of nursing English might provide a possible solution.

Background

With the steady rise of long-term foreign-born residents (3.5 million in 2024), medical tourism, and the various initiatives to encourage international tourism, the need for healthcare professionals, notably nurses, who can communicate via English is now critical to healthcare provision in Japan. In 2018 this was reflected in the creation of a series of hubs responsible for treating so-called culturally and linguistically diverse (CALD) patients with more serious conditions, as well as the Japan Nursing Association's updated Code of Ethics in 2021, which requires its members to be sensitive to the needs of patients of diverse cultural backgrounds and their families.

Teaching English to Japanese nursing students presents several challenges. Porter et al. (2025) identify large, mixed-ability classes and limited content knowledge as key issues in the university sector. It is often felt that first- and second-year students may not yet be ready to engage fully with the specialised vocabulary and communication strategies of clinical practice, while anxiety around speaking and low motivation can create further barriers (Crosby, 2026; Patterson et al., 2026).

One response might be to prioritise general English until students gain greater clinical knowledge and practical experience. However, Hussin (2011) argues for more "courageous curriculum choices", challenging the assumption that learners with low English proficiency are not able to engage with ESP and emphasising that healthcare is "as much about caring as it is about curing". Introducing this principle early allows it to shape learners' communication from the outset. Using clinical communication models with students who have limited linguistic competence

and clinical knowledge represents one such curriculum choice.

What Are Clinical Communication Models?

Clinical communication models are used extensively in the healthcare setting in the English -speaking world. They are designed to enable healthcare professionals to accomplish a particular function or set of functions safely and effectively. Examples include SPIKES, a model for the delivery of bad news, and ISBAR, used to communicate key patient information during handover and escalation of care.

Kurtz et al. (2006) cite a variety of advantages to employing clinical communication models. Use of such models increases levels of accuracy and efficiency, not only during individual patient encounters, but also in terms of the overall provision of care and the eventual health outcomes for the patient. Clinical communication models increase the level of support provided to the patient and their relatives and help promote a collaborative environment, thus developing a partnership between healthcare professionals and the patient. In other words, clinical communication models go a long way to developing and maintaining a patient-centred approach to care, which in turn increases both patient and professional satisfaction.

Clinical communication models can be transposed easily into the language classroom, making use, as advocated by Dudley-Evans and St John (2005), of the "underlying methodology and activities of the discipline it serves". By incorporating such models into the curriculum, trainers endeavour to employ the methodology used in clinical communication skills training in the English-speaking world; providing a sound, evidence-based approach, which appeals to learners and stakeholders alike. In doing so, English language trainers ensure their credibility, while helping prepare learners for their future workplace.

From a pedagogical perspective, clinical communication models provide a useful framework for designing authentic tasks or even entire syllabuses. Their clear objectives create a structure around which to teach the key language learners need to perform specific clinical functions. As many focus on high-frequency tasks, they provide a relevant and legitimate basis for language input. Models such as SPIKES and ISBAR are also transferable across different scenarios, allowing them to be recycled throughout a course and incorporated into both formative and summative assessments. As a scaffolded approach to spoken communication, they can make learning more relevant, manageable, and motivating, particularly for pre-experience and lower-level learners.

Clinical Communication Models for Japanese Nursing Students

If the goal of healthcare education is to promote patient-centred care, a logical starting point is a model that develops active listening skills. SOLER is particularly suitable for pre-experience learners as it requires neither specialist knowledge nor advanced linguistic competence. Instead, it focuses on the non-verbal behaviours that signal attentiveness: sitting squarely (S), adopting an open posture (O), leaning in (L), maintaining eye contact (E), and relaxing (R). Together, these behaviours can help nurses build trust and encourage patients to express themselves more openly.

Patient-centred care also depends on managing expectations and keeping patients informed. Doing so can build rapport, reduce anxiety, and support a smoother patient journey. Evidence from the Spoken Corpus of Foreign and Immigrant Patient Narratives (2025) highlights how differences in cultural expectations and clinical procedures can disrupt this journey for CALD patients. One Latvian patient, for example, was surprised to be catheterised for a urine

sample with neither prior explanation nor request for consent, while a New Zealand patient was left uncertain as to the decision behind a sudden change from general to local anaesthetic. As the latter observed, even a brief explanation that someone was checking what was happening "would have helped". Such examples underline the important role of nurses in Japan in explaining procedures and decisions, including those involving other healthcare professionals (Porter, 2025).

AIDET offers a simple model for addressing those needs. By smiling and making eye contact, nurses first acknowledge the patient (A) before introducing themselves (I) and stating their role in the patient's care. Next, they offer a realistic duration (D) for the particular test or procedure, etc., and then explain (E) what will happen next and why. With (I), they invite questions from their patient, and finally, thank (T) him or her for their patience or understanding. By making communication more explicit and predictable, AIDET can reduce uncertainty and help prevent the kinds of surprises experienced by the patients above.

Another key nursing role is patient education. Although a South African patient praised the care she received in Japan, she did recall that nurses often had to rely on pointing to printed phrases such as "We're going to give you an injection now" or "We're going to draw your blood" to get their message across. Hussin's (2008) six-stage framework for explaining procedures could have supported clearer, more concise communication and helped facilitate the nurse's role as patient educators.

A slightly adapted version of Hussin's model breaks the explanation into the following stages: (1) explore the patient's prior understanding of the procedure, (2) explain the procedure, (3) ask for cooperation, (4) encourage the patient, (5) offer reassurance, and (6) provide feedback, e.g. on the results of the particular procedure. From there, it is then possible to identify and teach the specific language needed at each stage. This includes going to for explaining what will happen, question forms to check understanding, polite requests to gain cooperation, and simple present and past forms to provide feedback.

As the procedure is familiar and the language requirements relatively low, Hussin's adapted model is well-suited to pre-experience learners in the early stages of their course. It is also transferable to other areas of patient education, including explaining conditions, medications, tests, and investigations, allowing for recycling as the course progresses and content knowledge increases. In addition, and beyond its functional value, the model also serves to reinforce the patient-centred approach, encouraging learners to involve patients more actively in conversations and decisions about their care, and as such respond to the expectations of many CALD patients.

Another model that promotes patient centredness is the CARE protocol. Tsujimura et al. (2016) found that in Japan, nurses were "expected to sense and anticipate the patient's needs" rather than explicitly elicit them. The CARE protocol—Connect, Ask, Respond, Empathise—used during bedside handovers (Chien et al., 2022) provides an opportunity for nurses to elicit and incorporate the patient's perspective at various stages during their hospital journey in a manner that is empathic and non-judgemental. By eliciting as opposed to anticipating needs, the CARE protocol helps to empower patients and ensure they are more directly involved in the handover process.

Differences in workplace culture can negatively affect Japanese nurses working abroad. Hussin (2008) and Ilieva (2020) identified a lack of assertiveness as a particular challenge for Japanese nurses in Australia, often resulting in reluctance to question decisions or escalate care when necessary. This undoubtedly reflects the stronger emphasis on seniority and hierarchical relationships in Japanese healthcare, behaviours

that Australian colleagues may interpret as a lack of clinical reasoning or problem-solving ability (Hussin, 2008), and ones that could potentially lead to adverse health effects and compromised patient safety.

ISBAR offers a practical communication model for addressing this issue. By helping speakers organise and prioritise information, ISBAR (Identification, Situation, Background, Assessment, Recommendation) supports concise, structured communication and reduces ambiguity for the listener. Importantly, it also provides junior staff with a recognised format for voicing concerns and escalating care, enabling them to communicate more confidently, act promptly, and help prevent errors.

Challenges and Pitfalls

While limited clinical knowledge and linguistic competence in the early stages of English language training can be addressed through carefully selected models, other pitfalls remain. One attractive feature of clinical communication models is their accessible, step-by-step structure, which highlights the key expressions and grammatical forms needed to complete a task and makes the process more manageable in English. However, learners should be discouraged from relying too heavily on these models, as this risks reducing communication to a tick-box exercise; a concern that is not unique to language learners. In evaluating the SPIKES model, von Blanckenburg et al. (2020) found that, although the framework supported effective conversations when breaking bad news, communication still needed to reflect individual patient preferences rather than simply follow the six stages.

Clinical communication models therefore provide a useful starting point, regardless of learners' language proficiency, but they should not become scripts. Once learners have mastered the structure, grammar, and lexis associated with a particular function, they should be encouraged to move beyond stock phrases and personalise their language. This means adapting communication to their own style, as well as to the patient, colleague, and clinical situation, therefore avoiding interactions that sound overly formulaic or unnatural.

The Culturally Sensitive Approach

Having argued for the inclusion of clinical communication models in the teaching of entry-level Japanese nursing students, it is useful to consider the culturally sensitive approach (CSA) advocated by Crosby (2026). Central to this approach is the use of linguistic scaffolding to enable learners to participate in communication without becoming overwhelmed by the demands of spontaneous language production. Crosby further argues for a gradual progression in which early-stage tasks are highly structured, narrowly focused, and linguistically manageable.

Clinical communication models fit well within the CSA. By providing learners with a clear structure, limited communicative goals, and the language needed to achieve these goals, models such as SOLER, AIDET, Hussin's six-stage framework, and ISBAR can reduce both the linguistic and cognitive loads while building confidence in clinical interactions. For Japanese nursing students, these models may also provide a bridge between differing cultural expectations toward patient-centred communication, assertiveness, and professional roles.

Conclusion

The value of clinical communication models, however, lies not in their use as fixed scripts, but as scaffolds from which learners can progress. As linguistic competence, clinical knowledge, and confidence develop, support can be gradually withdrawn, and learners can be encouraged to adapt the language to the individual patient, colleague, or situation. As such, clinical communication models offer an accessible entry

point into English for nursing while remaining consistent with a culturally sensitive pedagogy that moves learners from structured practice towards more flexible, autonomous, and patient-centred communication.

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