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EALTHY magazine

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Giant Xmas Bauble, Nice - R. Wright (2011)

From All the Team @ EALTHY

'Happy Holidays!'

Top Stories

SEASON'S GREETINGS

EALTHY
European Association of Language Teachers for Healthcare

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EALTHY is the *European Association of Language Teachers for Healthcare*, a members association for teachers of English for medicine & healthcare and for other professionals with an interest in the provision of language training for the healthcare sector. We have a global membership.

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Editorial

Following the *3rd English for Healthcare Conference* this October and the realisation that sadly some members may not have been able to join us, this last issue for 2017 is dedicated to bringing you some of the flavour of the event.

We start with a letter of thanks from Leigh Daynes, Executive Director of Doctors of the World. Leigh thanks conference delegates for their contribution to the NGO which seeks to provide equitable healthcare for those with refugee status, amongst others.

Plenary speaker, Professor Jennifer Jenkins responds to questions regarding the evolution of ELF (English as a *lingua franca*). Jennifer talks us through 'similects' and 'translanguaging', and explains her thoughts on the relevance of ELF to healthcare communications training.

Proving a popular topic this year was medical interpretation. Maureen Ehrensberger-Dow and Gary Massey discuss the complexity of medical interpreting, while Claudio Bendazzoli gives us an insight into the life of the interpreter. You'll be amazed to learn the speed at which they are expected to work!

Winner of the *European Language Label 2017*, the *HELP Project* was the subject of a talk by Lukas Merz. The project offers a wealth of free materials dealing not only with clinical matters, but also ethical and cultural issues.

The 'Hot Tips' session was a run-away success. With only 3 minutes to present his most tried and tested activity, Stevan Mijomanović shared ideas using medical comics and demonstrated just how much fun EMP can be.

I've chosen to conclude with some of your conference feedback. We were delighted to hear delegates' appreciation of the conference (*of course!*), but equally interested to read their constructive thoughts for future events.

As this is the last issue of the year, I'd like to thank all those who have contributed to the *EALTHY Magazine* in 2017 and look forward to receiving lots *lots* more of the same in 2018.

Ros Wright
Editor

A Word from the President

I'm feeling a little spoilt: two excellent *EALTHY Magazines* in the space of 8 weeks? Ros and our contributors have done it again: they've come up with a varied, thought-provoking and informative read, and all of it related to English for medical purposes.

The whole point about being a niche association is that we focus on a specialist area not fully addressed by mainstream associations and organisations. I would go so far as to say that, with the teaching and learning of medical and healthcare English, our needs are not addressed at all elsewhere. But niche does not have to mean restricted or narrow and this month's issue proves the point.

The variety of articles is evidence not only of our members' interests and professions but of the richness of the field itself: medical interpreting; the training of healthcare professionals as mediators; simulation in a professional English course for nurses; the use of animated video in the classroom - and of medical comics; online medical English training and, in an interview with Jennifer Jenkins, a consideration of *lingua franca* English and its role in medical and healthcare communication.

I'm very happy with the balance between the practical and the more theoretical in the magazine, as we saw at this year's 3rd *English for Healthcare Conference* in Bern, for this reflects what Ros and I consider EALTHY to be about. We're about teaching *and* learning, research *and* practice. There will always be a handful of members who would prefer only one or the other, but the majority of you seem to agree with the balance. And thus we will continue to develop our association and the conference in this manner - and we certainly have some very interesting developments in the offing!

2018 looks set to be a busy year for us, full of beginnings, and it will start with an announcement of the location of the 2019 conference (clue: you may want to pack your swimming costume) along with some other very exciting developments. We will also be announcing the venues for some EALTHY workshops.

Some of you may not have noticed that there is now a Forum on the EALTHY website: please use it, ask questions, respond and share your experiences and ideas. Feel free to post on the EALTHY Facebook page and get in touch if you're interested in hosting an EALTHY workshop or writing a piece for the magazine. Why not make one of those a New Year's resolution?

Thanks to some creative thinking, a little determination and the precious help offered by a few of you, I'm happy to say that EALTHY can continue to grow and become, we hope, a global point of reference for those working with foreign or second languages for healthcare and medicine.

Wishing you all a peaceful Christmas and New Year,

Catherine Richards
President

Welcome to Stevan Mijomanović

… Who joins the EALTHY team and is in charge of **Public relations**

Stevan is a teaching assistant of Medical English at the Faculty of Medicine, University of Belgrade, Serbia. His work is at an intersection of language, healthcare, and education. Stevan teaches medical and nursing students. He has published several papers and works as an editor, translator, and proof-reader of academic texts. He is currently a doctoral student with a focus on medical terminology, terminology planning, and plain language. His main interests are terminology, language of medicine, applied linguistics, and cognitive linguistics.

DOCTORS OF THE WORLD منظمة أطباء العالم LÄKARE I VÄRLDEN MEDICI DEL MONDO Γιατροί του Κόσμου DOKTERS VAN DE WEREL
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Ms Catherine Richards
EALTHY Magazine
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14th November 2017

Dear Catherine and everyone at EALTHY Magazine,

Thank you for your very generous donation of £ 300 in support of Doctors of the World's programmes around the globe. Your gift will go towards our work to ensure equitable healthcare for everyone, no matter where or who they are.

Your kindness will allow our medical staff to provide a glimmer of hope to some of the most vulnerable refugees. The horror of the current situation on Greek islands such as Chios cannot be over-stated. A recent report found that one in three refugees there had witnessed a suicide. Without the work of our team, the number could be even higher.

"We see a lot of people with mental health problems like depression, and it gets worse the longer they are in the camps. People get frustrated because they don't know what's happening with their lives," says Kharman Adhim, a volunteer translator for Doctors of the World who works primarily with refugee women.
"The majority of people we see need counselling – and not just the women, but their children too."
It all sounds bleak and often, it is. However, Kharman goes on to say, "In some ways you feel powerless to help, but at least by listening to them they know you care and are there."

I am proud that so many kind people like you want to help. Together we can bring hope, compassion and care at the most difficult of times.

Thank you again for caring and offering your support. It is hugely appreciated by everyone at Doctors of the World. Please pass on our heart-felt thanks to all your readers and participants to the English for Healthcare Conference, who contributed to your initiative and are helping our staff to reach out to the most vulnerable.

With very best wishes,

Leigh Daynes
Executive Director, Doctors of the World UK

5Qs for Jennifer Jenkins

For those that missed it, in this exclusive interview ***Professor Jennifer Jenkins*** *highlights some of the points made during her plenary session at the 3rd English for Healthcare Conference.*

The first empirical research into ELF communication was your own research into ELF pronunciation in the 1980s. Can you tell us some more about this?

It all started when I was an EFL teacher in London in the mid-1980s, and noticed that my students, who came from a range of different L1 backgrounds, generally learned what I taught them and reproduced it in tests, but didn't use much of it outside the classroom, *e.g.* they often didn't put an -s on the third person singular present tense, or talked about 'advices', 'informations', and the like. Despite this (or, as I later realised, more likely because of it), they usually understood each other easily, and if any communication breakdown occurred, resolved it quickly, by a process I learned later was called 'accommodation'. The other thing I noticed was that the majority of any communication problems were caused by pronunciation.

I was fascinated by this and registered for a PhD at London University to research it. And to cut a long story short, in my research I found that accommodation was a key factor, probably *the* key factor, in ensuring successful communication in what I later named 'English as a *lingua franca*' (ELF) settings. That is, it played an essential role in ensuring interlocutors were able to repair any breakdowns by both being aware of what they'd said that was problematic and being able to adjust it. In addition, the phenomenon I've more recently called *pre-emptive accommodation* was critical: *i.e.* by engaging in pre-emptive accommodation, interlocutors were able to predict which items might cause a problem in any specific interaction and avoid using them. This particularly involved certain L1-influenced pronunciation features as well as native English idiomatic language. Overall, the research demonstrated that native English was by no means the most intelligible in ELF communication, and that accommodation skills, regardless of whether the result was an 'error' according to native English, were far more useful than the ability to mimic native English speakers.

How has ELF evolved conceptually? How do you see ELF evolving in the future?

In those earliest years of ELF research, when the only previous research in EFL/ELT was SLA research whose aim was to find out how learners could achieve native-like English, there were no precedents for the kind of research that my early ELF peers and I were doing. The nearest example was that of World Englishes (WE), which shared the same ideology as that of ELF, essentially that English was not learned primarily to communicate with its native speakers, and that the latter were not entitled to determine global English norms. The aim of WE scholars was to describe, analyse, and legitimise varieties of English used in the postcolonial countries. And for several years, ELF researchers followed their lead.

However, as increasing amounts of ELF data became available through ELF corpora, it became clear that ELF was far too fluid and variable to be considered a variety or varieties, because unlike WE, whose Englishes are situated *within* national linguacultural boundaries, ELF by definition *transcends* these boundaries. So in the second phase of ELF research, attention switched to exploring the processes underlying ELF's variability. During this time, Mauranen (2012) proposed the concept of 'similects' and 'second order contact', according to which all non-native English users have a 'similect', *i.e.* LI influences on their English. But as they don't normally communicate in English with their L1 peer group, the future development of their English depends on influences from their interlocutors in ELF communication, *i.e.* 'second order contact'. By contrast with old-fashioned interlanguage theory, which still prevails among many SLA scholars, and according to which any deviation from native English is a 'problem' to be addressed, similects and second order contact are normal, natural, and unproblematic insofar as ELF users are also able to employ accommodation skills, which the majority (unlike many monolingual, and even some bilingual, native English speakers) are amply able to do.

The most recent conceptual development in ELF's evolution has been the understanding of its essential multilingualism. Although ELF has always been considered a multilingual phenomenon – after all, it could not exist in the first place if it weren't – the focus until recently was firstly on the 'Englishness' of ELF and only secondly on its multilingualism and the role of the other languages of its multilingual majority.

… / …

Jennifer Jenkins, contin.

A key phenomenon in this regard is that of *translanguaging*. This refers to the way in which multilinguals, including ELF users, make use of their full linguistic repertoire as a single resource from which they select as appropriate in the context of any one interaction. It sees languages as having fuzzy boundaries between them, and leads to the use of hybrid forms. As regards ELF, translanguaging means there may be situations where English is known to everyone but they prefer to use another language they share. So whereas ELF was previously defined in terms of its 'Englishness', *e.g. 'any use of English among speakers of different first languages for whom English is the communicative medium of choice, and often the only option'* (Seidlhofer 2011), it's been (re) defined in relation to its 'multilingualness', as *'multilingual communication in which English is available as a contact language of choice, but is not necessarily chosen'* (Jenkins 2015). As for the future of ELF, my guess is that it will move ever further away from native English use, particularly post-Brexit.

Where does English for medicine and healthcare fit into ELF?

I suggest turning the question round and asking how ELF fits into English for medicine/healthcare! In this respect, the two aspects of ELF that I've highlighted in my previous answers, i.e. accommodation and translanguaging, are paramount. 21st century healthcare professionals are likely to be both working with and treating people from large numbers of countries and languages other than their own, often in transient encounters. In such situations, the most likely *lingua franca* will be English. However, it's unlikely to be native English but English influenced by a wide range of L1 backgrounds (or 'similects'). In situations such as medical encounters, where mis/non-understanding can have very grave consequences, it's essential for interlocutors to understand each other easily. And this involves both receptive and productive accommodation skills – being able to understand English uses different from our own, avoiding features of our own English that might cause communication problems (pre-emptive accommodation), and the ability to adjust very quickly if any such feature 'slips out'. As for translanguaging, although it would be ludicrous to suggest medical practitioners should be able to speak all the languages they come into contact with, it will help if they're able to move in and out of English and other languages when they and their patients/colleagues share any language(s) that they're more comfortable with than English, both for intelligibility and for building rapport. And in the case of both accommodation and translanguaging skills, ELF research suggests that multilingual healthcare professionals are likely to be more effective communicators than monolinguals in ELF communication contexts.

Can research into ELF inform classroom practice for those of us involved in English for medicine and healthcare? If so, in what way?

My answer to question 3 has already answered this question to quite an extent. In other words, I see the most useful ELF-related classroom practice as developing healthcare professionals' productive and receptive ELF accommodation skills in the various ways I've already discussed. As well as this, although the English for medicine/healthcare classroom is obviously not the place to teach languages other than English, health professionals can be made aware of the value of having, and translanguaging among, other languages in medical encounters, and encouraged to develop their own multilingual repertoires.

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Interviewed by ***Catherine Richards***
President

Simulation: Patient cases for emergency care students

Between role-play and simulation, many trainers prefer the comfort of the former. ***Katja Hämäläinen*** *discusses an approach used in her university which I think will convince you otherwise.*

Language teachers have always aimed to use authentic written material to provide students with opportunities to see how languages are used in real-life situations. Simulation takes this one step further: instead of written material, students have the chance to practice their language and communication skills in a situation they are likely to face later in real life. In this article, I shall briefly explain a language learning session where emergency care students at a Finnish university of applied sciences in Helsinki practiced their English (L2) and communication skills as well as their emergency care skills.

The group consisted of 20 second-year emergency care students at B1-B2 level who had studied an obligatory course in *Professional English for Emergency Care Nurses*. The course was taught and led by an English teacher, with a teacher in emergency care present during the simulation class, one of the teaching techniques used during the course. The simulation class took place in the middle of the course, so that the students would have time to study professional and field-related terminology and communication skills and the teacher had more time to get acquainted with the strengths and weaknesses of each student.

The simulation environment consisted of a normal home, complete with furniture. The English language teacher played the role of the patient, while the

emergency care teacher took care of the technology and provided information on the patient's vitals, sometimes via loud speaker. Working in pairs, the students played the roles of emergency care nurses going for a home visit. They received some pre-information about the patient as well as the emergency dispatch code. During the simulation, the patient (*i.e.* the English language teacher) was only allowed to communicate in English in order to provide information about the health problems and symptoms of the patient, past medication as well as other important indicators necessary for the correct treatment and diagnosis. The students had to use English with the patient, but were allowed to discuss with each other in their first language (L1) if necessary. In addition to the patient interview and giving possible medical explanations, the students had to fill in a pre-admission form which is part of the usual patient documentation. This simulated a real-life situation where the patient does not understand or communicate in the first language of the emergency care team. To solve the patient cases, the students needed not only language and communication skills but also information on the current national health care system and emergency care regulations *e.g.* knowing in which situations they could transfer patients to hospital.

Each patient case took 10-15 minutes to perform and was followed by a debriefing session. During the debriefing, students were asked to analyze their own performance and were also evaluated by both the teachers and by the rest of the group. The English language teacher focused on language and communication skills while the specialist teacher gave feedback on the emergency care and first aid skills of the students.

According to the feedback given at the end of the *Professional English for Emergency Care Nurses* course, the students were satisfied with the simulation classes.

… / …

Simulation for emergency care students, contin.

They appreciated having had a chance *'to practice real life things'*, stating *'we should have more* [of] *this kind of exercises'*, that it was *'the best thing about the course'* and that they got *'a feeling of authentic patients'*. As for the teachers, they also enjoyed the simulation classes. It was interesting and rewarding to co-operate with a colleague whose field of expertise was less well known to them; the teachers had to think outside of the box, and the process had given them new insights into their own subject. For the language teacher, it was rewarding to see how well the emergency care students had survived in a situation where a foreign language and communication skills were needed.

In many cases, students compensated for their lack of accurate grammar skills or knowledge of professional vocabulary with good non-verbal communication skills; they performed excellently in simulation classes, showing good first aid skills. Moreover, the specialist teacher stated he had never truly understood the importance of language and communication skills until he'd actually seen the students working on the cases. Using language and communication skills makes a real difference! Simulation was a new technique, even though the focus was still on language and communication skills given everything was carried out in the L2, including the debriefing session.

Working on real-life patient cases in a foreign language is not easy and can provoke various feelings in the students. It was therefore very important to emphasize that all the discussions needed stay within the simulation classroom and not leak out onto social media, for example. Furthermore, it had taken time to create and adapt suitable patient cases for language learning purposes to ensure they were realistic and met the university requirements for emergency care studies.

This article is based on my presentation at the 3rd *English for Healthcare Conference* 2017 in Bern, Switzerland. For more information, please contact the author at katja.k.hamalainen@metropolia.fi

Katja Hämäläinen

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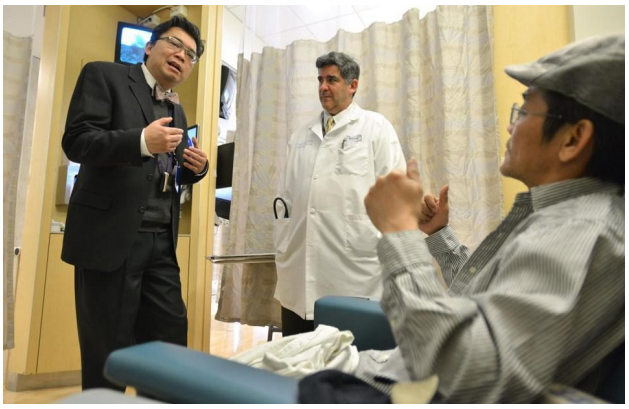
Healthcare Professionals as Language Mediators

Maureen Ehrensberger-Dow *and* ***Gary Massey*** *speak of the need for extreme care to be taken in the training of medical interpreters .*

In our ever more multi-ethnic, multilingual society, translation and mediation have become increasingly important – often via the *lingua franca* of English. But are healthcare professionals equipped to deal with the challenges, responsibilities and risks that go with their mediatory role?

The 3rd International Conference in Non-Professional Interpreting and Translation in 2016 highlighted the need to professionalise and certify interpreters and translators working in healthcare settings. Research presented there and elsewhere (cf. Antonini *et al*., 2017) reveals a widespread lack of awareness of the competences, roles and responsibilities essential to mediated healthcare communication, which ranges from non-professionals – even children – translating interactions between health professionals and patients, to the professionals themselves explaining procedures and medication regimes to patients unable to understand the dominant language of the community. The risks and potential harm to the patients involved cannot be underestimated, spanning misdiagnosis, lack of informed consent, restricted or no access to mandatory services, non-compliance of medication or treatment as well as liability claims.

The true complexity of mediating between languages is frequently obscured by reductive conceptions of what it actually involves. These foster a view of translation and interpreting as simple acts of transcoding from one language system to another with a unique solution for each message conveyed. Yet, like language itself, translation and interpreting cannot be isolated from the cultural environments in which they are used, from the purposes for which they are used or from the people who use them. Since translation and interpreting constitute acts of intercultural mediation, they depend decisively on their setting and on the way in which those requiring such services want and need them to function. Acquiring skills in understanding and producing a foreign language is not synonymous with the ability to mediate between it and your native language, as the substantial body of cognitive research on translation competence amply demonstrates. Empirically validated models (*e.g.* PACTE 2005) show it to comprise multiple components, among which language competence forms just one alongside intercultural, textual, thematic, technological,



information-literacy, professional, service-provision and interpersonal constituents. Central importance is given to translators' self-concept and awareness of their multiple roles and responsibilities to their users and other stakeholders, which our research has shown to be a main distinguishing feature between professional translators and non- or pre-professional students (Ehrensberger-Dow & Massey, 2013). Those models have had a major impact on translator and interpreter education, finding their way, for instance, into the influential competence profile of the European Commission's European Master's in Translation (EMT) network.

So it was with considerable misgivings that leading supranational associations representing the translation professions and their educators, including the EMT, received the new descriptors for the CEFR (2017). These contain many additional descriptors covering mediation skills, and in doing so convey the wholly unwarranted impression that language courses alone, and teachers without specific training in translation or interpreting, can educate students in the skills needed to mediate successfully in community settings, including healthcare. The ambitiously formulated descriptors for overall mediation and mediation of written texts (CEFR, 2017, 101, 110), namely *'Can mediate effectively and naturally, taking on different roles according to the needs of the people and situation involved, identifying nuances and undercurrents […] conveying evaluative aspects and most nuances precisely, and pointing out sociocultural implications'* and *'Can translate into (Language B) technical material outside his/her field of specialisation written in (Language A), provided subject matter accuracy is checked by a specialist in the field concerned'*, are outcomes normally expected of graduates of MA courses in translation and interpreting; as such, they go far beyond the scope of C2 language courses and teachers trained in second-language teaching. Significantly, no translation studies specialists are referenced in the report on how the mediation descriptors were developed (North & Piccardo, 2016).

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Language Mediators
contin.

In our view, there should be a structured approach to incorporating key components of language mediation into language-teaching syllabuses for healthcare professionals. For this to work effectively, the teachers themselves will also need training in the fundamental concepts, competences and practices of translation and interpreting. They should be familiarised with the specific challenges, techniques and strategies of the many sub-forms of language mediation, from sight translation to consecutive interpreting, from equivalence-orientated translation with its focus on word equivalents to user-centred, functionally adequate adaption with a focus on the needs of the reader, within their diverse socio-technical contexts. Above all, they should be made aware of the roles and responsibilities necessary to enabling effective, low-risk communication in healthcare settings. Only then will they acquire a solid grounding in the core aspects and skills of translation and language mediation that have become so necessary to delivering healthcare services in our globalised world.

Part of our Institute's mandate is to provide continuing education and other services tailored to the needs of professional groups and the communities in which they operate. By working together with healthcare professionals and those who train them, we can promote inclusion and the quality of care by improving mediation skills in this vital field. We would welcome any suggestions, requests or initiatives the English language teaching community may have in this regard.

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Maureen Ehrensberger-Dow *and* ***Gary Massey***

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Communicating via an Interpreter

Claudio Bendazzoli *gives an overview of the interpreting world and gives advice on how to maximize time spent working with a medical interpreter.*

The *3rd English for Healthcare Conference* held in October 2017 was the first in its series to include a panel on interpreter-mediated communication. It was a stimulating opportunity to widen the research and teaching perspectives from which English can be looked at, both as the language of medicine worldwide and as a *lingua franca* in increasingly multicultural and transient communities.

Interpreters can be involved in a wide range of settings and apply different interpreting modes or techniques to help participants in a communicative situation understand each other. In this article, I will give an overview of interpreting modes and settings, with a special focus on medical interpreting.

Before doing that, however, a distinction between professional and non-professional interpreting is in order, especially when considering healthcare-related settings. Professional interpreters may be hired on a case-by-case basis from the freelance market or be staff members of the institution in need of their services. These are likely to have an educational background in Translation and Interpreting Studies, and in some countries may even need to obtain accreditation from established associations. Conversely, non-professional interpreters are known as 'natural' interpreters in the sense that they were not trained for that and just 'happen' to help for being around when linguistic needs arise, *e.g.* family members (even children) or friends accompanying one of the parties in the communicative exchange, medical staff such as nurses and so on. This raises many controversial issues, ranging from confidentiality and accuracy to patient safety, while calling for greater awareness of what it means to communicate effectively via an interpreter, be they spoken language or sign language interpreters.

Interpreting modes

Depending on the kind of communicative situation, participants and the technological equipment available, interpreters apply different techniques to deliver the source message into a target language. In general, if the interpreter's output comes after the presentation of the source message and there is alternation between the interpreter and the source message speaker it means that interpreters are using **consecutive interpreting** modes. These are further differentiated into short consecutive, with limited or

no note-taking at all and bidirectional translation between the two languages involved in a dialogic interaction (as in a doctor-patient interview), and classic consecutive interpreting, which entails a specific note-taking technique the interpreter needs to be able to recall long stretches of source speech delivered in a monologic fashion (as in a formal lecture). Typically, the source speech is divided into 'chunks' (up to 5 minutes or more). On the other hand, when the source speech and the interpreter's target speech are produced at the same time, without alternation between source speaker and interpreter, interpreters perform **simultaneous interpreting** modes. This can be done by means of a sound-proof booth, where two interpreters (or even three, as they need to alternate about every 30 minutes) are acoustically isolated from the external environment, listen to the source speaker through a headset, and use a microphone to deliver the target message to the target audience who listens via a headset. The same system is sometimes used without the booth, thus having interpreters exposed to the external environment. In this case, the interpreting equipment is portable to accompany groups during visits or study trips. Finally, in case of individual users or very small groups of users, the interpreter may sit next to or behind them and whisper the translation in what is known as whispered interpreting or *chuchotage*.

In addition to all these modes, communication technologies can also influence the way interpreting services are provided. Videoconferencing systems and telephones are being increasingly used for remote interpreting; speech recognition software instead is exploited for respeaking, *i.e.* the provision of subtitles in real time (mostly intra-linguistically, more rarely from a source language into another language). Different types of interpreting (*e.g.* conference interpreting, legal or court interpreting, business interpreting) are the result of these modes applied to specific settings.

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Communicating via an Interpreter, contin.

Medical interpreting
All the interpreting modes described above can be applied to communicative situations concerning medicine or healthcare-related subjects. Looking at some specific features of such situations can help pinpoint in which terms they differ from each other. For instance, varying degrees of formality, confidentiality, and the types of interaction format (monologue vs. dialogue, more or less institutionalized, more or less pre-determined) can be taken into account.

Conference Interpreting In medical conferences or symposia, simultaneous or classic consecutive interpreting services are usually provided. Communication is largely monologic, but Q&A (question and answer) sessions are more dialogic in nature (albeit speaking turns are managed by the chairperson). Conference speakers should be aware of the need to always use the microphone to allow interpreters to listen to the source message, and to avoid overlapping speech with other delegates. Also, it is important to know that simultaneous interpreting service users have access to the target message with a slight time delay with respect to the delivery of the original source message, thus presenters should manage slides and expect reactions from the audience accordingly. Another piece of good practice is to provide interpreters with the conference agenda, slides and material in advance (all the information is considered confidential), and possibly to brief the interpreters before proceedings start. According to the literature, the ideal speaking speed for simultaneous interpreting is around 100-120 words per minute, though more often than not average speaking speeds may even reach 160 words per minute.

Community or *Public Service Interpreting* This type of interpreting generally occurs in dialogic exchanges between an institutional representative or service provider (*e.g.* hospitals, family doctors, clinics, social services) and a client (*e.g.* patients and their relatives, especially from minority groups, migrant people, asylum seekers, etc.). When all the participants are physically present in the same setting, a triangular seating arrangement would be best to assure direct communication between all of them. The interpreter should be introduced to clarify the roles of each participant. Far from being 'invisible' and 'neutral', interpreters play an important role also in coordinating the interaction and may be engaged in dyadic exchanges with either the service provider or the client (*e.g.* expanding on some information, asking for clarifications). Remote interpreting, e.g. over the phone, is often organized to guarantee maximum coverage of linguistic combinations and availability. Yet, *lingua francas* (above all English, but also other languages such as French) may also be used, especially by speakers of minority languages for whom it would be impossible to find an interpreter on site.

Regrettably, in many countries community interpreters have a lower professional status than conference interpreters, but efforts are being made to fill this gap and raise the awareness of interpreting service users. The interest expressed by EALTHY members is a welcome and encouraging step in this direction.

Useful links
Critical Link International: www.criticallink.org

International Association of Conference Interpreters: https://aiic.net/

Claudio Bendazzoli

Claudio is assistant professor of English Language and Translation at the University of Turin (Italy) and also works as a freelance interpreter. He earned his PhD in Interpreting Studies from the University of Bologna.

The HELP Project: Healthcare English language programme

Quality materials for free for your healthcare learners may seem like a dream come true. ***Lukas Merz*** *tells how the HELP Project came about and how you and your healthcare learners an benefit from their work.*

The quality of healthcare largely depends on effective communication and intercultural skills. English is a prerequisite for the majority of healthcare professionals throughout continental Europe. The free movement of persons within (and outside) the EU, medical tourism and shortages of healthcare staff necessitate language competence and cultural awareness. Despite this fact, curricula in Higher Education often do not provide sufficient space for learning the specialised language, and working healthcare professionals usually lack the time to attend classes or do not have access to quality learning materials. What can we do to aid language learning and intercultural skills in order to facilitate labour mobility? We are offering HELP.

The HELP Project is a comprehensive, modular, interactive programme for learning healthcare English for intercultural competence. The aim of HELP (Healthcare English Language Programme) was to create an innovative learning environment both for the formal classroom as well as for informal settings: colleges, universities, lifelong learning programmes and professional practice. HELP is intended for learners in higher education as well as healthcare professionals and self-learners on the B1/B2 levels of the CEFR. The list of potential benefactors is long, including non-medical specialists and allied health professionals, people in medical tourism, language agencies, translators and interpreters; virtually anyone who has to deal with the English language in the healthcare industry.

At the start of the project, the consortium conducted an extensive needs analysis to ascertain the current needs among healthcare students, teachers and professionals. The online survey included some 250 students and 70 teachers from healthcare education. One of the interesting findings was that the majority of respondents appreciated online learning materials, yet they still viewed a printed textbook as a necessity for language learning. Despite having Internet access in the classroom, teachers seldom used online material in their courses and very few make use of any learning platform (LMS). The survey also suggested that teachers were somewhat reluctant to teach intercultural competence, although students stated there was a strong need for this kind of education. The HELP Project wanted to deal with these challenges.

An international interdisciplinary team of language teachers, linguists, medical doctors and software engineers from seven countries created an online learning platform, a mobile app and print-ready materials. The online learning platform is built on the LMS, Moodle and consists of 14 broadly conceived medical modules. These cover general topics in healthcare: from anatomy to ethics, from admission to wounds and injuries. The modules are constructed around the four language skills: reading, writing, speaking and listening and feature audio and video materials, images, reading comprehension tasks, input for writing and speaking activities and discussion, as well as vocabulary exercises. Six intercultural modules follow, providing general insight into the topic and introducing some of the basic concepts related to intercultural differences. These modules supply a hint as to what it means to work in a multi-national team and how knowledge, sensitivity, and respect help overcome cultural barriers.

All the media resources can be downloaded for fully functional offline use. Platform users can also download all the modules in PDF format for a printed version. The online platform is also mirrored in a mobile app for Android devices. This allows users to choose how and where to learn, giving them the freedom to access the materials at anytime, anywhere. Assistance is provided by a user guide and useful learning tips. Self-learners can also join the HELP Skype community to find communication partners and practice speaking skills. Access is entirely free, only email self-registration is required. Although things tend to disappear quickly from the Internet, the Erasmus+ project sustainability ensures that the platform will be operational for more than a decade.

... / ...

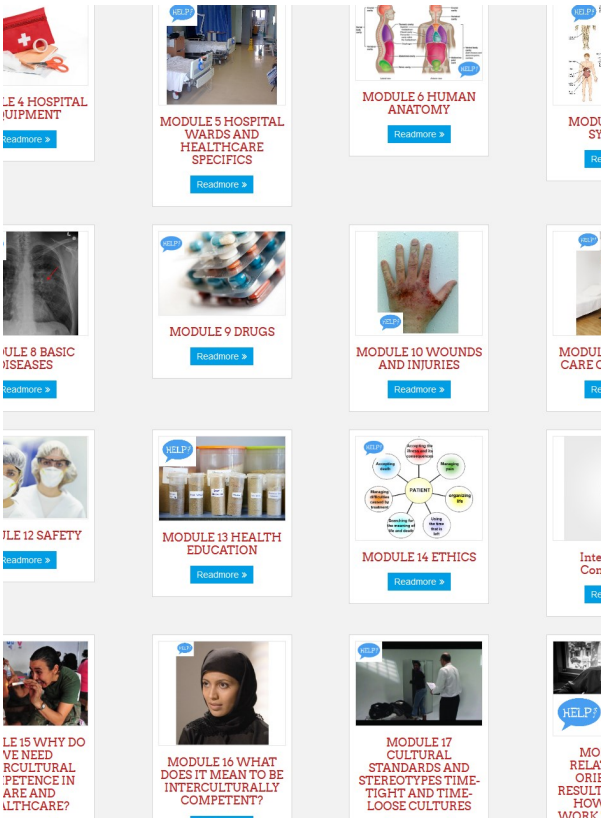
HELP Project, contin.

The HELP platform uses official ICNP (International Classification for Nursing Practice) terminology to guarantee professional standards. HELP was also awarded the *European Language Label* for 2017, recognized by the jury for being innovative and well-structured. The judges appreciated the fact that it supplies materials which are unique and focused and which are particularly well-supported for autonomous learning.

The intention of HELP is to contribute to consolidating professional knowledge learned in the national language, and present the most relevant medical topics in a practical way. Content and media involve the student emotionally and support learning. HELP fulfils specific practical communication requirements for different fields of professional activity (such as social care, hospital, medical tourism), as well as ethical and intercultural preparation in a holistic way. We offer a high-quality product which has the ambition to change the traditional approach and address learners across the healthcare system. Everyone is invited to join in: you can access the HELP platform at http://help-theproject.eu or in Google Play under 'HELP English for Healthcare'. Come and try it for yourself.

Lukas Merz

Lukas is a lecturer and a translator with a focus on ESP and academic writing. He teaches English to both medical and non-medical professionals. He has co-authored a number of the HELP Project modules.



Selection of available modules (2017)

European Language Label
An Séala Eorpach Teanga

Interested in writing for the EALTHY magazine?

EALTHY European Association of Language Teachers for Healthcare

We're looking for contributions:

- Medical / healthcare related issues
- Teaching and testing in medical / healthcare English
- Activities and lesson plans
- ESP classroom practice
- Specialised medical / healthcare English teacher training

Contact Ros at: ros.wright@ealthy.com

Comical Medicine

From manga to graphic novels, the comic genre is one that is increasingly popular. ***Stevan Mijomanović*** *is a fan and here offers some ideas for their use in EMP.*

Teachers, nowadays, have many different materials at their disposal. However, more often than not, faced with that plenty we are at a loss as to which materials to choose and for what purpose. Teachers of English for Medical Purposes (EMP) have an additional problem. We often need to mirror the curriculum of other medical subjects. Thus, we need to do our research of the topic, for some of us often beyond the scope of our linguistic or teacher education, and incorporate it into our lessons in a way that is interesting and motivating for our students. For that purpose, EMP teachers reach for authentic materials that include abstracts, research articles, case reports, etc. Use of these kinds of materials is invaluable and of vital importance in a language for specific purposes classroom. However, no matter how interesting the materials are they are still foreign to many students as they might be coming into contact with them for the very first time. So, how can EMP teachers approach their students in a way that is palatable and closer to them, and at the same time use authentic materials? What kind of authentic materials can we use that are accessible, motivating, not (completely) technology-reliant, relate to all types of learner, and are easy to find and adapt to an EMP classroom? The answer is comics, specifically, medical comics.

Comics do not necessarily have to be humorous, but most of them are. Comics make the students laugh, relax, and help create a motivating, learning environment. They are suitable for all types of learners, apart from many kinaesthetic learners ('tactile' learners excepted - see below). Visual and reading learning is quite obvious, auditory would be the pronunciation of certain words (and listening – in the case of animations), writing and tactile can be included in games and exercises. But what can medical comics be used for in an EMP classroom?

Firstly, comics are an excellent way of introducing new vocabulary. For example, if we are teaching the skeletal system we would probably mention the largest bone in the body and the smallest one. However, instead of telling the students the names of the bones we can show them (Fig. 1), and then ask them to provide us with the equivalents of those terms in plain English.

Fig. 1. www.theAwkwardYeti.com

Another use of comics could be to activate the acquired vocabulary. This can be done by introducing not only the jargon used by health professionals, but also by patients. Some patients, especially children, will probably not use words like *urination* and *defecation*. Instead, they might say *number one* and *number two*. By recognizing the organs in Fig. 2. the students can guess/remember these phrases and then provide the medical terminology.

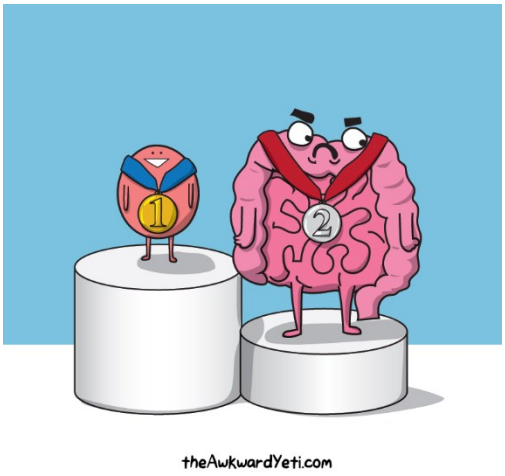


Fig. 2. www.theAwkwardYeti.com

Comics can also be useful for more advanced students, both language and medicine wise. A teacher can use more elaborate comics to introduce and cover different conditions, processes, procedures, diseases, etc. (Fig. 3. and Fig.4.).

… / …

Comical Medicine, contin.

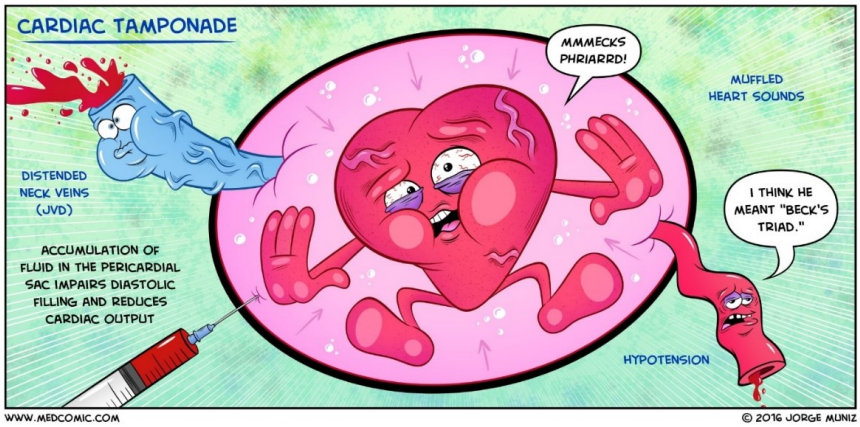


Fig. 3. www.medcomic.com

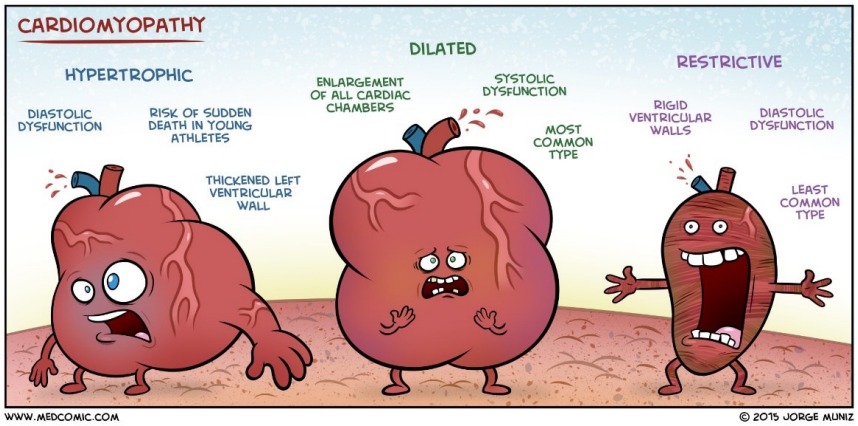


Fig. 4. www.medcomic.com

Fig. 5. www.theAwkwardYeti.com

The class can then explain what led to these conditions, how to diagnose and treat them. Depending on the lesson, students can talk about the system affected, the patients affected, *e.g.* the elderly, types of treatments, etc.

There are many options for the use of comics in the classroom, not all of which are limited to learning new vocabulary. Many health-related topics are suitable for practicing speaking, *e.g.* bioethics, differences in health systems, hospital and healthcare reforms, issues of health insurance, etc. In these instances, comics come in handy for introducing discussions on topics such as doctor-patient communication or use of animals for therapeutic purposes (Fig. 5).

Typically, when we think of comics we think of drawings that are satirical or humorous. However, comics/cartoons can also be animated and have an educational purpose. There are many animations like these available on the Internet and a lot of them can be used in the classroom, some even offer handouts (*e.g.* www.amoebasisters.com). One just needs to be careful when it comes to the level of language, length, and appropriateness of the video to the students in terms of their subject knowledge.

Another important note to make is that some of the comics have intellectual copyrights applied. However, most authors are happy for their work to be used for educational and non-profit purposes and many overtly state this on their websites. For others, a simple e-mail explaining why we would like to use their work generally suffices. With this in mind, one should ask for permission if any changes are to be made to the comic, *e.g.* translation. If permitted by the author, a teacher can use the comics to create activities or games, *e.g.* erase the dialogue balloons and ask students to put them back in the correct place, or come up with their own dialogue. Another option could be for the students to create their own comics or even write an essay about the issue illustrated in the comic.

The use of comics for educational purposes is multifaceted and provides numerous opportunities for the creativity of both the teacher and the students.

Stevan Mijomanović
Public Relations

References and useful links

www.amoebasisters.com
www.danscartoons.com
www.glasbergen.com
www.medcomic.com
www.theawkwardyeti.com

Teaching & Learning with Medical Animations & Videos

Continuing on our theme, ***Reima Al-Jarf*** *provides a rationale for using video and animations in the EMP classroom before suggesting an approach for their use.*

Introduction

Many students, enrolled in colleges and universities that use English as a medium of instruction, have difficulty understanding lectures delivered in English in specialized courses such as medicine, dentistry, pharmacy, biology, biochemistry, anatomy, physiology, etc. They also have difficulty learning specialized terminology. To help students majoring in health sciences promote their listening, speaking, writing and vocabulary skills in English, class lectures can be supplemented by online medical videos and animations. A review of the literature revealed numerous studies that integrated videos in second language teaching and learning such as Baker (2016), Underdown & Martin (2016), Kaur *et al*. (2014), Huang and Hung (2013) and others. Use of videos with ESP students proved to be effective in enhancing students' learning. Animations and videos provide a variety of themes, speakers and accents, as well as levels of difficulty, lengths and speeds. They bring courses alive and allow learners to use their visual and auditory senses to learn complex concepts and difficult procedures (Hartsell and Yuen, 2006). Subtitles help students comprehend the content.

Materials and tasks

The instructor can locate medical animations and videos on YouTube. The medical animation/video theme chosen should depend on the length, the students' proficiency in English as well as the complexity of the video language and content. Assign several videos and animations on the same topic to suit the different ability levels in the group. Students can suggest online videos and animations of interest to them and, to save time, instructors can create an online medical animations and video repository which they can use for future courses. The following are some examples:

Biology: Cell Structure
Human Digestive System Animation (Reading)
The Digestive System - an animation
Circulatory System Animation
Human Circulatory System
What is cancer?
Osteoporosis
Osteoporosis Treatment
Living with Osteoporosis

Instructional Strategy with Online Videos and Animations

Before watching a video, post the video title and URL on your preferred platform, discussion forum or social media. Introduce the video and provide a vocabulary overview and pre-questions. Tell the students what they need to do/focus on. The students should not watch a video/animation passively without having to carry out some comprehension tasks. They should take notes, outline the main ideas and important details, and answer questions that require them to give examples, classify, describe structure and functions, give similarities and differences and cause-effect relationships.

After watching a video, the students could practice pronouncing medical terms, breaking them down into prefix, root and/or suffix, learning singular and plural forms. They could then discuss answers to questions, summarize or retell the video content orally or in writing. Tables, flow charts, diagrams, photos and mind maps can be used to show video information detail.

During the different phases of the lesson, the instructor serves as a facilitator, supporting inquiries, discussing students' difficulties and encouraging them to participate fully in the learning process. The students should be required to engage in, respond to and be actively involved in the activities. The instructor can give extra credit for participation and completing the tasks and can include the video/animation content on tests.

Finally, ESP trainers should always keep in mind that technology in general, and videos and animations, in particular, do not teach by themselves and their use does not guarantee the automatic learning of the content. The students' active role and the instructor's guidance are crucial in facilitating learning, practice and acquisition of English language skills, medical information and terminology.

Reima Al-Jarf

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Hartsell, T. & Yuen, S. (2006). Video Streaming in Online Learning. *AACE Journal, 14*(1), 31-43.

Huang, H. & Hung, S. (2013). Exploring the Utility of a Video-based Online EFL Discussion Forum. *British Journal of Educational* Technology, *44*(3), 90-94.

Kaur, D., Yong, E., Zin, N. & DeWitt, D. (2014). The Use of Videos as a Cognitive Stimulator and Instructional Tool in Tertiary ESL Classroom. *Malaysian Online Journal of Educational Technology,* 2(3). 32-41.

Underdown, K. & Martin, J. (2016). Engaging the Online Student: Instructor-created video content for the online classroom. *Journal of Instructional Research,* 5, 8-12.

See opposite for ideas to practice these skills based on Circulatory System Animation.

Reima (PhD) taught ESL, ESP and translation at King Saud University, Saudi Arabia for 26 years. She has 600 publications and conference presentations and reviews articles for numerous journals worldwide.

THE HUMAN HEART

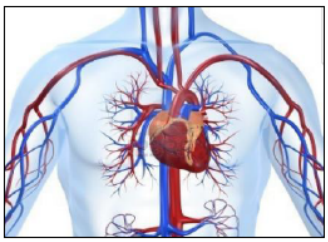
Fig.1

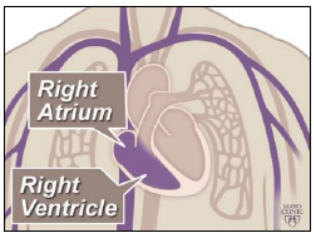

Fig. 2

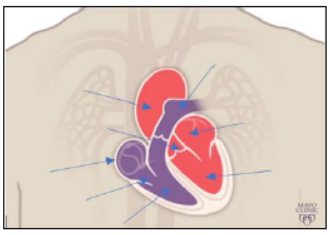
Fig. 3

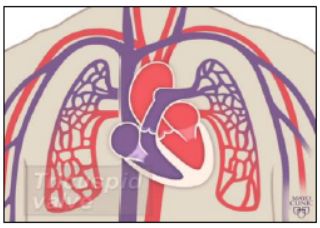
Fig. 4

Ideas for focus on medical terminology:

- Pronunciation: *aorta, atrium, diastole, pulmonary, rhythm.*
- Parts of speech: *pulmonary, systolic, atrium, aortic, tricuspid, muscular, circulate, cardiovascular, coronary.*
- Nouns & verbs: *contract, circulate, relax, pump, muscular, electrical, wiring, circulatory.*
- Affixes & roots: *pulmonary, atrium, systolic, ventricle, circulatory, tricuspid, cardiovascular, coronary, electrical, capillary.*
- Singular & plural forms: *atrium, ventricle, capillary.*

Possible comprehension tasks:

Watch and answer the questions.

1. How big is your heart (*Fig. 1*)?
2. What are the red and blue parts in Figs. 1, 3 and 4?
3. What is red/blue blood in Fig. 4?
4. Write the names of the parts of the heart in Fig. 3.
5. Which aspects of the circulatory system were compared to a pump, electrical wiring and ketchup?
6. What keeps us alive?
7. What causes poor blood?
8. How does blue blood become red?
9. How can poor blood become useful?
10. Explain how blood circulates throughout the body (*Fig. 4*).

Fill in the chart below with the parts of the heart and their function.

Part	Function	Part	Function
heart		valves	
ventricle		aorta	
left and right sides		veins	
atrium		arteries	

Fill in the outline below.

1. Structure of the heart:
1.1 Right chambers
a. Upper right chamber:_____
i. _____ valve
b. Lower right chamber: _____
i. _____ valve

1.2 _____
c. Upper left chamber: _____
i. Upper left valve: _____ valve
d. Lower left chamber: _____
i. lower left valve: _____ valve

2. Function of the heart and its parts:
a. Left atrium: _____
b. Pulmonary aorta: _____
c. Mitral valve: _____
d. Veins: _____
e. Arteries: _____

3. General information about the heart:
Size: _____
Location: _____
What connects the heart with the body: _____
Beats: _____
Amount of blood pumped: _____

3rd English for Healthcare Conference : Delegate feedback

3rd English for Healthcare Conference, S. Golini (2017)

3rd English for Healthcare Conference, S. Golini (2017)

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SEASON'S GREETINGS

EALTHY
European Association of Language Teachers for Healthcare