

**How to Cite:**

Al-Mansori, Z. K. A., & Reishaan, A. H. K. (2022). A pragmatic study of the communication skills in doctor-patient discourse. *Linguistics and Culture Review*, 6(S2), 383-406. <https://doi.org/10.21744/lingcure.v6nS2.2131>

# A Pragmatic Study of the Communication Skills in Doctor-Patient Discourse

**Zainab Khdhair Abbas Al-Mansori**

University of Kufa, Faculty of Arts, Department of English Language, Iraq

**Abdul Hussein Kadhim Reishaan**

University of Kufa, Faculty of Arts, Department of English Language, Iraq

**Abstract**---As people rely heavily on sharing information, they need to increase focus on having good communication skills. Hence, poor communication between doctors and patients has a direct and indirect impact on the quality of medical care provided to patients. This study focuses on communication skills and discourse tact in diagnosis because of their wonderful role in strengthening the doctor-patient relationships. It was conducted by collecting the medical discourse by only visiting al-Sadr Teaching Hospital as it includes the largest number of doctors in Najaf. It further emphasized the incorporation of some elements of pragmatics into medical curricula for their great communicative benefits in creating collaborative interlocutors, specifically, Grice's (1975) Cooperative Principle and Ayeloha's (2019) types of discourse devices. The study aims to identify the strong and weak points in doctor-patient discourse, evaluate the linguistic tools and communication strategies used in this discourse to assess the efficiency of the interaction between doctors and patients, and highlight the impact of the integrative curriculum adopted by University of Kufa on doctors' communication with patients in comparison with the traditional curriculum taught at Jabir Ibn Hayyan Medical University.

**Keywords**---communication skills, discourse tact, doctor-patient, medical curricula, pragmatic study.

## Introduction

Undoubtedly, interpersonal communication, whether verbal or non-verbal, has had a great impact on almost every aspect of life. However, people never stop thinking about whether they are communicating in the most effective way or not. Indeed, communication skills (CSs) require both content (what is communicated)

---

Linguistics and Culture Review © 2022.

**Corresponding author:** Al-Mansori, Z. K. A.; Email: [zainabkhdairabbas@gmail.com](mailto:zainabkhdairabbas@gmail.com)

Manuscript submitted: 27 Oct 2021, Manuscript revised: 09 Dec 2021, Accepted for publication: 18 Jan 2022

and style (how it is communicated) (Windle, 2017). Empathy, giving hope, attentive listening, and the use of open-ended questions are some examples of skillful CSs. Besides, improved doctor-patient communication (DPC) has tended to increase patient adherence to a recommended therapy, satisfaction, and help patients (Pts) be more comfortable and confident (Arora, 2003; Brinkman et al., 2006). Pts often regard their doctors (Docs) as one of their most important sources of psychological support (Baile et al., 1999). According to Matusitz & Spear, (2014), "medicine is an art whose magic and creative ability have long been recognized as residing in the interpersonal aspects of the patient-physician relationship" (Rees et al., 2004; Deveugele et al., 2005).

DPC has been a keystone of MC (Medical Care). It is the medium through which data is collected, diagnoses are made, plans are arranged, support is given, compliance is achieved, and healing is provided (Carroll et al., 1995). Hence, while effective DPC has been a source of motivation, confidence, and reassurance (Kaplan et al. (1989), this relationship has sometimes been problematic, with negative consequences for Pts, including higher levels of anxiety, distrust of medical providers, and dissatisfaction with HC (healthcare) in general. Additionally, "the patient will never care how much you know, until they know how much you care" (Tongue et al., 2005). A poorly delivered message could create passive feelings or bad outcomes and might result in misunderstandings, frustration, and, in some cases, disasters. In accordance with Tongue et al. (2005), "Most complaints about doctors are related to issues of communication, not clinical competency." Pts want doctors who can skillfully diagnose and treat their illnesses as well as communicate with them effectively (Duch et al., 2001).

The present study concerns itself with the doctor-patient communication skills in some of the Iraqi medical institutions in Najaf (Aljumily, 2021; Sarah & Oladayo, 2021; Sinha, 2021). It tackles problems related to miscommunication, their causes, and their effects from a pragmatic point of view. Hence, according to the best knowledge of the researcher, it is the first study that will be conducted in Iraq and will examine the role of effective CSs in DPD (doctor-patient discourse) and their effect on improving HC outcomes (Virtanen et al., 2007; Urzúa & Vásquez, 2008).

## **Literature review**

### **Pragmatic approaches**

The term 'pragmatics' emerged for the first time in the 1930s, which is the first stage in which it was a branch of semiology or semiotics as the study of signs. In 1938, Carnap mentioned that pragmatics should focus and study the relationship between users, words and reference relationship. Morris divided semiology into three parts: syntax or syntactics, semantics and pragmatics. In the second stage, which is from the 1950s to 1960s, three philosophers: Austin, Searle and Grice put the main foundations for their theories of speech act and implicature theory. In the third stage, which was in 1977, Mey was the first to publish a journal of pragmatics in Holland. In 1983, Leech wrote his book 'Principle of Pragmatics', whereas Levinson wrote his book 'Pragmatics'. Pragmatics was developed in the late 1970s as a subfield of linguistics that studies communication (Taha, 2019).

Besides, according to [Levinson \(1983\)](#), pragmatics is a branch of linguistics, which studies how both the explicit and implicit aspects of a communicated linguistic meaning are recognized differently by listeners according to different physical or social contexts. Furthermore, it is the study of deixis, implicature, presupposition, speech acts, cooperative principles, and so on. Pragmatics has been a primary focus for both linguistics and philosophy of language in the twentieth century ([Flor, 2003](#); [Slotta, 2018](#)).

The word 'pragma' is Greek and refers to activity, to do or to act. It is the study of how people interact when using language and it explains language use in context including the effect that a context has on an utterance, and the goals the speaker intends to reach through the choice of means of expression. Hence, it refers to the study of language in use. As a matter of fact, pragmatics is the study of meaning of words, phrases and full sentences in a social context, unlike semantics which deals with the meanings of words that can be found in dictionaries ([Mey, 2001](#)). Pragmatics as a field of linguistic inquiry was initiated in the 1930s by the philosophers [Morries](#), [Carnap](#), and [Pierce](#). They cited that [Syntax](#) addressed the formal relations of signs to one of another, [Semantics](#) the relation of signs to what they denote, and [Pragmatics](#) the relation of signs to their users and interpreters ([Morris, 1938](#)).

### **The cooperative principle**

[Grice \(1975\)](#), identified in a sophisticated theory, certain rules for conversation, known as conversational maxims, based on how people interpret each other's utterances. He claims that the co-operative principle accounts for the general standards that govern verbal communication and hence he developed his principle into nine maxims classified into four categories.

- Adequately but not overly informative (quantity maxim).
- telling truth and providing evidence (quality maxim).
- being relevant (maxim of relation or relevance).
- being clear, brief, ordered and avoiding ambiguity (maxim of manner).

And accordingly, interlocutors should avoid ambiguity and obscurity and be as brief and ordered as possible. Adopting cooperative participants, for sure, will make the process of communication easier by saving both time and effort. "The sum and substance of the Cooperative Principle might be put this way: Do whatever is necessary to achieve the purpose of your talk; don't do anything that will frustrate that purpose" ([Nordquist, 2019](#)).

### **What might Happen to the Maxims?**

As the purpose of using them is cooperation, in this study, the maxims have been carried out in relation to:

- 'flouting' as a characteristic in some interactions and in which the speaker is deliberate to conceive the listener overtly and the hearer is perceptive for that; for the purpose of making a joke, irony or stressing something.

- ‘violation’, which has been defined by Grice (1975) as ‘unostentatious’ or non-observance of a maxim. It occurs when speakers violate a maxim, and as a result, they will be liable to mislead for some self-serving purposes.
- ‘infringing’, which occurs when one of the interlocutors has no perfect knowledge to communicate.
- ‘opting out’, which indicates an interlocutor’s unwillingness to cooperate or share confidential information with others.
- ‘suspending’, which appears in some specific events in particular cultures, like funeral orations and obituaries, when the description of the deceased needs to be trustworthy.

### **Types of discourse devices**

In general, discourse refers to any spoken or written communication. It can also be described as any expression of thought through the use of language. Foucault (1972), defined discourse as “Systems of thoughts composed of ideas, attitudes, and courses of actions, beliefs and practices that systematically construct the subjects and the worlds of which they speak”. Etymologically, the word ‘discourse’ has its roots in Latin ‘discursus’ which means conversation, which is dated back to the 14th century and its meaning slightly differs from one context to another. More explicitly, discourse can be defined as a complete meaningful unit delivering a complete meaningful message (Nunan, 1993). For example, in literature, it means speech or writing which is usually longer than sentences and requires a certain subject (Willems et al., 2005; Krupat et al., 2000).

Nine discourse devices were predominant in the data. Docs employed a phatic communion to open an interview, circumlocution to communicate medical information, rapport expressions to open a discourse and show acceptance, cordiality and solidarity language-switch to apply both explicitness and mutuality, counseling for guiding Pts on how best they may handle their health, interlocutor’s religious belief for enlightenment and correction, direct and indirect questions were applied for diagnosis: Interrogatives to elicit information, answers to respond to Docs’ inquiries: Declaratives to provide information, repetition to emphasize important points, and closing the interview to terminate consultations (Ayeloja, 2019).

### **Doctor-patients communication**

Despite the increasing significance of CSs training in different medical settings, there is a lack of generally accepted definitions of adequate doctor-patient communication. According to Lipkin et al. (1995), “Doctor’s communication skills encompass the ability to gather information in order to facilitate an accurate diagnosis, counsel appropriately, give therapeutic instructions, and establish caring relationships with patients.” Clinical skills are the core in the practice of medicine, with the ultimate aim of accomplishing the best outcomes and both patient compliance and overall satisfaction, which are essential for the effective delivery of HC (Brinkman et al., 2006; Ranjan & Sahu, 2014). mentioned that “Communication is a fundamental clinical skill that, if performed competently and efficiently, facilitates the establishment of a relationship of trust between the medical staff and the patient-customer, a truly therapeutic alliance.” Matusitz &

[Spear \(2014\)](#), mentioned that “Effective doctor-patient communication is a central clinical function in building a therapeutic doctor-patient relationship, which is the heart and art of medicine.” It is very important in delivering high-quality HC. Many patient complaints and much dissatisfaction come back to breakdown in doctor-patient relationships. For [Ranjan & Sahu \(2014\)](#), “Good communication skills among the doctors are crucial in building a trustworthy doctor-patient relationship that not only helps in therapeutic success by providing holistic care to the patient but also leads to job satisfaction among the doctors” ([Jones et al., 2001](#); [Deveugele et al., 2005](#)).

### **Types of communication**

CSs are vital to an efficient and healthy workplace, which are often categorized as ‘soft skills’ because they make it easier to form relationships with people, create trust and dependability, and lead teams. In essence, they are essential for success in the workplace and personal life ([Barnard, 2019](#)). Communication is the act of sharing information from one person to another person or more than one person. There are several different ways to share information with one another. For example, these CSs might be used as verbal communication when sharing a presentation with a group or in a written communication when applying for a job or sending an email ([Swasey, 2013](#)).

- **Verbal communication**  
Verbal communication is one of the most essential and common types of communication, which is used during presentations, meetings, one-on-one conversations, video conferences and phone calls. Verbal communication means engaging in speaking with others. It may be face-to-face, over the phone, via Zoom or Skype, etc. Some verbal engagements are more formal, such as a scheduled meeting, while others are informal, such as chatting with friends. Regardless the type, it is not just about the words, it is related to the complexity of these words; how these words are linked together consistently to create a meaningful message, in addition to the influence of intonation (tone, pitch, cadence, etc.) on listeners ([Willkomm, 2018](#)). Linguistically, verbal communication is defined as any means of communicating that uses language (words, numbers or symbols). Verbal communication requires an organized language system. Such a system is composed of a group of labels used to describe people, events and things in our environment. These labels are conveyed from one person to another by a variety of means, including vocalization and writing ([Tortoriello et al., 1978](#)).
- **Non-verbal**  
Non-verbal communication is the use of body language, gestures and facial expressions to convey information to others. It can be used both intentionally and unintentionally. According to [Swasey \(2013\)](#), the eyebrows and the eyes, together communicate different attitudes such as compassion, surprise, anger, fear, doubt or dislike, “Maintaining friendly eye contact with others often promotes trust. On the other hand, our clients may doubt our sincerity or competence if we avoid respectful eye contact during conversation”. [Swasey \(2013\)](#), addressed the use of language, as used by a doctor and the role of eye contact, “Simply slowing down their speech and

maintaining good eye contact significantly improved understanding.” In linguistics, nonverbal communication is defined by many Communicologists, like Tortoriello, Blott, and DeWine as:

“The exchange of messages through non-linguistic means, including: kinesics (body language), facial expressions and eye contact, clothing and physical appearance, tactile communication, space and territory, culture and social system, paralanguage (tone, pitch, rate, inflection), and the use of silence and time” (Tortoriello et al., 1978).

- **Written**  
Written communication is defined as the act of writing, printing or typing symbols, like letters and numbers to transfer information. It is helpful because it provides a record of information for reference. Whatever the written type is, whether it is an email, a Facebook post, a Tweet, a memo, a report, a contract, and so on, all have the same goal to provide information in a clear and concise manner, otherwise that objective is often not achieved. Indeed, poor writing skills may lead to a confusion, embarrassment and sometimes a legal jeopardy.
- **Visuals**  
Visuals are often used as an aid during presentations to provide helpful context alongside with written or verbal communication. Visual communication is the act of using photographs, art, drawings, sketches, figures and graphs to convey information

### **Barriers to effective communication and medical errors**

Sutcliffe et al. (2004), reported that seventy sorrowful medical accidents happened because of miscommunication as a direct or contributing element in that occurrence. Furthermore, “In 2000 alone, between 44,000 and 98,000 people died in hospitals because of medical miscommunication”. According to the Handover (2004), there are several barriers to effective communication between Pts and Docs. The most important one is a lack of insight due to inadequate training and knowledge in CSs (Swasey, 2013). Many times, Docs tend to use close-ended questions, interruptions Arora (2003); Brinkman et al. (2006), and do not give sufficient time and heed to the importance of keeping Pts adequately informed. Other important barriers are related to a lack of privacy, empathy and respect, in addition to ignoring the non-verbal components of communication, such as eye contact. In a heavy burden setting, human failings like tiredness and stress are major contributing factors (Glasgow & Riley, 2013; Noveck & Reboul, 2008).

### **The curricula in UoK and JMU**

Because it is significant to highlight the role and effect of curricula in the development and training of CSs in health institutions, it is necessary to make a comparison of such curricula in two Iraqi medical institutions: UoK and JMU. It is noteworthy that the colleges of medicine at Kufa in Najaf, al-Zahraa in Basra and Hammurabi in Babylon have followed the clinically integrated curriculum. This authentic curriculum was recommended by Cambridge Calgary Guides Silverman (2013), and it was adopted by Faculty of Medicine, UoK as Dr. Bassim al-Mudhafar, College of Medicine, UoK mentioned. The curriculum encompasses 23 hours given theoretically and seven hours practically. This curriculum has

been adopted by 70\_80 medical colleges around the world because of its crucial role in improving communication skills. According to Dr. al-Mudhafer, the integrated curriculum has been officially adopted by UoK in 2012/2013, while in 2017/2018, communication skills started being given very intensely to medical students through the Communication Skills Foundation Skills (CSFC), a module taught in the first stage for twelve weeks, twenty-four hours a week, whereas the fourth, fifth and sixth stages were given separated courses for one week (five days), four hours a day and twenty hours a week by prominent and experienced specialist Docs., like al-Mudhafer, Muhammed Saed Abud al-Zahraa, Shaymaa al-Hassani, Zainab Kadhim, Asmaa Hassan, Zina Zwain, Sultan Muhsin, Nadia Abd al- Hassan and Sawsan al-Aridhi. Dr. al-Mudhafer has managed a course that has been conducted in the College of Medicine, UoK (2019), which lasted for a month and engaged professors from Ministry of Health and other universities who participated in training, and included lectures related to obtain medical history from Pts, how to treat some difficult cases, like angry Pts and how to tell bad. Delivering bad news requires the attendance of Pts'companions and specific psychological preparation, like giving Pts hope, encouragement and showing empathy (Andriitso et al., 2021; Rashid et al., 2021).

## **Research Methodology**

### **Research design**

This research used both qualitative and quantitative methods to gather data for the objectives of the research study. The tools employed for collecting data were particularly through direct observation by visiting al-Sadr Teaching Hospital in Najaf, Iraq, eighteen audio recordings, interviews and a questionnaire for the objectivity and reliability of results. The main headings below included the sample, research instruments (procedures for data collection) and validity of research and the findings of the instruments (Bravo & Gámez, 2021; Ariyanfar & Mitchell, 2020).

Multiple approaches have been used in this study (eclectic model). The research design was descriptive in nature, which tended to determine specific facts related to an existing phenomenon. The research integrated both qualitative in gathering and analyzing non-numerical research data and quantitative using statistics and numbers. In such an investigation, the descriptive analytical approach has been used to describe and analyze data on Docs-Pts' miscommunication. Hence, the study is going to look at DPC from multiple pragmatic perspectives. The practical part of this thesis included visiting al-Sadr Teaching Hospital to collect and analyze the data by investigating the effect of the integrated curriculum taught in UoK and the traditional one of JMU on the Docs' performance (Zulvany, 2020; Rinartha et al., 2018).

### **The sample**

The sample of the study is presented according to availability. It includes 55 Docs who received a questionnaire (see Appendix G) and 45 Pts who received both a direct observation and an interview, respectively. In addition, there is a number of 45 Docs who were subjected to the same direct observation that Pts received.

Although not all were included in the study, Docs who have studied the integrated curriculum taught in UoK and those of JMU who were taught according the non-integrative or traditional curriculum in 2018/2019 and 2019/ 2020, who were considered as the sample here. They were resident rotators in five hospitals: Al-Sadr Teaching Hospital, al-Hakeem General Hospital, al-Zahraa Teaching Hospital, the Middle Euphrate and al-Manadhera. As a teaching hospital, al-Sadr Teaching Hospital was chosen in particular to collect data because it includes the largest number of Docs. Docs there teach both the theoretical and practical sides of the curriculum.

In the questionnaire (see Appendix G) , the total number of Docs- participants from three hospitals, al-Sadr Teaching Hospital, al-Hakeem General Hospital and al-Zahraa Teaching Hospital was 58, 43 from UoK and 12 from JMU and three participants did not mention their universities, hence excluded. The distinction between the numbers of Docs in the instruments fundamentally comes back to the number of recent graduates from UoK, 84 and 61 Docs in the academic years 2018/2019 and 2019/ 2020, which is obviously bigger than the number of those from JMU, 36 and 27 Docs. These numbers were according to the data that the researcher obtained from al-Najaf Health Directorate.

The sample also included Pts seeing those Docs. The total number of 38 Pts checked by 28 Docs from UoK and 7 Pts checked by 7 Docs from JMU were directly observed by the researcher and a checklist was filled up accordingly (see Appendix D). Then the same Pts were subjected to 7-10 minute individual interviews and according to a list of questions that inquired into the same items on the checklist (see Appendix D). The material of the interview was supposed to be audio-recorded, but unfortunately, some Docs rejected the idea of recording their Pts. The researcher as a result, was obliged to write the answers down on sheets of paper. The audio recordings were only eighteen because some Pts or Docs hesitated or were unwilling to cooperate. The recorded and written materials were then tabulated according to the same checklist (see Appendix D). The two instruments were used successively to guarantee that Docs and Pts were communicating effectively or not; i. e., for the solidarity of the results obtained. Accordingly, while collecting the data, the study tries to overcome the effect of the different circumstances that both Docs and Pts may be under.

## **Discussion of Findings of direct observation**

### **Gricean maxims**

Indeed, this study was carried out to investigate DPD and to check how often Docs observe the Gricean conversational maxims in DPC. As Table 1 below shows, the observation of Gricean Maxims by Docs of both UoK and JMU in Docs-Pts meetings in numbers and percents can be explained as follows:

Table 1  
The observation of Gricean maxims

Maxims	Docs of UoK	%	Docs of JMU	%
Maxims of quantity				
1. Make your contribution as informative as is required	4	14%	0	0%
2. Do not make your contribution more informative than is required.	4	14%	0	0%
Maxims of quality				
1. Do not say what you believe to be false.	4	14%	0	0%
2. Do not say that for which you lack adequate evidence	4	14%	0	0%
Maxim of relation				
Be relevant.	28	100%	7	100%
Maxims of Manner				
1. Avoid obscurity of expression.	28	100%	7	100%
2. Avoid ambiguity	4	14%	0	0%
3. Be brief.	4	14%	0	0%
4. Be orderly.	28	100 %	7	100%

For quantity, the majority of Docs 24 (or %86) of those in UoK did not provide Pts with any oral clarification regarding their health case at the conclusion of the session, while none of the Docs of JMU, 0 (or 0%) observed this maxim either; Docs just sufficed in asking the routine questions mentioned in "The Medical History and Physical Examination Sheets" (see Appendix H), making some physical examinations and then writing a summary about the case because rotator Docs' daily routine work is limited to in-patient clinic such as emergency rooms and wards. Only two maxims those of quantity and ambiguity, were violated in 24 (or 86 %) interactions among Docs and Pts, while the maxim of relevance was flouted and opted out only once. The first example indicates the violation of the maxim of quantity.

- شنو مشكلتج What is your problem? ).
- شوكت سويتى هذي العملية؟ (When did you conduct this surgery?).
- يوجع الكيس؟- (Does the cyst hurt you now?).
- الألم قوي لو عادي؟ (Is it sharp or mild?).
- الألم يروح و يجي لو مستمر؟ (Is the pain intermittent or continuous?).
- عندج مشكلة بالبلع؟ (Do you have a difficulty in swallowing?).

In the previous examples, the doctor asked the patient, who was suffering from a cyst on her pharynx and had undergone a suction surgery before, some questions, but the doctor did not provide the patient with adequate information about her health problem, but rather sufficed with writing down a summary about the case, whereas many patients could not understand medical jargon, English or Latin, and more particularly, could not understand Docs' handwriting. Therefore, the image was completely unclear or ambiguous to the patient; hence,

the doctor violated both the maxim of quantity and ambiguity. The second example indicates flouting and opting out of the maxim of relevance.

- يا ربي شكك حارة! ( My God! What a hot day is today!). Indeed, patient's irrelevant reply in this example flouted the maxim of relevance, when he did not answer the doctor's question: ها تفضل حجي □ شنو عندك؟ (Yes, please, hajji , what is your problrm?) , because the patient refuses to talk about the medical problem in front of ears and eyes of others. The study showed that just 4 Docs (or 14%) from UoK respected the maxim of quality, in which Docs tended to deliver Pts true information or bad news about their health problems, supporting the news with evidence (Physical examinations and double checking up), e.g.

- يمكن يكون مو ورم حميد ( You may not have benign tumor).
- يحتاج يظل تحت المراقبة (He needs to stay under observation).
- تحتاج خزعة للنخاع العظمي (you need bone marrow biopsy).

In regard to bscurity, all Docs from both universities,100%, adhered to observe this maxim and avoided the use of medical jargon, English and Latin, as much as possible, which indicates a language-switch by which Pts could understand what Docs say more easily, e.g.,

- صداع (headache) is used by Docs instead of وجع راس-
- نوبة صرع (convulsion) is used instead of شمرة .

For ambiguity, 4 (or 4%) of the Docs, those from UoK provided their Pts only a written summary about their health problems at the end of the sessions, whereas most Pts cannot read English and understand the Docs' ways of handwriting. The violation of this maxim might occur as a result of interruption when discussing health issues with more than one doctor at a time, which might lead to confusion, misunderstanding and bad medical consequences as each doctor has a different point of view. Hence, the summary Docs write might include repetition to focus on some essential information, e.g.

- المريض حالته مستقرة □ ميحتاج عملية (Patient's case is stable, he does not need a surgery).

The maxim of brief also was rarely applied, only 4 Docs, 4%, from UoK used it, while none of those of JMU, recording 0 % applied it, e.g.,

- لازم تعيدون اختبار الحساسية للمريض و تغييرين الدواء الحالي (You have to repeat the allergy test to the patient and change the recent medicine).
- سوينا كل اللي نكدر عليه لكن نسبة الاكسجين د تتناقص □ (We did all what we can but the amount of oxygen still decreases, 86).

As for the maxim of order, Docs adhere to ask the routine questions, starting from personal questions to medical questions, according to what is mentioned in 'The Medical History and Physical Examination Sheet' (see Appendix H). Docs typically begin with a phatic communion, then elicit information from the Pts via open- and closed-ended questions, whether directly or indirectly, check the Pts, and

finally close the session. This maxim was applied by 100% of Docs from both universities, 28 and 7, respectively, e.g.

- شنو اسمج؟ (What is your name?),
- شكدمرچ؟ (How old are you?),
- شنو مشكلتج؟ (What is your complaint?),
- الرئتين (Lungs, a difficulty in breathing or a problem in your Lungs?) □ صعوبة بالتنفس او مشكلة بالرئتين؟
- القلب؟ (Heart?),
- الكبد؟ (Liver?),
- الطحال؟ (Spleen?),
- كلياتك؟ (Kidneys?),
- امراض مزمنة؟ (Chronic diseases?).

The maxim of relevance was completely applied by all Docs, 100% from both universities. This maxim is achieved by asking both direct and indirect questions in [Ayeloja \(2019\)](#) terms. Pts may fail to be cooperative interlocutors because their messages are not conveyed meaningfully to Docs, especially when they talk about irrelevant things or use circumlocution. Relevance appears as follows when the doctor ask the patient questions related to a specific health problem, strangulation or difficulty breathing, e.g.

- سويت اختبار مسحة؟ (Did you conduct a smear test?).
- تدخن؟ (Do you smoke?) .
- عندك امراض مزمنة □ ربو مثلا؟ (Do you have chronic diseases, like asthma?).

Relying on the results of this study, not all Gricean Maxims have been observed during the session as the main barrier behind Docs- Pts miscommunication in a comparison to types of discourse devices that were used more frequently and effectively as a direct and indirect factor in creating a strong doctor-patient relationship. In addition to that, Docs from UoK who have followed the integrative curriculum seemed to adhere observing Gricean Maxims and applying discourse devices more than those from JMU who have adopted the traditional curriculum, which indicates that those Docs lack competence, as a main reason behind medical errors (see Figure 9).

### Discourse devices

Table 2 below clarifies the use of discourse devices by Docs from both universities in terms of numbers and percent. Through direct observation of the researcher in 45 sessions and 35 Docs, the results evidently showed that there was a variety in Docs' application to types of discourse devices during consultation. The results clarified that 100% of the Docs from both universities adhered to use a phatic communion, e.g., how to open the discourse with Pts, greeting patients, asking them some open-ended questions, personal questions and others related to the reason behind the visit, e.g.

- شلونكم؟ (How are you?).
- شلونك □ ها حجي؟ (How do you do?).

- شسّمك عيني؟ (What is your name, dear?).

On the other hand, empathy as a phatic communion was not completely achieved; only 5 (or 18%) of the Docs from UoK showed empathy to their Pts like children, e.g.

- عزيزتي (dear).
- حبيبيتي (my darling).
- ماما (mum).
- عمو (uncle).

Empathy was also observed by sitting on a Pts' bed and putting a hand on the Pts to make them feel comfortable and supported. However, this discourse device was not completely used by the Docs of JMU. The results have shown that only 5 Docs (or 18%) from Uok used it, while 0% of those from JMU used it. As the following calculation shows: The number of Docs who observe a specific maxim or apply a linguistic device at a certain university ÷ the total number of Docs at that university × 100= the result in a percentage.

Table 2  
The use of discourse devices

Discourse Devices	Docs of UoK	%	Docs of JMU	%
Phatic Communion				
1.Opening up Discourses	28	100%	7	100%
2.Showing Empathy	5	18%	0	0%
Circumlocution	28	100%	7	100%
Rapport Expressions	18	64%	2	29%
Language-Switch	28	100%	7	100%
Counseling	5	18%	0	0%
Interlocutor's Religious Belief	0	0%	0	0%
Questions and Answers				
1.Direct Questions	28	100%	7	100%
2.Indirect Questions	28	100%	7	100%
Repetition	2	7%	0	0%
Closing Clinical Interviews	11	39%	3	43%

Docs were showing Pts empathy, particularly for those who have very dangerous or complicated cases, like gangrene, cancer, bone marrow biopsy, and so forth. It has been observed that Docs sometimes tend to show empathy by joking with Pts or using soft words and a gentle tone of voice in a calm discussion to convince patients of a specific medical procedure, e.g.

- May Allah يساعدك حجي □ ترا هذا الاجراء علمود صحتك لا تخاف منه procedure is good for your health. Do not be (afraid).

For circumlocution, all Docs from both universities, 28 Docs from UoK and 7 from JMU applied it, recording 100%, e.g.

- تحتاج الحمام دائما و خاصة بالليل؟- (Do you urinate a lot, often at night?)
- تحس بالتعب؟- (Do you feel tired?)
- تحس بالعطش؟- (Do you feel thirsty?)
- تحس بالجوع؟ (Do you feel hungry?)
- نظرك شلونه؟- (Do you have a blurry vision?)

Meanwhile, 18 (or 64%) Docs from Kufa used rapport expressions during the sessions, whereas only 2 (or 29%) Docs from JMU used them, e.g.

- الصحه والعافيه (I wish you have a good health).
- عاشرت ايديك (Saved are your hands).
- الحمد لله (Praise be to Allah).

Through the researcher's direct observation for language-switch, 100% of the Docs used Arabic Language during the interviews, but when two or more Docs come together to check up on a specific medical case, those Docs usually shift to English or Latin. Unfortunately, some Pts think that Docs might use English just to hide some bad news, e.g.

- عندك تساقط شعر؟- (Do you have hair lose?).
- عندك خدر بالاطراف؟- (Do you have anaesthesia in your extremities?).
- اظفرك يتغير لونها مرات او تنزف؟- (Is the color of your nails changing, do they bleed sometimes?).

In regard to counseling, Docs provided Pts with essential encouragement and guidance on how best to care of their health; only 5 (or 18%) of the Docs from UoK applied this device, e.g.

- المريض يحتاج اوكسجين - (The patient needs oxygen).
- المريض ميحتاج عملية (The patient does not require a surgery).
- حافظوا عليها من البرد (Keep her away from coldness).
- طفوا السبلت وجيبوا بعد بطانيات للمريضة □ أطرافها كلش باردة و القراءات دتطلع مو دقيقة (Switch the air conditioner off and bring more blankets, the physical examinations do not give accurate results).

However, interlocutor's religious belief was not used at all, recording 0%. In regard to direct and indirect questions, these devices have been applied 100% by all Docs from both universities, e.g.

- شوكت دخلت؟- (When was your admission?), as a direct question.
- عمليتك أي ساعة؟- (What time is your surgery?), a direct question.
- ضغط؟- (Blood pressure?), an indirect question.
- سكر؟- (Diabetes?), an indirect question.
- امراض قلب؟- (Heart diseases?), as an indirect question.

Regarding other devices, it has been found that repetition was only used by 2 (or 7%) Docs from UoK.

- المريض ميكر هسة يرجع للبيت اوحتى ينتقل لردهة □ وضعه بعده ما مستقر (The patient could not go home now because his case is not stable yet. He can't even leave here (emergency room) to go to the ward. Repetition was applied in this example by a doctor talking with one of the patient's companions to emphasize the necessity for the patient to stay under observation in the emergency room.

Additionally, 11 (or 39%) of the Docs from UoK and 3 (or 43%) from JMU tended to close the discourse by saying some words or expressions, like:

- راح يجي الطبيب الاخصائي حتى يشيكك مرة ثانية- (your specialist doctor will come to check you up again).
- الصحة و العافية- (I wish a good health for you).
- خليك مرتاح □ حجي- (Stay comfortable, hajji).
- كل شي واضح؟- (Is everything clear to you?).
- عندك بعد سؤال؟- (Do you have another question?).

### Findings of the interviews

The outcomes of the interviews (see Appendix F), which were conducted with Pts of Docs from both universities, UoK and JMU, respectively, after direct observation. The interviews included 45 Pts that have met 35 Docs in 45 sessions. More precisely, the interviews included 38 Pts to Docs of UoK and 7 Pts to those of JMU. The results obviously show that Pts who met Docs that have studied the integrated curriculum are somehow satisfied with the MC provided to them more than those of JMU, and others, unfortunately, are unsatisfied at all with the MC provided to them by Docs from both universities, as it is clarified below: The number of Pts of Docs at a certain university ÷ the total number of Pts of Docs at the same university × 100= the result in a percentage.

Table 3  
Results of interviews for Pts of UoK docs

NO.	Item	Always	Sometimes	Never
1	Did you feel comfortable while discussing your health issue with the HCP?	30 79%	8 21%	
2	Were you interrupted during the discussion?		5 13%	33 87%
3	Do you have a problem in discussing your health issue with a different doctor each time?	9 22%	24 65%	5 13%
4	Can you summarize the key messages after your completed medical check out?		5 12%	33 88%
5	Did your doctor give you enough time to talk about your medical problem?	28 74%	10 26%	
6	Did you face a difficulty to talk about your health problem in front of other Pts, when there is no a kind of a privacy?	25 66%	8 21%	5 13%
7	Did you feel that the doctor understood you?	23 61%	15 39%	
8	Was it easy for you to understand what the doctor said?	31 82%	7 18%	

9	Was there eye contact among you and the doctor?	18	47%	20	53%		
10	Did the doctor reply to all your questions, concerns and expectations?	37	97%	1	3%		
11	Did you observe a kind of empathy when you talk about your problem?			6	13%	32	87%
12	Did your doctor hide some information and he/she did not let you know about it?			9	24%	29	76%
13	When two Docs attend, do they use English so that Pts cannot understand what is going on?	29	76%	9	24%		
14	Do Docs tell their Pts the news directly and frankly?	38	100%				
15	Did your doctor use rapport expressions?			17	45%	21	55%

Table 4  
Results of interviews for Pts of JMU Docs

NO.	Item	Always	Sometimes	Never			
1	Did you feel comfortable while discussing your health issue with the HCP?	6	86%	1	14%		
2	Were you interrupted during the discussion?			1	14%	6	86%
3	Do you have a problem in discussing your health issue with a different doctor each time?	3	42%	2	29%	2	29%
4	Can you summarize the key messages after your completed medical check out?					7	100%
5	Did your doctor give you enough time to talk about your medical problem?	5	71%	2	29%		
6	Did you face a difficulty to talk about your health problem in front of other Pts, when there is no a kind of a privacy?	5	71%	2	29%		
7	Did you feel that the doctor understood you?	4	58%	3	42%		
8	Was it easy for you to understand what the doctor said?	5	71%	2	29%		
9	Was there eye contact among you and the doctor?	1	14%	6	86%		
10	Did the doctor reply to all your questions, concerns and expectations?	4	58%	3	42%		
11	Did you observe a kind of empathy when you talk about your problem?			1	14%	6	86%
12	Did your doctor hide some information and he/she did not let you know about it?			3	42%	4	58%
13	When two Docs attend, do they use English so that Pts cannot understand what is going on?	5	71%	2	29%		
14	Do Docs tell their Pts the news directly and frankly?	6	86%	1	14%		
15	Did your doctor use rapport expressions?			2	29%	5	71%

### Findings of the questionnaire

The majority of participants were from the UoK, 43 Docs, while only 12 were from JMU (see Section 3.2). The majority of participants were from al-Sadr Teaching Hospital; 11 Docs, 4 from al-Hakeem and 3 from al-Zahraa Teaching Hospital. The majority of participants 24 Docs were graduators of 2020, while 22 were graduators of 2019. Evidently, the results that were reached by the observer from the questionnaire directed towards Docs 2018/2019 and 2019/2020 (see Appendix G), as Table 5 below shows:

Table 5  
Results of the questionnaire for docs of both UoK and JMU

NO	Items	Completely Agree	Agree	Neutral	Disagree	Completely Disagree
1	Iraqi Docs communicate effectively with their Pts.	2 3.45%	4 6.9%	35 60.3%	16 27.6%	1 1.7%
2	Pts are engaged in the decision-making.	5 8.6%	19 32.8%	25 43.1%	18 13.8%	1 1.7%
3	The main barriers of effective DPC are lack of training programs and clinical practice rather than random theoretical materials that were put by designers of medical curricula.	8 13.8%	31 53.4%	10 17.2%	9 15.5%	
4	Docs tend to use a direct way to deliver bad news to their Pts.	1 1.7%	26 44.8%	15 25.9%	16 27.6%	
5	Docs adhere to use discourse devices while they talk to their Pts (Discourse devices are linguistic tools that allow you to lead or manage a session or meeting successfully, they related to how to open up a discourse, elicit and provide information and then gradually close it).	1 1.7%	19 32.8%	22 37.0%	15 25.9%	1 1.7%
6	The usual occurrence of medical errors is a result of carelessness, not lack of competency.	2 3.4	24 41.4%	16 27.6%	15 25.9%	1 1.7%
7	There is no a priority to teach medical students CSs in Iraqi medical colleges.	6 10.3%	31 53.4%	12 20.7%	8 13.8%	1 1.7%
8	Pts usually understand the information that they receive from their Docs.		9 15.5%	26 44.8%	23 39.7%	
9	Non-verbal communication like eye contact among Docs and their Pts leads to better understanding.	20 34.5%	31 53.4%	3 5.2%	4 6.9%	
10	Pts' first impression about their Docs is affected by what the Docs say rather than how to say it.	3 5.2%	11 19%	11 19%	32 55.2%	
11	Pts talk about irrelevant things during their medical history-taking.	28 48.3%	24 41.4%	4 6.9%	1 1.7%	1 1.7%
12	Pts' perspectives are taken into consideration.	1 1.7%	20 34.5%	24 41.4%	12 20.7%	1 1.7%
13	Doctor-patient relationship is affected by other factors like a doctor's personality, educated Pts, governmental support and	43 74.1%	14 24.1%	1 1.7%		

	so on.					
14	Pts' compliance or adherence to the plans that Docs usually make depends on Docs' competency rather than their care.		11 19%	16 27.7%	29 50%	2 3.4%
15	A large amount of information that Docs give leads to distraction rather than better understanding.	3 5.2%	25 43.1%	17 29.3%	10 17.2%	3 5.2%
16	Docs use rapport expressions with their Pts.	1 1.7%	25 43.1%	23 39.7%	8 13.8%	1 1.7%
17	Some Pts are unwilling to cooperate.	18 31%	35 60.3%	3 5.2%	2 3.4%	
18	There is a difficulty in understanding Pts.	7 12.1 %	30 51.7%	11 19%	9 15.5%	1 1.7%
19	Docs give their Pts enough time to talk about their problems.		7 12.1%	23 39.7%	25 43.1%	3 5.2%
20	Pts take (2-5) seconds to reply their Docs' questions after attentive listening to them.		17 29.3%	25 43.1%	15 25.9%	1 1.7%
21	Different perspectives by Docs may lead to misunderstanding by Pts.	14 24.1%	41 70.7%	3 5.2%		
22	Docs give their Pts a summary about their problems at the end of the session.	1 1.7%	11 19%	19 32.2%	25 43.1%	2 3.4%
23	Docs take into consideration how to initiate the session and how to close it.		15 25.9%	22 37.2%	19 32.8%	2 3.4%
24	Docs encourage their Pts for a second physician' perspective.	1 1.7%	6 10.3%	22 37.2%	26 44.8%	3 5.2%
25	Docs suffer from circumlocution used by Pts.	2 3.4%	23 39.7%	11 19%	19 32.8%	3 5.2%
26	Docs allow Pts to bring one of their family members or a close friend to the session when Pts ask them for a permission.	8 14%	42 73.7%	6 10.2%	1 1.8%	
27	Docs provide Pts enough information about their health problems.		12 20.7%	25 43.2%	17 29.3%	4 6.9%
28	Docs tell their Pts the truth about their health problems and provide evidence.	1 1.7%	29 50%	19 32.2%	7 12.1%	2 3.4%
29	There is a need to get a brief background about Pts' personal life before treatment.	11 19%	30 51.7%	10 17.2%	7 12.1%	
30	Docs repeat important information to their Pts.	7 12.1%	36 62.1%	13 22.2%	2 3.4%	

## Discussion of results

### Direct observation & interviews for patients

Pts, as mentioned in their interviews (see Appendix F), really miss good CSs with their Docs. 33 Pts which accounts for 88% of Docs from UoK and 7 (or 100%) of those from JMU claimed that they did not receive good MC for many different reasons. First of all, they claimed they were not provided with adequate information about how progressive or stable their health cases were (there was not an oral summary provided to them by their Docs), in addition to semi-lack of eye contact, and very rare use of rapport expressions, empathy, etc. 2. Although most Pts 36 (or 83%) of Docs from both UoK and JMU mentioned that they felt

comfortable while talking to their Docs, according to the researcher's direct observation and the interviews (see Appendices E and F), other Pts were very frustrated and strongly dissatisfied with dealing with Docs. They claimed that some Docs seemed unwilling to allow them to ask more questions, while others did not demonstrate any kind of empathy or hear rapport expressions. 3. All Pts, from both universities, 28 from UoK and 7 from JMU, recorded 100% mentioned that their questions were answered by Docs but very briefly and quickly. Pts also complained that they had no privacy when Docs asked them about their health problems or medical history because it was done in front of other Pts, their companions, and other Docs' ears and eyes. 4. 44 (or 93%) of Pts reported receiving news directly and candidly.

### **Direct observation & questionnaire for doctors**

- While 25 Docs with a percentage of 43% claimed that they use rapport expressions with their Pts, 25 (or 65%) of Pts from UoK and JMU Docs reported that it is very rare to hear these expressions from Docs, while around 20 of the Docs, which equals 47%, from both universities used these expressions, according to direct observation made by the researcher. Moreover, empathy was very rarely shown to Pts; only 5 Docs, which equals 18% of the UoK, showed their Pts any kind of empathy. Additionally, 25 Docs (or 43%) confirmed that they did not provide Pts with an oral summary at the end of the session.
- The majority of Docs, 38, which equals 22%, were in doubt that Iraqi Docs apply linguistic tools or discourse devices with their Pts throughout the session, like speaking in a plain language (Arabic Iraqi slang). Sometimes, Docs tend to use English Language only when discuss with each other; they use some English medical expressions just to conceal some bad news from Pts. According to the majority of Docs 32 (or 55%), the method of breaking the news to Pts is more important than the news itself.
- The majority of Docs, 25 with a percentage of 43 acknowledged that they do not give their Pts enough time to talk about their medical problems.
- Whereas building a strong Docs-Pts relationship is crucial to solving any problem that Docs might face with Pts sooner or later, there are many different barriers that decrease this relationship, e.g., lack of empathy, privacy, eye contact, not understanding Pts' perspectives, in addition to other effective communication strategies that were recommended by both the American Academy of Ophthalmology [Simpson \(1991\)](#), and the Cambridge Calgary Guides (Silverman, 2013), (Section 2.6).
- The results were reached by the researcher after testing the following supporting hypothesis: According to the results obtained from the interviews (see Appendix F) conducted with Iraqi Pts and through direct observation by the researcher, Docs tend to use a direct method in order to deliver bad news or health status to Pts. Almost 26 Docs (or 44%) agreed that bad news is delivered without reservation to Pts.
- The majority of Docs (62%) also claimed that they usually repeat the most important information to Pts, whereas direct observation by the researcher revealed that repetition was rarely used, with only 2% of Docs from the UoK using this tool. As the findings that the researcher reached through direct observation.

- Only 5 Docs from UoK 35 demonstrated empathy, while no one, 0 Docs from JMU (or 0%) demonstrated Pts empathy.

### **Communication skills in UoK and JMU**

- According to the results obtained from the questionnaire (see Appendix G), almost 31 Docs (or 53%) declared that the main barriers behind poor CSs are a lack of training programs and clinical practice more than inadequate theoretical curricula taught in Iraqi medical colleges. Most Iraqi medical colleges do not adopt the integrated curriculum that includes both the theoretical and practical materials and gives crucial significance to DPCSs, and that is according to the information obtained from Dr. al-Mudhafer, Faculty of Medicine, UoK and the dean of JMU, Dr. Adel al-Mayali.
- The results clearly show that Docs from UoK adhere to and observe [Grice \(1975\)](#) Cooperative Principle and [Ayeloja \(2019\)](#) discourse devices more than those from JMU, who adopted the traditional curricula.

### **Conclusion**

- The ultimate aim of any DPC is to improve patients' health and MC. The results show that some Docs usually tend to overestimate their ability to communicate with their patients. The findings evidently show through the questionnaire (see Appendix G) that the Docs themselves, 35 (or 60%) were unsatisfied with the effectiveness of their communication skills with their Pts. Almost 30 Docs (or 52%) face difficulty understanding their Pts, and they claim that a large number of Pts are uncooperative. Docs also were in doubt about that they give enough time, or apply discourse devices with Pts. Additionally, almost 25 Docs (or %43) declared that they did not provide patients a summary at the end of the session. This study on DPC has demonstrated patients' displeasure, dissatisfaction and distrust with MC provided to them for many different reasons related to privacy, empathy, eye contact, medical summary, rapport expressions, repetition of some essential information at the end of the session, etc., even when many Docs considered the communication acceptable or even excellent. Patient surveys have consistently shown that Pts need better communication with their Docs, which verifies the hypothesis that Docs and Pts in Iraqi medical institutions lack verbal and non-verbal communication skills.
- According to the results reached by the researcher, not all of the pragmatic maxims were fulfilled by Docs from both universities; despite the appearance of flouting, violation, and opting out in some doctor-patient interactions, the study revealed that some few other maxims, like those of obscurity, order and relevance, were applied 100% by Docs, which refuted the hypothesis that Iraqi Docs and Pts tend not to adhere to Grice's Maxims. The study also concluded that Docs from UoK were adhered to apply communication skills more than those from JMU, and particularly, they were using discourse devices more than observing the Grice's Maxims, which verifies the hypothesis that Docs and Pts in Iraqi medical institutions lack verbal and non-verbal communication skills.

- According to 24 Docs, which accounts for 41%, the main reason behind the usual sorrowful medical errors is, unfortunately, carelessness rather than lack of clinical competency. Hence, the results of the researcher indicate a similarity with the findings of the studies reached by both [Sutcliffe et al. \(2004\)](#); [Tongue et al. \(2005\)](#) (Sub-section 2.3.2.) that most medical accidents usually happen as a result of miscommunication as a direct or contributing factor, which supports the hypothesis that miscommunication is the main reason behind medical errors. Moreover, some other barriers that were referred to by the American Academy of Ophthalmology [Simpson \(1991\)](#); [Handover \(2004\)](#) and the Cambridge Calgary Guides [Silverman \(2013\)](#), (Sub-sections 2.3.4. and 2.3.5.), like a lack of practice and knowledge in diagnosing and treatment options, with regard to Docs, not educating patients enough about their medical problems. In addition to the unsurpassed application of discourse devices, the majority of Docs 22 which accounts for 38% were in doubt that Iraqi Docs applied these linguistic tools with their Pts throughout the session.
- The study also checks the linguistic tools, which are applied but not completely by the Docs during clinical interviews. Therefore, the present study is compatible with the study done by [Ayeloja \(2019\)](#) that found linguistic tools or discourse devices are indispensable for both Docs and Pts because they facilitate the discourse and enable the interlocutors to achieve result-oriented and execute talk successively. Hence, the results support the hypothesis that DPD tends to show pragmatic tools and communication strategies in delivering health status. The findings show the perfect implementation of Docs of both universities to some discourse devices, like opening a discourse, circumlocution, language switch, direct and indirect questions, with 100%. Furthermore, the findings show the poor application of these tools by those Docs, e.g., empathy, rapport expressions, counseling, interlocutor's religious belief, repetition and closing a session.
- The results evidently clarify that a high percentage of Docs 31, which accounts for 53%, emphasize that there is no priority and a real concern to teach medical students effective CSs in most Iraqi medical colleges. Hence, these results are compatible with the results reached by [Swasey \(2013\)](#) (Sub-section 2.3.2.), that very few schools, if any, unfortunately spend time teaching medical students the basic sciences of communication with Pts. In fact, many Iraqi medical colleges do not care about improving communication skills through clinical practice and training programs. Therefore, the study refutes the hypothesis that the curricula taught in Iraqi medical colleges provide effective DPCs in medical institutions and enhance the use of pragmatic tools and communication strategies.

## References

- Aljumily, R. (2021). Who was the translator of the anonymous 1821 of Goethe's Faustus? Could the translator have been Coleridge?. *International Journal of English and Comparative Literary Studies*, 2(2), 50-63.
- Andriitso, V. M., Tsyhanyk, M. I., Shevtsova, I. M., Shiutiv, M. A., & Kutsyk, O. P. (2021). Features of communication between the stage director and members of the group during the preparation of choreographic performances. *Linguistics*

- and Culture Review, 5(S2), 697-707.  
<https://doi.org/10.21744/lingcure.v5nS2.1412>
- Ariyanfar, S., & Mitchell, R. (2020). Teaching writing skills through genre: applying the genre-based approach in Iran. *International Research Journal of Management, IT and Social Sciences*, 7(1), 242-257.  
<https://doi.org/10.21744/irjmis.v7n1.843>
- Arora, N. K. (2003). Interacting with cancer patients: the significance of physicians' communication behavior. *Social science & medicine*, 57(5), 791-806.
- Ayeloja, A. A. (2019). Conversational maxims in doctor-patient verbal bad news and managing patient reactions to illness. *Cancer*. 86:887-897.
- Baile, W. F., Kudelka, A. P., Beale, E. A., Glober, G. A., Myers, E. G., Greisinger, A. J., ... & Lenzi, R. (1999). Communication skills training in oncology: description and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness. *Cancer: Interdisciplinary International Journal of the American Cancer Society*, 86(5), 887-897.
- BARNARD, M. D. (2019). Investigating The 'Attainment Challenge' policy Discourse In Scotland And Its Effect On Emergent Teacher Agency. In *Cambridge Conference Series | December 2019* (p. 38).
- Bravo, R. E. S., & Gámez, M. R. (2021). Information and communication technologies, their impact on the teaching-learning process. *International Research Journal of Management, IT and Social Sciences*, 9(1), 19-25.  
<https://doi.org/10.21744/irjmis.v9n1.1981>
- Brinkman, W. B., Geraghty, S. R., Lanphear, B. P., Khoury, J. C., del Rey, J. A. G., DeWitt, T. G., & Britto, M. T. (2006). Evaluation of resident communication skills and professionalism: a matter of perspective?. *Pediatrics*, 118(4), 1371-1379.
- Carroll, J. G., Lipkin, M., Nachtigall, L., & Weston, W. W. (1995). A developmental awareness for teaching doctor/patient communication skills. In *The Medical Interview* (pp. 388-396). Springer, New York, NY.
- Deveugele, M., Derese, A., De Maesschalck, S., Willems, S., Van Driel, M., & De Maeseneer, J. (2005). Teaching communication skills to medical students, a challenge in the curriculum?. *Patient education and counseling*, 58(3), 265-270.  
<https://doi.org/10.1016/j.pec.2005.06.004>
- Deveugele, M., Derese, A., De Maesschalck, S., Willems, S., Van Driel, M., & De Maeseneer, J. (2005). Teaching communication skills to medical students, a challenge in the curriculum?. *Patient education and counseling*, 58(3), 265-270.  
<https://doi.org/10.1016/j.pec.2005.06.004>
- Duch, B. J., Groh, S. E., & Allen, D. E. (2001). Why problem-based learning? A case study of institutional change in undergraduate education. *The Power of Problem-Based Learning*.
- Flor, A. M., Guerra, A. F., & Juan, E. U. (Eds.). (2003). *Pragmatic competence and foreign language teaching* (Vol. 13). Publicacions de la Universitat Jaume I.
- Foucault, M. (1972). The discourse on language in the archaeology of knowledge. *New York, itd: Harper and Row*.
- Glasgow, R. E., & Riley, W. T. (2013). Pragmatic measures: what they are and why we need them. *American Journal of Preventive Medicine*, 45(2), 237-243. <https://doi.org/10.1016/j.amepre.2013.03.010>
- Grice, H. P. (1975). Logic and conversation. In *Speech acts* (pp. 41-58). Brill.

- Handover, S. (2004). Safe Patients: Guidance on Clinical Handover for Clinicians and Managers. National Patient Safety Agency. *British Medical Association. Care*, 27(3 Suppl.), S110–S127. <https://doi.org/10.1097/00005650->
- Jones, R., Higgs, R., De Angelis, C., & Prideaux, D. (2001). Changing face of medical curricula. *The Lancet*, 357(9257), 699-703. [https://doi.org/10.1016/S0140-6736\(00\)04134-9](https://doi.org/10.1016/S0140-6736(00)04134-9)
- Kaplan, S. H., Greenfield, S., & Ware Jr, J. E. (1989). Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Medical care*, S110-S127.
- Krupat, E., Rosenkranz, S. L., Yeager, C. M., Barnard, K., Putnam, S. M., & Inui, T. S. (2000). The practice orientations of physicians and patients: the effect of doctor–patient congruence on satisfaction. *Patient education and counseling*, 39(1), 49-59. [https://doi.org/10.1016/S0738-3991\(99\)00090-7](https://doi.org/10.1016/S0738-3991(99)00090-7)
- Levinson, S. C. (1983). *Pragmatics* Cambridge University Press. Cambridge UK.
- Lipkin, M., Frankel, R. M., Beckman, H. B., Charon, R., & Fein, O. (1995). Performing the interview. In *The medical interview* (pp. 65-82). Springer, New York, NY.
- Matusitz, J., & Spear, J. (2014). Effective doctor–patient communication: an updated examination. *Social work in public health*, 29(3), 252-266.
- Mey, J. L. (2001). *Pragmatics: an introduction*.
- Morris, C. W. (1938). Foundations of the Theory of Signs. In *International encyclopedia of unified science* (pp. 1-59). Chicago University Press.
- Nordquist, R. (2019). The Cooperative Principle in Conversation. Retrieved from thoughtco website: <https://www.thoughtco>.
- Noveck, I. A., & Reboul, A. (2008). Experimental pragmatics: A Gricean turn in the study of language. *Trends in cognitive sciences*, 12(11), 425-431. <https://doi.org/10.1016/j.tics.2008.07.009>
- Nunan, D. (1993). *Introducing discourse analysis*. Penguin Books.
- Ranjan, A., & Sahu, H. B. (2014). Advancements in communication and safety systems in underground mines: present status and future prospects.
- Rashid, M. H., Ye, T., Hui, W., Li, W., & Shunting, W. (2021). Analyse and challenges of teaching writing among the English teachers. *Linguistics and Culture Review*, 6(S2), 199-209. <https://doi.org/10.21744/lingcure.v6nS2.2004>
- Rees, C., Sheard, C., & McPherson, A. (2004). Medical students' views and experiences of methods of teaching and learning communication skills. *Patient education and counseling*, 54(1), 119-121. [https://doi.org/10.1016/S0738-3991\(03\)00196-4](https://doi.org/10.1016/S0738-3991(03)00196-4)
- Rinartha, K., Suryasa, W., & Kartika, L. G. S. (2018). Comparative Analysis of String Similarity on Dynamic Query Suggestions. In 2018 Electrical Power, Electronics, Communications, Controls and Informatics Seminar (EECCIS) (pp. 399-404). IEEE.
- Sarah, B., & Oladayo, M. M. (2021). Code-Switching and Code Mixing in the Selected Tracks of the Hip Hop Music of Flavour and 9ice. *International Journal of English and Comparative Literary Studies*, 2(3), 55-70.
- Silverman, J. E. (2013). *Skills for Communicating with Patients*.
- Simpson, P. K. (1991). *Artificial neural systems: foundations, paradigms, applications, and implementations*. McGraw-Hill, Inc..

- Sinha, K. K. (2021). The Role of Pragmatics in Literary Analysis: Approaching Literary Meaning from a Linguistic Perspective. *International Journal of English and Comparative Literary Studies*, 2(2), 29-40.
- Slotta, J. (2018). Pragmatics.
- Sutcliffe, K. M., Lewton, E., & Rosenthal, M. M. (2004). Communication failures: an insidious contributor to medical mishaps. *Academic medicine*, 79(2), 186-194.
- Swasey, M. L. (2013). *Physician and patient communication: A grounded theory analysis of physician and patient Web-Logs* (Doctoral dissertation, Southern Utah University. Department of Communication. 2013.).
- Taha, Q. (2019). Pragmatics Dfinitions, Historical Background and Scope.
- Tongue, J. R., Epps, H. R., & Forese, L. L. (2005). Communication skills for patient-centered care: research-based, easily learned techniques for medical interviews that benefit orthopaedic surgeons and their patients. *JBJS*, 87(3), 652-658.
- Tortoriello, T. R., Blatt, S. J., & DeWine, S. (1978). *Communication in the organization: An applied approach*. McGraw-Hill Book Comp..
- Urzúa, A., & Vásquez, C. (2008). Reflection and professional identity in teachers' future-oriented discourse. *Teaching and teacher education*, 24(7), 1935-1946. <https://doi.org/10.1016/j.tate.2008.04.008>
- Virtanen, H., Leino-Kilpi, H., & Salanterä, S. (2007). Empowering discourse in patient education. *Patient education and counseling*, 66(2), 140-146. <https://doi.org/10.1016/j.pec.2006.12.010>
- Willems, S., De Maesschalck, S., Deveugele, M., Derese, A., & De Maeseneer, J. (2005). Socio-economic status of the patient and doctor-patient communication: does it make a difference?. *Patient education and counseling*, 56(2), 139-146. <https://doi.org/10.1016/j.pec.2004.02.011>
- Willkomm, A. C. (2018). Five Types of Communication.
- Windle, R. (2017). Communication Skills.
- Zulvany, V. (2020). Macrolinguistics: texts and discourses, conversation interactions and conversation components. *Macrolinguistics and Microlinguistics*, 1(2), 104-116. Retrieved from <https://mami.nyc/index.php/journal/article/view/10>

**Appendices**

Appendix A: Names of Referee Panel

Appendix B: The Authorization Letter Addressed from Faculty of Arts to Medical College in UoK

Appendix D: A Checklist of Elements to Check whether Doctors Apply/Observe or not with their Patients through direct observation

Appendix E. Real Samples of DPD

Appendix F: The Final Form of the Interview

Appendix G: The Final Form of the Questionnaire: Communication Skills in Doctor-Patient Discourse in Iraq: A Pragmatic Study

Appendix H: Medical History and Physical Examination Sheet