

Multimodal recontextualization in medical TV series: Pedagogical insights from *The Good Doctor*

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ABSTRACT

This paper explores medical discourse as realistically portrayed in audiovisual materials, in order to extract potential pedagogical implications for ESP settings (English for Specific Purposes). In particular, we focus on recontextualization strategies used in medical communication, which can help enhance the communication skills of future healthcare professionals and science communicators. The study takes a communicative perspective and supports using TV series as sources of quasi-authentic interactions that provide examples of realistic, context-rich discourse. Our approach is multimodal, taking into account the wide range of semiotic resources that aid effective communication in medical settings. We perform a Multimodal Interaction Analysis of six selected excerpts of the TV series *The Good Doctor*, featuring recontextualization strategies. Our results reveal significantly different modal configurations in the two distinct layers of recontextualization found in the materials: recontextualization for characters in the series (e.g. patients and care-givers), which is performed through a combination of verbal and non-verbal resources; and recontextualization for the audience, present in complex unabridged medical interactions, which is mainly achieved through filmic resources. The results can inform pedagogical proposals for EMP courses (English for Medical Purposes) as well as training for Health Care scientists willing to disseminate their findings.

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1. Introduction

In this paper we present an analysis of specific discursive practices within medical discourse, i.e., recontextualization strategies (Luzón, 2019; Ruiz-Madrid & Valeiras-Jurado, 2023; Valeiras-Jurado & Ruiz-Madrid, 2023). These strategies entail linguistic and non-verbal resources which are necessary to adapt specialized communication to non-expert audiences. Examples of these strategies include the use of analogies, the use of visual supporting resources or paraphrasing using more familiar language, among others. An efficient use of these types of strategies would facilitate smoother interactions between health care providers and patients, and could potentially be of use to improve the communicative skills of both future practitioners and science disseminators in the field of Health Sciences. The present study is based on a communicative approach and advocates for the use of TV series as input of quasi-authentic discourse that offer examples of contextualized,

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realistic language use. Our proposal adopts a multimodal approach, considering the full array of semiotic resources that facilitate communication in medical contexts.

1.1. English for medical purposes

English for Medical Purposes (EMP), or English for Health Sciences, is the branch of ESP directly related to medical discourse, which comprises the communication practices used within the healthcare field. It aims to address the academic and professional needs of students from any of the disciplines within the Health Sciences. Maher (1986) defines EMP as the teaching of English to (future) professionals in medicine, nursing, and related fields. It therefore focuses on the type of vocabulary, language skills, and communicative abilities that health professionals need to master in the course of their work (Antic, 2007).

According to Salager-Meyer (2014), research on EMP has focused on addressing the needs of EMP users across three main areas. The first focuses on improving the English language skills of non-Anglophone medical students and health professionals to provide them with the communicative skills they need. The relevance of this approach becomes evident when considering that language barriers reduce satisfaction for both health care professionals and patients, as well as the quality of care and patient safety (Al Shamsi, Almutairi, Al Mashrafi, & Al Kalbani, 2020). The second area is linguistic analysis of medical conference presentations. Scientific communication at nursing conferences has been the subject of study in Ruiz-Garrido (2019), who analyzes the initial stage of nursing presentations from a multimodal perspective, and in Ruiz-Garrido and Molés Julio (2021), who examine how Spanish-speaking nursing professionals face the challenge of giving presentations in English at conferences.

The third category aims to analyze the way doctors (DRs), patients (PTs) and care-givers (CGs) communicate and interact. Previous studies highlight the importance of the relationship between health care professionals and PTs, which largely depends on communication being fluent, empathetic, cooperative, and based on trust (Kuo, Chin, & Chou, 2011; Lin, 2008). In this respect, Fong Ha and Longnecker (2010) identify a number of communication and interpersonal skills necessary for health care providers. These include the ability to gather information in order to facilitate accurate diagnosis, counsel appropriately, give therapeutic instructions, and establish caring relationships with PTs. They consider that the three main goals of current DR–PT communication are 1) creating a good interpersonal relationship, 2) facilitating exchange of information, and 3) including PTs in decision making. It follows from this that health care professionals need to communicate effectively not only with other members of their discourse community, such as colleagues, but also with PTs, family members, and CGs, and this communication is most often spoken (Medlin, 2009). Previous needs analysis studies in ESP settings show that students of EMP place greater importance on spoken skills (listening and speaking) and less on written production (Chien, 2019). This is because, in their professional day to day practice, they tend to have more opportunities for spoken than written interaction. Furthermore, as Lu (2018) points out, students are also very aware of the need to adapt information when speaking with PTs and families (e.g., replacing technical terms with semi-technical or general ones). In this paper we expand on this previous line of work by adopting a multimodal approach to describe the interaction among DRs–PTs–CGs. In particular, we present an analysis of specific discursive practices within medical discourse used to tailor information to non-experts (i.e., recontextualization strategies—See Section 1.4), that can be of use to improve the communicative skills of future practitioners and science disseminators.

1.2. Fiction as pedagogical material in Health Sciences

The present study adopts a communicative approach, viewing EMP not merely as course content but as a practical set of communicative skills essential for students' future professional practice. Conveying this view of English requires providing realistic examples of language use, as well as opportunities and contexts for students to practice the language. According to Bonsignori (2019), to train future practitioners in these discursive practices we need to have access to real DR–PT and DR–DR interactions. Unfortunately, these are rarely accessible due to confidentiality policies. As a substitute, clips from TV shows might entail a suitable alternative. These shows portray specialized and professional communicative contexts, being not only entertaining, but also accurate in their staging of realistic situations (McGann, 2015; Shevell, Thomas, & Fuks, 2014; Stanhope, 2015). However, an important distinction needs to be made when assessing the appropriateness of TV material for the teaching of ESP, which is that between *verisimilitude* and *truthfulness*. In cinema studies, *verisimilitude* relates to plausibility, that is, how believable or consistent a narrative is perceived according to its own logic and genre conventions. *Truthfulness*, on the other hand refers to fidelity to real-world facts or ethical authenticity, especially in representations of actual events or professional practices. While *verisimilitude* promotes audience engagement and entertainment, *truthfulness* makes the narrative faithful to reality and turns it into a valuable resource to learn about real professional practices (Sánchez-Escalonilla, 2013). The line separating these two concepts in TV shows is somewhat blurry; thus, it is always necessary for instructors to bear this in mind.

The interest of medical TV series for research and pedagogical purposes is evidenced by projects such as the House Corpus (Baldry, 2019; Baldry, Thibault, Coccetta, Kantz, & Taibi, 2020; Coccetta, 2019; Loiacono & Tursi, 2019; Taibi, Marenzi, & Ahmad, 2019). This corpus includes episodes in the TV series *House, M.D.* (Shore, 2004–2012), which were divided into scenes, transcribed and annotated in terms of character types (e.g., DRs, PTs and CGs) and voice characteristics. It has been used to explore terminological, textual, and interactional aspects of medical English, as well as for the training of medical students with respect to medical acronyms (Loiacono & Tursi, 2019), or color-based medical grading systems to determine the level of severity in accidents (Baldry et al., 2020). Other studies have also exploited the TV series *The Good Doctor* (Gordon et al., 2017) for pedagogical purposes. For example, Hayugraha, Nababan, and Marmanto (2019) focus on the teaching of speech acts; and Kusumawati (2019) looks into the use of subtitles for vocabulary teaching. Furthermore, Aulia, Rachmawati, and Tarwana (2022) identify vocabulary needs of medical students (e.g., vocabulary related to drugs, diseases, body anatomy, and medical equipment) and discuss how the series can help cover those needs. Similarly, Vignozzi (2020) analyses the TV series *Grey's Anatomy* (Rhimes, 2005) and reveals some recurrent linguistic usages and attached pragmatic functions that could feed ESP courses of medical English. He concludes that the series provides a wide repertoire of medical contexts which portray medical interactional exchanges both between medical professionals and between DRs and PTs and recommends further research to check the validity and authenticity of this material.

1.3. Multimodality in medical discourse

It is also important to highlight that medical discourse is not limited to written or spoken language. Research has revealed the key role of individual non-verbal elements (e.g., gestures, facial expressions, head movements, gaze, intonation, and posture, among others) in PT engagement and management (Duffy, Gordon, Whelan, Cole-Kelly, & Frankel, 2004; Franceschi, 2017; Yasmeeen, 2015). In other words, medical discourse is inherently multimodal, as it draws on semiotic resources (or modes) that combine in multimodal ensembles. However, the combined effect of these elements in relation to the context where they occur, is still scarcely studied (Manusov & Patterson, 2006).

More recent studies show how some of these modes are performed with the body and can be referred to as embodied modes (Valeiras-Jurado & Bernad-Mechó, 2022). These modes have been shown to play a decisive role in producing convincing and persuasive messages in academic and professional spoken genres (Valeiras-Jurado, 2020; Valeiras-Jurado, 2021; Valeiras-Jurado & Ruiz-Madrid, 2019). In professional contexts specific to the field of Health Sciences, other semiotic resources also come into play, such as the use of uniforms or medical instruments. Unlike the former, these modes are external to the body (although they can also be manipulated with it, for example, by holding an object in one's hands) and can be called disembodied modes (Ruiz-Madrid & Valeiras-Jurado, 2023). Lastly, in the case of digitally mediated spoken genres, such as videos, vlogs, or podcasts, a third type of mode comes into play—one that is not controlled by the speaker but by the editing team in the post-production stage, such as visual and sound effects. These are known as filmic modes (Bernad-Mechó & Valeiras-Jurado, 2023; Valeiras-Jurado & Bernad-Mechó, 2022). Therefore, in order to provide realistic examples of medical discourse in line with a communicative approach, it is vital to consider the variety of semiotic resources involved in communication, or in other words, its multimodal nature. For this reason, this study adopts a multimodal approach.

Multimodal (Inter)action Analysis (MIA), as developed by Norris (2004), offers a particularly suitable framework for exploring the complexity of recontextualization strategies in fictional medical discourse. This approach can help identify how social actors organize their actions across various modes. Central to MIA is the concept of higher-level actions (HLAs), integrated actions (e.g., *explaining a problem* or *giving an example*) composed of sequences of lower-level actions (LLA) (e.g., *gestures, gaze, spoken language, use of artifacts*, etc.). Moreover, when HLAs are the result of actions that took place in the past, they are referred to as *frozen actions*. For instance, the presence of a soundtrack in a movie can be seen as a frozen action resulting from the previous HLAs of *composing, recording*, etc. A representation of the semiotic modes co-occurring in any single moment is referred to as *modal configuration*. Modal configurations are not static; instead, they shift depending on the attention and awareness they receive in interaction. This fluid structure is particularly valuable for analyzing fictional DR–DR and DR–PT exchanges, where recontextualization emerges through complex layers of meaning-making involving speech, body language, visual cues, and objects. The amount of modes playing a role in conveying meaning in a modal configuration may be referred to as *modal density*. Particularly relevant to our analysis is the way HLAs often merge into one another to create interactions in the TV series that mirror real-life communication while serving narrative and didactic functions. These interactions are constructed to balance technical accuracy with audience accessibility, and MIA enables us to trace the semiotic mechanisms behind this balance. By focusing on how modal density and attention foreground certain actions while backgrounding others, we can identify the semiotic strategies that facilitate recontextualization for viewers,

distinguishing between actions oriented toward diegetic interlocutors and those designed to guide audience understanding.

One of the key ideas underlying this study is that to ensure effective communication, it is not only necessary to be aware of the variety of available semiotic resources (embodied, disembodied, and filmic), but also to know how to use them coherently so they contribute together to convey the intended meaning and adapt to the interlocutor's response. This can be referred to as *modal coherence*, which has been shown to play a decisive role in the potential success of communication. However, incoherent use of modes can negatively impact the persuasive effect of a message (Valeiras-Jurado, 2019). This has also been noted in the case of medical discourse. Manusov and Patterson (2006), for example, point at the need to consider how verbal and non-verbal aspects of communication interact in DR–PT communication. They argue that “the social meaning of nonverbal behavior—and thus its production, understanding, and effects—is fundamentally and irremediably shaped by, and thus must be studied relative to, its situation within a variety of aspects of interactional context” (p. 454). Furthermore, Valeiras-Jurado & Bernad-Mechó, 2022 emphasize the importance of *modal coherence* in spoken science communication genres, particularly in digitally mediated genres that employ complex multimodal constructs involving filmic and embodied modes.

1.4. *Recontextualization in medical discourse*

As argued in the previous sections, we can conclude that it is of utmost importance for health care professionals not only to master specialized language, but also to be able to adapt it so that it becomes understandable to non-experts. This process of adapting communication to a new audience has been referred to in previous literature as *recontextualization*, and the communicative practices that make it possible are known as *recontextualization strategies* (Luzón, 2019). Furthermore, previous research has shown how these strategies are frequently multimodal, because they involve the use of different semiotic resources (Ruiz-Madrid & Valeiras-Jurado, 2023; Valeiras-Jurado & Ruiz-Madrid, 2023).

Recontextualization is a phenomenon which is present in many discursive situations. Bezemer and Kress (2008) study how this multimodal process of adaptation to the audience occurs in educational contexts, where professional genres are reshaped to become more pedagogical and are transformed into teaching genres. On the other hand, recontextualization in science communication has also sparked considerable and recent interest. In the context of science popularization, recontextualization involves transferring scientific content from academia and its associated genres to a different context, where new genres and new multimodal constructs (multimodal ensembles) emerge. In the case of scientific discourse, Luzón (2019) identifies four groups of recontextualization strategies based on their function: establishing credibility, constructing persuasive arguments, engaging the audience (*engagement strategies*), and adapting information to the presumed knowledge of the audience. The present study focuses on the latter.

Luzón (2019) also notes that these strategies are multimodal, orchestrating words, gestures, and images among other semiotic resources. Along this line, Ruiz-Madrid & Valeiras-Jurado, 2023 offer an in-depth analysis of multimodal recontextualization in science dissemination videos, showing how even less obvious modes (such as clothing or handled objects) significantly contribute to the recontextualization process.

Recontextualization practices in medical discourse have not been systematically addressed from a multimodal perspective. To our knowledge, few studies undertake multimodal studies of recontextualization in medical discourse. Franceschi (2017) identifies verbal strategies such as simplification, repetition, reformulation and informality, which contribute to tailoring the information to the PT. Furthermore, he points out how gestures can contribute to clarifying content for the PT. In follow-up studies (Franceschi, 2018), he also demonstrates how a multimodal approach can be integrated into an EMP curriculum and presents a series of activities that can raise multimodal awareness among learners of medical English drawing attention to modes as gestures, facial expression, gaze or clothing.

Although the importance of non-verbal aspects in medical discourse has long been acknowledged, a focus on multimodal ensembles and the way modal configurations evolve throughout the interaction is still lacking, since previous studies tend to consider isolated aspects (e.g., gestures) without conclusive results (Manusov & Patterson, 2006). From a pedagogical point of view, medical TV series have been used to teach vocabulary, jargon, and some pragmatic functions. However, to our knowledge they have still not been exploited to teach complex discursive skills. The present study aims to contribute to this line of research and cover what we perceive as a gap in the field of EMP. We explore how recontextualization is multimodally realized in selected DRs-PTs-CGs interactions in the series *The Good Doctor*. By emphasizing the joint effect of multimodal ensembles and modal coherence in sensitive medical interactions, trainers can help future practitioners master discursive skills, such as recontextualization. This, in turn, can result in smoother interactions with PTs and more efficient communication. To address this gap, we aim to answer the following research question:

- What multimodal recontextualization strategies can be identified in the series *The Good Doctor*? What semiotic modes are involved in the recontextualization process?

2. Methodology

2.1. The dataset

To conduct our study, we compiled a dataset consisting of 6 short fragments extracted from season 1 of the *The Good Doctor* (Gordon et al., 2017). *The Good Doctor* is an American medical drama series that premiered on ABC in 2017, developed by David Shore and produced by Sony Pictures Television, ABC Studios, 3AD, EnterMedia Contents, and Shore Z Productions. The show follows Dr. Shaun Murphy, a young surgical resident with autism and savant syndrome, navigating the challenges of hospital life. As argued above, the difficulties in acquiring real medical discourse make TV shows such as *The Good Doctor* plausible alternatives, especially when it comes to portraying clinical interactions and ethical dilemmas and how these are communicated to a lay audience (either the characters in the series or the ultimate recipients of these interactions, i.e., the viewers).

The fragments were manually selected after both researchers carried out a comprehensive viewing of season 1, focusing on scenes where recontextualization occurs (where complex medical jargon and procedures are adapted for a lay audience). These excerpts were chosen to represent two primary types of contexts observed in the series: (i) specialized conversations among medical professionals, and (ii) interactions between DRs and PTs or their CGs. The former type (Group 1–G1) include conversations among DRs that are typically less recontextualized, including jargon and technical explanations, which contribute to building on the verisimilitude of the show. In fact, an abridged conversation in these cases could trigger a disbelief reaction in the viewers. Yet, while these contribute to building credibility between viewers and the fiction, they might also be too complex for the understanding of lay people. In these cases, the producers sometimes resort to non-diegetic visuals (post-production elements not seen or heard by the characters in the fiction) that help spectators grasp a better understanding of the specialized content. This type of recontextualization is a direct one between the producers of the series and the audience. On the other hand, the interactions between DRs and PTs or their CGs (Group 2–G2) entail two-degree recontextualizations: initially, the conversations are adapted so that the characters in the series can understand the main message. At the same time, this recontextualization is also useful for the viewers, who might still not be quite aware of the medical issues at hand. In these interactions DRs may also resort to diegetic artifacts to help in their explanation (elements seen and heard by the characters in the fiction, such as organ models, tablet computers or diagrams). Finally, although we also identified less frequent forms of recontextualization—such as exchanges between specialized and non-specialized DRs—, these examples were not included in the dataset, as they lacked the explicitness of recontextualization of the two types selected. Table 1 below summarizes the dataset, describing the type, content, duration of the fragments and number of words.

Table 1
Fragments selected for the analysis of recontextualization.

Code	Episode	Type	Content	Duration	No. of words
G1_01	S01E07 09:50–10:07	DR–DR + non-diegetic visuals	Two DRs discuss the differential diagnosis for biliary tree scarring.	17"	47
G1_02	S01E15 15:40–15:56	DR–DR + non-diegetic visuals	Three DRs discuss the possibility to use a resorbable material to create an artificial sternum.	16"	45
G2_01	S01E10 30:12–31:56	DR–PT + diegetic visuals	Four DRs explain the complex procedure to excise a tumor in a PT's brain. The procedure is highly risky and will leave the PT partially paralyzed.	104"	171
G2_02	S01E17 00:52–01:18	DR–PT + diegetic visuals	Three DRs explain a procedure to restore the mobility of a facial nerve to a PT and her CG.	26"	82
G2_03	S01E12 19:35–19:55	DR–PT	Two DRs explain to a PT and her mother how the PT's sister is clinically dead.	20"	40
G2_04	S01E12 30:50–31:19	DR–CG	Three DRs explain to a CG the urgency to find a heart donor for her daughter.	29"	91

2.2. Analysis of multimodal recontextualization

To analyze how specialized medical discourse is adjusted for non-expert audiences, we examined each fragment in terms of recontextualization strategies. We drew from previous taxonomies of recontextualization in science communication (Luzón, 2019; Valeiras-Jurado et al., 2018; Valeiras-Jurado & Ruiz-Madrid, 2023) and adapted these

frameworks to the fictional nature of our dataset. While these previous taxonomies typically encompass strategies related to *tailoring information*, *building credibility*, and *engaging the audience*, we focused exclusively on the first type of strategies, i.e., a range of techniques used to make complex or technical content more accessible to a lay audience. The reason for focusing on this group exclusively is because this is the only set of strategies that clearly operates within the two narrative layers identified in our dataset. As discussed above, one layer involves specialized DR–DR interactions that the producers adapt for viewers using non-diegetic visuals. The other involves DR–PT/CG conversations within the diegesis, which are also carefully crafted by the scriptwriters to ensure audience comprehension. In both cases there is an effort by the producers to facilitate comprehension (tailoring information). In contrast, strategies for *building credibility* are mainly directed to the audience to create a sense of verisimilitude, and they are not necessarily made explicit for the characters within the fiction. Similarly, *audience engagement* is achieved mainly through narrative and cinematic devices directed to the audience (e.g., plot tension, music, acting), rather than through discursive strategies in the fiction.

Thus, following an inductive approach to the video dataset (Goldman, Pea, Barron, & Derry, 2007), we identified a range of techniques to tailor information to non-expert audiences in line with Luzón (2019) and Valeiras-Jurado & Ruiz-Madrid, 2023:

- Definitions and explanations: DRs provide definitions of concepts or brief explanations of procedures or other important information.
- Selection of content: Omitting or simplifying information deemed too complex or irrelevant for the audience, and/or arranging this information in a suitable order.
- Paraphrasing: Restating medical information using simpler or more familiar language.
- Analogies: Using comparisons to familiar ideas or objects to explain medical concepts.
- Examples from everyday life: Drawing on common experiences to contextualize information.
- Scenarios or storytelling: Inviting the PT to imagine situations (“picture yourself ...”) to aid understanding.
- Visual representations: Including diegetic tools and artifacts such as diagrams or tablets, or iconic gestures that help clarify the message. We also expand this category to include non-diegetic visual representations added by the producers to facilitate comprehension.

To carry out the multimodal analysis of recontextualization strategies, we paid attention to the specific modes present in each type of interaction. For Group 1 (DR–DR interactions), we limited our analysis to filmic modes, as these interactions are not recontextualized within the diegesis itself but rather through the interventions of the producers. That is, the fictional DRs continue to speak in technical, unabridged language, and it is through visual aids provided non-diegetically that the audience is able to understand what is being discussed. Based on a simplified version of Valeiras-Jurado & Bernad-Mechó, 2022 taxonomy, we examined the use of visual prompts (including on-screen text and images) that help clarify or reinforce medical content for non-expert viewers, as well as visual and sound effects accompanying those prompts. For Group 2 (DR–PT/CG interactions), we focused on both embodied (Valeiras-Jurado & Bernad-Mechó, 2022) and disembodied modes (Ruiz-Madrid & Valeiras-Jurado, 2023), as the recontextualization is integrated into the diegesis and designed to make medical information comprehensible for both the fictional PTs and the real audience. As for the embodied modes, we analyzed spoken language, paralinguistic, gestures and gaze. For spoken language we focused on the content and use of pauses. Paralinguistic includes voice qualities and vocalizations other than the sounds of language (Poyatos, 1983). In our case, we focus on instances of linguistic prominence. Regarding gestures, we classified them according to McNeill’s (1992) functional typology: iconic (gestures that visually represent concrete actions or objects), metaphoric (which represent abstract ideas), deictic (used to point to locations or referents), and beats (rhythmic hand movements that follow the cadence or emphasis of speech). Finally, for gaze, we considered its direction (towards PTs, other DRs, artifacts, etc.). Disembodied modes, such as the use of artifacts (e.g., tablets, diagrams), were also considered for how they supported the transmission and clarification of information within the interaction. Importantly, we excluded purely filmic techniques aimed at creating dramatic or aesthetic effects (such as soundtrack, shot types, or editing cuts), as our focus remained on the semiotic resources that directly contributed to viewers’ comprehension of medical discourse.

2.3. Procedure and analysis

To conduct our multimodal annotation and analysis, we employed GRAPE-MARS (Multimodal Annotation Research Software), an open-source platform specifically developed for the systematic study of multimodal discourse (Fortanet Gómez, Ruiz Madrid, Bernad-Mechó, & Valeiras-Jurado, 2025; Ruiz-Madrid, Fortanet-Gómez, Bernad-Mechó, & Valeiras-Jurado, 2023). Designed by the XXXX (Name of research group) at XXX (Affiliation), GRAPE-MARS facilitates the detailed manual annotation of audiovisual data across a range of customizable communicative modes. In fact, the software supports the tailored integration of diverse semiotic resources—organized into tiers—into a unified analytical framework. This enables both fine-grained qualitative analyses of the distribution of modes across the clips as well as quantitative representations of modal density and interactional patterns for any specific instant. This quantitative analysis is done by providing

percentages of use and number of occurrences for each mode as well as detailed visual descriptions of specific modal configurations.

The analytical process began with the identification of actions within the dataset (HLAs for the interaction among characters, and frozen actions when interacting directly between producers and audience). It is important to highlight that only HLAs carried out by DRs were analyzed, as these are the actions including recontextualization strategies. These actions were annotated on dedicated tiers in GRAPE-MARS (one per speaker). In the case of PTs and CGs, the analysis was limited to their response to recontextualization strategies. Parallel to this, we developed another tier to annotate recontextualization strategies, allowing us to explore the interplay between these strategies and the broader communicative actions in which they were embedded. The annotations in these tiers were data-driven and developed collaboratively: both researchers jointly reviewed the selected fragments, discussing and refining the classification of recontextualization types and the structuring of actions to ensure analytical coherence and intersubjective agreement. Following these initial layers of annotation, we proceeded to create a third group of tiers corresponding to the specific modes under analysis (see section 2.2), and to annotate the occurrences for these modes.

After annotating the fragments, we combined quantitative and qualitative approaches to examine how recontextualization strategies were multimodally realized across the dataset. From a quantitative perspective, we used the “Analytics” function in GRAPE-MARS to calculate the frequency (number of occurrences of a given annotation) and duration (percentage of time of a given annotation over the total length of each clip). This approach allowed us match each recontextualization strategy with the modes employed in their realization, determining which semiotic resources were most prominent for each strategy and in each context. Through this analysis, we could define which recontextualization strategies were embedded within each action, and we could provide a description of the modal configurations realizing each strategy. Qualitatively, special attention was also paid to the sequential development of actions in each fragment, identifying how actions emerged, merged, or transitioned into others, adapting to the PT’s response, and contributing dynamically to the recontextualization process. Finally, we considered the pedagogical implications of these findings, particularly how this multimodal awareness and analytical framework can inform the design of teaching materials and training practices in ESP in health communication contexts.

3. Results and discussion

Our analyses of the dataset revealed at least two levels of recontextualization: one between the producers of the show and the audience (Group 1), and a second one between DRs and PTs/CGs (Group 2). It may be argued that the second layer also implies the first one, since recontextualizing content for the characters in the series also has the effect of facilitating the content for the audience.

Group 1 recontextualization is not realized by the characters in the fiction. In fact, their conversation in these excerpts is unabridged, using complex jargon, arguably inaccessible for the viewers. To maintain interest and help viewers follow the storyline, producers resort to the use of non-diegetic filmic resources, i.e., elements that are external to the characters. In the two fragments considered in the dataset, these filmic elements consist of images of organs and parts of the human body. In other words, *visual representation* is the recontextualization strategy used in these clips, as shown in Table 2.

Table 2

Quantitative data on the use of recontextualization strategies for Group 1.

Annotation name	Occurrences	Time %	Total duration
Recontextualization Strategies	2	61.49 %	00:00:20.30
 definitions and explanations	0	0.00 %	00:00:00.00
 selection of content	0	0.00 %	00:00:00.00
 analogies	0	0.00 %	00:00:00.00
 examples	0	0.00 %	00:00:00.00
 scenarios	0	0.00 %	00:00:00.00
 visual representations	2	61.49 %	00:00:20.30
 paraphrases	0	0.00 %	00:00:00.00

In terms of semiotic modes, the strategy *visual representation* is realized by means of *images* and *written text* appearing on screen. Furthermore, these images appear and disappear and are rearranged on the screen, which can be regarded as *visual effects*. As these animations are accompanied by sounds, there is also presence of *sound effects* (see Table 3).

Table 3

Quantitative data on the use of semiotic modes for Group 1.

Annotation name	Occurrences	Time %	Total duration
Spoken language	0	0.00 %	00:00:00.00
● Spoken language	0	0.00 %	00:00:00.00
● Pauses	0	0.00 %	00:00:00.00
Paralanguage	0	0.00 %	00:00:00.00
● Prominences	0	0.00 %	00:00:00.00
Gestures	0	0.00 %	00:00:00.00
● metaphorical	0	0.00 %	00:00:00.00
● iconic	0	0.00 %	00:00:00.00
● deictic	0	0.00 %	00:00:00.00
● beats	0	0.00 %	00:00:00.00
Gaze	0	0.00 %	00:00:00.00
● interlocutor	0	0.00 %	00:00:00.00
● other	0	0.00 %	00:00:00.00
● artifact	0	0.00 %	00:00:00.00
Use of artefacts	0	0.00 %	00:00:00.00
Text	1	37.22 %	00:00:12.29
Image	2	61.09 %	00:00:20.17
Sound effects	7	42.79 %	00:00:14.13
Visual effects	4	47.01 %	00:00:15.52

Concerning Group 2, the strategies employed are more varied. The results show that *definitions and explanations* are present 22.44% of the time, closely followed by *visual representations* (16.8%). Next in frequency are *scenarios* (16.8%), in which DRs ask PTs to picture a specific situation, and *selection of content* (9.63%), in which DRs select what information to give and in which order. These results are summarized in Table 4.

Table 4

Quantitative data on the use of recontextualization strategies for Group 2.

Annotation name	Occurrences	Time %	Total duration
Recontextualization Strategies	21	67.46 %	00:02:00.10
● definitions and explanations	6	22.44 %	00:00:39.95
● selection of content	5	9.63 %	00:00:17.13
● analogies	1	1.13 %	00:00:02.01
● examples	0	0.00 %	00:00:00.00
● scenarios	4	10.24 %	00:00:18.23
● visual representations	2	16.80 %	00:00:29.90
● paraphrases	3	7.22 %	00:00:12.85

As for the modal realization of these strategies, an analysis of the modes employed reveals an important presence of spoken language (49.49%), pauses (19.02%) and prominences (13.15%), as well as a remarkable role of gaze directed to the interlocutor (73.89%). In comparison, the use of gestures is rather limited (1.97%). [Table 5](#) summarizes these results.

Table 5

Quantitative data on the use of semiotic modes for Group 2.

Annotation name	Occurrences	Time %	Total duration
Spoken language	38	68.51 %	00:02:01.98
● Spoken language	22	49.49 %	00:01:28.11
● Pauses	16	19.02 %	00:00:33.86
Paralanguage	24	13.15 %	00:00:23.41
● Prominences	24	13.15 %	00:00:23.41
Gestures	7	1.97 %	00:00:03.50
● metaphoric	1	0.58 %	00:00:01.02
● iconic	0	0.00 %	00:00:00.00
● deictic	3	0.67 %	00:00:01.19
● beats	3	0.72 %	00:00:01.27
Gaze	35	93.03 %	00:02:45.63
● interlocutor	19	73.89 %	00:02:11.56
● other	10	9.67 %	00:00:17.22
● artifact	6	9.46 %	00:00:16.85
Use of artefacts	0	0.00 %	00:00:00.00
Text	0	0.00 %	00:00:00.00
Image	0	0.00 %	00:00:00.00
Sound effects	0	0.00 %	00:00:00.00
Visual effects	0	0.00 %	00:00:00.00

In order to provide a more qualitative and contextualized view of these quantitative results, two excerpts are analyzed in detail in the following paragraphs.

Figure 1 below shows screenshots from excerpt G1_01, in which two DRs discuss the differential diagnosis for biliary tree scarring—the formation of scar tissue in the bile ducts. For this diagnosis, the main character, Dr. Shaun Murphy, suggests a list of symptoms they could look for in the PT to confirm the disease (“primary sclerosing cholangitis, liver failure, secondary to primary biliary cirrhosis”). To help the viewer—partially—understand this complex medical jargon, images of these symptoms fade into the shot, accompanied by text. The quantitative analysis in GRAPE-MARS reveals the use of *visual representation* strategies in 71% of the clip. The strategy is realized through the use of image and text accompanied by sound and visual effects. It is worth noting the importance of synchronization among these modes, providing coherence to the multimodal configurations. For instance, sound and visual effects help transition from one representation to the next. Moreover, the visuals are positioned following the rule of thirds in cinematography (Wheeler, 2012), i.e., using one third of the image and leaving the other two less prominent. In this example, the visuals are placed alternating between the left and right third of the screen, with the main character in the center, and contributing to a compelling well-composed shot.

In Norris’ (2004) terms, these visual representations entail frozen actions, as they are actions carried out by the producers in the past that have an effect on the audience viewing the series. This layer of recontextualization balances verisimilitude (keeping the jargon intact for authenticity) with accessibility for the audience (adding visual explanations). It may be argued that, in these fragments, producers assume the lay audience lacks medical background but is willing to suspend disbelief if the show feels authentic (Weber & Wirth, 2014).



Figure 1. Use of filmic modes for the recontextualization of unabridged conversations (G1_01).

“The differential diagnosis for a biliary tree scarring includes primary sclerosing cholangitis, liver failure, secondary to primary biliary cirrhosis ...”

Group 2 recontextualization, on the other hand, is realized by the characters in the fiction. In these fragments, the characters, DRs in the series, make use of embodied and disembodied resources to ease communication with PTs and CGs. The following example, excerpt G2_01, shows three DRs explaining a complex surgical procedure on the brain and its potential risks to a PT (paralysis, speech impairment, etc.). The recontextualization strategies they use involve the use of several embodied modes such as gaze, pauses, and prominence. Occasionally, these strategies are also fulfilled through the use of artifacts, in this case a tablet with images of the brain and the part where surgery will be conducted (see Figure 2).



Figure 2. Use of artifacts for DR–PT recontextualization (G2_01).

In this example, the sequence of HLAs carried out by each DR was identified and described in Figure 3. This diagram marks how HLAs merge into one another for each of the DRs (pink nodes) as well as the HLAs aimed at recontextualizing (dark pink). These HLAs adapt to the uptake of the PT (green nodes). Moreover, the recontextualization strategies employed

for every HLA are represented in blue nodes. Finally, the modes contributing to the realization of each strategy are represented in the orange boxes.

The clip begins with one of the DRs carrying out the HLA *Explaining Surgery*, using *Definitions & Explanations* as a recontextualization strategy. The PT shows partial understanding of the explanation and so this DR expands on the explanation (*Explaining Surgery and Consequences* HLA) using an artifact (the tablet) to show the exact place where the surgery will be conducted. For this explanation, the DR uses *Definitions & Explanations*, but also *Visual Representation* (through the use of the artifact) and *Scenarios*, as he introduces some of the possible outcomes of the surgery (e.g., “you’d be paralyzed on the left hand side”). At this point a second DR takes over, expanding on the consequences of the surgery (HLA *Expanding on consequences*) resorting to further *Scenarios* in the form of a list (e.g., “It could also result in difficulty in eating and swallowing; speech difficulties”). Despite this, the PT verbally consents to the surgery. To make sure the PT is really conscious of the risks, a third DR decides to expand on this (HLA *Expanding on risks*), carefully *selecting content* and highlighting the potential negative outcomes, and using more *scenarios* (e.g., “You could die on the table [...] You’ll be severely disabled”). The PT insists on consenting, to which DR 3 reacts once more with the HLA *Restating consequences*, using *paraphrases* and *selecting content* once again, and focusing on the PT’s career, which is particularly relevant for him as a professional gamer (e.g., “Your career is over”). As for the modal configurations realizing each recontextualization strategy, there seems to be an evolution throughout the excerpt. Spoken language, prominence and gaze on the PT are present almost in every HLA. However, the use of *Visual Representation* relies also on the use of an artifact, which also provokes a change in gaze alternating from this artifact to the PT. It is worth noting that embodied and disembodied modes operate in synchronization throughout the interaction. Towards the end of the clip, as the DRs insist on expanding on the risks and consequences, a higher use of pauses and prominence is noticed, with gaze fully focusing again on the PT. Thus, while the HLA *Explaining Surgery* by DR1 is realized using pauses during 10% of the action and prominence during 6%; the last HLA (*Restating Consequences*, by DR 3) is produced with a 22% of pauses and 31% prominence, achieving an effect of assertiveness.

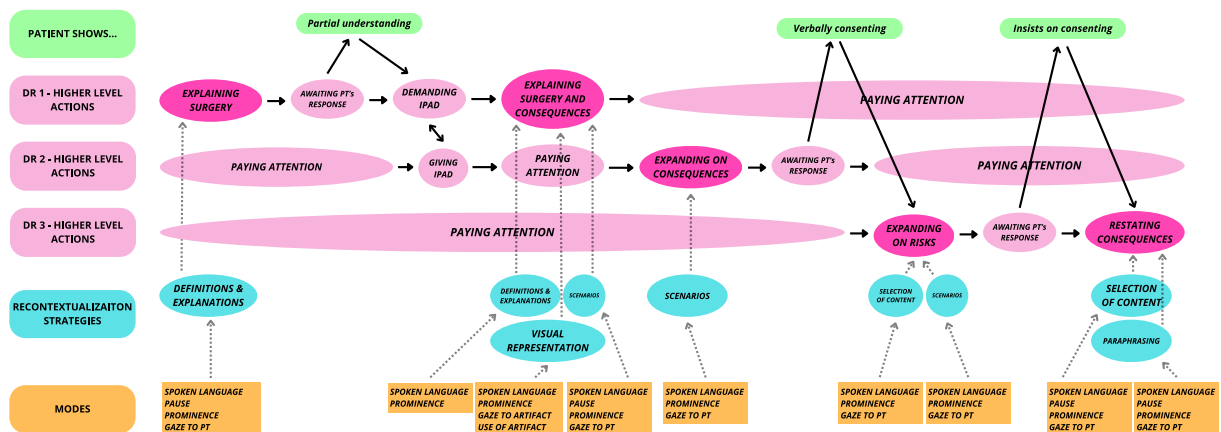


Figure 3. Sequence of HLAs, recontextualization strategies and use of modes in G2_01.

Arguably, two complementary aims may be pursued behind this thorough recontextualization process: first, to ensure the PT is fully aware of the significant risks associated with the procedure—thereby securing truly informed consent—and, second, somewhat more implicitly, to protect the medical team against potential future claims or litigation. This dual purpose may highlight an important cultural dimension, the “waiving of responsibilities”, which is very noticeable in American contexts, where tort costs in healthcare are overwhelmingly high (Berlin, 2017; Katz, 2019; Rechovsky & Saiontz-Martinez, 2018). This manifests how TV shows actually reflect and reinforce real-world power dynamics, legal cultures, and professional identities in the medicine field, serving as a cultural mirror which can help enculturate future practitioners.

4. Conclusions

This paper set out to examine how multimodal recontextualization operates in medical discourse while validating the use of medical TV series to inform future practitioners in EMP contexts. Two main layers of recontextualization were found in *The Good Doctor*: (1) a producer-to-audience layer, in which non-diegetic visuals render unabridged, jargon-heavy DR–DR talk comprehensible to lay viewers; and (2) the DR–PT/CG layer, in which on-screen clinicians deploy embodied modes (e.g., gaze, gestures, ...) and artifacts (tablets, diagrams) to negotiate understanding. An annotation and analysis with GRAPE-MARS and the use of MIA (Norris, 2004) helped describe how visual representation strategies were used in DR–DR interactions, while DR–PT/CG recontextualizations seemed to evolve dynamically across a sequence of strategies depending on the perceived understanding by the PT/CGs.

The results of the study bring to the fore the crucial role of recontextualization in medical discourse. The need to master recontextualization strategies and use them effectively is even more pressing in the specific context of DR–PT interactions, where smooth communication is essential to achieve an adequate health care that meets the needs of the PT. It is for this reason, that recontextualization needs to be integrated in EMP curricula. According to our analysis, strategies such as using explanations and definitions, selecting content and using scenarios are among the most widely used in the medical context, and students should master them as part of their training. Furthermore, our results show that recontextualization in medical discourse is multimodal, and resorts to a wide array of meaning-making resources which future practitioners need in order to become competent professionals (i.e., the adequate use of gaze and paralinguistic features like pauses and prominence). Therefore, it is crucial that EMP students become aware of these resources and learn how to use them coherently. This is why a multimodal pedagogy is particularly suitable for EMP training (Beltrán-Palanques & Bernad-Mechó, 2024; Franceschi, 2018; Ruiz-Madrid & Valeiras-Jurado, 2020). Such proposals may include a guided multimodal analysis of authentic examples of medical discourse (such as the clips from medical series included in this study) to identify good practices, and the use of role plays to provide opportunities to practice this discourse. More specifically, students could be trained to deliver short PT explanations in which they are required to define technical terms clearly, anticipate PT questions through relatable scenarios, and support explanations with gesture, gaze, and visual aids (e.g., annotated diagrams). The incorporation of these strategies could help students adjust their explanations depending on the interlocutor's expertise, coordinate verbal and visual modes coherently, and reflect critically on how multimodal choices affect PT understanding.

On the other hand, recontextualization is also a need for science disseminators in the medical field, who may resort to social media like Instagram or YouTube to communicate medical content to lay audiences (Muñoz Gallego, De Sousa Lacerda, & Costa Araujo, 2023). This context may involve the use of more elaborate genres, such as presentations or short videos, where filmic modes gain especial importance. In particular, the use of visuals, sound effects and visual effects to clarify content stands out as a recurrent and effective strategy. In our corpus this is used to facilitate understanding for the audience of the series. Science disseminators can replicate it when they present their findings to lay audiences, designing visual scaffolding that reduces cognitive load and fosters audience engagement without sacrificing technical accuracy.

Several limitations are acknowledged. First, access to genuine clinical interactions would enrich the validity of this study; yet, this was beyond this paper's scope, which aimed, precisely, at validating fictional materials for the study of medical communication. Second, the dataset is confined to six excerpts from a single television series, raising questions of generalizability across genres, cultures, or real-world settings. Third, viewer reception data, i.e., the effect of recontextualization practices in addressees, for instance, through comprehension tests or affective responses, remains largely unexplored. This is particularly the case when using fiction for EMP training (Piqué-Buisan, Sorribes, & Cambra-Badii, 2024).

Future research might expand the corpus to include multiple medical dramas from different cultural backgrounds and, ideally, real hospital encounters that would help compare the multimodal interactions in both contexts. Also, the effectiveness of the use of fiction-based materials to raise multimodal awareness in the teaching of EMP needs to be explored. In this sense, broader studies with students could examine whether exposure to structured multimodal recontextualization enhances learners' readiness for authentic clinical communication.

Ultimately, this work aims to contribute to a high-quality health care by fostering accessible interactions, promoting open science and effective dissemination, and cultivating practitioner awareness of empathy and multimodal communication.

CRedit authorship contribution statement

Julia Valeiras-Jurado: Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Edgar Bernad-Mechó:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

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Data availability

Data will be made available on request.

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