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Physician-patient communication: An integrated multimodal approach for teaching medical English☆

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1. Introduction

The physician-patient relationship is essentially asymmetric: the physician possesses the knowledge of how to potentially solve or improve a certain medical condition, while the patient suffers from that condition and needs to be helped; the physician delivers a healthcare service which the patient has to pay for, i.e., the patient is a 'client' or 'consumer'; the physician is a specialised professional, while the patient is usually a lay person with limited or no medical knowledge, and so forth. These conditions may create an 'up-down relationship' in which the physician exerts expert power and the patient acts as a passive recipient. This may be reflected in the communicative style and mode of interaction, and ultimately have a negative impact on the patient's healthcare experience itself.

A number of studies have stressed the importance of patient-centred care (Dorđević, Bras, & Brajković, 2012; Haidet & Paterniti, 2003; Levinson, Lesser, & Epstein, 2010; Poole & Sanson-Fisher, 1979, among others), i.e., that which is respectful of the patient's medical as well as emotional, and socio-cultural status. This necessarily needs to entail a process of adaptation to such status on the part of the physician from many perspectives, including the communicative perspective. It seems crucial to create an 'across' rather than an 'up-down' relationship between the physician and the patient, a sort of partnership in which asymmetries are reduced and the patient is treated as an equal. It has been demonstrated that what physicians say is as important for patient satisfaction and health outcomes as how they say it (Stewart, 1995). In particular, their ability to build rapport and trust appears to play a fundamental role in the therapeutic process (Halpern, 2007, 2011, 2012). For this reason, physicians need to be aware of and use language forms that contribute to maintaining a harmonious and constructive relationship with their patients. Since language is an embodied phenomenon (Kress, 2009), though, there are also other factors that come into play for effective physician-patient communication, namely the ability to use appropriate body signals (such as eye contact, facial expressions, hand gestures, etc.) that support the semantic content of spoken language and help to consolidate the relationship (Franceschi, 2017a). The success of a physician-patient encounter is thus the product of a number of factors, some of them going beyond, but in fact running parallel to, strictly medical expertise, such as the ability to express empathy and warmth, and to speak affectively.

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The existing materials for teaching medical English focus primarily on activities aimed at improving learners' linguistic competence in various contexts, but most of them still fail to adequately prepare practicing and future physicians to incorporate non-verbal elements in their speech, which also may improve the quality of the relationship with patients. The field of Gestalt psychotherapy/counselling offers a series of useful techniques that could be felicitously used in ESL/EFL teaching and learning contexts to raise learners' awareness of the various communicative modalities they have at their disposal and of the effects that these modalities have on patients.[1]

The present article is structured as follows. Section 2 will first briefly summarise the literature on multimodality and on physician-patient communication. The latter has been widely investigated both from a strictly linguistic and broader perspective that also examines the role played by a number of other, non-language based factors, e.g., gaze orientation, face animation, body posture, etc. Section 3 discusses some of the activities proposed in three main coursebooks for teaching medical English, showing that multimodal research results have not always been applied in this particular area of ESP. Section 4 will first introduce the main principles of Gestalt psychology and then outline those techniques of Gestalt psychotherapy and counselling that may be applied in language teaching. The adoption of these techniques has made it possible to structure multimodal activities, described in detail in section 5, aimed at stimulating learners' awareness about the importance of certain communicative styles and behaviours for fruitful physician-patient interactions. Section 6 presents the methodological practice followed to structure the teaching activities proposed in the paper. Section 7 discusses the advantages and challenges of adopting a multimodal approach when teaching medical English: some initial considerations are made on the basis of the results of the application of the methodology presented. Finally, section 8 provides conclusive remarks and suggests possible future directions for research.

2. Literature review

It is now an acknowledged fact in linguistic research that meaning construction is a complex process involving the interplay of several communicative modes and that it is not enough to analyse only verbal production in order to fully understand communication (Baldry, 2000; Jewitt, 2014; Kress, 2000, 2003). What is still not so obvious is how different modes combine and interact in various social contexts. In addition, a single communicative event may also go through several changes from the moment it is conceived to its final outcome due to a constant process of resemiotization (Iedema, 2001: 36). It is therefore challenging to identify recurrent patterns of interaction among semiotic modes, i.e., regularities in the construction of meanings, within a certain communicative situation. Although some generalizations about the workings of multimodal relations have been made (cf., for instance, the generalized multimodal hierarchy in Tang, 2013), their application to discourse analysis continues to present both theoretical and methodological difficulties (Bateman, 2011; Kress, 2009), primarily because each semiotic resource presents its own features that call for different analytical frameworks. This has resulted in a "distinct preference for monomodality" (Kress & van Leeuwen, 2001: 1) in linguistic research, which has translated into pedagogical tools that give prominence to verbal communication and do not systematically foster awareness of multimodality.

Despite the fact that already in the 1980s and 1990s scholars of conversation analysis had started expanding the scope of their studies to include communicative modes going beyond speech (e.g., Goodwin, 1981; Heath, 1984; Kendon, 1990, among others), research on physician-patient communication was for a long time language-oriented and, still today, often remains prevalently confined to the examination of its main linguistic characteristics and recurrent patterns, both at the micro level of lexical-syntactic choices and from the broader perspective of the discourse strategies that physicians use, e.g., to instruct, advise and guide patients (Howard, Jakobson, & Kripalani, 2013). Several studies have shown that physician-patient communication is a complex type of spoken discourse characterised by internal variations. According to Coupland, Robinson, and Coupland (1994), a typical physician-patient interaction consists of a basic three-part structure, i.e., the opening, history taking, and making of a diagnosis, each of which has its own linguistic idiosyncrasies, e.g., the history taking phase generally includes several (more or less direct) questions, whereas the style is more instructive when communicating a diagnosis or discussing a therapeutic plan. Thomas and Wilson (1996) and Adolphs, Brown, Carter, Crawford, and Sahota (2004) have conducted the two main corpus-based studies of physician-patient communication and have identified the linguistic items that are more prominent in this specialised discourse than in general spoken English.[2]

Another widely investigated aspect in the literature regards how power relations are manifested in the linguistic structure of physician-patient interactions. Cordella (2004) observes that physicians' power is not imposed, but intrinsically expressed every time the patient is asked to do or restrain himself/herself from doing something. She notes that a common strategy used to maintain power on the part of the physician consists precisely in the use of a polite, respectful, and colloquial language,

[1] In addition to being an Adjunct Instructor in English Language and Linguistics, I am also a certified Gestalt counsellor.

[2] After examining a collection of physician-patient interactions totalling 1.25 million words, Thomas and Wilson (1996) concluded that the language of healthcare professionals presents a number of distinctive elements that contribute to a generally informal and interpersonally-oriented style. These results were later confirmed by Adolphs et al. (2004), who analysed data obtained from a collection of physician-patient telephone conversations. They also defined the language of these interactions as involved and interpersonal (as reflected, for example, in the high frequency of the second person singular pronoun 'you' and of the possessive adjective 'your'), but also directive (owing to the frequent use of imperatives), full of vague language items (as in the case of the phrase 'or anything' used as a question tag, which reflects the informal nature of the exchanges) and marked by an abundant use of mitigating elements (e.g., the modal verb 'may').

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while at the same time also avoiding technical terms typical of medical jargon: adapting one's speaking style to that of the patient by using his/her 'voice' would be seen as a form of control, allowing the physician to be perceived on an equal footing and thus giving him/her the possibility to more easily 'engage' the patient.

Finally, physician-patient communication has been extensively analysed from a sociolinguistic perspective as well, by taking into consideration, for instance, how cultural differences and gender diversity may lead to conflictive encounters (Gotti, Maci, & Sala, 2015). Within this study tradition, several studies have suggested that the creation of rapport and the expression of empathy in the interaction with patients are fundamental for building trust (Candlin & Crichton, 2013) and for ultimately improving the patient's health and medical care in a broad sense (Duffy, Gordon, Whelan, Cole-Kelly, & Frankel, 2004). Gradually, non-verbal communication has been recognized as an important ingredient for patients' satisfaction, understanding of information, and adherence to medical recommendations (cf. Robinson, 2006). The affective-relational dimension appears to play a key role when dealing with patients' feelings of uncertainty, anxiety, fear, and frustration, as well as with their difficulty in disclosing private and sometimes embarrassing information about themselves (Bensing & Dronkers, 1992; Bensing, Kerssens, & van der Pasch, 1995; Duggan & Parrott, 2001; Frankel, 1995; Harrigan & Rosenthal, 1986; Ruusuvuori, 2001). Non-verbal behaviours, however, cannot be treated as a whole in that they appear to have different effects on the quality of the physician-patient interaction.[3] There is a high level of uncontrollability and unpredictability in terms of outcomes with the use of non-verbal elements. Put differently, there is an interpersonal context that affects the production and understanding of non-verbal communication (Street, 2003), but overall the use of appropriate, i.e., 'controllable' and 'teachable', non-verbal elements appear to improve the quality of the relationship with patients both from a strictly medical-technical viewpoint and from a socio-psychological perspective as well (Bensing et al., 1995; Streeck, 1993). Physicians' gaze towards patients is generally interpreted as the intention and availability to listen (Goodwin, 1981; Kendon, 1990), especially when accompanied by other elements such as nodding and facial animation. Interestingly, there appear to be differences in the amount of nodding, with female physicians generally nodding more, especially with female patients (Hall, Irish, Roter, Ehrlich, & Miller, 1994). The amount of time that physicians spend gazing directly at patients' faces seems to determine patients' willingness or unwillingness to reveal information (e.g., about their lives as well as about their symptoms) and ask for medical support (Van Dulmen et al., 1997; Duggan & Parrott, 2001). The orientation of the physician's body also appears to positively or negatively influence patients' satisfaction and understanding (Larsen & Smith, 1981; Smith, Polis, & Hadac, 1981). Franceschi (2017a) shows how potential misunderstandings and conflict in physician-patient interactions may be resolved through the adoption of specific verbal and non-verbal strategies, systematically used in combination by the physician, which on the one hand facilitate the comprehension of medical information and, on the other, promote patients' compliance.[4]

Despite the recognition that physician-patient interactions are positively conditioned by the use of specific verbal as well as non-verbal elements on the part of the physician, materials for teaching medical English still today contain activities that utilize primarily a mono-semiotic rather than a multimodal approach to the study and learning of communication in the healthcare sector. They tend to focus on the verbal dimension to the detriment of a more holistic approach that should also stress the existence of various modes of communication and meaning making (Franceschi, 2017b). In addition, learners are not sufficiently taught how to develop their listening skills in a broad sense, i.e., in a way that will allow them to comprehend the meaning of the utterances, but also to read and interpret what remains unsaid. This is because didactic materials propose very few activities that teach learners how to deal with patients more affectively, not just by means of words.

3. Medical English teaching materials

Although there exist a number of different materials for teaching medical English, the textbooks sampled in this section are by two mainstream publishers and may be considered as representative of what is currently available on the market.

English in Medicine (Glendinning & Holmström, 2005) contains many well-prepared and useful activities for learning vocabulary and fixed expressions to be used in physician-patient interactions. However, these activities remain quite physician-centred and do not seem to take patients' emotional responses into consideration. As a matter of fact, it is difficult, if not impossible, to work on this aspect without introducing video-recorded and possibly authentic sequences of physician-patient dialogues. However, prosodic aspects, such as stress, pauses, intonation patterns, voice tone, etc., and paralinguistic cues (e.g., the recognition of enthusiasm/emotions or lack thereof in the melodic aspect of speech), which could have been addressed in a post-listening exercise, have been completely ignored. The focus remains on helping students to understand/memorise explicit lexical items and conversation routines. Table 1 shows part of an activity taken from *English in*

[3] The role of gaze orientation, for example, cannot be compared with the impact produced by smiling, touch, body posture, etc. Research has sometimes yielded contradictory results because patients' reactions to a certain communicative style are to a large extent subjective and variable. For some, being looked at in the eyes by the physician is perceived as reassuring, while other types of patients may instead appreciate smiles, touch or a certain body posture.

[4] There are many examples in Franceschi (2017a) of body language accompanying speech that facilitate communication and promote collaboration. Simplification of technical vocabulary and terminology, for instance, is typically accomplished both by means of verbal reformulation (e.g., 'adjunctive' -> 'in addition to') and through the use of hand gestures that iconically mimic the semantic content of a certain word (e.g., the term 'adjunctive' is also explained by physically reproducing the act of putting something inside a container) (Franceschi, 2017a: 310–312).

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Table 1
Example of an exercise adapted from *English in Medicine* (Glendinning & Holmström, 2005: 70/101).

How would you explain these diagnoses to the following patients or their relatives? Work in pairs. Student A should start. A: Play the part of the doctor. Explain these diagnoses to the patients or their relatives below. B: Play the part of the patients. In 2 play the part of a parent.	1. A 33-year-old salesman suffering from duodenal ulcer: DOCTOR: *Your stomach has been producing too much acid. This has inflamed an area in your bowel. It's possible that your stressful job has aggravated the situation. This is quite a common condition and there is an effective treatment. It doesn't involve surgery.*
1. A 33-year-old salesman suffering from duodenal ulcer. 2. A 6-year-old boy with Perthes' disease, accompanied by his parents. 3. A 21-year-old professional footballer with a torn meniscus of the right knee. … …	2. A 6-year-old boy with Perthes' disease, accompanied by his parents. DOCTOR: *What's happened to your son's hip is caused by a disturbance of the blood supply to the growing bone. This causes the bone to soften. When he walks, it puts pressure on the bone and it changes shape. It's painful and he limps. This problem isn't uncommon with young boys and if we treat it now, it won't cause any permanent damage.*
When you have finished, compare your explanations with the recording.	3. A 21-year-old professional footballer with a torn meniscus of the right knee. DOCTOR: *The cartilage, which is the cushioning tissue between the bones of your knee, has torn when your knee was twisting.* PATIENT: *Right.* DOCTOR: *We need to do some further tests – an MRI scan and possibly an arthroscopy.* PATIENT: *Sorry...* DOCTOR: *That means looking into the joint with a kind of telescope. If there is torn cartilage we can remove it then. Footballers often get this kind of problem and with treatment and physio, you will be able to play again.* PATIENT: *Oh, right.*

Medicine (Unit 6, Task 10, page 70 and page 101) for teaching how to make a diagnosis and some of the corresponding transcripts of the audio recordings, which should ideally provide learners with model exchanges.

Although the experienced teacher may use this task only as a starting point and then expand on it with additional activities, there are some issues that should be pointed out. First of all, the transcripts illustrate what appear to be rather static and fabricated conversations. In the case of the 33-year-old salesman suffering from duodenal ulcer and of the 6-year-old boy with Perthes' disease, the physician simply describes the cause of the problems without any real interaction with the patient himself or the boy's parents. We do not know what kind of reaction or response the communication of the diagnosis produces: what the physician says may perhaps be perceived as somewhat frightening, for instance, despite the presence of final reassurances aimed at softening the scenarios presented. As for the 21-year-old professional footballer with the torn meniscus, on the other hand, there is a bit of interaction here, but the physician only describes the medical condition to the patient and then explains how an arthroscopy is carried out. Even in this case, there is no attention to the patient's feelings and learners can only assume what the effects of the diagnosis could be on him. These are examples of physician-centred exchanges, which confirm and even feed the (clichéd) idea that the physician-patient relationship ought to be asymmetric.

In Oxford English for Careers – *Medicine 1 & 2* (McCarter, 2009/2010) the role of non-verbal communication in physician-patient interactions has been progressively taken into account. In Unit 1 (page 10), for instance, a 'culture project' is presented in which learners are asked to look at some pictures and match them with descriptions of body language provided in a list. Learners then have to reflect on the importance of the use of body language in other sectors and in their culture. Finally, they are asked to use the Internet to do some research into what a patient-centred approach is and to find out about the Calgary Cambridge[5] method.

The only coursebook that systematically proposes more comprehensive and multi-modal activities for the development of patient-centred communication is *Good Practice – Communication Skills in English for the Medical Practitioner* (McCullagh & Wright, 2008), which is also innovatively accompanied by a DVD showing a range of realistic physician-patient interactions. Learners therefore have the chance to examine and analyse non-verbal aspects of communication that they do not normally have access to in more static activities. It is possible, for instance, to observe the physician's posture and distance from the patient during the interaction, as well as his/her facial expressions and emotions, in addition to the patient's feelings. There is a strong emphasis in *Good Practice* on the various components of communication and the exercises/tasks proposed reflect this integrated and multi-dimensional view. In order to stimulate learners' awareness of the importance of voice management, they are asked to analyse how the same sentence is spoken by different physicians and to describe each style with an adjective, e.g., *bored*, *friendly*, and *irritable*. Active listening is encouraged in various ways, typically with discussions on the difference between 'hearing' and 'listening', and on the hurdles to attentive listening. Learners' cultural awareness is also developed by drawing their attention to the fact that beliefs, habits, and attitudes are inherently biased and that physicians may unintentionally offend their patients with the use of a certain speaking style and/or behaviour. Finally, several non-verbal factors are addressed with activities that also stimulate attentive watching.

[5] http://www.gp-training.net/training/communication_skills/calgary/.

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Good Practice certainly represents an innovative coursebook for teaching communication skills to the (future) medical practitioner, indirectly utilising a psychological-didactic approach that combines traditional ESL/EFL exercises with specific awareness-raising activities. However, an increase in the number of explicitly psychological tasks may further improve medical English teaching materials and learners' communicative abilities. In particular, the field of Gestalt psychotherapy and counselling appears to offer a range of experiential techniques, which may be felicitously used in the classroom to heighten self-awareness, awareness of the others' feelings and emotions, and ultimately increase the here-and-now power of communication. The following section briefly discusses the basic principles of Gestalt psychology that underpin the teaching activities described in section 5.

4. Gestalt psychology

The central principle of Gestalt psychology is that we cannot be considered as separate from the environmental field in which we live, i.e., we are part of a unified 'whole' or 'configuration', which is different from the mere sum of its parts. The German word 'Gestalt' itself means 'pattern', 'form', or 'organized whole'.

The initiator of Gestalt therapy was Fritz Perls (1969, 1973), who pioneered an existential and phenomenological approach, further developed and integrated by Claudio Naranjo (1993), aimed at increasing people's awareness of what they are seeing, feeling, sensing, and interpreting in the 'here and now' of a certain situation. Gestalt therapy promotes direct experiencing rather than reflecting on or speaking about situations. The focus is on the 'what' and 'how' of a person; 'why' questions are seldom asked because they generally lead to excessive rationalizations, self-deception, and breaking away from the immediacy of the moment. The therapist constantly encourages the expression of feelings instead of simply talking about them. The main assumption in Gestalt therapy is that our (past negative) emotions must be brought into the foreground, i.e., into the 'here and now', so as to be better able to deal with them. Unexpressed feelings would result in both physical and mental symptoms. Therefore, the therapist's function is ultimately that of guiding people to become more aware of their senses, assume ownership of their experiences, take responsibility for what they do, and help them to move from seeking external support towards an increasing ability for self-support. These goals are achieved through a number of specific techniques and strategies, such as, among others, the Empty-Chair exercise, the Making the Rounds exercise, the Exaggeration exercise, and by asking the client to stay with a certain feeling.

4.1. Gestalt techniques

The main objective of the techniques that the Gestalt therapist uses (cf. Mann, 2010) is to promote learning by direct experience. They encourage spontaneity and put the person in a position in which he/she has to do and say rather than just think or remember something.

4.1.1. The empty chair

The Empty-Chair or Double-Chair technique is used to help a person to get in touch with other views or aspects of the self in order to potentially resolve a conflict. To get started, the therapist or counsellor places an empty chair opposite the client, who will have to imagine that a person or one part of himself/herself is sitting on it. The client will be encouraged to speak to whoever is sitting there, explaining his/her perceptions and feelings. The next step consists in asking the client to sit on the empty chair (assuming the role of that person or side of the client's personality) and respond to what was just said. The client may have to move several times from one chair to the other in order to become more aware of opposing positions, and then be able and willing to find a compromise between them.

4.1.2. Making the rounds

This is a group work-based exercise that consists in asking someone to go round the room and say or do something with the other group members. This activity gives the client the opportunity to try out new behaviours, express thoughts and feelings more spontaneously in a protected setting, and then get feedback in terms of the effects and reactions that a certain behaviour has on the other participants. Not only does the person involved in this activity get a clearer understanding of his/her thoughts and emotions, but he/she will also learn to take responsibility for what he/she communicates or does not communicate on the basis of the reactions of the other people in the group.

4.1.3. Exaggeration

The main aim of the exaggeration technique is to elicit feelings of absurdity and ridiculousness. Let's say, for example, that you have an assignment due at the end of the week and that you fear you may not be able to work on it because of lack of time. Suddenly the thought comes to you "I'm a total loser and I'll never be able to graduate!" and then you catch yourself, and say "Wait a second. That's a negative thought!". With the exaggeration technique, you will be encouraged to envisage a hypothetical catastrophic scenario and say things like "I will never graduate and everyone I know will not talk to me anymore", and so forth. After a while, your mind will say "OK, enough, this is ridiculous!" and you will find yourself laughing at your thoughts. Exaggeration ultimately helps awareness of the obvious.

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4.1.4. Staying with your feelings

This technique is meant to strengthen one's ability to face rather than escape or avoid unpleasant feelings. The therapist will encourage his/her client to sit with and really feel the pain, anxiety, sadness, or whatever other negative emotion might be present at a certain moment. Paradoxically, digging deeper into the feeling will promote courage, growth, and acceptance as well as the realization that feelings are not, in and of themselves, something to be afraid of. This Gestalt exercise may also entail rehearsing, i.e., experimenting with a certain behaviour that accompanies the unpleasant feeling in order to become better able to handle it.

5. Gestalt techniques in medical English teaching

Current research on physician-patient interactions demonstrates that effective communication continues to represent a challenge for physicians, as evidenced by the analysis of patient dissatisfaction and complaints (Kee, Khoo, Lim, & Koh, 2017). Patients seem to prefer a psychosocial approach to communication (Roter & Hall, 1992; Roter, Frankel, Hall, & Sluyter, 2006), while physicians still today tend to adhere to a biomedical model, which "does not include the patient and his attributes as a person, a human being" (Engel, 1980: 536). Therefore, a more humanistic approach is called for to improve the quality of care. This goal may be achieved by incorporating emotional awareness into medical training. Medical English teaching courses too should not underestimate the importance of adopting a broader, multimodal approach that puts more emphasis on the non-verbal dimension of communication.

The application of the Gestalt techniques outlined above represents a possible advancement in the field of ESL/EFL medical teaching in that they appear to increase the awareness of affective aspects of physician-patient communication that are usually overlooked, but which are nonetheless of paramount importance for a successful interaction. The following activities suggest ways to integrate traditional speaking exercises, such as interviewing, role-playing, and social conversation, with techniques aimed at developing learners' relational communication skills and emotional intelligence.

5.1. Playing both roles

Pair work and role-playing are classic activities used in language teaching. However, learners are typically asked to play just one role and are not encouraged to reflect on the impact that their words have on the other person. The Empty Chair technique may be useful to help learners focus their attention on the effects produced by what they say on the interlocutor. It may be used to practice speaking in a number of different situations, e.g., during the history-taking phase, when communicating a diagnosis, etc. One learner (learner A) will play the role of the physician and will be given specific instructions as to what to communicate to a potential patient sitting in front of him/her. Table 2a illustrates a role-play instruction card.

The patient's chair should be left empty. The other learner (learner B) will work as an external observer and will later give learner A some feedback on his/her performance as physician. Once learner A finishes talking to the patient, he/she should sit on the empty chair and pretend he/she is now the patient he/she has just talked to. The language teacher should ask what it was like to be in conversation with the physician. A multimodal analysis should be encouraged. Learners typically give more importance to the verbal dimension and do not usually pay sufficient attention to how the message is conveyed. Therefore, the teacher needs to ask questions regarding the choice of words and expressions, as well as about the mode of delivery of information. A card may be given to learner A to facilitate self-reflection and comments on his/her own performance as physician (Table 2b).

At this stage, learner A and learner B may also exchange opinions and impressions (e.g., learner B might say 'I had the impression that you as the physician didn't give enough credit to the patient and that you looked rather bored. What do you think?'). This exercise has proved to have intra-psychic outcomes, i.e., it promotes self-awareness and opens a door for self-criticism. Learner A may, for instance, realize that he/she could have been less straightforward and that the patient may have felt unjustly criticized about something. The teacher will then encourage learner A to swap seats again, go back to the first role as physician and try to restructure the conversation with the patient in a more collaborative way. He/she should then again imagine himself/herself as the patient and talk about his/her experience with the physician. Learner B will also comment on learner A's role as physician with respect to whether or not there have been any changes and improvements in communicating with the imagined patient after pretending to be him/her. At this stage, the teacher should start a class discussion about those verbal and non-verbal strategies that, according to the learners, have facilitated the communication with the patient. A list of effective non-verbal behaviours as well as useful phrases, and expressions may be made and later used by the learners when preparing for their dialogues.

Table 2a
Example of a role-play card.

A: You are a family doctor. Pretend that one of your patients who has recently suffered from insomnia is sitting in front of you. You have not seen him for several months now and you think he has come back for the same problem. You do not believe in prescribing pills and you would like him to solve the problem with a change in his lifestyle (e.g., stress, too much caffeine, personal problems?). You need to see many other patients today, so you are in a hurry.
B: Stand or sit next to A and watch his/her performance. You will have to give him/her feedback about his/her ability to speak empathically.

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Table 2b
Example of a card with questions regarding the physician's performance.

1) Did the physician use clear language?
2) Did the physician give you enough time to explain what your problem is?
3) What was the physician doing while you were talking? Did he/she remain seated all the time?
4) What was the physician doing while he/she was talking?
5) How would you describe the physician's attitude during the consultation?
6) What tone of voice did the physician use?
7) Did the physician use any body language signals that you liked/disliked?
8) How did you feel during the consultation with this physician?

The Empty Chair technique may also be used with only one learner by asking him/her to play not just the roles of the physician and the patient, but also of the external observer, so as to report on his/her own performance while pretending to be in consultation with a patient. The benefits of the Empty Chair technique result from looking at oneself from the outside, a condition that contributes to a more objective understanding of learners' own communicative strengths and weaknesses. Ideally, learners should have an upper-intermediate/advanced level of English proficiency to actively engage in this activity.

5.2. Group confrontation

The Making the Rounds exercise may be adapted to the teaching context in two main ways. First of all, the teacher may ask a learner to sit in the middle of a circle of other learners and pretend he/she is the patient. The other participants in the group will instead be the physicians. Each of them will have to talk to the patient using a different communicative style as suggested by the teacher. Everyone in the group, including the learner playing the role of the patient, will receive a card with information about what to say and how to say it (Table 3).

The aim of this exercise is to expose the patient to different communicative and behavioural styles and draw his/her attention to what works best in this situation. However, since opinions are necessarily subjective to individual experiences and personalities, it is useful to repeat the exercise with other learners playing the role of the patient in order to see whether the group can come to a consensual conclusion about the most successful speaking strategy.

The other activity consists in asking the learner who is sitting in the middle of the circle to act as the physician and to speak to the other learners in the group as if they were all patients. The physician should imagine that everyone suffers from the same condition and should go round the room giving advice. The patients this time will be told beforehand what kind of attitude they should have towards the physician. The teacher will first ask the physician to use as few non-verbal elements as possible and then encourage him/her to accompany his/her speech with body signals and also be open with the expression of emotions. The aim here is that of putting the physician in the position of experimenting and dealing with opposing feelings while in conversation with the patients, such as liking/disliking, anger/fear, happiness/sadness, etc. There should be a wrap-up activity at the end of the session to consider what worked best in terms of the interaction itself and also how the learner playing the role of the physician handled the various emotions. This final discussion will prove useful to understand what needs to be reinforced at the level of one's own emotional responses when dealing with patients and how these responses may be improved both verbally and through the use of specific facial expressions, hand gestures, body movements, and other non-verbal signals. As in the case of the Empty Chair exercise, the higher the level of English proficiency that the learners have, the more able they will be to focus on extra-linguistic aspects of communication and thus benefit from this activity.

5.3. Dealing with polarities

Although in most cases physicians do not have to face extremely conflictual situations, patients can indeed be difficult and physicians often need to be able to deal with them beyond a strictly medical point of view. This is when having some knowledge of psychological dynamics and processes comes in particularly handy. It is important to be able to handle emotive reactions without losing the necessary control. Although medical training may already provide the adequate preparation for this aspect, language teaching represents another opportunity that learners have to improve their relational skills.

Table 3
Example of a Making the Rounds exercise.

PATIENT: You have come to see your doctor because you don't feel very well and have had a pain in your chest for 3 days. You're very worried, but reluctant to go to the hospital.
PHYSICIAN 1: Talk to the patient in a caring and reassuring manner, using smiles and tapping on his/her shoulder, but refer him/her to a cardiologist.
PHYSICIAN 2: You are afraid that the patient might be having a heart attack. Call an ambulance to take him/her to the E.R. immediately. Ask him/her to lie down and not to move.
PHYSICIAN 3: Reassure the patient, but use a cold and detached tone. Remain seated and do not look at the patient in the eyes.
PHYSICIAN 4: Ask the patient to tell you what he/she is worried about and why he/she does not want to go to the hospital. Use a calm and slow voice.
PHYSICIAN 5: Inform the patient in a very straightforward way about the potential risks of a heart attack. Keep looking at him/her in the eyes.

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Table 4
Example of a role-play using the Exaggeration technique.

A: Play the part of the patient. You have been suffering from anxiety for a long time and have decided to follow your doctor's advice to take medication. Unfortunately, you have been experiencing a lot of side effects, including nausea and a constant headache. You are very upset and disgusted with your doctor. Go and see him/her, and tell him/her in a very aggressive way that he/she needs to find a solution soon otherwise you will sue him/her!
B: Play the part of the doctor. Talk to an extremely angry and verbally aggressive patient who is not benefitting from the drugs you prescribed him/her for his/her anxiety problem. Try to calm him/her down and do your best to solve the situation.

The Exaggeration technique proves useful to experiment and learn how to better deal with a variety of strong emotions. It may be used in combination with the Empty Chair and Making the Rounds techniques discussed above or in a classic role-play scenario (Table 4).

The teacher should encourage the strongest expression of feelings possible and may have to ask the learners to repeat sentences in the dialogue using more emphasis both verbally and non-verbally. In the exercise presented in Table 4, it is the patient who has to express frustration and rage, but other scenarios can be imagined in which the physician too may get annoyed about something the patient has (not) said or done. In these enactment activities, it is important to constantly remind the learners not to get distracted and to really pretend they are in the physician or patient's shoes. The more powerful the expression of emotions, the easier it will be to get to recognize them and to find strategies to better deal with them. At the end of the role-play, the other learners in the group should comment on how the exchange was conducted and suggest alternative ways to improve it.

5.4. Empathic listening

The physician's ability to identify with the patient's problems and feelings has been shown to promote empathy, rapport-building and to facilitate treatment (Boudreau, Cassell, & Fuks, 2009). However, neither patients nor physicians find it easy to deal with emotions during the consultation. There is a general tendency to avoid their expression and to stick to verbal communication – mainly out of shame and embarrassment. Therefore, a useful activity entails asking a learner to play the patient's role and to present his/her symptoms in a rather detailed way; the other learner in the physician's role should simply listen attentively while assuming a non-judgemental, non-critical manner. Both learners will have to be given clear instructions before starting the dialogue. The teacher should encourage the learner playing the physician's role to simply 'act like a mirror', i.e., to 'reflect' back without using words what he/she thinks the patient is feeling. Words should only be used as invitations to say more, e.g., "Tell me about it", "How do you feel about that?", "I'd like to hear more about that", or as backchannels ("Uh-huh", "I see", etc.). The aim of this exercise is learning how to give non-verbal acknowledgements by means of eye contact, facial expressions, head nodding, and other body movements. The physician should therefore remain prevalently silent and simply stay with the patient's emotions. This may appear as an easy task, but in fact physicians often have an automatic tendency to use stock phrases as a deflection strategy ("You'll be fine", "Don't worry about it", "It's not that bad", and so forth) instead of listening actively and tuning in to the patient's wavelength first. A final discussion may be useful to address the difficulties, if any, that the learner playing the physician's role had while interacting with the patient. From a strictly linguistic perspective, learners will also benefit from a conclusive activity on the use of the various types of back channels in English.

6. Methodology

All the exercises and tasks proposed above were personally tested in my Medical English courses at the University of Pisa between 2008 and 2014. The students involved were mostly eighteen-to twenty-year olds who had just enrolled in their first year of the undergraduate degree course in Medicine. Approximately 500 students took part in the activities in this six-year period. With only a few exceptions, they all had at least an intermediate or upper-intermediate level of English proficiency.[6]

The methodology followed consisted first in administering a questionnaire to the students, which they had to complete in the classroom in fifteen minutes, regarding what they thought was important in physician-patient communication. They simply had to write a short paragraph (approximately 250 words) on this topic in their own words relying on their personal experiences, if possible, and hand it in before the end of the lesson. This warm-up activity proved useful to start raising students' awareness about the many facets of physician-patient communication. Secondly, the Gestalt techniques outlined in Section 4 were explained and presented by means of video clips. The students were expressly informed that the approach they were about to experience had never been utilized before for language teaching purposes and that the video clips consisted of short segments of psychotherapy/counselling sessions only used to show them how to apply the Gestalt techniques in the exercises. The reasons motivating the use of this experimental, integrated approach were then explained, also by making quick reference to the conclusions reached in the research literature on physician-patient communication. Finally, the

[6] It has become common in Italian secondary schools to ask students to take the Cambridge First Certificate in English or the Trinity College of London examinations.

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students were given the instruction cards (see Tables 1–4) in preparation for the dialogues and asked to structure a possible physician-patient exchange in pairs. They were told, however, that the activities did not necessarily entail acting out conversations in pairs, but that this preparation would in any case be useful to them as a launch pad for the other types of exercises.

7. Advantages and challenges of the integrated approach

The teaching techniques proposed and described above have proved to be powerful tools for learning how to better communicate with patients. The medical students that were involved in these activities reported that the experience was difficult but positive, because it helped them to feel more confident and potentially prepared to deal with real (future) patients. In particular, students seemed to benefit from the highly interactive nature of the tasks and from the constant invitation to try and identify as much as possible with the role they were playing. Some of them even brought personal stethoscopes and other patient-care equipment into the classroom in order to add authenticity to the activities.

All the activities proposed above generally appeared to improve the students' linguistic output by (rather paradoxically) diverting their attention away from their main worry, i.e., that of having to find and use the right words, phrases, and expressions. Being asked to communicate in a more holistic way somehow supported their use of English, which progressively came across as more correct and less stilted. The less static the interaction, the easier it became for the students to integrate and remember the suggested vocabulary and the essential elements of communication in medical encounters.

During the Empty Chair exercise students developed an ability to express themselves with more compassion, empathy and understanding, primarily via the use of mitigating words and phrases. They progressively managed to incorporate several new language items in the dialogues (i.e., hedging adjectives, adverbs, and clauses) after participating in whole-class brainstorming activities performed at the end of a certain number of Empty Chair exercises. It proved particularly useful to prepare lists of expressions that they could read and internalise before acting out the dialogues. At the level of non-verbal communication, the most frequent behaviour that could be observed was the students' tendency to physically reduce the distance between them during the role-play: some students playing the role of the physician moved their chairs to get closer to the patient or simply bent over in an attempt to create a more intimate conversation; others even established physical contact with the patients as a way to express their willingness to help.

Shy students and those with a lower level of English proficiency typically found the empathic listening exercise easier and more rewarding in that they could remain prevalently silent and express themselves not just by means of words. This activity, however, also helped more talkative students to develop/improve their ability to accompany speech with appropriate facial expressions. Unless they were explicitly asked to stay in touch with their emotions during the conversations, many students often tended to remain focused on what they had to say rather than how to say it, worrying that they might not be able to remember everything they had to say. As a result, they sometimes seemed to maintain a psychologically detached and unaffected attitude. It was thus often necessary to interrupt the dialogues and ask the students for ideas about how they could integrate language with gestures and/or facial signals expressing empathy. This turned out to be an important moment of reflection and an opportunity to exchange and experiment with new communicative modes. Several students noticed that they had to divert their gaze from the patient out of embarrassment. Male students in particular found it difficult to establish and maintain a 'warm' relationship with other male students playing the role of the patients. Female students, on the other hand, reported that it was relatively easy to resort to smiles, nodding, and even engage in physical contact. Overall, students admitted their surprise in seeing how important the use of non-verbal strategies can be in the context of medical care.

The most challenging activity for most students was the Exaggeration technique. They reported that the amplified expression of emotions was not always an easy task, because of their fear of losing control or simply due to their embarrassment. Many reported that the formality of the University context did not match well with the uniqueness of this Gestalt approach. Generally speaking, the expression of emotions was associated with something negative to be ashamed and they even saw it as a sign of incompetence or non-professional behaviour when they resorted to it as physicians. Although these difficulties did not impinge on the overall effectiveness of the technique, which has proved useful to learn how to better deal with strong feelings, communication issues, and conflict resolution, it often reduced the actual amount of words that the students used. Therefore, the strictly linguistic benefits of the Exaggeration technique have to be reconsidered.

The other common hurdle that some students experienced was to truly 'forget' about themselves and take one of the roles suggested, either as physicians or patients. Initially, some of them giggled or stopped in the middle of the activities and refused to carry on. One strategy that significantly helped them to identify with the situations represented in the activities and to become emotionally involved was to enact a real, lived experience from their past. Only a limited number of students decided to share a personal story, though, and use it for the exercises instead of the prompts given in the instruction cards. However, when they accepted basing the activities on a real past situation, they became spontaneous, fluent, and receptive to learning new language items, and to building more effective communication pathways that also involved the use of non-verbal elements, such as more recognizable facial expressions and body signals.

To sum up, the inclusion of an emotive component in the tasks proposed has appeared to facilitate the memorization of specialized vocabulary and of the typical conversation patterns used in physician-patient interactions, in addition to improving students' general communication skills and rapport-building capabilities. However, these are only initial results that require further exploration and explication. It would be useful to design experimental activities in the future to compare and contrast students' performance first during traditional role-plays and then in speaking tasks in which they are explicitly

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encouraged to use 'emotive language'. This will enable us to more objectively verify the extent to which the conversations can be improved by the inclusion of non-verbal elements.

8. Conclusions

The activities proposed in this paper are the result of a fusion between speaking exercises commonly used in the ESL/EFL classroom and four techniques employed in Gestalt psychotherapy/counselling that involve semiotic modes beyond verbal language. Such integration has proved successful in stimulating medical students' awareness about the importance of speaking affectively when dealing with patients. This aspect has been neglected in Medical English teaching materials, which tend to focus almost exclusively on broadening learners' knowledge of specialised terminology, fixed phrases, and expressions to be used in a number of medical contexts. A multimodal approach is instead needed and attention should be paid to the interactional and non-verbal aspects of communication as well, i.e., to the message as a whole. This is because meaning is constructed both by means of verbal and non-verbal cues. The recognition of non-verbal messages appears as particularly important in the context of physician-patient communication in which affect attunement makes it possible to maintain a dialogic relationship and to more easily respond to patients' needs. Medical students should therefore be helped to listen to all types of messages and to use not just verbal modes when communicating with patients. This first requires the learner to develop an ability to listen actively and to 'read' beyond words.

Video-recording students' performances[7] in the various activities outlined above may prove an extremely useful technique to further improve their relational, English language and non-verbal communication skills. Feedback/critiquing sessions could be scheduled after watching the recorded conversations in order to make students more aware of the impact of their verbal choices and non-verbal messages on the quality of the interaction. These observation sessions may also be useful to identify the possible generalizable modes of successful physician-patient communication and discuss which are the preferred or more effective ones. An in-depth quantitative and qualitative analysis of the features of medical spoken English interlanguage and a systematic examination of the non-verbal elements that accompany speech are also necessary. This will make it possible to produce innovative multimodal teaching materials based on what the various learner populations experience as difficult.

The methodology proposed here raises a number of questions. First and foremost, language teachers and instructors working with medical students should ideally receive some training in psychological counselling skills in order to be able to adopt a less traditional approach and teach how to build an inter-subjective bridge between the self and the other, i.e., the physician himself/herself and the patient. In addition, teachers need to be mindful that the meaning of language is not fixed, but a function of the interaction between the speaker and the listener and that such function changes depending on the context of the interaction and on the participants involved.

Since teaching materials do not pay much attention to modes other than speech, there are no assessment tools to evaluate learners' ability to identify and then use non-verbal messages (Campoy-Cubillo & Querol-Julián, 2015). Therefore, language teachers will have to rely on their own creativity to prepare ad-hoc teaching and assessment materials until interdisciplinary, multimodal course- and textbooks based on authentic exchanges between physicians and patients are produced and launched onto the market, hopefully in the near future.

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[7] The conversations were not video-recorded due to both logistical and consent issues. Therefore, I could only observe and take note of the students' performances. It would be extremely useful for future research to collect and store student data in the form of ESP computer learner corpora. Although there already exist several English learner corpora, all of them include general English data and are mono-semiotic. A new learner corpus project aimed at collecting video-recorded data is currently under way at the Centre for English Corpus Linguistics at the University of Louvain-la-Neuve in Belgium (https://uclouvain.be/en/research-institutes/ilc/cecl/nessi.html).

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