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Becoming Blind

Onto/Epistemological 'Seeing' of White Coat Literacy & Pedagogy

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Abstract

Medicine has always been regarded as one of the most significant disciplines, grounded in a humanistic approach, due to its ultimate exposure and connection with people as 'patients' and hence a holistic understanding of the patient as 'human' is fundamental. In our potentially dangerous times, the instrumental, technical and fragmented ways of seeing knowledge tend to permeate most disciplines, including medicine. This may result in individuals becoming alienated with the 'self' as potential doctors, with the discipline and with patients through the monologic discourse of academia or clinics. This article examines this (in)visible global issue in the specific context of Iran, where bilingual medical education adds another level of complexity in dialogic 'seeing' of self, knowledge and patients. Grounded in Bakhtin's theory of dialogue and critical literacy approach to language and literacy, this article explores the affordances of a pedagogical intervention at an Iranian university. This offers diverse avenues for constructing a holistic medical knowledge in the process of becoming a professional through narrative medicine, clinical scenarios, evidence-based medicine and personal experiences. Selected stories of participants' ontological and epistemological transformations, in their process of ideological becoming, are offered to argue for the urgency of dialogic ways of 'seeing' in potentially dangerous times.

Keywords

ontology – epistemology – integrated learning – dialogic pedagogy – critical literacy

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1 Introduction: 'Seeing' the Scene

I grew up in a family and a city (Yazd) in the desert of Iran – famous for medical expertise, and therefore, I have had continuous exposure to the professional and social discourse of medical communities. This afforded me, as someone involved in language education, to reflect deeply on the ways in which patients are 'seen' by doctors and the way doctors are 'seen' by patients and in society through their language and discourse.

Dialogue between doctors and patients and listening to their stories to capture the more holistic account of the problem have always been fundamental in medical practices I observed. However, more recently, and as a result of a fast-paced world, and the dominance of technology in all disciplines, including medicine, the human relationality and significant of those stories is becoming under-recognized. This is mainly at the expense of developing 'fast' knowledge, in series of fragmented information. While the affordances of technology and machine-driven data in medical world are acknowledged, its substitutions for human interaction and grasping a holistic account of patients is potentially dangerous.

This instrumental way of 'seeing' is not limited to clinical and professional settings; it permeates the academic context as well where the medical knowledge tends to be taught or learned in a fragmented and monologic way. My involvement in teaching and researching in the medical faculty also revealed to me that there is an increasing detachment of medical students from the reality of the profession. In many cases, they may only rely on the commercial side of the discipline in terms of profitability of the job in future, or the social prestige of the field. In other words, there is less of identity investment in the chosen field, to feel belonged or to 'own' the profession. Hence, it is not just seeing the 'patient' which might be compromised, but also seeing the 'discipline' and more urgently seeing the 'self'.

This issue related to underestimation of relationality and dialogue among people has been acknowledged as a global matter in most disciplines. Its urgency in the medical field was explored in the symposium regarding the 'politics of seeing in medical education' from both clinical (Warmington, 2019) and academic perspectives and in a global as well as local contexts (AVP conference, 2019). This article unpacks the issue of alienation of self, of other and of knowledge in a particular context of medical education in Iran where the bilingual nature of medical education adds another level of complexity and consequent fragmentation. The specific context of medical language courses is examined through the lens of dialogic pedagogy, to underscore the affordances of language classes, as sites of identity construction, in

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circumventing possible alienation of individuals in such sensitive fields, and to open up possibility for reweaving the 'self' and new narratives.

First, the context of medical education and its bilingual nature in Iran is explained to justify the need for an integrated and dialogic pedagogy.

2 Context of 'Seeing': Medical Education in Iran

Iran is famous for the medical expertise, with reputable medical universities and globally famous medical professionals, surgeons and researchers. The unique feature of medical education in Iran is its bilingual nature (English-Farsi) both in academic and professional contexts. The significance of English in this discipline is twofold: medical students need to gain a mastery of English not only for participation in international medical communities such as publications or conferences, but also in order to pass medical courses at local and national levels, since these courses are mostly supported by sources which are in English. Secondly, in medicine, English is not only learned for academic purposes, but is also intended to be used in professional settings, as Iranian doctors write prescriptions in English and they use medical English terminologies when they brainstorm amongst each other over proper clinical decision-making. Rarely do doctors or even medical students use any translation or equivalent of medical terms in Farsi as this is the normative way they are taught and have practised medical English. Nevertheless, the language they need to use in dialogue with patients is clearly Farsi/Persian. Although there has not been much research on how and why medical education in Iran is conducted in this apparently alienated way, this shows the vital significance of English for medical students, and therefore there are specific courses, called English for Medical Purposes (EMP) to address this particular need in medical schools.

I have been teaching and researching in the medical school of a high-rank Iranian University for many years and been reflective of the potential and pitfalls of the EMP pedagogical practices which led to my multiple research interventions in that context. The purpose of this article, though, is not specifically on pedagogical aspects of medical English and its complexity in the Iranian context, rather, my focus is on the affordances of language classes in making students aware and self-conscious of the special discourse of the discipline to which they are supposed to feel belonging. Identity construction has always been a significant matter in language education, but this significance is double in academic language courses because they are learning language of their own discipline, through which they can present

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their voice locally and globally. Besides, in such courses, students have the content knowledge which gives them a better sense of ownership of their learning; this in turn creates a power balance between students' content knowledge and teachers' language expertise and creates a better possibility for dialogue among peers and with the teacher (Wenger, 1998a; Skidmore & Murakami, 2016). In medical contexts per se, the language awareness is significant in students' future professions and in making meaningful dialogue with patients. Hence, the 'power of language' needs to be taught and attended to, especially when the context demands the knowledge of discipline to be presented through the 'language of power' (English).

The next section elaborates on the diverse ways of seeing the language and literacy practices in academic contexts and how they potentially reinforce fragmented, instrumental and monologic perspectives upon knowledge and self.

3 Identifying the Gaps: Ways of 'Seeing' or Obscuring

Hyland (2006) examined three approaches to literacy practices in academic contexts, namely: *skills-based, socialisation* and *critical* approaches. *Skills-based* approach is grounded in behavioral psychology and assumes that literacy is a set of atomized skills to be learnt by students and transferred to other contexts. Hence, the focus is 'on attempts to 'fix' problems with student learning, which are treated as a kind of pathology' (p.120). Van Lier (2004, p.26) refers to this as the 'componential assumption' of language as a set of building blocks. In a skills-based approach, texts are regarded as unitary cultural artefacts, so the inferred meaning is static, and the teacher's role is authoritative. This approach resonates with what I have observed in the EMP course in Iran: students needed to memorize specific terminologies as 'language fragments', as they are taught detached from whole texts, and context in which these terms might be used in clinical spaces. This instrumental, fragmented learning of academic terms and concepts does not support a process of internalization and meaningful learning as it is not integrated with students' prior knowledge, their existing schemata, or with authentic examples from their professional contexts (Hayatti, 2008; Ahmadi & Bajelani, 2012; Barjesteh and Shakeri, 2013).

Furthermore, this tightly-governed pedagogy does not provide much space for dialogic negotiation over multiplicity or complexity of meanings for the learners to operate as inquirers in the world (de Silva & Feez, 2016;

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Pennycook, 2014) and they remain as voiceless outsiders who cannot 'see' themselves in the language they memorize or use.

The socialisation approach is also called *disciplinary socialisation*. It is a more discipline-sensitive and discourse-based approach which sees learning as an induction or *acculturation* into a new culture rather than an extension of existing skills. This approach appreciates community of learners as central to leaning process and appreciate the culture, however the notion of culture is treated in a homogenized and static way. It also takes a utilitarian view of texts as vehicles of information from the writer to the reader and is not concerned with readers' perception or creation of meaning in dialogue and thus negotiation of power is dismissed (Wilson, 2009). Therefore, although it goes beyond the instrumental level of language and addresses the epistemological level of learning, the notion of 'self' is mainly defined as the 'other', or within the global/English framework and hence, the exercise of power does not seem to be sufficiently theorized. In some EMP courses, following this approach, the communication competence is practised, but the main aim is to facilitate the memorization of terminologies, and the focus on accent and fluency is still bold. Consequently, the communication does not feed into the actual dialogue with the peers, future patients, or with the 'self' as such. In other words, relationality is still under-recognized in this approach.

The critical approach tries to embrace the other two approaches but goes deeper to address the ontological aspect of language learning and students' sense of selves in relation to others and their agency (Deters, et al., 2014). This approach emphasizes students' experiences, or more critically, the unequal power relations which structure those experiences (p.21). Hyland (2006) maintained that academic literacy should view students' learning at the level of epistemology and identities, rather than that of skills or socialisation. Students in this approach are encouraged to switch between literacy practices (the way they use language) in different settings and deploy a repertoire of linguistic practices, appropriate to the setting in order to negotiate the social meaning and identities that each evokes (p.120). This echoes how Barton and Hamilton (1998) see literacy, as an activity 'located in the interactions between people' (p.3) and also attends to students' agency more fundamentally as is theorized and analyzed by Deters, Gao, Miller, and Vitanova (2014).

Benesch, in her influential book, *Critical English for Academic Purpose* (2001), underscored this focus on learners' autonomy, voice and identity and the way students construct their new identities in the academic English of their discipline. According to Benesch (1996) in dominant skill-based

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approaches, students' needs are seen as 'lacks' leading them to assimilate to and accommodate the existing hierarchy. In other words, it 'narrows human capacities to fit particular forms' (Simon, 1992, p.142), Benesch (1999) talked about 'rights analysis' which calls attention to the importance of taking into consideration learners' opportunities for negotiation and resistance both within and beyond the language classroom.

Despite this advancement in theoretical perspectives of Academic English literacy, in practice most research favors the first two approaches (Charles & Pecorari, 2015). There has been valuable research on epistemological developments and changes in the medical discourse community (Taavitsaianen and Pahta, 2000), and applying simulation techniques to enhance authenticity and problem-based learning (PBL) (Wood and Head, 2004). Few researchers also incorporated critical paradigms and academic literacy in their practices (Chun, 2015), with a focus on reading or writing skills (Hu and Gao, 2015; Ibrahim, 2015; Lillis, 2013; Tribble, 2017).

In the specific context of academic English in Iran, some recent critical work emerged strongly (Aliakbari and Allahmoradi, 2012; Borjian, 2013; Mazdaee & Maftoon, 2012), but in the EMP context, the emphasis on a critical perspective is yet underestimated except in few works done at the time of a more liberal government a decade ago (Ghahremani et al., 2007, 2009; Sheykhan, 2008; Janfada, 2008, 2016).

Grounded on those insights, and to accommodate to the current socio-political context of education in Iran and students' needs and rights, I identified the gap in EMP literacy and pedagogy of Iran in terms of incorporating the critical literacy approach in the way students come to learn the language of their disciplines in a voiced, agentive sense and be able to establish meaningful dialogue in their local and global communities. This approach to literacy informed the basis for a pedagogical intervention I proposed in an Iranian university, to examine its affordances in terms of re-visioning of students about their own identity and place at large society.

At the philosophical level, this intervention was informed by Bakhtin, and his theory of dialogue which signifies the power of language in terms of relationality and process of ideological becoming. I elaborate on this framework next.

4 Theoretical Framework: Beholding through Bakhtin

The Russian-Soviet literary theoretician and philosopher of language, Michale Bakhtin (1986) conceptualizes language as 'dialogue'. Bakhtin's main

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philosophical claim is that language is inherently dialogic and there is a dialogic relation between language, culture and the formation of the self (Bakhtin, 1981, 1986). Morson and Emerson (1990) acknowledge that, contrary to common perception, for Bakhtin, dialogue is not necessarily just a 'verbal act of communication' (p.49); rather it manifests the basic principles of both culture and individual human existence. The concept of 'dialogism' by Holquist (1990) emphasizes the social nature of language, dynamicity and multiple voices, inherited in each utterance. Bakhtin was concerned about the reductionist view, that dialogue is recognized as a means or tool for the delivery of message. Dialogue, therefore, is a 'complex metaphor that incorporates the intricate relationship between speakers, between points of views, between social discourses, between past, present and future that are held together in language' (Hamston, 2006, p.56).

Importantly, Bakhtin's philosophical stand is focused on the formation of an individual's coming to ideological consciousness (Bakhtin, 1981, p.348) through language as 'dialogue'. The potential for change resides within the language that circulates amongst students, in a classroom and in any future context in which they participate (Hamston, 2006). True dialogue, in Bakhtin's terms, leads to transformation of the self, or what Bakhtin calls 'ideological becoming' (Bakhtin, 1986).

Bakhtin's concepts of 'dialogue' and 'ideological becoming' informed this intervention significantly. Bakhtin extrapolates the multi-faceted nature of dialogue (Bakhtin, 1981, 1986) and the way dialogue leads individuals in the process of their ideological becoming. Bakhtin's concept of 'ideological becoming' (1986, p.51) is in essence shaped by interactions between different ideologies or the way in which 'members of a given social group view the world' (Morris, 1994, P.249). This perspective acknowledges that the world is contested and full of tensions and struggles, which result in multi-voicedness (the existence of multiple voices in one utterance). This describes what students went through in the proposed intervention

Understanding language as dialogue is significant, because one important aspect of the intervention I proposed is the dialogic relationship *between* students and *within* students' consciousness. This study was concerned with the way dialogue can support students to simultaneously learn about themselves and others. It is also essential to explore how social and historical meanings are inscribed in an individual consciousness (in this case, medical students), which in turn, shapes the 'needs and rights' of each individual (Benesch, 2001) in the educational context of Iran.

In relation to literacy practices, examined above, the perception of language as skills is reductive as there is no relationship between the

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language and the user; even the socialization approach is deemed to be monologic as it reinforces the assimilation to the target culture and hence, creating homogenized rather than heterogenized voices. The critical approach, as grounded in the proposed intervention, opens a window to learn 'language', 'culture' and 'self' in the dialogical sense, rather than being assimilated into it.

Bakhtin's ideas about shaping self as 'I for myself', 'I for other', 'others for me', explained in *Toward a Philosophy of the Act* (Bakhtin, 1993, Trans) is applicable to my work regarding medical students' images of themselves, their images of other members of the local and the global medical communities and the way they are addressed or 'seen' by others as potential professionals.

5 Methodology of 'Seeing': Bricolage

In the practical arts and the fine arts, bricolage (French for "tinkering") is the construction or creation of a work from a diverse range of things that happen to be available, or a work created by such a process. Roger (2012, p.1) states that bricolage research, as conceptualised by Denzin and Lincoln (2011) and further theorized in educational research by Kincheloe (2004a, 2005a) and Berry (2011), denotes the use of multi-perspectival research methods where diverse theoretical traditions are employed in a broader 'critical theoretical' and 'critical pedagogical' context to lay the foundation for a transformative mode of multi-methodological inquiry. Hence, bricolage can be considered a critical, multi-perspectival, multi-theoretical and multi-methodological approach to inquiry.

As the methodological paradigm, bricolage fits well with the theoretical and conceptual framework of this study in relation to politics of 'seeing' as it offers diverse way of identifying, allocating and interpreting pieces of information or knowledge to make a new picture or vision or perception. This is also aligned with main aim of the study which was creating a holistic and integrated knowledge versus fragmented information.

In a macro methodological sense, content of my bricolage was the combination of action research and critical ethnography. I elaborate how this combination afforded deeper ways of seeing myself as a researcher as well as students as co-constructors of meaning and active agents of change.

Action research was helpful due to its innovative, reflective and dialogic nature of this intervention on EMP pedagogy. Particularly in the ESP context, students, as a source of content knowledge, have a crucial role in

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constructing the mutual and comprehensive knowledge of the field in English. The employment of action research provided an opportunity for medical students to be central to the decision-making process (Roth et al., 2008). Besides, while action research allows for dialogic contributions from students in the language practices in the workshops, the students' participation in learning was not limited to their reflection on my actions or a new way of teaching; rather they had contributed to the design of language practices. In essence, students were creating/authoring the activities particularly in final sessions and the symposium event; they were posing questions and provoking discussions, rather than acting as mere evaluators of the materials given to them. In other words, mutual action or 'dialogic actions' were happening in each session.

Apart from these dialogic action process, happened as the core practice of this intervention, the other important aspect of the study was the ethnographic part: examining students' lived experiences throughout this workshop series. This was not limited to how they might see the medical English differently, but also how they see themselves and the discipline differently. At the same time, it informed how I could see myself as a researcher and author. Importantly these two levels of ethnography (autoethnography and ethnography of students) were constructed in relation to each other, as they mutually inform each other.

Critical ethnography, the term proposed by Carspecken (2013), highlights the dynamics of social, cultural, political and educational layers in each research context. Critical ethnography has the advantage of permitting the research process or the researcher to acknowledge the ideological structures that exist within the research context. It also provides sensitivity to gender and marginalized others, and exploits the richness of the use of language, text and symbols (Rudkin, 2002; Harkalu, 2005). Saleh (2008) depicts distinct features of 'critical ethnography' which highlight significant aspects of my research as well. Critical ethnography, he articulates, goes beyond *what is* to *what could be* and does not only *describe* culture, but also offers *changes* in culture. It does not *report* the current situation to other researchers but *raises voice* to speak to an audience on behalf of the subjects as a means of empowering them. Critical ethnography also afforded me with an understanding of how a group of people within a social setting such as a class or a community construct and experience their world, to produce a 'slice of life account' (O'Toole & Beckett, 2013, p.48). therefore, it mirrors my study since my proposed intervention aimed to go beyond mere investigation of the current problems of EMP pedagogy in Iran and caters for their experiences, critical needs and possible rights (Benesch, 2001).

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In a micro level, I have provided them with my bricolage or ways of seeing integration by introducing diverse resources which could put together or re-visioned to make new knowledge or understanding. This was comprised of mediated language practices such as different genres of medical knowledge in English including medical narratives, clinical scenarios, evidence-based research, personal clinical exposure, medical simulation etc. In doing so, I attended to both academic and professional discourses of medicine as these will be intertwined in the way medical students see themselves as future doctors.

In turn students had the chance throughout their dialogic discussions, to create their own ways of integrating, appropriating and presenting knowledge. This was in itself manifestation of students' transformations in the way they see learning, language, medical knowledge, English and themselves as bricoleur.

In the actual design of study, I ran a series of workshops as an extracurricular research activity at Tehran University of Medical Sciences over a semester where 14 medical students volunteered to participate, comprising 7 females, 7 males, all around 20 years old and in their second year of their studies in medicine out of a seven-year study cohort attaining the General Physician degree (GP). These workshop series were preceded and followed by focus groups (pre and post workshops), to give explicit chances for students to reflect and discuss their experiences in the workshops and elaborate on their responses to the questionnaires, distributed online, prior to the sessions. students' continuous reflective notes throughout the workshop as well as in the online dialogic page of the group strengthened the data collection process.

More specifically, this workshop series was represented in four phases, throughout which, the 'dialogue' was a central concept as shown in Figure 1. Dialogue was perceived and practised both at abstract level (students' inner dialogue, dialogue with the text) and concretely (dialogue with peers, and imaginary clinical communication).

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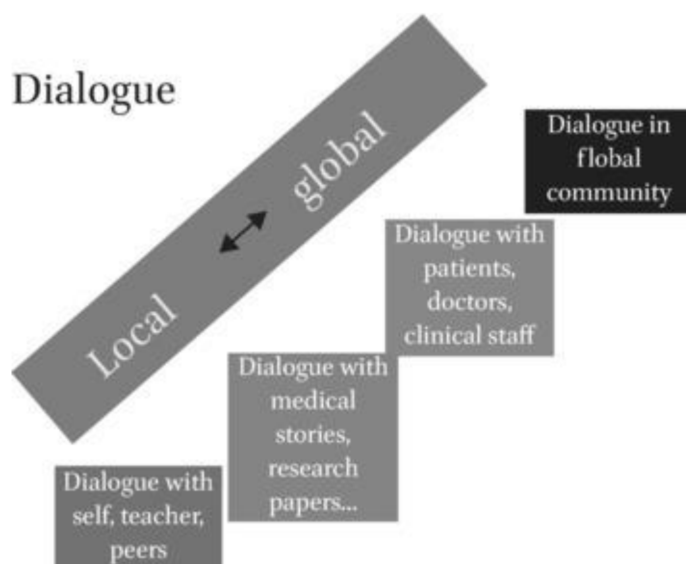

FIGURE 1 The centrality of dialogue to the 'ID' workshop series

The first phase focused on 'dialogue with self' and peer and addressed the ontological and fundamental questions of medical identity 'who am I?', 'why I chose medicine?', 'the language of the white coat' and 'the language of hospital'. These conceptual issues were mediated through diverse literacy practices such as listening to other students at international universities and listening attentively to peers at the local communities, who had already chosen medicine and succeeded in this field. This targeted the main goal of 'seeing themselves' and what kind of doctor they want to become.

The second phase focused on dialogue with medical texts and addressed epistemological aspect of the discipline through offering diverse genre of medical knowledge in English. This addressed the goal of seeing the knowledge as heterogenous and contested, rather than static and fixed.

Phase three, focused on dialogue with patients, tried to combine new insights from previous phases to exemplify an exposure with imaginary patient and how diverse sources of information can be helpful for that doctor-patient effective dialogue. The final phase was where students in peers or groups presented their newly-shaped voice, or their own bricolage of ideas to talk about one medical topic. This included both academic and professional aspect of their profession as I will unpack in the next section.

All these data sources as well as audio/video-recorded sessions were coded descriptively and analytically to discover themes/patterns *within* and *between* participant data (Hays & Singh, 2012, p.300). I have applied 'thematic

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analysis' and 'content analysis' (Clandinin & Huber, 2010) to make sense of their ways of seeing and the way they might resist, appropriate or possibly create new learning opportunities.

In the next section I elaborate on those practices throughout the intervention and how diversely students reported on the transformation at multiple levels of seeing themselves, their discipline, language and the EMP pedagogy.

6 Data Analysis & Discussion: From Alienation to Illumination

As stated before, this was a vast study examining different aspects of language learning and pedagogy in medical English context of Iran through the proposed intervention. Though the primary purpose was to offer more efficient ways of learning medical terminologies in English, the aim was beyond instrumental learning of language and embraced students' awareness of self and of language in which they study and live. Therefore, the collected data from this study was examined and analyzed from different perspectives to explore different ways students reacted to, or appropriated the language practices in the workshops as well as challenges that I had to face in the process of creating and implementing a dialogic workshops based on critical theories of language and learning in the politically monologic and conservative society of Iran. Some previous work elaborated on detailed narratives of participants and how they went through the process of transformation in a zoomed-in way (Janfada, 2019). However, for the purpose of this article, I present the data from the whole cohort but analyzed it from the way they did 'see' themselves as medical students and future doctors, the nature of learning and knowledge in medicial profession and seeing the patients as core element of their clinical exposure. I call this process a transition from alienation to illumination as they became aware of the language in which they created those perceptions. Of course, there are different degrees and different levels of these transformations in their process of ideological becoming (from blindness to become aware). Hence, the complex and intricate notion of 'seeing' is analyzed and interpreted both metaphorically (as their perception of self, patience and discipline) and literally (as how they visually see classroom, community of learning, peers, teacher/researcher) and the visuals they produce afterwards. This in turn calls for the affordances of dialogic approach and critical literacy paradigms in opening up such space for emancipation and new ways of 'seeing'. This account is unpacked in the next section chronologically. I also reiterate that

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the analysis provided below captured the dialogic collaboration and relationality among students and students/teacher via action research as well as ethnography process of self (teacher) and students. This is at the heart of dialogism and Bakhtin's emphasis in emergence of insights and new knowledge in 'in-between' spaces.

7 Springboard: Breaking the Monologue

The very first focus group was arranged to bring all potential participants together and hear their reflections/elaboration on the online questionnaire which they had already responded to. Main questions were around the possible potentials and pitfalls for their EMP course as they perceived it and what their suggestions for improvement were.

The first thing that as an ethnographer I could 'see' was the scattered way students sat in relation to each other. Almost all were reading a medical text related to other subjects and, detached from other peers. This signaled for a dominant perception of learning as an individual act, rather than engaging in conversation with others to construct knowledge collaboratively. They were only waiting for me, as the main authority in the class, to break the silence and reveal what 'solution' I had brought to improve their EMP courses.

This heavy reliance on teacher's authority was also evident in the responses to the questionnaire regarding their identification of problems or lacks and what they wished to change. Responses were minimal with few words per questions and for majority of participants the section related to their preferred practice was left blank. This was clearly an indication of cultural and ideological grounds of the 'banking system' of education (Freire, 1993). As a result, they revealed fairly weak 'voice' and agency as they showed a preference for monologic, vertical teaching than dialogic, collaborative learning.

In the whole session, there was barely any further elaboration on their ways of seeing the problem except for few students who commented on the instrumental and measurable aspect of language learning, directly linked to their assessment requirement:

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> Minoo: Our EMP book is good, but I cannot learn too many terminologies per session well. I forget immediately; I want to see if you offer a better way.
>
> Mostafa: I just want to find a way to read medical papers faster, it is very hard to get stuck in each paragraph.
>
> Niyusha: In our EMP course, we do not have much time for speaking and listening skills to improve, I hope this workshop improves my speaking ability.
>
> Alireza: I am very unhappy with these old, outdated books we have, have you brought new resources for us to work from in these workshops?

Not surprisingly, each individual only addressed me in their responses, and they expected new and 'better' knowledge to be transferred to them through me as a researcher from the western university. Moreover, instead of engaging in a conversation to find out the problems (inside-out), they preferred a solution, as a form of package from outside-in. When they realized that I did not necessarily introduce a concrete piece of material or a template on that very first session, half of participants did not turn up to the next sessions as they did not find it necessarily worthy to spend time on. Hence, that session was revealing in the way participants 'see' me as human capital, with my insider/outsider identity as an Iranian but representative of a Western University and expected worthy cultural capital (textbooks, etc.) from the more power-full place. This addressivity of 'self-other' was a constant theme throughout the workshop and became a strong theme in terms of alienation of self and knowledge and how critical dialogic approach could potentially emancipate human from that blindness. With this knowledge in mind, I ran the actual workshop series beginning with the theme of 'dialogue with the self '.

8 Phase One: Dialogue with the Self

With that dominant monologic attitude socially, politically and educationally, the most challenging part of workshop series was this first phase as I wanted to establish that dialogic community and made them aware of the nature of dialogue not merely as a pedagogical tool to encourage

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communication, but rather as a powerful essence of their profession and in relation to patients.

The 14 participants who remained in the process attended our first official workshop; I deliberately asked for a space where students could sit in semi-circle way and they could 'see' each other. This is atypical in the tertiary setting of Iran, but it was crucial for establishing the dialogic community and fostering their attention to listening to peers as fundamental skills for their future dialogue with patients. To establish this, language practices in first phase was mainly around themselves, why they chose to be in this discipline and who they wanted to become:

8.1 *Who am I? Why I Chose Medicine?*

As the first ontological question in relation to making connection with self and peers, we began with the theme of 'me and medicine' and students were encouraged to share their stories on this.

After a long silence, few students responded to the question, most of which showed strong detachment from the profession. The majority of responses were related to the high social status of medicine and the fact that they have achieved a high rank in entrance examinations and therefore medicine is chosen. In fact, they tended to explain more about how others see them as top-ranked students rather than how they perceived themselves as medical students and future doctors.

> Reza: I didn't choose medicine; the entrance exam chose it for me!
>
> Mohammad: I chose medicine as I saw my parents as model and I thought I should be a doctor as well; no other way in life I could think of: they are rich, successful, and respectable.
>
> Ali: My parents wanted me to be a doctor…

For many of them contemplating on these philosophical questions was irrelevant and somehow a waste of time. Mehdi strongly commented as such:

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> Sorry, I do not know 'who I am' and actually who cares, what will change, I do not think it is important at all. The only thing about me is that I am not a good listener; I have no idea why I chose medicine, may be it was the default set by my Dad, but it does not matter.

Another interesting aspect as they were listening was their judgmental lens based on each person's accent and fluency in English, as their initial 'seeing' of each other and therefore, many participants chose to be silent. This was indicative of their perception of language at the surface level and that being competent in language has been always assessed based on how strongly one could speak with a native accent. This silence was completely visible between the genders, which I tried to moderate by persuading them to listen and comment on their peers' viewpoints. This needed to be done in a cautious way due to the conservative context of the university and my identity as a female

To circumvent this ideological issue, I reassured everyone that accent has no value in this community, and it is all about sharing our perspectives. The consequent literacy practice was exactly to make this connection between local and global professional communities. The task was to watch a clip from international medical student across countries (with diverse accents) and how they defined themselves and their medical identity. This was a powerful observation for students as they reported later on. I also shared the story from my own family and communities and how and why I was involved in medical language education. Their sharing was essential in fostering the dialogic and trustful and non-hierarchical relationship with the teacher.

By the end of this session, students seemed to feel more comfortable and gained a sense of trust and were more open to talk (some began talking in online spaces as well). This feeling of opening-up was evident in Rosa's compelling note:

> I feel a break in my medical identity, I don't know myself, why I am here and where I will be next. I've always thought to find the answer for the question why I've chosen medicine and what was my motivation?

While this clearly stated she had a deep self-awareness of the significance of what she should 'become' rather than what and where the educational system demanded and led her to be, Rosa's point was powerful in boosting the dialogic nature of community. The impact on other peers' sense of self and sympathy was significant and led to a longer conversation among the group even with those silent ones.

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Rosa's point also brought attention to the other side of medical identity which was the clinical space, which is the next topic in this phase.

8.2 *The Language of White Coats*

In order to make a metaphorical bridge between the academic and professional sides of the students' medical identity, I asked them to think about their discipline outside of academia and hospitals as their future place of being, doing and becoming (Fecho, 2010). The question seemed unusual and even confronting to some students as their medical life is reduced to the obligatory classes at university classes and library. The language practice for this session was more of visual literacy. This was scaffolded on their initial sharing of any possible clinical exposure or experience they had so far and their immediate impression or reflection on those moments and how they retrospectively 'see' themselves in the place. Watching clips in which few professionals told their story of becoming a doctor and their perception of self in a 'white coat' and in front of patients led to an engaging discussion among the students. I tried to make them aware of the language these professionals used to describe their identity which in turn made them more conscious in their own language as well and foster their sense of belonging to a broader community of professionals which they would join.

I encouraged the students to think about the philosophy of the white coat and how it might affect their language and ethical clinical communications. Shiva pointed out the immediate influence of the white coat on her sense of being a professional:

> In our anatomy lab, as soon as I wear the white coat, I think I am a different person, I have a new identity and I should talk more seriously. … This colour is psychologically a highly loaded concept for me as it reminds me of Boghrat [one Eastern medical intellectual] who says this colour implies purity, honesty, trust and peace in a doctor.

Next, students asked to be more reflective on how they perceive the language of hospital and its discourse; what is most hurtful or not pleasant, how they would choose or appropriate the language as they imagine themselves in the context. To foster this, I distributed the hospital reports of a group of students, from the past, who wrote about their hospital visit in the form of stories about their first clinical experiences and the kind of language they detected in different hospital wards. Each narration prompted different responses from the students. Some saw the authority as the most visible element of the hospital, while others pointed out a complaining tone, a

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respectful language, a terminology-embedded language, or the social hierarchy in the language, etc. The students became extremely involved in the very critical discussions about the different language themes and patterns in the reports. Some students expressed amazement at the enthusiasm of their fellows who were brave enough to take this challenging language journey in the clinical context. Some other students wondered if going to hospital would be the better way to learn terminologies and assessed the more pragmatic outcomes of this action. Sharing these materials with students was beneficial in important ways: in raising students' contextual awareness of their future professional place; in provoking their sense of agency and action for making any change rather than conforming to the system; and in encouraging them to attend more carefully to the explicit/implicit language of clinical spaces.

By this stage, there was an initial sense of trust in our community and students were willing to share insights gradually (and to different degree of course). So, the first building blocks of dialogue with self and peers was established in the first phase. The aim was to foster this ontological sense of self throughout other phases as they engaged with the actual medical texts.

9 Phase Two: Dialogue with the Text

This phase was epistemologically-driven and focused on recognizing the diverse channels and discourses of medical knowledge (presented in English). This is aligned with the integrated nature of learning in this intervention as well as empowering students with a reflective ability in 'seeing' the text with critical language awareness. We began with narrative-based medicine:

9.1 *Narrative-based Medicine: 'Seeing' the Author*

Unlike typical EMP texts which are static and full of terminologies to be looked up in Dorland's medical dictionary and memorized in isolation with the (con)text, the first exposure of students with the text in our dialogic workshop was with the medical stories or 'narrative-based medicine'.

The pedagogical justification of narrative-based medicine in my workshop was, firstly, to provide students with the chance to perceive any medical case as a complete story rather than as fragmented sets of information. Since medical narratives are essentially bringing terminologies, symptoms and diagnosis together, this was aligned with the integrated learning central to our practice. Secondly, the nature of narrative helped students become

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immersed in the reading process by engaging their medical intuition and schematic knowledge to make sense of content. This led to students developing different epistemological views of learning in that they found medicine to be livelier and more dynamic, rather than as a static or neutral profession. Thirdly, it invited a form of dialogue between reader and author, which was not only a reflection on the content, but which provoked higher levels of critical language awareness in attending more closely to the choice of words and tone of the author (story-teller).

In the broader scope, this significant dialogic feature of narrative medicine was seen to be effective for their future clinical communications in understanding patients' stories more carefully. Hence, though it appears as an academic literacy practice, narrative medicine directly links the students to their future professional world.

With this rationale, I brought to the fore a discussion with students on how they could consider medicine as 'story'. This was accompanied by the paper defining Narrative Medicine titled: '*NM: Re/introducing doctors to listening*' (by Mary Carmichael, 2004) with relevant pictures as background – the image of a stethoscope in one diary notebook – to imply the power of story and proper listening. With this background, they read the first text called '*The bomb in my brain*' was the title of one paper, in the *Journal of Medical Anthropology* and related to the story of a woman who was a doctor herself and narrated the story of the heart attack she experienced

We applied critical literacy practices such as attention to the choice of words, tone of the author etc. as if they were listening to a patient. It gave students better confidence to relate with the text and try to 'see' the author as their potential colleague, not merely series of printed words. Students' initial reactions with medical stories was diverse: some like Rosa were very engaged with that and stories helped them 'see' themselves more clearly:

> Medical narrative was like a written movie for me in which I should act as a doctor. Actually in each line, there is an implicit reminder who you are. It affects the way we read the text, careful but not stuck in that reading. It reminded me of my Mom when she explains in very details about her knee pain, she really thinks I am a doctor!

By contrast, few students such as Mostafa and Minoo, were still worried about structural issues and needed to check up every single word, separately, rather than seeing it as a whole. We did some group work and peer readings to facilitate this process. These students related much better in consequent sessions after some practice based on this new literacy perspective. Another

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practice was another visual literacy task, which exemplified narrative medicine in the reality of hospitals, Dr. Patch.

9.2 *Dr. Patch: Embodied Narrative*

Aligning with the theoretical and conceptual framework underpinning this intervention, introduces Dr. Patch, who actualizes medical stories in his fictional professional life, aimed to reassure students that narrative medicine is pragmatically applicable to real life and particularly in the professional setting of the hospital, beyond the academic context. As an authentic model from the medical world whose knowledge and understanding of medicine comes from medical stories, Dr. Patch movies and scripts are used globally in international universities to encourage medical students to create a dialogic interaction with the patients in different stages of diagnosis and clinical decision-making instead of total reliance on the blind information provided in books. For him, the patient is the most reliable source of knowledge and proper dialogue provokes this input from patients.

Students watched some selected pieces from his movie, accompanied with the scripts. Particular insights from this character for students were threefold: firstly, students noticed why dialogue mattered foremost in medicine and why attending to details and reflective listening have been practised before; secondly, a reassurance of the integrated nature of medicine was provided, and thirdly, students could imagine themselves as a person who could act similarly to Dr. Patch in the future, engaging in the hospital and with clinical stories, rather than spending the whole time in the medical library studying individually.

In fact, using Dr. Patch as a role model could potentially transform students' views about themselves and how they could be possibly different from the mainstream. After this, a clip from an Iranian scholar in USA, with the similar perspective to medicine and clinical profession was shown, this provoked an interesting comment and discussion. This simultaneous integration of local and global resources was a deliberate pedagogical decision to address that self-other dichotomy and its comparison in students' minds.

Rosa revealed how Dr. Patch and that Iranian medical professional inspired her to construct her own agency in the academic/professional world of medicine in English.

> Patch and other clips taught me that we can be different even under most strict rules and assessment system. Patch understood very well

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> who he is as a medical student and a doctor at the same time. He set his own rules and goals and tried to reach them.

Narges added:

> You know, it is amazing to enter the hospital and try to act like Dr. Patch. As I changed my view, I could see the whole things differently and I could learn a lot from that place. I was blind to it before.

Having engaged very well with the first text type (medical stories), students were ready to 'see' evidence-based medicine as another branch on the tree of knowledge in medicine.

9.3 *Evidence-based Medicine: 'Seeing' the Facts*

The other part of my proposed bricolage in this study was embedding evidence-based medicine within the broader body of medical knowledge and in parallel with narrative-based medicine. 'Evidence-Based Medicine Revisited' was an abstract of a book that grew out of a series of articles published in the *Journal of American Medical Association* (JAMA), written by medical educators and clinicians who made invaluable contributions to EBM. This text introduced the concept with live and tangible case studies and clinical questions which afforded students with deeper conceptualization and actualization of EBM in their professional life as doctors.

The architecture of this text was helpful for our practice in different ways: firstly, to resonate with the dialogic nature of our practice, the text included a group of professionals who discuss and assess different aspects of one issue (EBM) and build up their arguments based on their peers' views. Reading this text reassured students about the dialogic and collaborative nature of knowledge construction, even when discussing very factual medical issues. On the other hand, this reading practice provided students with the opportunity to create their own dialogue in their community of practice, in parallel to the professional dialogue that occurs in the global space, which in turn, fostered their sense of belonging to both local and global communities of doctors.

Secondly, to support the integrated nature of our workshop, different areas of medical knowledge were presented in a holistic way, with some real-life case studies; and thirdly, to enhance students' power of reflection and to strengthen their voice, a deliberate meticulous sequence from NBM to EBM was followed. This in turn provided them with a meaningful transition to engage with more scientifically medical research papers.

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The next literacy practice was bringing narratives and evidences together in one task to explore the affordances of this integration in creating a holistic knowledge about the patient.

9.4 *Dialogic Diagnosis: Integrating Stories and Evidences*

The text chosen for the integration of these two approaches was a 'clinical review' from the *British Medical Journal* (BMJ), which presented an integrated narrative – and evidence-based case report – on a particular medical disease. What promoted this text was the fact that this case report considered both factual and narrative aspects and also attended to the doctors' stories as they were going through the process of self-reflection and brainstorming with other doctors in order to come up with a most appropriate clinical decision. The text detailed the story of a patient who had produced written narratives about her illness and shared them with her doctor and documented all evidences and symptoms throughout. In the second section of the text, patient's and doctor's narratives were presented over a time span and the final discussion concluded that a combination of EBM and NBM can enhance shared decision-making and patient-doctor bonds and enhance the doctor's personal and professional development. Through the combination of stories and evidence of doctors and patients, the reader was guided to reach a sound clinical decision, which I called 'dialogic diagnoses'.

Students interacted with this task very powerfully and could see how integrating voices of patients and doctors alongside of factual evidences can enrich the diagnosis process. Moreover, students were engaged in a passionate discussion and dialogue examining different aspects of the text, including the language choices and bringing different elements other to shape a holistic seeing of a case. Beyond this epistemology, as an ethnographer I could see how they were progressing through this process of becoming and acting like a doctor by engaging in a discourse through meticulous language. These various language practices throughout the first two phases prepared students to move to phase three and bring all this knowledge in actual dialogue with the patient.

10 Phase Three: Dialogue with Patients

This phase was dedicated to integrating those ontological and epistemological questions and discussions to the concrete dialogue with the patients. First, language practice was a dialogue with an imaginary patient through a text called clinical scenario:

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10.1 *Clinical Scenarios: 'Seeing' the Imaginary Patient*

Scaffolded on that dialogic diagnosis practice, a clinical scenario is a kind of literacy practice in which one imaginary patient describes his or her disease and students are required to have an imaginary dialogue with this patient. This genre of medical English texts serves as a platform for medical students to enhance their ability for critical observation of patient's symptoms, to synthesize this evidence and pose questions, and to integrate their medical intuition and medical knowledge to reach proper clinical decision-making. Clearly, this task reinforced the dialogic and integrated nature of student learning and situated students in the position of 'acting as a doctor' to enhance their medical identity.

Students seemed motivated, confident and competent to lead this discussion, and showed more reliance on themselves as a source of content knowledge. Each group was challenged by questions from other groups and females were gradually more comfortable asking questions from male students. Gradually even the less talkative and shy students such as Minoo and Shiva felt eager to talk, and after a few minutes their dialogue permeated the whole class and sounded highly technical, particularly when they shared their views about the types of examinations that the patient in that case story had undergone. They appeared as highly engaged students in medical discussions in English and commented on language matters thoughtfully. By this stage, the main leadership of the class and activity was in the students' hands and they felt comfortable with this.

The next task brought more practical, realistic and professional aspects of medicine to the fore through role plays.

10.2 *Role-plays & Medical Simulations*

I invited students to view one filmed role play, produced by my university in West, in which international students had interviews, simulations and role plays with real patients. This was perceived as a real-life example of a clinical scenario in a hospital. Students could observe a face-to-face type of clinical scenario in which not only evidence and symptoms must be taken properly, but where the linguistic aspects such as tone of language, patients' feelings and language preferences must be attended to, vigilantly.

I asked students to listen carefully to the way questions had been asked by the students regarding: the content, hierarchy of questions and required evidence, critical language awareness of the choice of words, the tone of dialogue with the patients, being tolerant in giving the patient enough time to talk about their disease, and verifying with the patient if the information gained matched what patient said. Moreover, watching these film clips

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helped students to visualize what they had read in the previous text and to notice the significance of meticulous language in both academic and clinical communications in medical settings. As students remarked later, they found the role-play clips very inspiring, though they still felt shy to practice role-play and simulation themselves. This real, embodied and visual language practice could embrace main goals of the intervention as students were preparing for making their own role-play and simulation in the final phase.

The last task for this phase was introducing a textbook (the one I had brought from the Western university resources) to which students' appropriation and interpretation was remarkable.

10.3 *Textbook: 'Seeing' the Other*

Introduction to Clinical Medicine (2009) was the title of a textbook from Medical School resources at my university (in West) which I brought for students' information. This created a strong provocation for a dialogic struggle and a significant 'Aha moment' for both students and me as teacher and researcher. Though students seemed keen and excited to browse the book and explored different parts of it, it was evident to me that they were seeing the book with a very different lens, compared to the first session, when they mainly waited for the textbook as the main cultural capital from the 'other'.

Initially, most students expressed their positive attitudes to the book. They remarked on 'the relevance and practicality of sections', 'the consideration of psychological aspects in clinical diagnoses', 'meaningfulness of tasks,' 'concrete practices of role-plays', and even on charts and figures and cover of the book. They also supported each other in these general views about the textbook and design of each chapter.

However, it was evident that the way they evaluated the book was grounded in their stronger sense of medical identity, how they could see themselves and their profession ahead:

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> Mary: I liked the book because I really felt the writer sees me, knows me and my needs, understands which stage I am in, cares about my time and my situation
>
> Shiva: You are right, when I read this chapter, I found what the essential and fundamental terminologies related to brain diseases are, and then the writer explained about the less frequently used terms. Our EMP book could introduce terms like this.
>
> Alireza: In their design of each chapter, role plays and clinical communications are focused, as importantly as the main text and terminology list. It was easy to adopt in our book too.

These initial comments led to a deeper and more critical conversation around students' needs and rights (Benesch, 2001) as they began to critique and challenge their current EMP courses in which they felt deprived of having such sophisticated sources. However, this observation did not impede them from feeling agentive in making changes by identifying aspects of the book which might work well for them and embed them in their own ways of thinking, learning and studying, or in their own bricolage of re/sources. So, students in pairs or group decided to choose a topic from the book and discuss/ present it in combination with other resources such as stories, role plays in the final phase.

11 Phase Four: 'Seeing' Classroom as Clinic

Scaffolded on initial phases with ontological and epistemological focus on medical identity and medical knowledge (locally and globally), this final phase was to bring all those insights together in a practical engagement with a medical topic. Students were responsible to bring diverse sources and put it together to make new knowledge, like pieces of puzzles (to create their own bricolage) and to shape a new understanding. The first round of practice was a collective effort on the topic, chosen by students from the introduced book on brain disease and specifically on seizure and syncope. Students contributed in different ways to the discussion: Hamid began with sharing his personal experience and clinical exposure related to his mother's seizure, in a very engaging and professional language. This was continued by other group members, viewing video-clips in which two Iranian medical professionals (one inside the country and one in USA) were sharing their

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experiences on these topics. Shiva has brought a medical narrative which resulted in a strong engagement of students and long discussions around it. Shiva commented later:

> The language of this woman was so marvellous in the way she paid attention to many details and did not miss anything, when I was reading, I could visualize and even feel the pain she was writing about. She actually built the evidences very well and then related the symptoms to the terms.

After all these constructive dialogue among class, they consulted the factual information from the textbook and brought it all together. This dialogue took a while as all seemed to be very engaged in the discussion to assess different terms. It appeared that students hardly noticed that they had been talking in English. They also used the information in the textbook chapter occasionally in the midst of their self-generated dialogue. I was totally silent, as students were leading a highly technical discussion using terms in meaningful ways.

These initial practices made them very confident for their final symposium day which was open to all students (medical and non-medical). This was a meaningful practice for our cohort as they could share the medical knowledge in plain language, comprehensible to everyone and in an integrated and meaningful way. It was in fact a chance for their full autonomy and agency in making their own bricolage of sources and share it with others.

11.1 *Changes in 'Seeing': Inside-out Voices*

Symposium day was indeed a magnificent scene where these students presented their potentially (re)constructed voices and revealed their potential transformation in their medical identity as well as their knowledge of various medical discourse and genres in English. It was a new 'seeing' of self, discipline, patients and community of professionals.

The first thing 'seen' by people and audience was the ecology of their presentation: they arranged the whole setting more like a clinic and different wards of hospital, instead of a typical classroom or lecture type so that they could bring their academic and professional capabilities together. Some students wore their white coats, some acted as patients in their live role plays and medical simulations they were offering to the audience. They also voluntarily set up their own cameras for video-recording the sessions.

The main purpose of the symposium was an opportunity for:

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- Students' manifestation of their medical identity which has been co-constructed within the community of workshop practices; the extent to which they could present themselves confidently in English as a member of local/global medical community,
- Students' use of tone in the presentations, the tenor of dialogue and the extent of dialogic engagement with the community in general,
- Students' ability to integrate different sources of medical knowledge and different kinds of mediational tools to create a holistic meaning of terms in English, such as personal stories, medical narratives, medical evidences, research papers, the new textbook, role plays, simulations and clinical exposure with patients, doctors and hospital staff,
- Students' attempt to show their internalizing, contextualizing and actualizing of medical English terms by their vivid explanation and proper implementation of them in the flow of their talk at both academic and professional settings.
- Students' contribution to their peers' learning experiences through dialogues, questions and debates

All activities were arranged and practised in an integrated way as shown in Figure 2: personal stories acted as narratives, clinical exposures as scenarios, and the textbook was occasionally used as a point of reference. The movement between language activities was subtle, and this meant that students created knowledge and concepts as whole rather than in a fragmented way. Thee was obviously a very high level of engagement, and hours of efforts that these medical students spent on this, despite it having no direct impact on their assessment. This was impressive for me as an ethnographer.

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FIGURE 2 Integrated language practices in the Clinic-like classroom

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FIGURES 3–8 Engagement of students in the integrated language practices
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Figures 3–8 offer snapshots of how students ran the symposium by themselves. They also reflected afterwards on how their perception has changed regarding medical language, medical field and being a medical student, albeit to different degree. For students such as Mostafa who have been initially hesitant about their language abilities and their accent, it was transformative at the instrumental level of language and learning as a collaborative process, as he stated:

> Now, I know better ways of approaching my texts and am more careful in my language with patients. I am happy with what I did in the symposium. It was the first time I did not memorize my talk. I also forgot I was speaking in English may be because I was not thinking about my accent. Also, my friends were attentively listening to what I say rather than how I say this.

Nader's transformation was more at the ontological level of 'self'. He was the most resistant person toward the concept of 'who am I?' in the first phase and showed extreme alienation or anonymity with his identity but his presentation on the symposium was the most engaging one; he even continued these conversations in the online space afterwards and was seeking to engage others in the discussion. This dramatic change was recounted by his peers as well. Nader reflected on how he unfolded his dialogic capacity from 'self' to 'other' to reconstruct his new 'self' in the reflective process of becoming a voiced member of medical community:

> I do respect myself and my ideas, they are important now for me, I am closer to my real self. Now I decide and define who I am, not others for me.

Nader could expand his critical view toward 'self' beyond his medical identity and began to question his ethnic and religious identity as well. He even invited his Dad, as the point of authority, for a dialogue about being a medical student and a doctor:

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> I told my Dad that although I respect him as a highly successful professional, I like to find and choose my way myself, want to express myself and I want to be heard.

The highlight of the symposium day was two female students, Rosa and Raha (see Figures 9–12) who raised all resources to the occasion and impressed all the audience as they had gone to the hospital in person and recounted the process of kidney transplantation as they actually 'saw' and learned. As shown in pictures below, they took an image of themselves in white coat and green coat as outside manifestations of their identity and also of their patient, as they had a chat with him.

FIGURES 9–12 Rosa and Raha in embodied practice of 'seeing' in medical context
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Rosa's and Raha's joint presentation was an example of an integrated and dialogic practice, mediated by various sources of medical knowledge. They

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integrated the story of this clinical experience with other video clips, research papers and their own challenges within the social and ethical aspects of this operation.

Also, as shown in pictures below, students' way of embodied practice in role plays and medical simulations were impressive. Raha and Rosa conducted their role play with an imaginary patient and were very careful about the choice of words/terms in their explanations for the patient. Raha was satisfied with this experience and could monitor herself and her transformation throughout the workshop series:

> I guess I reach the main aims of this project, which is integration. I actually feel integration in my character too. I felt integration in the academic context of the class very well and then I transferred it to the clinic. I learn disease through memorizing that patient, not just terms and symptoms; I have a picture from each patient in my mind. Now I actually see how we can learn medical terms as a package rather than many separate things.

Rosa, the initially hesitant medical character, appeared very confident and settled in her white coat, leading a dialogic discussion with peers in the community, which revealed her multi-faceted appropriation of medical English practices in the dialogic workshops.

> I redefined my identity as a medical student. Now I am much more hopeful, more motivated and more in charge. I know what is related to me and what is irrelevant. I know I can choose, decide, select and act strongly. I am not waiting for others to decide for me what to read, where to go. I think my targets have changed from mark to more of understanding and self-satisfaction

11.2 *Artifacts: Power of 'Visuals'*

Along with their powerful talk and presentations, what students produced as their artifacts to make the knowledge around one medical topic more accessible and meaningful was a very powerful field of seeing themselves and their new vision toward their identity and place. As shown in Figures 13–18, most visuals are story-based, with the name of the patient at the middle and all symptoms and other facts around. The language is meticulously chosen, and the affective aspect of the language and clinical practice is attended to. This was the space where seeing the patient was not just metaphorically but literally significant to these students.

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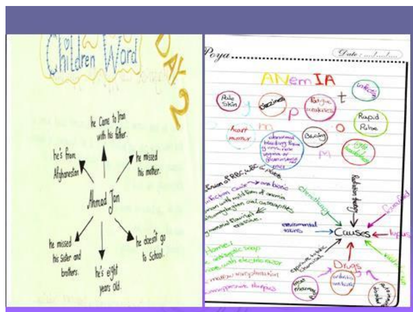

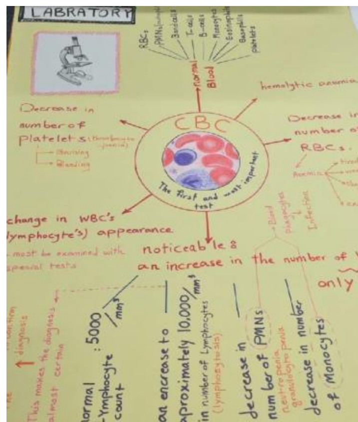

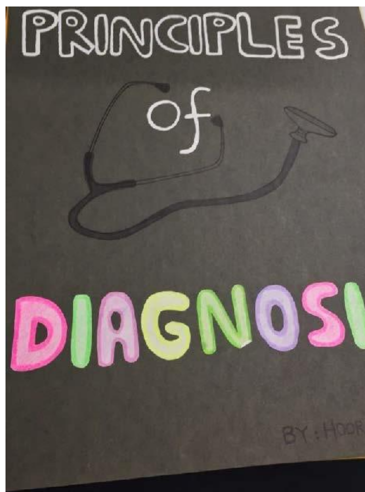

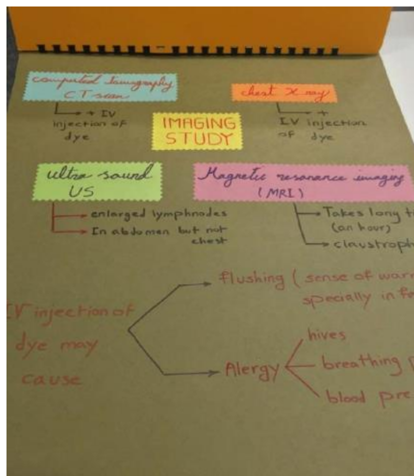

FIGURES 13–18 Artifacts as power-ful visuals

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Students were very proud of these artifacts as well as whole symposium experience. After the project finished, they continued these integrated dialogic practices by themselves.

12 Weaving Vision: Power of Eyes/Is

This article has interrogated the dangerous tendency for underlying epistemological assumptions of academic and professional knowledge to foster instrumental, monologic and fragmented way of seeing the self, the world and others. The significance of this issue in the dangerous times of self-alienation and forgetfulness of humanity was examined in the specific and sensitive context of medical language courses in an Iranian university. Although the context presented in this paper was explicitly monologic, due to the conservative political and educational system, the closer 'seeing' of this matter reveal the urgency of the issue more globally. The dominance of authoritative voices over internally persuasive voices (Bakhtin) is a worldwide matter which results in individuals' becoming blind to who they are and who they could become. Language and literacy education offer a powerful space to bring the attention back to the ontological and identity investment we make through language, especially when it is chosen to be the language of power, English. Learning English is more than simply learning a second or foreign language; it bears huge political, historical, cultural and social weight (Canagarajah, 2014; Jenkins, 2013; Chowdhury & Phan, 2014) which makes the purpose of learning English an intriguing phenomenon. How individuals strive to locate themselves within such powerful and complex language norms, matters significantly and therefore the way people 'see' themselves in the other language is very significant. Nader emphasized that delivery of these concepts in English made a difference in the way he re-visioned his view:

> If I heard about these concepts in other classes in Farsi, I would not be affected that much, while in English it becomes suddenly important.

Though this clearly shows the value-laden nature of English, our responsibility as language educators is to use this space for creating more awareness, autonomy, authenticity and agency (Van Lier, 1996) rather than educating people toward becoming blind and anonymous with self and

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others through assimilating to the instrumental technicality of language pedagogy.

Equally important as power of language in the ways we 'see' and create the reality, is the powerful politics of seeing through different eyes as it shapes different 'I's/identities: this was revealed to me vividly in how the way students 'saw' me changed from day one to the last day. Initially my positionality as insider/outsider to that space was seeing as 'other' with that associated capital (both human and cultural ones). Gradually and as the trust emerged throughout the dialogic discussion and the power hierarchy was deliberately broken, students 'saw' me very differently. Roza and Raha, two female students who showed the utmost engagement with integrated, dialogic practice, commented on my gender, ethnicity and my agency to run this intervention in a way to empower them to do the similar thing:

> You may not notice, but in our class, females were more active than male students; your impact was very strong on us, I liked your passion to make change despite any constraints, I told Rosa we can do this in our context.

This comment was revealing to me in terms of how we see ourselves dialogically in relation to others. The way I came to 'see' myself as an ethnographer was dramatically shaped through interaction with people. This is what Bakhtin beautifully terms as 'I for myself', 'I for other', 'others for me' which can be seen as a profound vision we can weave as educators in dangerous times.

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