style is assumed to soften the perception of fear and danger associated with the description of the procedure in question:

> (7) Your liver is up here under the ribs. We numb up the area of the skin and we put the needle directly into the liver, we suck up a little piece of liver and take it back out. […] And the piece of liver that we take out, it's about as thick as the lead in the lead pencil, not the pencil itself, just the lead.

This is an example of recipient-tailored language use (Brown and Fraser 1979), aimed at establishing doctor-patient alignment. Learners of Medical English need to be aware of the fact that the use of a certain type of register may have a significant impact on the quality of the relationship with patients. Therefore, they should experiment with different speaking styles and consider what effects they may bring about. For instance, Table 11 below shows an example task where learners substitute the underlined items with more formal words and expressions carrying the same meanings.

Table 11. Example of a completed exercise on register variation

Exercise: Provide Latin-based alternatives to the underlined verb phrases
Your liver is up here under the ribs. We numb up (**anaesthetise**) the area of the skin and we put (**insert**) the needle directly into the liver, we suck up (**suction**) a little piece of liver and take it back out (**extract**). […] And the piece of liver that we take out (**extract**), it's about as thick as the lead in the lead pencil, not the pencil itself, just the lead.

Another activity may consist in simply asking learners to identify instances of informal language use in a series of sentences, as in Table 12 below, in order to draw their attention to the fact that register variations may be due to different elements, e.g. the presence of colloquialisms, onomatopoeic phrases and slang expressions.

Table 12. Example of an exercise on register variation

Exercise: Identify colloquial elements in the following sentences
1) Well, turns out, if you get rid of the hepatitis C with treatment, there's a good chance that your risk of cancer is gonna go way down. 2) The biopsy itself, the needle is in there less than a second. Boom boom, it's done! 3) Why the heck would you want treatment?

Generally speaking, it may be argued that the use of body language and gestures emphasise informality and add a sense of commitment and enthusiasm to what the doctor is talking about. Instead of focusing on a fragment of a videoed doctor-patient interaction, learners could be invited to watch a longer segment and locate all those relational signals that help to establish an informal rapport.

IV.IV. Figurative language

Speaking figuratively, i.e. by means of similes and metaphors, is a common strategy that doctors use to increase message clarity, as can be observed in the following example, in which hepatitis C infections are compared to different types of cars:

> (8) Cos hepatitis C is more than one virus, if you will. There are different subtypes, just like Ford has different kinds of cars, they are all Fords, but one's a truck and one's an SUV etc. Hepatitis C has different subtypes.

In the data examined, hepatitis C is also figuratively associated to a fire and drinking alcohol is presented as dangerous for the liver of a person with hepatitis C as pouring gasoline on fire would be (9). The hepatitis C virus is then indirectly referred to as a friend when it remains dormant and does not cause any complications (10). The latter meaning is activated by the phrasal expression *to get along alright together*, which is normally used to refer to people who are on good terms:

> (9) The combination of alcohol with active hepatitis, I look at this **as kind of putting alcohol on a fire or putting gasoline on a fire**, it just makes the fire worse.
>
> (10) […] and their disease never progressed anywhere very seriously. So for some reason their body and the virus are kind of **getting along alright together**, without major damage occurring.

A rather challenging, creative activity may consist in asking learners to enrich the descriptions and explanations provided by doctors, in the conversations they analyse, with imagined scenarios that compare different aspects on the basis of qualities they have in common, as in the examples above. Such a technique seems to facilitate comprehension of both human anatomy and medical conditions and processes. The doctors under scrutiny repeatedly also show their patients anatomical models and

encourage them to think in terms of comparisons and associations, as exemplified in Table 13 below.

Table 13. A doctor's use of a liver model to aid the patient's understanding of its physiological/pathological anatomy

Image frame	Non-verbal behaviour & interpretation	Verbal text
1 	Showing a healthy liver model, rubbing hand on its surface (indicates it has a smooth surface)	*This piece of a liver, if you will, is what a normal liver would look like. It's* ***kinda like*** *what you'd see in a supermarket. You know, just kind of smooth and a little reddish-purple, but a very smooth, shiny, nice surface*
2 	Showing a cirrhotic liver model, pointing to its surface (indicates that it has a very hard, non-smooth surface)	*This would be cirrhosis, which would be stage four disease. Lumpy, bumpy,* ***rock hard****. […] Cirrhotic liver is […],* ***it literally feels like a rock***

Since it might be complicated for learners to use objects and models in the language classroom, they could simply try to draw or find photos on the Internet in order to complement their talking with visual aids or props.

IV.V. Empathy and sympathy

The doctor's ability to imagine himself/herself in the patient's position, thus experiencing the emotions and ideas of that person (empathy), will most probably activate feelings of sorrow and compassion (sympathy) and then a willingness to help. The development of both empathy and sympathy seems to play a fundamental role in the doctor-patient relationship (Anfossi & Numico 2004, Halpern 2003, Larson & Yao 2005, Williams & Bendlow 1996). The analysis of the data used for the present study has suggested that initially uncooperative patients, who refuse to undergo treatment and

to follow their doctor's advice, may eventually change their attitude if approached in a suitable communicative style that shows understanding and care. The latter elements therefore appear as crucial for building trust and achieving patients' compliance.

The expression of sympathy and empathy needs to be made explicit both linguistically and non-linguistically, i.e. it has to translate in the use of specific language patterns and also find support in a series of non-verbal signals that sustain what words are communicating. These two aspects are bound together and cannot contradict each other. In other words, there has to be a correspondence between the choice of words and expressions that doctors use and their behaviour. Caring words alone would not be enough if the doctor's attitude expressed disinterest, for instance. Therefore, learners of Medical English should be constantly reminded of the importance of accompanying their speech with suitable behaviours, thus reflecting their ideas and intentions. The multi-modal transcription in Table 14 shows how the verbal and non-verbal dimensions can be felicitously combined for effective and affective communication.

Table 14. Showing and expressing sympathy/empathy

Image frame	Non-verbal behaviour & interpretation	Verbal text
1 	Keeping lips shut, looking at patient with a sad expression, almost about to cry (simply listens and deeply sympathises/empathises with the patient)	***I hear you***. *I think that I'm not gonna take your alcohol away from you right this minute, but […]. And so,* ***I hear you***, ***I hear that*** *this is really important for you and that you're not ready to give it up…,*
2 	Keeps looking at patient, but with head slightly turned to the right (suggests that she is considering things from another perspective), hands pointing together (suggests the idea of cooperation)	*…, but if you are willing to talk about alternatives* ***I can certainly help you*** *in that, in that way.* ***I'm willing to be there for you and work with you*** *in terms of being able to trade the alcohol for those alternatives to PTSD.*

Learners should discuss techniques and brainstorm ways to express empathy and sympathy that they feel most comfortable with. Owing to individual differences in personality, certain communicative styles may be perceived as more or less natural or difficult to adopt. It is therefore crucial to assist learners in finding a personal compromise in their choice of the type of language and behaviour they are willing to use with patients, within their own abilities and limits.

V. CONCLUSIONS AND FUTURE PERSPECTIVES

This article has put forward some alternative classroom activities for teaching Medical English multi-modally, thus going beyond what is usually found in ESP texts and coursebooks to this day. The basic assumption is that meaning does not lie solely in the choice of language forms and strategies in given situations, but it is also created in the course of the interaction via non-verbal signs (Argyle 1975/1988, Poyatos 1992, Wharton 2009). This is particularly true in doctor-patient exchanges, in which what is left unsaid and is otherwise communicated appears to be of paramount importance for building rapport and trust. Such an aspect, however, has not been taken into consideration sufficiently in English language teaching materials geared towards the medical profession.

Future research should be aimed at producing a systematic taxonomy of non-verbal behaviours that doctors could adopt in various situations of their daily practice with patients. While medical staff certainly know how to express thoughts and feelings verbally, they seem to find it much harder to pinpoint their natural behaviour non-verbally in different contexts, e.g. to express concern, disappointment, empathy and so forth.

This consideration raises a number of questions. It seems clear that there is a need to train English language instructors for Healthcare and Medicine to combine their teaching skills with specific competences and knowledge that are usually required of psychologists and counsellors. This is certainly not an easy task, as it presupposes a significant change in our training programmes. In addition, there are both cultural and gender-related issues that need to be observed if a behavioural repertoire were to be proposed for its use in the language classroom. What works in one country might be

viewed as culturally inappropriate in another. The same applies to the perceived level of acceptability in the use of certain non-verbal elements by men and women doctors with their male or female patients.

Notes

[i] These interviews are part of a database prepared by Caring Ambassadors Program Inc., Oregon City, OR, which can be accessed for free at http://hepcchallenge.org. I would like to thank Lorren Sandt (Executive Director of Caring Ambassadors Program Inc.) and Dr Lyn Patrick (Medical Director at Progressive Medical Education, Irvine, CA, www.progressivemedicaleducation.com) for allowing me to use the interviews and reproduce some images for my research.

[ii] Authentic video-recorded doctor-patient dialogues are extremely difficult to find and use because of privacy issues. However, there are several medical drama TV series, which may also be used for teaching purposes, despite their tendency to present situations in a more dramatised way.

[iii] Kress & van Leeuwen (2001: 20) have defined multimodality as "the use of several semiotic modes in the design of a semiotic product or event, together with the particular way in which these modes are combined – they may for instance reinforce each other […], fulfil complementary roles […], or be hierarchically ordered".

[iv] This can be easily verified by checking the curricula of University courses on-line. The University of Yale, for instance, only offers basic and clinical courses for students of Medicine (e.g. Energy and Metabolism, Genes and Development, Human Anatomy) and does not seem to include modules on more 'peripheral' topics, such as communication (http://medicine.yale.edu/education/curriculum/integrated/index.aspx). The same applies to courses offered by Harvard-MIT Programmes in Health Sciences (https://ocw.mit.edu/courses/find-by-topic/), which are also strictly medicine-oriented to the detriment of a more humanistic approach to healthcare.

[v] 2-3 minutes of silence can actually be perceived as quite long by the language instructor, who usually promotes frequent spoken interaction in the classroom. However, it is important not to interrupt this silent phase in that it helps learners to observe rather than listen.

[vi] See Lambertz (2011) for a discussion and a review of the literature on the use of backchannels to show engaged listenership.

[vii] It would be useful to encourage learners to think of alternative expressions, possibly with different levels of formality, to what they have written. For instance, instead of saying *What can I do for you?* a conversation with a patient might begin with other questions, such as *What brings you here today?* or *How can I help you?* and so on.

[viii] This technique is commonly used in Gestalt therapy (Naranjo 1993). It proves particularly powerful and effective for making people more aware of the costs/harms/risks and benefits of a certain behaviour.

[ix] Medicalese is the jargon used by medical and healthcare professionals.

[x] Technical terms are in bold, while their explanations have been underlined. It is also interesting to note that the reformulations are often introduced by a word or phrase signalling that we are faced with a paraphrase into a more popularised/ordinary style. These words or phrases have been italicised.