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THE DYNAMIC CONSULTATION

A discourse-analytical study of doctor-patient communication in Chilean Spanish

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To Aldo

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ABSTRACT

This study explores the discourse that develops in the interaction between doctors and patients in medical consultations in a metropolitan hospital in Santiago, Chile. It adopts the interactional sociolinguistic perspective, incorporating Gumperz's 'socio-cultural background knowledge' and Goffman's 'interactional framework' approaches to understand the institutional alignments and socio-cultural identities that are portrayed in the discourse used throughout the consultation.

The data set consists of twenty-two natural tape-recorded consultations involving four medical doctors (two females and two males) and thirteen female and nine male patients.

Doctors and patients performed distinctive forms of talk (i.e. *voices*) during the communicative routine of history taking and treatment/management, producing a dynamic and interactive consultation. Each of those *voices* was performed using particular types of discourse strategies that had a central function associated to the *voice* at issue. Doctors displayed three main *voices* during the interaction. The *Doctor voice* aims at seeking information about patients' health, assessing test results and assessing patients' compliance with the medical recommendation. The *Educator voice* educates patients by aligning them to the medical institution and by using accounts of factual medical issues that explain test results, the functioning of the human body and issues surrounding patient discomfort. In this *voice* the doctors also give an account of the medical treatment/management that is recommended. Such accounts show the doctors' alignment to the medical field and also project their social/cultural identity into the conversation with their patients. It is in this *voice* that the exercise of power has the potential of being negotiated by using different persuasive discourse strategies ranging from a subdued authority to a more friendly, persuasive form of socio-cultural

power termed *simpatía*. The data shows that the consultation does not only include *voices* that are medically oriented. In addition doctors use the *Human Fellow voice* to create empathy with the person who is sick. The *Human Fellow voice* facilitates patients' contribution to the consultation by using affiliative markers and *simpatía*. This allows patients to perform their *voices*, which facilitates our understanding of the discourse that they bring to the consultation. Patients perform four *voices* in the consultation. They seek medical help, describe their feelings, discomfort, concerns, and share with their doctors the difficulties in following a medical recommendation by using the *voice* of *Health-related storytelling*. Patients who are knowledgeable about their medical condition and who comply with the medical advice use the *voice* of *Competence*; whereas the *voice* of *Initiator* is used by those patients who are interested in learning about their health status and therefore initiate questions that lead to an educative episode. In this study I argue that this *voice* is fundamental to increase the chances of developing medical competence in patients, whose improved understanding and knowledge of their health should lead to an increase in negotiation of treatment with their doctors. The consultation also allows the manifestation of the *voice* of the *Social Communicator* that aims at telling a story that does not belong to the medical institutional discourse but to everyday talk.

In the process of a medical consultation both doctors' and patients' *voices* interact in the discourse creating a dynamic process in which both participants show alignment to the medical institution as well as their own socio-cultural identities. This study reveals that although the consultation is constrained by the 'voice of medicine' - that generally exercises power over the patient - it also allows for the presence of a *voice* that facilitates patients' participation in the discourse. Patients can therefore

expand their discourse beyond the medical institutional one and bring to the consultation their own identities and communication patterns.

DECLARATION

This thesis contains no material that has been accepted for the award of any other degree or diploma in any university or other institution.

To the best of my knowledge this research contains no material published or written by another person, except where due reference is made in the text of the thesis.

[redacted]

Marisa Cordella

4. July 2001

Date

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CHAPTER 1

INTRODUCTION

We are all potential patients, none of us can be certain, unfortunately, that our 'good health' will remain so indefinitely. Our visits to the doctor can be planned on a regular basis, or they can be unplanned due to an unexpected health condition. Whatever the case, we are sooner or later faced with the need to communicate with a medical doctor regarding our health state, and our well being relies, to a variable extent, on the successful accomplishment of such communication.

It is well documented in the literature of doctor-patient communication, and certainly the topic is regularly raised in everyday talk, that the conversation that emerges in the consultation is not free of communication difficulties. The visit represents an instance where doctors and patients come together in a medical setting, which is a familiar environment for the health professionals but a foreign place for the patients. The consultation also presents differences in term of the medical knowledge, knowledge that the doctor possesses and the patient (usually) lacks. These discrepancies contribute to the asymmetry in the interaction between doctor and patient and account for the doctor's exercise of power over the patient. Such exercise of power is manifested through the introduction of most questions, the interruption of the patient's discourse and through circumscribing the talk to the medical frame. In this scenario of over representation of the doctor in the consultation, the patient is left with few opportunities to interact in the event and consequently patient's dissatisfaction is likely to emerge. This could have a negative impact on the patient's health, since a connection between the patient's satisfaction and compliance appears to be a common characteristic of the patient's behaviour.

My interest in the research of doctor-patient communication springs from two main motivations. Firstly, such studies can contribute to knowledge acquisition by testing the hypotheses and models developed in the area, in this case within the empirical framework of medical consultations of Chilean Spanish speakers. In this way we may develop new approaches to comprehend the medical consultation. Secondly, this study can contribute to achieve a satisfactory consultation for both doctor and patient. Therefore, I aim at unveiling the participation of both interactants in the speech, in order to understand how communication between doctor and patient develops in a Chilean Clinic during the medical consultation, within an institutional and social framework of operation.

To achieve this aim, Chapter 2 adopts the interactional sociolinguistic perspective, incorporating both Gumperz's (1982a, 1982b, 1999) 'socio-cultural background knowledge' and Goffman's (1967, 1971, 1981, 1983) 'interactional framework' approaches to understand the institutional alignments and social identities that are represented in the discourse. Here both the concept of power, following Giddens' (1976, 1977, 1979, 1981, 1984, 1987) and Foucault's (1975, 1980) interpretations, and the concept of *simpatía*, following Triandis et al. (1984), are introduced. Both power and *simpatía* appear to be working together in the discourse. Finally, the chapter reviews the linguistic and medical studies published in the area of communication between doctor and patient, highlighting the major trends and findings in the field. Subsequently, Chapter 3 describes the location where the research took place, gives a profile of the institution and of the participants in the study, and documents how the data was collected. It also illustrates how the deconstruction of doctors' and patients' contributions in the consultation accounts for participants' 'forms of talk', which in this study are referred to as *voices,* that unfold

during the development of the discourse. This chapter also addresses the limits of the study in terms of the number of *voices* that are associated with each participant and suggests that they could be further expanded making finer differentiations, or limited by using broader descriptions. Nevertheless, I argue that the differentiation used gives an accurate representation of the *voices* of participants in the exchange.

Chapters 4 and 5 present the deconstruction of doctor and patient *voices* by differentiating among three *voices* used by doctors: *Doctor*, *Educator* and *Human Fellow voices* and the performance of *voices* accomplished by patients: *The voice* of *Health-related storytelling*, *Competence*, *Social Communicator*, and *Initiator*. The analysis firstly observes how the *voices* can be differentiated among themselves and which discourse features are commonly found in each *voice*. Then, it analyses the interaction that emerges between doctors' and patients' *voices*. Following this, Chapter 6 presents the interpretation of the results of my investigation in the context of the background knowledge acquired in previous studies of doctor-patient communication. The results are synthesized into a 'dynamic model' that accounts for the interactive process that takes place between doctor and patient, whereby the patient may increase knowledge of the medical condition s/he is suffering. Education, as a process of patient's acquisition of medical knowledge, is at the core of a better treatment, compliance and ultimately (hopefully) healing. The final chapter, Chapter 7, concludes this study by highlighting the significance of the findings and provides suggestions for future research.

CHAPTER 2

DISCOURSE, SOCIETY AND DOCTOR-PATIENT COMMUNICATION: A REVIEW

2.0 Introduction

This study aims to understand how the participation framework of doctors and patients unfolds during the consultation by identifying participants' forms of talk in the institutional medical exchange and by exploring the interaction that emerges through the interplay of doctors' and patients' discourses. An interactional sociolinguistic approach will be adopted incorporating Gumperz's (1982a, 1982b, 1999) 'socio-cultural background knowledge' and Goffman's (1967, 1971, 1981, 1983) 'interactional framework'. The approaches complement each other in the understanding of language, society and culture and they help to shed light on participants' roles in the conversation by understanding how and why participants may shift in their alignments during the medical consultation. As the consultation may have instances where 'power' can be exercised in the discourse due to the inherent asymmetrical nature of the exchange (e.g. diverse medical and institutional knowledge of participants), the concept of power will be discussed as it has been developed in the area of social theory and critical discourse analysis.

In order to account for the medical discourse, a description of the linguistic features found in everyday and institutional conversations will be further developed followed by a synopsis of the micro and macro realities of the social group, suggesting that the performance realised in a micro-setting (i.e. the consultation) is not completely independent from the macro level structure of the socio-cultural group. The exercise of power in a medical consultation is not necessarily a peculiar

characteristic of the consultation, but it may also be a representation of an asymmetrical interaction that is present in discourses used in other social contexts as well. Having established the mutual interconnection between micro and macro levels, there is a need to understand whether the consultation follows a particular model of interview/interaction.

As a consequence, this review will introduce the two most widely used medical approaches (i.e. bio-medical and socio-relational) and will identify the linguistic studies that have contributed to the understanding of doctor-patient communication as a reflection of the asymmetrical relationships present in the exchange. Such asymmetrical relationships may be negotiated, if desired, in the course of the interaction. In what follows the theoretical framework of this thesis will be introduced. The first part describes the approach of interactional sociolinguistics followed by an introduction to the concept of 'power' that is expressed through the local discourse.

2. 1 A multidisciplinary approach: Interactional sociolinguistics

Interactional sociolinguistics is a multidisciplinary field of research that combines anthropological, sociological and linguistic studies with the aim to understand and interpret the relationships among culture, society and language. Gumperz (1982a, 1982b, 1999), as a linguist-anthropologist, and Goffman (1963, 1971, 1981), as a sociologist, have been pivotal in this field as the intellectual contributions of both authors taken together give shape to a comprehensive conception of language and society. Gumperz's interest in language focuses on the concept of language as a means of social interaction (1982a, 1982b, 1999). When people come together in a conversation they not only exchange words, but in the

course of talking, people recreate socio-cultural knowledge, further reproducing in this process a network of relationships which is manifested contextually by the speakers' verbal behaviour.

During the verbal exchange both inferences and contextualization cues play a fundamental role in speakers' interpretative schema and therefore in the understanding of speakers' speech (Gumperz 1971, 1982a, 1999). The recipient's interpretation of the speaker's speech is accomplished by the recipient's use of inference. Speakers' analogous interpretation of the same act reflects the participants' shared social background knowledge necessary to interpret the contextualized cues of the speaker. Thus, what is said and how it is said is not in a vacuum, but is the result of the speaker's intention to convey particular socio-cultural knowledge, that reflects both his/her communicative competence in using the language in connection with the context, and the speakers' socio-cultural background (speaker's speech community) revealed by the use of discourse strategies (Gumperz and Hymes 1972). In order to make this point clearer, I have selected one of the examples offered by Gumperz, based on his sociolinguistic studies carried out in North America. Following a graduate seminar, an African-American student approaches his white instructor and asks for an appointment.

> a. Could I talk to you for a minute? I'm gonna apply for a fellowship and I was wondering if I could get a recommendation?'
> The instructor replied:
> b. O.K. Come along to the office and tell me what you want to do.
> As the instructor and the rest of the group left the room, the black student said, turning his head ever so slightly to the other students:
> c. Ahma git me a gig! (Rough gloss: 'I'm going to get myself some support.')
> (Gumperz 1982a: 30)

Gumperz presents this example to show how individuals make inferences about someone else's speech. He asked a group of students about their understanding of the above verbal exchange. The interpretation varied depending on individuals' socio-cultural knowledge and contact with the African American speech community. For example the last utterance *Ahma git me a gig!* was interpreted as a shift from the standard English usage [see (a)] to the African American English [see (c)] by those whose knowledge of African American speech was minimal. The interpretation given by African American and white individuals who have had greater exposure to African American speakers differed from the previous one. The last utterance in this case was interpreted as an African American speaker's identity marker. When the African American speaker asked for a recommendation letter from a white American instructor he used a form of talk that conformed to the predominantly white society. The identity marker was used in communication with his peers.

The above quote exemplifies Gumperz's theory of language in interaction, offering the opportunity to illustrate the framework for this research. Firstly, a theory of interaction is based on both recipient's and speaker's shared knowledge of the structure of the language and the social rules. This shared knowledge has to be such as to at least permit understanding between interactants, by taking into account their underlying expectations, i.e. the interpretative frame or schema used in the situation. As Tannen has observed:

> The only way we can make sense of the world is to see the connections between things, and between present things we have experienced before or heard about. These vital connections are learned as we grow up and live in a given culture (1993a: 14-15).

There is therefore a culturally determined propensity to perceive and assimilate what does make sense and is recognisable in our mind (Gumperz 1982a: 13). Following

van Dijk, the notion of schema needs to be understood at the level of social cognition, thus:

(a) Structures and strategies of social information in memory, for instance, about groups, functionally reflect the role of this information in communication and interaction, and

(b) These processes of communication and interaction are structurally embedded in social micro macro contexts. These two dimensions assign both a functional and a contextual dimension to the nature of social cognition (1987: 251-252).

This implies, according to van Dijk (1987), that people process social information as members of a social group rather than as individuals lacking any connection with other individuals.

Secondly, the above example highlights the concepts of inference and the relationships that exist between the socio-cultural background of the recipient and the understanding of the speaker's contextualization cues and intentions bound to interpretative frames. Thirdly, it highlights that a shift from one variant of the language to another implies both speakers' acquisition of a repertoire of varieties of the language, as well as social knowledge about the appropriateness of using one variant or another. According to Gumperz:

> The use of one variety where another is expected is not simply an instance of inappropriate usage, but can have communicative significance (1982a: 34).

Whereas for Gumperz the socio-cultural background knowledge of people has an effect on their understanding and production of an utterance, for Goffman (1971, 1981) language reflects the social roles and the relationships that people negotiate throughout the encounter. In what follows I summarise Goffman's contribution to interactional sociolinguistics.

Initially Goffman's attempt was to create a field of research separated from sociology, claiming that the study of interaction, what he called 'interaction order', was an independent field of research (Goffman 1981). His research at first appeared to be carried out unconventionally, as mentioned by Drew and Wotton 'no clear hypotheses, no standard research designs, nor even a theory that could be tested or used to make sense of a variety of research findings' (1988: 2) were presented. And as suggested by Levinson, one of the biggest complaints about Goffman's work has been that his research is not empirical and it is difficult to see how it could be so (1988: 162). In other words, in contrast with Gumperz, Goffman's models are not based on ethnographic research but on the social basis of any conversation. For Randall (1988) Goffman's approach conforms to an ecological perspective, since Goffman takes a stance of observing what people do when they are in the presence of others. Also, it has been said that his research has methodological flaws. For example Drew and Wotton (1988) mention:

(a) Vagueness in the use of concepts.
(b) Lack of care in managing the data, and
(c) Subjective data selection.

All those observations may appear to diminish the impact of Goffman's ideas and views of a participation framework of interaction. Nevertheless, his contribution to the field of interaction of social order was profoundly increased in his later years when he became associated with the University of Pennsylvania, and when his research became influenced by colleagues in the field of anthropology and sociology (Drew and Wotton 1988) making an impact in the field of linguistics. Goffman realised the importance of studying face-to-face interactions and to carry out

microanalysis to better understand the 'traffic of rules' that makes the interactions possible in the first place. In Goffman's own words:

> My concern over the years has been to promote acceptance of this face-to-face domain as an analytically viable one -a domain which might be titled, for want of any happy name, the *interaction order*- a domain whose preferred method of study is microanalysis (1983: 2).

The interaction order has been defined by Goffman as the 'syntactical relationships' (1967: 2) that exist among individuals acting in the presence of others. Thus, through microanalysis it is possible to observe how face-to-face interaction operates. According to Goffman, in the interaction participants exert mutual influence over each other when they are in the proximity of one another or when they are close to someone else.

> An interaction may be defined as all the interaction which occurs throughout any one occasion when a given set of individuals are in one another's continuous presence (Goffman 1959: 26).

Participants' immediate physical presence in turn can modulate and have an impact on individuals' actions and language. This implies that the conception of interaction for Goffman does not include only the production of language but rather every action carried out by participants. Thus there is an 'interdependency of action' (Goffman 1963: 22) that makes the interaction possible. In the presence of others, the individual performs a role associated with a given situation and this potentially has an effect on the performance of other participants in the encounter.

When an individual (e.g. a doctor) performs a role to the same audience (e.g. a patient) on different occasions (e.g. different consultation times) a social relationship is likely to occur. A social role is defined by Goffman as:

> The enactment of rights and duties attached to a given status, we can say that a social role will involve one or more parts and that each of these different parts may be presented by the performer on a series of occasions to the same kinds of audience or to an audience of the same persons (1959: 27).

During the consultation time, doctors play the social role of care providers whose duties and obligations are attached to their medical profession and are enacted during the interaction with patients. Following Goffman, in any given encounter individuals gather information from each other in two different ways:

(a) Participants give content information. This implies that the individual who provides the information supplies the content of the delivered message through the use of symbolic actions that are reciprocally recognised by participants as something other than the speaker themselves.
(b) Individuals also give additional linguistic and extra-linguistic information. This relates to how the information is transmitted and therefore to the additional information that the recipient obtains from speakers' selection of their own words, in addition to any extra-linguistic features (e.g. intonation). This can have an effect on the meaning attached to the transmitted message (Goffman 1963).

Thus, the information delivered and the form of the message being exchanged in the encounter may have an impact on the participation framework of individuals. This may alter the interaction of participants in the encounter and produce a shift in the participation structure. This is referred to as 'footing' and it will be developed further in the next section.

2.1.1 Footing

Goffman took interest in the work of Gumperz (1971) who observed that code-switching may not necessarily be associated with the shift from one language to another, but with the changes in the participants' behaviour and the position they

occupy in the discourse. This is what Goffman refers to as participants' stances and alignment in the encounter (see Section 2.2 for Giddens' description of 'dialectic control' and the alteration of individuals' participation). Goffman's concept of footing (1981) centres on his conviction that the dyadic division of speaker and hearer is not sufficient to understand the participation framework of an interaction. He believes that the speaker needs to be differentiated into different parts and that each part may identify a different participant's alignment in a given situation. For example according to Goffman:

> We can momentarily affect a podium speech register, or provide a theatrical version (burlesque, melodramatic) of an aside. All of which, of course, provides extra warrant - indeed, perhaps, the main warrant - for differentiating various participation frameworks in the first place (1981: 154).

A theatrical performance is Goffman's most descriptive illustration of the different social masks that we individuals 'wear' in everyday encounters. Any shift from one form of talk to another constitutes an example of footing and it is precisely at this point that Goffman emphasises that the changes of footing are 'very commonly language related' (1981: 128). In order to identify shifts in the participation structure of individuals Goffman centres his attention on footing and underlines the main characteristics of this term:

(a) 'Participant's alignment, or set, or stance, or posture, or projected self is somehow at issue' (1981: 128).
(b) The participant's performance cannot be entirely traced back to grammatical sentences 'it seems clear that a cognitive unit of some kind is involved, minimally, perhaps a "phonemic clause". Prosodic, not syntactic, segments are implied' (1981: 128).
(c) A continuum of stances need to be observed, this can be identified from subtle to clearly perceivable shifts of footing.

(d) Footing generally involves participants' code switching and/or slight changes in tone of voice, volume, rhythm, pitch among other sound markers.

(e) 'The bracketing of a "higher level" phase or episode of interaction is commonly involved, the new footing having a liminal role, serving as a buffer between two more substantially sustained episodes' (1981: 128).

It is possible to observe that Goffman's understanding of footing is associated with the framework of participation that is both influenced by the production of language and by the alignment and stance participants project in the encounter. Even the slightest change in participants' language and behaviour can be an instance of shift from one footing to another and this in turn can have an influence on the participation structure of the interaction.

Participants in a verbal exchange can perform a number of roles (see also Bakhtin's description of dialogic voices, Holquist 1981, Morris 1994). One person can perform all three of Goffman's roles simultaneously or the individual can perform one or more than one role in the discourse. Goffman differentiates them as: 'animator', 'author' and 'principal'.

(a) The animator has the role of emitting the right sounds to produce a recognisable utterance, the animator has not a social role but a functional role of being the 'machine of communication-production'.

(b) The author is defined as the individual who authors a text that is scripted and formulated.

(c) The principal establishes his/her position by conveying his/her own words that represent his/her beliefs and commitments of what is being said. The principal represents an active individual 'in some particular social identity or role, some special capacity as a member of a group, office, category, relationship, association, or whatever, some socially based source of self-identification' (1981: 145).

During the consultation both the doctor and the patient will be animating their own words and in this process of talking they will be scripting their own text. The

authoring of the text will be a reflection of participants' social identity role manifested throughout their projection of beliefs (i.e. principal) and commitments in the exchange. This suggests that any shift from one form of talk to another can be interpreted as an instance in which the alignment position of participants has suffered a change. Through these shifts, participants' may alter the interaction and this in turn may have an effect on the power exercised during the exchange. The following section focuses on understanding 'power' through discourse and 'power' as a representation of the hierarchical system of the social group.

2.2 Power, Society and Discourse

This section explores the concept of 'power' within the social structures and discourses where it emerges. Much research undertaken in critical discourse analysis has centred its attention on unveiling the exercise of power inflicted upon individuals and on reflecting upon the different participation of individuals in a given context (Ainsworth-Vaughn 1994, 1998; Borges 1986; Fairclough 1985, 1989, 1992; Fisher 1991; Fisher and Todd 1986, 1993; Holmes et al. 1999; van Dijk 1995a, 1995b, 1996, 1997b; Wodak and Matouschek 1993; Wodak 1989, 1996, 1999a). Following Tannen, power can be interpreted as an activity that separates those 'knowledgeable' from those 'not knowledgeable' within the social system. Those that know the system are doing:

> Business as-usual on their home turf, while their clients pass through the system, often confused and always ignorant of the intricacies of the system (1987: 5).

This asymmetry, as it will be shown in the 'gate keeping' encounter (see Section 2.6.2), constitutes the central issue when trying to comprehend the exercise of power in the exchange (Tannen 1987). Emphasis has been given to the investigation of

participants' speech in association with the asymmetrical interaction that is bound to the institutional and societal context of the exchange. The dialectics between the exercise of power and the discourse constraints that differentiate participants of unequal power (Fairclough 1989, 1995; Fisher and Todd 1986, 1993; van Dijk 1995a, 1996, 1997b; Wodak 1989, 1996, 1999a) has been the concern of critical discourse analysts whose interest in 'uncovering injustice, inequality, talking sides with powerless and suppressed' (Wodak 1989: xiv) has been the core motivation of their studies.

My intention in understanding the presence of power in doctor-patient interaction is not based primarily on presenting only those instances of injustice and/or inequalities within the process of communication, but rather to discover the expression of power as a form of talk that interacts with other forms of talk in the discourse. Following Davis:

> Although power cannot be eliminated from a study of interaction, this does not mean that it is sufficient for explaining how social interaction is produced (1988: 86).

Thus, I expect to find performances of both power and non-power interacting in doctor-patient communication. I have confined the description of power to those theoretical features that contribute to the understanding of an institutional interaction like the medical one. This shall give an insight into the interrelationship between the exercise of power and society and the connection between power and discourse. The conceptual ideas of Foucault (1975, 1980) and Giddens (1976, 1977, 1979, 1981, 1984, 1987) are taken into account in the analysis. Their theoretical ideas will be expanded by the contribution developed in critical discourse analysis.

Foucault does not describe power as a colossal force that oppresses a particular group of individuals; for instance, as in the case of a social body that dictates 'the universality of will' (1980: 55). On the contrary, power is perceived as not being in anyone's hands.

> Power must [be] analysed as something that circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth (1980: 98).

In Foucault's view, power must be seen as a fluid activity that is exerted or suffered by the same individuals in a dynamic way.

> Power is employed and exercised through a net-like organization. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target; they are always also the elements of its circulation. In other words, individuals are the vehicles of power, not its points of application (1980: 98).

Power is not perceived as a crushing force that operates at a supra-individual level, but rather the exercise of power lies within the individual. This implies that power is exercised through the individual's actions (1980: 89). Foucault's offering of an alternative way of interpreting power, from the interpretation of power as an oppressive, centralized force, suggests that power produces knowledge, pleasure and discourse. In Foucault's words:

> What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression (1980: 119).

That is, for Foucault, power is a creative network of relationships that engage individuals within a social-group.

One of Foucault's limitations in regards to the description of power, according to Wodak (1996), has been that agency is not included in Foucault's theory, as it is in Giddens' framework. Giddens' theory on the exercise of power develops around 'the capability of the actor to intervene in a series of events so as to alter their course' (Giddens 1976: 11). Giddens' notion of power, mainly his structuration theory is based on the understanding of how power operates at the level of social practice. The dynamic organization of society has its roots in the historical facet of the interrelationship of time and space (Giddens 1976, 1979). Thus for Giddens, time is an essential part of social action. The concept of time in relation to the production of a discourse is also considered a fundamental component of a speech by Wodak (1995, 1996, 1999) and Fairclough and Wodak (1997). They refer to it as intertextuality, implying that the discourse exists always in relation to another discourse being used at a particular point in time (either synchronically or diachronically). In other words, the medical consultation of today, may differ from one in the past and/or the future, and may have some similarities with current discourses.

According to Tannen, the dynamism of discourse is also influenced by the changes in the interaction itself. She suggests that 'power may be there in different forms and in different ways - all constantly changing in dynamic response to the behaviour of others' (1987: 5). The dynamic composition of power relates to Giddens' theory of structuration that centres on the 'action' that is accomplished through the enactment of social actors. According to Giddens the production and reproduction of society works as follows:

> A. One: *Sociology is not concerned with a 'pre-given' universe of objects, but with one which is constituted or produced by the active doings of subjects.*
> A. Two: *The production and reproduction of society thus has to be treated as a skilled performance on the part of its members.*
> (Giddens' emphasis, 1976: 160).

Following Giddens, the individual is perceived as a skilled and knowledgeable agent who is able 'to monitor their activities at various concurrent flows...' (1976: 83) because the actor is 'aware' of the demands of any given situation. This view relates to the active social role that the individual may play in social practice by bringing changes to the course of the event, even in the most adverse circumstances, through a 'dialectic of control' (Giddens 1981, 1987). This dynamic idea of interaction is referred to as 'duality of structure'; i.e. structures are both created and recreated through individuals' actions. Following Giddens:

> Language exists as a 'structure', syntactical and semantic, only in so far as there are some kind of traceable consistencies in what people say, in the speech acts which they perform. From this aspect, to refer to rules of syntax, for example, is to refer to the reproduction of 'like elements'; on the other hand, such rules also *generate* the totality of speech-acts which is the spoken language. It is this dual structure, as both inferred from observations of human doings, and yet as also operating as a medium whereby those doings are made possible, that has to be grasped through the notions of structuration and reproduction (Giddens' emphasis, 1976: 121-2).

Hence, the reproduction of a structure is both the means of social practice and the medium by which social practices are preserved in time. Nevertheless, the exercise of 'dialectic control' has the potential of making alterations to those structures, much in the same way as in the process of reproduction, following a biological analogy,

changes may occur (e.g. mutations). In terms of a social theory the actors/agents have the potential of changing the structure in the process of reproducing them.

The perception of power as a transformative and non-static activity is further explored by Wodak (1989, 1996, 1999b), in her development of critical discourse analysis. In her view there is a need to understand where (i.e. institutional setting) and how (i.e. participants' interaction) power is produced in order to find alternatives to deal with it or to resist it. '*"Diagnosis" first, interpretation and "therapy" to follow!*' (Wodak's emphasis, 1989: xiv). This suggests that once there is an understanding of how power is exercised in a particular context, then there is a chance to bring changes into social practice.

Communication in institutions appears to be a fertile ground for the reproduction of power because the different power positions of participants intermingle with a system where resources are not equally distributed among individuals (Fairclough 1989, 1992, Giddens 1976, 1987 van Dijk 1995a, 1995b, 1997b). Giddens refers to the concept of power in relation to the resources available to individuals and to the rules that structure, give shape and organise social practice (Giddens 1977). Rules are followed by individuals as a collective norm in a given context. They are in constant transformation and are used and sanctioned by individuals (Giddens 1979). Giddens, interprets rules as twofold phenomena: they enable and constrain the exercise of power. Thus, they relate 'to the constitution of meaning, and that [relates] to sanctions involved in social conduct' (Giddens 1979: 82).

According to Giddens, social sanctions[1] may vary in severity and can range from the most violent response to the absence of any talk (Giddens 1984: 178).

[1] Giddens borrows this concept from Foucault's theory.

According to Giddens (1979, 1984), social interaction is more than a set of rules that must be followed in a given context since the outcome of an interaction is affected by the resources available to individuals. The distribution of resources separates people from one another, thus, the 'resources are asymmetrically distributed...[and] members are seldom really peers in the interaction game' (Davis 1988: 87). Nevertheless this does not mean that this asymmetrical interaction leaves one of the participants without the opportunity of exercising some power over the other. In Giddens' view any agent can transform the course of an event. Davis (1988) highlights the connection between power and agency:

> By linking power to agency, it becomes essential to uncover the subtle mix of what actors do (and refrain from doing), what they achieve (and fail to achieve) and what they might have done (but didn't) (1988: 88).

Giddens' notion of power has not passed uncriticised by linguists working within his model of social theory. According to Davis (1988), Giddens' theory describes generalised features of power, leaving unattended a clear definition of actors/agents that practice power as well as a definition that could account for the use of rules and resources. Davis also argues that Giddens does not identify the contextual phenomena that organise power in a social practice. For Davis:

> Power relations are always and everywhere contextual. They are embedded in *specific* contexts, involving *specific* actors or groups of actors drawing upon *specific* rules and resources which are organized in *specifically* structured ways. Power, along with structures of domination, is implicated in concrete situated social practices (Davis' emphasis, 1988: 99).

The specificity of the context and the involvement of actors/agents have been widely recognised as vital components of discourse and power in context (Davis 1988; Fisher and Todd 1993; Holmes et al. 1999; Wodak 1996, 1999a). Although Giddens' social

theory presents some obstacles due to his abstract composition of society, his work has been widely analysed and used by social analysts to interpret society (see Craib 1992 for criticism and commentaries on Giddens' work).

An alternative view of the notion of power is presented by van Dijk (1995, 1996, 1997a, 1997b) whose interpretation is rooted in the power/control that elitist groups (such as politicians and journalists) exercise over less powerful groups (e.g. ordinary citizens). He notes that 'one group has power over another group if it has some form of control over the other group' (1997b: 17), similarly 'power is not simply imposed, but often shared and distributed over several powerful groups' (1997b: 23).

The basic manifestation of control can be produced by making a group of people act, or restrain them from acting, in accordance with what is desired by the control group. The ways in which people are made to do what the powerful group wants vary in terms of the force of repression over a group and in terms of the discourse structure used to accomplish the act. Van Dijk notices that although coercive power (like military force) can be imposed to make a group adopt a determined behaviour, the majority of the time the power exercised in a societal group is mental (cognitive), thus cognition appears to be one of the three key elements in van Dijk's notion of power/control. The other two are discourse and action. In van Dijk's words:

> Mind control and the actions that derive from it may be based on even more subtle and indirect forms of text and talk. Instead of letting others know what we want through commands, requests, suggestions or advice, we may shape their minds in such a way that they will act as we want out of their own free will (1997b: 19).

This mental manipulation stays unrecognised by the individual who becomes the target of it. Van Dijk refers to this as hegemonic power because it makes people behave 'as if it were natural, normal, or simply a consensus. No commands, requests or even suggestions are necessary' (1997b: 19). Hence, hegemonic power is the act of making people behave naturally by the process of shaping people's minds and making them do what the group in control wishes. This control is achieved through discourse, which produces a cognitive appreciation of an event when it is unchallenged, over time, by individuals. Thus for van Dijk:

> Social power of groups is not monolithic, permanent or without contradictions. It is daily being exercised and enacted by group members, also through text and talk. Such individual enactment allows for variation, dissent and even change, which also partly explains historical changes of power (1997b: 24).

In this section the emphasis has been on examining the notion of power within the social group that produces and/or reproduces it through discourse. Below I summarize the major features relating to the concept of power that will recur throughout this study:

1. Discourse reproduces power and power is maintained through discourse in any historical point in time.
2. Power is contextualised and it is exercised through the individual's actions.
3. Power is exercised in a dynamic way. The exercise of power can be altered in the course of an event (agency), and
4. Power is enabling and constraining.

2.2.1 Discourse, Power and *Simpatía*

If I take the view that in the medical consultation we may encounter different forms of talk, then it is necessary to understand whether all forms of talk are

associated with the exercise of power or whether there are forms of talk that present an alternative interpretation to the concept of power.

Previous studies have identified that the 'blunt' form of power is not always present in the medical discourse. For example, Davis notices in her study that 'control was not accomplished in a straightforward fashion... but rather in a paradoxically friendly and even intimate fashion' (1988: 283). Fisher and Todd (1986) found a similar pattern of behaviour when male doctors where talking to their female patients in relation to methods of contraception. But this interpretation still has power at its core. In other words, the above studies indicate that power is always present in the interaction and that the way it is exercised varies from an authoritarian and coercive form to a more subtle and gentle and presumably palatable form.

An alternative view to the central role of power can be found in Erzinger (1989, 1991) who focuses on the misunderstandings that arise between Spanish speakers and non-Spanish speakers interacting with doctors whose level of Spanish language may vary from near-native to poor language competence. She realises that miscommunication is mainly due to differential communicative styles resulting from cultural differences between participants. She explores the concept of *simpatía*, studied in Social Psychology by Triandis et al. (1984) who define it as follows:

> ... [*Simpatía*] has no equivalent in English but refers to a permanent personal quality where an individual is perceived as likeable, attractive, fun to be with, and easygoing... behaves with dignity and respect towards others, and seems to strive for harmony in interpersonal relations. This latter characteristic implies a general avoidance of interpersonal conflict and a tendency for positive behaviors to be emphasised in positive situations and negative behaviors to be deemphasised in negative situations (1984: 1363).

Erzinger in her studies (1989, 1991) notes that *simpatía* is manifested through conversational style and that there are supportive tasks that are used in the exchange to favour a cooperative interaction where both participants can understand each other. Thus doctor and patients work together to minimise their differences in vocabulary while showing respect for each other. Although there were instances in Erzinger's study where conflict emerged between participants, there were also instances in which conflict was avoided. This cooperation in the conversation is underlined in the concept of *simpatía* that intends to diminish the chances of conflict. The avoidance of conflicts (criticising, fighting, insulting) in asymmetrical exchanges has been documented in a study carried out in Santiago de Chile, by Forbes and Cordella (1999). Similarly, it has also been observed that playful argumentative style can be interpreted in Chilean Spanish as a way to show camaraderie and friendship in the interaction (Cordella and Forbes 1998).

Cordella (1999) performed a preliminary study to evaluate the presence of *simpatía* in the medical discourse of Chilean-Spanish speakers. She found instances where the doctor uses discourse strategies to make the conversation more friendly. For example, the doctor may use an *in crescendo* informal greeting, show respect to the patient, avoid potential conflict, use resolution strategies, give time to the patient to answer and s/he may use latching, avoid using jargon, and use colloquialisms. Are these examples an expression of power? *simpatía?*, or is *simpatía* a 'nice' way to exercise a persuasive power? These issues will be addressed in the current study.

Before starting to analyse the forms of talk that doctors and patients use in their interaction and identifying which functions they may reveal, I shall make a distinction between discourse used in an institutional (medical) setting and discourse used in everyday talk.

2.3 Everyday and institutional conversation

People typically engage in a number of conversations during any ordinary day. The type of conversations used (i.e. friendly conversation, parent-child communication, co-workers talk), the medium or channel of communication (i.e. telephone, internet, face-to-face) and the kind of talk (i.e. lecture, counselling, medical visit) modulate the speech being developed by participants who, apart from bringing the 'content' (what it is said or done) to the conversation, portray both their 'social relation' (the social relationship they bring into the discourse) and 'subject' (the 'subject positions' people can occupy) in the speech (Fairclough 1989: 46). This suggests that in everyday communication the speaker's discourse is conditioned by a number of variables that impose certain restrictions as to how to perform the discourse. For example, let us assume that we follow the 'discourse track' of a person during one day. The imaginary individual has an afternoon appointment with a specialist doctor. Before arriving at the doctor's office the individual has stopped at a petrol station and exchanged some words with the cashier, then the individual has gone to work and has exchanged some words with colleagues, later in the day the person has chaired an executive meeting where important issues have been discussed and in the afternoon the same person has gone through a number of medical check-ups and has developed a conversation with several medical specialists to determine a diagnosis. In each of those communicative events the individual (in 'normal' circumstances) might have shifted from one role to another and it is probable that this would have been reflected in the individual's speech.

According to Goffman (1981), everyday talk consists of a conversation that does not seek an elevated role or requires any special competency in order to be

successfully carried out. Indeed, even the simplest gesture may suffice to accomplish everyday performances. A similar view is taken by Prieto-Castillo (1999) who emphasises that the knowledge required to engage in an everyday talk does not need to be a specialised one. This is mainly due to the absence of any need to show a theoretical appreciation of a current affair or a state of being. Nonetheless, he claims that everyday talk requires the speaker to respond promptly to the demands placed upon the speech (Prieto-Castillo 1999: 38). It is assumed that this is achieved by following a turn-taking system (Sacks et al. 1974) and communication strategies bound to the socio-cultural group. According to Prieto-Castillo (1999), the realisation of everyday talk achieves both a functional communicative goal, like asking someone to do something, and an interpersonal communicative satisfaction that is based on the communicative pleasure that emerges in the act itself of communicating. To quote his own words: *para gozar con el acto mismo de la comunicación* (1999: 41) 'to enjoy the act itself of communication'. Prieto-Castillo appears to represent the indulgence of communication as a versatile form of language that allows *el juego de la palabra* 'the playing with words', to show friendship and warmth towards others. Fairclough (1992) uses the term 'conversationalism' to refer to a friendly talk (the use of feedback that conveys attentiveness and expressions of empathy) that may be present in medical discourse. Fisher and Todd (1986) use the term 'ordinary conversation' to describe everyday talk, and observe that, when a discourse is studied as a social activity, there are considerable similarities in the performance of the speakers. They interpret everyday talk as having discourse patterns that are recurrent among conversations:

> There is an expectation of balanced participation which is, in most cases, realized. Speakers take turns and change topics in orderly fashion. They ask

> and answer questions, exchange greetings, and interrupt each other in equal measure (Fisher and Todd 1986: ix).

Fisher and Todd also indicate that the asymmetrical relationship that makes an unequal participation in the speech possible can be interrupted when participants are of similar status. When the status of a participant differs from that of the other participants in the exchange asymmetries ensue. This appears to become exacerbated in institutional contexts where the 'social relations' and 'subject' positions of each participant are different, creating the bases for an asymmetrical interaction. Fisher and Todd say:

> This asymmetry is highlighted in institutional contexts. The structure of the institution is organized so as to lend those in power the authority to pursue defined goals. This authority is reflected in the forms and functions (structure and content) of educational, legal and medical discourse (1986: ix).

This asymmetrical structure creates a dichotomy in the interpersonal relationship. On the one hand, there are the insiders (those with knowledge of the system) and, on the other, the outsiders (those with no knowledge of the system). In medical discourse, Wodak observes that 'disorders in discourse' and communication problems may occur for this very reason:

> ... From gaps between distinct and insufficiently coincident cognitive worlds: the gulfs that separate insiders from outsiders, members of institutions from clients of those institutions, and elites from normal citizen uninitiated in the arcana of bureaucratic language and life (1996: 2).

The diverse positions that participants occupy in speech tend to highlight their alignment in the conversation (Goffman 1981), and reinforce, maintain and perpetuate their different position through the reproduction of an asymmetrical organization. If

this asymmetry is challenged, the result is the so called 'frame conflict' which implies that:

> Worlds of knowledge and interests collide with one another, and those who possess linguistic as well as institutional power invariably prevail (Wodak 1996: 2).

This is in accordance with the socio-cultural realities expressed in the micro situation of the medical consultation which, apart from reproducing an 'organised' institutional interaction within an institutional discourse, also projects and reproduces the macro societal level of the socio-cultural group through the specific discourse of the institution. The interrelation between the micro and macro realities of a socio-cultural group has been a fertile field of research for sociologists and critical discourse analysts. The following section shall develop this point further.

2.4 Micro and macro realities of a socio-cultural group

Sociological research (e.g. Grimshaw 1981; Malotch and Boden 1985) suggests that there is a connection between the production of talk and the structural organization of the societal group in which the talk is performed. According to Malotch and Boden:

> The organization of talk is tied to social structure generally - to the political, economic and historic forces of which talk is inevitably part (1985: 273).

Following Wodak, language and the social are 'connected to each other through a dialectical relationship' (1995: 206), which interpretation needs to account for the dynamic social processes that are historically based (Wodak 1995,1996,1999b). Thus, the understanding of talk requires an interpretative perspective to the 'social structure' that makes the talk relevant and identifiable to other speakers, who recognize the

communicative constraints and obligations imposed in different social-historical situations within the same speech community (Gumperz and Hymes 1972). This implies that a micro-representation (such as a medical consultation) needs to be interpreted in relation to the macro level structure of the socio-cultural group in which the exchange takes place. The content of the speech and the social relation and subject positions occupied by the participants in the exchange can be interpreted as a micro performance which is not unique to a particular micro-representation, but is rather a representation that reproduces similar performances found in other social interactions reflecting the broader macro-societal organization.

Discourse analysis and critical analysis research (Cicourel 1975, 1981, 1995; Fairclough 1985, 1989, 1992, 1995; Fisher and Groce 1990; Fisher and Todd 1983; Holmes 1990, 1997; Holmes et al. 1999; van Dijk 1987, 1996, 1997a, 1997b; Wodak 1989, 1996, 1999a 1999b) account for the accomplishment of participants' speech by analysing discourse as an interactive phenomenon in which both 'social structure' and 'social interaction' are interrelated. According to Fisher and Groce 'social structure' involves the 'relationship between interaction and institutional, structural and cultural forces' (1990: 225). This suggests that there is a dynamic interaction with the broader societal organization in which socio-cultural expectations are likely to be met. Fisher and Groce indicate that:

> By treating social interaction and social structure as reflexively related, features of a larger social structure... can be found in the analysis of talk, whereas the act of talking reveals this structure and displays how talking helps to sustain it (1990: 225).

Doctor and patient communication has been studied in the fields of discourse analysis and critical analysis as a discourse that reflects social, political, historical and cultural aspects. It is social because it occurs as a face-to-face interaction; it is political

because it reflects the power struggle reproduced in a hierarchical organization (Fisher and Groce 1990; Fisher and Todd 1993; Molotoch and Boden 1985; Waitzkin 1983; Wodak 1996, 1999a); it is historical because it may show changes (e.g. institutional and interrelational) over time (Fisher and Todd 1986; Helman 1994, Wodak 1999b); and finally it is cultural because socio-cultural values and beliefs emerge in the interaction (Fisher and Groce 1990; Fisher 1991; Kleinman 1980; Hein and Wodak 1987; van Dijk 1997a, 1997b; Wodak 1996, 1999a).

The approach used in this study tends to understand the medical exchange at two levels: the micro and the macro. The micro level of the exchange accounts for the discourse sequences and the use of particular communicative strategies that are accomplished through face-to-face interactions; while the macro level attempts to:

(a) Find explanations for the participants' interaction in the context of the medical institution and the social/cultural constraints which participants are part of (e.g. socio-cultural norms about prestige), and
(b) Understand the interaction as a result of 'macro-institutional factors', such as: the understanding of health issues at a socio-cultural level; medical practices, procedures and treatments to be adopted in a given society and institution.

In other words, the consultation itself is not performed in a vacuum, independent of other forms of speech and independent of any connection with the global structure. Similarly, we should not disregard the impact a medical consultation may have when a particular medical approach is favoured over another in the consultation. In order to obtain an overview of the most widely used approaches in western medicine, I shall explore in the next section the main characteristics that distinguish the bio-medical and the socio-relational medical approaches with regard to the interaction that the doctors may establish with their patients.

2.5 Bio-medical and socio-relational medical approaches to doctor-patient communication

Medical discourse in western societies tends to be associated with a bio-medical frame that follows a reductionist approach, viewing health as primarily a biological phenomenon (Mishler 1984). This frame tends to favour an asymmetrical relationship between doctor and patient, with the doctor primarily seeking information about the patient's complaint, giving a diagnosis and prescribing a treatment. According to Mishler, medical training is likely to stress the:

> Technical-scientific skills and the diagnosis of specific diseases; rather than the patient being viewed as a person, the person is viewed as a patient (1984: 9).

The emphasis tends to be on the body part that needs to be 'patched up', while the effect of the illness on the whole life of the patient is overlooked. Doctors usually use a discourse sequence composed of three parts: asking questions, answering, and expressing an acknowledgement or evaluation of the last statement made by the patient (Fisher and Groce 1990; Coupland and Coupland 1994; Pauwels 1995). This structure is repeated in all consultations, independently of the specific approach (bio-medical or socio-relational) used by the doctor. However, some specific differences appear depending on which approach the doctor uses throughout the consultation. Whereas the bio-medical approach tends to favour a discourse directed to the body part in need of restoration or cure, isolating the sick body part from the whole person, the socio-relational approach (Mishler 1984) tends to favour a discourse that focuses on the person who is sick, the sufferer of a medical condition who is part of a social network.

Doctors who use the socio-relational frame aim to engage in the patient's 'lifeworld' (Mishler 1984) by being a good listener and using the patient's own life experiences to build up the discourse. Mishler suggests a more 'humane' medical practice by proposing a patient-centred approach that shows:

> Respect for the dignity of patients as persons and recognition of their problems within the context of their lifeworld of meaning (1984: 6).

For Mishler, the medical discourse is divided into two distinct voices: 'the voice of the lifeworld' and 'the voice of medicine'. In his view, 'the voice of the lifeworld' disrupts and interrupts the dominant 'voice of medicine' (Mishler 1984: 63). Mishler understands medical discourse as two antagonistic discourses in which both voices interrupt each other during the exchange. On the other hand, Silverman (1987) perceives medical discourse as an interactional speech activity, which allows the socio-relational frame to interact at any time with the bio-medical one. Silverman's (1987) idea of the interaction of voices is also expressed by Cohen-Cole (1991) who developed, in conjunction with Julian Bird, a three-function approach to the medical interview that responds to both the medical condition of the patient and his/her emotional and motivational needs. The three functions consist of:

(a) Gathering data to understand a patient's problem.
(b) Developing rapport and responding to a patient's emotions, and
(c) Developing patient education and motivation.

The incorporation of these three functions into the medical consultation creates the opportunity for doctors to gather accurate information about the patient's health, to educate the patient in relation to the treatment and to explore psychological and social variables that may influence the patient's health. Thus, the:

> Three-function model of the interview represents an operationalized application of the biopsychosocial [2] model designed to facilitate doctor-patient communication processes (Cohen-Cole 1991: 7).

The three-function model of communication focuses on understanding the medical consultation as an opportunity to care for the whole person of the patient. This holistic approach tends to amalgamate 'the voice of the lifeworld' with the 'the voice of medicine'. Fisher and Todd (1993) in their studies of medical discourse argue that doctors and patients understand the exchange in a different way. Doctors mainly operate in the bio-medical frame, while patients operate in the social frame.

2.6 Doctor-patient communication: The medical and linguistic perspectives

The study of doctor-patient communication has been traditionally undertaken within two major traditions. Studies conducted by medical researchers establish themselves within a sociological framework (Cohen-Cole 1991; Neighbour 1987) and emphasise the ways in which communication can accomplish the ultimate medical goal: achieving a cure for the patient. On the other hand, the linguistic (or microanalytical) tradition emphasises the communicative strategies used in the doctor-patient interview and the variables (sex, age, social status, etc.) that influence the development of the discourse (Blanchard et al. 1988; Charon et al. 1994; Fisher 1995; Fisher and Todd 1986; Irish and Hall 1995; Sundquist 1995). Here I review

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[2] This model stresses that both psychological and social variables play a crucial role in the development, course and outcome of all illnesses (See Cohen-Cole 1990, Cohen-Cole 1991, Engel 1974).

both traditions, arguing with Charon et al. (1994) that analytical and microanalytical analyses of doctor-patient interactions complement each other, and that a synthetic approach would serve a better purpose by first understanding and then achieving a more effective doctor-patient communication. The following section shall explore the medical approaches used to understand doctor-patient communication. This will be followed by an overview of the research carried out by linguists in the field of doctor-patient communication.

2.6.1 Medical approaches to doctor-patient communication

Early attempts at establishing a framework for the study of doctor-patient communication emphasised structural and semantic aspects of discourse (Cassell et al. 1976). Subsequent research has focused on the dominant role of the doctor in the communicative process displayed in the interview (see Epstein et al. 1993 for a review). More recently, a paradigm shift has occurred in doctor-patient communication studies towards the incorporation of the patient's perspective into a relationship-centred medical model of communication (Roter 2000). Although much work still needs to be done since variables such as gender are under-researched in the field of doctor-patient communication (Gabbardalley 1995).

In a recent comprehensive review, Ong et al. (1995) identify three purposes of doctor-patient communication:

a) To create a good inter-personal relationship.
b) To exchange information, and
c) To make treatment-related decisions.

Good inter-personal relationships can be created between doctors and their patients through empathic relations, by incorporating a lifeworld approach (Mishler 1984), and

by eliciting feelings, paraphrasing and reflecting, using silence, listening to what the patient is saying and to what s/he is unable to say, encouraging the patient and using non-verbal communication (Ong et al. 1995). In a study of the communicative styles of doctors in an oncology consultation, Dowsett et al. (2000) found that individuals watching a videotape of the consultation significantly preferred a patient-centred consulting style over a bio-medical approach. The establishment of an environment conducive to good inter-personal relationships can be jeopardized by the doctor's use of technical terms that are unknown to the patient or that have a different 'lay' meaning (Hadlow and Pitts 1991).

The exchange of information is a two-way process: seeking and giving information. Doctors need to obtain information from their patients in order to give a diagnosis, whereas the patients need to describe their symptoms in a way that is understandable to their doctors. In this process, doctors sometimes underestimate the patient's desire for information (Ong et al. 1995). This is currently being emphasised by 'emancipatory models' where appreciation of patient expertise is at the core of good doctor-patient communication (Thorne et al. 2000). However, a patient's participation in the consultation is not always achieved. Heath (1992) analysed video-recordings of doctor-patient interviews in the U.K. in order to investigate how patients receive the doctor's diagnosis. He found that the manner in which the doctor delivers his/her diagnosis can silence the patient. Even when the doctor leaves a pause after the diagnosis has been made, the patient may feel at unease and unable to participate in the discourse particularly if the doctor is preoccupied with the writing out of a prescription. At such a time, a patient may believe that talk would be inappropriate. In such contexts, patients may use a downward-intoned *er* or *yeh*. Conversely, Heath (1992) found that patients' participation increased when there was a mismatch

between diagnosis and the patient's lay knowledge of his/her condition, since this prompted patients to clarify their ideas and in this process the chances of a negotiation were increased.

Although the relationship between doctor and patient has been depicted traditionally as a paternalistic one, with many patients still thinking that 'the doctor should take primary responsibility in the decision-making process' (Ong et al. 1995: 905), patients need cure and care in their treatment, where cure implies knowing and understanding, and care implies the feeling of being known and understood (Ong et al. 1995). Charles et al. (1997) propose a model of shared 'decision-making' for a more effective doctor-patient communication. Their model is structured into four main building blocks:

a) Both patient and doctor are involved in the consultation.
b) Both parties share information.
c) Both participants build a consensus about the preferred treatment, and
d) Both reach an agreement on the treatment to be implemented.

However, Stevenson et al. (2000) studied 62 consultations between patients and general practitioners and found little evidence to support this model of 'shared decision-making'. In their study, some of the consultations did not even present the last two of the four (c and d) conditions suggested by Charles et al. (1997), that is the consultations did not achieve a doctor-patient consensus on treatment and implementation of the treatment.

At the core of a successful doctor-patient interview is patient satisfaction leading to proper compliance with medical recommendations (see Burgoon et al. 1991; Gerber 1986; Korsch et al. 1968; Lieberman 1996; Roter et al. 1987; Stearns and Ross 1993; Williams et al. 1998). Daly and Hulka (1975) argue that patient dissatisfaction with a medical consultation is related to:

(a) The absence of warmth and friendliness on the part of the doctor.
(b) A failure to fulfil patient expectations, and
(c) The use of confusing terminology.

Studies of doctor-patient communication strongly suggest that good communication among the interactants favours compliance with the medical recommendations. In a study that was carried out in an epilepsy clinic in South India, Gopinath et al. (2000) found that there was a significant positive correlation between effective doctor-patient communication and compliance. After analysing questionnaires and interviewing patients, Daly and Hulka (1975) concluded that compliance is a result of a good relationship with the doctor. Affective behaviour, as part of a patient-centred behaviour, such as a doctor showing interest in the patient, eye-contact, empathy and encouragement of the patient by using semi-verbal, non-specific utterances, such as *hm-hm, ah,* is associated with greater compliance by the patient (Bensing 1991).

Conversely, lack of proper communication may lead to a patient not complying with medical recommendations. For example, confusion in doctor-patient communication arising from the doctor's use of technical terms that have a different 'lay' meaning may cause patient frustration and dissatisfaction, leading to a lack of compliance (Hadlow and Pitts 1991). In a comprehensive review, Donovan and Blake (1992) indicate that between one third and one half of all patients in their study were non-compliant, although the reasons for this vary. Non-complying patients tend to carry out a 'cost-benefit' analysis of each treatment, with their perceptions and social circumstances at the core of their decision-making. This means that an apparently irrational act of non-compliance, from the doctor's perspective, may be a completely rational act as far as the patient is concerned.

Hitherto attention has been on understanding doctor-patient communication from the point of view of research carried out mainly in the field of social science and medicine, and from observing the medical approaches used in the consultation and the relationship that may exist between them and patients' satisfaction and compliance in the medical field. These studies, however, tend to underestimate issues regarding the use of language throughout the discourse in the consultation, and therefore they do not thoroughly represent the linguistic exchange and the interaction that may occur. In the following section I shall present an overview of the linguistic approaches to medical discourse dividing them into the doctor's perspective and the patient's perspective.

2.6.2 Linguistic approaches: The doctor's perspective

Parsons (1951) suggests that doctor-patient interaction is 'essentially' asymmetrical. This could be supported by the fact that the medical institution acts as a 'gate-keeping' encounter (Erickson and Shultz 1982; Royster 1990). Doctors are familiar with the medical institution and its procedures, and they are able to make decisions in regard to the patient's health, whereas patients enter the consultation as outsiders and are sometimes unaware of the medical procedures that will be involved in their treatment. This difference marks the first asymmetry within a medical consultation and it is present even before the interaction takes place.

A number of studies carried out in the area of doctor-patient communication have focused on the miscommunication that emerges in such interactions. These communicative problems appear to increase when two different language and/or cultural groups interact, as in the case of Hispanics, mainly from Central America, living in the United States and interacting with Anglo-American doctors (Erzinger 1989; Kline and Acosta 1980; Muñoz 1981; Prince 1986). Nevertheless, the

communicative problems do not necessarily disappear when the same-language cultural group is involved in the interaction (Bamberg 1991; Byrne and Long 1976; Thompson and Pledger 1993).

Byrne and Long (1976) have pioneered research in the area of doctor-patient communication with their analysis of 2,000 general consultations in Great Britain and of the interaction that emerged during the diagnostic stage. They observed that doctors controlled the exchange and that the contribution of patients was restricted mainly to the end of the consultation. The control exercised by doctors is most apparent in the preference they show for asking questions, introducing topics and participating unequally in the exchange (Shuy 1983).

Frankel (1984, 1990) and Ten Have (1991) note that questions have been a major topic in the study of medical interaction, and the large number of work published in this area confirm their observation (Coulthard and Ashby 1975, 1976; Kess 1984; Mulholland 1994; Rozholdova 1999; Seijo et al. 1991; West 1984, 1990). Questions are used to acquire an understanding of the patient's condition and to lead to a diagnosis. Their function is usually medically oriented, and they tend to centre on the onset and development of the ailment up to the time of the consultation. Questions have been studied with a view to:

(a) Observing their type of linguistic form
(b) Assessing the relative use of the question form by the participants
(c) Investigating and categorising their functions in a medical interaction
(d) Observing the sequences of questions, and
(e) Investigating the social variables that may lead doctors to modify their speech

In early studies, Coulthard and Ashby (1975) observed that doctors asked most of the questions, while patients provided the answer. They enumerate three kinds of questions used by doctors:

(a) Testing exchanges, where the information is transferred in the next move, which may be identified by particular items (e.g. *good*, *that's right*) or by a high-key *yes*
(b) Transfer exchanges, where the doctor uses *yes* or repeats what the patient has said, and
(c) Matching exchanges, where the first speaker presents something to be confirmed, and the second confirms it

Coulthard and Ashby (1975) show that the doctor takes control of the interview by asking questions aimed at getting information about the patient's health, while often disregarding additional information the patient may provide in the interview. Similarly, West (1984) notes that doctors initiate the majority of questions and that the kind of question they ask in the consultation influences the patient's contribution to the speech. Questions made in sequence and multiple-choice questions do not inspire much of a contribution from patients because of 'constraining structural circumstances' (West 1984: 82).

Whereas West (1984) suggests that the form in which the question is presented to patients may affect their participation, Mulholland (1994) understands the contribution of both doctor and patient as an interactional phenomenon since she expanded further the concept of directives. She centres her attention on 'multiple directives' rather than on independent directives, as in the case of West (1984). Mulholland notes that directives can be identified as a coherent unit when they produce a single task, thus multiple directives are interactionals, allowing both participants to engage in a 'single complex task, a single set of related tasks or a set of

tasks which, from the speaker's point of view, have a single goal' (1994: 75). The interaction that has been achieved in this process is broken when any one of the participants ends the conversation or introduces another speech activity.

As far as questioning sequences are concerned, Coupland et al. (1984) observe that they are often used in a three-part structure. The doctor initiates the topic, the patient responds to it and the doctor retakes the floor to express a third-position assessment. Other studies have observed how the function attached to questions can modulate a patient's contribution. Royster (1990) found that some questions were intended to elicit a patient's knowledge and understanding of his/her health condition. She called these 'probing questions'. Similarly, Fisher observes that some questioning strategies offer the opportunity for the patient to show their competence in the medical framework (Fisher 1993: 170).

However questions are not the exclusive discourse form used by doctors to gain information from their patients. Bergmann (1992) studied the interaction between psychiatrists and their patients, and found that specialists do not always use direct questions to obtain information from patients. They may simply use an assertion as a way to make the patient volunteer information. This process has been called 'fishing' by Pomerantz (1992). For Bergmann, it is a recurrent feature of his data.

Questions and interruptions by doctors are interpreted as a form of control (Ong et al. 1995) exercised over the patient. Buller and Buller (1987) identify two kinds of behaviour manifested by doctors: affiliation and control, where control is expressed through domination of the conversation, verbal exaggeration (to emphasize a point) and dramatization (being very argumentative, and constantly making gestures when communicating). This form of control may also manifest itself in the tendency

of some doctors to interrupt their patients' discourse with questions (Irish and Hall 1995). Nevertheless, the use of questions by doctors seems to be much more complex and varied. Harres (1996, 1998) analysed 29 audio-taped consultations and found that tag questions were used by doctors not only as control mechanisms, but also as involvement strategies. Doctors used tag questions to:

(a) Elicit information from patients
(b) Summarize and confirm information
(c) Express empathy, and
(d) Give positive feedback

The amount of information delivered by doctors is dependent on the patient's style of speech and personality. Doctors tend to underestimate the patient's desire for information, whereas patient satisfaction is achieved, *inter alia*, if doctors are not dominant and their style not controlling (Ong et al. 1995).

Consideration of the patient's forms of talk has not been a recurrent theme in most of the studies carried out on medical discourse. As Mishler (1984) notes, the emphasis on the doctor's discourse has silenced the participation of the patient. Some studies of the patient's contribution to medical discourse have focused on paralinguistic features while others have noted some linguistic features of patients in the recounting of their story (Ainsworth-Vaughn 1998; Davis 1988; Labov and Fanshel 1977). Bensing (1991) observes that eye-contact with patients helps to create a rapport with them, while Ong et al. (1995) found that doctors' touching and proximity were considered breaches of patient privacy, a view shared by Parrott et al. (1989) and Parrott (1994). Interestingly, this attitude was not shared by Chilean patients in Scarpaci's (1988) study, since Chileans did not feel that their territorial space was threatened when their doctor came close to them. Scarpaci's study was carried out in the Villa O'Higgins clinic and aimed at understanding the satisfaction

rate for 140 frequent users of the National Health Service System (SNS). The clinic was located in an area where 'most low-income residents live' (Scarpaci 1988: 200). It was found that patient satisfaction was associated with:

> Physicians who listen to, examine, and touch patients provide support in the difficult and stressful lives of the urban poor (1988: 208).

As for studies on the discourse strategies used to bring about a less symmetrical interaction between doctor and patient, the work of Ten Have (1991) in Holland is worth mentioning. Following a critical analysis framework, Ten Have observes that doctors may use the particle *oh* at the beginning of their third turn. Contrary to the discussion above, this use of a doctor's third turn is not intended to express an assessment of the patient's last utterance(s). Rather, the particle is free of medical evaluative remarks. Similarly, Atkinson (1992) found that third turns, such as *mhm O.K.* and *mhm, ah,* as studied by Bensing (1991), show a similar tendency. Coupland et al. (1984) also found a third position lexicon item present in their data. For them,

> The term 'continuer' is most appropriately applied to non-referring expressions (such as *uh- huh* or *yes*) uttered with high-rise contours, or to referring expressions which request patients to elaborate upon a summary account (such as *Not well?*), said with a fall-rise on the tonic syllable (1984: 117).

Whereas they suggest that a third position continuer marker can allow the patients to elaborate on their talk they also indicate that it can restrain the speaker from continuing to elaborate further upon the topic by using a low-falling contour.

In summary, it has been observed that:

(a) Doctor-patient interaction is essentially asymmetrical, and

(b) Doctors' control of the discourse is expressed by specific linguistic means such as: questioning, introducing topics and contributing more in the exchange.

2.6.3 Linguistic approaches: The patients' perspective

In this section I shall first explore patient perception of health as a macro representation of socio-cultural realities, and second I shall overview patient linguistic participation in medical exchanges. As mentioned earlier, it has been suggested that doctors perceive the medical exchange as an encounter where the bio-medical and the socio-relational frame form an important part of the medical discourse, whereas patients perceive health as a personal phenomenon, with associated socio-cultural and psychological implications (Helman 1994; Mishler 1984). The different views of illness taken by the doctor and patient may influence whether the medical consultation takes place in the first instance. Defining oneself as ill usually involves a subjective experience which might include: changes in body appearance, regular bodily functions and bodily emissions; changes in motor ability and emotional state; behavioural changes towards others as well as changes in any of the five major senses; and the experience of unusual physical discomfort (Helman 1994: 109). In anthropological medicine it has been shown that patients belonging to different cultural groups generally declare themselves ill when:

> There is an agreement between [their] perception of impaired well-being, and the perception of those around [them] (Helman 1994: 110).

According to Helman, illness is interpreted as a social-cultural process that involves both the person who is sick, because s/he is experiencing something unusual in her/himself, and those around the unwell person who note those changes and

comment on them to the potential patient. It has been reported that Mexican-American children interpret the 'hearing of voices' as a religious experience, whereas Anglo-American teenagers interpret it as a sign of insanity or hallucination (Quesada 1976). In this case, Mexican-Americans may not see the need to seek medical help as might their Anglo-American counterparts. Similarly, some illnesses may not be viewed as requiring medical intervention due to a cultural schema that differs from medical practice. Quesada (1976) has shown how the 'cosmology of destiny' -the implication of illness and death- can be a factor in determining whether a Mexican-American goes to see a doctor. While some complaints are perceived by patients as detrimental to their good health and therefore need medical treatment, others are not considered life-threatening since 'nobody has died from [them]' (Quesada 1976). Therefore, they are disregarded, in line with the cosmology of destiny.

The patient's perception of health appears to be the initial factor that determines whether the visit will or will not take place. Nevertheless, when the visit does take place, Rehbein (1994) shows that participants may not share the same concept of illness, and a schema conflict (Tannen and Wallat 1993b) is likely to occur. This was the case reported by Rehbein (1994) of a Spanish-speaking patient interacting with a German doctor, where there was a mismatch in the concepts of obesity and mental illness. The patient interpreted obesity as a hereditary condition and mental illness as a synonym for being crazy, whereas the doctor interpreted both in a medical framework as two illnesses requiring a treatment.

To conclude, one can say that the patient's concept of illness:

(a) May determine whether the medical consultation takes place or not.
(b) May provoke a schema conflict, and
(c) May vary culturally.

These three points make us aware that doctor-patient interaction may be conditioned by some initial obstacles that need to be overcome and negotiated throughout the consultation. In what follows I shall expand on how patient participation in the medical exchange can have an impact on the interaction of both participants.

The achievement of communicative competence on the part of the patient is no easy task. Lacoste (1981) analysed the different strategies used by patients to make their needs known to their doctors, despite the obvious asymmetry in knowledge that existed between them. The author describes instances of 'territorial disputes' between the two participants, as in the case of a patient who used an inappropriate, non-technical word to describe his symptoms. This resulted in a tension that indicated that each participant should stay in his/her own territory. When a patient takes the initiative, the doctor may refuse to follow by using a silence, not terminating a response, announcing but not giving a response, taking another initiative (e.g. asking a question) or giving a purely formal acceptance. The patient may also use 'dramatization' as a globalising strategic resource where s/he may 'play' with the doctor in order to achieve what s/he desires. Specific discursive strategies used in this context are for example: mocking and self-irony (Lacoste 1981).

Irish and Hall (1995) studied video-taped doctor-patient consultations for interruptive and overlapping speech by both participants. They found that patients engaged in significantly more interruptive and overlapping speech than doctors, and that they interrupted more with statements, whereas doctors tended to interrupt with questions. This bias in the use of questions is evident in a review by Ong et al. (1995) in which the authors show that patients may be reluctant to ask questions. They also found that there is a correlation between doctor communication and patients' outcome

in terms of patient satisfaction, compliance and recall and understanding of medical information (Ong et al. 1995).

In an experimental study, McCann and Weinman (1996) provided a group of patients with an intervention leaflet that encouraged them to take an active role in the consultation, whereas a control group of patients were given a leaflet containing dietary advice. The results showed that patients in the intervention group had significantly longer consultations than those in the control group and that they asked more questions, although there was no significant change in the level of their satisfaction. It is of interest to note that the doctors tended to feel that they had a better understanding of the patients in the intervention group because more information was exchanged. This empirical finding suggests the importance of participants' interaction during the consultation because, although patient satisfaction was not at issue, the information gained by doctors might have helped them to give a better diagnosis and propose a more appropriate management treatment.

An improved doctor-patient communication may lead to greater competence and well being of the patient. Therapeutic results are likely to be better for competent patients (see Gruninger 1995 for a review). In spite of this, Gopinath et al. (2000) concluded that one third of the patients in their study received insufficient information about epilepsy and its treatment from the doctor. In another study, Blanchard et al. (1988) found that a majority of cancer patients wanted to be wholly informed, no matter how positive or negative the information was. However, older patients were more prone than younger ones to follow an authoritarian model by decreasing their level of participation.

The failure of doctors to acknowledge a patient's expertise has been shown to lead to a spiral of mutual alienation in the case of the treatment of chronic diseases

(Thorne et al. 2000). The patient's participation in the medical discourse depends to a large extent on the opportunities given to him/her to participate in the consultation and on the appropriateness of the linguistic features and strategies used by patients in the institutional setting.

West (1984), in her investigation of question sequences used in medical consultations, found that of a total of 773 questions, 9% were initiated by patients and 91% by doctors. Of interest is her comment that: 'given their scarcity, it is notable that patient-initiated questions failed to elicit answers from physicians more often than the reverse' (West 1984: 84). She notes that the stammered questions of some patients may have been the reason for the doctor's lack of response. Korsch et al. (1968) corroborate the view that patients' questions were frequently disregarded by doctors. West (1984) also explores the possibility that questions may be interpreted as an intrusion into medical territory and as a threat to the doctors' status and authority (West 1984). Similarly, Lacoste (1981) observes that territorial disputes arise when patients intrude into the medical area by using incorrect medical terms to describe their symptoms.

The discourse style of patients in their responses to doctors can also influence a medical consultation. Coupland et al. (1994) observed that patients very rarely responded to the initial question, "How are you?", following a medically oriented response. Instead, patients interpreted such a question as a request to initiate the talk.

Of the 80 initial questions reported in Coupland et al.'s study, 54 received an answer that was related to the patient's life. The simple fact of listening to patients recounting their stories is considered by Coupland et al. as a starting point to engage in the patients' lifeworld. Conversely, Mishler (1984) notes that doctors often ignore and disregard the personal experiences of patients, favoring those contributions that

were medically-oriented or those that were factually-based answers to medical issues. In his study of the diagnostic stage of the medical consultation and of the participants' contribution to the exchange, Heath (1992) claims that a patient's reluctance to engage in the discourse creates and maintains the asymmetry throughout the exchange.

Davis (1988) observes in her study of patient participation in medical discourse how patients' trouble-telling is made possible when both the doctor and the patient work together in the exchange. To quote Davis own words, 'recounting the trouble, like getting the floor is an interactional accomplishment, requiring specific tasks from both the patient as a trouble-teller and from the GP as a trouble-recipient' (Davis 1988: 230).

To summarise:

(a) Patients' discourse style can have an effect on the interaction of both participants.
(b) Territorial disputes between doctor and patient are likely to occur in medical discourse.
(c) Patients' preferred treatment and management depends on the individual characteristics and the kind of disease the patient is suffering, and
(d) Patients may increase their participation in the speech if doctors use linguistic strategies that favor patient communication.

The realisation of the consultation, like any other speech encounter, is dependent on the interaction of sociological factors, such as the social class, education and gender of the participants, as well as the medical discourse. The following section reviews some of the most prominent studies in this area.

2.7 Sociological factors and doctor-patient communication

While there is a flourishing literature in the area of medical discourse that analyses the speech of female and male patients in their interaction with doctors (Ainsworth-Vaughn 1994, 1998; Atkinson 1992; Borges 1986; Coupland and Coupland 1994; Davis 1988; Dawson 2000; Fisher 1995; Fisher and Todd 1993; Harres 1996, 1999; Heath 1992; Hein and Wodak 1987; Mynard 1992; Pauwels 1995; Todd 1983; West 1984, 1990; Wodak 1996) relatively few studies have analysed the effects of a patient's age, social class and education in the same process. In western societies, the medical profession has usually been associated with high social prestige and high annual income:

> The medical profession can be seen as a healing 'sub-culture', with its own world view. In the process of medical education the students... also acquire a high social status, high earning power and socially legitimated role of healer which carries with it certain rights and obligations (Helman 1994: 101)

While it may be possible to predict the social status of a doctor, the social class and education of a patient attending the consultation cannot always be predicted in the same way. However, it is worthwhile noting that, according to Helman (1994), causes of illness in anthropological medicine are closely linked to social factors. For example, patients from lower social classes are more likely to suffer particular kinds of illnesses (Sunquist 1995). Also, being a member of a lower class is often an indicator of poor health (Blaxter 1987). As for education, some differences have emerged in studies on the topic. Educated people tend to challenge the doctor's authority more often than the less well educated (White et al. 1984). Age followed the same pattern with younger patients confronting their doctors more often than older ones (White et. al. 1984). These social factors as well as the cultural characteristics of patients may have an effect on the development of the discourse. Fisher indicates how

young white females were more likely to receive 'a more conservative treatment' in hysterectomy interventions than older Mexican American women consulting for the same health problem (1993: 166). Patient sociological factors have been introduced in linguistic studies of doctor-patient communication to account for the complex system of variables that are interacting in the realisation of medical consultation discourse.

In the present study the variables of social class, cultural group and age have been controlled and kept as similar as possible in the consultations under investigation, whereas the gender variable will not be studied in great detail (see Chapter 3).

2.8 Conclusion

My aim is to investigate the roles that both doctor and patient play in the consultation as a way of understanding the dynamics of the interaction that emerges in the exchange. From now on, those roles will be referred to as *voices*, since through participants' own discourse it will be possible to 'hear' and interpret their own alignment position in the interaction. The discourse will be analysed by identifying doctor and patient *voices* in the verbal exchange and by observing the occurrence of any shift in footing from one *voice* to another.

CHAPTER 3

METHODOLOGY

3.0 Introduction

This chapter outlines the research design implemented in this study of doctor-patient communication in a Chilean clinic, and gives an overview of the medical institution, doctors and patients involved in the research. The specific aspects of the discourse that became the focus of my analysis were selected following a bottom up approach. As soon as the transcriptions of doctor-patient conversations were completed, the linguistic behaviour of the participants was surveyed in order to determine whether there was any obvious general trend that reflected the participants' specific role played in the consultation. In the process of familiarisation with the data it emerged that both the doctor and the patient were performing different 'forms of talk' (Goffman 1981) during the medical interview. As a result of this, I carried out a formal analysis to distinguish each of the 'forms of talk' found in the doctor's and the patient's discourse and to understand the interaction between these 'forms of talk' in the medical discourse. The analysis focuses on the 'forms of talk' of both doctor and patient in the communicative routines classified by Pauwels (1995) as 'history taking' and 'management and treatment of a health problem or a health issue'.

The above communicative routines appear to be of great interest especially in the context of follow-up visits, since the doctor and patient have already met at least once before. Therefore, in this kind of visit doctors may check on previous information and add new details to the discourse. Follow up visits constitute a rich source of information for doctors, that allow them to assess the development of a patient's health and to comprehend the patient's knowledge and understanding of

his/her health condition. This is achieved through observing patients' negotiation of the recommended medical treatment.

The following section lists the research questions that served as the focus of attention of this study. It gives an overview of the health system in Chile and describes the main characteristics of the Clinic where this project took place. The methods of analysis, discourse analysis and the ethnographic approach are explained, and the criteria used for their selection justified. The main methodological approaches used for data collection are presented in four Stages: Stage I: observation period; Stage II: questionnaire; Stage III: semi-structured interview and Stage IV: tape recording of the medical consultations. Participants involved in each of these Stages are also profiled, noting the selection criteria used in the process. A description of how the analysis of the doctor and patient discourse was carried out and the limitations that such analysis might have are also indicated. Finally I explore the ethical issues and permits involved in this study.

3.1 Research questions

The present study intends to expand the current knowledge of medical discourse by investigating doctor-patient communication in a Chilean Clinic. Specifically, with this research I intend to:

- Investigate Chilean doctor-patient communication and discover 'forms of talk' that the participants use in the consultations.
- Describe the interactions between doctors' and patients' 'forms of talk' in the consultation.
- Explore the role of power and affiliative discourse in the medical consultation.
- Explore the characterisation of doctors as 'healers' and patients as 'sick' persons and investigate whether their participation framework present a dynamic interaction.

3.2 The Chilean health care system

The health care system in Chile offers two major health care plans: a public one and a private one. Chileans may 'choose' either of the two, although the choice is generally determined by the monthly family income. According to Giaconi (1994), 68.8% of the population have public health cover (FONASA), whereas 15.1% have private cover (ISAPRE). A total of 2.5% of the population have health cover provided by the Armed Forces (FFAA), and 12.1% are *particulares* who pay a full fee when visiting a doctor since they have no particular health cover. The remaining 1.5% have medical covers which have not yet been classified (see Table 3.1)

Table 3.1 Distribution of Chilean population in regard to health insurance cover

Health cover system	Population in thousands	%
FONASA (Public health system)	8,809	68,8%
ISAPRES (Private health system)	1,927	15,1%
FF.AA. (Army health system)	318	2,5%
Particulares (Full fee paying)	1,550	12,1%
Other (Other medical plans)	197	1,5%
TOTAL	12,801	100%

(Data are from Giaconi 1994)

Chileans with public health cover may attend health Clinics (*policlinicos)* run by the *Sistema Nacional de Servicio de Salud* (SNSS), or visit outpatient Clinics run by the *Fondo Nacional de Salud (*FONASA). Under the current system, fees are dependent on the patient's monthly income and the medical speciality being consulted (cardiology, oncology, radiology, etc.).

3.3 The research site

Doctor-patient communication has been widely studied in different specific settings (see Chapter 2) and some patterns of linguistic behaviour may be sensitive to the environmental context of the consultation. The research site where the investigation took place may have an effect on doctors' and patients' communication. This implies that the location and context of the investigation should be made explicit and explained in detail; e.g. discursive strategies used in an emergency department may differ from those used in a check-up visit.

In this section I provide a broad description of the medical institution that was involved in this study and then I focus on identifying the main characteristics of the Clinic where the recording took place. There follows a description of the medical consulting rooms and the equipments used for the recording of the data.

3.3.1 The PUC outpatient Clinic

The Pontificia Universidad Católica de Chile (PUC) in Santiago has a medical network that includes four *Centros asistenciales* (Medical Clinics) located in the metropolitan area. The data for this study was collected in the outpatient Clinic of the PUC located in San Joaquín, a working-class suburb in the southeast part of Santiago.

The PUC hospital itself is located in the city centre. Unlike the other three Medical Centres, it has a casualty department and an outpatient and inpatient teaching hospital. The three remaining Centres are positioned strategically around the metropolitan area of Santiago (in the suburbs of San Joaquín, Irarrázaval and Las Condes). Patients are free to visit the Centre closest to their suburb.

According to the last census held in 1992 (Instituto Nacional de Estadísticas, Chile 1992), the population of San Joaquín (114,017 inhabitants) represents 2.16% of

the total population of the metropolitan area. The average monthly salary of people living in the suburb and who visited the Clinic was in the range of $A750 (personal communication from Mr. Enrique Mena, Manager of PUC outpatient Clinic, December 1997).

The PUC outpatient Clinic used in this study is a teaching centre that trains both medical students and *internistas* (medical graduates). Junior health professionals are supervised by a group of experienced doctors whose responsibility is to ensure that the diagnosis and treatment given to patients are correct. The PUC outpatient Clinic is one of the few innovative tertiary institutions in Chile interested in research on doctor-patient communication; a subject on the topic is offered to students in the final years of their course. The Clinic also encourages patients to be aware of doctor-patient communication issues by inviting them to assess trainee doctors, invites scholars to talk on the topic of doctor-patient communication, and fosters postgraduate research on patient satisfaction. In addition, the PUC runs health awareness and disease prevention campaigns and public lectures throughout the year as part of its education programme.

The Clinic had, at the time of doing this research, 39 medical areas that were divided into specific departments such as Cardiology, Endocrinology, Gerontology, Pathology, General Medicine, Oncology, Psychiatry and laboratory areas for blood tests and X-rays. The laboratory facilities allow patients to consult a doctor and have any prescribed tests conducted in the same centre. The PUC outpatient Clinic is not used exclusively by residents of San Joaquín; it is also consulted by middle-class patients who come from a number of suburbs in Santiago or from the provinces (information provided by the General Adminstration of the outpatient Clinic). The

number of female patients is almost double that of males, according to statistics collected by the Centre.

3.3.2 The Consultation room at PUC

This section describes the waiting rooms and the consulting rooms where the recording took place and refers to the equipment used to record the data.

Upon arrival at the Clinic, patients take a seat in one of the two waiting rooms used for general medicine. One is in an area where there are three consulting rooms and a staff room, and the other is in an area where there are four consulting rooms and an Information Desk. A corridor separates the two waiting rooms. The consulting rooms have aluminium walls, glass windows and two doors, one which connected to the patients' waiting room and the other to an internal corridor that led to the staff room, where the doctors who supervise the medical trainees were located. This enabled doctors to move from the consulting rooms to the supervisors' room easily and unobserved by the patients in the waiting room. It also allowed the researcher to switch the tape-recorder discretely on and off when participants were absent from the consulting room. Consulting rooms were furnished with a wooden desk, two chairs, a consulting bed, and a basin (see Figures 3.1 and 3.2).

A tape-recorder stand was built in the corner of each consulting room used for this study. The corner closest to the consulting bed was chosen since it was facing the patient's back (see Figures 3.1 and 3.2). Due to the type of construction of the consulting rooms, it was decided to hang a personal clip microphone to the ceiling to obtain maximum clarity of sound. The microphone was placed above the eye contact of both participants to avoid any discomfort to either party.

A portable Marantz cassette recorder PMD 222 was used for this study. Pitch, tone and a decibel controller made for a better quality recording than the standard tape-recorder with a personal microphone.

Figure 3.1 Consulting room 1

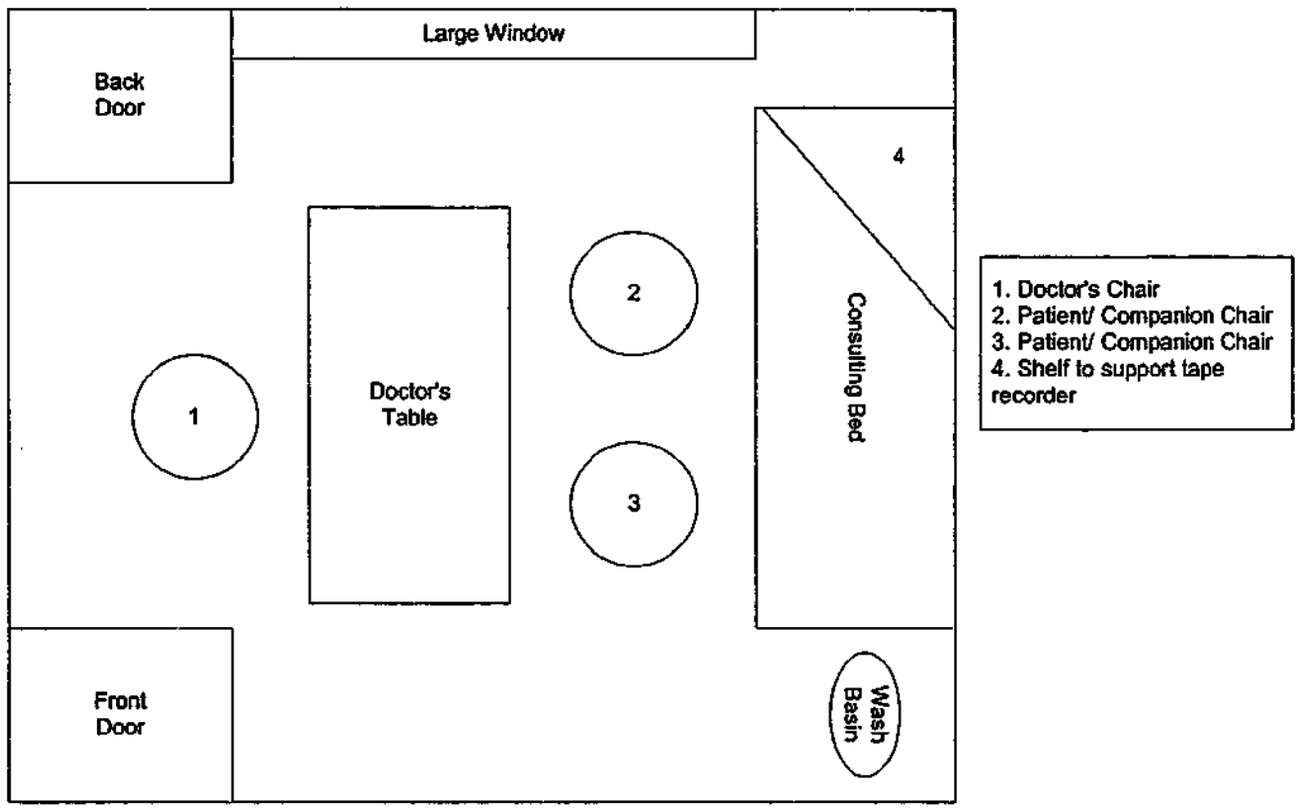
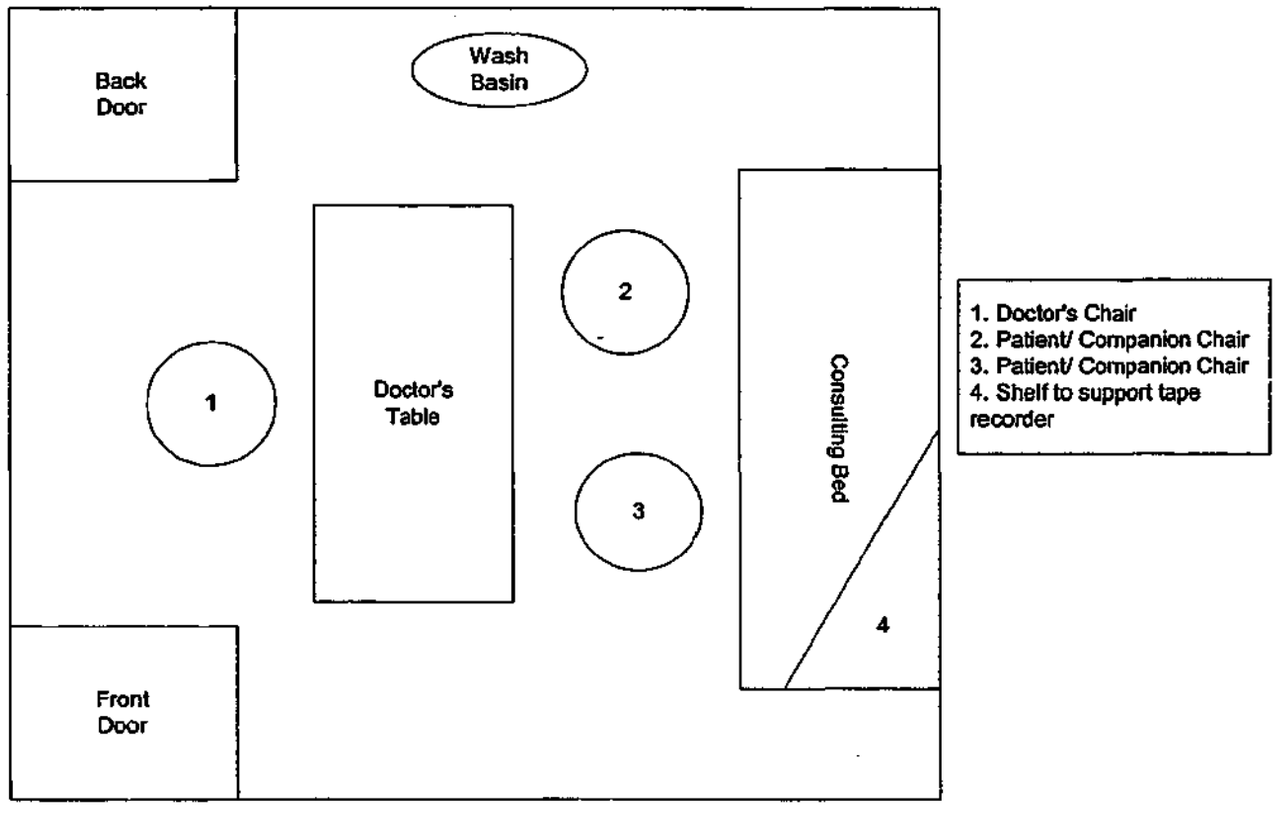


Figure 3.2 Consulting room 2



3.4 Methods of analysis: Discourse analysis and ethnographic method

The selection of methodology to analyse the doctor and patient consultations was bound to the research questions that this study aims to answer (see Section 3.1). In this study I take interactional sociolinguistics and ethnographic approaches to discourse analysis, since both approaches complement each other in the understanding of discourse as a social/cultural event (see Section 2.1). Following van Dijk:

> Discourse [is] a form of social interaction between social members taking place in social contexts that are constrained by (interpreted) social structures and cultural frameworks (1987: 32-33).

Discourse analysis can provide the analytical tools and the theoretical basis necessary to understand which 'forms of talk' doctors and patients use in the consultation and to comprehend the interaction taking place among these 'forms of talk'. By using

interactional sociolinguistics approaches to discourse analysis, the speech of participants can be divided into small units or episodes (van Dijk 1982) that share similarities in terms of their type of discourses (e.g. questioning, accounts, affiliative discourse strategies). Interactional sociolinguistics also allows the study of the participation framework that develops in the interaction.

In addition, interactional sociolinguistic approaches to discourse analysis aid in the interpretation of the speech of participants by providing an account of the local discourse and by connecting it to the broader institutional socio-cultural system. All these may reveal a participation framework that favours a good communication or hamper it by showing 'disorders in discourse' (Wodak 1996). Consequently, discourse analysis can lead to the detection of conversational medical practices of variable effectiveness, and it can help in the process of making recommendations to doctors and patients about the selection of those conversational practices that favour a better communication.

The ethnographic approach to discourse complements discourse analysis by analysing the spoken interaction in a particular speech event (e.g. doctor-patient communication) in association with a particular social setting (e.g. the Clinic) where the talk takes place. The ethnographic approach 'studies patterns of observed and recorded communicative behaviour' Stubbs (1983: 40). Consequently my study is based on observed, recorded information and tape-recorded naturalistic data.

Data were collected between September and December 1997. The research design comprises four Stages: an observation period (Stage I), the administration of the questionnaire (Stage II), the semi-structured interview (Stage III) and the tape-recording of the medical consultation (Stage IV).

3.4.1 Stage I: Observation

Before any recording was undertaken, the researcher observed how social exchanges were conducted in the PUC outpatient Clinic, this helped the researcher in her choice of a language style and behaviour to be adopted throughout this study and that would encourage people to cooperate in the project. It was critical to show at any time respect and friendliness to everybody involved in the Clinic.

Particular care was taken to speak with an accent that matched that of a middle-class female professional (see Section 3.5.1). This was done in order to prevent speaking with an inappropriate accent that might have made both doctors and patients reluctant to cooperate in the study. Refining the paralinguistic and linguistic aspects of communication proved to be the crucial key to being accepted by doctors, administrators, secretaries and patients of the institution.

3.4.2 Stage II: Questionnaire

The aim of the questionnaire was to gather demographic information about participants. This information was important for the selection of the tapes to be transcribed and studied (see Section 3.5.2 Stage IV and 3.5.3 Stage IV).

After agreeing to participate in the study, participants completed one of two questionnaires: the one designed for doctors (see Appendix 3), or the one for patients (see Appendix 2). Doctors were asked about their age, gender, years of medical practice and nationality (see Section 3.5.2 Stage II). Patients were asked about their age, gender, occupation and nationality (see Section 3.5.3 Stage II and Tables 3.3) before their medical consultation took place. Information about the number of visits made to the Clinic by patients and their familiarity with the medical procedures in the Clinic were also requested.

3.4.3 Stage III: Semi-structured interview

The aim of the semi-structured interview was to understand patients' attitude towards doctors and to comprehend whether patients' opinions were revealed in the consultation. Following an ethnographic approach toward discourse analysis, two questions aimed at determining what patients liked and disliked about their visiting doctor were added as a result of the patients' own interest in the topic. I realized soon after talking to patients that they would spontaneously initiate a conversation about their likes and dislikes of the medical system and of the doctors in the Clinic.

A total of 134 patients contributed in the semi-structured interview, patients were allowed to give extensive answers that were written verbatim by the researcher so as to keep an accurate record of their views. Completing each semi-structured interview took 20 to 30 minutes.

3.4.4 Stage IV: Tape-recording of the medical consultation

Tape-recording of the data was developed in two Stages. A pilot study was carried out initially. This served to improve the final design for the recording of the data to be used in this study.

The pilot study was undertaken during the first few weeks of the study (September 1997) in order to determine the best location for the tape recorder and to select the best consulting rooms for recording purposes. At this Stage any doctor or patient willing to participate in the pilot study was involved, this means that participants knew that they were collaborating in a trial and that their recording was not part of the data designed to be transcribed nor to be analysed in any way. Participants were asked to participate and give any feedback (at the end of the

consultation) that could help to maximise the chances of a naturalistic recording that would not interfere with the medical consultation. After a number of trials it became clear that patients were uncomfortable with a tape recorder visible on the doctor's desk. Therefore the solution was to place the tape recorder in a corner of the consulting room (see Figures 3.1 and 3.2). Consultations were recorded in the morning session.

3.5 Participants

Doctors and patients that contributed in this study also completed a questionnaire (see Section 3.5.2 Stage II and 3.5.3 Stage II) aimed at obtaining demographic information that may be relevant for a better interpretation of the analyses of the tape-recorded consultations (see Section 3.5.2 Stage IV and 3.5.3 Stage IV). Patients also cooperated in giving their opinions about the liking and disliking of a doctor in the semi-structured interview (see Section 3.5.3 Stage III).

In the following section I give a profile of the researcher, identifying the manner in which she was involved in the study. I then explain the involvement of doctors in the study as described in Stage II (see Section 3.4.2) and Stage IV (see Section 3.4.4), and finally I describe patients' participation in Stage II (see Section 3.4.2); Stage III (see Section 3.4.3); and Stage IV (see Section 3.4.4).

3.5.1 The researcher

Since this research has an ethnographic approach to discourse analysis a description of the researcher involved in this study is necessary. The researcher is a Chilean-born female with a middle class social background; she is in her mid thirties and completed primary, secondary and tertiary education in Chile, and she completed

postgraduate studies in Australia. She left Chile in 1985 and lived for three years in Italy before establishing herself in Australia in 1988. The researcher's participation in the study was one of an observer (see Section 3.4.1) of the institutional arrangements and interactional system of operation in the Clinic. She also conducted the questionnaire (see Section 3.4.2) and the semi-structured interview (see Section 3.4.3), and maintained regular contacts with medical and general staff, participating in their social and academic activities. The involvement of the researcher in the tape recording was not noticed by participants (doctors and patients) since she used the back door to get in and out the consulting rooms when changing tapes (see Section 3.3.2). Therefore the researcher was never in the consulting room when the doctor and the patient entered the room.

3.5.2 The doctors in the study

This section describes the profiles of doctors who were involved in Stages II and IV of the study.

Stage II

Three of the six doctors that completed the questionnaire were Chilean females who had completed their primary, secondary and tertiary education in Chile. They were in their late twenties and had less than two years of medical practice. The three male doctors had also completed their entire education in Chile. Two were in their late thirties and had ten or more years of medical experience. The third male doctor was in his late twenties and had less than a year's medical experience.

Stage IV

The analysis of doctor-patient tape-recorded communication involved four doctors: two females (Dr. Ana and Dr. Berta) and two males (Dr. Carlos and Dr. Daniel) (see profile tabulated in Table 3.2). The female doctors were in their late twenties/early thirties with less than two years' medical practice. The two male doctors were in their late thirties/early forties and had more than ten years' medical experience (see Table 3.2). Two doctors (of the original six, see Section 3.5.2. Stage II) were excluded from this study because they attended patients who did not match the selection criteria for inclusion in the analyses (see Section 3.5.3 Stage IV)

Since male doctors' ages and experiences differed from those of female doctors, the emergence of differences in the linguistic production of female and male doctors should be interpreted with caution, as gender effects may be confounded by age-experience effects (see Cicourel 1995). This is the reason why the emphasis in the analysis is not on the gender differences that female and male doctors may exhibit in their discourse practices, but on the understanding of how the 'forms of talk' used by participants in the medical talk may interact among themselves.

Table 3.2 Doctors in tape-recorded consultations

Doctor's name	Sex	Doctor's age category	Number of years of medical experience
Dr. Ana[1]	Female	25-35	Less than two years
Dr. Berta	Female	25-35	Less than two years
Dr. Carlos	Male	36-45	Over 10 years
Dr. Daniel	Male	36-45	Over 10 years

[1] Chilean socio-cultural pragmatics requires doctors to be addressed by their surname. However, first names are used in this study to indicate gender. Pseudonyms were assigned to the doctors in order to maintain confidentiality and anonymity.

3.5.3 The patients in the study

In this section I provide a description of the patients who participated in Stages II, III and IV.

Stage II

The total number of patients who completed the questionnaire was 134. Patients ranged in age from 15 to 87 years old, with females generally being younger than males. They included professionals, tradesmen, students, housewives and retirees. The age and sex of the patients are given in Table 3.3 below.

Table 3.3 Age distribution of female and male patients completing the questionnaire

Patients	≤20	21-30	31-40	41-50	51-60	61-70	71 +
Females	7	9	14	23	15	21	7
Males	1	3	6	3	10	12	3

Female patients visited their doctor almost three times more often than male patients (96/38). The majority of them (61.4%) were in their forties and sixties, while those who visited less frequently (7.2%) were in the youngest category (below 20 years of age) or in the mature adult category (over 71 years of age). The majority (58%) of male patients who attended the Clinic were in their fifties and sixties. According to the information obtained from the hospital administration in January 1998, participants in this study belong mainly to the public health system (FONASA) (see Section 3.2).

Stage III

The patients that were involved in the semi-structured interview were the same that completed the questionnaire (see Section 3.5.3 Stage II).

Stage IV

Of the 134 participants who completed the questionnaire more than one hundred gave permission to tape record their consultation. After a careful selection

procedure (explained below in this section) twenty-two consultations were selected for study. In order to make the most of the comparison of the patients' discourse it was important to gather information from a group of patients who shared socio-demographic similarities. I selected the age group that was most prominently represented in the Clinic (information provided by Gerencia General PUC 1997). Teenagers and mature adult patients were excluded. Participants were also controlled on the basis of the number of visits they had made to the same doctor in the Clinic. Those familiar with the procedures were selected, those visiting the Centre for the first time were excluded.

The selection of the recorded material also took into consideration the number of participants involved in the speech. Many mature and young women and men were frequently accompanied by family members to the medical visit. Multiple-participant consultations were excluded in this study since they involved patients that were visiting the clinic for the first time. In addition, consultations were excluded when the sound quality was poor due to echo resonance or when the voices were not clearly differentiated due to overlapping external noise. These situations severely hampered transcription of the data and led to many untranscribed sequences.

The composition of each doctor-patient dyad is given in Tables 3.4 to 3.7 (see below), with the pseudonym of the attending doctor, the pseudonym of the patient, together with the age range and occupation of the patient.

Table 3.4 Profile of female patients consulting female doctors

TAPE	NAME	AGE RANGE	OCCUPATION OF PATIENT	DOCTOR
28B	Alicia	31-40	Housewife and student	Dr. Ana
5B	Beatriz	51-60	Housewife	Dr. Ana
20B	Carmen	41-50	Secretary	Dr. Ana
48A	Gina	51-60	Secretary	Dr. Berta
34A	Hilda	61-70	Accountant	Dr. Berta
32B	Javiera	61-70	Housewife	Dr Berta

Three female patients visited Dr. Ana and three female patients who fulfilled the selection criteria visited Dr. Berta. Female patients attending female doctors were in the range of 31-70 years of age.

The profile of male patients who visited a female doctor is provided in Table 3.5 below.

Table 3.5 Profile of male patients consulting female doctors

TAPE	NAME	AGE RANGE	OCCUPATION OF PATIENT	DOCTOR
36Bi	David	41-50	Publisher	Dr. Ana
13B	Esteban	51-60	Worker	Dr. Ana
36 A	Flavio	31-40	Engineer	Dr. Ana

Three male patients were attended by one of the female doctors, Dr. Ana. The youngest patient was in the range of 31-40 years old and the oldest was in the range of 51-60. Dr. Berta did not attend a male patient who fell within the required patient selection criteria. This situation arose principally because most of her male patients were not familiar with the PUC Clinic, as they were first-time visitors.

The profile of male patients attending a male doctor is given in Table 3.6 below.

Table 3.6 Profile of male patients consulting male doctors

TAPE	NAME	AGE RANGE	OCCUPATION OF PATIENT	DOCTOR
44A	Leonel	61-70	Butler	Dr. Carlos
21A	Manuel	61-70	Worker	Dr. Carlos
52B	Nicolás	61-70	Pensioner	Dr. Carlos
29A	Samuel	61-70	(information not provided)	Dr. Daniel
19B	Tito	41-50	Assistant	Dr. Daniel
38A	Victor	41-50	Mechanic	Dr. Daniel

Both male doctors had three male patients each. Dr. Carlos had male patients in the range of 61-70 years old, whereas Dr. Daniel had one patient in the range of 41-50 and the remaining two were in the range of 41-50.

A profile of female patients attending a male doctor is given below, in Table 3.7.

Table 3.7 Profile of female patients consulting male doctors

TAPE	NAME	AGE	OCCUPATION OF PATIENT	DOCTOR
46	Olga	41-50	Housewife	Dr. Carlos
39Ai	Paola	31-40	Secretary	Dr. Carlos
14B	Rosa	41-50	Housewife	Dr. Carlos
35B	Wilma	41-50	Housewife	Dr. Daniel
11B	Ximena	41-50	Accountant	Dr. Daniel
29Ai	Yolanda	71-80	Housewife	Dr. Daniel
19A	Zenobia	61-70	Housewife	Dr. Daniel

As shown in Table 3.7 the age of female patients was in the range between 31 and 80 years old. There is one patient in the age range of 31-40, the majority of them 4/7 are in the age category of 41-50. One patient is in the category 61-70 years old and one in the age range of 71-80. Dr. Carlos attended three female patients and Dr. Daniel attended four female patients.

3.5.4 Gaining access and consultation procedures

The first step towards gaining permission to carry out my research in the Clinic was to make scholars of the Faculty of Medicine and administrators aware of the potential contribution that the study could make to the work of the institution and to the understanding of medical discourse generally.

Contacts in Chile were initiated two years before the recording of data took place in order to ascertain and meet the ethical requirements of the Pontificia Universidad Católica de Chile, as the principal institution, and of the outpatient Clinic

where the research was to be conducted (see Appendices 5 and 6). During this time, I also provided the documentation required by the Ethics Committee of Monash University before being able to proceed with the research (see Section 3.7 permission for ethics committees). On my arrival in Chile I had to overcome some initial obstacles in winning the support of the participants in this project. Gaining the trust of doctors and administrators was essential for this purpose. Following the example of Corsaro (1982), I involved also the *auxiliares,* the assistant nurses, who worked in the Clinic and who were responsible for the allocation of doctors to the seven consulting rooms. With their cooperation, I was able to arrange for those doctors who were taking part in the project to be allocated to the two (see Figures 3.1 and 3.2) consulting rooms equipped with the recording facilities required for this study.

During the first few weeks of fieldwork I held meetings with the Dean of the Faculty of Medicine, the Medical Head of the outpatient Clinic and the Administration personnel of PUC to learn more about the structure and functioning of the Clinic, and the public health system in Santiago.

There are a number of procedures that a patient follows before visiting a doctor. The regulations provide for the patient to choose a particular doctor, or for one of the doctors on duty to be assigned to the patient. On the day of the consultation, the patient provides the assistant nurse with the receipt, *bono,* which indicates that the consultation has already been paid for. The assistant nurse then weighs the patient and records the information on the patient's medical card. Patients then wait to be called to the consulting room. The average waiting time is twenty minutes. However, waiting time may be much longer if doctors encounter difficulties in their consultation, patients do not arrive on time, or an emergency occurs.

3.6 Data analysis

I analysed data available from questionnaires that include demographic information about participants, this represents Stage II (see Section 3.4.2); the semi-structured interview, representing Stage III (see Section 3.4.3); and the tape-recorded medical consultations (Stage IV, see Section 3.4.4).

Stage II

The main focus in this study is the analysis of the 'forms of talk' employed by both participants in the medical discourse. Nevertheless, the questionnaire also served the purpose of selecting the participants to be included in the analysis of doctor-patient communication (following the exclusion criteria outlined in Section 3.5.2, Stage IV and Section 3.5.3, Stage IV).

Stage III

The semi-structured interview provided information on patients' opinions in relation to what they liked and did not like about doctors. The information gathered through this exercise complements the data obtained from the consultation that took place between the participants. Each patient's answer was reported verbatim, thus giving the same degree of importance to each of the opinions given. Subsequently, their answers were categorised according to key themes that emerged from their responses (see Section 5.7).

Stage IV

The analysis of the tape-recorded data involved twenty-two consultations. One female and one male doctor attended three female and three male patients each, while the second female doctor attended three female patients and the second male doctor attended four female and three male patients. The data was transcribed following a selective number of transcript symbols employed by Du Bois since:

> Discourse transcription can be defined as the process of creating a representation in writing of a speech event so as to make it accessible to discourse research (1991: 72).

This means that the system of transcription is based on 'what kind of research questions one seeks to answer' (Du Bois 1991: 72). Similarly, Ochs (1979) supports the view that the system of transcription is bound to the theoretical framework of the research analysis and rejects the idea that it is simply a mechanical written reproduction of the speech. According to Ochs 'the transcript should reflect the particular interests-the hypotheses to be examined- of the researcher' (1979: 44). The transcription system used in this study includes the Du Bois' transcript symbols that were relevant for the data analysis employed in this study to answer my research questions (see Section 3.1). Whereas a set of transcript symbols were included, others were modified to accommodate the Spanish data (see Appendix 4). For example, Du Bois' truncated intonation unit was altered. The transcription system used in this study differentiates between the truncated first syllable with the symbol ' (i.e. *pa'* for *para* 'for' or 'to') and the middle and final truncated syllable with the symbol – (i.e. *Uste-* for *Usted*, 'you'). The symbols ¿ ¡ are added in the classification of transitional continuity to be consistent with the Spanish first and end position of appeal and exclamation markers in the sentences (i.e. *¿cómo está?*, 'how are you?'; *¡hola!*, 'hi!'). Capital letters were also added to the list of transcript to indicate that the voice quality of the speaker was loud and emphatic (i.e. *AHORA*, 'NOW'). The symbol to show vowel elongation differs from the one of Du Bois. In this study the lengthening of a vowel is shown by a colon (i.e. *pero:*, 'but'), in some cases the lengthening is longer and it is represented by double colons (i.e. *pero::* 'but'). The symbol = (used by Du Bois to represent vowel lengthening) is used here to indicate that no pause has been

left between the last word uttered by the first speaker and the first word uttered by the second speaker. This is referred to as latching by Sacks et al. (1974). Following Coates 'an equals sign at the end of one speakers' utterance and at the start of the next utterance indicates the absence of a discernable gap' (1996: xiii). In order to maintain the authenticity of participants' speech, the transcription represents the natural and unpolished spoken language. In those cases where the pharmaceutical name has been mispronounced the correct pharmaceutical name is provided in a footnote, this has been included to prevent any medical misunderstanding.

The identification of the communicative routines to be analysed in the medical discourse was accomplished following Pauwels (1995). She identified a number of communicative routines commonly used by health professionals during a medical consultation. These include: 'greeting and introduction', 'history taking', 'explanation and instruction during the physical examination', 'the management and treatment of a health problem or health issue' and 'prevention'. Greetings and introductions were excluded from this study since the initiation of communication between the doctor and the patient usually started in the waiting room where a patient's name would be called out by the doctor. Greetings and introductions between the two would be exchanged while they were walking to the consulting room where the recording would take place. Physical examination was also excluded because it took place too far away from the microphone and the quality of the recordings was poor. This also meant that the prescription stage could not be included since it could not be linked to the talk that preceded the delivery of the prescription. Thus, the analysis of data in this study includes:

(a) The communication developed during the taking of a patient's history in follow-up visits to the Clinic, and
(b) The management of a patient's health problem.

The communicative routine of 'history taking' mainly comprises medical questioning aimed at determining how the medical condition has developed since the earlier visit (Pawels 1995: 74). 'The management and treatment of a health problem or health issue' aims at informing the patient about a diagnosis, educating the patient about his/her medical condition, proposing/advising and explaining a therapy or a physical or manipulative procedure to be undertaken, as well as reassuring the patient and arranging a follow-up visit or a referral (Pauwels 1995). Follow-up visits differ from the first visit since the diagnoses usually have already been discussed with the patient, thereby allowing the emphasis to be placed on the assessment of test results and the patient's ongoing health condition. Also, in follow-up visits, patients generally have a better understanding of their health condition and can raise queries during the consultation.

Pauwels' (1995) system of initiation of 'history taking' was considered in this study. For example:

(a) The doctor's summary of the last visit (Pauwels 1995: 74).

The following example is extracted from the current study:

Example 3.1 Consultation No 15 (Doctor: Carlos, Patient: Rosa) Tape 14B

13 D *: ... la última vez que nos vimos fue el veintidos de agosto*
...
15 D: *... nos vimos porque estaba bajo un tratamiento por un*
16 *cuadro depresivo*

13 D: ... the last time we saw each other was 22 August
...
15 D: ... we saw each other because you were being
16 treated for depression

(b) Questioning by the doctor.

The following example has also been taken from the data:

Example 3.2 Consultation No 5 (Doctor: Ana, Patient: Esteban) Tape 13 B

10 D: *¿Cuénteme le han vuelto a dar esas crisis? ¿Se acuerda que tenía como crisis*
11 *de angustia ? Ahora son pequeños momentos de angustia?*

10 D: Tell me, have you had these crises again lately? Do you remember that you used to
11 have, as it were, crises of anguish. Are they short periods of anguish now?

In the data, 'history taking' was usually followed by the doctor's assessment of the test results. The initiation of this function is marked by topicalised utterances followed by an adjective.

Example 3.3 Consultation No 10 (Doctor: Carlos, Patient: Leonel) Tape 44A
56 D: *El antígeno prostático ... está funcionando O.K. ...*

56 D: The prostatic antigen ... is working O.K. ...

The assessment of test results has been included in my study since it is a function that links the 'history taking' to the 'the management and treatment of a health problem or health issue'. The conclusion of 'the management and treatment of a health problem or health issue' was marked by the doctor's request to carry out a physical examination, which usually involves checking the patient's blood pressure.

Example 3.4 Consultation No 9 (Doctor: Berta, Patient: Javiera) Tape 32B
48 D: ... *Vamos a ver como están las presione- ahora*

48 D: ... We'll check to see how it is now

Similarly the end of the management of health problem was marked by the physical examination of the patient.

Example 3.5 Consultation No 12 (Doctor: Carlos, Patient: Nicolás) Tape 52B
500 D : ... *Descúbrase la camisa que le voy a ver donde le duele*

500 D: ... Open up your shirt so that I can see where you have the pain

3.6.1 The volume of data

The doctors used a total of approximate 12,830 words, a number almost identical to that used by patients, which was approximately 12,920 words (see Appendix 1). The mean number of words for doctors (males and females included) in the consultation, per conversation is 583.1 (± 505.4 Standard Deviation, n = 22 conversations) and the mean number of words per patient (males and females

included), per conversation is 587.4 (± 361.8, n = 22). The difference is not significant (Two-way ANOVA: $F_{1,36} = 0.128$, P = 0.722). Moreover, there is a no significant difference in the word count for 'history taking' and 'the management and treatment of a health problem or health issue' by the four doctor-patient dyads ($F_{3,36} = 0.553$, P = 0.649); nor is there any significant interaction between the two factors: doctor-patient dyad and communicative routine ($F_{3,36} = 0.537$, P = 0.659). This analysis reveals that both doctors and patients used a comparatively similar number of words in their discourse. This information suggests that both participants had the opportunity to take the floor and elaborate their own discourse. In order to fully understand how the participation of doctor and patient develop during the consultation I deconstruct doctors and patients' talk into distinctive *voices*. These voices are described in the section that follows.

3.6.2 The analysis of *Doctors' voices*

During 'history taking' and 'the management and treatment of a health problem or health issue', the doctors used different 'forms of talk' in order to assess the patients' health and propose treatment. In this study, those 'forms of talk' are referred to as voices. The *voices* are present in the interaction in order to accomplish the functional medical goals of gathering information about the patients' health, educating the patients to 'adhere' to a medical recommendation, giving support to the patients (Cohen-Cole 1991: 4) and empathising with their concerns.

The analysis identified and examined the occurrence of three *voices* - the *Doctor voice*, the *Educator voice* and the *Human Fellow voice* - to discover what physicians 'do' in their medical talk and to understand the relationship that exists between the doctors' use of a particular *voice* and its interactional accomplishment. In

each of the three *voices* doctors accomplish their speech by animating, authoring and principaling (Goffman 1981) their medical discourse.

In the analysis of *Doctor voice* I intend to study:

(a) Questioning behaviour that aims at seeking information about patients' health.
(b) Expectations and practices used in follow-up visits, and
(c) Pronominal use, particularly 1st person singular and plural; inclusive and exclusive. For example the Spanish pronoun system within the *Doctor voice.*

Example 3.6 Consultation No 1 (Doctor: Ana, Patient: Alicia) Tape 28B
168 D *Yo recuer- bueno, la dejé con control ...*

168 D: I remem- well, I left you for a check up ...

The doctor's recall of a patient's earlier history is fundamental to a correct diagnosis and to obtaining an understanding of the patient's recent health development (Neighbour 1987). The *Doctor voice* was studied by categorising the linguistic forms that belong to the function of 'Seeking information', 'Expectations and practices in follow-up visits' and 'Doctors performing credibility'. In this process doctors may show alignment to the medical institution and/or the socio-cultural group they belong to, as well as shifting footing in their participation framework.

Following Goffman's 'forms of talk', the *Educator voice* represents an example of a rehearsed theatrical performance, which moves beyond the ability to entertain and capture the attention of the audience or participants (in this case, the patients). In Goffman's frame of analysis the lecturer is not merely a performer, but rather his/her subject matter 'is meant to have its own enduring claims upon the listeners apart from the felicities or infelicities of the presentation' (Goffman 1983: 166). This underlines the basic purpose of the *Educator voice* and calls for an investigation of those linguistic functions and forms that serve to give knowledge to

patients, and which may enable them to better understand their health condition and take a better care of themselves and of their illness.

In the analysis of the *Educator voice* I intend to study its role in the:

(a) Management and treatment of a health problem or health issue (Pauwels 1995).
(b) Education of patients about medical practices.
(c) Use of types of accounts and the linguistic strategies associated with the educational activity, and
(d) Interactional patterns that emerge when doctors give medical accounts to their patients.

The third *voice, Human Fellow voice* is characterised by a shift from the *Doctor voice* and the *Educator voice*. Doctors are not required to 'author' a particular role or to show a specific competence when performing their *Human Fellow voice* (Goffman 1983: 166), other than displaying their socio-cultural competence (Hymes 1972), by knowing how to create an interaction with their patients which encourages empathy. This *voice* differs from the *Doctor voice* and the *Educator voice* since its performance is likely to be linked to an affiliative discourse (Davis 1988) that creates a friendly and cooperative (Schiffrin 1984) atmosphere in the conversation.

It is difficult to document all the linguistic features or strategies used to achieve empathy through the *Human Fellow voice*. However this study explores the *Human Fellow voice* in the communicative routines of 'history taking' and 'the management and treatment of a health problem or health issue', through an investigation of:

(a) The functions involved in the performance of the *Human Fellow voice*, and
(b) The range of discourse forms used to achieve a 'friendly' and affiliative communication.

3.6.3 *Patients' voices*

This study investigates patients' participation in the communicative routines of 'history taking' and 'the management and treatment of a health problem or health issue'. The analysis of the patients' discourse aims at describing and analysing what patients 'do' during their medical consultation, how they present themselves in the medical event and whether patients take this opportunity as one where they can develop their stories. These stories may relate to their health condition, their families or job situations or indeed any story considered appropriate for them to be raised in this speech event.

As we all know, patients, in contrast to physicians, have not been formally trained to be 'patients' and to perform certain roles while interacting with physicians. Nevertheless, as reported in Section 2.6.3, some studies have found some agreement in the description of patients as passive entities who respond to physician's questions (West 1984, Bergman 1992), lacking initiative in asking (West 1984), and accepting, without hesitation, any decision offered to them by the care providers (Blanchard et al 1988). It is the aim of this analysis to 'hear' what patients have to say during the consultation as well as to analyse what patients 'do' in response to physicians' talk. In particular the analysis focuses on:

(a) The *voices* performed by patients during the medical consultation to determine whether the asymmetry pre-established by the nature of the interaction is maintained, re-established and/or contested in the patients' talk.

(b) The kind of interactional roles and participation performed by patients in the consultation.

3.6.4 Limitations to the number of *voices*

It might be argued that the number of doctors' and patients' *voices* included in my analysis may not represent all possible *voices* that may occur in a discourse. The process of inclusion of *voices* followed Sinclair and Coulthard's criteria of descriptive analysis (1975: 15-17), which have also been adopted by Stubbs (1983) in his study of the metacommunicative functions performed by a teacher when interacting with his students in a classroom situation.

Sinclair and Coulthard's criteria are as follows:

(a) Incorporation of further descriptive categories should be allowed,
(b) Descriptive categories need to be connected to the data in order to avoid repeating classifications,
(c) Descriptive analysis should be used throughout the transcript, and
(d) Descriptions should share structural similarities and constraints.

In this research, the number of *voices* could have been expanded by making even finer distinctions in each of the main *voices*. However, the four performances of voices accomplished by patients appear to clearly identify differences in terms of their form and the topics being developed in the consultation. Similarly, the three *voices* studied within the doctor's performance represent the discourse used in the consultation and correspond to the 'three functional approaches' of medical discourse developed by Cohen-Cole (1991). Utterances were classified carefully in terms of their linguistic form and categorised according to the structural similarities of their grammatical form or communicative function (Gumperz 1982b). This process was complex and delicate due to the multifunctionality of utterances. Some utterances were easily classified due to the grammatical structure of their discourse form and the communicative function they were accomplishing (e.g. questions in search of information). Nevertheless, in other cases the linguistic forms used to accomplish a function differed among

utterances, therefore the classification took into account the recurrent communicative function as the basis for classification (e.g. patients' telling their story). In order to prevent the problem of classifying the same utterance twice I carefully codified those utterances that had the same communicative function and then investigated whether there was a linguistic form that could be identified in them. This process minimised the risk of counting the same utterance twice.

In order to understand the frequency of each *voice* in the medical discourse and to comprehend the frequency of each function within the *voice*, I will also include an analysis of frequencies. Analyses will outline the most prominent features emerging from the data.

3.7 Ethical issues and permits

This study takes the view of Cameron that an 'empowering research must give attention to the research process as well as the research product' (1992: 121). In terms of the research process participants were free to participate in this study. Participants were informed that refusal or withdrawal from the tape recording would not affect them in any way. They had the right to withdraw their consent to participate at any time as well as the right to listen to their recording and withdraw their consent if they wished to do so (see Appendix 6). The information gathered was strictly confidential all the real names of doctors and patients were changed for pseudonyms. In addition, personal information like patient's own address and citizen identification numbers given during the consultation were modified to protect the informants that cooperated in this study. Participants signed a consent form after reading the explanatory statement or after they were asked to give permission to tape record their talk during the consultation time (see Appendix 5)

In terms of research product I strongly believe that the findings of this research project should be made available to doctors and patients interested in the issue of doctor-patient communication. Regular contacts have been kept with medical staff at PUC since the start of this research and a trip to Chile aiming at delivering seminars on the topic of doctor-patient communication is on schedule for the near future. I strongly share the view of Cameron (1992) that the knowledge acquired in any research that investigates people/discourse's behaviour has to be fed back to the community that originated the information for the study, so that there is a 'redistribution [of] knowledge' Cameron (1992: 119). According to Cameron 'speakers themselves should possess the relevant information and the analytic tools to make use of it in ways which they determine' (1992: 118).

The study was approved by the Standing Committee on Ethics in Research on Humans, Monash University (date: 1996, project number: 258/95); by the Doctors' Committee of the *Pontificia Universidad Católica de Chile* (letter dated: 20 September 1995); and by the Head of GP in the *Centro de Diagnóstico de la Universidad Católica de Chile* (verbal communication: September 1997).

The following chapters summarise the results of the analyses of the *Doctor voice, Educator voice, Human Fellow voice* and of the *Patient voices* carried out taking an interactional sociolinguistic and ethnographic approach to discourse analysis.

CHAPTER 4
DOCTOR, EDUCATOR
AND
HUMAN FELLOW VOICES

4.0 Introduction

In this chapter I investigate doctors' performance of *voices* during the communicative routines of 'history taking' and 'management and treatment of a health problem or health issue'. The aim is to identify the discourse functions of the *Doctor, Educator* and *Human Fellow voices*, describe a range of discourse strategies used in each *voice* and observe their frequency of use. The first part of the chapter focuses on the analysis of the *Doctor voice*, followed by the *Educator voice* and concluding with the analysis of the *Human Fellow voice.*

4.1 *Doctor Voice*

4.1.1 Seeking information

The function of 'Seeking information' focuses on searching for useful informative data about patients' health condition. This helps the doctor to give a diagnosis and/or assess patients' health changes that have occurred since their previous visit. Doctors use a number of different types of discourse strategies to elicit the patients' contribution in the consultation and to make them provide relevant information about their health status.

In the next sections I present the type of discourse strategies associated with the function 'Seeking information'. The analysis identifies 'QIS one' (questions in search of information), 'QIS chain', 'QIS multiple choice', 'Recycling/repetition of QIS', and 'QIS + Summary /Summary + QIS'. The analysis of the examples given in each type of discourse strategy shows their forms and functions.

The study recorded those instances where, during the history taking and management of the patient, doctors ask only one question to ascertain the patient's health condition. These questions have been termed 'QIS one'. In the following example the female patient tells her doctor that she has been experiencing stomach aches and diarrhoea every evening before returning home from work.

Example 4.1 Consultation No 3 (Doctor: Ana, Patient: Carmen) Tape 20B

23 D: *Ya y eso ¿desde cuándo que está con esa mo[lestia?]*
24 P : *[Desde] digamo- desde que*
25 *empecé ma- o meno- con esto*
26 D: *Ya*

23 D: Right, and since when have you been feeling that dis[comfort?]
24 P: [Since] let's say since I
25 more or less started with this
26 D: O.K.

The 'QIS one' used by the physician - *¿desde cuándo que está con esa molestia?* 'since when have you been feeling that discomfort' - seeks information about the time period the patient has been feeling unwell. This is marked by *desde* 'since', a temporal conjunction. The patient does not provide an answer that relates to time, like 'last week', 'two weeks ago'. Instead, she replies: *desde que empecé ... con esto* 'since I've started ... with this'. 'This' relates to her previous utterance in which she mentions that her discomfort starts every evening when she's preparing to leave work for home. The doctor's minimal response is given by the use of *Ya* 'O.K'.

From the analysis of 'QIS one' it is evident that these questions could be further divided into those that are oriented towards the patient who is sick and therefore relate primarily to the patient's health condition, and those questions that are intended to seek information about the effect that the health condition might have or has had on the patient's life. In the following Example 4.2 the female patient indicates that she experiences difficulty in moving her right hand due to some bone and

ligament problem. The male doctor wants to know whether her current health condition has impeded her 'usual' activities.

Example 4.2 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46
329 D: *¿Hay alguna cosa que le agrade hacer sobre manera?*
330 P: *Me fascina jardinear…*
331 D: *¿Y en este tiempo lo ha estado haciendo ?*
332 P: *... aunque esté cansa-a, cansa-a, cansa-a yo jardineo igual.*

329 D: Is there anything you really enjoy doing?
330 P: I love gardening
331 D: Have you been doing it lately?
332 P: … even if I'm feeling tired, tired, tired, I do the gardening nevertheless.

The patient has been having severe pain in her arm. The doctor uses 'QIS one' in line 331 *¿Y en este tiempo lo ha estado haciendo ?* 'Have you been doing it lately?' to seek information about the patient's ability to carry out her favourite activity, i.e. gardening. This type of question underlines a holistic approach to understanding health. This is so, since the doctor might have uttered a QIS focusing on the pain (i.e *¿tiene dolor en el brazo?* 'do you have any pain in your arm?'), instead of focusing on the effect that the discomfort has on the patient's daily routine. This idea will be explored further by identifying those questions that are not related to a patient's health condition, but rather to his/her social identity (see Section 4.3.4.3).

This study has recorded the appearance of the 'QIS chain', which, according to West (1984: 82), may reduce the patient's chances of answering all the questions in the utterance, and which may even lead to the patient answering only one of the questions produced in the chain, or series of questions. In the following example the doctor uses three questions in succession.

Example 4.3 Consultation No 5 (Doctor: Ana, Patient: Esteban) Tape 13 B
10 D: *¿Cuénteme le han vuelto a dar esas crisis? ¿Se acuerda que tenía como crisis*
11 *de angustia ? Ahora son pequeños momentos de angustia?*
12 P: *Pequeños momentos de angustia sí.*

10 D: Tell me, have you had these crises again lately? Do you remember that you used to
11 have, as it were, crises of anguish. Are they short periods of anguish now?
12 P: Short period of anguish yes.

In this example the three questions refer to the patient's episodes of anguish. In line 10 the doctor asks the patient about the re-occurrence of those episodes: *¿... le han vuelto a dar ...?* '... have you had these (crises) again lately?' The second question asks about the patient's recall of such episodes: *se acuerda que tenía como crisis ...* 'do you remember that you used to have as it were, crises of anguish ...' The final question wants to know the current pattern of episodes. This is marked by the temporal adverb *ahora* 'now' that initiates the last question, which is made in the present tense. The patient mirrors doctor's last utterance in line 12 *¿... pequeños momentos de angustia?* '... short periods of anguish?'. This confirms West's previous findings (1984) where the information provided by the patient only partly reflects the set of questions posed in the chain by the doctor.

In the data the strategies of seeking information 'QIS multiple choice' comprise two discourse parts. The second utterance in the question represents the converse form of the first. The link between the two forms is accomplished by the conjunction *o* 'or'.

In the following example the doctor asks his patient to indicate whether the pain is present from the time he wakes up in the morning, or, whether it is related to something in particular that he does during the day.

Example 4.4 Consultation No 12 (Doctor: Carlos, Patient: Nicolás) Tape 52B

211D: *Cuándo está ese uh ese malestar ¿ocurre toda- la- mañana- al despertar. O*
212 *Uste- me decía ¿cuándo se pone nervioso o cuándo tiene que hacer algo?*
213 P: *Cuando me levanto yo de la cama yo me levanto completamente perfecto.*
214 *cuando YA salgo fuera de la casa ahí:=*

211D: When you have this discomfort, does it happen every morning when you
212 wake up? Or, as you were telling me, is it when you feel tense or when you have to
213 do something?
214 P: When I get up I feel perfectly well. It's when I leave home that I get it:=

In this example the multiple choice question provides three alternatives that have been offered in a chain. Each alternative is introduced by the interrogative *cuándo* 'when'.

The conjunction *o* 'or' and the elliptical verb form *ocurre* 'does it happen' are repeated in the second and third utterance. Thus, (a) *ocurre ... al despertar* 'does it happen ... when you wake up' (b) *(ocurre) cuándo se pone nervioso* '(does it happen) when you feel tense? (c) *(ocurre) cuándo tiene que hacer algo* '(does it happen) when you have to do something'. The patient's answer relates to the last option offered to him by the doctor, i.e *cuando YA salgo fuera de la casa ahí:* 'It's when I leave home that I get it:'.

The use of recycled questions was also found in the data. Doctors use 'recycled questions' when they repeat the same or a similar question after the patient has not provided the information that the doctor required. The following example shows how the question uttered in line 479 appears reformulated later in the same episode in line 485.

Example 4.5 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46

479 D: *¿Uste- se nota que está más irritable de lo habitual, que explote con más*
480 *facilidad?*
...

485 D : *¿Las cosas que antes le irritaban ahora también le irritan ?*

479 D: Have you noticed that you are more irritable than usual, that you get angry more
480 easily?
...

485 D: Do the things that irritated you in the past still make you irritable?

The comparative utterance *está más irritable de lo habitual* 'you are more irritable than usual' implies that the patient's behaviour may have changed from less irritable to more irritable. The reformulation in line 485 is performed by the inclusion in the utterance of two temporal adverbs, *antes* 'before' and *ahora* 'now', which contrasts the pattern of the patient's irritability in the past and in the present. These questions help the doctor to ascertain whether the patient has given full and accurate information about her health status.

The data also include examples of a combination of QIS and summary components, i.e. 'QIS + Summary' and 'Summary + QIS'. In the examples of 'QIS + Summary' a QIS that searches information about patients' health and current condition is followed by a summary that focuses on some relevant points already discussed in previous visits. In 'Summary + QIS' the doctors use a concise summary that underline the main medical ailments discussed in the earlier consultation, followed by a question seeking information about the development of their patient's condition.

The discourse forms of the 'QIS + Summary' and 'Summary + QIS' were similar, regardless of whether the QIS initiated or concluded the utterance. The summary was always delivered in the past tense (preterite or imperfect), and served the function of describing the past event in order to start building up the new, current, event of patient's health. The following example illustrates the presence of a 'Summary + QIS'.

Example 4.6 Consultation No 15 (Doctor: Carlos, Patient: Rosa) Tape 14B

29 D: *Vamo- a repasar un poco. Hoy dia estamo- hace má- o meno- ocho meses,*
30 *tuvo un conflicto con un sobrino*
...

35 D: *Ya y eso la ha, la ha angustia-o ah: le ha quita-o el ánimo*
36 *[le ha quita-o gana de hacer cosa]*
...

44 D: *¿Cuénteme qué medicamento está tomando?*

29 D: We are going to review (your case) a little. Today we are. It's about eight months
30 ago that you had a row with your nephew
...

35 D: And (that's) upset you. It's taken away your energy
36 [your wish to do things]
...

44 D: Tell me, what medication are you taking?

The doctor summarises the patient's last visit in lines 29-36 and asks if she is currently taking any medication. It is understood in the discourse that the medication

in question is used to treat her response to this emotional episode. Similarly, the following example shows how the doctor summarises the patient's description of his medical problem and then asks a question to find out how long the patient has been feeling low in spirits.

Example 4.7 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46
317 D: *El ánimo Uste- me dice que está malo ¿desde hace cuánto tiempo ... que está*
318 *malo?*

317 D: You're telling me that you feel low in spirits. How long ... have you felt
318 low?

The doctor outlines the patient's medical complaint in few words: *el ánimo Uste- me dice que está malo* 'you're telling me that you feel low in spirits'. The topicalisation of the complaint, *el ánimo* 'spirits', followed by the verb *estar* 'to be' to describe the condition, is followed in turn by a question to ascertain the time frame of the condition *¿desde hace cuánto tiempo ... que está malo?* 'How long ... have you felt low?'

4.1.2 Expectations and practice in follow-up visits

As mentioned earlier in the methodology chapter (Chapter 3), this study investigates the discourse that develops in follow-up visits. It is possible that there are some discourse strategies that are associated with follow-up visits that are not part of the first visit. This section identifies the major characteristics of the discourse used in follow-up visits. Follow-up visits are characterized by:

(a) A summary of the previous visit.
(b) An assessment of the test results, and
(c) An assessment of the patient's compliance.

In this study follow-up visits can be initiated with a summary of the previous visit. The following example of a summary does not start with a question as in the verbal exchange reported above, rather it is used as a starting point in the medical discourse.

Example 4.8 Consultation No 15 (Doctor: Carlos, Patient: Rosa) Tape 14B

13 D: *A ver la última vez que nos vimos fue el veintidós de agosto*
14 P: *Sí=*
15 D: *=Ya, ahí estamos, nos vimos porque estaba bajo un tratamiento por un*
16 *cuadro depresivo=*
17 P: *=Sí=*
18 D: *=Y un trastorno digestivo=*
19 P: *=Sí=*
20 D: *=Este reflujo de presofágico=*
21 P: *=Sí*

13 D: Let's see, the last time we saw each other was 22 August
14 P: Yes=
15 D: =O.K. here we are, we saw each other because you were being
16 treated for depression =
17 P: =Yes=
18 D: =And a digestive problem=
19 P: =Yes=
20 D: = This oesophageal reflux =
21 P: =Yes

In this example the doctor describes the patient's medical history. The summary starts by indicating the date of the last consultation: *A ver la última vez que nos vimos fue el veintidos de agosto* 'let's see last time we saw each other was 22 August'. It continues by enumerating the medical problems the patient had at the time: *estaba bajo un tratamiento ... depresivo* 'you were being treated for depression', *un trastorno digestivo* 'a digestive problem', and *este reflujo de presofágico* ' this oesophageal reflux'.

In the follow-up visits, the patients usually brought their test results to the consultation. These were interpreted by the doctor and discussed with the patient during the visit. The discourse form of the assessment showed similarities among the doctors. The assessment was performed by using the verb *estar* 'to be', indicating that the current test results had some particular characteristics. This was accompanied by an adjective that described *bien* the 'good' or *mal* the 'bad' qualities of the results. In

the data the doctors were able to describe all the test results by making one comment only. This meant that all the tests under their examination had a common descriptive attribute. The example below illustrates this phenomenon.

Example 4.9 Consultation No 12 (Doctor: Carlos, Patient: Nicolás) Tape 52B
424 D : ... *Están bastante mejor los exámenes*

424 D: ...Your test results are considerably better

In this case the doctor uses a comprehensive assessment in a comparative form *están bastante mejor los exámenes* 'your test results are much better'. The adjective *mejor* 'better', preceded by the adverb of manner *bastante* 'considerably', signals an emphatic comparison, underlining the fact that the previous results were not as good as the ones being discussed currently in the consultation. The doctors may also choose to enumerate every test conducted on the patient and make individual assessments. This is the case in the following example.

Example 4.10 Consultation No 10 (Doctor: Carlos, Patient: Leonel) Tape 44A
54 D: *El antígeno prostático ... está funcionando O.K. Está bien, no hay*
55 *problema. Listo. El examen de sangre ... [está]*
56 P: *[¿Ah sí?]*
57 D: *En buena- condiciones=*
58 P: *=O sea está normal=*
59 D: *=Está normal. El eloctrocardiograma, impecable=*
60 P: *=Ya=.*
61 D: *=Todavía no pasan balas por ahí=*

54 D: The prostatic antigen is working O.K. It's O.K. There's no problem.
55 All right. The blood test ... [is]
56 P: [Oh! Yes?]
57 D: It's good =
58 P: =Or rather, it's normal=
59 D: =It's normal. The electrocardiogram impeccable=
60 P: =O.K=
61 D: =It is still bullet free=

In this example the doctor's assessment is performed by initiating every utterance with the subject: *antígeno prostático* 'prostatic antigen', *examen de sangre* 'blood test', *electrocardiograma* 'electrocardiogram', followed by the verb *estar* 'to be', which can be explicitly uttered *el antígeno prostático está ... O.K.* 'the prostatic

antigen is ... OK.', or used elliptically: *el electrocardiograma impecable* 'the electrocardiogram impeccable'. The assessment not only includes an adjectival phrase *en buenas condiciones* 'it's good' and adverbs like *bien* 'good' and *impecable* 'impeccable' to describe the patient's health, but the doctor also uses a metaphor to describe the patient's electrocardiogram which presents no trace of anomalies: *todavía no pasan balas por ahí* 'it is still bullet free'. This metaphor implies that the patient's heart is so strong that not even a bullet (a sickness) can damage it. But the use of the adverb *todavía* 'still' also suggests the temporality of the condition; his heart may not function as well in the future (Cordella 1999).

One of the functions of the follow-up visit is for doctors to assess to what extent their patients are taking the medication that has been prescribed, and to comment on this. Sometimes the feedback to the patient is minimal, as seen in the following example.

Example 4.11 Consultation No 12 (Doctor: Carlos, Patient: Nicolás) Tape 52B

74 D: *¿Ha estado tomando el Liposor[1]?*
75 P: *... Eh: eh: es que me tomo el coktail en la mañana*
76 D: *Ya*
77 P: *Lo- tre- que tomo Fluxotina[2], y lo do- el Liposor[3] y no sé:*
78 D: *Nitrendipina*
79 P : *El que me dió Uste-*
80 D: *Ya y¿el Alopurinol lo sigue tomando?*
81 P: *No*
82 D: *Ya, y la ¿Ranitidina?*
83 P: *Esa la tomo en la noche...*
84 D: *¡Ah la Ranitidina!=*
85 P: *=Uhm=*
86 D: *=Ya=*

74 D: Have you been taking the Liposor[1]?
75 P: ... Eh: eh: I take a cocktail (of medicines) in the morning
76 D: O.K.
77 P: I take three Fluxotina[2], and the two Liposor[3], and, as for the rest, I don't know:
78 D: Nitrendipina

---

[1] Lispor
[2] Fluoxetina
[3] Lispor

79 P: The one you gave me
80 D: Yes. And are you still taking the Alopurinol?
81 P No
82 D O.K., and the Ranitidina?
83 P: I take that one at night...
84 D: Ah the Ranitidina!=
85 P: =Uhm=
86 D: =O.K.=

This sequence begins in line 74 with a 'QIS one', the function of which is to assess the patient's compliance with taking a particular medicine: *¿Ha estado tomando el Liposor?* 'Have you been taking the Liposor?' The progressive form of the verb (*ha estado tomando*) underlines the fact that the action should have started in the past and be continuing in the present. This question, then, wishes to ascertain the period of time the medicine has been taken. In line 78 the question is in elliptical form, with only the name of the medicine mentioned. On the four occasions the doctor asks if the patient has been taking the prescribed medication (lines 74, 78, 80 and 82), the doctor uses the minimal feedback sign: *ya* 'O.K/Yes' after the patient's reply. It features on its own in lines 76 and 86 and accompanies a question in lines 80 and 82.

The following example presents a doctor's discourse when the test result of the patient shows his compliance with the medical recommendation. In this case the discourse expands from the minimal feedback presented in Example 4.11.

Example 4.12 Consultation No 18 (Doctor: Daniel, Patient: Victor) Tape 38A
74 D: *... Con la glicemia que trae (exámenes) lleva en forma muy correcta el*
75 *régimen ...*

74 D: ... The result of the glycemia test shows that you're following your diet
75 perfectly ...

The use of the present tense of *lleva* 'to follow' underlines the certainty of the fact that the patient is following his diet properly, and this is then accentuated by the intensifier *muy* 'very' that precedes the descriptive adjective *correcta* 'correct'. The utterance *lleva en forma muy correcta el régimen* 'you're following your diet perfectly' could also be interpreted as a compliment (see Cordella et al. 1995 for the

use of compliments in Spanish) towards a patient who is clearly competent in the management of his health problem (see Section 5.2).

The data also showed that complying patients do not always receive feedback. In these cases, the doctor may use a series of 'QIS', without even providing a minimal feedback to the patient regarding his/her compliance. In the following example the doctor has noticed that the patient has put on weight since her last visit in spite of the diet she has been prescribed. The initiation of this sequence is marked by a 'QIS one' that wishes to ascertain the patient's eating habits in line 47 *¿cómo es Uste- para comer grasa-?* 'do you usually eat fatty food?'

Example 4.13 Consultation No 8 (Doctor: Berta, Patient: Hilda) Tape 34A

47 D: *¿Cómo es Uste- para comer grasa-?*
48 P : *Eh: la verda- es que ahora yo me estoy cuidando y todo lo que es grasa lo he*
49 *dejado de la-o incluso cuando como pollo, al pollo se le saca el cuero se se*
50 *come sin, sin el cuero y trato de evitar la grasa naturalmente. Ahora si me*
51 *pregunta si me gusta le digo que sí pero no, no=*
52 D: *=¿Y la fritura, el chancho, el cordero?*
53 P: *No, cordero no consumo, chancho muy a lo lejo-=*
54 D: *=¿Chuleta?*
55 P: *Muy a lo lejo-, muy a lo lejo-*
56 *... (N)*

47 D: Do you usually eat fatty food?
48 P : Eh: the truth is that I'm looking now after myself and
49 I don't touch any fatty food. Even when I eat chicken, chicken I take the skin off
50 and I eat it without, without the skin. I try to avoid any fatty food obviously.
51 Now if you ask me if I like it I'll tell you that I do, but no, no=
52 D: =And fried food, pork, lamb?
53 P: No, I don't eat lamb, pork rarely=
54 D: =Chops?
55 P: Very rarely, very rarely
56 D: ... (N)

The doctor does not offer any kind of feedback at any stage in this sequence. She seems to be interested only in checking whether the patient has been following a low fat diet. This is marked in line 47 *cómo es Uste- para comer grasa-?* 'do you usually eat fatty food?' and in line 52 *y ¿ la fritura, el chancho, el cordero?* 'fried food, pork, lamb?'. The doctor's choice of high-calorie food in her questions could be interpreted as a reprimand and as doubting that the patient has been complying with the

prescribed diet. In line 56 there is a period of silence. From the noises heard on the recording, the doctor was probably writing in the patient's file. The silence is broken when the patient starts expressing her concern about her weight control. Patients' initiation of talk while the doctor has left a pause contradicts the finding of Heath (1992). He suggests that doctors' speech style modulate patients' participation, therefore in such a case a patient should have felt uneasy to participate in the event (see Section 2.6.2 and 2.6.3). The transcript below shows how the female patient continues her discourse.

Example 4.14 Consultation No 8 (Doctor: Berta, Patient: Hilda) Tape 34A

57 P: *Lo que má- me preocupa es el peso doctora la obesida-. Hoy día me pesaron*
58 *yo juré, he jurado que todo este tiempo que no la he visto me he, he como se*
59 *llama me he cuidado he deja-o la carne roja, he estado comiendo*
60 *prácticamente pollo, pescado. Juraba que había baja-o y: y:=*

57 P: What concerns me most is my weight, doctor, the obesity. Today I've been weighed.
58 I swore, I swear that for the whole time I haven't seen you I've, how can I say it,
59 I've been looking after myself, I haven't touched red meat, I've been eating mainly
60 chicken, fish. I'd swear I would have lost weight and=

Once again the doctor does not respond to the patient's concern (i.e. the doctor does not shift footing) instead, the doctor continues questioning her patient about her eating habits by aligning to the *Doctor voice* and searching further information from the patient. This is shown in Example 4.15.

Example 4.15 Consultation No 8 (Doctor: Berta, Patient: Hilda) Tape 34A

61 D: *=¿Y pan?*
62 P: *Muy poco pan*
63 D: *¿Cuánto po'?*
64 P: *Uno al día*
65 D: *¿De qué tipo de pan ... marraque[ta ha]llulla?*
66 P: *[No, no] estoy comiendo centeno o del otro*
67 *con fibra ¿cómo se llama? ... integral*

61 D: =And bread?
62 P: Very little bread
63 D: How much?
64 P: One a day
65 D: What kind of bread? Marraque[ta ha]llulla?
66 P: [No, no] I'm eating a low-calorie bread, or the other
67 one with fibre, what's it called? ... wholemeal.

This time the doctor focuses on the intake of bread: *¿y pan?* 'and bread?', *¿cuánto po'?* 'how much?', *¿de qué tipo de pan ... marraque[ta ha]llulla?* 'what kind of bread *marraque[ta ha]llulla* ?' Even though the patient appears to be competent (see Section 5.2) by showing an awareness of the kind and amount of food to be eaten while on a low-fat diet (for example: *muy poco pan* 'very little bread', *estoy comiendo ... intergral* 'I'm eating ... wholemeal bread', and her negative responses to the doctor's questions relating to consumption of high-fat food such as fried food, pork, lamb chops), the doctor does not offer her patient any support or understanding for the effort she is making to lose weight. On the contrary, the doctor takes the actual weight of the patient (she has been weighed by the assistant nurse before coming into the consulting room) as proof of the patient's lack of compliance, and she makes a negative comment in this regard, as evidenced in the following lines:

Example 4.16 Consultation No 8 (Doctor: Berta, Patient: Hilda) Tape 34A

68 D: *Ya, pero igual digamo- ha pasado un mes desde que la vi la semana la vez*
69 *pasada=*

68 D: O.K, but (you've put on weight in any case). It's a month last week since I
69 saw you =

The first minimal feedback - *ya* 'O.K.' - is uttered in line 68, but this is followed by the conjunction *pero* 'but' which contradicts the patient's description of her food intake. The utterance *pero igual digamo-* 'but (you've put on weight in any case)' implies that the patient has put on weight even though she knows how to follow her diet. Another example of this type is seen in the following extract. In this case the patient has not complied with the doctor's recommendation that he should measure his blood pressure regularly. In contrast to Dr. Berta in Examples 4.13, 4.15 and 4.16; Dr. Daniel (Example 4.17) uses a more affiliative response by offering the patient to take the blood pressure for her.

Example 4.17 Consultation No 21 (Doctor: Daniel, Patient: Yolanda) Tape 29Ai

91 D: *¿Se ha controlado la presión pa' ver cómo ha anda-o?*
92 P: *Eh: no fijese*
93 D: *No ... vamo- a ver*

91 D: Have you checked your blood pressure to see how you've been doing?
92 P: Eh: not really
93 D: No ... let's see

The doctor initiates the dialogue with a 'QIS one' *¿se ha controlado la presión pa' ver cómo ha anda-o?* 'have you checked your blood pressure to see how you've been doing?' which requests information about the patient's blood pressure and his compliance with the doctor's recommendation on this score. The difference between this example and the previous one is that the doctor here uses the mirroring *no* 'no' to confirm the patient's last utterance and then offers to check the blood pressure on the spot: *vamos a ver* 'let's see'.

The following example takes up the same theme, the checking of blood pressure, so it is of interest to compare the two. In the following case, the patient does not comply with the doctor's request that she should measure her blood pressure regularly. This time the doctor does not offer to take it for the patient, but remains silent. This could be interpreted as a sign of disapproval.

Example 4.18 Consultation No 7 (Doctor: Berta, Patient: Gina) Tape 48A

11 D: *[¿Se ha seguido] tomando la presión ¿Uste- en su casa?*
12 P: *No, no me la he seguido tomando, doctora*
13 D: *... (N)*

11 D: [Have you been] taking your blood pressure at home?
12 P: No, no I haven't been taking it, doctor
13 D: ... (N)

The examples above show that doctors may provide an evaluation to their patients in regards to their degree of compliance used in their accounts. This is achieved by using a number of discourse strategies such as: minimal feedback, complimenting, negative comments, and silence.

4.1.3 Doctors performing credibility

The data show that doctors use the Spanish pronominal system to assert their alignment to the institution and to show authority and credibility to support a recommendation given by themselves or by other doctors. The pronouns are explicitly uttered in the discourse, in spite of the fact that they could be marked by the ending of the verb (Butt and Benjamin 1988). This is achieved by using:

(a) 'The performance of self', the first person pronoun in the singular form *yo* 'I'.
(b) 'The performance of self within the institution', the first person pronoun in the plural form *nosotros* 'we'; and
(c) Finally 'the performance of other doctors', the third person pronoun in the plural form *ellos* 'they'.

The following example shows how Dr. Ana asserts her position in the medical field by incorporating the first person singular into her summary of the patient's previous visit.

Example 4.19 Consultation No 1 (Doctor: Ana, Patient: Alicia) Tape 28B
168 D *Yo recuer- bueno, la dejé con control, pero la idea era mandarla a hacer*
169 *algo así o psicoterapia*

168 D: I remem- well, I left you for a check up, but the idea was to
169 ask you to do something like that or psychotherapy

The use of the 1st person singular *yo ... la dejé* 'I ... left you' underlines the essence of the asymmetrical condition of both participants in the exchange. The doctor's request to have the patient go for a check-up establishes the doctor's right to assert her authority in this way. Similarly, the failure of the patient to question that authority confirms the fact that both participants know their obligations in a medical setting (I, the doctor, prescribe to you, the patient. You, the patient, do not prescribe to me, the doctor).

Example 4.20 below shows the use of *nosotros* 'we' that includes the doctor who is talking as well as the medical body that makes part of the clinic where the visit takes place.

Example 4.20 Consultation No 5 (Doctor: Ana and Patient: Esteban) Tape 13B

51 D: *... Si, lo tratamos como una micosis=*
52 P: *=<WH Si WH>=*
53 D: *=y lo dejamos con eh Enfungio por diez dia-*

51 D: ... Yes, we treated (the case) as a mycosis =
52 P: =<WH Yes WH>=
53 D: =and we prescribed Enfungio for you (to be taken) for ten days

In this example the doctor's use of the first plural person *nosotros* 'we' form of the verb in the summary of the patient's last visit sets the medical treatment in the wider context of the hospital: *lo tratamos*, 'we treated (you)'. It is as if the institution is the one responsible for patient's well being and not the doctor, as in the previous example. The subject pronoun *(nosotros)* 'we' incorporates into the speech both the speaker (the doctor) and the other health professionals (involved in the treatment of the patient). It could also be argued that it is merely an example of a false attribute to the medical institution since the institution *per se* does not exist without medical bodies to represent it.

The following Example 4.21 shows how the doctor summarises a diagnosis given by other doctors in the hospital. This is achieved by using the third person plural pronoun *ellos* 'they'. This pronoun makes the distinction between what the doctor recalls from the last visit *nos vimos nosotros* 'we saw each other' in line 12, and *habia estado con un dolor en la rodilla y en la muñeca derecha* 'you'd had a pain in your knee and right wrist' in lines 12-13, and the diagnosis provided by the orthopaedic surgeon, which is referred to as *ellos* 'they'.

Example 4.21 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46

12 D: *... Nos vimos nosotros el 3 de octubre...habia estado con un dolor en la rodilla y*
13 *en la muñeca derecha y en la muñeca derecha le habian encontrado un túnel*
14 *carpiano.*

12 D: ... We saw each other on 3 October...you'd had a pain in your
13 knee and right wrist, and in your right wrist they'd found a carpal tunnel.

This example differs from the 'the performance of self *yo* 'I'' and 'the performance of self within the institution *nosotros* 'we'' since, in this case, the speaker is fully excluded from the diagnosis given to the patient: *le habían encontrado* 'they'd found'. The doctor's task is simply to summarise and report the work of other specialists (in this case, the orthopaedic surgeon); his credibility is not at issue. The third person plural pronoun represents the other health professionals who are responsible for the diagnosis.

4.1.4 Frequency of types of discourse features in the *Doctor voice*

In this section the frequency of use of discourse strategies found in the functions 'Seeking information', 'Expectations and practices in follow-up visits' and 'Doctors performing credibility' is provided.

The frequency of the type of discourse strategies used by the doctor to seek information about the patient's health is presented in Table 4.1.

Table 4.1 Frequency of doctors seeking information

Type of Discourse Strategies	Frequency	%
QIS one	249	69.4
QIS chain	28	7.8
QIS multiple choice	42	11.7
Recycling/ Repetition of QIS	19	5.3
QIS + Summary/ Summary + QIS	21	5.8
TOTAL	359	100

Table 4.1 shows that 'QIS one' is the discourse strategy most widely used to seek information, accounting for 69.4% of information seeking strategies. A distant

second is the 'QIS multiple choice' type with 11.7%. Other discourse strategies were used less frequently.

Table 4.2 shows the frequency of use for the two types of discourse strategies found in the function 'Expectations and practices in follow-up visits'.

Table 4.2 Frequency of doctors' expectations and practices in follow-up visits

Type of Discourse Strategies	Counts	%
Assessment of test results	27	61.4
Assessment of patient's compliance	17	38.6
TOTAL	44	100

In follow-up visits doctors provide discussion of 'assessment of test results' (61.4%) more frequently than 'assessment of patient's compliance' (38.6%). The relation in the relative use of those two discourse strategies is about two to one.

Table 4.3, below indicates the frequency of use of the type of discourse strategies aimed at performing credibility in the medical discourse.

Table 4.3 Frequency of doctors performing credibility

Type of Discourse Strategies	Counts	%
Performance of self	22	40.8
Performance of self Within the institution	23	42.6
Performance of other	9	16.6
TOTAL	54	100

The function 'Doctor performing credibility' shows that there are two discourse strategies that are mostly preferred by physicians when interacting with their patients. These are: performance of self within the institution and performance of self, comprising 42.6% and 40.8% of the total respectively.

From Tables 4.1, 4.2 and 4.3 presented in this chapter, it appears that 'Seeking information' is the function most frequently used by doctors. There were 359 examples of use of this function in the communicative routines of 'history taking' and

'management and treatment of a health problem or health issue'. This was followed by the doctors' alignment with their profession and institution, with 54 examples. The third function, 'Expectations and practices in follow-up visits', was used only 44 times.

Table 4.4 summarises the discourse strategies that doctors used in the medical routines of: history taking and management/treatment.

Table 4.4 Frequency of type of medical discourse among the four doctors

Doctors	n	Seeking information		Expectations and practices in follow-up visits		Doctors performing credibility		Total Count
		No	M	No	M	No	M	
Dr. Ana	6	81	13.5	11	1.8	22	3.6	114
Dr. Berta	3	22	7.3	2	0.6	2	0.6	26
Dr. Carlos	6	187	31.1	20	3.3	26	4.3	233
Dr. Daniel	7	69	9.8	11	1.5	4	0.5	84
TOTAL Count for doctors		359	78.6%	44	9.6%	54	11.8%	457

The values shown in Table 4.4 are the frequencies of use of each discourse strategy over all the consultations performed by each doctor. However, the number of consultations (Column n in Table 4.4) varies among doctors as already indicated in Section 3.5.3 Stage IV. Clearly, it is not appropriate to compare directly the frequency of use of different discourse strategies (Column No in Table 4.4) among doctors, as one might expect that the frequency of use of strategies may simply reflect the number of consultations each doctor was involved in. For instance, Dr. Berta used all strategies less frequently than any other doctor, but she also participated in the smallest number of consultations (n=3). Therefore, for comparative purposes, we have to take into account the number of consultations of each doctor. This is done in column M where the average frequency of use of each strategy per consultation is shown for each doctor. Values appearing in column M are now comparable among

doctors. Total counts are shown in the final line along with the percentage of use of each discourse strategy over all doctors. The percentages are directly comparable across discourse strategies.

'Seeking information' represents the discourse strategy most frequently used (78.6%) by the four doctors. According to Table 4.4 Dr. Carlos used this strategy with a frequency of 31.1, the highest value among all the doctors. Similarly, Dr. Carlos used 'Expectations and practices in follow-up visits' (3.3) and the 'Doctors' performing credibility' (4.3) more frequently than the other three doctors. Dr. Ana also presents a high use of 'Doctors' performing credibility' (3.6), whereas both Dr. Berta and Dr. Daniel present a lower frequency in this type of medical discourse, 0.6 and 0.5 respectively.

4.1.5 Summary of *Doctor voice*

This section has shown that there is a prevalent use of questions in the *Doctor voice*. It has confirmed, as suggested by West (1984), that 'QIS chain' and 'QIS multiple choice' do not lead patients to answer fully with all the information required. Part of the question, however, remains unanswered due to the type of discourse form used to ask it. It has been shown as well that the *Doctor voice* includes the interpretation of the test results and the feedback that doctors give to patients when compliance is expected. This presented interesting discourse patterns ranging from silence (Example 4.13) to affiliative strategies (Example 4.17).

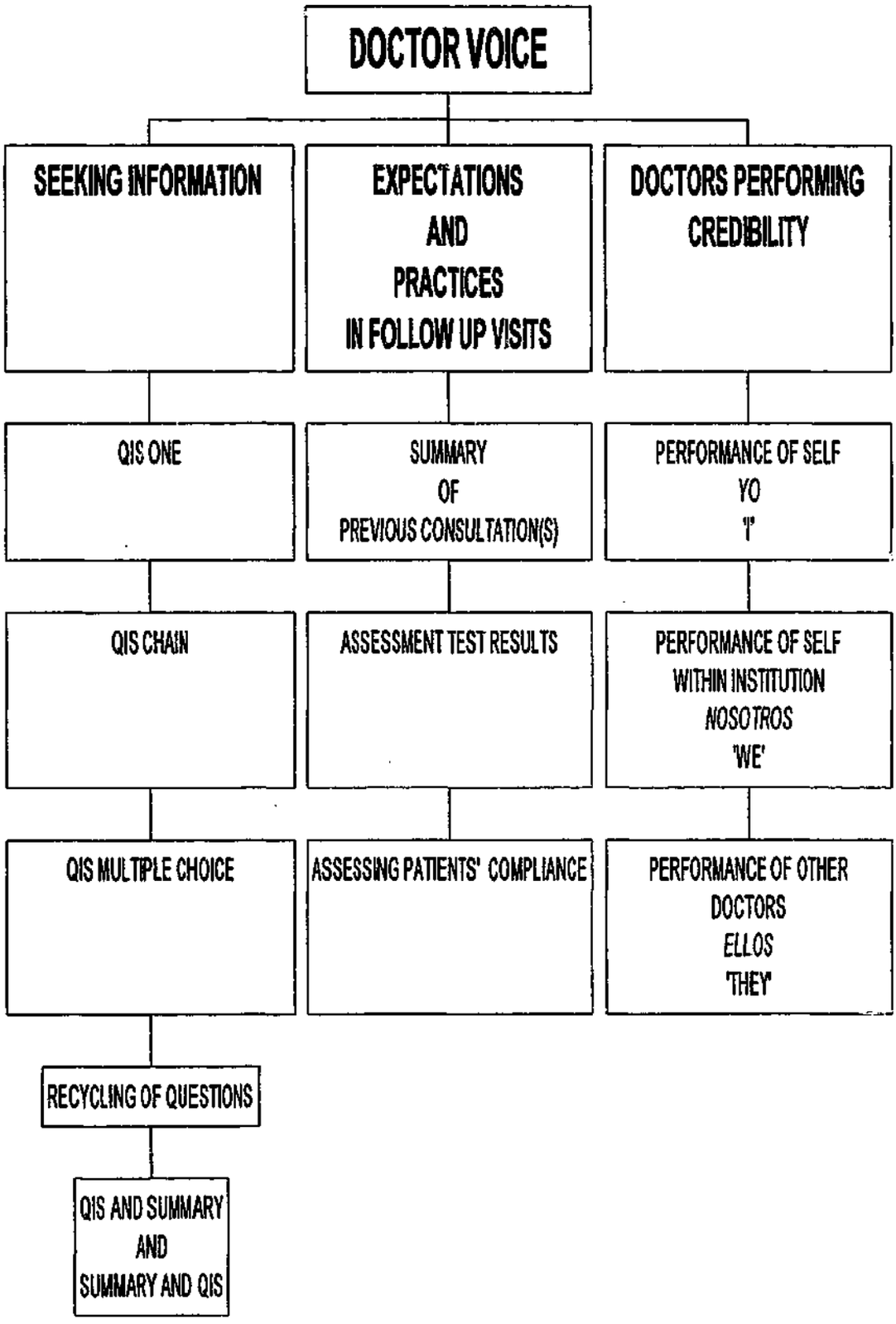
In terms of doctors' stance to the medical institution it was possible to observe that the Spanish pronoun system can be used as an expression of the alignment that doctors take in the discourse. For example, the use of the first person pronoun *yo* 'I'

expresses the doctor individual credibility and authority in the speech; the second person plural form *nosotros* 'we' expresses a commitment that goes beyond the individual by incorporating the group of professionals in the medical institution who are in charge of looking after the patient's health. The third person plural *ellos* 'they', distances the speaker from the hearer by indicating that s/he is not taking responsibility and authority of the speech. In this analysis it was observed that this form was used when the doctor was referring to another health professional who worked in another area of specialty.

The following Figure (Figure 4.1), illustrates the three main functions found in the *Doctor voice*: 'Seeking information', 'Expectations and practices in follow-up visits' and 'Doctors performing credibility'. Each function is accomplished by using a number of types of discourse strategies.

Having analysed how the *Doctor voice* is performed in the medical consultation I now introduce the *Educator voice* in the medical discourse.

Figure 4.1 Discourse functions and strategies of *Doctor voice*



4.2 Educator Voice

The *Educator* authors a *voice* of knowledge in the medical practice by showing alignment to the medical institution and by giving medical accounts that can help the patients understand their health status.

4.2.1 Accounts in the medical discourse

This section analyses the presence of a *voice* that aims at educating the patients about their health condition. This is achieved through giving them the relevant medical knowledge that will enable them to understand their health status and to take better care of themselves. The *Educator voice* is manifested through the function 'Accounts in the medical discourse' which focuses on the accounts used by doctors in the communicative routine of 'management and treatment of a health problem or health issue'. This function can be subdivided into two sub-functions:

(a) Accounts of factual medical issues and of patient discomfort, and
(b) Accounts of medical treatment/management in doctor-patient interaction.

The sub-function 'Accounts of medical treatment/management in doctor-patient interaction' usually leads doctors to give advice and negotiate with their patients the medical procedure to be followed (Fisher and Todd 1986). The following section describes and analyses the types of accounts, and their discourse forms, found in this study.

In this section, I will present examples of four discourse forms of this sub-function that have been found in the study. The four types of 'Accounts of factual medical issues and of patient discomfort' identified in the study are:

(a) Accounts of test results
(b) Accounts of tests to be carried out
(c) Accounts of the functioning of the human body, and

(d) Accounts of patient discomfort.

The first three types are associated with a factual scientific medical knowledge that doctors may decide to share with their patients, thus allowing them to become familiar with the medical aspects that relate to their particular health condition. Alternatively, doctors may prefer not to give information to patients and may withhold educative episodes, thus avoiding the use of the *Educator voice* in their interaction with patients. This may have consequences for the patients' competence in understanding how best to care for their health (see Section 6.6). In addition, the absence of the *Educator voice* may imply a disregard for, or a transgression of, the basic principles of the teaching institution that hosts the clinic (see Section 3.3.1).

With regard to the accounts of patient discomfort, the study has found that doctors frame patients' contribution as a medical issue that is mainly the responsibility of the specialist and the institution treating the patient. Through account practices doctors show their expertise in the medical field.

4.2.1.1 Accounts of test results

As discussed above (see Section 4.1.2), in follow-up visits patients are required to bring the test results that were requested in earlier consultations. The interpretation of those results is carried out through the discourse type 'assessment of test results' that is conducted in the *Doctor voice* (see Section 4.1.2). Doctors may also choose to provide additional information to the scientific factual interpretation of a test result. In this case, doctors may provide education regarding the medical tests the patient has undergone. This is accomplished through the use of the *Educator voice*, as illustrated in the following example.

Example 4.22 Consultation No 10 (Doctor: Carlos, Patient: Leonel) Tape 44A

56 D: *El antígeno prostático para ver cómo está funcionando la próstata está*
57 *funcionando O.K. ... El examen de sangre para ver como está el sodio, el*

58 *potasio que eso se puede alterar por los diurético- que estaba tomando ...*
...

71 D: *El colesterol un pelo más alto de lo normal. Lo normal es hasta 200 y*
72 tiene 202
...

104 D: *Lo otro que está un pelo alterado es la creatinina que eso ve la función*
105 *del riñón*

56 D: The prostatic antigen to see how the prostate is working, to see if it's
57 working O.K. ... The blood test [is] to see (the level of) sodium, potassium since
58 they can change as a result of the diuretic you're taking ...
...

71 D: The cholesterol level is a fraction higher than normal. Normal is up to 200,
and yours is 202
...

104 D: The creatinine is the other (thing) that's changed a fraction. This looks
105 at how the kidneys are working

In this example the doctor provides information about the medical tests of the patient by explaining what the tests have measured. This is achieved by introducing the subject *el antígeno prostático* 'the prostatic antigen' in line 56, and *el examen de la sangre* 'the blood test' in line 57 followed by *para ver* '(in order) to see' and the respective predicates in lines 56 and 57 *el antígeno prostático para ver cómo está funcionando la próstata* 'the prostatic antigen to see how the prostate is working', *el examen de sangre para ver como está el sodio el potasio* 'the blood test to see (the level of) sodium, potassium'. Similarly, the subject can be followed by a descriptive noun phrase *la creatinina ... que eso ve la función del riñón* 'the creatinine ... looks at how the kidneys are working'. The *Educator voice* also provides information about the normal level of cholesterol *lo normal es hasta 200 y tiene 202* 'normal is up to 200, and yours is 202'.

Another example that shows an 'account of test result' is conveyed in the following excerpt. In both examples (Examples 4.22 and 4.23) the doctor is authoring a script as part of his medical training. Whereas in Example 4.22 the focus is on the

statistical knowledge of knowing the range value of the level of sodium and cholesterol in the blood of a healthy person, Example 4.23 presented below focuses on the authoring of a script that includes a longer and more detailed explanation of the patient's X-ray. The physician educates her patient by showing and explaining to her what can be seen in her chest X-ray, thus helping her to understand how an X-ray should be read.

Example 4.23 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46

63 D : *En la radiografía se demuestran algunas cosas. Aquí a ver para verlo con*
64 *un poco más de calma, a ver cómo explicarle. Aquí están los cuerpos*
65 *vertebrales. ¿Ya ? Y aquí hacia lo- lados se ven un poco aumentado su*
66 *espacio y ahí salen incluso así como a ver no se visualiza bien, pero hay*
67 *un poquito un cachito que en la vista lateral imagínese aquí tenemos este*
68 *es el corazón y aquí tenemo- todo- lo- cuerpo- vertebrales y aquí se ve un*
69 *espacio entre un cuerpo vertebral y otro hay un espacio que aquí está*
70 *[el disco vertebral]*
71 P: *[Eso negro]*
72 D: *Eso negro que no se ve nada ahí pero hay un disco gelatinoso que*
73 *mantiene el espacio que permite lo- movimientos*
74 *si Uste- se fija en este otro espacio la parte anterior hay*
75 *como una cosa más blanca y el espacio está más apretado*
76 P: *Sí=*

63 D: The X-ray shows a few things. Here, let's see if we can look at them a little more
64 calmly, let's see how I can explain it to you? Here are the vertebrae of the spine
65 O.K.? And here, towards the sides, you can see the space slightly enlarged,
66 and there they come out, even if you can't see it very well, but here there's a slight
67 swelling for, from the side view, imagine that we have this is the heart and here we
68 have all the vertebrae, and here you can see a space between one vertebra and
69 another, and here's a space that's
70 [the vertebral disk]
71 P: [that black thing]
72 D: That black thing which you can't see anything of here, but there's a
73 gelatinous disk that maintains the space which allows the movements (to take place)
74 If you look at this other space, the earlier part, it's like a whiter object and the space
75 is tighter
76 P: Yes=

In this extract one can observe how the *Educator voice* emerges in the discourse. In line 64 the educative episode is initiated by: *a ver cómo explicarle* 'let's see how I can explain it to you?' which marks the knowledge divide between the two participants. This is so since the participation framework of doctor and patient differs. The doctor by aligning to the medical knowledge is able to explain something to the patient who

is lacking that particular area of expertise. The doctor shows the patient her chest X-ray and at the same time explains what can be observed there. This is done by using the adverb of place *aquí* 'here', followed by the verb e*star* 'to be' + body part *aquí están los cuerpos vertebrales* 'here there are the vertebrae' *aquí está el disco vertebral* ' here's the vertebral disk'. This helps the patient to locate the vertebrae within the X-ray. Similarly, the *Educator voice* explains to Olga the extent to which her vertebrae are affected. The doctor says: *aquí hacia lo- lados se ven un poco aumentado su espacio y ahí salen ... un poquito un cachito* 'here towards the sides you can see the space slightly enlarged and there they come out ...'. The inclusion of the colloquial word *cachitos* 'slightly enlarged', used in the diminutive form, may be an indication of the doctor's effort to make this educative episode one that can be easily understood by the patient. Thus, the doctor avoids medical jargon when he refers to the position of the patient's vertebrae. The *Educator voice* may also be observed in the doctor's use of anatomical terms: a*quí tenemos este es el corazón y aquí tenemo- todo- lo- cuerpo- vertebrales* '...here we have this is the heart and here we have all the vertebrae' in lines 67-68. The doctor also captures the patient's attention and interest by involving her in the explanation: *imagínese* 'imagine' in line 67, and *si usted se fija* 'if you look' in lines 74.

4.2.1.2 Accounts of medical tests to be carried out

The *Educator voice* can be used to give an account of a medical procedure the doctor is advising his/her patient to have. This is illustrated in Example 4.24. The patient suffers from diabetes, and he has brought to the consultation the result of his glycemia test, which indicates that the level of glucose in his blood is within the

'normal' parameters. The doctor would like to carry out another test to ascertain whether the level is maintained over a period of a month.

Example 4.24 Consultation No 18 (Doctor: Daniel, Patient: Victor) Tape 38A

75 D: *Eh: ... sí, me interesaría saber cómo, cómo sigue el regimen durante el*
76 *mes, hay un examen que no es ese pa' chequearlo día a día, solamente,*
77 *da una fotografía de ese momento solamente, pero hay otro- que, que*
78 *evalúan má- o meno- como ha estado dentro del me-*

75 D: Eh ... yes, I would like to know how, how you follow your diet over a month.
76 There's a test that isn't the one to check the level every day since that one
77 gives only a picture of a particular moment, but there's another
78 that checks roughly how you go over a month.

The educative process begins with *hay un examen* 'there is a test' in line 76 that indicates the certainty and existence of a medical test. The doctor then distinguishes between this test and another he recommends to the patient: *hay un examen que no es ese pa' chequearlo día a día ... pero hay otro que evalúa ... dentro del mes* 'there is a test that isn't the one to check the level every day ... but there's another one that checks roughly how you go over a month.' The education episode is marked by the explanation given by the doctor in relation to the medical tests available to assess the level of glycemia in the blood.

4.2.1.3 Accounts of the functioning of the human body

In the data the doctors explain to their patients about the biological function of their bodies. This is presented in the following two examples. In the first extract, the doctor gives an account of the patient's back pain, while in the second he offers an account of the numbness in the patient's arm.

Example 4.25 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46

75 D: *... el organismo reacciona frente a una situación de roce generando más hueso*
76 P: *Ya=*
77 D: *=Y esos cachitos despué- a la larga producen problemas aquí se ve más*
78 *acentuado aún llega hasta aquí afuera y eso va produciendo dolor en la espalda,*
79 *pero eso no implica la molesia en el brazo*

75D: ... the body produces more bone when there's friction

76P: O.K.=
77D: =and afterwards those small bumps in the long run produce more trouble. Here
78 you can see the swelling is more accentuated, and even reaches the surface here, and
79 this is what causes your back pain, but it doesn't explain the pain in your arm

In line 75 the doctor initiates his observation with the statement: *el organismo reacciona frente a una situación de roce generando más hueso,* 'our body produces more bone when there's friction'. The subsequent information that back pain can be the result of persistent friction is presented as a medical fact: *esos cachitos despué- a la larga producen ... eso va produciendo dolor en la espalda* 'afterwards those small bumps in the long run produce more trouble ... and this is what causes your back pain.' Thus far the doctor has given a general account of the problem, but he has not offered an answer as to why the patient is experiencing numbness in her arm. The discourse marker *pero* 'but' reveals and emphasises (Carranza 1998: 56) that the education given has to be understood as a general explanation: *pero eso no implica la molestia en el brazo* 'but it doesn't explain the pain in your arm'. The doctor has used the colloquial word *cachitos* 'small bumps' instead of a less familiar term (e.g. *protuberancia* protuberance), which could have jeopardised patients' understanding. The educative episode concerning the patient's problem is represented later in the discourse as shown in the following example.

Example 4.26 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46

124 D: *Digamo- los huesitos que pasan por ahí o sea los huesitos que están ahí*
125 *no dejan pasar fácilmente un nervio que queda atrapado entonces eso*
126 *comprime un poco el nervio y eso produce este adormecimiento del*
127 *bra[zo].*

124 D: Let's say the tiny bones that pass through there, or rather the tiny bones that are
125 there, don't allow the nerve to pass through easily, and it gets trapped, which
126 compresses the nerve a little and causes the numbness in your
127 a[rm].

The explanation is given by using *entonces* 'so', a marker of cause and result: *los huesitos ... no dejan pasar ... un nervio ... entonces eso ... produce este adormecimiento del brazo* 'the tiny bones ... don't allow ... a nerve pass through ...

which causes the numbness in your arm'. The doctor shows alignment to the medical knowledge by giving her patient an explanation about the numbness in her arm. This allows the patient to gain medical knowledge as well as to understand her health condition.

4.2.1.4 Doctors' accounts of patient discomfort

This study found that doctors use accounts to provide an explanation to their patients about their discomfort. The discourse forms used in the explanations may vary. Nevertheless, it will be seen from the discourse that doctors confirm their knowledge in the medical field and consider any decision taken by the institution as irreproachable. Doctors' role as educators has shifted from giving accounts to patients aimed at making them more knowledgeable about their health condition (i.e. giving accounts of test results, accounts of tests to be carried out and accounts of functioning of the human body) to showing their alignment to the medical institution they represent by defending any decision taken by the medical body. The three examples given below illustrate the main characteristics of this phenomenon:

(a) The discomfort is framed as a medical ailment that requires a medical interpretation.
(b) Doctors express complete faith in the medical decisions taken in earlier consultations, affirming that they were the right decisions, and
(c) Doctors minimise the side effect associated with a prescribed treatment.

In order to illustrate the three points mentioned above I present a set of examples.

Example 4.27 Consultation No 21 (Doctor: Daniel, Patient: Yolanda) Tape 29Ai

236 D: ... *El cuerpo por un lado se acostumbra a tener un medicamento. Pudiera*
237 *tener alguna- molestia- pasajera- que despué- del me- deberían pasar*

236 D: ... On the one hand the body gets used to the medication. You might have
237 some temporary discomfort that should pass in a month.

Here the doctor is making her patient aware that the change of medication dosage might have some effect on her since the body becomes used to the intake of a particular drug: *el cuerpo por un lado se acostumbra a tener un medicamento* 'on the one hand the body gets used to a medication'. The discourse continues, with the doctor telling the patient that she may experience some minimal discomfort. This is accomplished in line 236 by the use of *pudiera* 'might have', a subjuntive form of the verb *poder* 'can', which acts as a hedge minimising the effect of discomfort for the patient, *pudiera tener alguna molestia pasajera* 'you might have some temporary discomfort'. In this case both *pudiera tener* 'you might have' and *pasajera* 'temporary' suggest the minimal impact of the treatment upon the patient. Similarly, earlier in the discourse, the doctor minimised the possible effects of the new medication, this is shown in the Example 4.28 below.

Example 4.28 Consultation No 21 (Doctor: Daniel, Patient: Yolanda) Tape 29Ai

227 D: *... El hecho de haber estado tomando harto tiempo puede que al cambiar*
228 *ahora al dejarlo esto- quince día- primero el primer, primer me- sienta*
229 *alguna- molestia- extrañas- alguna cosa porque en el fondo tiene*
230 *algún medicamento*

227 D: ... The fact is that, when you change the medication or discontinue it after
228 you've been taking it for a long time, for the first fortnight, the first month
229 you may feel some discomfort, something strange, because basically
230 you've been on medication.

In Example 4.28 the discomfort is presented as *alguna - molestia – extrañas – alguna cosa* 'some discomfort, something strange'. The pronoun *alguna cosa* 'something' minimises the level of discomfort, frames it as something unusual and 'strange', and gives no clear definition of the condition - *cosa* 'thing'. The time frame is stated as brief: *quince día-* 'fifteeen days' in line 228, and *primer mes* 'the first month' in line 228.

The following Example 4.29 also relates to a doctor's account of patient discomfort in a case in which the patient has been suffering from headaches as a result

of changing the dose of his medication for blood pressure. This example is particularly interesting because the doctor does not criticise the practice of medicine (the source of a medical cure), but rather questions the patient's attitude towards the intake of the medication. This could indicate the doctor's strong alignment to the institution he represents.

Example 4.29 Consultation No 10 (Doctor: Carlos, Patient: Leonel) Tape 44A

49 D: *Puede ser ah el problema que frente a cambio de medicamento, suele a*
50 *veces ocurrir alguna- veces explicaciones por culpa de lo- medicamento-,*
51 *pero también está el factor humano que uno piensa que a lo mejor el*
52 *medicamento me está haciendo algún problema=*
53 P: =Sí, sí ...

49 D: Ah, the problem could be connected to the change of medication. Sometimes it
50 happens that, sometimes there are explanations that blame the medication,
51 but there's also the human factor for one thinks that the
52 medication is probably causing the problem=
53 P: =Yes, yes ...

The doctor introduces his discourse with explanation: *puede ser ah el problema* 'the problem could be'. This is followed by an account that aims to minimise the risk of the medication being seen as a source of discomfort: *suele a veces ocurrir alguna-veces explicaciones por culpa de lo- medicamento-, pero...* 'sometimes it happens that, sometimes there are explanations that blame the medication, but ...'. The use of *suele a veces ocurrir* 'sometimes it happens' and *algunas veces* 'sometimes ' in lines 49-50 indicate that the discomfort is not usually associated with the intake of the medication. This idea is reinforced by the use of the discourse marker *pero también* 'but there's also' in line 51 that indicates that there is the need to take the human factor into consideration as well. This time the doctor presents his account as a fact by using the verb *estar* 'to be' *pero también está el factor humano que uno piensa que a lo mejor el medicamento me está haciendo algún problema* 'but there's also the human factor one thinks that the medication is causing the problem' in lines 51-52. The doctor's reference to the possibility of a psychosomatic response towards the

changed medication implies that the dosage itself is unlikely to be the cause of the problem, and that the amount of medication being currently taken is the appropriate one. Why does this happen? It could be that the medication itself and the dosage are not the core of the problem, but rather the professional who had prescribed the medication in the first place. His credibility is at issue, and he (and the medical institution he represents) would have 'lost face' (Brown and Levinson 1987; Goffman 1967) had he admitted that the prescribed dosage might have not been appropriate. It is assumed that, if the problem persists, the patient will be given a different dosage of the same medication, or a new prescription.

In the following example the patient has been experiencing pain in his ankle. The doctor has not requested any tests, claiming that the 'wait and see' approach was the best way to observe how the problem was developing.

Example 4.30 Consultation No 5 (Doctor: Ana, Patient: Esteban) Tape 13B

57 D: *Porque no había ningún elemento como para pensar en algo má-*
58 *Así que por eso que no yo me quedé tranquila y observar solamente porque*
59 *hay mucha, de repente uno tiene muchas molestia-*
...

62 *Y se da cuenta que muchas van y pasan sola-*
...

64 *Hay muchas molestias que son así y que no vale la pena en gastar en*
65 *examenes y cosa- así ...*
67 *=Claro, uno la la la cuando hay algunas orientan a cierto tipo de cosas y*
68 *ahí uno le pone má- ojo, pero:=*
...

70 *En este caso era muy inespecífico, era una cosa que:=*
...

72 *Sin gusto a nada entonce- no no habla mucho como para tampoco*
73 *po' pa' asustarse=*

57 D: Because there was no reason to think otherwise. Uhm. That's why I
58 remained calm and only observed
59 because there are many, sometimes one feels many discomforts
...

62 And one realises that many come and go by themselves

64 There are many discomforts like that, and it's not worth paying
65 for tests and such like ...
...

67 =Of course, when some (discomfort) points to something specific, then
68 you've got to take a closer look, but=

70 In this case it was unspecific, it was something that=
...

72 Nothing was showing, nothing much could be said, so there was not much
73 to be frightened about

Here the doctor uses the *Educator voice* to make the patient understand that he has no medical problem. In the discourse the doctor reconfirms her decision not to have the patient undergo medical tests to ascertain the condition of his ankle. She defends her decision in line 57 *no había ningún elemento como para pensar en algo má-* 'there was no reason to think otherwise'; again, in line 70 *en este caso era muy inespecífico* 'in this case it was unspecific'; and for the third time in line 72 *era una cosa que ... sin gusto a nada entonce no no habla mucho* 'it was something that ... nothing was showing, nothing much could be said.' All these utterances are intended to confirm that the doctor had made the right decision. The other utterances support the doctor's reluctance to order medical tests and are designed to educate her patient not to pay attention to every discomfort that he experiences *hay muchas, de repente uno tiene muchas molestia-* 'there are many, sometimes ones feels many discomforts' in line 64. Such discomforts, the doctor reasons, are temporary *muchas van y pasan sola-* 'many come and go by themselves' in line 62, a belief that is repeated again in line 64 *hay muchas molestias que son así* 'there are many discomforts like that'. The doctor's view is that anyone can feel uncomfortable, so there is no need 'to be frightened' or to 'pay for tests'.

Although the doctor says that discomfort can often be disregarded because it cannot be linked to anything in particular, she does mention that there are other kinds

of discomfort (without specifying them) that could indicate a medical problem. In these cases she calls for greater care and attention *hay algunas orientan a cierto tipo de cosas y ahí uno le pone má- ojo* 'when some (discomfort) points to something specific, then you've got to take a closer look.'

The analysis of the discourse function ' Accounts in the medical discourse' found that doctors differ in the way they give accounts (i.e. 'accounts of the functioning of the human body' and 'accounts of patient discomfort'). In the 'accounts of the functioning of the human body' the factual medical explanations are part of a rehearsed and learnt medical speech that constitutes the medical knowledge acquired during the doctors' training. 'Accounts of patient discomfort' comprise two distinctive types of discourse. The first indicates that doctors are authoring a medical script, the second constructs the doctors' credibility in the medical field, in the institution, and in themselves. Doctors are able to accomplish this by projecting their own beliefs (i.e. projecting the 'principal' role following Goffman (1981)) and position in the discourse. Credibility may be at issue due to the possibility that the discomfort could be a direct consequence of the doctor's management of the patient. The study found that doctors tend to undermine (by ignoring) the association that might exist between a decision taken in the medical institution and a patient's discomfort by stressing the probability that the discomfort is due to the patient (see 6.3).

4.2.2 Accounts of medical treatment/management in doctor-patient interaction

This study also found that doctors may explain to their patients the medical treatment/management they recommend. This sub-function differs from the earlier one since these accounts lead doctors to give advice, which could be contested openly by patients (Fisher and Todd 1986). As shown above, diagnostic medical accounts

were never contested in this study. However accounts of medical treatment/ management should be regarded as a potentially negotiable discourse unfolding throughout the interaction of both participants in the speech. This study will analyse such accounts by observing how the medical treatment is presented and negotiated within the doctor-patient discourse. The discourse that emerges in this sub-function is the result of the doctors' use of discourse strategies that educate the patients about their condition and negotiate with them about the treatment to be undertaken.

The starting point for the study of how the medical advice about treatment is negotiated in the discourse, is to identify the discourse structures involved in giving advice. It was found that doctors may use a discourse strategy either to express the fact that the accomplishment of an act is inevitable and that there is no other option (this I will call a 'marker of inevitability'), or to leave open to the patient the possibility of an option (this I will call a 'marker of conditional inevitability'). Conditional inevitability springs from the fact that the utterances are expressed in the conditional mood. In the analysis that follows, the first part differentiates the two types of Spanish markers, while the second part analyses doctor-patient negotiation in the sub-function of 'Accounts of medical treatment/management in doctor-patient interaction'.

4.2.2.1 Spanish 'marker of inevitability' and 'marker of conditional inevitability'

The 'marker of inevitability' shows in its discourse structure that the recommendation of the doctor is to be followed. The obligatory essence of this marker distinguishes it from the 'marker of conditional inevitability' where obligatory force is not expressed linguistically with the same force, thus making the imposition (Brown and Levinson 1987) less forceful because of the conditional mood used in the

advice. In the data the 'markers of inevitability' were represented by the verb structure *tener que/deber* + infinitive 'to have to' (Salazar 1978) and *hay que* + infinitive 'one must'. Prieto-Castillo (1999) classifies *hay que* 'one must' as a discourse strategy that denotes *despersonalización* 'depersonalisation' of the act. In other words, the subject is not explicitly mentioned in the discourse. Prieto-Castillo indicates:

> *[En] este recurso [lingüistico], cuyo paradigma está dado por... el empleo del verbo "haber", llega a tener la fuerza que reconocimos a la universalización. En realidad, se trata de una suerte de universalización por la acción. Las expresiones se alzan también como leyes, como mandatos para cumplir... Cada una de esas afirmaciones aparece como si nadie la hubiera dicho, como un valor en sí mismo* (1999: 114)
>
> [In] this [linguistic] tool whose paradigm is given... the use of the verb 'to have' comes to have the force of being recognised as a universal. In reality, it is universal due to the action it accomplishes. The utterances are also raised as laws, orders to be followed... Each of these affirmative statements appears as if nobody had said them, as if they have a value in themselves.

The data also show examples of:

(a) The verb structure *ir* 'to go' in the 2nd person singular + *necesitar*, 'you will need to'.
(b) The verb structure *ir* 'to go' in the 2nd person singular + *requerir* 'you will be required', and
(c) The verb structure *ir* 'to go' in the 2nd person singular + *a tener que* 'you will have to'.

These are classified as 'markers of inevitability' due to the non-optional, or obligatory force that their discourse forms convey. The following examples of 'markers of inevitability' highlight the presence of one particular type of marker. Example 4.31 below, presents a patient who had expressed feeling lonely and lacking in energy and reported that when her sister visits her she does not spend time with her, thus creating a difficult situation for both of them. The doctor tries to encourage the patient to

interact with other people and gives her advice as to what to do when her sister visits her. This is accomplished by a 'marker of inevitability'.

Example 4.31 Consultation No 3 (Doctor: Ana, Patient: Carmen) Tape 20B

232 D: *Entonce- va a tener que: eh: e- dificil ¿uhm?, pero va a tener que tratar de*
233 *hacerse como un día que vaya ella y olvidarse de to-o lo otro y*
234 *sentarse má- a conversar, ya porque Uste- tiene la idea que ella va como*
235 *por cumplir ¿ya?:=*

232 D: So you'll have to: eh: it's difficult, uhm?, but you'll have to try
233 to make it a day just for her and forget everything else
234 because you have the impression that she comes, as it were,
235 out of obligation. O.K?=

In this excerpt the doctor uses the 'marker of inevitability' *va a tener que* 'you will have to' in line 232, followed by the verb *tratar* 'try' which minimises the effect of the obligation, presumably to maximise the chance of the patient accepting the advice. The advice here centres on the educative role of making the patient realise that she will benefit from company, and that she needs to spend time with her sister when she comes to visit her *hacerse como un día que vaya ella y olvidarse de to-o lo otro* 'to make it a day just for her and forget everything else' in line 233.

The following example illustrates the use of the marker *hay que* 'one must' in the discourse. Here the patient is suffering from stress and high blood pressure. The doctor uses her *Educator voice* to explain that there is a need to change the medication and to reduce the stress level.

Example 4.32 Consultation No 4 (Doctor: Ana, Patient: David) Tape 36Bi

254 D: *Lamentablemente, como por lo que me cuenta va a necesitar má- dosi- o*
255 *agregar un poquito má- de medicamento de por ese lado ¿Ya ?. Eh en la*
256 *cosa de la presión ... se exacerban con la tensión o sea hay que manejar*
257 *la tensión.*

254 D: Unfortunately, from what you're telling me you'll need to
255 increase the dose, or increase slightly your medication. O.K.? In
256 regards to your blood pressure ... it gets worse with stress, so it means that one must
257 manage the stress.

The use of *hay que* 'one must' in line 256 is to educate and make the patient aware that there is a correlation between high blood pressure and stress. This is achieved in

line 256 by saying: *en la cosa de la presión ... se exacerban con la tensión* 'in regards to your blood pressure ... it gets worse with stress'. Therefore, one must control the stress in order to reduce the blood pressure *hay que manejar la tensión* 'one must manage the stress'. The doctor insists on this point later in the discourse as shown in Example 4.33.

Example 4.33 Consultation No 4 (Doctor: Ana, Patient: David) Tape 36Bi

262 D: *Hay que atacar principalmente la cosa nerviosa es lo principal que hay*
263 *que manejar*

262 D: One must attack mainly the nerve problem, that's the main
263 thing that one must manage

Here the doctor reiterates the importance of reducing the level of stress by repeating *hay que* 'one must' in line 262, accompanied by two synonymous verbs *atacar* 'to attack (i.e. overcome, control') and *manejar* 'manage'; by the adverb *principalmente* 'mainly'; and by the noun phrase *lo principal* 'the main thing'. Clearly the repetition is designed to reinforce the importance of the doctor's advice.

The data shows that doctors also used the 'marker of conditional inevitability' in their advice. This is accomplished by using the verb *ser* 'to be' in the conditional mood: *sería* 'it would be'. Example 4.34 demonstrates this usage. The patient suffers from obesity, and her GP advises her on how to manage her weight. This is achieved by using a 'marker of conditional inevitability' *(lo ideal) sería que* ... 'the ideal thing would be to ... in line 72.

Example 4.34 Consultation No 8 (Doctor: Berta, Patient: Hilda) Tape 34A

72 D : *... lo ideal sería que ... Uste- se comprara una pesa, una buena pesa, una*
73 *buena balanza ...*
...

90 *lo ideal sería digamo- que anotara en un papelito*

72 D: ... the ideal thing would be ... for you to buy scales, good
73 scales, a good weighing scales ...
...

90 the ideal thing would be, let's say, to write down your weight.

Later in the discourse the doctor advises the patient to keep a record of her weight. The use of the 'marker of conditional inevitability' in line 72 could be interpreted as the doctor understanding the imposition being put on the patient when she recommends the purchase of weighing scales *lo ideal sería que ... Uste- se comprara una pesa* 'the ideal thing would be ... for you to buy scales'. The same reasoning could be applied to line 90 when the doctor advises the patient to keep a record of her weight *lo ideal sería digamo- que anotara en un papelito* 'the ideal thing would be, let's say, to write down your weight'. The use of the Spanish 'marker of inevitability' and 'marker of conditional inevitability' suggests that doctors can modulate their advice from a more to a less forceful recommendation. This equates with previous studies (Davis 1988; Fisher and Todd 1993; van Dijk 1995a, 1996, 1997b; Wodak 1996, 1997, 1999a) that indicate that those who are in a position of power may use alternative discourse strategies to accomplish their communicative aim of persuasion. This point is further explored in Section 6.3.

4.2.2.2 Impersonal agents

The sub-function 'Accounts of medical treatment/management in doctor-patient interaction' can also be performed by the use of the impersonal agent *uno* 'one' (see Examples 4.30, 4.35 and 4.36). 'This is similar to the English 'one' in that it is often an oblique way of saying 'I' or 'we' (Butt and Benjamin 1988:307). When *uno* is used self-reference is sometimes intended. In Example 4.35, below, *uno* (line 94) refers to the doctor herself and to the institution that she represents. Had the doctor chosen the first personal pronoun *yo* 'I' e.g. *yo lo que hago mucha- vece-* instead of *uno* 'one' *uno lo que hace mucha- vece-* the discourse might have been interpreted differently. The use of the impersonal pronoun *uno* 'one' conveys the idea

that the medical practice that the doctor is recommending is within the medical procedure of the institution. In the following excerpt the doctor explains to the patient the new treatment to be followed.

Example 4.35 Consultation No 4 (Doctor: Ana, Patient: David) Tape 36Bi

92 D: *Yo encuentro que Arax es una buena opción para Uste- el, el Arax ¿ya?*
93 *si vamos a tener le voy hacer un cambio en las dosis pero vamos a tener*
94 *que por lo meno mantenerlo por lo meno durante un tiempo: y uno lo que*
95 *hace mucha- vece- bajando dosi- y haciendo cambio para no tenerlo por*
96 *tanto tiempo::*
...

98 D: *=Claro en general uno lo deja por un tiempo: limitado pero, Uste-*
99 *necesita má- dosi- uhm necesita má- una ayuda má-*

92 D: I believe that Arax is a good option for you, Arax O.K? Yes
93 we'll need, I'll need to make a change in the dose but we'll need to
94 maintain it, at least for some time. What one often does
95 is to (start) decreasing the dosage and changing it in order not to
96 stay (on the medication) for a long time
...

98 D: =Of course one usually leaves it for a time, a limited time, but you need
99 a larger dose uhm you need more help, more.

The transcript shows two examples of *uno* in lines 94 and 98. In both cases the doctor uses her *Educator voice* to inform the patient how the medication is usually administered *uno lo que hace mucha- vece- bajando dosi- y haciendo cambio* 'what one often does is to (start) decreasing the dosage and changing it' in line 94, and *uno lo deja por un tiempo: limitado* 'one usually leaves it for a limited time' in line 98. In this way the patient acquires relevant medical knowledge. The use of *uno* conceals the agent of the advice, in this case the doctor. This suggests that the doctor uses *uno* 'one' to make a shift of footing from the agent (the doctor, marked by the first singular person pronoun or the institution, marked by the first plural pronoun form) to a non-explicit agent *uno* 'one'. Thus both utterances in lines 94 and 98 have been articulated as if such knowledge is shared by health professionals. In other words, the information is presented as if it were 'normal' in medicine.

The study has identified another use of the impersonal agent *uno* 'one' in the sub-function 'Accounts of medical treatment/management in doctor-patient interaction'. *Uno* 'one' can also be used as a first person plural form, *nosotros* 'we'.

Example 4.36 Consultation No 3 (Doctor: Ana, Patient: Carmen) Tape 20B

205 D: *... uno necesita de un, de un cierto apoyo social de amigo- ...*
...

227 D: *... uno requiere de otra- persona-, amiga-, no sé qué sé yo a juntarse al*
228 *(El) Club de Tango o Centro de Madre lo que sea, lo que sea, pero necesita*
229 *un grupo eso es inevitable ¿ya? Uno necesita algo donde poder hablar*
230 *además- que ahí uno se da cuenta además- de otra- realidade- ve la- cosa-*
231 *como distinta también la visión de, de otra- persona-*

205 D ... one needs a kind of social support, of friends ...
...

227 D: ... one needs other people, a friend, to get together in some way in
228 (The) Tango Club or Mothers' Centre, whatever it be, but you need a group,
229 that's essential. O.K? One needs a place where one can talk, for there
230 one learns another reality,
231 another way of looking at things

The use of *uno* 'one' here differs from the earlier example. In this case the *Educator voice* underlines the importance for the patient to be part of a social group and to have a network of friends with whom to exchange ideas *uno necesita ... apoyo social de amigo-* 'one needs ... other people, friends' in line 205; and *uno requiere de otra persona-, amiga-* 'one needs other people, a friend' in line 227. The doctor suggests where she might find friends (el) *Club de Tango o Centro de Madre* '(the) Tango Club or Mothers' Centre'. Even though the choice of a social group is left to the patient, *lo que sea* 'whatever it be', the doctor presents it as a necessary step in line 228 if the patient is to feel less isolated and lonely. The *Educator voice* is also used to explain why it is important to meet other people *uno necesita algo donde poder hablar ... ahí uno se da cuenta además- de otra- realidade- ve la- cosa- como distinta también la visión de, de otra- persona-* 'one needs a place where one can talk ..., for there one learns another reality, another way of looking at things.' By citing examples

of the social activities that are available to the patient, the *Educator voice* highlights socio-cultural aspects of Chilean society as well as socio-cultural expectations placed on women to belong to an approved gender specific group.

4.2.2.3 Accounts of medical treatment/management: Doctor's and patient's words

The doctors use accounts of medical treatment/management to negotiate with their patients the medical treatment to be undertaken. As we have seen this is accomplished by the use of 'markers of conditional inevitability' and 'markers of inevitability'. The following two examples demonstrate the discourse forms used when discussing the treatment/ management of patients.

In the following example the patient is suffering from depression. The doctor advises psychotherapy sessions which, she claims, will be very helpful. The doctor uses 'markers of conditional inevitability' to persuade the patient to accept her advice.

Example 4.37 Consultation No 3 (Doctor: Ana, Patient: Carmen) Tape 20B

101 D: *... A ver, bueno el ánimo está mejor aunque todavía claro,*
102 *queda cosa. Yo, yo le hablé alguna ve- que sería bueno en alguna-*
103 *ocasione- apoyo con en psicología o con psicoterapia*

101 D: ... Let's see, well, you're in better spirits, although it's still clear
102 there's something wrong. I, I've sometimes told you that it would be good in
103 same instances to have some psychological or psychotherapy support

The doctor starts by telling the patient that she is in better spirits *el ánimo está mejor* 'you're in better spirits' in line 101, although there are still some remnants of depression *aunque ... queda cosa* 'although it's still clear there's something wrong' in line 102. This observation provides a platform for giving her patient some advice which is marked by a 'marker of conditional inevitability' *sería bueno* 'it would be good', followed by *en alguna- ocasione- apoyo ...* 'in some instances to have ...

support'. It is understood that the phrase 'in some instances' refers to the present moment and to that particular patient, and that it is she who will benefit from therapy.

In the following passage (Example 4.38) of the same episode, the patient presents herself as a worker, *yo trabajo* 'I work' (105), whose daily routine will be affected by the treatment proposed by the doctor *tengo que viajar ... me significa toda la mañana* 'I have to commute ... that means taking up the whole morning' (105-106). This observation is presented as a personal concern and as a potential obstacle to complying with the doctor's advice *¿cuánto tiempo eh: cita a esto, si e- una ve- al me- una ve- a la semana o:?* 'how often is it, once a month, once a week or?' in line 107 as shown below.

Example 4.38 Consultation No 3 (Doctor: Ana, Patient: Carmen) Tape 20B

104 P: *Sí, sí lo que pasa doctora que yo: estoy dejando mi salud un poquitito de*
105 *lado digamo- para lo- permiso- es decir como yo trabajo tengo que viajar es*
106 *decir a a mi significa toda la mañana eh: acá, entonce- sí tengo que pedir, no sé*
107 *¿cuánto tiempo eh: cita a esto, si e- una ve- al me- una ve- a la semana o:?=*
108 D: *=Es como generalemte es como una o cada una o cada do- semana- ah en*
109 *general*

104 P: Yes, yes what's been happening, doctor, is – let's say - I've been neglecting my health a little.
105 As for sick leave, since I work I've got to commute and that means taking
106 taking up the whole morning, so if I need to ask (for sick leave) I don't know
107 how often it is once a month, once a week or? =
108 D: =It's usually once a week, or every fortnight

The discourse continues in the next passage, her decision to go to psychotherapy depends on her employer *lo quiero conversar con mi jefe* 'I want to talk it over with my employer' in line 111. This is because sick leave has to be granted every time she goes to psychotherapy, which is every week or every fortnight, as we know from the above passage.

Example 4.39 Consultation No 3 (Doctor: Ana, Patient: Carmen) Tape 20B

110 P: *Eh: yo ni siquiera me averigué tengo en todo caso la hojita que Uste- me dio,*
111 *pero: lo quiero conversar con mi jefe para, para no he podido conversar porque*
112 *pasa en [reunione-]*
113 D: *[Claro]*

110 P: Eh I didn't even make enquires. In any case, I've got the note you

111 gave me, but I want to talk it over with my employer but I haven't been able to talk to him because
112 he's has been in [meetings]
113 D: [Right]

The doctor reiterates once more the validity of the treatment she is proposing in lines 114-118 (Example 4.40) but she does not make any comment on the patient's concern about her work obligations. The discourse continues as follows:

Example 4.40 Consultation No 3 (Doctor: Ana, Patient: Carmen) Tape 20B
114 D: =*Claro sería bien bueno porque por lo meno- la parte de la, de la*
115 *angustia, de la ansieda- hay cosa- que lo- remedio- ayudan, pero también*
116 *depende mucho como la persona enfrente la situación y en eso ayuda*
117 *harto la psicotera:pia*=
118 P : =*Me imagino que sí*

114 D: =Of course it would be very good because at least in regards to your
115 anguish, your anxiety, there's a remedy, something that helps, but it also depends
116 a lot on how the person faces the situation, and in this respect
117 psychotherapy is very helpful=
118 P: =I imagine so

Once again the physician uses a 'marker of conditional inevitability' *sería bien bueno* 'it would be very good' in line 114. This time the discourse form is emphasised by the adverb of manner *bien* 'very' and by *claro* 'of course' that initiates the passage. The doctor also introduces the idea that medication is not the only answer to the patient's problem. This is indicated by the use of the conjunction *pero* 'but' which links the medication to the psychotherapy, co-constructing them as complementary treatments *hay cosa- que lo- remedio- ayudan, pero también depende mucho como la persona enfrente la situación y en eso ayuda harto la psicoterapia* 'there's a remedy, something that helps, but it also depends a lot on how the person faces the situation, and in this respect psychotherapy is very helpful' in lines 115-117. The patient latches onto the doctor's talk, agreeing with the proposal *me imagino que sí* 'I imagine so' in line 118. The doctor's final observation in the consultation is shown in the last passage selected for this analysis.

Example 4.41 Consultation No 3 (Doctor: Ana, Patient: Carmen) Tape 20B

119 D: *¿Ya? Así que yo creo que Uste- se ayudaría así es que la idea que*
120 *cuando Uste- vea que se pueda hacer el hueco ojalá, lo pueda hacer ¿ya?*
121 *Para Uste- sería bien beneficioso ¿ya?*

119 D: O.K? So I think you would benefit, so the idea is that when you see
120 that you can manage to make the time, hopefully you'll do it. O.K? It
121 would benefit you greatly. O.K?

The phrase *así que yo creo* 'so I think', which initiates the final observation, indicates the doctor's irrevocable decision to have the patient attend psychotherapy sessions. This is followed by a 'marker of conditional inevitability', *se ayudaría* 'you would benefit', and a subordinator of time, *cuando* 'when', which indicates that the doctor has taken into some account the patient's alleged lack of time. The discourse continues with *ojalá* 'hopefully' and *para Uste- sería beneficioso* 'it would benefit you greatly', both of them intended to address and re-assure the patient who needs this kind of treatment. From Examples 4.37-4.41 it is possible to observe that the doctor uses her *Educator voice* to give an advice on a treatment to be undertaken (i.e. psychotherapy). Discourse strategies like the 'marker of conditional inevitability' (i.e *sería bueno* 'it would be good' in Examples 4.37 and 4.40) are used as persuasive forms to make the patient comply with the medical recommendation. This becomes clearer in Examples 4.40 and 4.41 when the doctor shifts her footing from the 'marker of conditional inevitability' (*sería bueno* it would be good') in line 114, to the first person singular pronoun *yo* 'I' (line 119). In so doing the doctor performs credibility and shows authority over the prescribed treatment.

The following example demonstrates how the *Educator voice* can be used as a means of making the patient acquire an understanding of medical practices and influencing their decision making process about treatment. The patient has been suffering from a pain in her arm. She has visited an orthopaedic surgeon who has advised her to have an operation. She is now consulting her family doctor and brings

up her fears about the operation. The physician educates her patient by informing her of the procedure.

Example 4.42 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46

136 P: *... si uno, y si uno no se opera ¿qué pasa?*
137 D: *siente las molestias que Uste- percibe eso [podría ir empeorando]*
138 P: *[Por eso si no me opero] estar más* relajada
139 D: *No, no, no*
140 P: *Me gusta jardinear por ejemplo*
141 D: *Pero Uste- va a notar las limitaciones Uste- debe ir aceptando sus*
142 *limitaciones en el fondo si se opera lo más probable que ocurra es que*
143 *eso vaya a recuperarse en forma optima y Uste- va a poder hacer su vida*
144 *completamente normal=*
145 P: *=Ya=*
146 D: *=Si no se opera debe aceptar un poco esas limitaciones que frente a*
147 *movimientos manuales, siente limitaciones siente adormecimiento,*
148 *dolore- nocturno- que a veces se despierta por esas molestias y hay*
149 *alguno- tratamiento médico que pueden tratar de combatir eso=*
150 P: *=Ya=*
151 D: *=Pero no son tan espectaculares como lo de la cirugía, la cirugía*
152 *le han explicado que es algo rápido=*

136 P: ... if I don't have an operation, what will happen?
137 D: You'll feel the discomfort you're feeling now [It could get worse]
138 P: [But if I don't have] an operation I should reduce the stress
139 D: No, no, no
140 P: I like gardening, for example
141 D: But you'll notice the limitations. You'll have to accept your limitations.
142 If you have the operation, what's almost certain is that you'll recover
143 perfectly well and you'll be able to carry out your life in a
144 completely normal way =
145 P: =O.K.=
146 D: =If you don't have the operation, you'll have to accept limitations to your
147 hand movements, you'll feel limitations, numbness,
148 night pain that will sometimes wake you up. There're some
149 medical treatments to fight that =
150 P: =O.K.=
151 D: =But they're not as spectacular as surgery.
152 They've explained to you that surgery's quite quick =

The patient initiates the episode by expressing her concern about the operation *si uno, y si uno no se opera ¿qué pasa?* 'if I don't have an operation, what will happen?' (line 136). She fears that the pain will interfere with her usual activities *me gusta jardinear por ejemplo* 'I like gardening, for example' in line 140. This utterance must be understood as a query intended to ascertain the extent to which her life will change if she does not have the operation. In lines 138 and 139 both participants understand and

frame the medical problem differently. Following Wodak's description of disruptive events (1996: 2), this is an example of a 'frame conflict' (see Section 2.3). The patient believes that her problem is associated with her stress *si no me opero estar más relajada* 'if I don't have an operation I should reduce the stress' in line 138. The doctor disagrees (line 140), having claimed earlier in the discourse that her problem is linked to an inherited malformation of the bones in her arm. The doctor's positive attitude towards an operation is carried out in the *Educator voice*. Education and persuasion work closely together in this episode to make the patient accept a decision made by the medical body (the doctor himself and the specialist who has examined the patient). This is accomplished by using a conditional clause, followed by a 'marker of inevitability' *si no se opera debe aceptar ... limitaciones* 'if you don't have an operation you'll have to accept ... your limitations' (line 146). The discourse form used in this utterance reflects the patient's obligation to accept the physical limitations that she may experience if she decides against an operation. The determination to make the patient accept an operation is also present when the doctor mentions that the condition of the patient's arm might deteriorate if an operation is deferred *podría ir empeorando* 'it could get worse' (line 137). In this case, the doctor uses '*podría* (conditional) + *ir* (infinitive) + gerund', which implies that the restrictions of her arm might (*podría* 'could') progressively deteriorate (*ir empeorando* 'get worse') if the patient's reluctance to have the operation prevails over the doctor's advice. Similarly, the doctor maximises the chances of success and of a quick recovery *lo más probable es que* vaya *a recuperarse en forma optima* 'what's almost certain is that you'll recover perfectly well' (lines 142-143), and: *la cirugía le han explicado es algo rápido* 'they've explained to you that surgery's quite quick' (line 152). All these utterances may sound appealing to a patient who fears not being

able to carry out her usual activities. The doctor leaves no doubt about his conviction that all will be well *Uste- va a poder hacer su vida completamente normal* 'you'll be able to carry on your life in a completely normal way' in lines 143-144. The adverb of manner, *completamente* 'completely', assures the patient of a favourable outcome. The *Educator voice* is used in this example to make the patient comply with the operation by presenting it as a success and by showing that the recovery after the operation is quick. The doctor in so doing authors a voice of knowledge in the medical practice and hence projects a sense of authority in the subject matter.

The data also includes an example of the *Educator voice* disrupting (Wodak 1996) the normal educative process of the doctor. The example provides an insight into the authority of the medical professional when making assessments and commenting on people's opinions. In the following example the doctor not only affirms his affiliation to the institution by making the patient have the operation, but he also uses his *Educator voice* to evaluate the opinions of non-professionals about the operation.

Example 4.43 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46A

175 P: *... con algunas personas que han tenido este problema*
176 *no te opere que es horrible y fuera de eso al final uno queda igual=*

175 P: ... some people who've had the same problem (have said to me)
176 don't have the operation, for it's horrible and, besides, it made no difference in the end=

The patient initiates this episode by mentioning that she has spoken to some people who have suffered from the same problem and that they have told her not to have the operation because of the pain involved and its lack of success *no te opere que es horrible y fuera de eso al final uno queda igual* ' don't have the operation, for it's horrible and, besides, it made no difference in the end' (line 176). The doctor fails to realise that this is a repetition of the fear already expressed in lines 136 and 138 (Example 4.42), and continues his discourse by educating the patient on the difference

between professional and non-professional knowledge. This is shown in Examples 4.44 and 4.45.

Example 4.44 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46A

179 D: *¿Quién son médico?*
180 P: *Eh, eh persona paciente=*
181 D: *=Exacto pero son pac[iente]*
182 P: *[Claro]*
...

206 D *... No le pediría la opinión a otra persona que no sea especialista en el*
207 *tema no creo que es buena fuente=*
208 P: *=Ya=*
209 D: *=De confianza*
210 P: <@@ >=
211 D: *=Ya yo no le estoy preguntando lo que tengo que hacer en un problema*
212 *legal a un vecino si no es abogado=*
213 P: =<@*Ya*@>=
214 D: *=Entonces uno tiene que ir donde gente que tenga experiencia porque*
215 *es re fácil opinar uh no te opere con eso uno queda tranquilo porque dice lo*
216 *que yo pensaba pero a lo mejor com- decirle a una persona*
217 *que tiene una apendicitis uh no te opere- el no operarse*
218 *significa la muerte probablemente para esa persona entonce- el caso no es*
219 *llegar y a lo que le digan si hacer es una fuente no* muy=
220 P: *=No muy con[fiable]*
221 D: *[entendi]da entendida en el tema*

179 D: ¿Are they doctors?
180 P: Eh, eh people, patients=
181 D: =Alright, but they're pat[ients]
182 P: [Of course]
...

206 D: ... I wouldn't ask the opinion of someone who's not a professional in the
207 field. I don't think that person will be a good source of information=
208 P: =O.K.=
209 D: =A Trustworthy (source)
210 P: <@ @ >=
211 D: = I don't ask my neighbour what I should do in a legal matter if he's
212 not a lawyer=
213 P: =<@O.K.@>=
214 D: =So one should go to those people who have (professional) experience
215 because it's very easy to give opinions – don't have an operation and you'll be right.
216 It's like me telling a person
217 who has appendicitis uh, don't have the operation. The failure to operate would
218 probably mean death for that person, so it's not a matter of
219 listening to what other people say if they're a source that is not very
220 = Not very [trustworthy]
221 D: [knowledge]able in the matter

In this transcript it is possible to observe the doctor's use of the 'marker of inevitability' *tiene que* 'have to/one should' in line 214 to stress that a suitable

opinion can only be made by a professional in the field. Those who are unqualified in the specialisation are not trustworthy (see lines 206-207 and 209). This observation is illustrated with an example *yo no le estoy preguntando lo que tengo que hacer en un problema legal a un vecino si no es abogado* 'I don't ask my neighbour what I should do in a legal matter if he isn't a lawyer', which is followed by a discourse marker of cause and result, *entonces* 'so' + an impersonal agent + *tiene que,* which repeats the idea that only professional experience can be considered as a reliable sources of information. The doctor even disregards the opinion of those people who have experienced the operation themselves. The doctor makes use of a second example to reinforce this point *es re fácil opinar ... como decirle a una persona que tiene apendicitis uh no te opere- el no operarse significa la muerte probablemente para esa persona* 'it's very easy to give opinions ... like telling a person who has appendicitis uh don't have the operation- failure to have an operation would probably mean death for that person'. The reference to an operation is designed once again to persuade the patient to follow the same path, while the allusion to *muerte* 'death' dramatises the event. This utterance is followed by *entonces* 'so', which marks the recommendation to be followed *entonce- no es llegar y hacer caso a lo que le digan si es una fuente no muy ... entendida entendida en el tema* 'so it's not a matter of listening to what other people say if they're a source that is not very ... knowledgeable in the matter' in lines 218-221.

In the following extract, the doctor continues by giving further advice to her patient. He aligns himself to the institution by rejecting any medical opinion or advice given by non-professionals in the field, claiming that Chileans generally offer such advice to acquaintances and friends without bearing in mind the negative effects their action could have on the person. This is expressed as follows:

Example 4.45 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46A

221 D: *... Aquí en Chile lamentablemente somo- todo- potenciale- médico- y*
222 *todo- damo- consejo- Mire la vecina se tomó esta pastillita, tiene lo mismo*
223 *tuyo. De ahí partimo- con un error ¿Tendrá lo mismo? Pero esta pastillita*
224 *le hizo bien pero a lo mejor esta otra persona no tenía lo mismo y esa*
225 *pastillita además le hace daño, pero todo el mundo está recetando así hay que*
226 *tener cuidado un poco en ese sentido ...*

221 D: ... Unfortunately, here in Chile we are all potential doctors
222 we all give advice look, my neighbour took this medicine, and she had the
223 same problem as you. This is the start of the mistake. I wonder if she has the same problem?
224 But this medicine made her better, but, at best, that person may not have had the same
225 problem. Moreover, it may damage her, and yet everyone is giving prescriptions,
226 so you have to be a little careful in this sense ...

The initiation of this educative episode is marked by a generalised observation about Chileans regarding themselves as potential health professionals *aquí en Chile lamentablemente somo- todo- potenciale- médico-* 'unfortunately, here in Chile we are all potential doctors' in line 221. This idea is again reinforced later in the episode: *todo el mundo está recetando* 'everybody is prescribing' in line 225. *Lamentablemente* 'unfortunately' reconstructs the misconception of assuming that everyone has sufficient knowledge to offer medical advice. Since the doctor rejects this attitude, he advises the patient against the custom, using a cause effect marker, *así que* 'so', followed by the warning *hay que tener cuidado* 'so you have to be careful'. The implication is that patients should not trespass beyond their boundaries and move into the medical territory where they do not belong. In other words, patients have to align to their condition of non-experts in the discourse, as well as they should be aware that other non-medical professionals do not offer trustworthy medical opinions since they lack the relevant knowledge to do so.

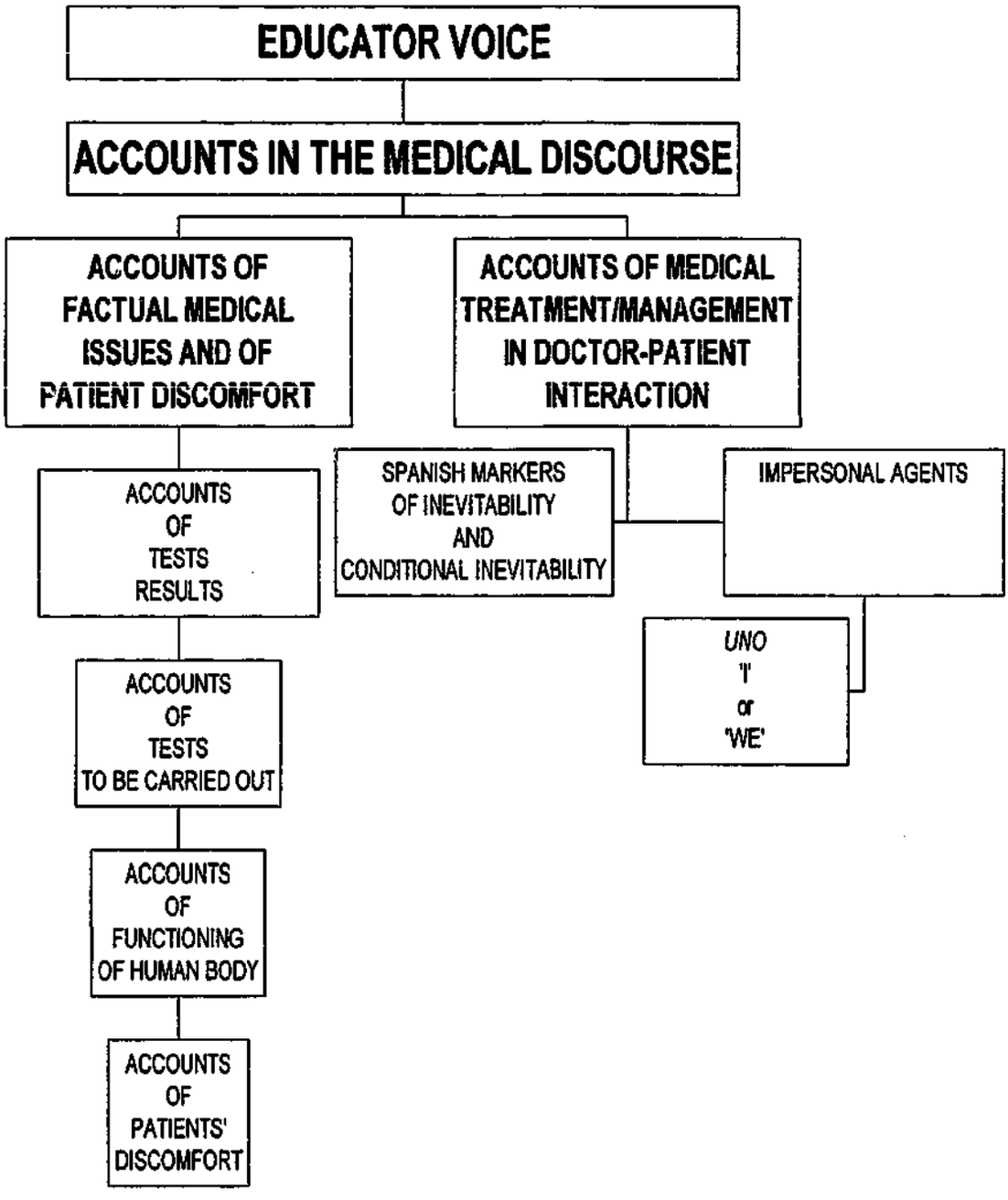
4.2.3 Summary

This section has shown that the *Educator voice* accomplishes the task of educating the patient in the communicative routine: 'management and treatment of a health problem or health issue' by using two sub-functions 'Accounts of factual medical issues and of patient discomfort', and 'Accounts of medical treatment/management in doctor-patient interaction'. While 'Accounts of factual medical issues and patient discomfort' are not contested, accounts that relate to patients' treatment/management are potentially contestable. This may explain why doctors make use of different discourse strategies in the communicative routine of 'management and treatment of a health problem or health issue'. It was found that both the 'marker of inevitability' and the 'marker of conditional inevitability' are used by doctors in order to recommend a course of action to be undertaken and make the patients comply with the medical advice.

The data shows that physicians can use a 'marker of inevitability', or a 'marker of conditional inevitability', or a combination of both in their discourse. The advice given by the use of a 'marker of inevitability' suggests that the doctors' instructions need to be followed (e.g. *tiene que/debe* to have to, *hay que* one must), and that the options left to the recipients are less apparent than if the advice is offered with the use of a 'marker of conditional inevitability' (e.g. *sería bueno* it would be helpful). This is so since the imposition and the obligatory force to follow the recommendation is less apparent. The use of the impersonal agent *uno* 'one' was also present in the data when advice was given. In this case the agent of the advice is ambiguously presented. *Uno* 'one' could represent the agent who emits an opinion (see Examples 4.30, 4.35 and 4.36) or a group of people who hold the same view, in this case the medical body (see Section 4.2.2 and Example 4.35).

Figure 4.2 illustrates the function ' Accounts in the medical discourse' and the two sub-functions 'Accounts of factual medical issues and of patient discomfort', and 'Accounts of medical treatment/management in the doctor-patient interaction' indicating the type of accounts and the discourse strategies involved in the *Educator voice.*

Figure 4.2 Discourse functions and strategies of *Educator voice*



4.2.4 Patterns of footing in the *Educator voice*

Following Goffman's understanding of the framework of interaction (1963, 1971, 1981, 1983) doctors' shift from one *voice* to another implies a move from one alignment/stance to another. In order to understand how the *Educator voice* emerges in the discourse it is important to have a closer look at the discourse patterns that favour the appearance and development of this alignment in the exchange. This is especially relevant since this study was accomplished in a teaching hospital where attention to education appears to be paramount (see Section 3.3.1).

The data shows that the doctor may initiate the educative episode spontaneously (i.e. usually after reading the patient's test results) or the doctor may offer an educative talk after the patient has asked for it (see Section 5.4). These two ways of initiating the *Educator voice* were the most prevalent ones in the fifteen conversations that included instances of the *Educator voice* (see asterisked value in Table 4.6). The length of time and the number of turns spent in each *voice* by doctors depends on the conversation and the interaction that is taking place. Thus the doctor may have one turn or more turns in one *voice* (*Doctor voice* or *Educator voice*) before shifting to another *voice* where the number of turns may vary again. In what follows I shall present the three main patterns found in this study.

Since the *Doctor voice* is one of the most recurrent *voices* in this study, then it is not surprising to observe that the shift usually occurs from the *Doctor voice* to the *Educator voice* and from the *Educator voice* to the *Doctor voice*. The *Doctor voice* initiating this is composed of one of two types of discourses associated with follow-up visits:

(a) Assessment of the test results (see Section 4.1.2), and
(b) Assessment of the patient's compliance (see Section 4.1.2).

The *Educator voice* that follows the *Doctor voice* is performed using accounting practices in the form of:

(a) Accounts in the medical discourse (see Section 4.2.1); or
(b) Accounts of medical treatment/management in doctor-patient interaction (see Section 4.2.2).

Usually this 'three-step' footing pattern (see Figure 4.3) comes to an end when the doctor reintroduces the *Doctor voice* in the form of a question that seeks information from the patient (see Section 4.1). This pattern represents doctors' prevalent exercise (see Section 4.1.4) of aligning to the medical practice of seeking information about patients' health. This is summarised in the Figure 4.3 below.

Figure 4.3 Discourse pattern of *Doctor-Educator-Doctor voices*

D ⇨ E ⇨ D

The second discourse pattern is associated with the voice of *Initiator* used by patients (see Section 5.4). Patients ask questions that relate to medical issues and this prompts the doctors to initiate an educative episode. In this case doctors animate and author a voice of authority in the medical matter at issue. The end of the *Educator voice* is marked by the doctors' shift of footing to the *Doctor voice*, usually this is accomplished by the use of a question that seeks further information from the patient (see Section 4.1). Thus the 'three-step' footing pattern in this case will be from the *voice* of *Initiator* to the *Educator voice* and from the *Educator voice* to the *Doctor voice*. This pattern is represented in Figure 4.4 below.

Figure 4.4 Discourse pattern of *Initiator-Educator-Doctor voices*

I ⇨ E ⇨ D

The pattern I ⇨ E can be extended as long as the patient continues asking questions to the doctor (see Section 5.4). In this case the number of turns used in the *Educator voice* is not dependant on the doctor's contribution, but rather on patient's

recurrent questioning (see for example, Example 5.14). This suggests that the patient's participation in the discourse may have an effect on the length the doctor alignment to the *Educator voice* (see Section 2.1.1). The *Educator voice* will come to an end when the doctor shifts footing to the *Doctor voice* (see Section 4.1). This pattern is illustrated in Figure 4.5 below.

Figure 4.5 Longer discourse pattern of *Initiator-Educator-Doctor voices*

I ⇨ E (P⇨ E) ⇨ D

The percentages of each type of account used in the *Educator voice* by the four doctors under investigation are shown in Section 4.2.5.

4.2.5 Frequency of the doctors' accounting practices

A summary of doctors' use of accounts in the communicative routine of 'management and treatment of a health problem or health issue' is presented in Tables 4.5 and 4.6. Of the twenty-two consultations studied, fifteen consultations presented accounts dealing with factual medical problems, patient discomfort and the treatment/management of a medical issue. This means that seven consultations (32% of the total) did not present any educative episode in the discourse, thus depriving patients of the opportunity to acquire a better understanding of their condition, and presumably limiting their chances of looking after their health adequately. The absence of educative episodes in seven of the twenty-two consultations seems to be contradictory to the basic teaching principles of the institution where the study was conducted. If we accept that this may be a problem, then what is its cause, and how should its occurrence be interpreted?

To begin with, the absence of educative episodes in some of the consultations may result from the intrinsic asymmetrical relationship that exists between doctor and patient. It is the doctor who possesses the medical information and the patient who is

the recipient of the medical recommendations. That is, medical knowledge is in the hands of 'experts' and, if they share it with their patients, they not only demonstrate their knowledge in the field but at the same time they may also lose the exclusiveness of such knowledge by contributing to their patients' competence. In addition, an extensive use of the educative practice could potentially jeopardise the control doctors have over their patients and cause them to fear that their patients may become potential trespassers into medical territory, as shown in the last example of the *Educator voice* (Example 4.45). This point will be further developed in Chapter 6 where the overall data of this study will be put into a macro perspective of doctor-patient communication. Formerly, I have pointed out that the initiation of an educative episode was performed as a response of patients' querying their doctors about medical issues (see Section 4.2.4). Thus, it is the question that the patient utters the one that may trigger the initiation of an educative episode. This suggests that those consultations (seven in total) that did not include any educative episode might have been a result of both the doctor's and the patient's reluctance to start an educative episode.

The frequencies of the different types of accounts found in the fifteen consultations are presented in Table 4.5.

Table 4.5 Frequency of doctors' accounts in the medical discourse

Type of accounts	Counts	%
Accounts of test results	22	16.7%
Accounts of medical tests to be carried out	4	3.0%
Accounts of the functioning of the human body	16	12.2%
Accounts of patient discomfort	15	11.3%
Account of medical treatment/management in doctor-patient interaction	75	56.8%
TOTAL	132	100%

Table 4.5 shows a high frequency of use of accounts dealing with health care treatment and management (56.8%) whereas 'accounts of medical tests to be carried out' (3.0%) were the least prominent. The type of discourse forms used by the four doctors involved in this study are tabulated in Table 4.6.

Table 4.6 Accounts in the medical discourse among the four doctors

Doctors	n	Accounts of Test Result		Account of Tests to be carried out		Accounts of Functioning of the Human Body		Account of Patient Discomfort		Accounts of Medical Treatment/ Management in doctor-patient interaction		Total Count
		No	M	No	M	No	M	No	M	No	M	
Dr. Ana	6	10	1.6	3	0.5	4	0.6	6	1.0	57	9.5	80
Dr. Berta	3	1	0.3	0	0	0	0	0	0	10	3.3	11
Dr. Carlos	6	10	1.6	0	0	11*	1.8	7	1.1	8	1.3	36
Dr. Daniel	7	1	0.1	1	0.1	1	0.1	2	0.2	0	0	5
TOTAL per doctor		22	16.7%	4	3.0%	16	12.1%	15	11.4%	75	56.8%	132

* 8 were initiated following requests from patients.

From Table 4.6 it can be seen that the function used most frequently by the four physicians was 'Accounts of medical treatment/management in doctor-patient interaction' (56.8%), followed by 'accounts of test result' (16.7%). A closer look at the data indicates that the two female doctors, Dr. Ana and Dr. Berta, used 'Accounts of medical treatment/management in doctor-patient interaction' more frequently (9.5 and 3.3 respectively, after taking into account the number of consultations, (Column n, for doctors) than their male colleagues. Dr. Daniel did not use 'Account of medical treatment/management in doctor-patient interaction' and his usage of the rest of types of account (test results, tests to be carried out, functioning of human body, and patients' discomfort) was low. Nevertheless, this was not the case for Dr. Berta who also showed a limited usage of the *Educator voice* (she only used test result and treatment/management), but whose use of the type of 'Accounts of medical treatment/management in doctor-patient interaction' was higher than that of both male

doctors. Both Dr. Ana and Dr. Carlos used the *Educator voice* more comprehensively throughout the types of accounts than their colleagues. In fact, Dr. Ana used every type of account (test results, test to be carried out, functioning of human body, patients' discomfort and medical treatment/management in doctor-patient interaction), while Dr. Carlos used all of the types of accounts except 'account of test to be carried out'. Therefore, although it appears that female doctors favour the type of account: 'Accounts of medical treatment/management in doctor-patient interaction', the individual characteristics of Dr. Ana and Dr. Carlos as well as the opportunities to use those types of discourse strategies during the consultation, make them provide educative episodes that expand the treatment/management. Thus, their patients might have developed a more comprehensive understanding of their health and, ultimately, experienced a more informative consultation.

4.2.6 Conclusion

The *Doctor voice* (see Section 4.0) aimed at seeking information about patients' current health condition, assess patients' compliance on the treatment prescribed in previous visits and assess patients' test results. It is at this stage that the *Educator voice* (see Section 4.2) can appear in the discourse by giving an 'account of test results', 'accounts of tests to be carried out', 'accounts of functioning body' and 'accounts of patients' discomfort'. These sub-functions can be accomplished by particular discourse strategies, such as 'marker of inevitability' and 'marker of conditional inevitability' used by doctors to persuade the patient to comply with a medical recommendation through the *Educator voice*. The section that follows analyses a *voice* that differs from both the *Doctor* and *Educator voices* since it presents discourse features which are likely to be found in everyday conversations. This is the *Human Fellow voice*.

4.3 Human Fellow Voice

The results reported in this section show that during the consultations, doctors may use a discourse that differs from both the *Doctor voice* and the *Educator voice*. Such a discourse is intended neither to search for information about the illness or ailment affecting the patient (*Doctor voice*) nor to educate the patient about his/her health condition (*Educator voice*), but rather to focus on showing empathy to the person who is sick and facilitating his/her involvement in the discourse by using affiliative discourse markers. The *Human Fellow voice* recognises the social identity and the multiple roles and obligations that people have when they visit a doctor. If, according to the holistic approach to medicine (see Section 2.5), a person's medical disorder can sometimes be understood by looking at his/her *milieu* (e.g. the patient may have ongoing problems in the family, workplace or elsewhere that may affect his/her health), then there is a need to investigate more than the *Doctor* or the *Educator voices*. One should explore the ways in which doctors encourage their patients to tell their stories, and the ways in which they show an affiliation, interest and involvement in the patient's description of that story. In other words, one should explore how doctors communicate with their patients by engaging in a discourse that is meant to be less 'medically' (asymmetrically) framed than the *Doctor* or *Educator voices*.

This study has found that the *Human Fellow voice* is performed by using five discourse functions. Doctors use this voice to:

(a) Facilitate the telling of patients' stories.
(b) Cooperate with the patient in the interaction.
(c) Create empathy with the patient.
(d) Show special attentiveness to the development of the discourse, and
(e) Ask questions unrelated to the patient's health.

All these discourse functions are characterised by a range of discourse features that will be illustrated in the following excerpts.

4.3.1 Facilitating the telling of patients' stories

This study found that doctors made use of three continuer markers (CMs) to prompt patients to tell their stories. Following the conversational analysis of Jefferson (1979), Sacks et al. (1974), Jefferson et al. (1977), a CM is part of a sequence in which the doctor's use of the CM represents the first part of the sequence, while the patient's response to it represents the second part. The function of a CM is to invite the patient to participate in the speech, and therefore it has the potential of being accepted or rejected (Jefferson 1979: 80) by the participants in the interaction.

From the data it emerged that very few opportunities (3/261) to elaborate upon the discourse were taken up by patients and that, as a result, the doctor quickly regained the floor in the conversation. There was also one example where the patient simply stated that she had nothing further to say, rejecting outright the opportunity given to her to expand her story. Having noted these few cases of rejection, our attention will now focus on how doctors attempt to get their patients to tell their stories.

This study identified *Ya,* 'yeah'/'O.K', *Mm/Uhm,* 'Mm' and *Mm/Uhm ya* 'Mm yeah/O.K.' as CMs employed by doctors to encourage their patients to elaborate upon and expand their discourse. These CMs appear to have more than one meaning attached to them. In some instances, they can be explained as: 'I understand'and/or 'I'm listening'. In the following example, the patient is talking about the medication that he has been taking. The doctor uses *ya* 'yeah'/ 'O.K' to encourage the patient to tell his story and to show an understanding of the event the patient is describing.

Example 4.46 Consultation No 6 (Doctor: Ana, Patient: Flavio) Tape 36 A

93 P: *El Flu- es la verda- que la última: semana parece que tomé una ve- o sea no me*
94 *acordaba si ¿tenía que tomar lo- de la caja?*
95 D: *El flu- el Fluxo me dice ¿Uste- ?*
96 P: *Sí*
97 D: *Ya*
98 P: *Ya así do- o tre- día- que no no lo- he toma-o*
99 D: *Ya*
100 P: *Pero: Eh: la verda- que durante el tiempo que me lo tomé=*

93 P: The Flu- it's true that last week I seem to have taken it once a day, but I've forgotten
94 whether I had to take those from the package?
95 D: You say you're taking the Flu- the Fluxo?
96 P: Yeah
97 D: Yeah
98 P: Yeah, I haven't been taking it for two or three days
99 D: Yeah
100 P: But : Eh: really during the time I was taking it=

Both the confirmation of the name of the medicine in line 95 and the recounting of the patient's intake of the medicine in line 98 call for the use of *ya* 'yeah'/ 'O.K' (in lines 97 and 99). These may be interpreted as receipt markers which imply: 'I understand what you are telling me', or 'I'm listening to what you are telling me' or as a combination of both. The use of *ya* 'yeah'/ 'O.K' does not appear to affect the patient's contribution to the discourse, in spite of the fact that in both cases *ya* 'yeah'/ 'O.K' (lines 97 and 99) can be socially recognised as a communicative intent (Gumperz 1982b) that is aimed at facilitating the patient's talk.

The number of CMs used during a consultation appears to be dependent on a doctor's wish to have the patient take his/her turn and elaborate on his/her story. This study has found some examples where only one CM was offered, thus restricting severely the patient's potential contribution to the discourse. Conversely, a number of examples were found where the use of three or four CMs allowed patients to recount their story over an extended period of time. This appears to contradict the format of medical consultations that favour a question-answer sequence in the interaction.

The following two examples contrast the number of CMs employed by a doctor in two different episodes of the same conversation. The first example represents a case of recurrent use of CMs. This helps the patient to tell her story and gives the doctor an opportunity to understand what the patient experiences in her episodes of anxiety. In the second example the doctor constrains the patient's participation through a restricted use of CMs.

Example 4.47 Consultation No 1 (Doctor: Ana , Patient: Alicia) Tape 28B

37 D: *Cuénteme en ¿qué situaciones ha presenta-o má- angustia?*
38 P: *En qué situacione-, por ser ahora han disminui-o la- angustia-*
39 D: *Ya:*
40 P: *Pero cuando <X X> una leve angustia fue cuando hubieron viento- o lluvia- muy fuerte*
42 D: *Uhm ya*
43 P: *Eh: resulta que estaba estudiando. Yo estoy estudiando ahora*
44 D: *Ya:*
45 P: *Y: y me dieron sensacione- de salir arrancando de ir pa' mi casa y llegar a mi casa pero así de una pata-a*
47 D: *Ya:*
48 P: *Lo único que quería era correr al lado de mi casa, dentro de mi casa:=*

37 D: Tell me, in which circumstances have you experienced an increase in anxiety?
38 P: In which circumstances, for now (I feel) they've diminished
39 D: Yeah:
40 P: But <X X> (I experienced) a small anxiety attack when it was windy or when it rained heavily
42 D: Mm yeah
43 P: Eh: the fact is that I was studying. I'm studying now
44 D: Yeah:
45 P: And: and I had this feeling to dash out and rush back home in a flash
47 D: Yeah:
48 P: The only thing I wanted to do was to run round my house, inside my house:=

In this extract the doctor uses her *Human Fellow voice* to allow the patient to remember one particular day when she experienced an anxiety attack. *Ya* 'yeah'/ 'O.K' is produced softly, and the elongation of the vowel *a* at the end of the CM *ya* (in lines 39, 44 and 47) gives the impression that the doctor is lending her ear to the patient in an attempt to understand her story.

The second example demonstrates the limited use of the CM and the effect this has on the elaboration of the story.

Example 4.48 Consultation No 1 (Doctor: Ana , Patient: Alicia) Tape 28 B

80 D: *... ¿Cómo anda el ánimo?*
81 P: *El ánimo ha andado bien*
82 D: *Ya*
83 P: *Ha andado bien y: de repente un poquito de angustia, pero superable, o sea lo supero al ratito, es momentáneo, por rato- chico-*
85 D: *¿Y cómo está durmiendo?*

80 D: ... ¿How are your spirits?
81 P: They've been alright
82 D: Yeah/O.K.
83 P: They've been alright. Sometimes (I feel) a bit of anxious, but I can overcome this, or rather, I overcome it for a while, it's temporary, for a short time
85 D: And how have you been sleeping?

In this example the doctor uses the CM *ya* 'yeah/O.K.' in line 82 to give the floor to the patient and allow her to talk about how she is handling her anxiety. In line 85 the development of the patient's discourse is disrupted by the absence of any CM, and consequently the patient's account is cut off while the doctor resumes his *Doctor voice* (see Section 4.1). The doctor shifts of footing from the *Human Fellow voice* to the *Doctor voice* restricts patient's further elaboration on her anxiety episode. From these two examples we can observe that there is a relationship between the number of CMs performed by the doctor and the number of opportunities granted to patients to elaborate on their stories. The more CMs uttered by the doctor, the more potential chances there are for the patient to express his/her story. The use of CMs constitutes an instance where the doctor invites the patient to take the floor. Thus, in practice, CMs should be used frequently in order to enhance the telling of the patient's own reality (see Chapter 5). However, the number of instances where the doctor invites the patient to participate in the discourse can vary greatly in frequency (due to their constraints on time among other factors), and depending on the specific case, the patient's telling of his/her story can be either facilitated or limited at the doctor's discretion.

4.3.2 Cooperating with the patient in the interaction

The *Human Fellow voice* aimed at showing an affiliation to the patient's talk by collaborating and participating in the patient's contribution to the discourse. The collaborative aspect of the *Human Fellow voice* is achieved by the doctor-patient joint production of speech. The ways two speakers perform a single proposition has been investigated by Falk (1980), Lerner (1991) and Schegloff (1984) among others. Joint productions differ from interruptions in that no attempt is made by the doctor to take the floor.

The examples found in this study are consistent with Ferrara's (1992) description of joint productions, which disregards the view that they are to be understood as a 'talk intruding into the talk of another' (Zimmerman and West 1975), or as a sign of violation of the conversational rules of speaking.

> Joint productions... are a second speaker's attempt to contribute to the syntactic and semantic intent of the first speaker. At times joint productions are explicable as efforts to clarify, to ensure completeness or correctness in terms of information and truth value and these semantic wishes are performed with syntactically compatible contributions by a second speaker to the first speakers' utterance. The result is one sentence contributed by two interlocutors (1992: 219).

Ferrara's description of joint production is consistent with Tannen's (1983) and Cordella's (1996) understanding of 'cooperative overlap' by which the building–up of the discourse creates affiliation and camaraderie between participants (Coates 1996, 1998, Schiffrin 1984). In her study Ferrara (1992) enumerates four types of joint productions:

(a) Utterance extension – 'the feasibility that a sentence or sentence analog (see Levinson, 1983, p. 18) can be extended by a second speaker beyond the point at which the first speaker considered it complete necessitates discourse analysis of all utterances in tandem with the subsequent utterance(s) to determine if they are in fact complete at the first possible completion point or receive continuation by another' (1992: 217-218);

(b) Predictable utterance completion – 'speakers project their intended utterances well before their point of completion' (1992: 219);

(c) Helpful utterance completion – 'minimal additions offered by a listener who detects some difficulty on the part of a speaker in accessing an item in the mental lexicon' (1992: 220); and

(d) Invited utterance completion – 'induced by initial speaker's eliciting the sentence completion from the second speaker by means of a word stretch (syllable elongation) followed by a brief pause' (1992: 221).

This study has identified twenty-four examples of joint productions performed by doctors. The majority (16/24) belong to the type of 'utterance extension'. Some examples are given below.

4.3.2.1 Utterance extension

In the following example the patient is talking about her breathing problems and the difficulties she experiences when taking a deep breath. The joint production is performed in lines 107-109.

Example 4.49 Consultation No 14 (Doctor: Carlos, Patient: Paola) Tape 39Ai

101 D: *¿No puede respirar profundo?*
102 P: *No siempre. Ahora sí=*
103 D: *=Ya=*
104 P: *=Pero no constante de repente yo me trato de observar como es mi respiración=*
106 D: *=Ya=*
107 P: *=Y no siempre llego*
108 D: *Hasta el fondo*
109 P: *Entonces pienso ...*

101 D: You can't take a deep breath?

102 P: Not always. Now I can=
103 D: =Yeah=
104 P: = But not always. Sometimes I try to observe what my breathing's like=
106 D: =Yeah=
107 P: = And I don't always reach
108 D: The very end
109 P: So I think ...

One can observe from this extract that both doctor and patient are cooperating to build up a discourse. They do this by contributing one turn each in lines 107-108, complementing the previous utterance with a new one that expands upon it. The collaborative joint production is initiated after the patient's turn in line 107 *y no siempre llego* 'and I don't always reach'. This is followed by the doctor's 'utterance extension' in line 107 *hasta el fondo* 'the very end', which is extended further by the patient in line 109 *entonces pienso* ... 'so I think ...'. From the data one observes that the doctor's use of the 'utterance extension' in line 108 *hasta el fondo* 'the very end' does not affect the patient's account of her story since the doctor's contribution cannot be interpreted as intruding utterances intended to control the discourse. This is illustrated in the following example:

Example 4.50 Consultation No 1 (Doctor: Ana, Patient: Alicia) Tape 28B
45 P: *Y: y me dieron sensacione- de salir arrancando de ir pa' mi casa y llegar a mi casa*
46 *pero así de una pata-a*
47 D: *Ya:*
48 P: *Lo único que quería era correr al lado de mi casa, dentro de mi casa:=*
49 D: *=Como má- protegi-a*
50 P: *Claro*

45 P: And: and I had this feeling to dash out and rush back home
46 in a flash
47 D: Yeah:
48 P: The only thing I wanted to do was to run around my house, inside my house:=
49 D: = To feel more secure
50 P: Of course

The patient shows her feeling of fear in line 48 by saying *lo único que quería era correr al lado de mi casa, dentro de mi casa* 'the only thing I wanted to do was to run around my house, inside my house'. The doctor uses 'utterance extension' in line 49

como má- protegi-a 'to feel more secure'. By using the 'utterance extension' the doctor appears to suggest that the doctor understands how fragile and insecure the patient was feeling at the time. The collaborative contribution highlights the doctor 's affiliation to the patient's feelings. Had the patient disagreed with the doctor's interpretation of her feelings in line 49, then she would have not replied with the agreement form *claro* 'of course' in line 50.

4.3.2.2 Predictable utterance completion

Only four examples of 'predictable utterance completion' appeared in the study. According to Ferrara, 'speakers project their intended utterances well before their point of completion' (Ferrara 1992: 219). This is observed in the following extract (Example 4.51) where the patient explains that stress and the resulting insomnia led to his taking sedatives again: *eso me alteró...entonce- eso do- dia- no dormía ... entonce- tuve que ...* (lines 122-123) 'that stressed me...so then (I couldn't) sleep for two days ... so I had to ....'.

Example 4.51 Consultation No 4 (Doctor: Ana, Patient: David) Tape 36Bi

115 D: *¿Cuénteme Uste- tomaba me dijo que tomaba ante el Alax y el Propasepán Uste-*
116 *había tomado por año- había estado toma[ndo?]*
117 P: *[No] no, lo que pasa es lo siguiente: en este*
118 *año donde yo trabajo se produjo un problema muy grave=*
119 D: *=Ya/*
120 P: *Y dentro de ese problema me repercutió a mi=*
121 D: *=Ya=*
122 P: *=Y eso me alteró, digamo-, el esquema: el sistema nervioso entonce- eso nervioso*
123 *do- día- no dormía en la noche entonce- tuve que[::]*
124 D: *[Volver a tomar]=*
125 P: *=Claro yo no había toma-o: como en 20 año- yo no había toma-o: cosa- de ese tipo:=*

115D: Tell me, you were taking, you told me that you were previously taking Alax and
116 Propasepán. You'd been taking them for a year, you'd been tak[ing it?]
117 P: [No] no, what
118 happened is the following: this year a very serious problem cropped up in work=
119 D: =Yeah/

120 P: And this problem affected me=
121 D: =Yeah=
122 P: =And, let's say, that upset my system, the nervous system, so because of that I
123 couldn't sleep for two nights, so I had [to ::]
124 D: [take it again]=
125 P: =Precisely. I hadn't taken it for some 20 years, I hadn't taken anything like that:=

In line 124 the doctor uses a 'predictable utterance completion '*volver a tomar* 'take it again' as an indication that she has been listening to and following the patient's description of the events that led him to take the medication. The use of the doctor's joint production (line 124) comes at a time when the patient's previous utterance contains an elongated vowel in his last word (*que::*). Use of elongated syllables and vowels have been suggested by Ferrara to indicate 'the mutual influence of the rhythmic patterns of speakers' (Ferrara 1992: 220; see also Scollon 1982; Tannen 1989).

4.3.2.3 Helpful utterance completion

In the data only four examples were found of a joint production that is intended to help the speaker in his/her attempt to construct and complete his/her speech.

Example 4.52 Consultation No 14 (Doctor: Carlos, Patient: Paola) Tape 39Ai
62 P : *=Yo, no soy muy tranquila que digamo- entonces en mi trabajo=*
63 D: *=Ya=*
64 P: *=De repente me altero y yo sentía como que esta- parte- de acá como que estaban*
65 *así como:*
66 D: *¿apretadas?*
67 P: *Sí, como apretada- ...*

62 P: =I, I'm not, what shall we say, a very relaxed person, so in my work =
63 D: =Yeah=
64 P: =Sometimes I get stressed, and I was feeling as if these parts (of my body),
65 as if they were like
66 D: tight?
67 P: Yes, as if (they were) tight ...

The doctor detects that her patient has difficulties in coming up with a lexical item to describe the muscular tightness that comes as a result of her stress. The tentative utterances in line 65 ... *así como:* '... as if they were like:' indicate a temporary difficulty in finding the right word. According to Ferrara (1992), 'upon this signal, listeners often supply a missing vocabulary item but make no further addition' (Ferrara 1992: 221). This is shown in line 66 when the doctor utters the word *¿apretadas?* 'tight?'. In so doing the doctor provides help, but the discourse is not disrupted and the patient continues her story.

4.3.3 Creating empathy with the patient

An analysis of the data shows that two discourse strategies are associated with the attempt to show empathy to the patient. The first strategy includes the use of agreement discourse markers that are used by the doctor in response to patient's contribution. The second feature plays a role in making the patient feel understood in his/her emotional feelings. In the section below these discourse markers are illustrated through examples extracted from the data.

4.3.3.1 Agreement discourse markers

This study has identified a frequent use of *marcadores pragmáticos de apoyos discursivos* (Pons and Samaniego, 1998) 'pragmatic markers to assist the discourse'. Pragmatic markers to assist the discourse are exemplified in Spanish by words like *claro* 'of course'/ 'you're right', which is classified by Pons and Samaniego (1998) as an *apoyador de opinión* 'opinion supporter'. This study has also identified the use of *exacto*, 'precisely' and *sí* 'yes', which are also classified in this study as opinion supporters. It was possible to identify as well the use of some utterances that acted as

markers of agreement to what the patient had been developing and as an affiliation to his/her discourse, but in this case more than one word represented the marker.

The first two of the following examples illustrate the doctor's use of agreement discourse markers.

Example 4.53 Consultation No 3 (Doctor: Ana, Patient: Carmen) Tape 20B

249 D: *Lo terminó (el medicamento), por eso se lo dejaron los ginecólogos para justamente*
250 *evitar este problema, pero Uste- me dice que ya no lo siente tan seguido*
251 P: *No porque no he ido má-. Tenía que ir este me-, me iban a dar una- hormona -no sé*
252 *que diantre=*
253 D: *=Exacto, justamente se usan hormona- para evitar esto- problema-=*
254 P: *=Ya=*

249D: You've finished (the medication), that's why the gynaecologist prescribed it for you,
250 to prevent precisely that problem, but you're telling me that you don't feel it (the
251 discomfort) so often now
252 P: I don't, and that's why I haven't gone again. I had to go this month, they were going
253 to prescribe me some hormones or something like that=
254 D: =Precisely, hormones are used precisely to prevent that problem=
255 P: =Yeah=

The use of *exacto* 'precisely' in line 253/254 marks doctor's approval of the patient's recollection of what the gynaecologist has advised her to do. The use of this agreement discourse marker may also indicate the patient's competence in understanding her hormonal problem (see Section 5.2) and could be interpreted as praise delivered by the doctor in recognition of the patient's familiarity with the topic.

Agreement discourse markers that are used by doctors to show empathy to their patient may also be employed to show an understanding of the idea being developed by the patient. This is shown in the next example.

Example 4.54 Consultation No 3 (Doctor: Ana, Patient: Carmen) Tape 20B

110 P: *Eh: yo ni siquiera me averigué. Tengo en todo caso la hojita que Uste- me dio, pero:*
111 *lo quiero conversar con mi jefe para, para :: no he podido conversar porque pasa en*
112 *[reunione-]*
113 D: *[Claro]*

110 P: Eh: I haven't even made enquires. In any case I have the note you gave me, but I
111 want to discuss it with my boss. I haven't been able to talk to him because he's
112 always in [meetings]
113 D: [Of course]

The use of *claro* 'of course' in line 113 indicates that the doctor understands the difficulty the patient has had in talking to her busy employer about the possibility of leaving work early to attend a psychotherapy group. The doctor's use of *claro* 'of course' also shows an affiliation and alignment to the problem her patient has had in the process of arranging a time to talk to her boss. Agreement discourse markers are interactional features which have context-dependent meaning. This is illustrated in Example 4.55 where the meaning of *claro* 'you're right' differs from Example 4.54.

Example 4.55 Consultation No 3 (Doctor: Ana , Patient: Carmen) Tape 20B

124 P: *Si yo pienso, bueno ahora me he da-o cuenta de que me falta que me siento bastante*
125 *sola y que me falta- amiga- o dónde tener que salir el día sábado o el día domingo*
126 *porque por último que no haga toda- la- cosa- en mi casa, pero po- poder salir un*
127 *rato digamo-*
128 D: *Claro, eso, eso en ese senti-o la va a apoyar la psicoterapia ahora ...*

124 P: Yes, I think, well, I've realised now that I'm missing something, that I'm feeling very
125 lonely and that I don't have a friend or somewhere to go on Saturday or Sunday. I
126 don't mind if I don't do all my housework, but at least to be able to go somewhere for
127 a short time
128 D: You're right, the psychotherapy group will help you in that regard ...

The use of *claro* 'you're right' in line 128 could be interpreted as:

(a) An empathy marker with the meaning of: 'I understand how lonely you feel and I sympathise with your feelings'; and
(b) An empathy and agreement marker with the meaning of: 'You're right in your reflection upon your situation, and I share your view'.

Either of these interpretations of *claro* highlights the main focus of the agreement discourse marker, which is to show empathy to the patient in order to show one's appreciation and understanding of what she has just said. This can also be achieved by using an affiliative utterance instead of a single word, as illustrated in the next example.

Example 4.56 Consultation No 9 (Doctor: Berta, Patient: Javiera) Tape 32B

48 D: *Ya aquí estaba (la presión) en 110 siempre. Vamos a ver como están las presione-*
ahora

49 P: *Venía al sol y eso yo creo que me sube la presión porque se me calienta mucho la*
50 *cabeza porque por Vicuña Mackenna da todo el sol y que <WH quemabaWH>*
51 *increible que tan temprano quemando tan fuerte el sol=*
52 D: *=Sí, sí y uno ya anda má- o meno- desabrigada bueno se supone que estamos en*
53 *primavera pero como fue la lluvia pasada digamo- con trueno- con relámpago-=*

48 D: O.K., your blood pressure was always at 110. We'll check to see how it is now
49 P: I was walking along in the sun and I think my blood pressure goes up because my
50 head gets very hot, because along Vicuña Mackenna you get the full sun <WH it was
51 burning WH> . It's unbelievable that the sun was so strong so early on=
52 D: =Yes, yes and we wear light dresses. Well, we think we're in spring, but the last time
53 it rained we had thunder and lightning=

The utterance initiated by the doctor in line 52 is intended to articulate a closeness to the patient by agreeing with her last utterance *Sí, sí* 'yes' 'yes', and by showing a willingness to develop further the topic of the erratic weather that the city has been experiencing during the spring. Thunder and lightning are unusual weather conditions for the brightest and most colourful season in Santiago. This affiliative utterance may also serve to make the patient feel at ease before her blood pressure is taken, since the patient herself introduces the topic as a concern, believing that the hot weather has a negative impact on her blood pressure. This example reveals that although the doctor aligns to the medical practice (i.e. to check patient's blood pressure), this is carried out after an affilitative discourse marker has been used (lines 52-53). This indicates doctor's understanding of the individual needs of her patient.

4.3.3.2 Emotional reciprocity

Emotional reciprocity is another strategy that denotes affiliation between participants. This is achieved by using discourse features that indicate an emotional reaction towards the patient who is telling his/her story.

Example 4.57 Consultation No 5 (Doctor: Ana, Patient: Esteban) Tape 13B
7 P : *... La verda- que me tardé un poco en venir porque, bueno*
8 *ah: tocó pa' empezar se me: complicó la salu- de mi señora=*
9 *=Ah /ya*
10 P *Y despué- tuve una tía de 82 año- que le dio como trombosi-=*

11 D: *=[Ah:/ya\]*
12 P: *[Justo ese] dia del dieciocho=*
13 D: *=Claro, sí, pero [la tuvieron ahí]*
14 P: *[Así que la tuvimo-] que llevar pa' la casa despué-, estuvo como*
15 *quince día- con nosotro- en la casa*
16 D: *Ya... ¡chu:ta !*

7 P: ... The truth is that I delayed a little in coming because, well, to start with, my wife
8 hasn't been well =
9 =Ah /yeah\
10 P: And then I had my aunt who is 82 with thrombosis =
11 D: =[Ah:/ yeah\]
12 P: [Exactly] on the 18th =
13 D: =Alright, yes, but [they had her there]
14 P: [So afterwards we had to] take her back home, and she stayed with
15 us for some fifteen days.
16 D: Yeah ... Oh gosh[1]!

The use of the colloquial expression ¡*ya chuta*! 'yeah Oh gosh!' indicates the doctor's emotional involvement with the difficulties the patient has experienced as a result of the ill-health of his wife and aunt. The use of a register that indicates everyday life, by including colloquial words in the discourse; e.g. ¡*ya chuta*! 'yeah Oh gosh!', may suggest that the doctor shows affiliation and sympathy towards the person who is sick by temporarily removing the constraints imposed by the strictly medical discourse.

4.3.4 Showing special attentiveness to the development of the discourse

In this study it was found that doctors use three discourse forms to demonstrate their attentiveness to and interest in the patient by allowing and encouraging patients to take their turn in the discourse. This is accomplished by (a) the performance of an utterance that mirrors the patient's last word(s), (b) the clarification of the patient's previous utterance, and (c) asking questions unrelated to the patient's health.

[1] Note that *¡chuta!* does not have a religious connotation, as is the case with the translation.

4.3.4.1 Mirroring

The understanding of mirroring in this study follows Coates since participants respond to each other's speech by 'reciprocal self-disclosure' (1996: 61). Coates points out that sometimes mirroring 'is so carefully done' (1996: 80) that participants start the utterance with the same phrase and use the same discourse forms in the utterance. This was precisely what it is found in this study. Doctors' mirroring the patients' word(s) was the most frequent (31/48) of the two strategies of performing attentiveness. It expresses an instance where doctors openly indicate their attention to their patients' last words by echoing them. The following examples illustrate this point.

Example 4.58 Consultation No 11 (Doctor: Carlos, Patient: Manuel) Tape 21A

32 D: *Mm ya, ya. Vio también el urólogo. Lo encontraron bastante bien.*
33 *Oftalmología y a cirugía ¿no ha ido?*
34 P: *No* <@@>
35 D: *Ya. Le tiene temor*
36 P: *No, lo que pasa es que doctor es que no hay tiempo=*
37 D: *=No hay tiempo=*
38 P: *=Estoy trabajando todavia [y te]ngo*
39 D: *[Y/a]*
40 P: *mucha responsabilidad incluso estoy tan nervio=*
...

133 D: *=¿Y uste- ¿cuándo se da cuenta que está má-, má- las narice- má- tapa-a-?*
134 P: *Hue- en, en la noche=*
135 D: *=En la noche=*
136 P: =Cuando ya uno ya descansa ya=

32 D: Mm yeah, yeah. You saw the urologist as well. They reported that you were
33 quite well. You haven't been to Opthalmology or Surgery?
34 P : No <@@>
35 D: Yeah. Are you frightened?
36 P: No, what happens, doctor, is that there's no time=
37 D: There's no time=
38 P: =I'm still working [and I'] ve
39 D: [Y/eah]

---

40 P: a lot of responsibility, and I'm feeling very tense=
...

133 D: =And when do you realise that your nose is more more, more blocked?
134 P: Well at night=
135 D: =At night=
136 P: =When one's already resting=

The use of mirroring is presented in line 37. The repetition of the phrase *no hay tiempo* 'there isn't time' immediately latches onto the patient's previous utterance (line 36). At the same time the tempo of the conversation is accelerated. However the mirroring turn does not change the development of the patient's discourse, which continues in line 38. Similarly, in line 135 the doctor repeats the patient's last words by again latching onto his previous turn. As in the earlier example, the echoing does not prevent the patient from elaborating upon his discourse. This point is demonstrated once again in the following example, but this time there is no latching.

Example 4.59 Consultation No 21 (Doctor: Daniel, Patient: Yolanda) Tape 29Ai
153 D: *=¿Cuándo vio al doc[tor?]*
154 P: *[Cuando] fui a la consulta, sí*
155 D: *Sí*
156 P: *Hace como quince día-*
157 D: *Quince día-*
158 P: *Mm*
159 D: *¿Y hace cuanto- año- o mese- llevaba tomándolo?*

153 D: =When did you see the doc[tor?]
154 P: [When] did I go to consult him, you mean?
155 D: Yes
156 P: Some fifteen days ago
157 D: Fifteen days
158 P: Mm
159 D: And how many years or months have you been taking it?

The use of mirroring in line 157 reveals the doctor's attentiveness to the discourse and his wish to indicate to the patient that he is listening to her without interruption, even though her only contribution is *Mm* 'Mm'. The opposite is the case in the following example where attentiveness is shown, but not the opportunity for the

patient to contribute to the discourse, thus making the mirroring merely a means of retaking the floor.

Example 4.60 Consultation No 10 (Doctor: Carlos, Patient: Leonel) Tape 44A
41 D: *[¿Y ahí] estaba tomando uno completo?*
42 P: *Uno completo, sí. Y el fraccionado*
43 D: *Fraccionado y ¿ese malestar cuánto tiempo le duró?*

41 D: [And then] you were taking a whole tablet?
42 P: A whole table, yes. And half of it
43 D: Half of it, and how long did the discomfort last?

The use of *fraccionado* 'half of it' in line 43 shows attentiveness to what the patient has just said, but it is not intended to allow the patient to take his turn since the doctor uses a 'QIS one' and takes the floor.

Based on the examples found in the data, it is possible to argue that the mirroring of a word or words by the doctor can be interpreted as reflecting a listening strategy that manifests attentiveness, interest and affiliation towards the patient. Nevertheless, in some instances it can also be taken as an opportunity to regain the floor while showing an affiliative attitude towards the patient (see Example 4.60).

4.3.4.2 Confirming previous utterance

In Example 4.61 the question uttered by the doctor intends to clarify a situation. It differs from questions that are used to search for medical information with a view of assessing the patient's health condition (see Section 4.1).

Example 4.61 Consultation No 12 (Doctor: Carlos, Patient:Nicolás) Tape 52B
95 D: ¿Y la Ranitidina ?
96 P : Esa la tomo en la noche eh : porque en la mañana … o sea no sé que será que me hace
97 evacuar en la mañana
98 D : ¿La Ranitidina ?

95 D: And the Ranitidina ?
96 P : I take it at night time eh : because in the morning … I don't really know
97 (what happens) but during the morning it makes my bowels open
98 D : Ranitidina?

The doctor asks his patient if he is taking a particular medication in line 95, the patient replies that he does not take it in the morning since it causes him discomfort (lines 96-97). The doctor shows alignment to the medical professional goal of getting clear information from patients and reiterates the question in 98. This time the doctor is not intent on assessing the patient' compliance but rather the question shows that the doctor is listening to his patient and wants to clarify that they are both referring to the same medication in their discourse.

4.3.4.3 Asking questions unrelated to the patient's health

In the data there are examples in which doctors' questions did not relate exclusively to their patients' health, but they also embraced the latter's work, life style, family, friends and social activities. In the following example the patient introduces into the conversation the problems she is experiencing at home. Instead of cutting her off, the doctor asks two questions that do not relate directly to her medical condition (she has head and stomach aches, and heart problems) but that are intended to lend a suporting ear and facilitate the patient's recounting of her story.

Example 4.62 Consultation No 21 (Doctor: Daniel, Patient: Yolanda) Tape 29Ai

77 D: *¿Y su marido porque sufre tantos cambio- de ánimo ? Ante- no tenía eso?*
78 P: *No:: es que Pedro tuvo un, un mucho ¿cómo lo llama Uste-? es trom- son no, no*
79 *trombosis esa grande NO, la chica*
80 D: *Ya, [sí]*
81 P: *[Vario] a raíz de eso estuvo hospitaliza-o en el, en la Católica hace tres año-*
82 *((Carraspera)), va a venir a verlo ah porque él mismo me pidió que quería, que*
83 *quería ver médico, entonces le había pedido así al lote no má-, le dije no porqué no*
84 *pides hora con el doctor Ponce [le dije y así]*
85 D: *[¿Y el también] de esto fuera de estos cambio*
86 *de ánimo eh tiene buena expresión está bien orienta-o no se pierde ni na-a?*
87 P: *No no no eso no=*
88 D: *=Ya=*

77 D: And why is your husband suffering so many changes of mood? Did he not have them before?
78 P: No:: the fact is that Pedro had a very - how do you call it? a throm- , not a
79 thrombosis the big one NO, a small one

80 D: Yeah, [yes]
81 P: [A number of them]. For that reason, he was admitted to the Catholic Hospital
82 three years ago. ((Clearing her throat)) He'll be coming to see you because he himself
83 told me that he wanted to make an appointment with a doctor. He asked me for
84 appointment with anyone (here in the centre). I said to him why don' t you make an
appointment with doctor Ponce [I told him and so]
85 D: [And he also] Apart from these mood
86 changes, eh does he look alright, is he well oriented, does he get lost or anything like
that?
87 P: No no no, not that=
88 D: =Yeah=

The doctor's interest and affilitiation to the patient's story are manifested in line 77 *¿y su marido porque sufre tantos cambio- de ánimo?¿ante- no tenía eso?* 'and why is your husband suffering so many changes of mood? did he not have them before' and again in lines 85-86 where the doctor allows time for her patient to talk about her husband's medical condition and his changes of mood ... *fuera de estos cambio de ánimo eh tiene buena expresión está bien orienta-o no se pierde ni na-a?* '... apart from these mood changes eh does he look alright, is he well oriented, does he get lost or anything like that?'. In this extract the doctor has shown affiliation as well as he has gained an understanding of patient's worries. This information could contribute to give a better prognosis to Yolanda by taking into account her daily life with her husband. The frequency of use of the *Human Fellow voice* is presented in the following section.

4.3.5 Frequency of use of *Human Fellow voice*

Doctors made use of discourse forms associated with the *Human Fellow voice* during their history taking and their management of the health problems of their patients. In this process they used continuer markers, joint production forms, agreement forms, confirming forms, and questions that were not strictly related to their patients' health. A total of 21 (out of 22) consultations contained in this study

present examples of *Human Fellow voice.* The discourse functions for 'Creating empathy with the patient' and 'Showing special attentiveness' were used in 16/22 consultations, though they do not always appear in the same consultation. The functions least represented in the study were 'Asking questions unrelated to patients' health' (23 questions) and 'Cooperating with the patient interaction' (25 examples). In this last function, only eight consultations made use of it, and a closer look at the data reveals that the majority involved Dr. Carlos, who was responsible for 17/25 joint production forms (see Table 4.7).

The following Table 4.7 illustrates the frequency of each discourse functions used in the *Human Fellow voice* by each of the four doctors.

Table 4.7 Frequency of discourse functions in the *Human Fellow voice*

Doctors	n	Facilitating the telling of patients' stories		Cooperating with the patient in the interaction		Creating empathy with the patient		Showing special attentiveness to the development of the discourse		Asking questions unrelated to the patient's health		
		No	M	No	M	No	M	No	M	No	M	Total
Dr. Ana	6	94	15.6	4	0.6	31	5.1	14	2.3	4	0.6	147
Dr. Berta	3	13	4.3	0	0	5	1.6	4	1.3	4	1.3	26
Dr. Carlos	6	113	18.8	17	2.8	13	2.1	27	4.5	12	2.0	182
Dr. Daniel	7	41	5.8	4	0.5	6	0.8	3	0.4	3	0.4	57
TOTAL		261	63.4%	25	6.0%	55	13.3%	48	11.7%	23	5.6%	412

Dr. Ana (147) and Dr. Carlos (182) most frequently used the discourse functions identified in the *Human Fellow voice* in contrast with their other two colleagues (Dr. Daniel 57 and Dr. Berta 26). This difference is not altered after taking into account the number of consultations (n). 'Facilitating patients to recount their story' was the function most favoured by the four doctors with a relative frequency of 63.4%. The second most widely used function was 'Creating empathy with the patient' with a relative frequency of 13.3%. Overall the two female doctors used this function more frequently than their male counterparts (Dr. Ana 5.1 and Dr. Berta 1.6,

as opposed to Dr. Carlos 2.1 and Dr. Daniel 0.8). The remaining functions were used much less frequently: 'Showing special attentiveness' with a relative frequency of 11.7%, followed by 'Cooperating with the patient in the interaction' with 6.0% and 'QIS not related to patients' health' with 5.6%.

Table 4.8 presents the frequency by which the continuer markers appeared in this study.

Table 4.8 Frequency of facilitating the patients to tell their stories

Continuer markers	Frequency	% Total
Ya	212	81.2
Mm/Uhm	22	8.4
Mm/Uhm ya	27	10.4
TOTAL	261	100

Ya 'yeah/O.K.' is the continuer marker most frequently encountered in the study, with a frequency of 81.2%. Both *Mm/Uhm* 'Mm' and *Mm/Uhm ya* 'Mm yeah' are used to a much more limited extent. Nevertheless, all three achieve the same purpose of making the patients elaborate their own discourse in the consultation.

Table 4.9 below indicates the frequency of usage of joint productions in the discourse. Doctors' use of joint production appears to show affiliation to patients' discourse by contributing in their speech.

Table 4.9 Frequency of cooperating with the patient in the interaction

Joint Production	Frequency	% Total
Utterance Extension	17	68
Predictable Utterance Completion	4	16
Helpful Utterance Completion	4	16
Invited Utterance Completion	0	0
TOTAL	25	100

Only three of the four joint productions studied by Ferrara (1992) appear in this study, and only one of these was frequently used. 'Utterance extension' was the preferred strategy to show that both doctor and patient were cooperating in the consultation by contributing to each other's talk and producing a collaborative discourse.

Table 4.10 below, indicates the frequency of use of agreeing forms by doctors in their talk.

Table 4.10 Frequency of creating empathy with the patient

Agreeing Forms	Frequency	% Total
Exacto	17	30.9
Sí	10	18.2
Claro	19	34.5
Agreeing Utterances	5	9.1
Emotional Reciprocity	4	7.3
TOTAL	55	100

In the study agreement forms and utterances were used as a mean of expressing support for and approval of what the patient had been recounting. *Claro* 'of course'/you're right (34.5%) and *exacto* 'precisely' (30.9%) were the most commonly employed agreement forms, followed by *sí* 'yes' (18.2%), agreement utterances (9.1%) and emotional reciprocity discourse markers (7.3%).

Table 4.11 illustrates the attentiveness forms found in the data and the frequency they were used.

Table 4.11 Frequency of showing special attentiveness to the development of the patient's discourse

Attentiveness Forms	Frequency	% Total
Clarifying last utterance	17	35.4
Mirroring	31	64.6
TOTAL	48	100

Of the two, 'mirroring' was the attentiveness form most widely used by doctors to encourage patients to develop their story. The frequency is 64.6% in contrast to 35.4% for 'confirming last utterance'.

The use of questions not strictly related to a patient's health is another strategy found in the *Human Fellow voice.* Its frequency can be compared with the total number of questions that emerged in the *Doctor voice* (see Table 4.1).

Table 4.12 Frequency of asking questions unrelated to the patient's health and doctor's search of medical information

Questions	Frequency	% Total
QIS not related to a patient's health	23	6.02
QIS searching medical information	359	93.98
TOTAL	382	100

Only 6.02% of all the questions uttered are unrelated to the patient's health. The vast majority of questions focus directly on the information that is required to understand more fully and diagnose correctly the condition of the patient.

4.3.6 Summary

The *Human Fellow voice* reveals the fundamental aspect of making the consultation more centred on the patient by showing affiliation to the patient. This is achieved by the use of five discourse functions that aim at facilitating patients telling of their story; cooperating with the patient in the interaction; creating empathy with the patient; showing special attentiveness to the development of the discourse; and asking questions unrelated to the patient's health. Doctors show a preference for using CMs (continuer markers) in their discourse to allow the telling of patients' stories. During the development of patients' stories doctors use special attentiveness strategies such as 'mirroring' to echo patients' previous utterances. Doctors also used

joint production features such as 'utterance extension' as a mean of collaborating with the discourse being developed by the patient and questions unrelated to patient's health. All of these strategies help patients to feel that they are listened to, understood and cared for not just as sick persons, but also as women or men who stand in front of the doctor as a human being, a person who just happens to be experiencing a (hopefully) temporary state of ill being.

Figure 4.3 illustrates the discourse functions and strategies found in the discourse of *Human Fellow voice.*

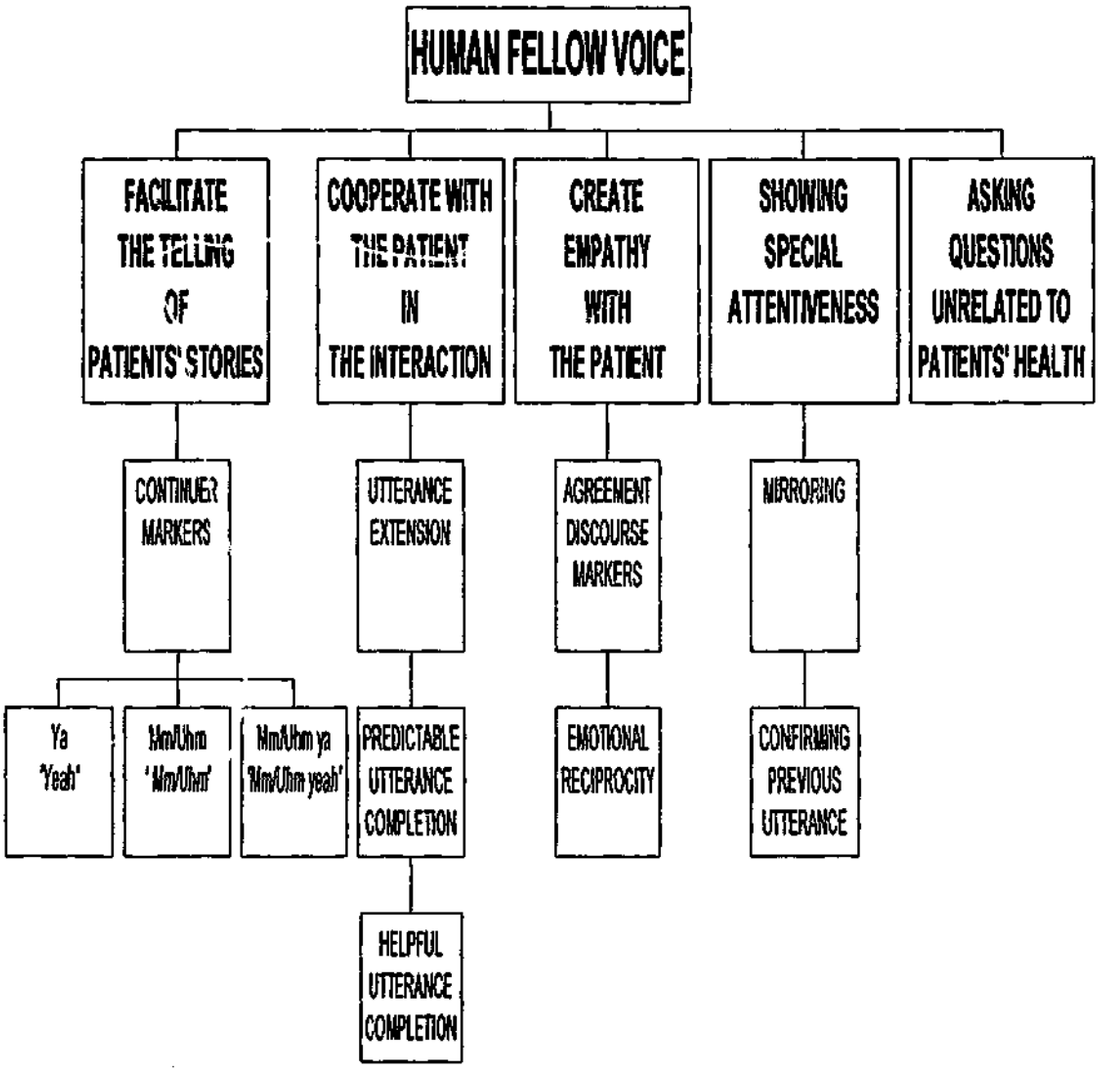
4.3.7 Conclusion

This chapter has found through the deconstruction of the medical discourse that doctors perform three distinctive *voices* during the medical consultations. Each *voice* presents particular characteristics in terms of both the function they accomplish in the discourse as well as the type of discourse strategies used to achieve their aims. Doctors' performance of these *voices* show an alignment to the medical script learnt during their training as health professionals (*Doctor* and *Educator voices*). In addition their discourse reveals doctors' adherence to their socio-cultural group where either social class and/or ideology may differentiate between both participants in the speech. Thus, through the medical discourse doctors' personal ideas and opinions may permeate the consultation.

Results also show that the consultation allows the expression of a *voice* that permits patients' elaboration of their stories (*Human Fellow voice*). This facilitates the patient to be 'heard' in the medical discourse and participate in the event. So far, the attention has been on the performance of doctors' *voices*, nevertheless the development of the talk is not independent of the participation that the patients

develop during the consultation. In order to account for patients' participation in the consultation I present in Chapter 5 the performance of *Patients' voices* by deconstructing their contribution in the consultation and by discovering how they interact with the *voices* of doctors.

Figure 4.6 Discourse functions and strategies of *Human Fellow voice*



CHAPTER 5

PATIENTS' VOICES

5.0 Introduction

Having discussed in Chapter 4 how doctors participate in the medical exchange, and how their *voices* recreate the medical institution and the social-cultural group they represent, in this chapter the focus turns to the patients by observing what they 'do' in the consultation and how the image they have of themselves is portrayed by their *voices*, which, in turn, interact with the *voices* used by doctors. In what follows I shall present the performance of patients' *voices*.

Patients use different *voices* when interacting with their doctors in the consultation. The production of those *voices* allows the patients to be 'heard' in the interaction by introducing their own stories in the discourse, by initiating questions to better comprehend their own health condition and by showing competence in their understanding of their health status. It would appear that patients' development of their own stories should be interpreted as an activity where both participants, doctor and patient, play important roles in the progress of the story. While doctors give patients the opportunity to take the floor and facilitate the enhancement of their talk (*Human Fellow voice*), patients also take opportunities to talk about themselves by engaging in discourses about their health, by projecting themselves as knowledgeable patients in relation to their own health condition and by presenting themselves as ordinary people with family and work related responsibilities.

Although patients are not trained to be 'patients', and although the experience they gain in medical settings over the years may differ from person to person, it is of interest to note that in this study there are some commonalities among patients in

terms of how they portray themselves as patients in the consultation and the kind of stories they bring to the consultation and share with their doctors.

The following categories of *voices* have emerged from the data of patients' talk:

(a) The *voice* of *Health-related storytelling.*
(b) The *voice* of *Competence.*
(c) The *voice* of *Social Communicator,* and
(d) The *voice* of *Initiator.*

With one exception, every consultation recorded in this study included examples of at least two of the above *voices* in the communicative routines of 'history taking' and 'management and treatment of a health problem or health issue'. This suggests that patients display a rich and versatile set of *voices* during the consultation, and that they do not restrict their speech to the strictly medical discourse of producing *Health-related storytelling* (Section 5.1). Patients contribute to the medical discourse by exploring topics that lie outside the medical institutional talk: everyday talk is accepted and elaborated throughout the exchange.

Before giving a description and analysis of the four *voices* identified above, it is important to emphasise the interactional work that is required in order to achieve the elaboration of a story. Patients have to feel the need to share a part of their lives with their doctors. In other words, there must be something worthwhile telling (Labov and Fanshel 1977), or, as Davis (1988) puts it, something unusual that calls for an evaluative point to be made. In addition, as some of the data shows, the patient may simply perform a story as a way of projecting a particular image in the interaction by 'authoring' (Goffman 1981) a particular discourse. If a patient's willingness to contribute to the speech dissipates at a particular moment in the consultation, the development of the story may not occur. Similarly, if the patient shows no interest in

developing a story, despite the opportunities to do so, the story will never occur. This is the case in the following extract, where the doctor gives the patient an opportunity to talk about the difficulty she has in following her prescribed low-calorie diet, but the patient does not take advantage of the offer.

Example 5.1 Consultation No 19 (Doctor: Daniel, Patient: Wilma) Tape 35B

17 D: *¿Cómo le ha ido con el peso?*
18 P: <@@> *no me ha ido*=
19 D: =*¿Bajó de peso?*
20 P: *Sí, parece*
21 D: *Sí, bajó <X 66 X>*=
22 P: =*Do- no má-*=
23 D: =*Poquito pero bajó. Cuénteme y y y eh ¿está tratando de hacer régimen? ¿cómo*
24 *lo ha hecho? eh ¿qué tanto le ha costado?*
25 P: *Eh eh uhm*
26 D: *Ya*
27 P: *Na- má- po'*
28 D: *¿Anda con ansieda- de comer?*

17 D: How's your weight loss been going?
18 P: <@@> it's not going=
19 D: =Have you lost weight?
20 P: Yes, I think so
21 D: Yes, you've lost <X 66 X>=
22 P: =Only two (kilos)=
23 D: It's a little, but you've lost (some weight). Tell me, and and and you're trying to
24 keep on the diet? How have you been doing it? How difficult has it been?
25 P: Eh eh uhm
26 D: O.K.
27 P: That's all
28 D: Do you have any anxiety for eating?

The initiation of this extract is marked by the doctor's use of a 'QIS one' (*Doctor voice*, Section 4.1) in line 17*¿cómo le ha ido con el peso?* 'how's your weight loss been going?' This question intends to seek information about the patient's weight loss. The patient's reply: <@@> *no me ha ido* '<@@> it's not going' (line 18) represents a mirroring of the doctor's question in the negative form by the inclusion of *no* 'no'. The laugh at the beginning of the utterance can be interpreted as a sign of feeling uneasy with the topic. When the patient says that (the diet) 'is not going' (presumably anywhere), she appears to believe that the diet is not working, and the doctor expects her to take this up in her conversation, as indicated in the doctor's

request to have the patient recount her difficulties in keeping on the diet. The doctor then tries again, using a 'QIS' one in line 19: *¿bajó de peso?* 'have you lost weight?'. The patient answers: *sí, parece* 'yes, I think so', but she does not go on to elaborate this point, thus prompting the doctor to express an interest in the patient's prescribed diet by producing three questions in sequence ('QIS chain', Section 4.1.1) that are oriented toward the patient, *¿cuénteme ... está tratando de hacer régimen?* 'tell me ... you are trying to kep on diet?', *¿cómo lo ha hecho? Eh ¿qué tanto le ha costado?* 'how have you been doing it? Eh, how difficult has it been?'. Despite the fact that the doctor invites the patient to recount her story, she rejects the offer and cuts off any further attempt to develop the topic. This is achieved in line 27, where the discourse marker *po'* is uttered at the end of the utterance: *na- má- po'* 'that's all', to show a decisiveness (Pons and Samaniego 1998) about her action. This suggests that storytelling is only possible when both patient and doctor cooperate in the elaboration of the discourse. Thus storytelling is a result of a collaborative effort in which both participants either enable or constrain the development of stories. The interplay between enabling and constraining is clearly seen throughout the discourse used in the medical consultation. On the one hand there is a need to enable the patient's contribution, this is done by facilitating patients' development of their own stories. On the other, there are constraints both in the medical system and in the context of the consultation that affect the number of turns the patients are allocated in order to unfold their stories. In other words, the patient will not be permitted to speak forever, but only as long as the doctor allows this to happen and as long as the patient wants to contribute to the discourse.

Similarly, the way in which doctors accept and welcome the storytelling of their patients constitutes another example of the interactive work that is necessary if

the story is to have any chance of being develo ped. In this process patients understand whether their stories will be taken as a valid contribution to the discourse by assessing the doctor's contribution in the exchange. This will alert patients as to whether the story can be elaborated further or if it should come to an end. The following example shows how the doctor respects the patient's story by taking a genuine and understanding approach towards the patient's own evaluation of the effect Spring has on her health.

Example 5.2 Consultation No 21 (Doctor: Daniel, Patient: Yolanda) Tape 29Ai

24 D: *¿Su ánimo?*
25 P: *Eh: mi ánimo ya está subiendo un poco, sí, es que sabe, doctor, a mí me afecta todo*
26 *esto, me afecta mucho la ::=*
27 D: *=Ya=*
28 P: *=Siempre me afectó la primavera y este año como tuvimo- primavera invierno,*
29 *primavera invierno, como que se me pegó un poco. NO pero ahora sí estoy ya*
30 *saliendo, ya no estoy haciendo sie:sta*
31 D: *Pero le afecta la primavera. ¿Cuándo llega la primavera le baja el ánimo?*
32 P: *Sí <@@ > ¡qué tontera! ¿no? <@@ >*
33 D: *No [no tiene na-a de tontera]*
34 P: *[Me parece que] no e- normal eh: no sé, y desde joven ah, se me había- pasa-o*
35 D: *Ya*
36 P: *Pero::*
37 D: *¿Y cómo ha esta-o de la- jaqueca-?*

24 D: Your spirits?
25 P: Eh: my spirits are getting a little better; yes, you know, doctor, all that affects me, it
26 affects me a lot=
27 D: =Yeah=
28 P: =Spring has always affected me, and this year, because we had spring winter, spring
29 winter, my problem persisted a little. NO, but now I'm coming out of it, I'm not
30 having my (usual) nap
31 D: But spring affects you. When spring arrives, your spirits fall?
32 P: Yes <@@ > how silly of me! Don't you think? <@@ >
33 D: No [no, it's not silly at all]
34 P: [It seems to me that] it's not normal eh. I don't know, and I've been like that
35 since I was young
36 D: Yeah
37 P: But::
38 D: Have you been with your migraines?

In line 33 the utterance *No no tiene na-a de tontera* 'no no it is not silly at all' not only marks the respect shown towards the patient's evaluation in that particular instance, but sets a platform of affiliative understanding that expands the boundaries of that utterance, thus giving the chance to the patient to talk freely about her

concerns. Had the doctor laughed in line 33 along with her patient, the explanation might have diverged from respect and affiliation, and become an instance of apparent fault friendship that would underline the futility of the patient recounting her feelings when all it did was to arouse a laugh (Davis 1988). Presumably this would have had a negative effect on any desire the patient might have had to elaborate the discourse.

5.1 The *voice* of *Health-related storytelling*

The first type of story found in the analysis develops around the medical condition of the patient. The analysis found 61 examples in 17 consultations. Patients develop their *Health-related storytelling* by:

(a) Describing their feelings (e.g. *me siento depre*, 'I feel depressed' *me siento bajoneá*, 'I feel down').
(b) Describing their discomfort or pain (e.g. *dolor de espalda* 'back pain', *dolor de cabeza* 'headache').
(c) Expressing their concern about their health condition and treatment management (e.g. *temor a la operación* 'concern about having an operation').
(d) Sharing their difficulties in following medical recommendations (e.g. *dejar de fumar* 'quit smoking').

Patients usually initiate *Health-related storytelling* after the doctor has uttered any type of QIS (see Section 4.1) aiming at eliciting information from the patient. The development of the story is made possible by the use of CMs (continuer markers) (see Section 4.3.1) employed by doctors and by patients when they are interested in developing their story.

Health-related storytelling is generally employed in combination with one or more of the other three voices in the discourse. This was the case for all the consultations except in one case in which the patient did not explore any of the other voices, but restricted himself to *Health-related storyteller*. The main characteristic of

Health-related storytelling is that it expresses a past experience that is conveyed by the use of more than one utterance. In terms of structural devices *Health-related storytelling* is identified by the time orientation of the event being described (past tense) and the comparison between patients' past state of being with the present one (i.e. adverb of time such as *antes* 'before' and *ahora* 'now' are commonly employed). *Health-related storytelling* sometimes also presents words such as *mire* 'look', *imagínese* 'imagine yourself' *¿sabe?* 'do you know? at the beginning or in the middle of an utterance. These aim at calling recipients' attention and alert them to the discourse that will be developed. Following Labov and Fanshel (1977) these discourse markers may be playing the role of indicating that the story the patient is about to tell or in the process of telling, is worthwhile to be reported. 'A central fact about all of these affective propositions is that they revolve about the social concept of 'reportability'' (Labov and Fanshel 1977: 105).

Health-related storytellers establish themselves as people who need help and ask for it from an expert in the field. This search for help in a health-related matter is what makes the medical consultation (or any health-care consultation) one that can be recognised as different from many other interactions. As Davis (1988) has suggested, in a service encounter, 'the issue of needing help is a potentially problematic affair'. This not only highlights the asymmetrical status/knowledge position that exists between participants in the speech, but it also acknowledges the risk of 'losing face' (Brown and Levinson 1987; Goffman 1967) by potentially projecting an image of a lack of adult competence, a failure in the ability to care and manage oneself (Labov and Fanshel 1977: 32).

In the following extract the patient talks about his constant fear of carrying out even the most ordinary daily routines, such as going to the backyard or taking the rubbish out (line 169).

Example 5.3 Consultation No 12 (Doctor: Carlos, Patient: Nicolás) Tape 52B

169 P: *... me empiezo a agitar ya cuando voy al fondo del patio a hacer alguna cosa sacar la basura*
170 D: *Ya*
...

179 P: *Es que yo tuve un problema ha: mucho- año-. Yo le temo, no me subo a un: o*
180 *sea ascensor, no lo soporto*
181 D: *¿Por qué? ¿Por qué es muy est[recho ?]*
182 P: *[Claro]*
183 D: *¿O no le gusta como apretado con otra persona?*
184 P: *Claro,no, no, no. Me da miedo=*
185 D: *=Uhm ya y Cuándo [va a un lugar]*
186 P: *[Ahora a Antofagasta] eh: me ofrecieron un viaje que*
187 *fuera en avión, pero le tengo terror=*
188 D: *=Uhm ya=*
189 P: *=Yo no sé porqué son esta- cosa-, pero de [repente]*
190 D: *[¿Ha tenido] alguna experiencia*
191 *desagradable en ascensor o en espacio reducido?*
192 P: *Eh: he tenido en ascensor tuve y también en el 73 que no- encerraron en la*
193 *empresa*
194 D: *Ya*
195 P: *Y de ahí noté que despué- de ya me vinieron=*
196 D: *=El encierro*
197 P: *Encierrro y la presión del momento que se estaba vivie:ndo. Eso me*
198 *chocó mucho*
199 D: *Cuénteme, y la ¿sensación de angustia [sen]sación ?*
200 P: *[Sí]*

169 P: ... I begin to get agitated even when I go to the back of my yard to take the rubbish out
170 D: Yeah
...

179 P: The fact is I've had a problem many years (ago). I'm scared. I don't take a lift, I
180 can't bear it
181 D: Why? Is it because it's very na[rrow]
182 P: [Precisely]
183 D: Or you don't like being hemmed in with other people?
184 P: Precisely, no, no, no. I'm afraid=
185 D: =Uhm yeah and when [you go somewhere]
186 P: [Now I'm going to Antofagasta] eh: I was
187 offered a plane ticket, but I'm petrified=
188 D: =Mm yeah=
189 P: =I don't know why this happens, but [suddenly]
190 D: [Have you ever had] an unpleasant experience
191 in a lift or in a confined space?
192 P: Eh: I've had one in a lift, and also in 73 when we were locked inside
193 the company

194 D: Yeah
195 P: And since then I've noticed this feeling of=
196 D: =enclosure
197 P: Enclosure and the pressure that people were experiencing at the time. That shocked
198 me greatly
199 D: Tell me, are you still feeling anxious [fee]ling?
200 P : [Yes]

Even if the patient expresses his feelings in line 169 *me empiezo a agitar* 'I get agitated', the patient's description does not provide an account of his understanding of the cause of his fear, or at least such an account is not spontaneously given but it requires intensive interactional work on the part of the doctor.

The patient commences his turn in line 179 with *es que* 'the fact is', a discourse marker that indicates an explanation is about to be given of his fear. But this is not the case. In the first part of the transcript (lines 179-187) his fear appears to be associated with a feeling of claustrophobia *yo le temo. No me subo a un: o sea ascensor no lo soporto* 'I 'm scared. I don't take a lift I can't bear it' (lines 179-180), and, *me ofrecieron un viaje que fuera en avión, pero le tengo terror* 'I was offered a plane ticket (to Antofagasta), but I'm petrified' (lines 186-187). Both of those utterances reveal a great fear of confined spaces. Nevertheless, up to this point not even the patient seems to be able to explain this disturbing feeling *yo no sé porqué son esta- cosa-* 'I don't know why this happens'. He feels powerless in the presence of this experience that causes him so much distress and anxiety. To quote Davis (1988), this example outlines a two-dimensional point 'evaluating the trouble as terrible and establishing the trouble teller's need of help' (Davis 1988: 253). The acuteness of the patient's feelings is shown in his selection of lexicon items that intensify the experience by presenting it as a terrifying one: *le temo* 'I'm scared' (line 179), *me da miedo* 'I'm afraid' (line 184) and even *le tengo terror* 'I'm petrified' (line 187). It is this cry for help that the doctor explores further; he makes use of 'QIS multiple

choice' to seek the information required to understand the patient's feelings *¿ha tenido alguna experiencia desagradable en ascensor o en espacio reducido?* 'have you ever had an unpleasant experience in a lift or in a confined space?'. The doctor's question appears to display affiliation (Jefferson 1984) towards the trouble-talk the patient is referring to. This is so since, it is at this point that the patient shares with the doctor his traumatic experience of 1973[1] when he and his colleagues were locked inside the building where they were working at the time. The doctor uses the continuer marker *ya* 'yeah' to allow further elaboration, but no emotional reciprocity is shown after the patient's contribution. This perhaps may indicate their non-reciprocal political allegiance. Had the doctor shared the patient's views in regards to those particular difficult moments for the Chilean population then, it might have been opportune to make a comment that would align the doctor to the patient's description of the event. Instead the doctor utters a 'QIS one' (line 199) aligning himself to the medical institution. For the patient the experience he went through in 1973 is still causing him a disturbing and enduring feeling of enclosure and claustrophobia.

To sum up, *Health-related storytellers* present themselves as individuals in search of medical advice and help. The more powerless the patient is projected (Example 5.3, line 189) in the consultation the greater the chances are that the asymmetrical relationship (lines 190-191, the key question that unveils the patient's problem) between the participants accentuates a clear differentiation of roles in the conversation. This is marked by a clear opposition of role performances. On the one hand, it is the patient who is unhealthy, powerless and not knowledgeable in the

[1] On 11 September 1973 the military overthrew the democratically elected government of Salvador Allende and assumed power.

medical field, and, on the other, it is the doctor who is (presumably) healthy, powerful and knowledgeable in that area.

5.2 The *voice* of *Competence*

Researchers working in the area of medical discourse have used terms like competent, knowledgeable and probing (Fisher 1991; Royster 1990) to describe patients who show knowledge and understanding of their health condition. In a recent study, Barton (2000) notes that competent patients are those who align themselves to medical recommendations by following the medical advice and showing expertise in the medical system, such as knowing the medical procedures involved in the treatment of a particular medical ailment. In this section I shall analyse the *voice* of *Competence* by describing and analysing how patients project themselves during the consultation. Two kinds of examples emerged from the data. First, there are patients who present themselves as *Apologisers* by acknowledging their responsibility for an act that has not been accomplished on time. Second, patients who comply with medical recommendations will be known as *Compliers*. They achieve this by:

(a) Showing that they have followed, step by step, the prescribed recommendation.
(b) Showing an understanding of and responsibility towards their test results, and
(c) Challenging the doctor in his role of health professional.

5.2.1 The *voice* of *Competence:* The performance of the *Apologiser*

The *Apologisers* project themselves as individuals who have failed to comply with medical recommendations. The patients' face (Brown and Levinson 1987) is at issue here since the lack of compliance manifests a breach of their adult competence in managing their responsibilities (Labov and Fanshel 1977). Therefore some

'remedial work' (Goffman 1971) is required to save their face. 'Remedial work' has the function of changing 'the meaning that otherwise might be given to an act, transforming what could be seen as offensive into what can be seen as acceptable' (Goffman 1971: 109). In this study the potentially offensive act is the lack of compliance on the part of the patient. Therefore, patients may choose to apologise in order to regain their position as adult and responsible individuals who align themselves with the medical institution, although in the process of apologising the patients, temporarily, 'lose face' (Brown and Levinson 1987, Goffman 1967). The following extract illustrates this point.

Example 5.4 Consultation No 20 (Doctor: Daniel, Patient: Ximena) Tape 11B

23 P: *Ya, ... me dio un remedio que tenía que haberlo toma-o, haberlo toma-o la caja que*
24 *Uste- me dio y despué- compré otra en el sup- no, no tomé como debería haberlo*
25 *hecho. Le voy a ser bien honesta ... fui a mi médico al que me ve en Osorno que que*
26 *cuando yo tengo algo yo lo voy a ver a él*
27 D: *Ya*
28 P: *Y él despué- él me dio una receta para que lo compre y la compré*
29 D: *¿La misma?*
30 P: *La misma la misma [la misma]*
31 D: *[Ya]*

23 P: O.K. ... You prescribed a medication that I should have taken. I should have taken
24 the packet you gave me, and then I bought another one in the sup- No, I didn't take it
25 as I should have done. I'll be very honest with you ... I went to the doctor who sees
26 me in Osorno. I go to him when I 've got something wrong with me
27 D: Yeah
28 P: And, afterwards he gave me a prescription to buy, and I bought it
29 D: The same one?
30 P: The same, the same [the same]
31 D: [Yeah]

The patient starts by indicating that she has failed to take the medication prescribed to her (presumably on her last visit). Her apology is expressed as an 'indirect apology' (Cordella 1990, 1991), aimed at acknowledging responsibility for an unaccomplished act, while the verb that expresses the apology is not explicitly uttered. This is shown in line 23 *me dio un remedio que tenía que haberlo toma-o* 'you prescribed a medication that I should have taken'. Cordella (1990, 1991, 1992) has classified Chilean apologies into direct and indirect apologies. The first category is expressed by

the explicit use of a verb that expresses an apology such as *lo siento, discúlpeme* I'm sorry, I apologise. Whereas in the second category the verb that manifests the apology can be absent, the apology taking a different form such as acknowledging responsibility and giving an explanation, for example: *no pude tomarme el remedio porque no lo pude comprar* 'I couldn't take the medicine because I couldn't buy it'.

In the excerpt above it is possible to observe how the patient's apology is supported later in the discourse when she says that she will be honest and recount what really happened *no tomé como debería haberlo hecho. Le voy a ser bien honesta.* 'I didn't take it as I should have done in lines 24-25. I'll be very honest with you.' There was no need for the patient to say that she had not taken the medication nor that she was going to be completely honest, but in so doing she aligns herself to the medical institution by acknowledging that hidden information should not be part of the patient-doctor interaction. Also, the fact that she says: *como debería haberlo hecho* 'as I should have done' indicates that she has failed to do what was expected of her. One learns at the end of the extract (line 28) that the patient is currently taking the medication that had been prescribed to her after she had received a new prescription from her doctor in Osorno, where she lives. Thus, the patient shows understanding of the expectations placed upon patients in the medical institution in complying with the prescribed treatment.

5.2.2 The *voice* of *Competence:* The performance of the *Complier*

The *Compliers* are individuals who align themselves to the medical institution by following the recommendations given to them. The linguistic devices used in their discourse project the patients as aligned to the medical recommendation and responsible towards their health. They are doing what has been asked of them.

Example 5.5 Consultation No 9 (Doctor: Berta, Patient: Javiera) Tape 32B

26 P: *=(Tomo la medicina) media hora antes de la comi-a tal como Uste- me dijo*
27 D: *Ya perfecto y ¿qué toma para la <X X> de azúcar?*
28 P: *Eh Nutrasuit*
29 D: *Ah ya*
30 P: *Y hago el régimen TAL CUAL me lo indicaron en el hospital*
31 D: *Uhm ya*
32 P: *En ese sentido no quiero que nada me tiente. Ya no voy a dejar...*

26 P: =(I take the medicine) half an hour before eating, as you told me to
27 D: Right, perfect. And what are you taking as a sub <X X> for sugar?
28 P: Eh Nutrasuit
29 D: Ah yeah
30 P: And I'm following the diet PRECISELY as it was given to me in the hospital
31 D: Uhm yeah
32 P: In that regard I don't want anything tempting. I won't give up ...

The alignment to the doctor who prescribed the treatment is shown in the first line of the extract, where the patient tells the doctor that she has been taking the medication as directed by him *tal como Uste- me dijo* 'as you told me to' (line 26). This utterance makes an explicit reference to the voice of the doctor that makes recommendations on the medical treatment to be undertaken (Section 4.2.2). The patient also shows a similar alignment to the hospital where she had been admitted in the past *hago el régimen TAL CUAL me lo indicaron en el hospital* 'I'm following the diet 'PRECISELY' as it was given to me in the hospital' in line 30. This time the emphasis on *TAL CUAL* 'PRECISELY' is expressed in the selection of the lexicon items with accompanying loudness that intensifies and dramatises patients' compliance (Davis 1988). In this way the patient is attempting to portray an image of responsibility and adult competence in the management of her health problem by following the directions of the institutional authority. This image is reinforced in the last line *no quiero que nada me tiente. Ya no voy a dejar* ... 'I don't want anything tempting. I won't give up' in line 32. The main characteristic to emerge from this example is that the *Complier* shows a total acceptance of the medical recommendation, which, in turn, makes her feel in control, because she is looking

after her health as she has been educated to (Sections 4.2.1 and 4.2.2). It is the patient's acquired medical knowledge that makes the person a competent patient, and it is this knowledge that has the potential to cause conflict with the established expertise of the doctors. In this case the medical knowledge that emerges from both participants in the discourse may clash, resulting in a power struggle that may require a 'delicate surgical' negotiation in order to maintain harmony in the conversation. The following extract shows the effect of a competent patient upon a medical discourse by describing how the patient challenges the prescribed treatment.

Example 5.6 Consultation No 22 (Doctor: Daniel, Patient: Zenobia) Tape 19 A

8 D: *¿Como le ha [ido?].*
9 P: *[Estuvimos] en régimen de tre- mese-, má- o meno-*
10 D: *Mm ya*
11 P: *Para ver si esto (colesterol) bajaba y ha baja-o bien poco a pesar de que*
12 *yo hice una dieta bastante rigurosa=*
13 D: *=Ya=*
14 P: *=No comí huevo-, no comí mantequilla, ehm: carne- chan-, cerdo ehm: fritura-.*
15 *Sólo verdura y fruta*
16 D: *¿Cuánto tenia(colesterol) ante-?*
17 P: *Eh: do- noventa*
18 D: *Ya bajó a dos cincuenta=*
19 P: *=Treinta gramos. Treinta, treinta, o cuarenta.¡NAda!.*
20 D: *¿Cuándo se hizo Uste- el examen?=*
21 P: *=Ahora la semana pasada*
22 D: *No, ¿el anterior a éste?*
23 P: *En el mes de junio. Junio me parece que fue y de ahí en eso estamo-. Me dieron un*
24 *régi[men]*
25 D: *[Do] noventa <WH ((lee los resultados de los examenes))WH>*
26 P: *¿Se fija? Sí, fue muy poco:=*
27 D: *=Sí, vamo- a tener que agregarle un medi[camento]*

8 D: How have you [been ?].
9 P: [We've] been on a diet for around three months
10 D: Mm yeah
11 P: To see if this (the cholesterol) would go down, and it's gone down very little despite
12 the fact that I've followed the diet quite rigorously=
13 D: =Yeah=
14 P: =I haven't had eggs, I haven't had butter, ehm: meats por-, pork ehm:, fried food
15 I've only eaten vegetables and fruit
16 D: What was your (cholesterol) level before?
17 P: Eh: two ninety.
18 D: It's gone down to two fifty=
19 P: =Thirty grams. Thirty, thirty, or forty. NOthing!.
20 D: When did you have your last test?=
21 P: =Recently, last week
22 D: No, the week before?

23 P: In June. June I think it was, and since then it hasn't gone down. They put me on a
24 [diet]
25 D: [Two] ninety <WH ((the doctor reads the test results)) WH>
26 P: Can you see? It was very little:=
27 D: =Yes, we'll have to increase your medic[ation]

The patient performs her role of competent patient by showing compliance with the diet that has been prescribed to control her cholesterol. She describes her diet as very rigorous in line 12 *yo hice una dieta bastante rigurosa* 'I've followed the diet quite a rigorously'. The kind of food the patient has avoided, and what she has eaten indicate a knowledge of a cholesterol-controlled diet *no comí huevo-, no comí mantequilla, ehm: carne- chan-, cerdo ehm:, fritura-. Sólo verdura y fruta* (lines 14-15) 'I haven't had eggs, I haven't had butter, ehm: meats por-, pork ehm:, fried food. I've only eaten vegetables and fruit'. Despite showing an adult competence in looking after herself and managing her own diet (Labov and Fanshel 1977), her cholesterol level is still high. Having followed the doctor's recommendation for a couple of months *estuvimos en régimen de tre- mese-, má- o meno-* 'we've been on diet for around three months' (line 9), the patient raises her voice and questions a treatment that did not work for her even though she had kept rigidly to the diet. This may be interpreted as an example of conflict in communication. She issues her first challenge, indicating a shift in footing (from a powerless to a powerful patient), in line 11 when she exclaims *(el colesterol ... ha baja-o bien poco* 'it (the cholesterol) ... it's gone down very little'. The challenge becomes a complaint in line 19 when the patient refers to the useless and ineffective diet. Her voice rises and her talk becomes louder (Davis 1988) *¡NAda!* 'NOthing! In line 19. Finally, in line 26 a challenge is expressed in the form of a question *¿se fija? Sí, fue muy poco:* 'can you see? It was very little:'. This time the question is not a cry for help from a powerless patient, but rather it marks the patient's power and control over her own body and 'demands' that the doctor realise the extent of her concern. This indicates that the patient may change her initial powerless

position into a powerful one, in those cases when the patient realises that the medical treatment that she has been thoroughly following has not been successful. In so doing the patient is shifting footing. In the Example 5.6 above the patient is 'principal' of her belief that she has carried out thoroughly the prescribed treatment. Therefore, the patient authors a *voice* of compliance and knowledge of the health matter at issue and contest her doctor's assessment.

The patient's unhappiness about the result of her diet puts the doctor in a difficult position. The expert is confronted with a patient who, because she is competent, she has an understanding of her health condition and probably even knows the consequences of having high cholesterol. In a number of medical discourses, knowledge about health generally marks the difference between the health and the non-health professionals. However, in the above extract this knowledge is shared by both participants, thus making their particular interaction less asymmetrical. In this case a closer similarity in the amount of knowledge shared by patient and doctor leads to a more confrontational interaction. Here the doctor tries to reassure the patient that her cholesterol level is lower than before *Ya bajó a dos cincuenta* 'It's gone down to two fifty'. But this is not considered an acceptable reassurance by the patient *treinta gramos treinta, treinta, o cuarenta ¡NAda!* 'Thirty grams Thirty, thirty, or forty NOthing!'. The doctor's last resource is to increase her medication: ... *vamo- a tener que agregarle un medicamento* '...we'll need to increase your medication'. It is the need for reassurance and negotiation that reveals the power struggle between a competent patient and the health professional.

The above analysis allows us to define a competent patient as one who:

(a) Understands his/her health condition.

(b) Prevents the deterioration of his/her health by complying with the medical treatment prescribed.
(c) Understands and is knowledgeable of the functioning of his/her body, and
(d) Responds to and even challenges the doctor's opinion when it contradicts his/her understanding of the medical issue that relates to his/her health.

These characteristics define a patient whose body and health are his/her primary concerns and who does not delegate all responsibility to the medical institution.

In sum, it appears that a competent patient is a powerful individual and a potential contester of medical practice. The power is based on the patients' knowledge and understanding of their health condition, their knowledge of how best to handle their body in the event of a health problem and compliance with the medical recommendations, the latter allowing patients to contest those recommendations (*a posteriori*) when they clearly did not work. Both participants enter the exchange with a closely 'analogous' knowledge of the patient's health condition, which confers them with a sense of control over the event. As the data has shown, it is the knowledge that the patient has acquired that can be used to confront the doctor in his/her treatment and in so doing the powerless patient becomes the powerful one who occupies temporarily a similar position than that occupied by the doctor. To be in someone else's territory (in this case the doctor's) requires interactional work from both participants in order to prevent a communication breakdown and facilitate the development of a discourse.

Although patients' competence in medical knowledge may lead to a power struggle due to the territorial dispute between the participants, the same competence can also facilitate both doctor-patient communication and contribute to the success of the prescribed treatment. Competent patients not only show alignment to the medical institution and to the medical commitment to cure, but they may also establish a

platform for further education to be developed in the discourse. This is so, since the time the doctor might have spent in educating the patient, in a medical issue that the patient is already knowledgeable about, can be used to deal with the same or other health issues in greater depth. This positive feedback between doctor's and patient's contributions in the medical exchange is expected to result into greater success of the treatment. The following example recalls two separate examples already mentioned in the *Doctor* and *Educator voices* (see Examples 4.12 and 4.24) and shows how patients' competence interacts with doctor *voices* creating an opportunity for the acquisition of further knowledge.

Example 5.7 Consultation No 18 (Doctor: Daniel, Patient: Victor) Tape 38A

63 D: *... Tolera bien el regimen, no anda con mucha hambre eh: ¿Cómo ha sido eso?*
64 P: *Doctor, le digo de que sí ando con hambre y he bajado bastante, por lo que Uste-*
65 *puede ver al al control de hoy día=*
66 D: *=Uhm=*
67 P: *=Estoy en 64 kilo-, y anteriormente, el otro control lo debe tener por ahí. Creo que*
68 *eran <X> y, o sea, sesenta y:=*
69 D: *=Setenta tiene aquí=*
70 P: *=Setenta cuando me empezó a tratar. Claro sí, he bajado. Y me he mantenido, no he*
71 *subi-o*
72 D: *¿Solamente con dieta?*
73 P: *Solamente con dieta -toy*
74 D: *Yo lo encuentro bastante bien po' ¿Ah? Con la glicemia que trae lleva en forma*
75 *muy correcta el regimen. Eh:... sí, me interesaría saber cómo, cómo sigue el regimen*
76 *durante el mes, hay un examen que no es ese pa' chequearlo día a día, solamente, da*
77 *una fotografía de ese momento solamente, pero hay otro- que, que evalúan má- o*
78 *meno- como ha estado dentro del me-*

63 D: ... Do you put up with the diet easily? aren't you very hungry? How has it been?
64 P: Doctor I can tell you that I certainly feel hungry, but I've lost (weight), as you can see
65 today =
66 D: =Mm=
67 P: = I'm 64 kilo, and at the previous check up, you should have it (written down) there I
68 was <X> sixty (something)=
69 D: =Seventy is (written) here=
70 P: =Seventy in my first check up with you, I've clearly lost (weight) I've watched
71 myself, and I haven't put on any
72 D: Just by following a diet?
73 P: I'm just following a diet
74 D: I think it is very good Ah? The result of the glycemia test shows that you're
75 following your diet perfectly. Eh ... yes, I would like to know how, how your
76 diet goes over a month. There's a test that isn't the one to check the level every day
77 since that one gives only a picture of a particular moment, but there's another that
78 checks roughly how you go over a month.

Competence is revealed in the above example by the patient's compliance with the medical recommendation that prescribed weight loss due to the patient's diabetic condition. The doctor's assessment is made clear by his use of reassuring words such as *lo encuentro bastante bien* 'I think it is very good' and *lleva en forma muy correcta el regimen* 'you're following your diet perfectly' (Section 4.1.2). The *Educator voice* (in lines 76-78) provides further information on the kind of tests available to check the glycaemia in the blood, e.g. *hay un examen que no es ese pa' chequearlo día a día, solamente, da una fotografía de ese momento solamente, pero hay otro- que, que evalúan má- o meno- como ha estado dentro del me-* 'there's a test that isn't the one to check the level every day since that one gives only a picture of a particular moment, but there's another one that checks roughly how you go over a month'. Thus the doctor does not provide basic information on the prescribed diet since compliance has been achieved, instead the doctor expands patient's knowledge by giving new information to the patient. The interconnection between patients' compliance and doctors' use of the *Educator voice* is further discussed in Chapter 6 (see Section 6.6).

5.3 The *voice of Social Communicator*

Social Communicators are patients who, in the medical consultation, refer to topics that are not directly associated to medical issues but to their social identities and experiences. In this category the family appears to be the centre of attention for both male and female patients. Patients refer to *mi familia* my family; *mis hijos* 'my children'; *mi marido/señora* 'my husband/wife'; *mis padres* 'my parents'; *mis hermanos* 'my siblings'; *mis tías/tíos* 'my aunties/uncles'. Men's and women's responsibilities as family caretakers were apparent in the data. This section will present two examples of this phenomenon, one from a male patient and one from a

female patient. The second example (see Example 5.9) will show how the different economic status of participants and the diverse social roles both sexes have in society influence the interpretation of an ordinary event. In the first example the patient projects himself as a *Social Communicator* by sharing with the doctor the story of his father's death. The family (his mother, father and himself) is the focus of attention.

Example 5.8 Consultation No 17 (Doctor: Daniel, Patient: Tito) Tape 19B

48 D: *¿Muy tenso en el trabajo, no está mal genio o cosa así?*
49 P: *No, lo que tuve ahora hace poco problema- familiare-*
50 D: *Ya ¿qué le pasó?*
51 P: *El 2 de octubre falleció mi papá*
52 D: *¡A[h:::!]*
53 P: *[Entonce-] eso me tiene medio=*

48 D: Are you very tense in your job, are you feeling irritated or something like
49 that?
49 P: No, but what I've had recently (are) some family problems
50 D: Yeah, what happened to you?
51 P: My father passed away on 2 October
52 D: A[h:::!]
53 P: [So-] I'm a bit=

In this extract the doctor's use of questions prompts the patient to introduce and disclose the topic of the family indicating in this way the acceptance of this talk during institutional discourse. The doctor initiates in line 48 with a QIS *¿muy tenso en el trabajo no está mal genio o cosa así?* 'are you very tense in your job, are you feeling irritated or something like that?' which could have been interpreted as a medical oriented question (see Section 4.1). The patient in line 49 replies by telling his family story. The patient's intervention starts with *no, lo que tuve ahora hace poco problema- familiar-* 'no, but what I've had recently are some family problems', this triggers a question by the doctor that is intended to further understand the patient's contribution *ya ¿qué le pasó?* 'yeah, what happened to you?' The question is then followed by the patient's reference to his father's death in line 51, to which the doctor utters *¡Ah:::!* 'Ah:::!', an evaluative remark (Davis 1988) that shows an emotional reciprocity (see Section 4.3.3.2) that intends to create empathy with the patient

(*Human Fellow voice*). The following extract marks the start of the patient's story and his account of the responsibilities that he had as a single child to look after his widowed mother.

Example 5. 9 Consultation No 17 (Doctor: Daniel, Patient: Tito) Tape 19B

58 P: *Sí, <WH no po' WH> Uste- sabe que cuando uno se acuerda de él como que*
59 *viene (pena), pero estoy tratando de, de salir adelante, porque en este caso tan, fue*
60 *muy duro pa' mí, mi mamá porque somo-, yo soy único hijo=*
61 D: *=Ya=*

58 P : Yes. <WH no WH> You know that when we remember him we feel (the pain), but
59 I'm trying to get over it, because in this case it was very hard for me, for my mother,
60 because we are, I'm the only child=
61 D: =Yeah=

The patient reveals the emotional impact of his father's death U*ste- sabe que cuando uno se acuerda de él como que viene* 'you know that when we remember him we feel', and the difficulties he and his mother have had *fue muy duro* 'it was very hard'. He reiterates this point later in the discourse *fue bastante duro* 'it was very hard', and *fue bastante, bastante duro* 'it was very, very hard' (lines 69, Example 5.10). The patient uses the consultation as a place to open up his feelings to the situation he is experiencing. This implies that the medical consultation is not just a place to refer to the medical issues that concern the patient, but it is also the site to share with the doctor intimate and profound feelings. This point is highlighted in Section 5.7 where patients classify as a positive attribute doctor's willingness to listen to them.

The lines that follow express the patient's family story. At its centre is his mother who needs help.

Example 5.10 Consultation No 17 (Doctor: Daniel, Patient: Tito) Tape 19B

62 P: *=Entonce- mi madre y yo, y madre como le digo está pero ::=*
63 D: *=Ya le ha afecta-o [mucho]*
64 P: *[Está]con una depre bastante: con dolore- de espalda, dolore- de*
65 *hueso, de poco ánimo, dolor de cabeza que tiene entonce:- y no tengo na' <X X> y*
66 *había pedi-o, estaba pidiendo hora pa' acá, pero le estaban dando pa' media-o de,*
67 *de: novie:bre pa' verla pa' que le hicieran acá un chequeo o darle alguna- pastilla- a*
68 *tomar alguna cosa, algún relajante para no sé, pero no me pude conseguir hora acá*
69 *así que voy a tener que ir por fuera pa' ver si ::. Fue bastante duro. Sí, el se trató*
70 *aquí en la Católica, acá le trataron la enfermeda- tenía un cancer a la próstata ...*
71 Entonce:- Fue bastante, bastante duro ... (N) (HX) ...

62 P: =So my mother and I, and my mother is, as I've telling you, but ::=
63 D: =Yeah. She's been very [affected]
64 P: [She's] very depressed; she has a pain in her back, pain in
65 her bones, she's low in spirits, (she has) headaches, so: and I don't have anything <X
66 X > and she asked for an appointment or she was trying to get an appointment here,
67 but they gave her one for the middle of November for a check-up or to prescribe her
68 some medication or other, a tranquilliser for I don't know what, but I couldn't make
69 an earlier appointment so I'll need to make one in another centre. It was very hard.
70 Yes, he (my father) was treated here at the Católica (hospital). They treated him for
71 prostate cancer ... So: it was very, very hard ... (N) (HX) ...

Here, even though the focus of the patient's attention is his mother and the impact that his father' death had on both his mother and himself, his story highlights both his position as a patient requiring help from a health professional (he is also suffering from back pain and depression), as well as his position as a son helping his mother who is in need of medical attention. In other words, the patient's discourse reflects his powerlessness regarding his health condition (that led him to seek medical help), while the *skandalon* syndrome (i.e. the feeling of being victim of circumstances, Rehbein 1980 quoted in Davis 1988) and his responsibilities towards his mother (that compel him to seek help for her) are responses to the socio-cultural expectations of family commitment. Thus, the patient in Examples 5.9 and 5.10 is aligning to the social expectations placed on him to look after his aged mother and provide her with help whenever it is required.

In the next example the female patient projects herself as a *Social Communicator* whose obligations and responsibilities are as a mother of three sons. From the extract we learn that she does not work outside the home and that she has a number of interests, including gardening, painting and reading. For many years the patient has gone camping with her family (three teenage boys and her husband) during the summer holidays. In the following lines she expresses her discontent about doing this activity by revealing her desire to have time for herself. It is at this point

that a conflict in the knowledge schema (Tannen 1993) between participants becomes evident.

Example 5.11 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46

303 P: *Además que mi- vacacione- nunca han sido vacacione-=*
304 D: *=Ya=*
305 P: *=Tengo una casa rodante=*
306 D: *=Ya=*
307 P: *=Un motor, entonce- ir a veranear*
308 D: *No es placer para Uste-*
309 P: *Eh pa' mi hijo fantástico, regio, estupendo*
310 D *[Para Uste- seguir trabajando]*
311 P: *[Aunque esté embarazada en cual]quier río lavando entonce- toda esa cosa así. Ya*
312 *estoy cansa-a pero tengo que hacerla igual, o sea me gusta salir me gusta yo por mí*
313 *me acostara en la playa a leer un libro*
314 D: *Esa serían su vacacione- ideale-*
315 P: *Eso sería mis vacacione ideal=*

303 P: Also my holidays have never been proper holidays=
304 D: =Yeah=
305 P: =I've a caravan=
306 D: =Yeah=
307 P: =A caravan, so we use it to go on holidays
308 D: It's not a pleasure for you
309 P: Eh, for my children (it's) fantastic, superb, marvellous
310 D: [For you, it keeps you working]
311 P: [Even when I was pregnant] I was in the lake washing- and things like that. Now I'm
312 tired, but I have to go anyway. I like going out, but if it were up to me, I'd lay down
313 on the beach and read a book
314 D: That would be your ideal holiday
315 P: That would be my ideal holiday=

In line 303 the extract presents the patient as a mother who sacrifices herself by going camping even when she dislikes the activity *mi- vacacione- nunca han sido vacacione-* 'my holidays have never been proper holidays'. She goes because she has no choice in the matter *tengo que hacerla igual* 'I have to go anyway' (line 312), and because she accepts that her children love the experience of camping *pa' mi hijo fantástico, regio, estupendo* 'for my children (it's) fantastic, superb, marvellous' (line 309).

For the patient, the beach, relaxation and reading would be the ideal holiday *me acostara en la playa a leer un libro ... Eso sería mi vacione ideal* 'if it were up to me, I would lay down on the beach and read a book ... That would be my ideal

holiday'. It is at this point that the patient and the doctor show different 'knowledge schema', as can be seen from the following extract.

Example 5.12 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46

316 D: *=En un hotel donde la atienda todo, todo=*
317 P: *=No, no=*
318 D: *=Un lugar donde la puedan atender=*
319 P: *=En la casa rodante no má- pero, comer cuando quiero, cuando tengo hambre. Si*
320 *tengo hambre, tengo. Si no, no tengo*

316 D: =(You'd like to be) in an hotel where you are looked after totally, totally=
317 P: =No, no=
318 D: =A place where you are looked after=
319 P: =In the caravan, that's all, but (I would like) to eat when I want to, when I'm hungry
320 If I'm hungry, I eat, and if I'm not, I don't.

According to Tannen, 'knowledge schema refers to participants' expectations about people, objects, events and settings in the world, as distinguished from alignment being negotiated in a particular interaction' (1993: 60). The doctor believes that, for her patient, the ideal holiday would be to stay in a hotel where she could be looked after properly *en un hotel donde la atienda todo, todo* 'in an hotel where you would be looked after totally, totally' (line 316). Although the patient rejects this idea, the doctor persists with his background assumption that for her a holiday is 'a place where (she) can be looked after' *un lugar donde la puedan atender.* For the patient, the ideal holiday would be one where she does not have family responsibilities and meal-time schedules *comer cuando quiero, cuando tengo hambre. Si tengo hambre, tengo. Si no, no tengo* 'to eat when I want to, when I'm hungry. If I'm hungry, I eat, and if I'm not, I don't'. In this example it appears that the background knowledge of the doctor diverges from that of the patient, provoking a 'mismatched schema' (Tannen and Wallat 1993:70). The expensive accommodation (where one can be fully looked after) suggested by the doctor differs from the low price accommodation that the patient has in mind (presumably because she cannot afford a more expensive alternative).

In the next extract from the same episode, instead of uttering an affiliative comment on the patient's desire to be by herself (which would show an understanding of her account), the doctor chooses to ask the patient a question *¿por qué no puede hacerlo?* 'Why can't you do it?' (line 321), which he follows up with the statement *es cosa de hacerlo participar* 'it's just a matter of making them cooperate'. Both of these strategies indicate differential knowledge. This time, it is not medical versus non-medical, but rather the different social roles and background experiences of the participants. In Chilean society, as a general rule women are responsible for keeping the family together and raising the children, while men usually are the main income earners. Although men's responsibility for raising their children has increased in recent years (http://www.serman.cl/public.html), this has not changed the social expectations placed on women. The background assumption of what represents a proper holiday for both participants also shows some conflict of 'knowledge schema'.

Example 5.13 Consultation No 13 (Doctor: Carlos, Patient: Olga) Tape 46

321 D: *¿Por qué no puede hacerlo?*
322 P: *Por lo- hijo- porque hay tienen hambre hay que lavar[le]*
323 D: *[¿Ellos] participan? Es cosa de*
324 *hacerlo [participar]*
325 P: *[Si este año] ello- lavaban loza ello- cooperaban con cosa que jamá-. Es que*
326 *son todos seguido 14 15 13 ya este año 16 15 14=*
327 D: *=Ya=*

321 D: Why can't you do it?
322 P: Because of the children. I have to cook for them, do their wash[ing]
323 D: Do [they] help? It's just
324 a matter of making them [cooperate]
325 P: [Yes, this year] they washed the dishes and cooperated as
326 never before. The fact is they were born one year apart. They're
327 14 15 13, and this year 16 15 14=
328 D: =Yeah=

This example shows that in the medical consultation not only is medical knowledge negotiated but also the *Social Communicator* voice has the potential to be contested. This may be due to the fact that the participants do not:

(a) Share the same background knowledge as a result of their gender difference (for example, the different responsibilities of a mother as opposed to those of a father), or

(b) Have an equivalent economic status that would allow them to enjoy similar holiday accommodation.

5.4 The *voice of Initiator*

Initiators are patients who initiate a question aimed at obtaining information about their health condition by prompting the *Educator voice* of doctors to emerge in the discourse. In the process they project themselves as people who are not members of the medical system and who lack the necessary medical knowledge to deal with their health problem. *Initiators* are potential *Compliers* with the medical recommendations. This is so, since the questions that they initiate show their interest in understanding more about their health condition and awareness of their status of the illness. Therefore, *Initiators* might represent those patients that comply (in future visits) with the prescribed treatments (see Section 6.6).

In the example given below the questions initiated by the patient focus on understanding which kind of food items are required to control the level of cholesterol in the diet.

Example 5.14 Consultation No 21 (Doctor: Daniel, Patient: Yolanda) Tape 29Ai

122 P: *... Ahora son cosa- de de alimento, doctor, ¿las almendra-?*
123 D: *A una persona le pueden caer mal, pero eso depende de cada persona. No hay na-a*
124 P: *Pero no hay ninguna contra indicación por colesterol,[por algo]*
125 D: *[A Uste-]*
126 P: *Uhm*
127 D: *Lo que sea de vegetale- o grasa- vegetale- no tiene problema: Uste- pa' eso*
128 P: *Ya*
129 D: *Con las grasa- animales*
130 P: *¿Y el aceite de oliva?*
131 D: *No, tampoco=*
132 P: *=Tampoco, ¿eh la- gelatina-?*
133 D: *Eh, bueno eso es agua con azúcar y colorante. No tiene mayo::r*
134 P: *No hay proteina-*
135 D: *<XX>*
136 P: *¿E- qué?*

137 D: *E- químico, no tiene na-a de, no tiene na-a de alimenticio, digamo-, salvo lo- hidrato-*
138 *de carbono de azúcar- que tienen*
139 P: *Uhm ya, eh y la- conserva- de marisco por ejemplo, ¿siguen siendo: eh: aunque estén*
140 *en conserva siguen manteniendo lo- mismo- previsión? digo pero si es una vez al*
141 *mes mi marido quiere un caldillo -*
142 D: *Sí, no, no hay problema*
143 P: *¡Ah! allí no hay problema ya*

122 P : ... Now, doctor, I want to ask you about, about food. Almonds?
123 D: They're not good for some people, but that depends on the individual. There's
nothing
124 P: But there's not a contra-indication for cholesterol, [or something]
125 D: [For you]
126 P: Mm
127 D: You don't have any problem with vegetables or vegetable fat. In your case, those
128 P: Yeah
129 D: But with animal fat
130 P: And olive oil?
131 D: No (problem), either=
132 P: =Nor with jelly?
133 D: Eh, well, that's water with sugar and colouring. It doesn't have::
134 P: It doesn't have protein.
135 D: <X X>
136 P: What?
137 D: Eh, (it's a) chemical. It doesn't have anything, it doesn't have anything of
138 nutritional value, let's say, except for the carbohydrates
139 P: Mm yeah, eh, and canned seafood, for example, does it keep the same nutritional
140 properties, even if it's canned? I say this because sometimes once a month my
141 husband wants seafood soup
142 D: Yes, that's not a problem
143 P: Ah! there isn't problem with that, yeah

The patient initiates a number of questions in an attempt to identify the food that is most appropriate for a cholesterol diet *ahora son cosa- de de alimento doctor, ¿las almendra-?* 'now, doctor, I want to ask you about, about food. Almonds?' (line 122). In line 132 she asks about jelly *¿eh la- gelatina?,* and in line 139 about canned seafood *aunque estén en conserva siguen manteniendo lo- mismo- previsión?* 'does it keep the same nutritional properties even if it's canned?'. The doctor mainly uses his *Educator voice* to answer the patient's questions, making this a learning opportunity for the patient and allowing her to acquire the knowledge that will make her a competent patient. Thus the discourse strategies used in Example 5.14 are a sequence of questions (initiated by patients) and answers (provided by the doctor).

This same act of questioning, which portrays the patient as a powerless individual, also has the potential to be a medical learning experience that may convert the non-professional individual into a patient who is knowledgeable about his/her medical condition, i.e. a competent patient. This study suggests that the *voice of Initiator* could serve as a platform for the patient to learn about his/her medical situation, that is, it could serve as a temporary stage for the powerless patient who by the act of questioning the doctor about his/her condition can become competent.

5.5 Pattern of footing in patients' performance of *voices*

Patients' performance of *voices* and their shift from one *voice* to another were also investigated in this study. It was found that patients' footing is partly, but not entirely, conditioned by doctor *voices*, and that patients do not always present a predictable pattern in their linguistic behaviour during the medical consultation. In order to give an insight into this observation I start by presenting the interaction of doctor and patient *voices* in the discourse and by observing discourse patterns that do not relate to patients themselves, as isolated individuals, but to the interaction that emerges between participants through their use of *voices*.

Patients' use of the *voice* of *Health-related storytelling* (HST) and the *voice* of *Competence* (C) are usually associated with the *Doctor voice* (D) (see Section 4.1) that prompts patients' contribution. In other words, the *voice* that initiates the sequence is the *Doctor voice*, then it follows the *Health-related storytelling* or the *voice* of *Competence* and the sequence concludes with the *Doctor voice* (see for example, Examples 5.2, 5.3, 5.4, 5.5 and 5.6). The following Figure 5.1 summarises this sequence

Figure 5.1 Discourse pattern of *Doctor-Health-related storytelling/Competence-Doctor voices*

D⇨ HST or C ⇨ D

Whilst the first turn in Figure 5.1 is represented by the *Doctor voice*, the second can be either expressed by the patients' *voice* of *Health-related storytelling* (Figure 5.1, see Example 5.3) or the *voice* of *Competence* (see for example, Examples 5.4, 5.5 and 5.6). There are few examples where the third turn is accomplished by the doctor's use of the *Educator voice*, but this does not prevent the patient from continuing to use the *voice* of *Health-related storytelling*.

In addition, the number of turns that the patients stay in the *voice* of *Health-related storytelling* is not entirely dependent on the voice of the doctor, but it appears to be related to patients' individual projection of themselves (see for example, Example 5.11). However, as has been suggested in Section 4.3.1, the use of CMs facilitates patients' elaboration of their stories. The following Figure 5.2 illustrates this point.

Figure 5.2 Discourse pattern of *Doctor* and *Health-related storytelling voices*

D⇨ HST ⇨ [D and/or HFV and/or E] ⇨ HST⇨ [D and/or HFV and/or E]

Of the 17 (out of 22) consultations in which the *voice* of *Competence* was present, the patients presented a pattern in which they could offer more than one turn related to their *Competence voice* (see for example, Examples 5.5). This was possible since the doctor used CMs after each contribution made by the patient. Alternatively, the doctor may ask further questions to the patient (see for example, Example 5.6) and the patient may reply and even use the *voice* of *Initiator* to initiate a question. This is illustrated as follows:

Figure 5.3 Discourse pattern of *Doctor* and *Competence voices*

D⇨ C ⇨[D or HFV] ⇨C or I

Whereas the discourse sequence patterns in Figure 5.1, 5.2 and 5.3 align to a medical discourse the sequence of Figure 5.4 is not necessarily expected in a bio-medical approach consultation, since the patient takes extensively the floor to tell his/her story by using the *voice* of *Social Communicator*. This suggests that the consultation takes place within a holistic approach (i.e. bio-medical and socio-relational) (see Section 2.5) as evidenced by patients' contribution in the discourse that is not interrupted by doctors. This holistic approach allows the doctor to show alignment to the medical institution and author a voice of knowledgeable in the medical matter at issue. In addition, it also allows the doctor to project him/herself as an individual who can relate to the patient in a more humane way (see Section 2.5).

The *voice* of *Social Communicator* and the *voice* of *Initiator* are described in Figure 5.4. It was also observed that the patient may initiate the performance of those *voices* regardless of the *voice* previously used by the doctor, and that the patients may shift to another performance of *voice* without following a predictable pattern. Thus, it is feasible to find a three-part sequence where the initial sequence is represented by either *Doctor* or *Human Fellow voices* followed by the *voice* of *Social Communicator* or *Initiator* and where the final sequence is represented by either *Doctor*, *Educator* or *Human Fellow voices* (see for example, Example 5.8) Doctor's use of the *Human Fellow voice* facilitates even further patients' contribution (see Section 4.3).

Figure 5.4 Discourse pattern of *Doctor/Human Fellow and Social Communicator voices*

D or HFV ⇨ [SC and/or I] ⇨[D and/or E or HFV]

The number of turns that the patient stays in the *voice* of the *Social Communicator* depends on both participants. Patients stay in this *voice* as long as they are telling the non-medical story to their doctors. This may be accomplished regardless of the *voice* of the doctor since the patient may interpret the doctor's contribution (e.g. QIS) as a

way to further develop the *Social Communicator voice*. The doctors' use of *Human Fellow voice* may help further the elaboration and development of the story by giving extra opportunities to the patient to contribute to the discourse, but this is not always the case. Nevertheless the absence of the *Human Fellow voice* does not always restrict patients in their performance of storytelling, but it may have an impact on the number of turns used by the patients (see Section 4.3).

Hitherto the emphasis has been on observing patients' *voices* by relating them to those used by doctors and by observing that there is not always a predictable pattern in patients' contribution to the discourse. The *voice* of *Initiator* confirms this variable pattern (see for example, Example 5.14), since the patient may utter a question at any time in the consultation regardless of the *voice* previously used by the doctor and regardless of the *voice* patients have been using thus far. Also, the patient can shift from the *voice* of *Initiator* to any other *voice*. This appears to suggest that whereas the doctors align to the medical institution by using medical scripts associated with the event, the patients, as non-institutional individuals, may show both alignment to the discourse sequences used by doctors and diverge from it. As already mentioned at the start of this chapter, patients have not been trained to be patients, therefore we might expect to find their shift of voices to be not as clear as in the case of doctors.

In summary, although the presence of *Health-related storytelling* and the *voice* of *Competence* are usually associated with the presence of the *Doctor voice*, this does not necessarily mean that the *Doctor voice* calls only for the exclusive use of those two patient's *voices*. As it has been described above, the contribution of patients is quite variable and not always conditioned by the specific *voice* used by the doctor.

5.6 Frequency of patients' use of storytelling in the consultation

The following Tables 5.1, 5.2 and 5.3 describe the frequency in which the four types of *voices* were found in the twenty-two consultations.

Table 5.1 Total frequencies of consultations that included *Patients' voices*

Type of *Voice*	Number of consultations	%
Health-related storytelling	17/22	77
Competence	17/22	77
Social Communicator	11/22	50
Initiator	11/22	50

A total of seventeen consultations used the *voice* of *Health-related storytelling* and the *voice* of *Competence* (Table 5.1), this represents a relative frequency of 77% in both cases. Both the *voice* of *Social Communicator* and the *voice* of *Initiator* appeared equally frequently in 50% of the consultations.

Table 5.2 describes the total number of examples found for each type of *voice*.

Table 5.2 Frequency of *Patients' voices*

Type of *Voice*	Counts	%
Health-related Storytelling	61	30. 4
Competence	68	33. 8
Social Communicator	34	16. 9
Initiator	38	18. 9
TOTAL	201	100.0

In this study it was found that both the *voice* of *Competence* (33.8%) and the *voice* of *Health-related storytelling* (30.4%) were the most frequently occurring types of patients' *voices* during history taking and management/treatment. It is the performance of those *voices* that demonstrates the attributes that make individuals a particular type of patient. Whereas competent patients in this study are regarded as individuals whose knowledge and power in the interaction originate from their understanding of their medical condition, *Health-related storytellers* are seen as powerless individuals in search of knowledge from the health professional. This lack

of competence reinforces the asymmetrical relationship already in place in the medical interaction by:

(a) Allowing doctors to exercise control over patients who delegate the treatment of their illness to them, and
(b) Diminishing the chances of contesting (if necessary or possible) the medical institution or system due to the patient's lack of knowledge.

The fact that the *Social Communicator* was less represented in the data does not necessarily mean that it is less important than the other *voices*. From the data it emerged that the differences in economic status and socio-cultural assumptions of gender roles in society may lead to a conflict between a patient and a doctor who do not share a 'knowledge schema'. The *voice* of *Social Communicator* provides an opportunity to understand the person who is sick within the social-cultural environment where s/he carries on his/her daily life, and therefore it is important to study this *voice* in spite of not being used as frequently as the other *voices* in the discourse.

The *voices* of *Competence* and *Initiator* are explored further by observing their frequency of use in relation to the gender of the patients. This is so, since both *voices* appear to be key elements in the patients' understanding of their health condition. Therefore it is of interest to explore further the *voices* of *Competence* and *Initiator* in terms of the gender identity of the patients. Table 5.3 presents the frequency of use of the *voice* of *Competence* and the *voice* of *Initiator* by female and male patients.

Table 5.3 Frequency of female and males use of *Competence* and *Initiator voice*

Voices	Women	%	Men	%	Total
Competence	35	51.4	33	48.5	68
Initiator	24	63.1	14	36.8	38

Both female and male patients used the *voice* of *Competence* with similar frequency (51.4% and 48.5% respectively). The *voice* of *Initiator* was used more often by female patients (63.1%) than by male patients (36.8%). A more detailed analysis of the *voice* of *Competence* reveals that women patients contest (see Example 5.6) the medical knowledge of their doctors more often than male patients. The data presented a total of 11 examples. Eight of these involved female (72.7%) and 3 (27.3%) male patients. This correlates with the higher number of questions (see Table 5.3) initiated by female than male patients (63.1% compared to 36.8%). The presence of the *voice* of *Initiator* suggests that some patients are actively participating in the consultation and by so doing they may be in the process of acquiring the necessary knowledge to become competent patients. It is through questioning that patients showed an interest in their health and, in turn, received an answer that could lead to an educative episode (*Educator voice*). As a consequence this can develop the patient's knowledge on a particular medical issue. This *voice* of *Initiator* could also represent an instance of power if we assume that the role of the patient is to provide a response (West 1984), not to ask questions. Nevertheless, this view does not give credit to the learning experience (in terms of becoming a competent patient) that the patient could gain, if what follows his/her questions is an educative interaction. Paradoxically, whereas doctors performing their *Educator voice* showed power towards a patient who lacks medical knowledge, the acquisition of that knowledge by the patient, generated from a powerless position, can lead to the development of a competent patient who can dominate his/her condition and therefore be equipped to contest the doctor, if required to do so. Female and male gender identity was revealed in the consultation by the *voice* of *Initiator* that was used more frequently by female patients. This pattern is further discussed in Section 6.6.

The analysis also investigated possible patterns in patients' linguistic behaviour in relation to the gender of the doctors. These results (see Section 3.5.2) should be read with caution, since gender differences may be confused by age/experience differences, due to the composition of the data that do not allow a proper distinction between age/experience and gender. In spite of this, it is of interest to investigate whether the dyad composition prompts patients to use a particular *voice* or whether patients' contribution is independent of the gender of the doctor. In order to study gender patterns I analysed the frequency of use of each patient *voice* in regards to the dyad composition (see Table 5.4).

Table 5.4 Patients' use of *voices* with their doctors

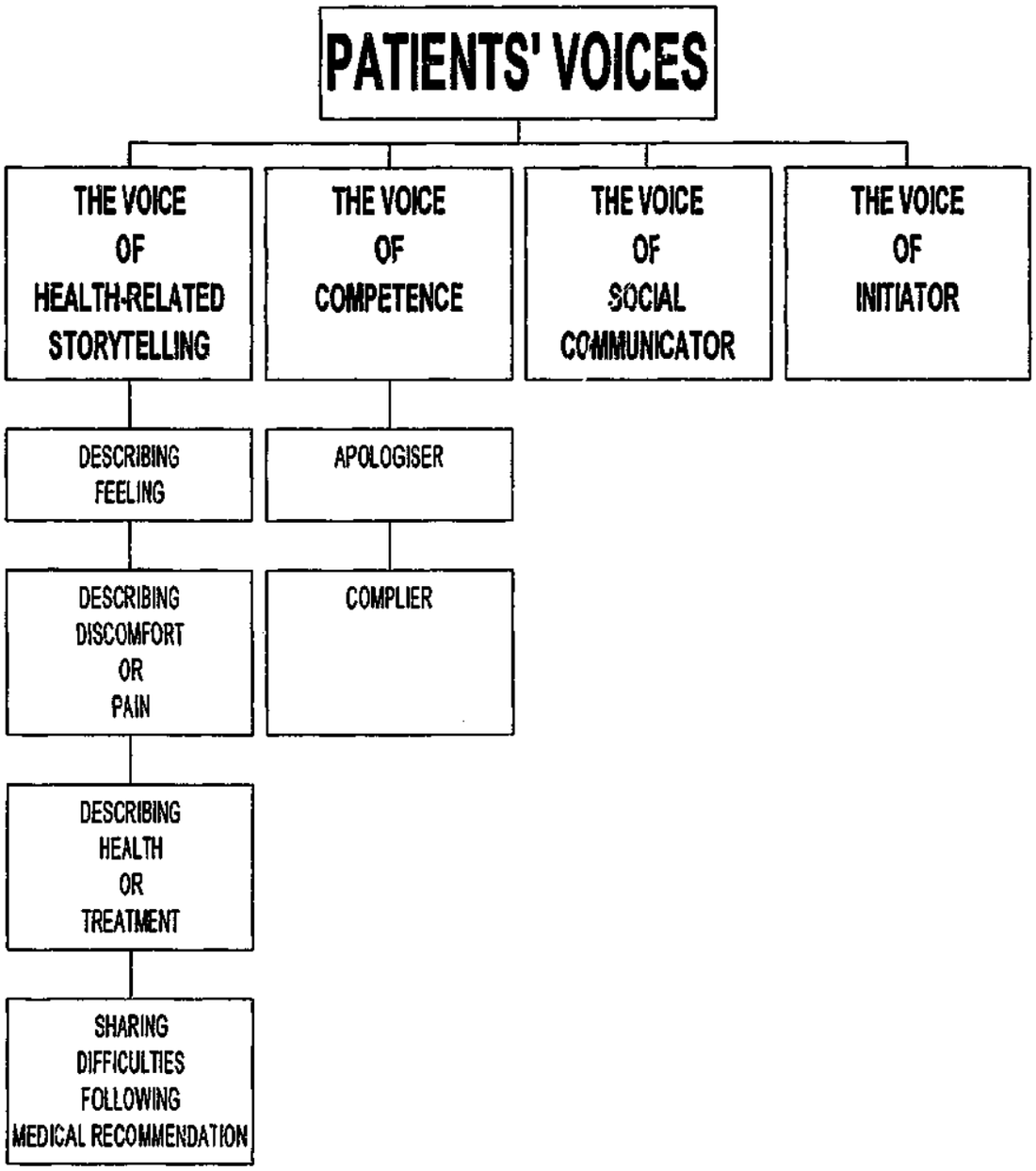
	Female doctors				Male doctors				Total	
Patients' voices	Female patients		Male patients		Female patients		Male patients			
	No	%	No	%	No	%	No	%	No	%
The *voice* of *Health-related storytelling*	17	28	13	21	19	31	12	20	61	30.4
The *voice* of *Competence*	18	26.4	10	14.6	17	25	23	34	68	33.8
The *voice* of *Social Communicator*	14	41.1	1	2.7	12	35.2	7	21	34	16.9
The *voice* of *Initiator*	1	2.6	8	21	23	60.4	6	16	38	18.9
TOTAL Count for all patients	50	24.8	39	19.4	52	25.8	60	30	201	100

The data summarized in Table 5.4 indicate that female patients use the *voice* of *Social Communicator* more frequently than male patients when interacting with both female (41.1%) and male doctors (35.2%). Male patients present a more frequent use of the *voice* of *Social Communicator* when interacting with male doctors (21%) than when interacting with female doctors (2.7%), whereas the *voice* of *Health-related storytelling* was used more frequently by female than male patients. Nevertheless, both female and male patients appear to have a similar pattern of behaviour with both female and male doctors in the performance of *Health-related*

storytelling. Female patients use this *voice* 28% with female doctors and 31% with male doctors and male patients use this *voice* 21% with female doctors and 20% with male doctors. This may suggest that the use of the *voice* of *Health-related storytelling* is not associated with the gender of the doctor but with the gender of the patient.

Female patients use the *voice* of *Initiator* mainly with male doctors (60.4%), whereas male patients use it more frequently with female doctors (21%) than with male doctors (16%). Female patients' use of the *voice* of *Competence* appears not to be associated with the gender of the doctor (26.4% when interacting with female doctors and 25% when interacting with male doctors). Male patients use this *voice* more often when interacting with male doctors (34%) than when interacting with female doctors (10%). A discussion of the important role of the *voice* of *Competence* and *Initiating* during the consultation is presented in Section 6.6. A summary of the discourse functions and strategies used in the *Patient voice* is presented in Table 5.5.

Figure 5.5 Discourse functions and strategies of *Patients' voices*



5.7 Results of Stage III: Semi-structured interview

As already mentioned in Section 3.4.3, the semi-structured interview was collected during Stage III of this study. The aim of this interview was to gather information about what patients consider as positive attributes of their doctors. Two questions aimed at determining what patients liked (*¿qué le gusta de un médico?* What do you like of a doctor?) and disliked (*¿qué no le gusta de un médico?* What do you dislike of a doctor?) about their visiting doctor were analysed. The semi-structured interview revealed that patients were very articulate in their opinions about what they liked and disliked about doctors in the consulting rooms. The following four main themes represent the major categories found:

(a) Sympathetic communication toward the patient.
(b) Language that was clear and jargon-free.
(c) Good medical and technical competence, and
(d) Communication that is familiar.

As follows I will describe each one of these categories and provide some examples. A sympathetic communication toward patients is described by Cordella (1999) as a positive quality that doctors show throughout their communication and the use of professional skills. It includes their ability to listen to their patients, understand and give them an answer to their queries, as well as to be patient when talking to them. In addition, this category includes ways of communicating that create an atmosphere that promotes trust during the consultation, respect, reliance, support, optimism and give chances to the patient to ask questions (Cordella 1999: 38). The following examples of sympathetic communication appeared in the data:

Example 5.15 (Doctor: Ana, Patient: Marta) Tape 5A

Me gusta que me escuche

I like a doctor who listens to me

Example 5.16 Consultation No 2 (Doctor: Ana, Patient: Beatriz) Tape 5B
Me gusta tener confianza venir con los brazos abiertos

I like to feel that I can come and open up to the doctor

Example 5.17 (Doctor: Berta, Patient: Blanca) Tape 32A
Me gusta un médico que me entienda bien

I like a doctor who can understand me well

Patients also consider doctors' ability to talk to them simply, clearly and avoiding the use of technical/scientific jargon as positive qualities. The category 'language that was clear and jargon-free' was represented by examples like:

Example 5.18 (Doctor: Ana, Patient: Raul) Tape 13A
Que le explique para que uno lo entienda, sin jerga

[I like] doctors who explain in a way that I can understand,

(doctors) who do not use jargon

Example 5.19 (Doctor: Daniel, Patient: Julio) Tape 11A
Que sea claro para explicarme

[I like] a doctor who explains to me clearly

Example 5.20 Consultation No 22 (Doctor: Daniel, Patient: Zenobia) Tape 19A
Que conteste a mis preguntas de una forma clara

[I like] a doctor who answers my questions clearly

Patients want doctors to give them a prompt and accurate diagnosis, to perform a thorough medical examination and to prescribe medical tests and medications. The category 'good medical and technical competence' is illustrated by examples like:

Example 5.21 (Doctor: Ana, Patient: Esteban) Tape 13B
Que me examine bien

[I like] a doctor who examines me thoroughly

Example 5.22 (Doctor: Carlos, Patient: Pablo) Tape 15A
Que le haga bueno examenes

[I like] a doctor who prescribes the right medical test to be carried out

Patients not only like doctors who are skilful in their medical field but also doctors who are friendly, warm and affectionate in their communication and behaviour. The following example represents an opinion given in the category 'communication that is familiar'.

Example 5.23 (Doctor:Carlos, Patient: José) Tape 37Bi

Me gusta cuando el médico es abierto para contarle penas y dolores

I like it when a doctor allows me to express my aches and pains.

Although patients realise that doctors are knowledgeable in the medical field they do not want them to show their superiority to patients. Instead a familiar and less asymmetrical interaction should prevail, this is manifested in the following examples:

Example 5.24 Consultation No 9 (Doctor: Berta, Patient: Javiera) Tape 32B

Que no sea un médico estirado. Uno sabe que ellos saben pero no me gusta que me lo muestren

[I like] a doctor who is not snob. I know that they are knowledgeable, but I don't like them to demonstrate that to me.

Example 5.25 Consultation No 14 (Doctor: Carlos, Patient: Paola) Tape 39Ai

Que no sea hosco. Soy el doctor, soy Dios

[I like] a doctor who is not surly. 'I'm the doctor, I'm God'.

From the semi-structured interview it is possible to see that patients prefer a communication with their doctor that is satisfactory from both the medical and communicative perspectives. The rapport that is created in the exchange appears to be of vital importance to patients 'indeed, three of the four categories [are] related to the rapport created in the exchange between the doctor and the patient' (Cordella 1999: 39). Female and male patients' contribution in the semi-structured interview is summarized in Table 5.5.

Table 5.5 Patients' positive attributes towards doctors

Doctor Attributes that patients consider positive	Female[2] Patients (94 interviewees)		Male[2] Patients (33 interviewees)		Total[3]	%
	No	%	No	%		
Sympathetic communication toward the patient	70	46.1	19	40.4	89	44.8
Language that was clear and jargon-free	25	16.4	7	14.9	32	16.1
Good medical and technical competence	35	23.0	15	31.9	50	25.1
Communication that is familiar	22	14.5	6	12.8	28	14.0
Total %	152	76.4	47	23.6	199	100

According to 44.8% of patients, doctors should be engaged in a sympathetic communication with their patients during the consultation. Doctors should also have good medical technical competence to deal with patients' ailments, representing 25.1% of patients' answers. Patients also took into consideration doctors' language and identified the use of jargon-free language as a doctor's positive attribute (16.1%). Comments were also made with regard to preferring a communication style that was familiar (14.0%) during the consultation. It is also of interest to see that the distribution of preferences for doctors' attributes between female and male patients was equivalent. They all preferred, in descending order: sympathetic communication, technical competence, jargon-free language and familiar communication.

[2] I recorded 96 questionnaires from female patients but two interviewees did not explain which doctor attribute(s) they considered positive. The same happened with five of the 38 questionnaires filled by male patients.

[3] Each patient might have mentioned more than one positive attribute of doctors in his/her response. Each one of those attributes was entered in Table 5.5, thus there may be more than one entry for each patient.

5.8 Summary

In summary, this chapter has revealed that patients use particular *voices* in the consultation that either align themselves to the medical expectations of the event or diverge from it. The latter is achieved through the introduction of *voices* that do not entirely respond to the medically oriented *voices* of the doctor. This results in situations where a patient may contest the doctor's medical knowledge, being also willing to understand more about his/her condition by initiating questions. The following chapter, Chapter 6, shall address the possible explanations that may account for the emergence of those behaviours. In Chapter 6 I shall also discuss the presence and interaction of *Doctor, Educator* and *Human Fellow voices* in the medical discourse as well as explore *Patients' voices*. The concepts of asymmetry, power and affilitiave discourse styles will be discussed in view of the results.

CHAPTER 6

DISCUSSION

6.0 Introduction

It is not unusual to hear complaints about the medical system and in particular about the unsuccessful consultations that patients vividly remember. These stories are shared with friends who contribute with many more stories around the same topic. In Chile for example it has been shown that people are discontented with the public health system. Martinic (1996) argues that patients' dissatisfaction is a long-standing historical feature in Chilean society.

> *En... Chile es ya una constante histórica la crítica que los usuarios hacen al "mal trato" que reciben por parte de los servicios públicos de salud. Esta se verbaliza como mala atención, burocracia, falta de consideración y respeto ...* (1996: 2).
>
> In... Chile the criticism towards the public health system is an historical phenomenon for those who use this service and receive "ill treatment", that is verbalised as poor service, bureaucracy, absence of consideration and lack of respect ...

Dissatisfaction in the medical consultation has been frequently reported (see Section 2.6) in medical and linguistic studies. Dawson et al. indicate that Australian women from migrant communities, including Chilean, had:

> ... Many complaints about the care they received from their doctors and they held positive opinions about the ways in which complementary medicine practioners are able to deal more adequately with 'the whole person' ... Women consider alternative medicines and the practioners, such as Chinese medicine and homeopathy, as being more in tune with their health as a totality (2000: 64).

The same studies have shown that patients' dissatisfaction is not unrelated to the medical consultation, but it is the result of both participants' verbal exchange (see Section 2.6). Doctor and patient discourse must be at the centre of our attention if we want to understand how the communication between participants develops during the consultation.

My study focused on the contribution of each participant in the medical consultation, and in the process of deconstruction of the discourse it was discovered that doctors and patients performed a set of *voices*. These *voices* were associated with the participants' role identities that emerged in the enactment of the consultation. The micro-realization of the discourse, helps to understand the interaction between doctor and patient. In addition, the interpretation of the local medical discourse may reveal the interconnection that participants' performances have within the socio-cultural group where they belong. This implies that the medical discourse may (re)formulate discourses used in other social contexts. This chapter illustrates, when appropriate, this interconnection.

In what follows I highlight the main characteristics of each of the *voices* found in the participation framework of both doctors and patients. Then, I explore the concept of asymmetry that has been usually interpreted as an expression of power in the medical discourse. Following this I discuss the concept of *simpatía* and the affiliative discourse markers found in the data. Having presented power and *simpatía* I then elaborate on the interactive work that doctor and patient carry out in the consultation. Participants' shift of footing is also considered by noting the advantages of incorporating a non-medical discourse to the consultation since it may lead to a more personalised and comprehensive consultation. The final section concentrates on

patients' compliance and the responsibility of the medical body to educate the patients in order to make them knowledgeable and competent about their health condition.

6.1 Voices in the medical discourse: A general overview in the consultation

The doctor and the patient bring to the medical consultation particular *voices* that mark the participants' social relation (Fairclough 1989: 46) in the medical exchange, their alignment to the medical institution and their own identity as members of a society. In the consultation, both doctor and patient take on the role of 'animator' (Goffman 1981) in their ability to be a spoke-person, and while this ability is shared, this is not the case for the role of the 'principal' (Goffman 1981) where an asymmetry between participants develops as a result of their (usually) different beliefs about medical and social matters. Whereas, in general terms, for the doctor the interpretation of the patient's health is within a script of medical knowledge and a social and institutional framework of operation (see *Doctor voice* in Section 4.1 and *Educator voice* in Section 4.2), for patients their health condition relates to their helpless feeling of not knowing what to do and ask for help (see the *voice of Health-related storytelling* in Section 5.1 and the *voice of Initiator* in Section 5.4) and to the roles they occupy in society (*the voice* of *Social Communicator* in Section 5.3). The 'authoring' (Goffman 1981) of doctors' and patients' discourse reveals the occurrence of particular forms of talk that are associated with the context-situational functions enacted throughout participants' *voices* (see Footing 2.1.1 and Sections 4.24 and 5.5). Doctors participated in the consultation with the use of the *Doctor*, *Educator* and *Human Fellow voices*, whereas the patients performed the *voices* of *Health-related storytelling*, *Competence*, *Initiator* and *Social Communicator* to interact in the medical exchange.

6.1.1 *Doctor, Educator* and *Human Fellow voices*

The *Doctor voice* aims at seeking information that leads to a diagnosis (Section 4.1.1), to recycle old information by summarising patients' condition and health development since the last visit and to assess patients' compliance with the prescribed medical treatment (Section 4.1.2). The *Educator voice* focuses on accounting practices that deal with factual scientific explanations and accounts of the medical treatment to be followed by the patient. This *voice* is the site for education, persuasion, negotiation and power struggle. Those two *voices* (i.e. *Doctor* and *Educator*) projected the doctors' medical and institutional alignment throughout the performance of their script.

The *Human Fellow voice* differs from the *Doctor* and *Educator voices* since the *Human Fellow voice* aims at getting closer to the patient's lifeworld. It facilitates the participation of patients and doctors allowing patients to develop their story and become a protagonist. This *voice* assimilates the characteristics that have been reported in the speech of health professionals such as female nurses. Fisher (1995) notes when comparing the medical consultation carried out by female nurse practitioners and male doctors, that female patients received a more comprehensive consultation when the health professional was a female nurse. In this case they 'encouraged [their patients] to talk about the social/bibliographical context of their lives- [i.e.] speak their emotions' (1995: 179), in contrast to male doctors who tended to dismiss any emotional appreciation by taking it as irrelevant. Haberland et al. (1981) also contribute to the idea that nurses tend to fill the communicative gaps left neglected[1] by doctors. Haberland et al. (1981) describe this situation as follows:

[1] The 6th International Nurse Practitioner Conference held in Melbourne, Australia (5-8 February 1998) addressed the need for a collaborative work between doctors and nurses.

> The common situation on hospital rounds, where the nurses afterwards have to "translate" the doctor's wording of the cases into normal, understandable language, so that the patient may get an idea of their situation, is the rule rather than the exception in therapeutic communication.
> (1981: 106).

In other words, Haberland et al. (1981) reveal that in their study doctors showed some inability to adapt to the patients' need and to use a discourse that narrows the gap between doctor and the person who is sick. Similarly, Fisher (1991) found that doctors overlooked the socio-relational side of the patient's care, delegating this responsibility to other health professionals. Fisher (1991) notes that doctors' and nurses' discourses differ in regards to the space given to the patients to recount their own stories. Nurses tend to prefer a discourse style that favour patients elaboration of their own discourse:

> Where the doctor provides very little space for the patient to explain what [their] symptoms mean in the context of [their] life, the nurse practioner, by asking open-ended questions, maximizes this kind of space. Where the doctor lets contextual cues pass unexplored, it is just the social clues that the nurse practioner pursues (1991: 166).

This division of responsibilities in the medical system, i.e. where on the one hand there is the expert who treats the medical condition and on the other there is the *Human Fellow* who listens and encourages the *voices* emerging from a person/patient in need of help, could be understood following Bamberg's (1991) suggestion. According to Bamberg (1991), there is a trend in the Western world to de-emphasise the use of non-medical voices in the doctor consultation due to the over-specialization required nowadays in the medical system, which promotes non-medical duties being passed on to other caretakers.

> ... Recent trends toward an increasing specialization and the necessity of an increasing technical expertise are viewed as contributing to a decrease in emphasis on the person as a whole, in particular, as one who is functioning and doing (relatively) well in his or her social and cultural life-world. Whatever may have "caused" these changes in perspectives, the common split between curing as the basic obligation of medical experts, and caring as a secondary obligation, which is handed over more and more to other caretaking professionals (nurses, social workers, psychologists, priests), seems to be widely shared in Western societies by laypeople and medical experts (Bamberg 1991: 330).

The separation of 'basic obligatory and secondary tasks' stated by Bamberg was not a recurrent feature in my study when observing doctors' behaviour. Doctors used both the bio-medical and the socio-relational approaches in their consultations (see Section 2.5). Although the medical voice projected through the *Doctor voice* was prominent in comparison to the *Human Fellow voice* when the type of questions aiming at searching patients' health condition is compared; see for example the question employed to understand patients' lifeworld (93.9% QIS searching medical information in contrast to 6.02% QIS not related to patient's health, see Table 4.12), this does not diminish the importance of the *Human Fellow voice*, since QIS not related to patient's health constituted one example among other affilitiative forms used throughout the discourse. The section of 'affiliative discourse and *simpatía* in the medical consultation' (see Section 6.4) further develops this point. The *Human Fellow voice* made the medical consultation more humane and more oriented toward the patient by looking after the person who was sick. Following Mishler (1984), the use of the *Human Fellow voice* could be interpreted as an interruption to the voice of medicine. Nevertheless, the present study shows that the performance of this *voice* creates the platform for an interaction (Silverman 1987) where doctors and patients

can develop a productive communication, which can benefit both participants. For the doctors it is an opportunity to achieve both a holistic understanding of the patients' ailment and a comprehensive diagnosis where the whole person/patient is taken into account (see for example, Examples 4.47, 4.57 and 4.62). For the patient it is an instance of being understood as a person who has responsibilities and obligations to fulfil as a member of a society, apart from being a body that needs to be cured.

The use of the three *voices* within the medical discourse has the potential to create a more 'balanced' bio-medical and socio-relational consultation where the whole patient/person is looked after in a process where (a) acquisition of information is satisfactorily achieved, (b) the education given contributes to the patient's well being and health and (c) the socio-relational information provides additional knowledge about the patient which appears to be favourable to both patient and doctor. All of these aspects will be further elucidated in the discussion that follows.

6.1.2 Patients' voices

In this study, patients' *voices* were interconnected with the *voices* performed by doctors. This implies that patients also show alignment to the medical consultation by performing *voices* that relate to their health condition and interact with the *voices* used by doctors. This was the case for the *voice* of *Health-related storytelling* (see Section 5.1) and the *voice* of *Competence* (see Section 5.2). Both projected a sense of understanding and commitment towards curing the patients' body either by using self-interpretation to narrate a health story or by showing compliance to a medical treatment. Nevertheless some consultations also presented examples of the *voice* of *Social Communicator* (see Section 5.3) that diverged from a strictly medical orientation by providing information that revealed patients' social contexts. The

emergence of this *voice* was both the result of doctors' use of 'questions unrelated to patient's health' (see Section 4.3.4.3) and patients wishing to recount their own stories (see Section 5.1). Patients may provide elaborate recounts of their condition and the social and family circumstances surrounding it, sometimes regardless of the *voices* doctors used. This appears to suggest that the consultation allows for the presence of other *voices* that do not entirely align to the medical institution, but whose use helps the smooth running of communication by allowing and promoting a discourse that goes beyond the strictly medical context.

Labov and Fanshel (1977) and Davis (1988) suggest that the development of patients' story (*i.e. voice* of *Health related-storytelling* and *voice* of *Social Communicator*) is subject to the 'reportability' of the event that justifies 'holding the listener's attention' (Labov and Fanshel 1977: 105) due to the affective proposition of telling something that is *funny/amazing/fascinating/fantastic/peculiar* (Labov and Fanshel 1977: 105). In this study however, it appears as if the narrative intended in the voice of the *Social Communicator* was to share people's dreams, fears and family concerns. Patients' stories were rarely reportable solely because they were funny or peculiar. However they were instances of sharing experiences, resembling conversations that develop between friends. This relates to what patients take as a positive attribute of a Chilean doctor. The semi-structured interview (see Section 5.7) revealed that patients would rate positively those doctors who would listen to them, favouring a communication that was sympathetic towards patients. One of the patients who was interviewed commented on this as follows: *me gusta [un médico] que me escuche* 'I like a doctor who listens to me'. Similarly, it was found that patients liked doctors who were friendly, warm, affectionate, kind and pleasant when talking to them (Cordella 1999), and who would listen to their stories as shown in the following

extract: *me gusta cuando el médico es abierto para contarle penas y dolores* 'I like it when the doctor allows me to express my aches and pains'. This comment appears to suggest that the sense of 'reportability' attached to the story is not always bound to the peculiarity of the reportable event but rather to the patients' willingness to share their life experiences with the doctor. The difference between my study and those of Labov and Fanshel (1977) and Davis (1988) may be due to the different socio-cultural expectations placed on individuals in connection with the context in which the conversation takes place (Gumperz 1982b) and the relationship that participants may develop in the consultation. This may result in the diverse selection of stories to be shared with doctors across cultural groups.

The use of both the *voice* of *Social Communicator* and the *Human Fellow voice* within the discourse of the medical consultation could be interpreted following Goffman's (1983) observation that the transformation of the participation framework emerges through the process of interaction:

> ... We quite routinely ritualise participation frameworks; that is, we self-consciously transplant the participation arrangement that is natural in one social situation into an interactional environment in which it isn't. In linguistic terms, we not only embed utterances, we embed interaction arrangements (1983: 11).

Following Goffman (1983) the interaction arrangements of both the *voice* of *Social Communicator* and the *Human Fellow voice* could be interpreted as a transplant from a social situation where their use (see Section 2.3) is a common feature, to another social setting, in this case the medical one, where its prevalence is much less documented (see Section 2.5 and 2.6).

With regard to the patient's own initiative, this study found that patients used the *voice* of *Initiator* to intervene in the medical consultation and in so doing they

were able to introduce topics to be developed in the conversation (see Section 6.5). From the observations already made it is possible to say that the medical discourse in this study shows a versatile style of production for both participants. This coincides with Wodak who notes that 'there exists not *one* discourse in the institution, but a whole set of interwoven, conflicting discourses which construct and establish multiple relationships' (Wodak's emphasis, 1996: 12). The participation framework of interactants called for the use of different forms of talk in the development of the consultation. These forms permeated the relationship between participants creating a multi-level asymmetrical interaction.

6.2 Asymmetry in the institution and use of *voices*

In this study asymmetry in the medical institution was observed at two main levels; it appeared through both the institutional practice and through the discourse used in the interaction. The focus of this research is to study fundamentally the presence and realization of the latter, a brief description of the effect that the institution has on the asymmetrical work of participants (see Section 2.3) will be also provided.

As mentioned in the methodology section (see Section 3.5.3 Stage IV), patients who attended the clinic were familiar with the medical centre since they had visited it before, had carried out most of the prescribed tests in that clinic and some of them had consulted other health professionals in the same setting. This familiarity of the patient with the institution, resulting from recurrent visits to the centre, is attested by the information stored in personal files available in the centre. As a matter of exemplification Foucault's (1980) depiction of 'Panoptism' describes the control that could be exercised behind the consultation and that can promote the asymmetrical

interaction at the local level. Such record keeping allows the medical institution to exercise some degree of control over patients, a control that can promote the asymmetrical character of the interaction. Foucault (1980) uses the metaphor of the 'Panopticon' (a circular system of jails devised in the nineteenth century to better control criminals) to describe the control that could be exercised by the doctor in the consultation and that could promote an asymmetrical interaction. For Foucault 'Panoptism' represents the material expression of surveillance and control exerted by a superior social body (e.g. the state medical institution) over the individuals through the accumulation of dossiers, patients' records and identification which are not available to the patient but they are to the medical institution. The interpretation of asymmetry in discourse analytic studies (see Sections 2.2 and 2.3) has been based on the unequal opportunities that doctors and patients have to participate in the speech due to the unequal resources (Fairclough 1989, 1992, Giddens 1976, 1977, 1987 van Dijk 1995a, 1995b, 1997b) available to them. These inequalities are also reflected in the asymmetrical relationship by which participants enter into the communication. On one side is the unhealthy individual needing medical attention and (usually) lacking medical understanding and knowledge and on the other side is the (presumably) healthy, knowledgeable expert. This well-known depiction of the medical consultation was certainly reproduced in my study. In what follows I will illustrate the asymmetrical use of *voices* in the discourse and analyse how they emerged in the consultation.

The asymmetrical relationship between participants was shaped by the distribution and frequency of use of particular *voices* in the discourse. Whereas doctors used the *Doctor*, *Educator* and *Human Fellow voices*, patients used the *voices* of *Health-related storytelling*, *Competence*, *Initiator* and *Social Communicator*. This

confirms that the participation framework (Goffman 1981) of interactants in the exchange is dependent on the subject position that they occupy and the social relation they introduce into the discourse that concomitantly constrains and modulates the content of participants' contribution (Fairclough 1989). The use of both the *Doctor* and *Educator voices* call for the patients to use a *voice* that is not at odds with the medically oriented discourse initiated by doctors. Similarly, the *voice* of *Social Communicator* calls for the doctors to produce a discourse that refers to the lifeworld of the patient. Whereas patients frequently respond to the *Doctor* and *Educator voices* by using *voices* of *Health-related storytelling* and *Competence* (see Section 5.5) indicating their accommodation to the prevalent medical discourse offered by the doctors, the doctors respond to the *voice* of *Social Communicator* by either encouraging patients' further elaboration (*Human Fellow voice*) or by limiting the use of it (shifting to *Doctor* or *Educator voices*). This marks an asymmetrical practice in terms of the function of the *voices* used by doctors in the medical discourse (*Doctor* and *Educator voices*) that contrasts with the function of the *voices* used by patients to operate in their lifeworld (the *voice* of *Social Communicator).*

6.3 Asymmetry in the medical consultation and power through discourse

The distinctive use of *voices* and the frequency by which they were used differentiate the roles that doctors and patients were performing during the consultation, contributing to a dynamic participation of individuals. Whereas the *Doctor voice* and the *voice* of *Initiator* aim at searching information about patients' health, the frequency and the type of questions used in each of those *voices* marked the asymmetrical distinction between doctors and patients. Doctors initiated the majority of the questions (359 questions were initiated by doctors and 38 questions

were initiated by patients) during the medical consultation (see Tables 4.1 and 5.3). This coincides with Ainsworth-Vaughn (1994); Coulthard and Ashby (1975); West (1984), who report similar results and with Frankel (1984) and Ten Have (1991) who reviewed the abundant literature that centres on questions in the medical discourse (see Section 2.6.2). The frequent use of questions in my study can be interpreted as a production mode that intends to exercise control over the conversation while investigating the patients' health condition. Wodak suggests that:

> Doctors exercise power over their patients, they ask the questions, they interrupt and introduce new topics, and they control the conversation. Patients are expected to comply with the explicit and implicit norms of the clinic procedures (1996: 170).

The expectations placed on patients to reply to doctors' queries coincide with the finding of this study where patients show alignment to the medical discourse by responding to the medically-oriented *voice*. The *Doctor voice* aims at searching information in order to give a diagnosis or to assess the current health condition of the patient. This relates to the communicative routine of 'history taking' in Pauwels' (1995) taxonomy of the medical interaction with its emphasis on the use of questions. In my study, the type of questions used by doctors in the exchange may have affected their understanding of patient's health. In the case of 'QIS one' patients provided information closely related to the doctor's request. Nevertheless in the case of 'QIS chain' and 'QIS multiple choice' (see Section 4.1.1) patients did not offer answers that would respond to every part of the question. Instead patients were inclined to answer part of the question and leave the other part unanswered. This coincides with the results of West (1984) who found similar tendencies for patients who disregarded part of the question when the question includes options or a chain of questions placed

one after the other. In a study carried out by Hein and Wodak it was found that open questions gave the opportunity to patients to 'produce a self-structured reply [and to] tell a real story' (Hein and Wodak 1987: 53); although they also found that a relationship existed between the types of questions asked by the doctors and the level of education of the patients. This reveals that some types of questions are more effective at getting an answer than others. In my study the use of 'QIS chain' and 'QIS multiple choice' appear to be counterproductive since the patient's answer accounts only for a portion of the question asked by the doctor. It could be possible to hypothesise that the lack of response to every part of the question is due to the nature of the type of question rather than to individual characteristics of the patients. Consequently, the doctor may not obtain the information required and this inadequacy of questioning, following Cicourel, can result in misdiagnosis due to incomplete or poor information collected by health professionals (1999: 183).

With regards to the type of questions, doctors use a greater variety of them than patients. Patients' questions repertoire do not include multiple choice questions or chain questions, instead there is a tendency for the patient to use the equivalent form of doctors' 'QIS one'. Thus, whilst the intrinsic nature of the consultation leads doctors to ask most of the questions, in order to give a successful diagnosis or assessment, patients' limitations in their use of questions could be interpreted as an alignment to the medical discourse, where the role of the *Initiator* of questions is in the hands of the health professional and not (at least in relative terms) in the hands of the individual who is after help.

The recognition of each other's roles in the medical consultation has been mentioned by Erzinger who suggests that the difference in roles is based on the responsibility that each individual has in the discourse and on the positive attribute of

respect that conditioned patients to restrict themselves in their initiation of a discourse:

> Doctors have a prominent position as initiators in the medical encounter because their status as interviewers makes them responsible for the introduction of new topics. Spanish-speaking patients in this study maintained their respectful position as the good patients and initiated topics less frequently than doctors (1989: 199).

The presence of patients' respect toward the doctor and their restriction in the use of a predominant characteristic of doctors, could be a result of an uncontested exercise of power where each individual conforms to each one's 'allocated' position of playing either the role of doctor or patient. This suggests that participants' behaviour is relatively fixed and dependent on each other's position in the discourse, regardless of the interaction that is developed during the consultation. Consequently, the chances of 'dialectic control' (Giddens 1984) and actions of participants may be diminished. If this were the case in my study, it might be expected to detect more evidence in the data supporting Erzinger's interpretation of respect. Nevertheless, this does not appear to be the case. The position of participants as actors makes them capable of intervening in the discourse and to alter its course (Giddens 1976: 11). This point will be elucidated throughout the development of this discussion.

In this study it was also possible to observe asymmetrical behaviour in the use of silence and reprimand remarks employed by doctors. These features were found in the discourse strategy 'assessment of patient's compliance' (see Section 4.1.2) classified under the *Doctor voice*. Such function exercises the legitimate authority of appraising whether the patients have or have not followed a medical recommendation. Doctors varied in their responses depending on whether they were dealing with complying or non-complying patients. While doctors congratulated their complying

patients for having followed the treatment as prescribed (see Example 4.12), they used silence and reprimand remarks (see Example 4.13) to show their disapproval of patients' negligence. The patients who failed to satisfy the medical recommendations performed as non-complying patients, and therefore demonstrated a lack of alignment to the medical institution. Example 4.13 presents an interesting scenario that allows us to understand how the medical voice, in this case the *Doctor voice*, prevails over *the Educator* and *Human Fellow voices*. I propose that in this process there is a risk of diminishing the chances of patient's future compliance due to the lack of educative information (*Educator voice*) that may afford the patient a better understanding of his/her health problem. In Example 4.14, the patient articulates a concern about her weight loss because, in spite of the fact that she has been following the diet, as prescribed, she does not seem to have lost weight.

The doctor's silence and reprimand featured after the patient's contribution (Example 4.13), not only show the different discourse strategies that both participants used in their asymmetrical discourse, but they highlight the counterproductive use of strategies that do not contribute to the patient's understanding of what could not be working well in her diet. The doctor's discourse is contributing to maintain the expert's and the layperson's knowledge apart (Cicourel 1999, Davis 1988, Fisher 1995, Fisher and Todd 1986, 1993, Hein and Wodak 1987, Wodak 1996). Therefore it is jeopardising the patient's understanding of both his/her health condition and treatment, and thus risks patient's compliance (see Section 6.6). Wodak refers to this separation of roles as 'the gulfs that separate insiders from outsiders' (1996: 2), claiming that this contributes to disorders in discourse and communication. This is in accordance with the study of Daly and Hulka (1975) and Gopinath et al. (2000) who found a correlation between patient's satisfaction and compliance. If it is assumed that

there is a relationship between patient's compliance and doctor's speech style then it would be possible to suggest that the better the health education delivered by the doctor to the patient, the better chances there are for the patient to comply. In the examples just described, the absence of an educative episode and the negative attitude of the doctor to understand the patient's difficulties in following her treatment promoted hostility and proved to be a counterproductive practice.

The *Educator voice* also shows an asymmetrical knowledge position of participants. Doctors give information to patients and impart education to them on medical matters that were not (usually) part of patients' initial background knowledge. In my study it was found that the education could be accomplished during the communicative routine of 'management and treatment of a health problem or health issue' (see Section 4.2.2). In this function doctors provide explanations that could serve as a learning platform for patients to acquire medical knowledge, leading to a better understanding of their health condition. Whereas in the sub-function of 'Account of factual medical issues and patients' discomfort' the following accounting practices: 'accounts of test results', 'accounts of test to be carried out' and 'accounts about the functioning of the human body' represent the 'authoring' (Goffman 1981) medical script that separates individuals by their different knowledge of the medical field, the 'account of patient's discomfort'- within the same sub-function - represents an instance where doctors confirm their alignment to the medical institution by framing patients' discomfort as a medical issue and by protecting the medical institution from any decision previously taken that could be the cause of patient's discomfort (see Section 4.2.1.4).

In Example 4.29 the patient's discomfort was not associated with the new dose of medicine that was prescribed, but with a psychosomatic response. Example 4.30

shows the doctor's support of her own decision not to carry out medical tests in spite of the patient's recurrent discomfort. The analysis of the above extracts suggests that doctors themselves exercise a degree of surveillance and control over the medical institution, not in terms of Foucault's understanding of control exerted by a superior social body, but in terms of one individual's control over another. In other words doctors appear to guard themselves (in terms of malpractices) and in so doing they save their 'face' (Goffman 1967), they shield the medical institution (in terms of reputation) where they belong and the medical field that they represent. In this way the medical centre, and in a broader scale the medical profession, maintains the high standard of trust put on them. Saving someone else' s 'face' means saving his/her own 'face' as a member of the medical institution. Following Helman (1994) this could be interpreted as a gradual process of 'enculturation' of medical doctors, through which they acquire a perspective of health as well as 'high social status, high earning power and the socially legitimated role of healers, which carries with it certain rights and obligations' (1994: 101). The legitimisation of health professionals places doctors in a category of authority in the medical field that makes them powerful entities in the education of patients and in the confidence that patients place on them. Similarly, Wodak (1996) comments on the medical training young doctors receive '...owing to the values and myths of the institution, they are expected to live up to the image of omniscience, although they are actually in training'. According to Cicourel (1999), medical schools in the U.S.A. promote the idea that doctors are special, through the selection procedures that students have to go through in order to be admitted into medicine. This is similar to the situation in Chile where medical students are at the

upper percentile of scores in the national entry university test *Prueba de Aptitud Académica*[2]. In Cicourel own words:

> In United States, medical students are accorded a status that other graduate or professional students seldom enjoy, and this selectivity provides an initial kind of "aura" or charisma and power to these individuals (1999: 190).

The data of my study appear to suggest that Chilean doctors are considered by themselves and by their patients as special. For instance, patients' lack of contest in the 'account of patient's discomfort' can be interpreted as a sign of unquestionable explanation of their own discomfort even in those cases where the prescribed treatment itself could have been the cause of the patient's distress (see Example 4.29). For those patients the doctor is the authority who interprets their own discomfort since they (the patients) are not in a position to give a technical opinion on the topic. This could support the idea of a positive social attribute to the medical procedures carried out by health professionals and would confirm the shared assumption that medicine is practiced to assist and find relief for the patient.

Although factual explanations were never contested by patients, this passivity was not always present in this study. Patients as social actors performed their role of adult-independent thinkers by not constraining themselves to the submissive and helpless role of unhealthy individuals, and sometimes contested their doctors (Giddens 1976). To illustrate this, I have selected three examples from the sub-function 'Accounts of medical treatment/management in doctor-patient interaction' because they show a different pattern of behaviour for doctors and patients. Whereas the former perform a role as educators that is achieved by different linguistic means,

[2] See http://www.puc.cl/admision/puntaje/index.html

the latter display interpretative schema of their illness in relation to their responsibilities in society that clashes with the medical one (see Section 2.6.3).

The three educative episodes (Examples 4.42; 4.37-4.41 and 4.36) – that I refer to in more detail below- call for the patients to interact in the discourse and for the doctors to negotiate with the patients since in this case it is not the interpretation of a factual scientific result, e.g. the level of the blood pressure, that is at issue, but rather it is a proposal of a treatment that might have an impact on patients' daily life. Therefore, the act of prescribing a treatment involves the interaction between the medical expert who imparts the treatment and exercises power over the patient to achieve a medical end, and the patient whose life might be affected in the process of receiving the treatment.

The sub-function 'Accounts of medical treatment/management in doctor-patient interaction' is a sensitive one for the doctor whose aim is to propose a treatment that will be successfully complied with by the patient. It is also a sensitive sub-function for the patients who may perceive the treatment as a potential obstacle to their usual routines (the attitude that the patient has about a treatment usually depends on the severity of the illness). This potential tension can be resolved through negotiation. It is not surprising then to see that doctors use different discourse forms – i.e. Spanish 'markers of inevitability', 'marker of conditional inevitability' and impersonal agents - to achieve (or try to achieve) their ends. This coincides with Tannen (1987) who suggests that the exercise of power can be achieved in different forms in response to the dynamic interaction produced by individuals, and by Holmes et al. (1999) who show 'that superiors in workplace 'do power' in interactions in a variety of ways' (1999: 377). The *Educator voice*, in 'Accounts of medical treatment/management in doctor-patient interaction', provides a tool to exercise

power over the patient while, at the same time, education is also at issue. The central point here is to understand how the doctors educate their patients and through which form of power this is attained, as well as how patients relate to the use of power by doctors in the consultation.

The way doctors exercised their power over their patients varied from blunt authority to a friendlier persuasive manner. This is in accordance with Wodak's study that shows that 'doctor's manner with the patient ranges from a gentle approach through stiff formality and impatience to harsh authority' (1996: 47). Doctors' forms of talk appear to be dependent on patients' resistance towards the treatment being proposed and the doctor's conviction that the treatment being proposed is the best. In order to explore this point I recall Example 4.42. In this transcript the main participants are Dr. Carlos and Olga, a female patient in her late forties who is a house-manager and looks after three boys and her husband. She had been suffering pain in her arm for some time. She had received medical advice to have an operation from a bone specialist. For her, the operation represents fear, disruption of daily routines and she does not believe that it will solve the problem of the pain in her arm. For Dr. Carlos the operation is the unquestionable and appropriate treatment to be used in this case. The way the doctor presents and selects the information to the patient, shows his commitment to make her align to the medical recommendation that both the specialist and himself have proposed as the best option for Olga. Dr. Carlos disregards Olga's fears about the operation and instead of using an affiliative voice and make the patient talk about her worries, he presents the operation as the best treatment to ameliorate the patient's arm problem and achieve a quick recovery. This is accomplished by using discourse strategies that depict the treatment as the best way to maximise the chances of success to enable Olga to return promptly to her normal

life. For example Dr. Carlos uses: *lo más probable que ocurra es que eso vaya a recuperarse en forma optima* 'what's almost certain is that you'll recover perfectly well', *le han explicado que es algo rápido* 'they have explained to you that surgery is quite quick', *Uste- va a poder hacer su vida completamente normal* 'you 'll be able to carry on your life in a completely normal way'. In contrast the non-alignment is presented as a future that is not promising, by the use of: conditional clause – *si no se opera debe aceptar ... limitaciones* 'if you don't have the operation you will have to accept ... your limitations', and progressive forms that indicate continuous deterioration in her arm mobility – *podría ir empeorando* 'it could get worse'. The doctor's 'persuasional strategies' (Fisher and Todd 1993: 169) are working together to persuade the patient to have the operation (see Example 4.42).

With regards to the presentation of the medical information concerning the operation, it is possible to observe that an alternative treatment to the operation is provided. The alternative treatment appears only once in the discourse and in a very succinct form: *hay alguno- tratamiento médico que pueden tratar de combatir eso, pero no son tan espectaculares como lo de la cirugía* 'there are some medical treatments to fight that, but they are not as spectacular as surgery'. Even if an alternative treatment is announced it is immediately disregarded in favour of an operation. No information is given about the alternative treatment nor is this topic developed further in the consultation. Thus the doctor's withholding of information reveals his own power in the medical field to avoid reporting to the patient all the available treatments for her condition. Olga might have left the consultation without a thorough understanding of all the possibilities available to address her problem. This finding mirrors many other already reported in studies of medical discourse (Davis 1988, Fisher 1995, Fisher and Todd 1986, Wodak 1996). Following Fairclough 'the

exercise of power: constraints on contents, subjects, and relations. In terms of the contents, discourse in a formal situation is subject to exceptional constraints on topic on relevance, and in terms of more or less fixed interactive routines' (1989: 65).

The example presented below shows how the exercise of power can be achieved in a more persuasive and gentle way than in the example just shown. The concept of *simpatía* is here presented following Triandis et al. who underline the avoidance of interpersonal conflict in favour of friendly and easy-going manners:

> [*Simpatía*] refers to a permanent personal quality where an individual is perceived as likeable, attractive, fun to be with, and easygoing... behaves with dignity and respect toward others, and seems to strive for harmony in interpersonal relations. [It is characterised by] the avoidance of interpersonal conflict... (1984: 1363).

Erzinger (1991) notes that *simpatía* is a cultural quality that can only be defined through illustration. It is my intention to demonstrate how *simpatía* stages itself in the discourse, sometimes *simpatía* 'wears' a friendly mask, that hides persuasion and power, other times *simpatía* appears to 'wear' a 'genuine' costume of friendliness that helps communication between both interactants. The following examples will illustrate this point.

Examples 4.37-4.41 are useful to explain how persuasive discourse strategies can be used with the purpose of making the patient align to the recommendation delivered by the doctor. In this extract Carmen, a patient in her fifties who works as a secretary suffers from depression. Dr. Ana recommends her to attend psychotherapy sessions as a complementary therapy to the medication she is currently taking. Carmen's reluctance to accept this therapy is based on her work commitment that restrains her freedom of action with regards to time availability to attend the psychotherapy session, as well as the long distance that she needs to travel to get to

the medical centre where the sessions take place. Dr. Ana in this episode uses the 'modality marker of conditional inevitability' by saying: *sería bueno en alguna-ocasione- apoyo con en psicologíc o con psicoterapia* 'it would be good in some instances to have ... some psychological or psychotherapy support' to make the patient understand that her condition can be ameliorated if she attends the therapy sessions (Example 4.37). Once Carmen has mentioned her problems of time the doctor continues her recommendation by using the 'marker of conditional inevitability' and increasing the intensity of the advice by including, this time, adverbs of manner to emphasise her recommendation; i.e. *sería bien bueno* 'it would be very good (to attend psychotherapy sessions)' (Example 4.40). Dr. Ana is using her *simpatía* to influence her patient's decision to attend psychotherapy sessions and to avoid an open conflict, which could jeopardise a 'working consensus' (Goffman 1959: 21). The 'modality of conditional inevitability' helps to create an atmosphere of friendliness where the imposition (Brown and Levinson 1987) put on the patient is less evidently expressed than in those cases where the 'marker of inevitability' (see Section 4.2.2.1) is used. This study also found that the imposition of the act to be accomplished can be modulated by selecting the information delivered and using discourse strategies that are menacing and convey fear, this was the case in Example 4.42 where Dr. Carlos used a conditional clause to strongly persuade his patient to have the operation by saying: *si no se opera debe aceptar ... esas limitaciones* 'if you don't have the operation you will have to accept ... your limitations'. This was used to make the patient align to the medical recommendation in the absence of *simpatía*. Although *simpatía* constitutes a recurrent feature in the episode presented in Examples 4.37-4.41 this does not mean that Dr. Ana does not show her 'legitimate authority' in making the patient comply with the medical recommendation. In the

concluding remark of this episode (example 4.41) Dr. Ana says: *¿Ya? Así que yo creo que Uste- se ayudaría así es que la idea que cuando Uste- vea que se pueda hacer el hueco ojalá, lo pueda hacer ¿ya?* 'O.K.? so I think that you would benefit, so the idea is that when you see that you can manage to make the time, hopefully you'll do it. O.K?'. It would benefit you greatly O.K?'. Her utterance represents the voice of authority in the medical field, the expert who knows what is best for her patient. The use of the first personal pronoun 'I' indicates her performance of credibility (see Section 4.1.3) in medical matters and legitimates the relevance of a treatment that is prescribed by her as a professional in the field. In the course of recounting of doctors actions the pronoun system was represented by the first person singular 'I' and the first person plural form 'we'. Both of them were used in similar proportion (see Table 4.3). Whereas the 'we' form showed doctors credibility in the performance of an action that involves both the speaker and the medical institution, the 'I' form makes the speaker fully responsible for the action. Since in Spanish personal pronouns can be avoided in a sentence by making the ending of the verb correspond to the gender and singular/plural form of the pronoun, the explicit use of the pronoun in Dr. Ana's (Example 4.41) statement *yo creo que Uste- se ayudaría* 'I think that you would benefit ...' appears to indicate an emphasis on the credibility that her, as health professional, attached to herself and the institution that she represents and in so doing she projects an image of 'knowing how to do things'.

There is no evidence to suggest that one form of power is more successful in terms of the patient's compliance than others, nevertheless there is evidence to suggest that doctors use different discourse strategies in response to patients' reluctance to follow a proposed treatment. These discourse forms varied from brusque

exercise of power to the exercise of *simpatía* that appears to act as a buffer of power. Similarly Davis shows:

> Occasional instance of... straightforward, authoritarian control..., it was, by far, the exception. Rather than being characterized by coercion or restraint, the most pervasive feature of my consultations was a quality of friendly intimacy. They bore more resemblance to a chat between friends than a chilly institutional encounter headed by a harsh, authoritarian physician (1988: 107).

The use of the *Educator voice* shows that doctors not only educate their patients with regard to their health by making them more knowledgeable and aware of the medical condition they are experiencing, but their status in society (Helman 1994, Cicourel 1999) puts them in a particular position of superiority with regard to their patients. They do not only communicate their knowledge and understanding of health issues, but they can also deconstruct some aspects of the society in which they live and through the use of the *Educator voice* they can articulate (i.e. principal) their opinions and beliefs that are intended to educate their patient beyond the boundaries of the medical territory. This is the case in the examples (see Examples 4.36 and 4.44-4.45) where the *Educator voice*, associated with the medical educative episode, is disrupted by the inclusion of doctors' personal opinions. Example 4.36 shows Dr. Ana advising her patient to attend social clubs to fight her loneliness. Dr. Ana refers to *(el) Club de Tango o Centro de Madre* '(the) Tango Club or Mothers' Centre' as possible alternatives for her patient. Whereas the Mothers' Centre is usually formed by a group of women who get together regularly to share their experiences and carry out craft works in order to raise money in the community, the Tango Club is a centre where her patient could meet a partner. Both recommendations deconstruct a gender identity in a social setting (Todd and Fisher 1988; Holmes 1987, 1990, 1992, 1997; Pauwels 1987; West and Zimmerman 1991; Winter 1992; Winter and Wigglesworth 1993; Wodak

1997) by highlighting those social activities where a female of her age would be welcomed. Another example that shows how doctors use their opinion to exert some educative influence on their patients can be found in Examples 4.44-4.45. In this extract the doctor educates her patient about disregarding any comment on medical issues that is not given by a health professional. The doctor claims that Chileans have the misconception of believing that everybody is a potential doctor. By saying this, the doctor creates a distinct separation between those who are inside and those outside the medical institution, giving authority to insiders and non-credibility to outsiders. Doctors' opinions and beliefs permeating the medical consultation appear to indicate the inclusion of ideological work in the medical discourse. Following Fairclough and Wodak:

> Discursive practices may have major ideological effects: that is, they can help produce and reproduce unequal power relations... through the ways in which they represent things and position people (1997: 258).

The concern that Chilean doctors have with respect to patients believing that they are themselves 'doctors', may undermine their potential role as educators. This may partly explain why only fifteen consultations included an educative episode. Doctors may fear that competent patients may be predisposed to go well beyond their limited knowledge and start acting like 'doctors' in the context of their local community. Misdiagnosis and incorrect treatment may be the end result of individuals stepping outside the limits of their competence, with consequent danger to their own and/or their acquaintances' health. A way to prevent this possibility occurring is by increasing patient's knowledge further and educating him/her about seeking proper professional advice. After all, the ultimate function of the *Educator voice* in doctor-

patient communication is not necessarily that of making the patient self-sufficient with regard to diagnosis and treatment of his/her illness, but to give the patient the knowledge needed for a successful application of the treatment recommended by the doctor and for competent monitoring of the development of his/her condition. Precision and accurate reporting of the information given to the doctor and competent understanding of doctor's discourse cannot but improve the chances of finding a better treatment (if available) or ... a better doctor!

As I have illustrated in the section above, doctors not only exercise their power in a straightforward way through their selection of discourse structures and forms but they can also perform *simpatía*, which acts as a buffer over the control of the patient. The section below will explore how *simpatía* and affiliative discourse work together in the attempt to create a more relaxed atmosphere that favours patients' participation in the consultation.

6.4 Affiliative discourse and *simpatía* in the medical consultation

The occurrence of affiliative discourse was represented in *Doctor, Educator* and *Human Fellow voices* (see Chapter 4). The frequency of use varied between those *voices* that are medically oriented (i.e. *Doctor* and *Educator voice*) and the *Human Fellow voice*. The latter presented many more forms (see Section 4.3) that express affiliation than the former two.

In this study it was shown that the main outcome of the use of affiliative discourse was to create empathy with the person that was sick and promote a cooperative communication where the expression of *simpatía* was at the core of action. It is possible to say that *simpatía* was acting as a device that made the

communication less asymmetrical, through the doctors' use of discourse forms that focused on building up a friendly relationship (see Section 4.3).

In the *Doctor voice* affiliation was achieved by doctors addressing questions that were patient-oriented and that centred on the impact that the health condition had had on the patient's activities (see Example 4.2). Similarly, in the *Human Fellow voice,* doctors posed questions that were not purely intended to get information about patients' health (see Section 4.3.4.3), but to gain extra information that could allow the assessment and understanding of patients' commitments, obligations and responsibilities that are an integral part of their lives. It is not my intention to categorically disregard the possibility that doctors might have used this type of question to investigate further the condition of the patient and to understand whether there is a connection between patients' disease and his/her *milieu.* In fact, psychological/psychiatric studies support the idea that health problems are connected with the environment where the individual carries out his/her activities (Stoudemire 1990). Although this might have been the case, the data show that these questions helped to create a more humane and caring interaction, where the patient was taken as a full member of a society with family and work commitments. It is worth stressing that it is not just the question itself that shows *simpatía* but rather *simpatía* appears through the interaction that is developed between doctor and patient around topics such as: divorce, funerals, difficulty with teenagers' behaviour, sibling relationships as well as work related issues. It would be possible to speculate that the risk in this is to transform the expert in medicine into the expert in social knowledge as well. This is precisely what happened in Example 4.44 and 4.45 when the doctor interpreted a social aspect of the community by making a judgement on Chileans' claims of feeling like potential doctors. Therefore special care is required to establish when the

contribution intends to show *simpatía* by making the patient explore his/her point in an almost non-judgemental and non-ideological manner. In other words by not imposing a point of view that denotes the doctor's ideological conviction, but instead making the patient the main protagonist of his/her story.

In the *Educator voice* affiliation and *simpatía* in the discourse were also present in some educative episodes where colloquialisms were embedded in the explanation (see Examples 4.23 and 4.25), as a way of avoiding the medical words that could (probably) prevent or impinge on the patient's learning process (Daly and Hulka 1975). Colloquial lexicon items were also used in the consultation as an alternative to technical scientific words, thus resembling everyday communication that is less restrained than the institutional one (Goffman 1981). In addition, the use of metaphors like: *sin gusto a nada* 'in this case it was unclear' to show that there was not need to carry out medical tests because the patient's complaints were not clear enough to pursue any medical investigation (see Example 4.30); or *no pasan balas por aquí* '[you are] bullet free' to refer to patients' strong health (see Example 4.10), equate to what Prieto-Castillo (1999) refers to as *el juego de la palabra* 'the playing with words' that occurs when informal speech is used. *Simpatía* in both *Doctor* and *Educator voices* finds its place in the incorporation of lexicon items, colloquialisms and metaphors, and functions as a parenthetical expression that is surrounded by the voice of medicine.

So far the point of interest in this section has been to deconstruct how education is achieved in the consultation and to observe the interconnection that appears to be present between education and the exercise of power. It has been possible to observe how the selection of information given to the patient and how the discourse developed in the communication process can impose different degrees of

power over the patient. The use of *simpatía* in the medical discourse seems to have two distinct features (a) with *simpatía* the exercise of power is accomplished by using persuasive discourse forms (b) the use of *simpatía* can favour affiliation and contribute to a communication where patients' participation is fostered. This point is developed below.

The expression of the *Human Fellow voice* constitutes the performance of a holistic interpretation of patient's health, incorporating in the consultation both the socio-relational and the bio-medical approaches to medicine. This *voice* favours communication where the patient can be heard, understood and can build up a relationship of trust with the doctor. *Simpatía* is mostly manifested in this *voice*. The absence of the *Human Fellow voice* is likely to produce a discourse that shows disregard for the individual who is after medical help by placing all the focus on the body part to be repaired. However, in this study the *Human Fellow voice* was used and through it people were treated as both persons and patients whose illness and individual identity were all taken into consideration.

Previous studies of discourse analysis (see Section 2.6) have indicated that taking the floor is a sign of the exercise of power over others. In the case of doctor-patient communication interruptions have been interpreted as a feature that aims at regaining the control over the medical conversation. If taking the floor can manifest the control over the topic and over the individual who has been cut off, then it would be possible to see doctors asking the patient to take the floor to elaborate and expand on his/her own story as an alternative or complement to the exercise of power. The simple use of CMs (*ya, Mm/Uhm, Mm/Uhm ya*; yeah/O.K., Mm, Mm yeah) produced softly between patients' contributions was indicative of doctors' willingness to hear their patients in an (apparent) non-rushed consultation. CMs proved to be important in

making the patients talk about themselves while concomitantly showing them that they are being considered as both a person and a patient. Although in the majority of the consultations CMs called for patients' elaboration of their discourse, there were only 3/261 examples where the patient was not willing to contribute further and the floor was given back to the doctor. Patients' inclusion of their stories in the consultation, that sometimes appeared to be unrelated to their current health condition, shows a medical discourse that is not just scientifically oriented but one that permits the display of other discourses as well. This could be further elaborated by the use of joint production units where both participants cooperate to construct a discourse together. Following Ferrara:

> ... The sentence itself can be viewed by interlocutors as a discourse unit under construction, because some speakers seize the opportunity to collaboratively shape discourse semantically and syntactically, one clause or phrase at a time, in the joint achievement of a sentence (1992: 208).

Doctors' cooperation to complete patients' discourse (Davis 1988; Fisher and Todd 1993) and finish their sentences is not interpreted as a paternalistic form, since no attempt was made to regain the floor or to impose a topic on the patient. Whereas 'utterance extension' was represented in 68% of the joint production units found in the study, both 'predictable utterance completion' and 'helpful utterance completion' were less represented, with 16% each. The occurrence of these 'collaboratives', following Sacks' (1965/1971) term -regardless of their frequencies- appears to indicate that the doctors were not just helping to produce the discourse but in so doing they were creating a rapport from where the interaction could be developed. Ferrara, however, observed that there is a correlation between a long-standing relation and building of rapport and the frequency with which joint productions are used in the

discourse (1992: 213). Doctor's contribution in joint production units helped to make the discourse flow smoothly as if a conversation was being developed between people who knew each other relatively well. This supports Schegloff' views that 'one person knows what the other person has in mind by saying it for him[/her] ... [s/he is] completing his[/her] sentence' (1984: 42). Similarly, Marshall (1988) observes that cooperation in doctor and patient discourse resulted in the use of 'duetting' and building up sentences. This point is also shared by Ochs et al. (1992) who, after observing the storytelling developed in family dinner table, indicate that the familiarity with one another's narrative event, shared background knowledge as well as family bonds of trust constitute fundamental elements that prompted individuals to participate in the joint construction of their stories. In their study the familiarity of participants elicited the joint construction, deconstruction and reconstruction of everyday activities. They argue that '...more distant personal and professional relationships may very well inhibit the development of these skills' (Ochs et al. 1992: 67). In my study doctors indeed contributed to patients' discourse. My intention is not to equate joint production fully with the complex storytelling shown in Ochs et al.'s set of data, since my data do not show the same pattern. Nevertheless the joint productions that occur in my study represent a collaborative cognitive and socio-linguistic form that presents some similarities of affiliation as is the case in family discussions. It is of interest to understand why joint productions appear in the medical consultation.

The use of joint production units may be interpreted as a precursor in the building up of trust between participants, as it represents a strategy that is most likely found in family informal get togethers (Polanyi 1989, Shiffrin 1984, Tannen 1983, 1984). This also relates to Carmichael's (1976) findings that the presence of

reciprocal family topics between doctors and patients are a sign of trust 'exposing one's unprotected part in a family relationship is not submission but evidence of trust' (1976: 562). Conversely, I hypothesise that the alternative for the doctor could be to avoid collaborative production of discourse with a patient, and this could potentially be interpreted as a sign of reprimand. This would be mainly the case when doctors deprive themselves of contributing in 'helpful utterance completion'. Their silence, as in the case of the non-complying patient (see Example 4.13) could be interpreted as a reproach in response to patient's forgetfulness for not recalling the word by him/herself and thus needing the doctor to cooperate in the construction of the patient's idea.

This study also indicates that the functions 'Create empathy with the patient' and 'attentive forms' are used to create the same pleasant atmosphere of a friendly and familiar interaction where the consultation can develop in an environment where the patient is heard, understood and where the doctor can interact with the patient in a less asymmetrical manner by cooperating with the patient in the discourse. Following Erzinger (1989) 'attentive forms' would represent a pivotal element in the elaboration of patients' story and the key to success in the interaction:

> The most essential component of the doctor's conversational manner in medical encounters with Spanish-speaking patients is assuming an attitude of respectful listener. Where the patient is unable to expand upon her concerns, the doctor's careful paraphrasing and use of the patient's own words encourage elaboration. The patient's perception of the doctor's understanding, the key to successful interaction, depends upon how the patient is able to describe her concerns (1988: 195).

My study suggests that the interaction is likely to be successful when both doctor and patient work together in the consultation to create a platform where the channel of

communication is open to understand each other. The following section develops this point.

6.5 One consultation, two participants: An interactional work

The realisation of the medical exchange is a twofold activity where both participants have the chance to modulate their speech within the communicative constraints of an institutional talk. The interaction of participants and the *voices* used in their exchange appear to indicate a dichotomous system of operation where patients are both constrained and encouraged to participate in the medical discourse, and where patients' individual decision to act accordingly is at the discretion of an individual's choice. In this study patients had the chance to intervene and influence the course of an action (Giddens 1976), as well as showing alignment to the medical institutional expectations put on them.

The participation of individuals is conditioned and mainly constrained to the central aim of the medical consultation: that of getting information about patient's health, making an assessment of their illness and prescribe (if necessary) a treatment. This explains the recurrent use of the *Doctor voice* and the number of questions posed to the patient, whose answers are associated to the type of question asked by doctors. This implies that there is a significance importance of producing a type of question (see 4.1.5) that has the potential to provide the relevant information that forms an integral part of the history taking of the patient. Similarly, patients' performance of the *voice* of *Initiator* also indicates their commitment to the medical institution and to their interest in understanding their health situation, doctors responded to these questions by providing the *Educator voice* and fulfilling the role of expert in the medical field.

Doctors and patients also show their mutual work through patients' compliance to the medical recommendations that may result in an improvement in their health condition. The importance of the *Educator voice* to achieve this end appears to be paramount when the literature of patient satisfaction and of compliance is taken into account (see Section 2.6).

The *Human Fellow voice* and the stories that develop within *Health-related storytelling* and *Social Communicator* present an interesting scenario of cooperation where the story that has been developed is the result of both participants' contribution. The doctors' use of discourse features that prompt the elaboration of patients' discourse and the patient's development of the stories in response to doctors' encouragement, represent the dual work that is taking place. As observed by Davis 'stories are not told, monologue-fashion to brick walls, but are collaborative achievements' (1988: 150). Following Goffman:

> Over the course of the interaction the roles of speaker and hearer will be interchanged in support of a statement-reply format, the acknowledged current-speaking right —the floor—passing back and forth (1981: 129).

The collaboration I have been referring to so far is the product of an activity of communication that is influenced by both the *voices* participants use in an episode and the shift that may occur in subsequent episodes, which might have an impact on the recipient's use of *voices.*

In the participation framework of the medical consultation the shift of footing is in accordance to both participants' interaction, the health practice of the medical field and the institution where doctors conduct the exchange. The prevalent use of the *Doctor voice* in the history taking and patients' response to it through the use of *voices* of *Health-related storytelling* and of *Competence*, account for the alignment

that both participants have with respect to the medical exchange and to the restraints put on the relevant medical discourse to be developed. Doctors' shift to the *Educator voice* represents, in this study, their stance to the medical institution, by aligning themselves to the principles of a teaching hospital that trains doctors and patients (see Section 3.3.1). The use of *Doctor* or *Educator voices* is a response to the *voice* of *Initiator* by which the patients themselves align to their condition of unhealthy individuals and introduce a medical topic to be developed further. On the other hand, the *voice* of *Health-related storytelling* usually appears in the discourse after the *Doctor voice* has been uttered. The development of the *voice* of *Health-related storytelling* is associated to both the patient interest of staying in that *voice*, regardless (in some instances) of the *voice* of the doctor, and the doctor's use of the *Human Fellow voice* that prompts the patient to continue the elaboration of a story or to shift to the *Doctor voice.*

Whereas on the one hand patients responded to the medical *voices* enacted by doctors, on the other they diverged from them by introducing the *Social Communicator* and the *Initiator voices* without the elicitation of doctors. Those instances where the patients did not respond to the medical *voices* and performed instead the *Social Communicator*, showed patients' own control of the topic to be developed in the exchange. Indeed patients' performance revealed a dual-dynamic as well as an individual system of operation. Their discourse was not always confined to their role as patients. On the contrary, they showed a mobility of action in the medical exchange thus portraying both the image of the unhealthy individual in the use of stories revolving around their health, as well as the image of a fellow human being through stories related to social contexts. This produced a consultation where the interaction of both the bio-medical and socio-relational frames were part of the

discourse. Similarly, in Coupland et al.'s (1994) study on the consultation openings, it was observed that patients could conform to the medical frame or diverge from it:

> Socio-relational talk is initially normative, and patients as well as doctors play significant parts in negotiating how and when they should move into medically framed talk. Indeed, there are instances when it is patients rather than doctors who first act to move their talk into medical disclosure and diagnosis, and instances when doctors persist with a socio-relational frame when they have clear opportunities to move into medical talk (1994: 119).

Whereas doctors appeared to present a clear pattern of behaviour in their use of *voices* (see Section 4.2.4), this is not always the case for patients (see Section 5.5). The lack of patients' distinct pattern of use of *voices* and the shift from one *voice* to another could be interpreted following Martinic, who claims that although the medical consultation is conditioned by the institutional talk, the production of the discourse is dependent on the interaction that is created at the local level of the consultation:

> En efecto, la conversación, pese a situarse en un marco institucional, tiene una contingencia que es propia de la situación local creada y ratificada por los interlocutores en el momento de la entrevista y de la consulta (1996: 16).
>
> In fact the conversation, although it occurs within an institutional framework it has its own contingency that is unique to the local situation that is created and maintained by the interlocutors at the time of the interview and consultation.

It would be possible to suggest that the presence of a non-recurrent pattern of patients' behaviour affords an opportunity for participants to create an interaction that responds to both patients' and doctors' needs. Conversely, the strict institutional medically oriented perspective gives privilege to the voice of medicine, i.e. *Doctor* and *Educator voices*. Thus, the local interaction created within the institutional medical exchange operates within dynamic institutionalised and personal levels. Patients in

this process may have the chance to receive individually tailored care throughout the development of the interaction. The practice of patients of not following a constant pattern of behaviour appears to be common and accepted by doctors, otherwise doctors, in their authority, might have challenged patients' interactional discourse. According to Fairclough (1989) this demeanour represents a:

> Common sense [that] gives us not only meaning systems, but also what we might call the 'interactional routines' associated with particular discourse types – the conventional ways in which participants interact with each other... It's generally only when things go wrong that they draw themselves to our attention (1989: 98).

Patients non-recurrent pattern of behaviour appears to be central to the personalised consultation that they may receive. In what follows I will expand on compliance and, as a result, on patients' competence.

6.6 Competence in the medical setting

Throughout this study I have shown how doctors and patients interact in the medical exchange, and how participants bring a set of *voices* to the consultation that frame the medical event and give the opportunity for the emergence of the social context of patients' lives. My interest in this section is to expand on the medical competence that patients can attain in the exchange and the benefit that this could bring to both participants. The performance of the *voice* of *Competence* reveals that patients are familiar with their health condition and understand what they should do to improve their health status. Patients also show alignment to the medical recommendations and in so doing they show adult competence of looking after themselves. In contrast, the *voice* of *Initiator* represents an instance where the patient asks for knowledge to be imparted from their helpless and powerless subject position

lacking knowledge in the medical matter (Labov and Fanshel 1977). It is precisely this differential knowledge position that participants occupy in such events that promote the asymmetrical relationship in the interaction. Although asymmetry is more apparent in the *voice* of *Initiator* due to the powerless position of the patient in search of an expert opinion and knowledge, this voice is also fundamental in the process of education and in making the patients knowledgeable about their health condition. I understand the acquisition of competence as a process where the patient goes from powerless – the *voice* of *Initiator* - to powerful – the *voice* of *Competence*- after a series of medical consultations. The acquired medical knowledge can be used by the patients to better understand their own health problem, to better describe their medical concern to the doctor, to better care for themselves and to better communicate, whereby the asymmetry between participants will be diminished. In fact Barton highlights that lack of competence creates a disruptive and asymmetrical discourse 'more specifically, it is in this interactional situation that asymmetrical communication may emerge' (2000: 271). Thus competence when welcomed and nurtured by doctors is likely to improve both patient's knowledge and communication between doctor and patient. This is consistent with Ainsworth-Vaughn's study where she found that cancer patients and their doctors benefit from a cooperative interaction:

> The physicians I studied often cooperated with patients' claims to power. Physicians can cooperate without compromising their own selves. Patients' appropriate efforts to take control of illness translate directly into better treatment and reduced demands on overburdened physicians (1998: 190).

There is another benefit to be considered. Barton (2000: 265) in her study found that the length of the referral sequence was shorter and more efficient in those consultations where patients had experience and expertise in the medical matter.

Consequently it would be possible to suggest that competence may bring efficiency to the consultation, not just in terms of making the consultation shorter, but also in terms of the time that the doctor may use to further educate the patient (who is already knowledgeable in the particular topic at issue) and to respond to any additional patient need.

Following Goffman (1959) the *Initiator* could represent patients' social mobility not in terms of status but rather in terms of knowledge. Patients' interest in knowing about their health status and becoming competent is not due (at least there is no evidence in my study) to a desire to get closer to some 'sacred' place (Goffman 1959: 45), but most simply to have more control over their own bodies and to make their own informed decision about the treatment to be undertaken.

In contrast, doctors' refusal or lack of willingness to educate patients, doctors exercise of territorial power throughout their use of controlling discursive features that dismiss patients' opinions when they are medically framed and doctors selective information on the treatment to be prescribed, lead to the potential development of a patient who is not informed, not knowledgeable of his/her condition, and who has less chances of compliance than those who participate in a more informative medical consultation (Daly and Hulka 1975).

The resistance against seeing doctors as educators could also be interpreted as a mystification of the medical knowledge. Goffman (1959) recalls the Ponsonby's advice to the King of Norway in his campaign to gain more popularity among people:

> He intended, he said, to go as much as possible among the people and thought it would be popular if, instead of going in a motor car, he and Queen Maud were to use tramways. I told him frankly that I though this would be a great mistake as familiarity bred contempt... Every man liked to think what he would do, if he was a King. *People invested the Monarch with every*

> *conceivable virtue and talent.* They were bound therefore to be disappointed if they saw him going about like an ordinary man in the street (my emphasis, 1959: 75).

This text serves as a useful metaphor to illustrate the idea that if doctors keep aloof from patients (and do not involve themselves in patients' education for example), this may reinforce the impression that doctors possess a knowledge that is magnified to a proportion that it lays completely out of reach of the average lay-person. Although mystification can be a factor in doctors' behaviour, patients in my study had the chance to introduce questions to the discourse and in this 'helpless temporary stage' they were able to shape their competence about their health in a dynamic way (Barton 2000, Maynard 1992, Ten Have 1991, Giddens 1979, 1987).

Female and male patients showed a relatively similar frequency in their *voice* of *Competence* (51.4% for females and 48.5% for males, see Table 5.3). Nevertheless, a more detailed analysis reveals that female patients, in contrast to males, contested and negotiated with their doctors the treatment to be undertaken.

The *voice* of *Initiator* presents a pattern that favours female patients' participation. Women asked many more questions (63.1%) than males (36.8%), see Table 5.3. Those patients who initiated questions received a relevant medical response that augmented patients' medical knowledge, which could later be used to negotiate with the doctor the course of action to be taken. If my interpretation is correct then female patients would acquire in the long term a better understanding of their health and ultimately would have the chance to negotiate health issues (e.g. the best treatment) with their doctors. Unfortunately I cannot prove this conclusively in this study but I can propose some explanations to account for this gender-related behaviour.

Anthropological medicine notes that one of the major female roles in most Western and non-Western societies is to look after the health of the family. Helman (1994) describes how the family constitutes the source of initial health practices during the diagnosis and treatment of a disease:

> ... The main arena of health care is the *family*; here most ill-health is recognized and then treated. It is the real site of primary health care in any
>
> society. In the family, as Chrisman [3] points out, the main providers of health care are *women*, usually mothers or grandmothers, who diagnose most illnesses and treat them with the materials at hand. It has been estimated that about 70-90 per cent of health care takes place within this sector, in both Western and non-Western societies (Helman's emphasis, 1994: 65).

The knowledge that women acquire is passed from generation to generation to provide health care to their own family. Concomitantly, female patients pay higher number of visits to a medical centre than males (Helman 1994). In the outpatient Clinic of PUC for example, female patients visited the centre three times more frequently than males (see Chapter 3), making them more familiar with the context-situation of the interaction and more articulate in their medical discourse. Hein and Wodak (1987) found that 'It turned out that half of the women gave a complete account while two-third of the men only used a sentence or less' (1987: 48). Female awareness of medical problems and family commitment might have been the result of the high use of the *voice* of *Initiator* among female patients.

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[3] Chrisman, N.J. (1977). The health seeking process: An approach to the natural history of illness. *Culture, Medicine Psychiatry* 1: 351-377.

6.7 A dynamic model of doctor-patient interactions

The main findings of this work can be summarized in a general model of doctor-patient interactions that I term 'dynamic'. I wish to emphasize the dynamic nature of the model as it depicts a process in time that can be accelerated or slowed down according to the specific circumstances of the case in study. Figure 6.1 depicts the model in its essential features. It is clear from this work that the doctor possesses an initial basis of power conferred to him/her by his/her training as a physician. Such technical power immediately establishes an asymmetry between doctor and patient, illustrated by the difference in the size of the boxes enclosing doctor and patient (Fig 6.1). Through the *Educator voice*, however, the doctor may be able to increase the medical knowledge of his/her patient, thus producing competent patients who will be able to express themselves through the *voice* of *Competence*. Clearly, the *voice* of *Competence* confers a relative increase of power to the patient, as illustrated by the hatched line enlarging the patient's box. A competent patient is then capable of contesting the doctor's power, to which the doctor may respond by simply ignoring the patient or by entering into a negotiation with the patient that produces a more accurate feedback between interactants. Such feedback should be intended as a constructive one leading to a better understanding of the patient's health condition. This process, repeated in time, can set the stage for a positive feedback loop, leading to increasingly better informed doctors and increasingly more competent patients, that can improve the quality of the treatment, the compliance rate and therefore the success of the healing process. Competence and negotiation should therefore lead to a more personal tailoring of the treatment.

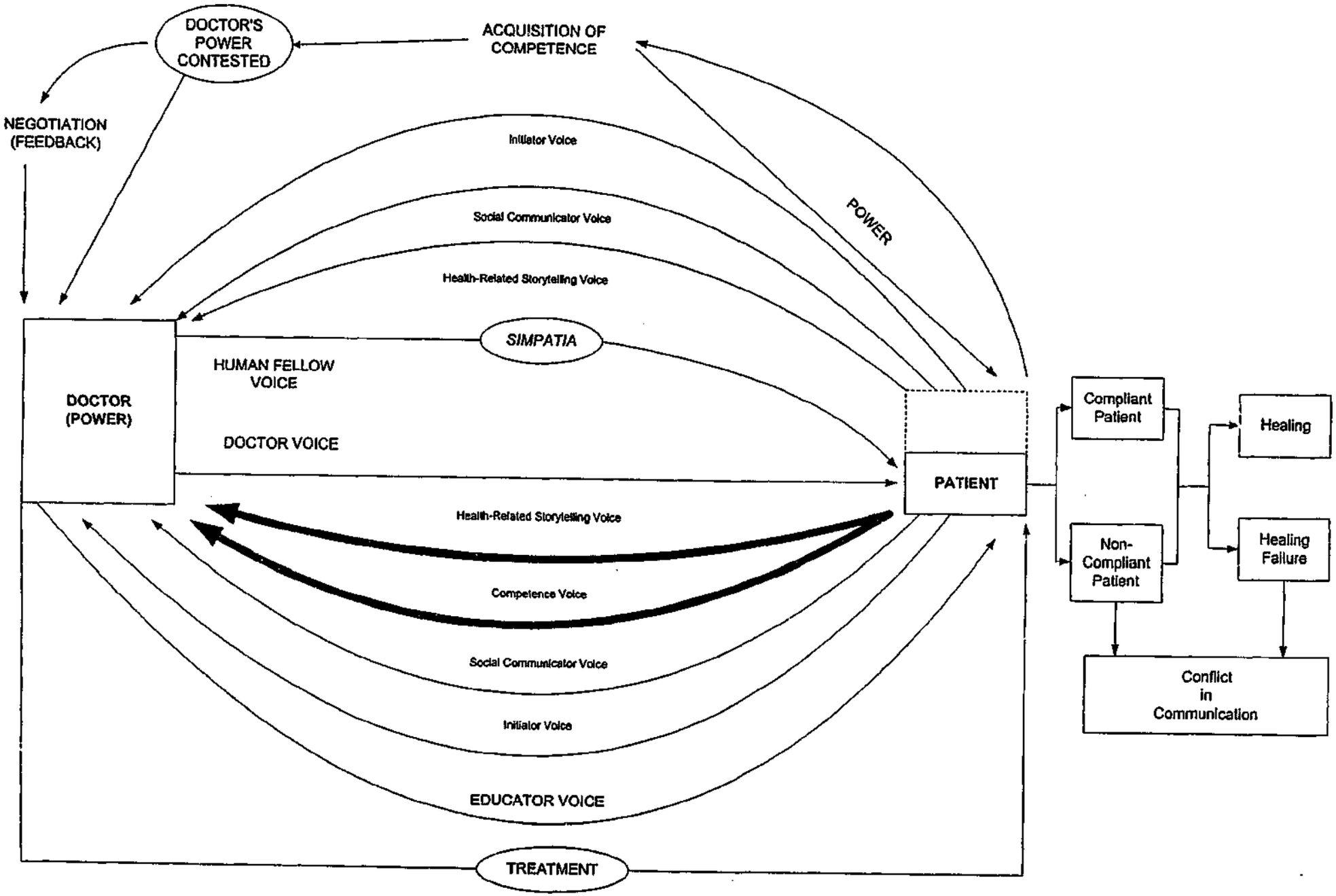
Doctors can use two other *voices* in their interactions with patients. The *Human Fellow voice* establishes a cooperative communication between doctor and patient that unfolds in a process characterized by *simpatia*, i.e. expression of friendliness and conflict avoidance. To this voice, the patient usually responds with the use of *Health-related storytelling*, the *Social Communicator* and the *Initiator voices*. The *Doctor voice* is used in order to gather information, assess test results and assess patient's compliance. The patient may interact with the *Doctor voice* by using the *voice* of *Initiator* (i.e. to ask medical questions), the *voice* of *Social Communicator* (i.e. to tell issues concerning personal life) and, above all, the *voices of Health-related storytelling* (i.e. the description, more or less elaborated, of his/her condition) and *Competence* (i.e. to show understanding and alignment to the medical recommendations).

Communication breakdown between doctor and patient is also possible. Such possibility of breakdown is likely to be diffused, that is it may occur anywhere in the network of *voices* linking doctor and patient (see Figure 6.1). In my study, I did not record any instance of complete communication breakdown leading to the end of doctor-patient communication during the consultation. Tensions in doctor-patient communication may also arise as a result of patient's lack of compliance to the treatment (doctor's perspective) or patient's failure to achieve healing in spite of complying with the treatment recommended by the doctor (patient's perspective).

This study has shown that medical consultations in a Chilean setting display a participation framework in which both doctor and patient can author distinctive *voices* during the interaction. The realisation of those *voices* projects both participants' alignments to the medical institution as well as individual stances reflecting their socio-cognitive understanding of the event at issue. The interaction among *voices* that

emerges during the consultation appears to be pivotal in the development of doctor-patient communication. In the final chapter I derive some general conclusions from this research and set the stage for a general analytical framework that may serve as a point of reference for further investigations in this field.

Figure 6.1 A DYNAMIC MODEL OF DOCTOR-PATIENT INTERACTIONS



CHAPTER 7

CONCLUDING REMARKS

The aim of this study was to understand how communication between doctor and patient developed during medical consultations in an institutional setting in Chile. In this conclusion I highlight the implications of the findings by stressing the dynamic and productive communication that can be achieved if both participants know how to contribute more effectively to the discourse.

The interaction between doctor's and patient's *voices* in the medical discourse reveals participants' social identity and institutional alignments that can set them apart -by increasing the asymmetry in the event- or, conversely, can make them come closer (communicatively) in the discourse -by decreasing the asymmetry in the event.

The representation of the *Educator voice* is one example where the initial asymmetry is seen as just a starting point that marks the beginning of a process, which could achieve a more symmetrical communication over time. This knowledge-acquisition process would be fuelled by the relevant health information patients receive in their visits. As a consequence of the above learning process, the patient may develop competence which, if uncontested, can have remarkable implications in terms of negotiation of treatment and, ultimately, on patient's compliance and (hopefully) healing. Nevertheless the *Educator voice* cannot by itself satisfy the overall needs of the consultation. This requires both the *Doctor voice* and the *Human Fellow voice,* that provide the essential tools for a holistic understanding of patients' health, throughout the discourse types that investigate patient's health condition and the discourse strategies that facilitate the recounting of patients own stories.

In this process of seeking information (*Doctor voice*), educating (*Educator voice*) and using strategies to facilitate patients' talk (*Human Fellow voice*), patients show alignment to the medical institution (the *voices* of *Health-related storytelling* and *Competence*), interest in further understanding their health condition (the *voice* of *Initiator*) and interest in sharing their personal stories (the *voice* of *Social communicator*). As a consequence, the communication develops as a 'dynamic system' where some *voices* restrict the participation of patients (increasing the asymmetry in the event), while other facilitate their contribution (decreasing the asymmetry in the event). This dynamic system operates within a range of different degrees of asymmetry that vary from the blunt exercise of power, which augments asymmetry, to the subtle expressions of power that moderate and diminish the asymmetry. This dynamic development of the consultation creates the participation framework that doctors and patients move in, and allows both power and *simpatía* to be represented during the consultation.

The communication between doctor and patient appears to reflect Chilean socio-cultural values and ideologies that are reproduced at the local level of the interaction. Thus, doctors show their authority by using persuasive discourse strategies to reinforce their opinions on what patients' medical treatment should be, as well as to exert influence on patients' cognitive perception of society. In other words doctors, in their performance as health professionals, express personal opinions that are framed in the medical context, and so their own ideologies permeate the discourse. Similarly, patients also show their alignment to the socio-cultural group where they belong by developing the voice of the *Social Communicator* and incorporating to their discourse themes that reflect their value system. The *voice* of *Initiator* could also be interpreted in terms of social mobility, since the patients by initiating the talk and

taking the floor author a voice of control in the event, but most importantly the *voice* of *Initiator* shows that both doctors and patients can be 'heard' in the consultation.

Following Wodak (1989) in order to bring changes to institutional practices there is a need to give a 'diagnosis' of the participation framework of individuals and propose a 'therapy' that will (hopefully) ameliorate the deficiencies of the institutional practice under investigation. The *Educator voice* appears to be fundamental to make patients more aware of their health condition and to give them more control over their treatment, nevertheless not every consultation provided educative episodes. This may suggest that there is a need to address health issues at different levels. First of all there seems to be a need to train doctors in the 'subtle art' of training patients. How to better convey biological and medical knowledge, how to make patients aware of health issues associated with a varied spectrum of lifestyles, how to educate patients on the when and where to seek proper professional advice and which interventions could be the primary responsibility of the patient. How to self-monitor the development of a disease state, when should one be worried and when not. Secondly, the benefits of such a patient-empowering programme are likely to feedback to the medical system by improving the quality of information doctors have at hand to establish their diagnosis and treatment. Moreover, the ability of patients to effectively and safely monitor their health condition, and to prevent disease states to occur in the first place, may relieve the health system from excessive pressure, thus making the possibly limited resources (especially in economically depressed regions) available preferably to those patients that really need them. This may be beneficial in terms of shortening queuing times at health care centres. Studies in discourse analysis and critical analysis can be of great help in this process, as they may provide practical

advice on improving the ability of patients to articulate their concerns and of doctors to improve their communication abilities.

Future studies should give special attention to research on the *Educator voice* by incorporating a larger set of data that could help us understand further the interaction that develops between doctor and patient when this *voice* is present in the consultation. In addition, future studies should also investigate diachronically the effect of patients' medical competence and its outcomes on the medical system and on the interaction developed with health professionals. If the efficient use of resources available to health systems (especially in developing countries) is a social desideratum, then there is a need to better educate people to be more competent about medical issues.

Appendix 1

Approximate total word count per doctor and patient

Dyad	Doctor	Word Count	Patient	Word Count
Consultation 1 FD-FP	Ana	1,019	Alicia Tape: 28B	1,017
Consultation 2 FD-FP	Ana	323	Beatriz Tape: 5B	307
Consultation 3 FD-FP	Ana	874	Carmen Tape: 20B	1,292
Consultation 4 FD-MP	Ana	1,684	David Tape: 36Bi	791
Consultation 5 FD-MP	Ana	338	Esteban Tape: 13B	305
Consultation 6 FD-MP	Ana	961	Flavio Tape:36A	592
Consultation 7 FD-FP	Berta	150	Gina Tape: 48A	171
Consultation 8 FD-FP	Berta	564	Hilda Tape: 34A	636
Consultation 9 FD-FP	Berta	222	Javiera Tape: 32B	280
Consultation 10 MD-MP	Carlos	756	Leonel Tape: 44A	664
Consultation 11 MD-MP	Carlos	871	Manuel Tape: 21A	6 25
Consultation 12 MD-MP	Carlos	842	Nicolás Tape: 52B	929
Consultation 13 MD-FP	Carlos	1,871	Olga Tape : 46	1,285
Consultation 14 MD-FP	Carlos	230	Paola Tape:39Ai	404
Consultation 15 MD-FP	Carlos	840	Rosa Tape :14B	1,000
Consultation 16 MD-MP	Daniel	50	Samuel Tape:29A	79
Consultation 17 MD-MP	Daniel	143	Tito Tape:19B	368
Consultation 18 MD-MP	Daniel	198	Victor Tape: 38A	281
Consultation 19 MD-FP	Daniel	170	Wilma Tape: 35B	105
Consultation 20 MD-FP	Daniel	72	Ximena Tape :11B	642
Consultation 21 MD-FP	Daniel	513	Yolanda Tape :29Ai	846
Consultation 22 MD-FP	Daniel	138	Zenobia Tape :19A	304
Total number of words:		12,829		12,923

Appendix 2 (English version)

PATIENT QUESTIONNAIRE

Name of the Project: Doctor and patient discourse in Chile: A social interactive investigation
Date:

Please make a cross □ where appropriate

Sex

Female □ Male □

Nationality: _____

Age

In which category are you?

20 - 25 □ 41 - 45 □

26 - 30 □ 46 - 50 □

31 - 35 □ 51-55 □

36 - 40 □ 56-60 □

Other _____

Occupation: _____

How many times (approximately) have you visited the same doctor before?

2 - 4 □

4 - 6 □

For how long have you visited the same doctor?

less than a year □ over two years □

a year □ over three years □

over a year □

Other _____

What do you like from a doctor? (leave ample space to write down patients' ideas)

What you dislike from a doctor? (leave ample space to write down patients' ideas)

Appendix 2 (Spanish version)

CUESTIONARIO PARA EL PACIENTE

NOMBRE DEL PROYECTO: El discurso hablado del médico y el paciente en Chile: Una investigación social interactiva

Fecha:

POR FAVOR MARQUE CON UNA CRUZ ◻

Sexo

Femenino ◻ Masculino ◻

Nacionalidad: _____

Edad

¿En qué categoría de edad se encuentra Ud.?

20 - 25 ◻ 41 - 45 ◻

26 - 30 ◻ 46 - 50 ◻

31 - 35 ◻ 51-55 ◻

36 - 40 ◻ 56-60 ◻

Otra _____

Actividad: _____

¿Cuántas veces (aproximadamente) ha visitado al mismo médico?

2 - 4 ◻

4 - 6 ◻

¿Hace cuánto tiempo que visita al mismo médico?

menos de un año ◻ más de dos años ◻

un año ◻ más de tres años ◻

más de un año ◻

Otro _____

¿Qué le gusta de un médico? (dejar bastante espacio para la respuesta de los pacientes)

¿Qué no le gusta de un médico? (dejar bastante espacio para la respuesta de los pacientes)

Appendix 3 (English version)

DOCTOR QUESTIONNAIRE

Name of the Project: Doctor and patient discourse in Chile: A social interactive investigation
Date:

Please make a cross □ where appropriate

Sex

Female □ Male □

Nationality: _____

Age

In which category are you?

20 - 25 □ 41 - 45 □

26 - 30 □ 46 - 50 □

31 - 35 □ 51-55 □

36 - 40 □ 56-60 □

Other _____

How many years practice in medicine do you have?

Appendix 3 (Spanish version)

CUESTIONARIO PARA EL MEDICO

NOMBRE DEL PROYECTO: El discurso hablado del médi[illegible] y el paciente en Chile: una investigación social interactiva

Fecha:

POR FAVOR MARQUE CON UNA CRUZ ◻

Sexo

Femenino ◻ Masculino ◻

Nacionalidad: _____

Edad

¿En qué categoría de edad se encuentra Ud.?

20 - 25	◻	41 - 45	◻
26 - 30	◻	46 - 50	◻
31 - 35	◻	51-55	◻
36 - 40	◻	56-60	◻

Otra _____

¿Cúantos años de experiencia médica tiene?

Appendix 4

Symbols for discourse Transcription

Unit		
	Truncated syllable (first)	'
	Truncated syllable (middle and final)	-
Speakers		
	Speaker identity/turn start	:
	Speech overlap	[ ]
	Latching	=
Transitional continuity		
	Final	.
	Continuing	,
	Appeal	¿ and ?
	Exclamation	¡ and !
Tone		
	Fall	\
	Rise	/
	Loud voice	CAPITAL LETTER
Pause		
	Long	... (N)
	Medium	...
	Short	..
Vocal Noises		
	Inhalation	(H)
	Exhalation	(Hx)
Quality voice		
	Emphasis	CAPITAL LETTERS
	Laugh quality	<@ @>
Lenghtening		
	Vowel elongation	:
Transcribers' perspective		
	Researcher's comment	(( ))
	Uncertain hearing	<X X>
Speciliazed Notations		
	False start	< >

The symbols of transcription used in this study correspond to Du Bois 1991. Adaptations made to accommodate Spanish data (see Section 3.6 Stage IV).

Appendix 5 (English version)

EXPLANATORY STATEMENT FOR PATIENT AND DOCTOR

The following pages briefly describe the project.

ANY INFORMATION GIVEN IS STRICTLY CONFIDENTIAL.

The title of this research is: "Doctor & patient discourse in Chile: A social interactive investigation".

The researcher is Marisa Cordella who comes from Monash University, Melbourne Australia. She will be involved with those who are willing to participate in this study and she will give you further information about the research if you so wish.

What is the aim of this research?

The aim of this research is to understand how doctor and patient communicate during consultation. The conversation between both of you will be tape-recorded and later analyzed according to current linguistic theories.

What are you required to do?

Patients will be asked to complete a questionnaire before the consultation. Doctors will be interviewed before the start of the day's session. The conversation between patient and doctor will be recorded provided they have agreed and signed the consent form.

How long should it take?

You will be required to participate in this study for the length of the consultation with an additional 5 minutes to complete the questionnaire.

Can I refuse to participate in this study?

YOU ARE FREE to participate in it. Your refusal or withdrawal from the tape recording **will not affect you in any way**. You have the right to withdraw your consent to participate at **any** time. You also have the right to listen to your recording and withdraw your consent if you wish.

CONFIDENTIALITY?

YOUR CONTRIBUTION IS STRICTLY CONFIDENTIAL.

No one will have access to the data except the researcher. Original names will not be included in any transcript or publication. The data will be kept under lock and key. Nothing which could identify an individual person will be released. The information will not go into the participant's medical record.

What should I do if I have queries or if I would like to have more information about it?

Further information can be sought at any time from Marisa Cordella who will be in the clinic during the recording. You could also write to her in Australia in case doubts and queries come to mind after the completion of recordings in Chile. You could also send a letter to Dr. Joanne Winter from Monash University, Melbourne, Australia to ask for further information:

Marisa Cordella or (I will get an address from Chile as well)
Monash University
Department of Romance Languages
Spanish Section
Wellington Road
CLAYTON VIC 3168
AUSTRALIA

Dr. Joanne Winter
Monash University
Department of Linguistics
Spanish Section
Wellington Road
CLAYTON VIC 3168
AUSTRALIA

Can I have access to the results?

Interested participants (doctors and patients) will be informed of the final results. Copies of the thesis and articles emanating from this work will be sent to the hospital. Please note that the time allocated for this study is around 6 years so results are unlikely to be ready before that date.

What should you do if I have a complaint about this study?

Should you have any complaint concerning the manner in which this research is being conducted, please do not hesitate to contact: The Standing Committee on Ethics in Research on Humans at the following address:

The Secretary
The Standing Committee on Ethics in Research on Humans
Monash University, Wellington Road, Clayton, Victoria 3168
Telephone (03) 990 52052 Fax: (03) 990 53866

At the end of the recording you will receive a small present to thank you for your cooperation.

Appendix 5 (Spanish version)

DECLARACIÓN ACLARATORIA PARA PACIENTE Y MEDICO

Las siguientes páginas describen brevemente este proyecto.

TODA INFORMACIÓN QUE UD. ENTREGUE SERÁ MATERIAL ESTRICTAMENTE CONFIDENCIAL

El título de esta investigación es: "El discurso hablado del médico y el paciente en Chile: una investigación social interactiva".

La investigadora es Marisa Cordella proveniente de la Universidad de Monash de Melbourne, Australia. Ella le entregará información sobre la investigación y estará junto a los participantes que deseen contribuir en este estudio.

¿Cuál es el objetivo de este estudio?

El objetivo de esta investigación es el entender cómo el discurso entre médico y paciente se desarrolla durante la consulta médica. La conversación entre Uds. dos se grabará, transcribirá, y luego analizará siguiendo las teorías actuales de lingüística.

¿Qué cosa se requiere de Ud.?

Se les pedirá a los pacientes que llenen un cuestionario antes de la consulta. A los médico se les entrevistará antes de comenzar la sesión del día y la conversación entre ambos (paciente y médico) se grabará si ambas partes han consentido

¿Cuánto tiempo se me requerirá?

El tiempo que se requiere de los participantes es equivalente a la duración de la consulta, con un tiempo adicional de 5 minutos para llenar el cuestionario.

¿Puedo rehusarme a participar?

UD. ESTA LIBRE EN PARTICIPAR EN ESTE ESTUDIO.

Si Ud. no desea participar o si se arrepiente luego de haber consentido, esto **no le afectará en absoluto**. Ud. tiene el derecho de retirar su consentimiento de participación en **cualquier momento** e incluso puede escuchar la conversación una vez que se haya grabado y pedir que no se incluya en el estudio.

¿Confidencialidad?

CUALQUIER INFORMACIÓN QUE OTORGUE ES ESTRICTAMENTE CONFIDENCIAL.

Sólo la investigadora tendrá acceso a los datos.

Los nombres originales de los participantes no se incluirán ni en las transcripciones ni en ninguna publicación. Toda la información se guardará bajo llave. Lo que se publique en el futuro no contendrá ninguna información que pueda descubrir la identidad de los participantes. Ningún tipo de información que Ud. haya dado en este

estudio se incluirá en los registros médicos.

¿Qué debería hacer si me surgen dudas o si deseo obtener mayor información al respecto?
Marisa Cordella quien estará en la clínica en el momento de la grabación puede darle mayor información sobre el proyecto en cualquier minuto que Ud. lo requiera. Ud. también puede enviarle una carta a Australia si tiene preguntas luego de haber completado las grabaciones en Chile. Ud. también puede escribirle a la Dra. Joanne Winter de la Universidad de Monash, Melbourne, Australia, si desea mayor información.

Marisa Cordella (Entregaré además una dirección en Chile)
Monash University
Department of Romance Languages
Spanish Section
Wellington Road
CLAYTON VIC 3168
AUSTRALIA

Dr. Joanne Winter
Monash University
Department of Linguistics
Wellington Road
CLAYTON VIC 3168
AUSTRALIA

¿Cómo podría tener acceso a los resultados?

Los participantes (médicos y pacientes) que estén interesados estarán al tanto de los resultados por intermedio de una copa de la tesis y de los artículos que se publicarán y que se enviarán al hospital. Tenga presente que el estudio durará alrededor de 6 años, por lo tanto será muy difícil tener resultados antes de esa fecha.

¿A quien debería contactar en caso que tuviera alguna queja sobre el desarrollo del estudio?

Si hubiera alguna queja con respecto a la forma en que la investigación se llevó a cabo, tenga la amabilidad de comunicarse con "El Comité Ético de Investigación con seres humanos", dirija su carta a la siguiente dirección:

The Secretary
The Standing Committee on Ethics in Research of Humans
Monash University
Wellington Road
CLAYTON VIC 3168
AUSTRALIA
Teléfono (03) 990 52052 Fax (03) 990 53866

Appendix 6 (English version)

CONSENT FORM

I have read the explanatory statement and I agree to participate in the study "Doctor and patient discourse in Chile: A social interactive investigation."

Date:_____

Name:_____

Signature:_____

Appendix 6 (Spanish version)

CONSENTIMIENTO

He leído la nota explicativa y estoy de acuerdo en participar en el estudio "El discurso hablado del médico y el paciente en Chile: una investigación social interactiva"

Fecha:_____

Nombre:_____

Firma:_____

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