TEACHING ENGLISH FOR MEDICINE: A THREE-FOLD APPROACH

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Abstract. *This article deals with some of the strategies that I use in teaching English for Medicine. I call this the three-fold approach because it consists of three different goals or objectives. The first one is communication. Since I mostly work with 1st year students who do not yet have a very accurate understanding of medical processes, my second strategy is to incorporate some basic practical skills throughout the course, acting both as contents and as opportunities for the development of other skills. And because one of the most important social skills for working in any medical setting is empathy, I will take a look at if and how can it be developed. Of course, in practice these three aspects are always overlapping and the boundaries between them are very fuzzy. However, I will treat each and every one separately for the sake of clarity.*

Keywords: *English for Medicine, content-based teaching, communication skills, affective skills*

Teaching Medical English to 1st year students may be challenging from a variety of reasons. Firstly, they lack any knowledge of or training in the specific field of Medicine. However, teaching English for Specific Purposes includes descriptions of "real-life" scenarios one might encounter in the profession, either in the form of communication with, in this case, patients and other medical staff, or using skills like reading and writing to document, assess and produce academic papers in the field of Medicine. Secondly, 1st year medical students as a group possess various levels of skill in General English, so it often expected that they improve not only ESP-specific knowledge and skills, but also their English skills as a whole. This article will try to explain a specific approach that I use for the 1st year Medical English course. It is not necessarily a "method", it is more like a sum of techniques that stem from theoretical principles of modern-day Medicine that I put into practice during the course.

There is one major advantage that 1st year medical students have over most of the other ESP fields, i.e. the fact that they do have a knowledge of basic human anatomy and physiology, and also chemistry and physics. Also, another major advantage is the fact that they are highly motivated to study Medicine and are interested in medical topics. Thus, during the course, I try to use this prior knowledge to develop their understanding of medical communication as a complex process which involves not only a General English skill-set, but also technical and non-technical terminology, medic-to-patient communication protocols and so on. Because I use their motivation and interest in the field of Medicine, the students are better able to focus on the content and not on language *per se*. This approach is a kind of Content-Based Language Teaching (CBLT); it uses English as a tool to communicate, and avoids teaching language for its own sake. For instance, this approach does not include grammar practice or translation activities. Even if some individual student levels are lower than the average group level at the beginning of the course, the approach is still effective because it focuses on communication within a medical framework without a strict emphasis on grammatical correctness.

Content-Based Language Teaching (also called Content-Based Instruction) is frequently employed in LSP courses designed for professionals that already work in their respective fields. Almost every ESP textbook assumes a prior knowledge of the specific processes, tasks, terminology, and communication patterns of a certain profession. Then, the courses try to focus on that reality using English, including some relevant cultural aspects of

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working in international English-speaking environments. Thus, they integrate some sort of Content-Based method. However, as Stryker and Leaver notice,

> In spite of broad recognition that the best way to learn these skills is by *doing* them, not just by studying about them or performing exercises and drills, our traditional foreign language classes resemble music classes in which all of the learners` time is spent practicing scales and studying theory, and they are not permitted to play any real piece until they are proficient enough to give a recital. Content-based foreign language instruction, on the other hand, encourages students to learn a new language by playing real pieces actually *using* that language, from the very first class, as a real means of communication. Furthermore, the philosophy of content-based instruction (CBI) aims at empowering students to become independent learners and continue the learning process beyond the classroom. (Stryker, Leaver 3)

The goal of any ESP course is, obviously, to help students understand the basics of language learning and be able to continue learning, usually *by using* the language. To get there, they need an immersion in specific topics, or contents. But courses and textbooks designed for a global or international audience are not always relevant when it comes to local professional or social issues. Of course, we may use materials designed specifically for ESP, but we should also try to include more particular elements.

There are three key components of a CBLT course, according to Stryker and Leaver: "it is based on a subject matter core", "uses authentic language and texts", and "is appropriate to the needs of a specific group of students" (Stryker, Leaver 5). The subject-matter core is probably the first thing we think about when we talk about CBLT: content, not grammar, meaning, not form, a top-down approach etc. There are a number of issues we must consider when dealing with the subject-matter of a CBLT course. Firstly, there is the question about grammar. Is it going to be included naturally into the course or completely left out? Stryker and Leaver argue that content-based classes overcome the "artificial separation between language instruction and subject-matter" (Stryker, Leaver 7). From my point of view, language-based activities can be completely left out because we can rely on the content to naturally develop grammatical patterns, linguistic building blocks and chunks that can be used to convey meaning. Secondly, there is a question of subject-matter selection. Since my course is designed for 1st year students, I usually pick very simple topics, at the same time trying to strike a balance between content and communication practice. The third issue is the teacher`s knowledge of the contents. Of course, anyone teaching such a course should research and investigate some of the basic practices of the field. On the other hand, empowering students by allowing them to explain, debate, research and so on, thus assuming part of the teacher`s role, contributes to the development of a learning process that extends outside the classroom.

The use of authentic texts and language is something very easy to do using YouTube videos, various articles, case studies and so on. The main point to consider is to use materials for which the students already have "schemata" ("the relevant linguistic, content, and cultural background knowledge") (Stryker, Leaver 9).

The needs of a particular group of students such as medical students gravitate around communication in various contexts. As a pre-requisite, they need to understand basic professional contexts, so they develop the ability to adapt to more complicated ones. Stryker and Leaver suggest that the teacher should use a combination of strategies, like "expository approaches: lectures, readings, presentations, and discussions and experiential approaches: role plays, workshops, simulations, field trips, demonstrations, and interaction with native

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speakers". Since we are confined to the classroom, not all of these strategies can be put to practice, but all of them are valuable if we keep in mind that a student-centered class does not necessarily mean that lectures, for instance, should be completely avoided (Stryker, Leaver 10).

The approach consists in three aspects of language teaching, three sets of objectives that I consider to be fundamental for future medical professionals. The first one is the cognitive aspect of communication skills. The second one refers to basic practical skills put to use in the field of Medicine, laying the foundation for understanding more advanced medical procedures and developing the skills that are needed to comprehend academic medical writing. The third is the development of empathy, an affective aspect. Thus, the general objective of this approach is the development of these three essential aspects.

Working in the field of Medicine also means having and/or exerting power over patients. Medical professionals are publicly seen as authority figures, and 1st year students may be fascinated by that promise of power that comes with a medical degree. Contemporary medical practice established ethical principles to dissolve that power into cooperation between medic and patient, to empower the patient, who used to be merely a subject of medical authority. In today`s medical practice, the biomedical perspective has been largely superseded by the "person-centered care" model. Thus, I believe that it is extremely important to help the students understand that the current model in medical care includes not only biological factors, but also psychological, environmental and social ones, and promotes the treatment of "persons" as opposed to the treatment of medical conditions.

Communication skills

It is crucial for medical students to understand that professional communication follows certain protocols. These protocols have been developed quite recently, from the 1960s onwards, to provide a structure for a new approach to medical practice, the "patient-centered" medicine. It includes concepts and practices such as "consent", "informed consent", the medical interview, "bedside manners" etc. Because most of the students have had very little, if at all, contact with the practical aspects of Medicine, I usually try to create a context to help them visualize the basic interaction between a medical professional and a patient. Role-playing, for instance, can demonstrate the common practice of a structured medical interview consisting in various stages, including medical history-taking, an essential process which tries to obtain as much information as possible from a patient to help reach a diagnosis. Many medical schools adopted the Calgary-Cambridge model of medical communication, which they use to teach future medics patient-centered skills (Kurtz, Silverman 83-84).

The Calgary-Cambridge communication model can be demonstrated using video resources freely available on YouTube, for instance. Once students understand the guidelines of the model and are able to follow the stages (Harrison, Hart, Wass 161), it is useful to role-play some scenarios using simple medical conditions and symptoms (using students` past interactions with the medical system as patients). It is also useful to help students understand the basic ethical principles behind the communication model.

"Consent" and "informed consent" are two of the cornerstones of contemporary medical practice. These are also legal requirements for medical communication and practice. Legally, consent is "authorization" of medical procedures by the patient. However, current medical patient-focused practice does not rely only on the agreement of the patient, on the patient`s right to say "yes" or "no", it also tries to include the patient in the medical decision-making process. This approach is called "shared-decision making", and it requires the medical professional to present information about the signs, diagnosis and treatment alternatives to the patient. He/she will express preferences or issues with the specific

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treatment alternatives and then together, medic and patient, they will establish a management plan for that medical condition (including the "no treatment" option) (Berg, Appelbaum 15).

The Calgary-Cambridge model is essential for the understanding of medical communication in a patient-centered environment because it provides a clear structure for conversation. This is what makes it so appropriate for role playing activities. The questions are pre-determined, focusing on getting as much information as possible from the patient about aspects such as symptoms, past medical history, family history, social history etc. It also serves as a fine example of establishing rapport with the patient to aid the shared decision-making process.

Another strategy that I integrate in this approach is to have occasional debates on social medicine. In the introduction of *Social Medicine* journal, the editors quote Rudolf Virchow: "Medicine has imperceptibly led us into the social field and placed us in a position of confronting directly the great problems of our time" (The Editors 2). The editors also identify social medicine as an "interface" between clinical care and social criticism. Of course, social problems often become medical problems (The Editors 3) and, perhaps, vice versa. In Romania, homelessness, teenage pregnancy, poverty and other social issues affect clinical care in specific ways. The debates around these social issues try to raise students` awareness and to help them understand that they will not have to deal only with middle-class patients, but also with the poor and the socially marginalized, individuals who have the right to the same treatment.

An important part of communication skills development is the ability to use specific terms that describe the human body. Since the students have prior knowledge of anatomy and physiology, I use group assignments to explain the specific terminology in English. Groups of students are assigned a topic (e.g. the digestive system) and they deliver a presentation of the relevant anatomy and physiology of that topic to their colleagues. Firstly, this ensures that every student learns the basic terminology because they are already familiar with the extra-linguistic reality of those systems. Secondly, it provides the opportunity for public speaking in a controlled and "safe" environment, i.e. in front of their peers. Thirdly, it offers the opportunity for debate over the terminology. From my point of view and for the purposes of a content-based ESP course such as this one, this strategy works better than the older translation method.

Basic practical skills

Obviously, Medicine is not just about communication models, interviews and medical histories. It is also a hands-on profession and maintaining proper communication with the patient during medical procedures is a very important part of the job. Since nothing is left to chance in the field of Medicine, even the simplest of medical procedures follow protocols and guidelines. During such a procedure, there are two aspects to take into account. The first one is instructing the patient to cooperate; the second one is technically performing the procedure.

To develop students` understanding of how things work in the context of a medical procedure, I use very simple examples, like intramuscular injections or intravenous catheterizations, which also allow me to use "Realia", real objects like syringes and peripheral IV catheters. For instance, eliciting the stages of an injection can turn into a brief debate. Once we identify the pre-procedure, procedure and post-procedure stages from a technical point of view, we can see that the medic or nurse needs the patient to cooperate and follow some instructions. Once again, role playing can be used to practice the relevant language.

Another strategy that may be used to develop this aspect of this approach to Medical English teaching is to assign some topics for the students to briefly research and present their

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findings to their peers. For instance, a group of students may research different types of injections and explain their particular uses and techniques in the form of a presentation. In addition to the cognitive factor, they also get to practice patient-doctor communication. Of course, if the procedures are more complicated, like different kinds of surgical operations, they still follow the same protocols, basic rules and guidelines.

Medical procedures are a good way to provide context for "bedside manners". In modern-day medical practice, the relationship between patient and doctor is central and, more often than not, it defines the evolution of the patient`s condition (Shannon 1218). The so-called "narrative medicine" is promoted today as a means to establish and develop the patient-doctor relationship around communication of stories:

> The self is the physician`s most important therapeutic tool, for the healing that comes from sitting by a patient, leaning forward and listening fully – without interruption or ready judgment – often goes beyond any cure. While listening for the nuances of a patient`s story, to what the body – and person – are saying, a relationship of authenticity and trust begins. It is a relationship which may also require the physician to make himself transparent, to move beyond the white coat to a shared, frail humanity – to be 'seen', so that in turn, he may 'see' ever more clearly. (Shannon 1218)

This approach does away with the strictly biomedical point of view in favor of a "holistic" bedside communication.

Affective skills and empathy

Perhaps this aspect of the medical profession is often overlooked in some parts of the world, but providing reassurance to the patient, being empathetic and, generally speaking, treating the patient as an individual, as a person, and not as a medical condition or a damaged organ is extremely important in contemporary medical practice.

In that famous book, *Birth of the Clinic*, French historian Michel Foucault explained that the development of the medical institution (the "clinic", the teaching hospital, but also the methodology) in the 18th century created a "medical gaze", a specific way of looking at bodies from a medical perspective (Foucault 131). The "medical gaze" operated by reducing individuals to systems, organs, tissues and diseases. Obviously, this is the "traditional" biomedical approach. As we have already seen, contemporary medical practice is trying to promote a "holistic", integrated approach to medical communication, to re-establish the fact that the patient is not simply a "disease", but a real person.

Empathy is one of the relevant traits of a medical professional, and many medical schools have included activities to develop their students` empathy. However, there is no universally accepted definition of empathy. On the one hand, empathy might be defined as "emotional contagion based on unconscious mimicry". On the other hand, it can also be defined as "the ability to accurately infer another person`s thoughts and feelings" or as "a complex affective-inferential process that often translates into prosocial behavior" (Decety, Ickes vii-viii). Empathy can also be explained as a neurological process (even if the human "mirror neurons" have yet to be explored).

Clinically speaking, medical professionals have had two approaches to their patients` conditions from an affective point of view (Halpern 15). The first one is the so-called "detached concern"; it is the strictly biomedical, rigid attitude of a medical professional who treats his or her patient as part of the job, without any interest in "narrative medicine" or any other form of elaborate patient-doctor relationship. The other one is a sympathetic attitude of

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affective merging with the patient`s condition. Clinical empathy has been promoted as a kind of balance between these two extremes, and has been recognized as an essential factor in the medical process. Clinical empathy has been described as "the idea of participating in another`s experience […], the ability to resonate allows the curious physician to use her imagination" (Halpern 85).

In *From Detached Concern to Empathy* the author, Jodi Halpern, presents a model of empathy as "emotion-guided imaging." (Halpern 129). To develop this trait in students and medical professionals is to make them curious about other people:

> One key path to cultivating empathy is to help students develop and retain their engaged curiosity about other people`s distinct experiences. A sense of knowing too much too soon about patients will impede this process. This openness is very difficult for doctors to achieve […] (Halpern 129)

Since a medical student or a physician (or anyone else) is unable to force him/herself to be more empathetic, this trait needs to be developed using some strategy. Halpern suggests engaging curiosity, which means a strong impulse to communicate with the patient about his or her experience of the illness. As we have already seen, this story-telling process creates a relationship between patient and doctor that is more efficient:

> One approach to teaching empathy, inspired by Rita Charon and others teaching in medical schools, is to have medical students write, in addition to the typical medical history, a narrative of the illness from the patient`s perspective. Charon has also worked with physicians by having them write narratives of their most troubling encounters with patients. The physicians felt that such practices build empathy and an awareness of ethical complexity. (Halpern 130-131)

In the classroom, we have no direct contact with real-life patients, but we do have our prior interactions with the medical system to provide us with examples of empathy or lack thereof. Thus, the strategies that I use to try and develop empathy revolve around debate topics of social medicine, for instance. Homelessness, poverty and so on are not choices that people make, but they do bear a social stigma. Being part of the LGBT+ community, being an alcoholic or drug-addict also means that one is socially marginalized. Most medical students come from relatively affluent middle-class families, so they will naturally avoid these marginalized groups. But, as future medical professionals, they need to understand that medicine is or should be universal and marginalized individuals are often in need of medical care and do not always receive it because of their social status. No matter how much we try to sugarcoat things, there is a very strong bond between social marginalization and access to medical care. Social medicine confirms that specific groups suffer from or at higher risk of developing specific medical conditions. By discussing what those medical conditions might be, what are the circumstances in which they develop, what do the socially marginalized individuals feel when they interact with the medical system or when they are refused medical attention, students develop a non-judgmental attitude and become if not more empathetic, at least more aware of the social issues and their impact on the medical field.

One group of patients that is socially stigmatized is that of the mentally ill. Marginalization of the mentally ill is a process society has yet to deal with. Usually, I include a mini-lecture on the history of mental illness and the way it was interpreted throughout (mostly) Western history. In so doing, I try to help the students accept the fact that the social stigma of the mentally ill, even if it is a historical one, should be lifted. It is difficult to

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change a tradition that treated the socially marginalized as "untouchables", and the development of empathy is key to that change.

Other strategies that I use to help develop empathy in students include giving a personal example of being empathetic. We do not yet have hard evidence on the existence of a "mirror neural system" that might explain empathy, but we do know that positive environments will trigger positive emotions and positive attitudes. Apart from maintaining a positive classroom environment, I also offer personal stories and examples from my own private experience with the medical system in order to encourage the students to do the same and create a sort of "narrative interaction".

The group projects are a very good way to develop affective skills. Students need to work as a team, to cooperate, and to surpass the internal competition of medical school procedures. Cooperation and socialization for collaboration are skills that one learns and develops. The group projects allow them to understand what it is like to work with others and the social dynamics involved in group activities. During the debates, I encourage them to express their own feelings and thoughts, but I also use the "devil`s advocate" strategy to show them multiple points of view so they can relate to other persons` experiences.

As we have seen, my approach to teaching Medical English to 1st year students focuses on the contents, not just on linguistic learning and practice, but also on a wider skill-set that medical professionals need to have in order to properly interact with patients, colleagues and so on. Taking into account various theories such as "narrative medicine" and "social medicine", my approach strives towards an understanding of the medical field and of medical processes that is not limited to the traditional biomedical perspective. It integrates various other perspectives, both old and new, some of them even ancient, which are used in contemporary medical schools.

Finally, I would like to add one more idea that my approach has yet to turn into practice. According to recent research, engaging medical students in humanities-related topics is beneficial for the development of empathy and other affective skills like self-reflective awareness (Graham et al.). Practically speaking, exposing and training medical students in arts and literature enhances the likelihood of them being better medical professionals. Of course, the Medical English class, whatever freedom of content it may assume, still needs to train students in medical communication and there is usually no time for such "eccentricities". However, if the voices of those researchers that are both defending the humanities in the current academic landscape and trying to help educate better medical professionals (and maybe also lawyers, engineers etc.) will be heard, an integration of these educational practices in the curriculum will be most welcomed.

Some programs have even tried to develop professional skills in the field of Medicine using arts. In the United States, there have been recent developments in an academic field called "medical humanities", that is, art-based programs in the curricula of medical schools, organized around workshops. One example would be *Performing Medicine*, which aims to develop skills such as "physical awareness, stamina, calmness, balance, concentration, voice skills, interpretation of a story, readiness for action, listening, observation, timing, confidence and flexibility" (de la Croix et al. 2011). For instance, *Performing Medicine* takes role-playing one step further by actually teaching students to "act" as doctors, helping them "to cope with difficult patients, colleagues and examiners" (de la Croix et al. 1095). Students are taught techniques for overcoming anxiety and building up confidence. During the program, students have been encouraged to focus on others through art and stories, thus developing empathy. Also, they have been trained to understand the importance of all aspects of communication, like non-verbal communication, voice, identifying emotions and so on. One

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interesting conclusion of the program is that emotional burnout can be avoided by accepting the situation, and not by "turning off" empathy:

> The arts are sometimes associated with a susceptibility to melancholy in sensitive individuals. Such ideas perhaps support the notion that surviving in the medical jungle requires, to some extent, that sensitivities be blunted. However, various studies have suggested that burnout is avoided not by curtailing empathy, but by moderating feelings of distress through the acceptance of, rather than detachment from, the limited control a doctor has in many clinical situations. (de la Croix et al. 1099)

The content-based Medical English class can take into account these recent findings and practices and integrate some of them, turning them into prospective strategies for language teaching and experimenting new ways to immerse the students in the medical context (real or classroom-based).

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