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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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