

Questioning and Responding Practices in Medical Interviews Revisited (Part I: Doctors)

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Abstract

The paper presents partial results of a long-term project involving research in the field of medical interviewing. The main goal of the project is to search for communicative strategies of doctors and patients that are capable of conveying empathy and trust. Via an interdisciplinary analysis, based on data excerpted from the most recent edition of the British National Corpus, the author attempts to bring quantitative and qualitative evidence that doctor–patient interaction has recently undergone significant modifications, resulting in the social redefinition of the asymmetrical roles of the main protagonists. The first part of the treatise focuses particularly on the communicative strategies of doctors, drawing attention to their questioning and responding practices.

Keywords: medical interviewing, questioning and responding practices, doctors, interdisciplinary research, British National Corpus

1 Introduction

Recent years have brought a significant increase of interest in research into the realm of institutional talk. With respect to the field of **medicine**, it has been suggested (e.g. Furst 1998, Humphreys 2002) that recent **social changes** have modified the traditional model of the doctor–patient relationship, being of distinctively asymmetric character, and prepared the ground for a gradual **weakening of hierarchies** and **redefinition of roles** in favour of the patient. The shifts are to be spotted particularly in the ways in which the main protagonists interact.

According to Coulthard & Ashby (1975), three main types of sequences occur in doctor–patient interaction: (i) **eliciting** (the doctor’s question followed by the patient’s response), (ii) **directing** (the doctor’s command succeeded by the requested action realized by the patient), and (iii) **informing** (information given by the doctor accompanied by an acknowledgement from the patient). As shown, among others, by Waitzkin (1984), the latter two occur much less frequently, while elicitation is of primary importance.

“Asking questions is a very important part of your visit to the doctor. By asking questions your doctor can help clear up doubts, concerns, or worries” (Roter & Hall 1992: 102). Questions “introduce, develop and dissolve topics” (Paget 1983: 71), and enable the dialogue participants to exchange information (West 1983: 76). As Mishler (1984) argues, the centrality of questions is rooted in the fact that they constitute a key mechanism by which **the doctor’s power** can be exercised and the process of consultation controlled.

In contrast to what Mishler (1984) states, the aim of this paper is to bring some evidence that doctors’ questions may also constitute a key mechanism by which the **equality** of the doctor–patient relationship can be exercised and the medical interview processed in a more **empathic** manner. My claim is that the successful engagement of empathy¹ and creating an **atmosphere of trust** is of essential importance for both doctors and patients, streamlining their communication and thus improving the delivery of medical treatment.

For the purposes of the analysis I have taken advantage of the spoken component of the *British National Corpus* (XML Edition 2007) and its collection of transcribed and annotated medical interviews. I have selected 50 medical interactions, all of them **dyads**, with the total text amounting to 34,376 words. In order to be successful in meeting my research objectives, I have combined the **quantitative**² perspective of medical science with the **qualitative** viewpoints of conversation analysis and discourse analysis (cf. Wynn 1995).

2 In search of definitions and classifications of questions

Though one may think that establishing the status of a **question** cannot be difficult, the reality is not so simple. You can find definitions in most dictionaries – both outdated: “An interrogative sentence calling for an answer; an inquiry” (*Britannica* 1964: 1034) or “A sentence in an interrogative form, addressed to someone in order to get information in reply” (*The Random House* 1975: 1083),³ and rather more up-to-date: “A form of words addressed to a person in order to elicit information or evoke a response, an interrogative sentence” (*Collins English Dictionary*). However, from the perspective of **discourse-oriented linguistics** these definitions are too narrow, as they do not take account of the **contextual variability** of particular communicative situations (cf. ten Have 1991, Urbanová 2005).

Two major concerns have been raised in relation to the definition of a question, both regarding the ‘struggle between function and form’ (see, e.g., Karttunen 1977, Weber 1993). The first argues that in spoken face-to-face interaction, functional questions do not necessarily appear in the interrogative arrangement, i.e. with **subject–verb inversion**. The second concentrates on the problem of **sentence completeness**, and attempts to show that the form of questions is frequently not sentence-like, but varies; sometimes an utterance may consist of one or two syllables (e.g. *Like?*, *Really?*), yet it can still be recognized as a question.

In this respect, Sacks et al. (1974) suggest an ‘operational definition’ of a question, which arises from its function as the first part of a **question–answer** adjacency pair and is closely related to the **turn-taking mechanism**. In other words, a question can be defined as a verbal (or nonverbal⁴) element that requires and is followed by an answer.

For the purposes of this research, taking all the above perspectives and views into consideration, I understand the question in the same way as Humphreys (2002: 20): “The definition of *question* includes any utterance requiring a response within the context of the

interaction, regardless of form (interrogative, declarative, etc.); any formal question; and any utterance that receives a response as though it were a question” (Example 1).

- (1) D: **No change at all?** (question)
 P: No. No change. No. (answer)

(BNC/H4J/23–24)

In the process of the present analysis, I have divided the excerpted questions into **doctor-initiated** and **patient-initiated**, and have classified them according to the phase in which they occur within the medical interview. Moreover, in accord with the functional target of elicitation, I have distinguished six categories of questions. My classification draws on Tsui (1992), who applies a functional description of questions, stating that **elicitations** are targeted towards: (i) **information**, (ii) **confirmation**, (iii) **agreement**, (iv) **commitment**, (v) **repetition**, and (vi) **clarification**. As Urbanová (2003) notes, these categories tend to blend into each other, and so it is more suitable to view them as members of a **cline**, representing different degrees of **symmetry–asymmetry** relations between participants in the communicative event.

“Pragmatically speaking, the functions representing extremes on the continuum, i.e. information and clarification on the one hand and repetition on the other, represent **asymmetrical relations** in conversation: the participants are ‘not sharing the same ground’, whereas the functions in the middle of the continuum, i.e. confirmation, agreement and commitment, reflect **mutuality** and are thus symmetrical” (Urbanová 2003: 45). The most beneficial contribution of this interpretation of questions based on tenor, as far as my investigation is concerned, is its potential to reveal questioning strategies which belong among the **patient-centred** communication devices and are capable of conveying empathy and trust in medical consulting.

Before approaching the actual analysis, both quantitative and qualitative, let me first offer a selective summary of results from previous studies concerning questioning practices in medical consultations (Chart 1). These findings, arrived at in the 1970s, 1980s, and early 1990s, will be compared with more recent findings of my own. Although the results refer to doctors as well as to patients, the following sections of the paper will focus predominantly on the questioning practices of **doctors**. Whether there have also been changes in the way patients pose questions will be specified in the second, independent part of this treatise, to be published in the subsequent volume of *Ostrava Journal of English Philology*.

Chart 1: Findings resulting from previous studies on questioning practices in doctor–patient interaction

Study	Research results
Byrne & Long (1976)	Doctors expect patient-initiated questions to occur towards the end of the consultation, i.e. during the treatment phase.
Boreham & Gibson (1978)	Most patients do not pose questions about diagnosis and treatment, even if they are not informed.
West (1983)	Out of 773 questions observed, 91% were initiated by doctors, 9% by patients.
Shuy (1983)	Requests by patients for clarification often resulted in diagnostic labelling, rather than increased understanding.
Frankel (1983)	In a study of ten medical interviews, 99% of the questions were doctor-initiated, 1% patient-initiated.
Simpson et al. (1987)	There is no room for patient-initiated questions during the diagnostic (information-gathering) phase. They are viewed as dispreferred.
Winefield & Murrell (1991)	Doctor-initiated questions are most often close-ended.
Friederichs-Fitzwater (1991)	Doctors do not answer 25% of patients' questions.
Roter & Hall (1992)	Patient-initiated questions constitute only 6% of the total time reserved for the medical interview.
Heath (1992)	Patients often do not ask questions, even when given the opportunity.

(cf. Wynn 1999: 57–61)

3 Statistical distributions

The distributional analysis of questions has resulted in the following findings (Table 1 & 2). Out of 50 medical consultations, comprising 5525 turns (34,376 words), there are 524 utterances that could be classified as questions. 334 (64%) questions are doctor-initiated, 190 (36%) are patient-initiated. 297 (57%) questions appear during the information-gathering phase, 56 (11%) during the phase of diagnosis, and 171 (32%) during the treatment phase. 313 (60%) questions are targeted towards information, 85 (16%) towards confirmation, 37 (7%) towards agreement, 23 (4%) towards commitment, 21 (4%) towards repetition, and 45 (9%) towards clarification.

Table 1: Absolute frequency of questions in doctor–patient interaction

Abs.	Participant		Phase			Total
	Doctor	Patient	Info-gather	Diagnosis	Treatment	
<i>Inform</i>	213	100	192	30	91	313
<i>Confirm</i>	50	35	48	12	25	85
<i>Agree</i>	18	19	15	6	16	37
<i>Commit</i>	19	4	2	1	20	23
<i>Repeat</i>	9	12	10	2	9	21
<i>Clarif</i>	25	20	30	5	10	45
Total	334	190	297	56	171	524

Table 2: Relative frequency of questions in doctor–patient interaction

%	Participant		Phase			Total
	Doctor	Patient	Info-gather	Diagnosis	Treatment	
<i>Inform</i>	68	32	61	10	29	60
<i>Confirm</i>	59	41	57	14	29	16
<i>Agree</i>	49	51	41	16	43	7
<i>Commit</i>	83	17	9	4	87	4
<i>Repeat</i>	43	57	48	9	43	4
<i>Clarif</i>	56	44	67	11	22	9
Total	64	36	57	11	32	100

The statistical data presented in the above tables reveal striking differences compared to the illustrations offered in Chart 1. The most prominent divergence appears in the fact that patient-initiated questions are **numerous** in the material I have investigated. Patients do pose questions, and they do so very often. Unlike in previous studies (West 1983, Frankel 1983), where the occurrence of patient-initiated questions was marginal (9%, even 1%), in my samples **patients are active questioners**. As a result, patient-initiated questions constitute much more than 6% of the total time reserved for the medical interview (cf. Roter & Hall 1992).

Tables 1 & 2 also indicate that neither doctors nor patients limit themselves in asking questions of any type (see Examples 2: information, 3: confirmation, 4: agreement, 5: commitment, 6: repetition, 7: clarification). In addition, there is no significant correlation ($r=0.0947$) between the category of participants and the category of question types. To put it differently, we cannot conclude that certain question types are preferred by doctors and dispreferred by patients, and vice versa. This statistical finding is supported by the results of the F-test (for an illustrative table see the Appendix).

- (2) D: **What can I do for you?**
P: It's eczema again.

(BNC/GYE/1-2)
- (3) D: Er are you on any sort of medication at all Suzanne? Nothing?
P: No. Nothing at all.
D: **Nothing? No er things from the chemist and cough mixtures or anything?**
P: No. Nothing at all. No.

(BNC/H4T/27-30)
- (4) D: **It still looks rather boggy, doesn't it?**
P: Mm. It's terrible.

(BNC/GYH/19-20)
- (5) D: **Don't go buying anything at the chemist to try to lose weight, cos they won't work. (.) Okay?**
P: Mmm.

(BNC/G4B/97-98)
- (6) D: You're not needing the pink ones?
P: **What?**
D: The wee pink ones.

(BNC/H5W/36-38)
- (7) P: Well it's this damn cough and cold get.
D: **Still coughing?**
P: I've had it since just before Christmas and it keeps going and coming.

(BNC/GY6/4-6)

What can, on the other hand, be inferred from the statistical analysis is that it matters in which part of the medical interview the particular question type is employed; whether during the **information-gathering** phase, the phase of **diagnosis**, or the phase of **treatment**. The F-test provides strong evidence that there is an unbalanced dispersion of questions targeted towards **commitment**, as the overwhelming majority of them occur in the treatment section. What is more, as the Pearson correlation suggests ($r=0.3852$), there is a significant **correspondence** between the category of **participants** and the category of **interview phases**. To put it yet more differently, it is very important to trace in which section of the medical consultation we can find a prevalence of doctor-initiated questions as compared to questions initiated by their patients.

As the quantitative perspective – though being able to give firm data – has only limited informative value, in the following passages I will aim at a **qualitative interpretation** of the statistical findings just introduced. I will also discuss those research results from Chart 1 which have so far been given little or no attention. I will occupy myself not only

with the communicative intentions realized via doctors' **questioning**, but also with the communicative strategies utilized by doctors when **responding** to their patients.

4 Questioning practices of doctors

Expectedly enough, the number of questions posed by doctors in my material is larger than the number of questions posed by patients; however, there is not such a striking discrepancy as was claimed by the preceding research. Figure 1 demonstrates that doctors most frequently initiate questions targeted towards information (64%), much less frequently towards confirmation (15%), and even less frequently towards clarification (7%), commitment (6%), agreement (5%), and repetition (only 3%). Figure 2 shows that most questions are employed during the information-gathering phase (72%), then during the treatment phase (22%), while the lowest percentage relates to questions occurring during the phase of diagnosis (6%).

Figure 1: Relative distribution of doctors' questions with respect to their classification

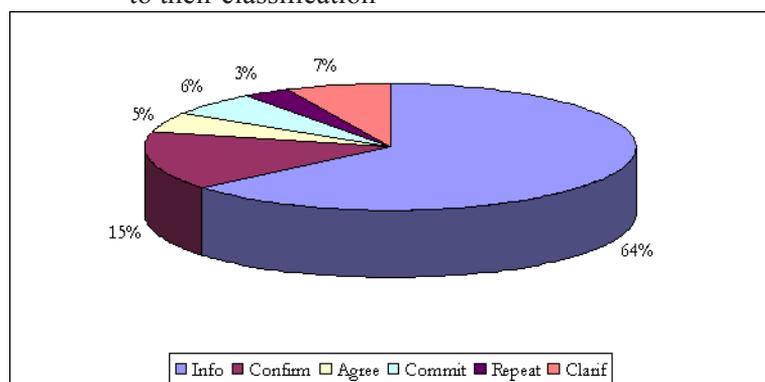
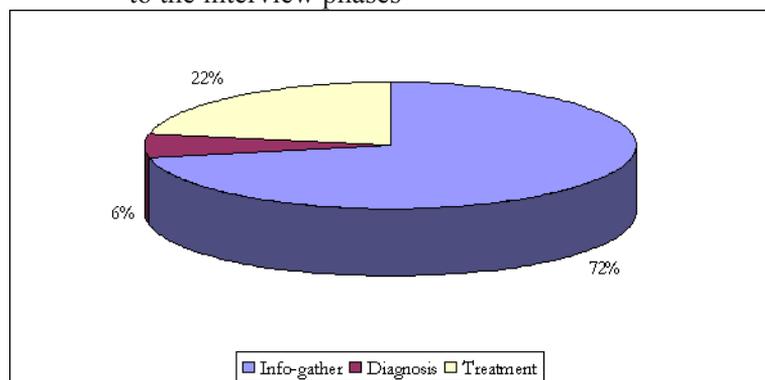


Figure 2: Relative distribution of doctors' questions with respect to the interview phases



Taking into consideration the classification of question types based on **tenor**, the data shows that questions representing **asymmetrical relations** between the dialogue

participants (i.e. information, clarification, repetition) prevail over questions representing **symmetrical relations** (i.e. confirmation, agreement, commitment) by 74% to 26%. With regard to interview phases, it can be generally said that questions compatible with asymmetry predominate in the **information-gathering** phase (see Example 8), whereas questions compatible with symmetry predominate in the **treatment** phase (Example 9). This suggests that at the beginning of the medical encounter doctors employ questioning strategies that allow them to gather enough information to make the diagnosis as swiftly as possible, and they do not pay much attention to the so-called **patient agenda**, whereas towards the end of the encounter they employ strategies aimed at the patient, her expectations and fears.

- (8) D: Do you smoke (unclear)? **Do you smoke?**
 P: No. (cough)
 D: (unclear) right, okay and **nothing coming up?**
 P: No I, I get a bit there every now and then and heave, and [that
 D: Yeah.]
 P: makes me feel even [worse
 D: Yeah.]
 P: like cos I
 D: Yeah, **what job do you do?**
 P: A miner

(BNC/GYC/10–19)

- (9) D: **Well we'll be seeing you fairly soon, won't we? We'll be seeing you in another two weeks anyway, won't we?** Yeah.
 P: Two weeks, yeah.
 D: Okay. Well we'll have a chat about what you're like then,
 P: Okay.
 D: nice fresh sample of wee, not the first wee of the morning,
 P: No.
 D: **Okay?** But a nice fresh sample.
 P: Okay.
 D: Okay. Have you got a bottle?
 P: I have [yes, thanks.
 D: **You've got your] bottle?** [Yes
 P: Yes I have.]
 D: Make sure you wash it out. And then we'll see if, take things from there, **is that okay?**
 P: That's fine

(BNC/GYA/22–35)

This rather sketchy characterization deserves more qualitative specification. Therefore, in order to align my investigation with the primary research objectives, I would like to draw attention particularly to those questioning practices of doctors that can be assessed as patient-centred and capable of conveying empathy.

The first detail which needs to be stressed – because is in sharp contrast with previous research (cf. Winefield & Murrell 1991) – is the fact that doctors participating in the

medical encounters incorporated into my samples tend to utilize roughly the same amount of **open-ended** questions (also called *broad questions*, *WH-questions*) as **close-ended** questions (*Y/N*, *E/O*). While close-ended questions prevail in the information-gathering phase (Example 10), open-ended questions are prevalent in the following two sections of the medical consultation (i.e. diagnosis and treatment; Example 11). Nevertheless, they are also frequently employed during the first part of the encounter.

- (10) D: Right. **You've just finished a course of antibiotics, haven't you?**
P: Yes.

(BNC/GYC/6–7)

- (11) P: I'd get pretty annoyed you know?
D: Aye, we'll stop it going to that. **How's Mrs (anonym) doing?**

(BNC/H4F/86–87)

It seems that doctors are beginning to realize the advantages of open-ended questioning, which enables them to pursue **information gathering** more effectively. Of course, the benefit of close-ended questions is that they require specific, to-the-point responses. However, such a questioning strategy is often ineffective, as it can **limit** the contributions of patients (Clark & Mishler 1992) and may thus lead to the avoidance or loss of crucial pieces of information (Wynn 1999: 58). By contrast, **broad questioning** gives the patient a useful opportunity to recount what she considers to be important with few or no restrictions from the other interlocutor – the doctor (Example 12, 13).

- (12) P: Erm, it's my back today.
D: Aha.
P: It's (.) for a, a couple of weeks there it wasn't too bad, but now I feel as if it's (unclear).
D: **What did you do to it?**
P: It doesn't look bruised, mind, but it feels, sore to touch or anything. I, I really don't know what I've done. I know times I get it, like (.) maybe just at one side, if I've been sitting in a hard seat

(BNC/G47/2–6)

- (13) D: Er you're Robert that's right?
P: Mm.
D: (.) You're Robert. Sorry I've forgotten your address Robert.
P: [(anonym)]
D: (anonym)] Right. (.) Right. **Now what other injury have you done yourself?**
P: I was carrying wall units and I'd taken fourteen wall units one after another up two flights of stairs. And I think I had about, I don't what I've done really but I just, the following day I felt in my, my groin, the left side of my groin down my leg and up my stomach. And I went to my mate this morning who's a boxer and he said that it's now maybe, maybe a groin strain.

(BNC/H4V/38–43)

Open-ended questions further function as potent devices giving the green light to more subtle communicative strategies. First of all, they enable the doctor to support the narration of the patient's story. In the following example (Example 14), we can read about a doctor who right from the beginning of the consultation invites a patient to share her problems in a narrative way. By using such verbal structures as *what's happened*, *what've you been doing*, he supports the patient in the attempt to define her reasons for visiting the doctor's office. Referring to Brody's (1980) **mutuality model of the doctor–patient relationship**,⁵ the doctor establishes an atmosphere conducive to participation by enhancing the patient's perception that her contributions are appropriate and appreciated.

- (14) D: Hello! (unclear) stranger, what can we do for you today? (.)
 P: Help me. (laugh)
 D: **What's happened?** (.)
 P: I've put on nearly two and a half [stone
 D: Mhm.]
 P: in weight in the last
 D: So I see.
 P: five months.
 D: **What've you been doing** in the last five months that's put on the weight?
 P: Mhm. And I'm permanently crying. (.) Help. (.)
 D: **What's happened**, has you appetite
 P: [No.
 D: changed?] No?
 P: No. And when I started putting on weight I and I'm still putting on weight.

(BNC/G4B/1–14)

The doctor may also pose open-ended questions which are not directly related to the patients' health but which target the talk towards social issues. Example 15 demonstrates how the doctor initiates a broad question to which the patient responds with a story about a medical problem of her relative. Interestingly, the doctor – instead of redirecting the conversation back to the health issues of the patient – allows the patient to develop the story, and he himself contributes certain comments to the narration. According to Cordella (2004), this discourse strategy is associated with the functions of the **fellow human voice**,⁶ and develops an empathic relationship between the doctor and the patient. The awareness of the larger context in which a particular medical problem is manifested “could contribute to making a more informed prognosis and formulating a better treatment regimen by taking into account the conditions of the patient's daily life” (Cordella 2004: 141).

- (15) D: Well now, what can I do for you [tonight?
 P: Er] [it's an insurance line doctor. Just keep me
 D: [unclear]]
 P: right. It's my thumb. (.) That's the excuse I've been giving, [and
 D: Mhm.]
 P: that's the one I'm sticking to.
 D: (ha-ha) **How are things doing?**
 P: Alex has not been too well the last couple of days, you [know.
 D: Yeah.]

- P: Doctor was in this morning.
 D: Mm.
 P: Er but I, as I say, there's nothing that anybody can do [really
 D: No it's]
 P: you know?
 D: just a matter of time.
 P: I meant to phone up this morning for an
 appointment for Doctor, but I forgot all about it.
 D: (ha-ha)
 P: I really did, of course she was (.) the nurse came in, first it was the doctor,
 D: [Mhm.
 P: then] it was the priest, then it was another nurse, then the priest...

(BNC/G49/4–23)

Also **close-ended questions** (on their own or in combination with open-ended questions) are capable of conveying strategies focused on the empathic relationship with the patient. Doctors may, for example, involve their patients in the decision-making process. As the following example (Example 16) shows, the doctor details the treatment by offering the patient certain options. Then he proceeds with a question (*Is that okay, shall we try a lower dose?*), giving the patient an opportunity either to accept the cure or to reject it. The **shared decision-making** is generally viewed as an instance of **patient-centredness**, resulting in a more equal relationship between doctors and patients (cf. Gwyn 2002: 79–80).

- (16) D: Or what we could do, if you say these this dose makes you a bit drowsy,
 we could give you the same stuff but in a lower dose.
 P: Mm.
 D: And see if that will help without actually making you
 P: [You feel too dopey.
 D: feel flaccid,] as you say.
 P: (ha-ha)
 D: Is that okay, **shall we try a lower dose?**
 P: Yes please.

(BNC/G5P/86–93)

What is more, doctors might strengthen the empathic relationship with their patients by employing questions which incorporate patients' ideas/words (Example 17). Such questions are sometimes called **circular questions** (Tomm 1988) or **empathic questions** (Clark 2007) and they are used by doctors with "the intent of enhancing an empathic understanding of a client" (Clark 2007: 197). To be more specific, this discourse strategy allows the patient to realize that the doctor is listening to her (Example 18). Additionally, it enables the doctor to explore details of the patient's ideas delivered during the info-gathering phase.

- (17) D: What've you been doing?
P: Doctor (anonym) gave me er I can't, I can hardly walk I've got a terrible **sore back**.
D: **You back giving you trouble again?**
P: Oh terrible.

(BNC/H56/17–20)

- (18) D: Well James, what can I do for you tonight?
P: It's (.) **my knee again**.
D: **Your knee? Still giving you trouble Jim?**
P: Aye. (.)
D: That's a boy, let's have a wee look at it.
See how we're doing. Did you get X-rays, Jim?
P: Aye, for (unclear) and I still didn't, they didn't show **anything**. (.)
D: **There's no arthritis or anything?** Good. That's good. (9.0)

(BNC/G46/1–7)

5 Responding practices of doctors

Not only the way in which doctors pose questions, but also the manner in which they respond to questions employed by patients can contribute to building an atmosphere of empathy and trust between both parties. Unlike the previous research suggesting that doctors do not answer 25% of patients' questions (Friederichs-Fitzwater 1991), the analysis of my data indicates that doctors fail to answer patients' questions only rarely and under specific circumstances, for example, when the doctor has a **phone call** (Example 19). Of course, the answer does not always follow the question immediately; there may be an insertion sequence. However, usually the answer does occur immediately afterwards (Example 20). The fact that doctors answer patients' questions is important as it gives the person seeking medical help a clue that her questions are appreciated and taken as relevant.

- (19) D: Let's have a wee look in here.
P: It's right here.
D: And there?
P: And there.
D: Right.
P: And right under here.
D: Underneath there.
P: You know?
D: **(phone rings)** Now tell me if I do
P: That's sore.
D: Sore in there?
P: Aye.

(BNC/H4T/5–16)

- (20) P: **How are you keeping yourself, Doctor?**
D: Me? **Fine**.

(BNC/H5A/128–129)

There is one more responding strategy which – besides being consistent in providing answers to patients' questioning initiatives – can help doctors to advance the communication closer towards equality in the doctor–patient relationship and which is worth mentioning at this point: facilitating the telling of patients' stories via **continuer markers** (e.g. *yeah, mhm, oh*). This discourse strategy is related to those questioning strategies that support the **narration of patients' stories**, either medical or social (see above). It functions as a language device conveying the doctor's willingness to play the role of a listener. According to Cordella (2004: 121), it belongs among the five functions of the **fellow human voice**.

As is obvious from the following example (Example 21), the doctor is (for a certain period of time) the more passive of the two interactants. Although the patient does not provide information related directly to the medical problem that has prompted her to come to the surgery, the doctor encourages her to continue in order to acquire the most comprehensive picture of the patient's condition (cf. Cordella 2004: 125).

- (21) D: How are things going on from the other point of view?
 P: Erm it gets
 D: [Mm.
 P: a bit of still.]
 D: Yes.
 P: Yeah. (unclear) we h we still haven't heard anything.
 D: From the psychologist?
 P: Er no, (unclear) go to see him.
 D: (unclear) you've got from them, certainly.
 P: Yeah. [Yeah.
 D: But you're still] in limbo as [as the
 P: Yeah.]
 D: the civil action is concerned?
 P: Erm even no second inquest, nothing.
 D: Oh.
 P: But er apparently got a solicitor. Er we haven't had to see anybody about that and he sent us a letter saying that he'd like to see us and we went and he says it there might not be a second inquest.
 D: Oh.
 P: Might go straight to court.
 D: Ah.
 P: And then we had a phone call from the police, about a month ago.
 D: Oh right, good.

(BNC/G5M/28–48)

6 Conclusion

Since any verbal interaction requires at least two protagonists, it would be strange to propose conclusions regarding questioning and responding practices in medical consultations after having discussed only the communicative practices of doctors. Let me therefore postpone concluding remarks and the discussion of my findings until after the analysis of patient-initiated questions and responses. It will, hopefully, be available in the subsequent volume of *Ostrava Journal of English Philology*.

Notes

¹ In general, I understand empathy as an “emotional experience between an observer and a subject in which the observer, based on visual and auditory cues, identifies and transiently experiences the subject’s emotional state. In order to be perceived as empathic, the observer must convey this understanding to the subject” (Hirsch 2009).

² Besides calculating absolute and relative numbers, I also use more sophisticated statistical approaches, namely correlation and the F-test. Correlation is a measure of the relation between two or more variables. Correlation coefficients (I employ Pearson) can range from -1.00 to +1.00. The value of the former represents a perfect negative correlation, while the value of the latter represents a perfect positive correlation. The F-test gives statistical evidence as to whether two samples have the same standard deviation with a specified confidence level. Samples may be of different sizes. In lay terms, it proves whether two samples differ to such an extent that this differentiation is worth studying.

³ Both quotations regarding definitions of a question are acquired in West (1983: 77).

⁴ It is not difficult to imagine a situation when one protagonist initiates a question either by a certain bodily movement or gazing pattern and the other protagonist responds with an answer.

⁵ Brody (1980) defines four levels by which mutuality might be advanced: (i) the establishment of an atmosphere conducive to participation by enhancing the patient’s perception that his or her contributions are appropriate and appreciated; (ii) the ascertainment of the patient’s goals and expectations; (iii) the education of the patient about the nature of his or her problem, discussing the pros and cons of the alternative evaluation and treatment approaches, and the explanation of the physician’s recommendations; and (iv) the elicitation of the patient’s informed suggestions and preferences and the negotiation of any disagreements between the physician and the patient.

⁶ According to Cordella (2004: 121–148), there are five functions of the fellow human voice: (i) facilitating the telling of patients’ stories, (ii) assisting the telling of patients’ stories, (iii) creating empathy with the patient, (iv) showing special attentiveness to patients’ stories, (v) asking questions unrelated to the patient’s health.

Appendix

Below are the results of the F-test, containing calculations relevant for the quantitative perspective of the analytical part of the study. The asterisk indicates when the results are of certain significance.

F-test calculation of questions with respect to participants and interview phases

F/ Participant	<i>Confirm</i>	<i>Agree</i>	<i>Commit</i>	<i>Repeat</i>	<i>Clarif</i>
<i>Info</i>	0.4772	0.4631	0.2986	0.5412	0.4771
<i>Confirm</i>		0.8396	0.1929	0.8347	0.8882
<i>Agree</i>			0.1863	0.9669	0.9501
<i>Commit</i>				0.2221	0.1904
<i>Repeat</i>					0.9242

F/ Phase	Confirm	Agree	Commit	Repeat	Clarif
Info	0.9829	0.7286	0.0277*	0.5381	0.6247
Confirm		0.7501	0.0375*	0.5636	0.6796
Agree			0.0337*	0.7783	0.5315
Commit				0.0297*	0.0899*
Repeat					0.411

Bibliography

- Boreham, Paul, Gibson, Diane. "The Information Process in Private Medical Consultation. A Preliminary Investigation." *Social Science and Medicine* 12, 1978. 408–416.
- Brody, David. "The Patient's Role in Clinical Decision Making." *Annals of Internal Medicine* 93, 1980. 718–722.
- Byrne, Patrick, Long, Barrie. *Doctors Talking to Patients*. Exeter: Royal College of General Practitioners, 1976.
- Clark, Arthur. *Empathy in Counseling and Psychotherapy*. New Jersey: Lawrence Erlbaum Associates, 2007.
- Clark, Jack, Mishler, Elliot. "Attending to Patients' Stories. Reframing the Clinical Task." *Sociology of Health and Illness* 14, 1992. 344–372.
- Cordella, Marisa. *The Dynamic Consultation. A Discourse Analytical Study of Doctor–Patient Communication*. Philadelphia: John Benjamins, 2004.
- Coulthard, Malcolm, Ashby, Margaret. "Talking with the Doctor." *Journal of Communication* 1, 1975. 140–147.
- Frankel, Richard. "The Laying on of Hands: Aspects of the Organization of Gaze, Touch, and Talk in a Medical Encounter." *The Social Organization of Doctor–Patient Communication*. Eds. S. Fisher, A. Todd. Washington, D.C.: The Center for Applied Linguistics, 1983. 19–54.
- Friederichs-Fitzwater, Marlene von. "Relational Control in Physician/Patient Encounters." *Health Communication Journal* 3, 1991. 17–36.
- Furst, Lilian. *Between Doctors and Patients: The Changing Balance of Power*. University of Virginia Press, 1998.
- Gwyn, Richard. *Communicating Health and Illness*. London: SAGE, 2002.
- Have, Paul ten. "Talk and Institution: A Reconsideration of the 'Asymmetry' of Doctor–Patient Interaction." *Talk and Structure*. Eds. D. Boden, D. Zimmerman. Cambridge: Polity Press, 1991. 138–163.
- Heath, Christian. "The Delivery and Reception of Diagnosis in the General-Practice Consultation." *Talk at Work*. Eds. P. Drew, J. Heritage. Cambridge: Cambridge University Press, 1992. 235–267.
- Hirsch, Elliot. *The Role of Empathy in Medicine: A Medical Student's Perspective*. Online: <<http://virtualmentor.ama-assn.org/2007/06/medu1-0706.html>> Retrieved 18. 10. 2009.

- Humphreys, Joanne. *The Role of Questions and Answers in Doctor–Patient Interaction*. Online: <<http://www.ling.lancs.ac.uk/staff/florencia/201/res/diss/humphreys.pdf>> Retrieved 11. 3. 2002.
- Karttunen, Lauri. “Syntax and Semantics of Questions.” *Questions...* Ed. H. Hiz. Dordrecht: Reidel, 1977. 165–210.
- Mishler, Elliot. *The Discourse of Medicine. Dialectics of Medical Interviews*. Norwood: Ablex Publishing Corporation, 1984.
- Paget, Marianne. “On the Work of Talk: Studies in Misunderstandings.” *The Social Organization of Doctor–Patient Communication*. Eds. S. Fisher, A. Todd. Washington, D.C.: The Center for Applied Linguistics, 1983. 55–74.
- Roter, Debra, Hall, Judith. *Doctors Talking with Patients/Patients Talking with Doctors*. Westport: Auburn House, 1992.
- Sacks, Harvey, Schegloff, Emanuel, Jefferson, Gail. “A Simplest Systematics for the Organization of Turn-Taking for Conversation.” *Language* 50, 1974. 696–735.
- Shuy, Roger. “Three Types of Interference to an Effective Exchange of Information in the Medical Interview.” *The Social Organization of Doctor–Patient Communication*. Eds. S. Fisher, A. Todd. Washington, D.C.: The Center for Applied Linguistics, 1983. 189–202.
- Simpson, Deborah, et al. “The Diagnostic Process in Primary Care: A Comparison of General Internists and Family Physicians.” *Social Science and Medicine* 25, 1987. 861–866.
- Tomm, Karl. “Interventive Interviewing: Part III. Intending to Ask Linear, Circular, Strategic, or Reflexive Questions.” *Family Process* 27, 1988. 1–15.
- Tsui, Amy. “A Functional Description of Questions.” *Advances in Spoken Discourse Analysis*. Ed. M. Coulthard. London and New York: Routledge, 1992. 89–110.
- Urbanová, Ludmila. *On Expressing Meaning in English Conversation. Semantic Indeterminacy*. Brno: Masarykova univerzita, 2003.
- Urbanová, Ludmila. “Some Methodological Remarks on Current Trends in Linguistic Research.” *Discourse and Interaction* 1, 2005. 119–124.
- Waitzkin, Howard. “Doctor–Patient Communication. Clinical Implications of Social Scientific Research.” *The Journal of the American Medical Association* 259, 1984. 2441–2446.
- Weber, Elizabeth. *Varieties of Questions in English Conversation. Studies in Discourse and Grammar*. Philadelphia: John Benjamins, 1993.
- West, Candace. “Ask Me No Questions...” *The Social Organization of Doctor–Patient Communication*. Eds. S. Fisher, A. Todd. Washington, D.C.: The Center for Applied Linguistics, 1983. 75–106.
- Winefield, Helen, Murrell, Timothy. “Speech Patterns and Satisfaction in Diagnostic and Prescriptive Stages of General Practice Consultations.” *British Journal of Medical Psychology* 64, 1991. 103–115.
- Wynn, Rolf. *The Linguistics of Doctor–Patient Communication. An Analysis of the Methodology of Doctor–Patient Communication Research*. Oslo: Novus Press, 1995.
- . *Provider–Patient Interaction. A Corpus-Based Study of Doctor–Patient and Student–Patient Interaction*. Kristiansand: Norwegian Academic Press, 1999.

Sources

British National Corpus (XML ed.). Published by Oxford University Computing Services on behalf of the BNC Consortium, 2007.

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