THE JOURNAL OF TEACHING ENGLISH FOR SPECIFIC AND ACADEMIC PURPOSES
Vol. 12, Nº 2, 2024, pp. 379–390

UDC: 378.147-048.582 https://doi.org/10.22190/JTESAP240124031K
Review research paper

RESEARCH PROPOSAL: INVESTIGATING EFFECTIVENESS OF TRAINING VIDEOS ON MEDICAL PROFESSIONAL COMMUNICATION – RELYING ON SFL ANALYSIS AND POLITENESS THEORY

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Abstract. *The proposal aims to document whether training videos on medical professional communication may be effective in identifying and improving the communication skills of doctors and other healthcare practitioners with patients. The strategy may be of particular importance for LSP students, medicine students, or pharmacy students who are non-native English speakers. After following a typical educational video, and based on their knowledge of communication in healthcare, they will need to identify the key semiotic resources that develop assertiveness and empathy in communication. The investigation should rely on SFL, with an emphasis on speech act theory and politeness theory.*

Key words*: multimodality, training videos, assertiveness, empathy, healthcare.*

1. INTRODUCTION

Multiple studies have shown high effectiveness of educational videos in blended and traditional learning (Kay, 2012; Kohler and Dietrich, 2020). This paper aims to present a proposal for a research project on the impact of multimedia contents on understanding communication in healthcare. In addition, the proposal aims to foster students' capacity to identify the key skills of medical professionals relating to empathy and assertiveness.

According to traditional concepts of healthcare, developing communication skills within the English for Specific Purposes (ESP) is of utmost importance for the professional education of medicine or pharmacy students, given that it puts more emphasis on the key 'pylons' of effective communication in healthcare. In order to present the complexity of healthcare and communication as a vital concept, medical training videos as a multimodal concept will be considered the most suitable way for teaching the most sensible aspects of professional communication in healthcare. This complex pragmatic approach is based on the theory of cognitive load, and a few complementary argumentative presumptions *(*Mayer and Moreno, 2003: 43 - 52):

- The theory of cognitive load implies that working memory has two channels for acquiring and processing information: the visual/image channel and the auditory/verbal channel.

Submitted January 24th, 2024, accepted for publication May 30th, 2024
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- The application of both channels can facilitate the integration of new information into existing cognitive structures.
- Learning online may help students manage the learning process, recognise learning difficulties, and find ways to overcome them by researching mental models (Schacter and Szpunar, 2015: 60–71).

1.1. The multimodal resources complementary used in a medical discourse: SFL, register, the speech act theory and the politeness theory

'Systemic functional linguistics (SFL; Halliday & Matthiessen, 2014) is a meaning-based theory of language that sees language as the realization of meaning in context. A language is a resource for making meaning, and meaning resides in the systemic patterns of choice. According to SFL, the grammar of a language represents system networks, not an inventory of structures (Halliday & Matthiessen, 2014)'. In terms of the systemic patterns of choice, the notion of 'Register, or the realization of the context of situation, is represented by the choices of field, tenor, and mode (Eggins, 2004; Halliday & Matthiessen, 2014). The field concerns what the language is being used to talk about. The mode concerns 'the role language plays in the interaction', whether it is written or spoken. The tenor concerns the 'role relationships [play] between the interactants' (Eggins, 2004, p. 90). These three variables determine what Halliday calls the three metafunctions in language (Halliday & Matthiessen, 2014): the ideational, the interpersonal, and the textual metafunctions, and they complementary characterize the lexicogrammatical resources of every language (Halliday & Matthiessen, 2014)' (Oliveira, 2019:3).

According to the language philosopher J. L. Austin ([1962]1975: 5) 'Some utterances… are not a matter of 'just saying something' but of 'doing an action'. This essential observation gave rise to the speech act theory, a theory that underpins much of pragmatics.' (Culpeper, J. and Haugh, M. (2014). Thus, a considerable attention should be paid to the wording of speech acts, and the three important types of features: the selection of speech act components, the degree of directness / indirectness, and the type as well as the amount of upgraders and downgraders. In these terms, the communication patterns in a medial discourse should be grounded on a selection of its semantic components and their in-depth analysis (Spencer-Oatey, 2008: 21-31).

'Brown and Levinson (1987) suggest that there are five pragmatic super-strategies for doing politeness as a matter of the selection of which is determined by the degree of face threat. They are ordered from least to most face threat, and include examples of linguistic output strategies:

Bald on record: The speaker performs the FTA (Face Threatening Acts) efficiently in a direct, concise and perspicuous manner, or, in other words, in accordance with Grice's maxims (1975). Typically used in emergency situations, or when the face threat is very small, or when the speaker has great power over the hearer.

Positive politeness: The speaker performs the FTA in such a way that attention is paid to the hearer's positive face wants. Includes such strategies as *paying attention to the hearer* (*Hello*), *expressing interest, approval or sympathy* (*That was so awful, my heart bled for you*), *using in-group identity markers* (*Liz, darling ...*), *seeking agreement (Nice weather today*), *avoiding disagreement* (*Yes, it's kind of nice*), *assuming common ground* (*I know how you feel*) and so on.

Negative politeness: The speaker performs the FTA in such a way that attention is paid to the hearer's negative face wants. Includes such strategies as: mollifying the force of an utterance with questions and hedges (*Actually, I wondered if you could help?*), being pessimistic (*I don't suppose there would be any chance of a cup of tea?*), giving deference, that is, treating the addressee as a superior and thereby emphasising rights to immunity (*I've been a real fool, could you help me out?*), apologising (*I'm sorry, I don't want to trouble you but ...*), impersonalising the speaker and the hearer (*It would be appreciated, if this were done*) and so on.

Off-record: The speaker performs the FTA in such a way that he can avoid responsibility for performing it. The speaker's face-threatening intention can only be worked out by means of an inference triggered by the flouting of a maxim.

Don't do the FTA: The speaker simply refrains from performing the FTA because it is so serious (Culpeper, J. and Haugh, M, 2014: 210-211).'

2. RATIONALE

Considering the complexity of healthcare, a more detailed presentation of communication between healthcare professionals and patients is needed, bearing in mind that healthcare systems are generally predicted on 'a single disease model' with a lack of collaborative work between specialities, which requires interpersonal collaborative work between healthcare practitioners and improving their communication with patients (Snaith et al., 2021: 1077-1092).

One method of understanding the core issues about patients is to use realistic rather than real consultations through the use of healthcare simulation, a common training process applied in medical training and underpinned by a number of educational theories (Ker and Bradley, 2010). The point of these simulations is to detect a wide variety of multimodal semiotic resources from verbal to non-verbal (the use of colours, images, signs, or symbols) with the aim of reviewing key communication problems with patients (The Open University, 2022, Unit 22.1, 2022).

The practical aspects of its application in a given context certainly enter the domain of applied linguistics and teaching language for specific purposes (LSP), which means not only learning technical terms but typical language registers implying the key semiotic resources used so that assertiveness and empathy, as the most significant drivers of communication, come to the fore (Cook, 2003).

The proposal for a research project investigating the effectiveness of training videos on medical professional communication with medical students whose first language is not English aims to draw attention to language registers and behaviours that may help healthcare practitioners (Culpeper and Haugh, 2014):

- To better know how to show through communication that their patient is accepted and empathised with in every situation when moral support is needed;
- To be aware that video materials based on applying different semiotic resources in communication have a special purpose in teaching medical students to give rise to empathised communication and to communicate assertively; and
- To understand that using multimodal semiotic resources is extremely important for non-native English speakers since they contain the lexical elements of interest for a non-native speaker.

3. DISCOURSE CONTENT

The medical relational discourse is a typical dialogue between a doctor and a patient. It is thematically divided into several thematic sections, which means that it should be analysed taking into account its thematic variety as well as its specific context and organisational structure. The discourse is carried out in mainly informal and plain language. Prevailing verbal communication and paralanguage are used to emphasise the mutual responsiveness and the doctor's politeness. The doctor mainly asks open-ended questions by using modal verbs that show his readiness to respond to the patient's needs. In view of gathering more information, he gradually paraphrases the request several times (Section 3) by addressing in a mainly informal style to get specific answers, and to make the patient more confident and the situation more familiar. In these terms, he even uses colloquial expression *'get up and go'* suggesting a more positive and energetic lifestyle to the patient.

As for the use of technical vocabulary, it contains only a few technical terms of general use, which actually represents the doctor's balanced approach in the co-use of professional terms and colloquial expressions, and which is often not the case in communication between doctors and patients, although it should be. Thus, the video is a good example of how to build communication according to the goals of assertive communication that builds a foundation on empathy.

The relational medical discourse between a doctor and a patient should be analysed by classifying it into a few thematic sections:

1. Initiating the session (lines: 1 to 8)

The doctor (D) outlines: his agenda consisting of a few informal general questions relating to the patient's feelings, symptoms and expectations, and endeavours to obtain the patient's consent for the interview. Accordingly, the doctor checks the patient's name using a formal confirmation question, briefly introduces himself and addresses an open-ended question relating to the consultation (lines: 1, 3, 5, 7). His strategic approach is aimed towards obtaining more information, but primarily to alleviate the patient's fear and hesitation. Due to his empathetic role, the doctor uses the bold-on-record strategy (lines: 1, 3) and positive politeness (lines: 5, 7). He also uses modal verbs '*can'* and *'would*', and more informal way of communication (informal exclamations such as '*okay'*). The patient in turn kindly apologises in long and often elliptic declarative sentences for wasting his time, and expresses the main reasons for her coming that are related to her insomnia (lines: 2, 4, 6, 8). She (P) constantly displays anxiety and distress.

2. Gathering information about the symptoms (lines: 9 to 29)

The doctor paraphrases his intention by posing another open-ended question to reveal the main reasons of the patient's visit (line: 9). The patient briefly outlines: the reasons for her insomnia by expressing deep disappointment about her husband who left the family, and consequently refers to her state of being unable to cope with the situation. She uses pauses and elliptic sentences that show her distress and hesitation (lines: 10 and 12). The doctor in turn expresses sympathy, and uses structuring again to pose new open-ended, probing questions (lines: 11, 13). He (D) pauses with exclamations (lines: 13, 15) trying to gain an insight into the patient's problems with sleeping, appetite, while the patient gives a brief narrative background of her bad habits. Her (P) thoughts are often

disjointed, so she often uses exclamations and short, declarative elliptical sentences that become understandable mainly from a wider context (lines: 12, 14, 20, 22).

In addition, the doctor addresses a few more questions about her life in general. He (D) does not stop communicating in an informal style, keeps using exclamations and even the colloquialism *'get-up-and-go'* to maintain and develop an empathetic relationship with the patient (lines: 13, 15, 17, 19, 21). The doctor poses open-ended questions relating to the patient's bad feelings by using reflection, which lead the patient to refer back to her main problem with sleeping (line: 23). She tries to relate to the problem by referring to a wide range of situations and reasons that pose a threat (lines: 24, 25). The doctor (D) in this vivid interaction constantly uses the bold-on-record strategy.

3. Social background (lines: 30 to 53):

The doctor asks many informal open-ended (lines: 30, 32, 34, 37) and yes-no questions (lines: 45, 47) about the patient's home life and work in order to reveal the circumstances within which the sleeping problems occur. He (D) also uses an empathetic declarative sentence (line: 37) and a few open-ended questions about the patient's home life to get closer to the patient's mind and feelings (lines: 37, 39, 41, 43, 45, 47, 50), while in line 52 the doctor even uses paralanguage. Their conversation is an example of 'chit-chat' that reflects the bold-on-record rapport by the doctor and a very intimate and sincere response of the patient.

4. Exploring the patient's personal expectations from the treatment and the causes of the patient's distress (lines: 54 to 59)

The doctor uses open-ended questions with negative politeness to initiate the discussion about the patient's expectations (line: 54). In order to be insightful, he (D) uses bold-on-record open-ended questions and statements. The doctor explores the patient's expectations by using multiple questions (line: 56) to help the patient make the best choice. The patient in turn responds in long, declarative statements that show willingness to overcome the crisis.

5. Negotiating treatment, explanation, and planning (lines: 60 to 74)

The doctor uses comparative questions to suggest all the options of treatment in order to avoid addiction to sleeping tablets, and negotiates with the patient about the best opportunities to get her back to normal life (lines: 60, 62, 64, 66, 68). He uses the modal verbs *'would', 'can'* and *'might'* to soften the suggestions.

The patient (P) agrees to see a counsellor, but points out that sleeping tablets are an inevitable option in the situations when urgent help is needed (line: 69). They come to an agreement on using sleeping tablets, but they also highlight the other available treatments if needed (lines: 70, 72). Consequently, the doctor asks the patient to fill in a questionnaire in order to understand better the feelings that impact her insomnia (lines: 72). The doctor, in this section, communicates less informally by using modal verbs and indications conveyed via positive politeness. He uses the technical term 'HADS questionnaire', but gives a very clear explanation (lines: 72, 74).

6. Summary and closure (lines: 75 to 95)

The doctor summarises the main information about the patient by highlighting the importance of working on her self-esteem and mental health (lines: 75 to 80). He informs the patient as to what will happen next regarding her therapy and reassures her that they will manage her problems together (line: 81). Although the doctor communicates less

informally in long affirmative sentences, he uses bold-on-record strategies and signposting language to highlight his empathetic approach.

4. A MULTIMODAL MEDICAL DISCOURSE ANALYSIS: AN EMIC AND ETIC PERSPECTIVE

The research will be considered from the angle of the LSP teacher and will imply the Systemic Functional Linguistics Analysis (SFL), taking into account the three variables as semiotic functions (Halliday and Hasan, 1991):

- The field or the ideational aspects in terms of defining the specific rapport between the medical practitioner and the patient;
- The tenor or the interpersonal aspects relating to the specific language and paralanguage that create this rapport;
- The mode or the intertextual aspects that make the text functional or the means through which the communication takes place.

These aspects become more complex when analysing communication in terms of the multimodality approach that makes communication realistic in educational videos. The excerpt used as a model is from video material that describes the key situations common in a medical check-up between a doctor and a patient. The investigation based on SFL will include both etic and emic perspectives.

4.1. The investigation: an etic perspective

From an etic perspective, the approach will imply:

a) asking the students (using a questionnaire) if they understand the lexis, the speed of delivery, the use of visual segments, and the paralanguage used in the videos; b) an analysis of the videos through discussion about verbal and non-verbal semiotic resources used to foster assertiveness through the rapport of self-esteem and politeness expressed by the health practitioner **(**The Open University, 2022, Unit 13.7, 2022**).**

Before applying this multimodal approach, the ESP students will be introduced to the most typical models of communication in healthcare. The contents are carefully systematised to foster doctors' assertiveness and empathy in communication with patients in the handbook Weatherall et al. (Eds.) (1996) *'English in Medicine',* 3rd edition, Oxford University Press. In these terms, two principal aims should be followed: 1. the patients' wellbeing; and 2. less painful psychophysical enduring of physical or mental pain (Canagarajah, 2022).

Based on their previous insight into the language patterns, students at the beginning of the course will distinguish five groups of speech-act frameworks (The Open University, 2022, Unit 11.1, 2022), and two types of questions. The lexical patterns created to highlight the specific language patterns are commonly used in medical check-ups between doctors and patients. This introductory semiotic resource implies some verbal and mental processes intended to be taken into consideration by students in their further conversation analysis. Two types of questions are also intended to be considered: 1) introductory *open-ended questions*, which aim to prepare the patients (by the doctor) for a delicate conversation about their health condition, and to attenuate their health problem; 2) *yes/no questions*, which aim to elicit positive or negative reply from the patients or to minimise the health problem. Thereby, the students are slowly introduced to the theory of politeness, which is at the forefront in medical care as refers to 'rapport management' (Spencer-Oatey, 2008). According to Helen Spencer-Oatey (2008), who proposes a model for the management of interpersonal relations, which she

calls 'rapport management' (Spencer-Oatey, 2008), it attempts to accommodate cultural and other variations bearing in mind the following norms: contextual assessment norms, sociopragmatic principles, pragmalinguistic conventions, fundamental cultural values, rapport management strategies. It is undeniable that these norms can be set as good 'pylons' within communication in healthcare, specifically for those who communicate and whose mother tongue is different.

Table 1 The language Foci characterising specific language patterns (Weatherall et al., 1996)

The Type of Language Foci	**Characteristic Assertive Patterns and Rephrasing Techniques**
Language Focus 1: Introductory Questions: 1. What **can I do for you?** 2. What **seems** to be the problem? 3. How long have they been **bothering** you?	Introductory assertive approach that includes modal verbs and assertive phrases used to attenuate the health problem and unobserved firm characteristics. The delicacy of the approach is also achieved by including mental (the verb: '*seem')* and verbal processes (the verb *'do'*) that create nuances in context (the verb *'bother')*.
Language Focus 2: Notice how the doctor asks where the problem is / what the type of pain is: 1. Is your head **affected?** Which part of your head is **affected?** 2. Where does it **hurt**? / Does it **hurt**? Is it **sore**?	The selective use of verbal and mental processes that attenuate an unobserved health problem: *affect (mental), hurt (verbal), sore (mental)*.
Language Focus 3: Notice how the doctor introduces a painful procedure to the patient, clarifies the health problem and tries to alleviate the patient's fear. ▪ I would like to find out ***what's giving you these headaches.*** ▪ **I'm *going to*** take a sample. ▪ *It* ***shouldn't be painful***, ***but*** **you will be aware of a feeling.** ▪ Now I'm going to give you a local anaesthetic so ***it won't be sore.***	A rephrasing technique used to encourage the patient (using the modal verb '*should'*), and to endure a painful procedure (using the conjunctions '*but', 'so'*; and the phrases: *'It shouldn't be painful', 'it won't be sore', 'it will take only a few seconds', 'what's giving you these headaches'*).
Language Focus 4: Notice how the doctor often combines reassurance with warning in order to make the patient feel more comfortable. This may feel a little bit ***uncomfortable, but it won't take long***.	A rephrasing technique used to encourage the patient and give him time to endure a painful procedure (using adjectives as modifiers and suitable phrases anticipated with conjunctions to attenuate the feeling of pain: *'a little bit* uncomfortable'; '*but* it won't take long').
Language Focus 5: Notice how the doctor asks if anything relieves the pain: Is there **anything** that **makes the pain better**?	A rephrasing technique used to inspect the patient, and to lead the patient to a more comfortable feeling (using nouns and phrases that create nuances in empathetic context).

4.2. The investigation: an emic perspective

An emic perspective will be taken into account, relying on the SFL ideational, interpersonal, and inter-textual meta-functions of language (Halliday and Hasan, 1991). A conversation analysis of a typical medical check-up will be made by the first-year medical students together with their LSP teacher. The students will observe a consultation between the doctor and the patient during which they will have to take an in-depth insight into the doctor's semiotic resources.

After observing the interplay between the doctor and the patient, the students will fill in a questionnaire referring to the following aspects:

1) Their ability to understand the lexis (e.g. for non-native students it might be more difficult to understand the patient's lexis that can be characterised as verbiage, vague language or colloquial language);

2) The speed of speech delivery;

3) The use of lexical and non-lexical patterns in a given context in view of applying assertiveness and empathy in communication with patients. Some of the most relevant questions in these terms are (Frank, 2013):

1. Do you understand all the lexical patterns used by the doctor and the patient?
   a) Yes; b) partially; understood c) no;

If your answer is *no* or *partially understood*, specify the sequences that you did not understand: _____.

2. What gestures did you notice that inferred empathy?
3. How do people greet each other? Do they hug? Do they shake hands?
4. How would you describe their relationship?
5. What polite things did you notice?
6. What is the polite thing to do in certain situations in your culture?

If you notice differences, please specify them: _____.

7. Do you understand the term 'empathic listening'?

If the answer is *yes*, please define it very briefly in your own terms: _____.

4.3. A medical discourse analysis: an emic perspective

Students should analyse a medical check-up in joint sessions together with their ESP teacher and, presumably, a clinical physicist who might be a part of a medical healthcare team. The aim of this angle of research will be to re-evaluate the medical relational discourse from an emic perspective, aiming to identify the new, complementary semiotic resources (with the results from an etic perspective) and their practical impact in a particular context.

According to the thematic sections enclosed in the video, the ESP teacher will highlight the most important semiotic resources used by the doctor to demonstrate the attitude of assertiveness and empathy expected in communication with patients.

In terms of defining the cross-cultural differences, the ideatic perspective of the medical relational discourse should take into account possible varieties in verbal and non-verbal communication between British people and non-native speakers in a medical context, bearing in mind their specifics (The Open University, 2022, Unit 15.7, 2022).

E.g., the approach to a patient suffering from a psychosomatic illness indisputably implies a certain cultural awareness that needs more pragmatically structured communication that will take into account the patients' cultural background. (Butler et al., 2004)

In order to find the most adequate approach, the students, together with the teacher and the clinical psychologist, should conduct many informative interviews with patients and doctors from their country on the strategies they would apply in accidental situations in their verbal and non-verbal communication. In parallel, it would be good to record conversations that are more authentic in order to compare the characteristics in verbal and non-verbal communicative approaches, referred to as semiotic resources. Accordingly, a field investigation, i.e. a field diary should be made in order to collect a variety of information from the researchers' perspective. This means the use of recorded sequences of mainly informal conversations that will provide a real insight into lexical patterns of the participants that might belong to different cultures and physical settings, which consequently imply a wide variety of linguistic or paralinguistic responses. It should further include 'evaluating the researcher's impressions after visits, including reflections on the research process, self-evaluation of how the interview had been conducted bearing in mind the rapport between the doctor and the patient' (The Open University, 2022, Unit 13.3, 2022).

For a field investigation, it is essential for students to understand that such observation should be *systematic* and based on the guidelines: set before starting the observation in the field. Useful questions that investigators (students with ESP teachers) should ask will include aspects that should be carefully structured together with their ESP teacher and a clinical physicist (The Open University, 2022, Unit 12.2, Scenario 3, 2022):

General questions:

- *Who or what is involved, and in what language(s)?*
  This implies the cross-cultural perspective relating to the language of communication.
- *How do the interlocutors make their case?*
  This implies the use of formal or informal ways of communication, including paralanguage.
- *What do interlocutors assume or know about procedures vs. treatments in general terms, and how does the presentation of their case and possible treatments link with this?*
  This implies the use of appropriate verbal, mental, and cognitive processes in communication.
- *What does the administrator or official assume or know about the applicant?*
  This implies that different cultures and nations may 'affect' politeness and mutual understanding, and these aspects should be seen in the context of their culture and the given problem.
- *What do the applicant and the administrator assume/know about the language of communication in general?*
  This implies that 'the adjacent correlation between language and culture affects appropriate messages' delivery to the target speaker.' (Frank, 2013: 7).

Questions that imply the complementary aspects of communication used in a specific context:

- *What are the specific features of relational discourses that reveal the quality of rapport, especially in patients with vulnerable diseases (such as verbal and non-verbal feedbacks of doctors to patients' complaints)?*
- *The adjacency pairs should be identified as a part of the turn-taking system, aiming to highlight the rapport between two interlocutors of different or the same nationality* (Corbett, 2011).

According to the guidelines, the students should pay attention to the following aspects:

1. Thematic segments should be analysed separately in order to get an insight into different aspects of approaching the patient's disorder.
2. Rapport management should be considered through analysing the adjacency pairs (Ibrahim, 2017). The doctor's and the patient's sequences should be analysed separately and as a whole in each thematic unit to gain a realistic picture of verbal and non-verbal semiotic resources used in the dialogue. Specifically, it should be pointed out the genre in which empathetic rapport and assertiveness are developed.
   - E.g. In the section *Initialising the Session* (lines: 03, 05, 07, 09, 011, 013, 015, 017, 019, 021, 023, 025, 027), and in all other sections, the doctor (D) mainly communicates in an informal way to get closer to the patient. In view of this concept, the doctor (D) paraphrases the same request by using the bold-on-record strategy through declarative and imperative sentences and questions. Instead of using more modal verbs that are common to kind addressing, he often uses signposting language in order to improve communication with the patient (in the first section, in lines: 5 and 7: the conjunctions *'and'*, as well as the prolonged exclamations *'um'* and *'okay*'; and in line 9: the conjunction *'so'*). The doctor also uses the exclamation *'um'* and paralanguage (such as eye contact or giving handkerchiefs) to non-verbally infer understanding (lines: 4, 6, 10, 11). Specifically, the doctor uses a colloquialism (line: 17) to cultivate empathy. These aspects are good examples in terms of identifying the equivalent semiotic resources in students' native languages, and should be highlighted and discussed (Tannen, 1984).
3. Tannen (1984) highlights the following communicative 'levels':
   - 'When to talk (e.g., what counts as silence?);
   - What to say (e.g., how should one respond to a compliment?);
   - Pacing and pausing (e.g., what kind of pause constitutes a transition-relevance point?);
   - Listenership (e.g., should one maintain eye contact to demonstrate attention?);
   - Intonation (e.g., what kind of intonation signals a question versus a statement?);
   - Formulaic phrases (e.g., what are set conventional phrases?);
   - Indirectness (e.g., how does one communicate a negative response such as a refusal?);
4. Cohesion and coherence (e.g., how does one make clear what the main point of an argument is?)' (Tannen, 1984, cited in The Open University, 2022, Unit 15.5, 2022).

5. CONCLUSION

As Blum-Kulka (Blum-Kulka,1989a: 24) claimed, we need to test 'the possibility that notions of politeness are culturally relativised, namely, that similar choices of directness levels, for example, carry culturally differentiated meanings for members of different cultures'. This matter should be a common issue of the students' analyses, which is even more reason for multimodality in learning to be a priority.

There are also other key situations where proper approach to the patient comes to the fore, such as the strategy of communicating information about a serious or incurable disease or communication between different healthcare professionals (Snaith, 2021). Given

that these topics are very complex, this proposal will not specifically address it, and the omission of this segment should not be considered a failure. Although, one should also be aware that the 'play on words' used in other contexts can be a good model for thinking in the mentioned sense as well.

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