

Doctor–Patient Communication

Florian Menz

23.1 INTRODUCTION: SELECTION OF RESEARCH AREAS

Since the 1970s, doctor–patient communication has become increasingly well established as an area of inquiry within sociolinguistics and discourse analysis, initially focusing, in particular, on the institutional frames of communication (Becker-Mrotzek, 1992; Drew and Heritage, 1992; Hein et al., 1985; Laluschek et al., 1990; Menz, 1991; Sarangi and Roberts, 1999). At the time of writing this chapter, in 2008, a quick search in the bibliographical database ‘medonline’ using the keywords ‘doctor patient communication’ yielded over 7500 publication entries, while the keyword ‘communication’ alone results in an astounding 360,000 hits. The scope of the present chapter is therefore necessarily limited.

The area of patient – care communication (interaction between patients and nursing staff, which includes non-medical aspects; see e.g. Candlin, 2006; Walther, 1997; see also Weinhold, 1997 for medical patient care and Sachweh, 2005, 2006 for care of the elderly) must be excluded here, as must be studies that focus on peer interaction among doctors (De Valck and Van den Wostijne, 1996; Herb and Streeck 1995; Lackner et al., 1996; Ploeger, 2005). Furthermore, the vast field of communication in psychotherapeutic and psychiatric contexts (Buchholz, 1998; Fritzsche and Wirsching, 2005; Küttemeyer, 2003; Morris and Chenail, 1995; Peräkylä, 2004; Schöndienst, 2002) as well as in medical consulting (see e.g. Sarangi and Brookes-Howell, 2006) cannot be treated here, nor can studies using experimental settings which thus analyse non-naturally occurring communication between doctors and patients (e.g. Li, 1999; Watson and Gallois, 1999). Lastly, neither

the interface of transformation from oral to written discourse and vice versa can be taken into consideration here (but see Iedema, 2003, 2006), nor can research concerned with the specifics of professional medical literature (Gotti and Salager-Meyer, 2006; Pahta, 2006) be included. Rather, this chapter will be restricted to a discussion of the most recent investigations, referring the reader to existing anthologies (Atkinson and Heath, 1981; Ehlich et al., 1990; Fisher and Todd, 1983; Heritage and Maynard, 2006b; Köhle and Raspe, 1982; Löning and Rehbein, 1993; Morris and Chenail, 1995; Neises et al., 2005; Redder and Wiese, 1994; Sarangi and Roberts, 1999; Tanner, 1976), and Hydén and Mishler’s (1999) review article for in-depth coverage of past research and the status quo of linguistic inquiry into these subject matters.

Recent research on doctor – patient communication (DPC) from a linguistic perspective can be categorized under three broad headings: (1) microstructure-oriented analyses of both conversational organization and interaction dynamics at a syntactic and semantic level; (2) investigations into the influence of macrostructural social dimensions; and, increasingly; (3) practically-oriented studies of the interest of social applicability. Conversation-analytic research on DPC is particularly concerned with the different phases of doctor–patient talk and the interactional tasks it fulfils. Such research is therefore oriented towards formal and structural processes, increasingly taking an interest in settings that include more than two participants (‘triadic and multiparty interaction’ – see Section 23.2.1). Furthermore, actual language usage and different forms of representation of symptoms, disorders and the subjective experience of illness are of special interest for sociolinguistic analysis (see Section 23.2.3).

Because the issue of the representation of pain also has great significance from a medical perspective, it is discussed in more detail in Section 23.2.3.

In contrast, the studies presented in Section 23.3 also take macrosocial dimensions beyond the local conversation into consideration in their analyses. Issues of multilingualism and migration (see Section 23.3.1) and of gender (see Section 23.3.2) constitute major areas of inquiry here, to which sociolinguistic research contributes notable insights. Questions regarding the practical applicability and social relevance of scientific research play an increasingly central role in a knowledge society. This is reflected in linguistic inquiry as well. Thus, Section 23.4 summarizes those studies that concern themselves with issues of applicability and are aimed at the (re-) integration of linguistic findings into medical practice. The concluding Section 23.5 represents an attempt to assess future research questions and trends that will play a role within sociolinguistic and interactional linguistic approaches to medical communication in the years to come. Content-based aspects will be discussed alongside those of methodological and interdisciplinary concern.

23.2 MICROSTRUCTURAL ASPECTS OF DOCTOR–PATIENT COMMUNICATION

23.2.1 *Phases of doctor–patient talk/ interaction dynamics*

Starting with a first broad field study by Byrne and Long (1976), discourse analytic and sociolinguistic investigation has repeatedly pointed out a systematic overall structure in doctor–patient talk. With only slight variations, the following phases recur in the context of acute primary care visits: greetings and openings; presentation of the complaint, exploration; examination; diagnosis; establishment of a therapeutic plan; closing of the talk; and leave-taking (Heritage and Maynard, 2006a; Nowak, 2009; Spranz-Fogasy, 2005). This overall structure can be further subdivided and differentiated. Thus, Nowak (2009), in a broad-range empirical meta-study, identifies and categorizes 48 activity types and over 100 activities within doctor–patient talk. Some special cases and recent findings will be discussed in the following.

At the **opening of a conversation**, doctors and patients must carry out a number of cooperative activities (greetings, offering a seat), as well as non-cooperative ones (patients closing the door, doctors reading the record, consulting the computer, etc.), to achieve mutual orientation and in order to establish their readiness to address the chief complaint, the reason for the patient's visit.

Communicating engagement or disengagement happens mainly via gaze and body orientation, whereby lower-body segments are used to determine the frame in which long-term action (communicating with patient vs studying records for example) is to be situated (Robinson, 1998: 114). Thus, multimodal resources are systematically employed to fulfil complex communication and orientation tasks here.

Subsequent medical **exchange of information** between doctors and patients is mainly carried out through question – response sequences, which have been discussed extensively in the linguistic literature. Different types of opening moves (Nowak, 2009) define and delimit a frame for patient responses which may restrict their 'room for maneuvering' (Spranz-Fogasy, 2005). The extent to which minimal variations in wording may trigger different responses was attested to in an experimental setting in a study by Heritage et al. (2007). The question 'Is there something else you want to address in the visit today?' elicited significantly more hitherto unmet concerns than the same question using the word 'anything' instead of 'something'. However, the length of the interaction did not increase.

Multi-topic presentations and so-called 'door handle' remarks (introduction of a new problem upon leaving a room), dreaded by many doctors, have in fact turned out not to present any real problems: such presentations and remarks have been shown to be the rule rather than the exception in medical consultations; and yet, because patients tend to announce them in the opening phase of presenting the complaint, doctors are able to process them successfully at the communicative level (Campion and Langdon, 2004).

Even potential information discrepancies between doctors and patients can usually be processed and cleared up by doctors without difficulty: for example by integrating divergences in patients' knowledge into their own knowledge and information system, or by offering additional information for support (Lehtinen, 2007).

Furthermore, Collins (2005) shows how doctoral explanations may in some cases be usefully supplemented with explanations by nursing staff. While doctors adopted the viewpoint of a biomedical intervention in their explanations, the latter, i.e. the nursing staff, incorporated the viewpoint of patient responsibility and oriented their interactional moves towards patient contributions. Thus, clashes of the voice of medicine with the voice of the 'life-world', as attested to by Mishler (1984) and confirmed by Lalouschek (2002), could be attenuated or altogether circumvented.

Yet, doctors may comply only in a limited way with interactive pressures to provide answers to or explanations for questions. Thus, doctors were

shown to invoke clinical agendas to postpone certain types of patient questions if they did not want to reply, and once postponing has taken place, patients do not tend to pursue their questions further, so that they often remain unanswered (Roberts, 2000). The exchange of information is driven by institutional agendas, and certain standard phrases and expressions in the initiation phase of medical diagnosis and treatment additionally inhibit patient participation (Diaz, 2000: 386) and reinforce the asymmetry in much doctor – patient talk. Also, the gate-keeping function that doctors have, by virtue of their power to make decisions about access to medical treatment, medication and other services, is also processed and reenacted via certain forms and content of questions. (Speer and Parsons, 2006). The situation increases in complexity in the case of multiparty encounters, for example in paediatric consultations. Here, a number of factors naturally play a role in next speaker selection – both concerning the paediatrician’s selection of addressee as well as in the parent – child negotiation of who will present the problem (Stivers, 2001). Factors that increase the likelihood that a child will be the presenter of the problem, and which thus deserve attention in view of promoting active involvement of the patient, are the child’s age, preceding speaker selection/address (e.g. during the greeting phase) and direct addressing by the doctor. Adolescents, by contrast, may explicitly disallow the addressing of a parent, usually a mother, as a stand-in informant for the medical problem (Mondada, 2002).

23.2.2 Forms of representation of illness and its subjective experience

In addition to an interest in the interactive processes of doctor – patient talk, some sociolinguistic and discourse analytic studies have also concerned themselves with content/semantic representations of illness and ailments. The use of professional jargon in particular is frequently cited as a problem area. But it has also been shown that the use of (English) medical vocabulary can have a practical function in rural African contexts (Odebunmi, 2006) – to avoid giving disturbing information as long as the diagnosis is not yet confirmed, and to avoid stigmatizing the patient in the presence of relatives. Mastery of code-switching is therefore a basic qualification for practitioners there.

Investigations of metaphorical language used in representations of illness constitute another important area of inquiry, although here data are not always drawn from natural contexts (Rees et al., 2007; Semino et al., 2004).

Metaphors and other forms of illustration are used as resources for a variety of purposes in the

process of knowledge transfer between experts and laypersons (Brünner and Gülich, 2002: 77). Experts may use such resources to explain and break down complex facts, while patients may employ them to grasp and illustrate sensations and experiences that are otherwise difficult to describe, such as experiences of pain, or of auras preceding epileptic seizures. Metaphors and similes are commonly used in these contexts, while exemplification and explications of scenarios are more frequent when the intention is to draw parallels to day-to-day life.

It is to be noted that such illustration processes are of course co-constructed, and that experts and laypersons do not necessarily employ different resources, but rather may employ the same ones in differentiated ways and for different purposes (Brünner and Gülich, 2002: 82ff.).

Divergences in usage preferences can also be analysed for the purposes of differential diagnostics. For example, epilepsy patients tend to employ metaphor more frequently in their description of seizure attacks than patients with dissociative disorders (Surmann, 2005). The ways in which either group tends to reconstruct the gap in consciousness during attacks show significant differences as well (Furchner, 2002). Analyses of divergences in linguistic strategies therefore lend themselves readily to support differential diagnosis, which in traditional terms and methods is complex, costly and prone to error.

23.2.3 Pain representation

The representation of pain, which is pivotal in medical communication, is typically rather problematic, because here, everyday language provides only a limited repertoire of expression, in contrast to, for example, the repertoires for the description of visual or acoustic phenomena, which are typologically highly developed in most languages. Category sets for the representation of pain have indeed been established from a medical perspective (see Reisigl, 2006 for systematic description and critique). These sets list dimensions such as temporal occurrence (‘When?’), localization (‘Where?’), intensity (‘How severe?’), quality (e.g. ‘stinging’, ‘piercing’), side symptoms (e.g. nausea), conditions of occurrence (e.g. when walking, when lying down), and pain management (‘What eases or increases the pain?’). One problem of such classifications is that it may not always be easy for patients to assign their subjective experience of pain to any particular medical category listed. For this reason, representations of pain typically also employ non-verbal, gestural resources, which nowadays can be easily captured with recording technology and have therefore become a strong focus in DPC research.

Non-verbal resources are mainly used to accentuate dimensions of the **intensity** and quality of pain. Such ‘demonstrative suffering’ (Heath, 2002) emphasizes the unique and particular qualities of pain.¹ By expressing the severity of the illness, it also serves to gain access to the ‘sick role’ in the first place, thus legitimizing medical consultation (Heritage and Robinson, 2006).

Non-verbal activity is well integrated into the frame of medical consultation: the turn-by-turn structure is maintained, and gesture is usually accompanied by talk, in accordance with the sequential requirements of interaction (Heath, 2002).

Non-verbal activity also plays a role in connection with the **localization** of pain. Resources like gaze, pointing gestures and body movement are typically combined with verbal deictic expressions (e.g. ‘here’), as in fact two interactional tasks have to be fulfilled: defining the locus of the pain and maintaining the interactive frame established with the doctor. In this context, differences in the expression of visible versus invisible targets have been confirmed (Stukenbrock, 2008). With visible targets (e.g. pain in the knee), the domain of scrutiny for the verbal deictic is pre-established via a partly simultaneous employment of gaze and gesture. The gaze moves from the addressee to the pointing hand and from there to the target (the knee). The co-orientation is therefore multimodal, being gradually intensified through gaze, gesture and talk (in this order). In the case of an invisible target however (e.g. pain in the back), the patient’s gaze remains on the addressee, in order to maintain the interactional frame.

The expression of the **quality** of pain then falls back, to a large degree, on verbal resources. A lack of ‘basic pain terms’ forces patients to use indirect means of description such as metaphor or visualization, as evidenced in a recent study on written and oral German data (Overlach, 2008). Within the oral context, lexical and syntactic variation was more strongly focused on basic metaphors of possession (‘to have a pain’) and copula construction (‘the pain is ...’).

In addition, not all resources that L1 speakers have at their disposal for the expression of pain are actually employed (Blasch et al., 2010). Thus, whenever patients are asked about their pain in **non-medical** contexts, they mainly talk about:

- subjective theories about the illness and possible sources of the pain
- various impairments they are subjected to due to the pain
- pain management in general – how they (successfully) try to avoid pain, or measures taken to attain relief.

Thus, the dimensions of **conditions of occurrence** and **pain management** are foregrounded.

By contrast, in medical contexts, the following themes dominate:

- talk about medication
- talk about side symptoms of the pain that occasioned the medical consultation
- differentiated specification of the pain and its occurrence (quality of the pain, local and temporal dimensions, intensity).

The points of discrepancy here can be subsumed under the headings of **contextualizing** vs **symptom-oriented** expressions of pain (see Figure 23.1). In informal, non-medical talk, patients put their expressions of pain into a broader context, and relate them to everyday experience, and in particular to personal experience and impairment. Thus, pain is not so much characterized in terms of its sensations and symptoms, but rather in terms of its suspected sources, its effects, and possibilities for avoidance or relief (Blasch et al., 2010).

Such divergences in strategies and foci in the representation of pain can lead to interactive difficulties. Thus, divergent **concepts of ‘pain’** may result in communication problems: for example, when doctors explore pain as a measure of mental sensation that is to be isolated, while patients describe it in practical terms as a phenomenon that is relative to context and has observable consequences (Deppermann, 2003). This manifests itself, for example, in divergences in the dimensions of expressions of pain, which can again be subsumed under the headings ‘contextualizing’ and ‘symptom-oriented’ (Blasch et al., 2010; Menz and Lalouschek, 2006). Pain consultations that are adapted to the patient’s perception of priorities and allow for narrative structuring may, instead of applying pre-established sets of categorization, succeed in eliciting new facts and information from patients with multiple complaints that other forms of anamnesis may be unable to reach. Thus, discourse analytic and/or conversation analytic preoccupation with forms of expression rather than content can contribute to the establishment and enhancement of medical diagnoses (Gülich et al., 2003).

Gender-based variation in the representation of pain is discussed in Section 23.3.2.

23.3 MACROSTRUCTURAL ASPECTS

23.3.1 Migration: multilingualism in doctor – patient interactions

Despite the fact that, because of mass globalization, multilingualism due to migration has become the norm in large urban areas, the issue has not yet been sufficiently addressed in research on medical

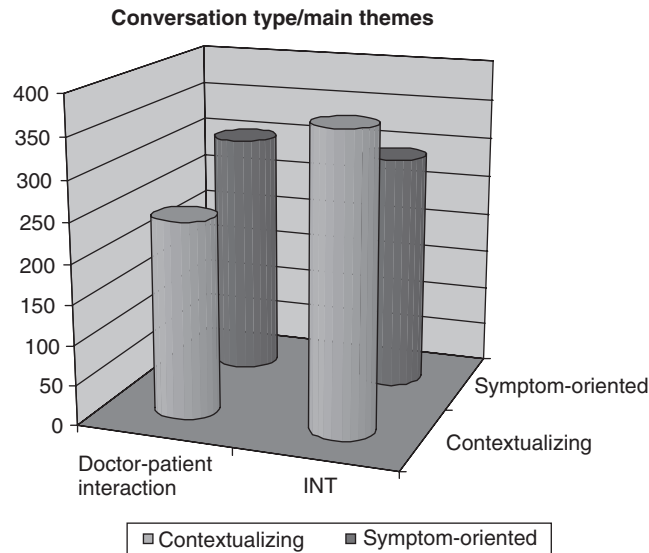


Figure 23.1 Different topics according to conversation type (medical consultation vs interview).

communication. There are indeed indications that doctors' role expectations and communicative tasks change in interactions with non-native speakers, for example towards an increase in non-medical questioning and a higher percentage of bureaucratic negotiation (Valero-Garcés, 2002). In addition, however, specific types of misunderstandings occur, at all levels of the linguistic system and social interaction, such as (a) pronunciation and word stress, (b) intonation and speech delivery, (c) grammar, vocabulary, and lack of contextual information, and, especially, (d) style of presentation (Roberts et al., 2005). The latter, in particular, typically plays a decisive role in misunderstandings, suggesting that differences in the styles of self-presentation may have more bearing on communication problems than, for example, culturally-specific health beliefs.

Of similar importance are structural discrepancies that can be traced back to the bureaucratic (administrative) organization of the respective health systems (Roberts, 2006), such as, for example, an increasing demand for documentation and the concomitantly required use of electronic forms and processes. These are geared towards monolingual English speakers and put patients with limited English knowledge, who have yet to familiarize themselves with the 'rules', at a disadvantage. Moreover, the exigencies of a health bureaucracy concerning parameters such as length of consultation, active monitoring of cholesterol levels, addressing drug use, etc., which in part form the basis of calculation for a family doctor's salary, may cause problems when patients do not

adhere to unfamiliar structures and, for example, raise multiple topics in the course of one consultation, which in turn cannot easily be processed by computerized systems (Roberts, 2006).

Most importantly, however, patient-centred conversational strategies, which are increasingly in demand in Western society, may stand in direct contradiction to the expectations regarding the doctor – patient interaction sought by patients with a different cultural background. In such situations, an increase in metatalk (Roberts, 2006: 190) tends to complicate communication rather than facilitate it. Thus, increasing sensitivity and raising awareness of different presentation strategies are important measures for improvement of the status quo. Conventional communication coaching on the basis of monolingual native speaker contexts is obsolete here, as it fails to address discrepancies in self-presentation, expectations and assumptions regarding consultations.

One frequently-employed remedy to address potential interactivity problems in multilingual and multicultural encounters is to enlist the help of **interpreters**. Due to the extensive literature in this area, the present discussion will limit itself to discourse-based approaches, which have recently gained importance and increasing attention as a research strand within interpreting studies, to the point that some scholars have begun to speak of 'dialogic discourse in triadic interaction' as a new research paradigm in its own right (Pöchhacker and Shlesinger, 2005: 157; see also Bolden, 2000; Bührig, 2001; Meyer et al., 2003; Bührig and Meyer, 2004b; Pöchhacker and Shlesinger, 2007).

In the literature on community interpreting, two broad areas can be distinguished: professional interpreting and un-trained (ad-hoc) interpreting. Those two areas represent two fundamentally different settings within multiparty communication. In addition, discourse analytic studies of professional interpreting are located on the interface between the classic research area of interpreting and translation, which to this day is strongly influenced by the traditional norms applying within the interpreting profession, and the applied linguistic research paradigm that foregrounds the interactive functions of interpreting activity. Contradictions growing out of the tensions between role-specific postulations and the ethic rules of associations of interpreters, on the one hand, and interactive situations and activities, on the ground on the other, may result in veritable interactional dilemmas (Angelelli, 2004). For example, institutions for interpreter education frequently still insist on the notion that interpreters should not intervene as individual ‘entities’ in interpreting situations but rather should take care to remain ‘invisible’. Yet, Angelelli’s analysis of almost 400 communicative events involving interpretation (of which the majority occurred in the context of telephone conversations) evidences a number of linguistic activities that point to the ‘visibility’ of the interpreter. These activities notably include the following: interpreters introducing themselves as participants in the interpreted event; verbalizing of interactional rules (e.g. for turn transition); paraphrasing of professional jargon and terminology; register changes (e.g. rendering translation more informal than the original statement); filtering of information; and taking up the perspective of one of the parties.

In addition, the interactional participation of interpreters in itself is largely determined by their conception of the purpose of the interaction, not only by the immediate goal of interpreting (Bolden, 2000). Interpreters are not merely passive participants in interactional activity: rather, their interpretations are substantially shaped by a medical/doctoral perspective. They share the doctors’ normative bias for objective, biomedically-relevant information. Such an orientation is not only manifest in an amplification of the kinds of information that are deemed relevant in the above sense (e.g. an exhaustive listing of symptoms the interpreter holds to be relevant) but also in the suppression of more subjectively-oriented patient information concerning socio-psychological aspects.

While Bolden’s study thus attests to an amplification of the ‘voice of medicine’ in Mishler’s (1984) sense, others have shown different results. In their analysis of (only three) interpreted conversations, Merlini and Favaron (2005) found that

interpreters develop an individual, third ‘interpreter’s voice’ in order to mediate between the voice of medicine and a patient’s ‘voice of lifeworld’. The investigation of a list of linguistic features (turn-taking, topic development, the interpreter’s choice of footing, departures from the primary speakers’ utterances, prosodic resources) led the authors to regard strong interactional involvement on the interpreter’s part as characteristic of the voice of interpreting, though only as an amplification of the voice of lifeworld, and hence in concomitance with strong involvement of the patient.

Multiparty conversations with **ad hoc interpreters** face a different set of clear communicative challenges. Such conversations appear to occur much more frequently in practice than is commonly assumed (see Pöchhacker and Kadric, 1999). In the course of knowledge transfer during briefings for informed consent, the translation of professional terminology is a particularly salient source of trouble here; it is often negotiated using procedures such as repetition of the word in the source language (‘insertional code switching’) or replacement with non-terminological wordings (Meyer, 2004). Further support measures include pointing gestures indicating the afflicted body part on the body itself or on illustrations in information leaflets, as well as morpheme-by-morpheme translations into the target language. The latter, however, may be prone to causing comprehension problems, so that the quality of interpreted briefings for informed consent can suffer and information is less exact and complete than in monolingual situations (Bührig and Meyer, 2004a; Meyer, 2002, 2004).

Additional differences in multilingual interactions without interpreting, with professional interpreting, or with ad hoc interpreting have been noted in the literature. For example, Valero Garcés (2002; 2005) finds that professional interpreters translate all doctoral questions and rarely add new ones, while ad hoc interpreters only translate about 14% of questions, answering an average of 50% of questions themselves, and raise a considerable number of new questions (with the interpreter and patient in this case being a spouse). More notable, however, are qualitative differences and commonalities in the different scenarios. Thus, the ad hoc interpreted conversations frequently exhibit shifts in the assignment of participant roles, in interaction order and in contribution type, whilst demonstrating a relatively low linguistic competence of the ad hoc interpreter. Similar to non-interpreted conversations, ad hoc interpreted interactions typically feature strategies meant to ensure comprehension, such as frequent questions, repetitions and recasts. In contrast to professionally interpreted conversations, situations of ad hoc interpretation are additionally

characterized by the interpreter's changing of roles, in the sense that s/he may take over questioning from the doctor, or give answers directly without translation. When the interpreter talks directly to one of the parties, those passages usually remain untranslated for the other, which is never the case in professionally interpreted settings. Thus, according to Valero Garcés, ad hoc interpretations carry a high risk of misunderstanding. Professional interpreters, furthermore, frequently use the first person in their translation, while ad hoc interpreters often use the third person in the context of reporting verbs ('she says').

Bot (2007) reports similar findings with regards to therapy sessions. However, Bot does not consider the shift in perspective from first to third person to be as problematic as commonly described in the literature; rather, she casts it as a necessary adaptation to interactive reality. These findings are, however, relativized by the small size of the corpora used, and thus must be regarded as tentative.

23.3.2 Gender

The fact that gender plays a role in institutional communication, including medical consultation, has been well established in past research, both with regards to the patient's as well as the doctor's gender (West, 1990). In particular, research has investigated interruptions as indices of status and power (Holmes, 1992; West, 1984), though with

discrepant results that were later traced back to shortcomings in the methodology, such as the fact that interruptions were technically defined on the basis of overlaps, with no allowance for the fact that overlaps are not necessarily disruptive but can also be communicatively supportive.

Controlling for and taking into account these methodological issues gives rise to more differentiated results (Menz and Al-Roubaie, 2008: 657ff.). Thus, non-supportive interruptions (meaning those that involve a change of topic or addressee) seem to grow out of status rather than gender differences: doctors of either sex interrupt more often than male or female patients (Li et al., 2004). Furthermore, interruption attempts by patients are increasingly less successful as the status of the doctor becomes higher. In all, this points to the fact that with regards to dominant linguistic behaviour, position and (social) status play a more important role than gender, as illustrated in Figure 23.2.

The situation is different in the case of supportive interruptions. Here, the numbers are significantly higher for both female patients and female doctors, in comparison with male doctors and patients, as illustrated in Figure 23.3.

This appears to be evidence for the fact that in the institutional setting of medical communication, women are more strongly consensus-oriented and cooperative than men, just as they are in other settings (Menz and Al-Roubaie, 2008: 659).

In addition to showing differences regarding interactional dynamics, the variable of gender also correlates with differences of linguistic realizations in, for example, representations of pain

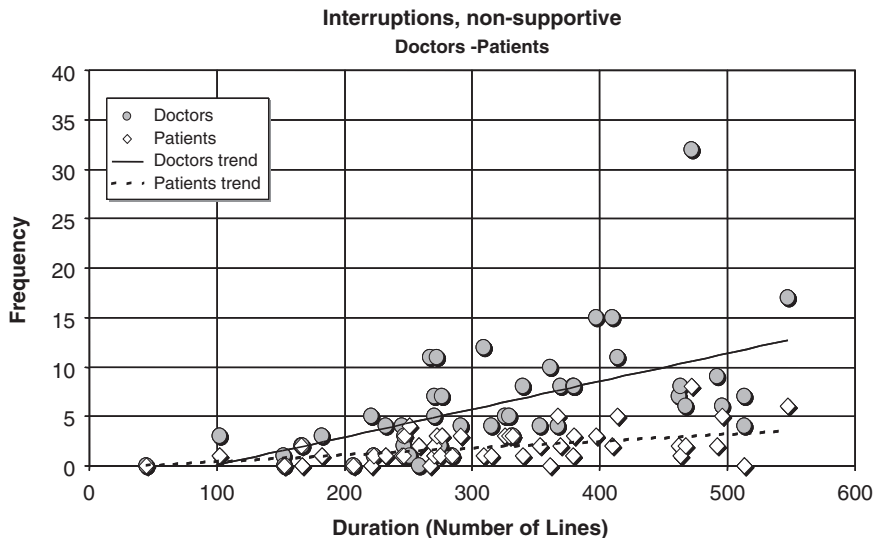


Figure 23.2 Distribution of non-supportive interruptions by doctors and patients over the course of an anamnesis ($p = 0.000$) (Menz and Al-Roubaie, 2008: 657).

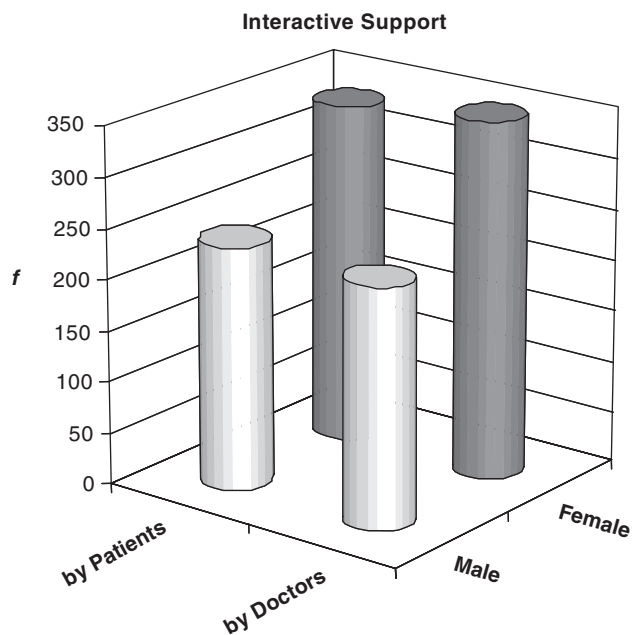


Figure 23.3 Cross-tabulation of the distribution of supportive interruptions for doctors vs patients, male vs female ($p=0.013$) (Menz and Al-Roubaie, 2008: 659).

(Blasch et al., 2010). Thus, in the context of medical consultations:

- Women, on referring to pain, use semantically-rich concepts and fewer 'empty subject' constructions ('it', 'this') than men.
- Women use significantly more 'marked' (non-formulaic) processes to represent pain than men. While men more frequently fall back on ready-made formulations ('to have a pain', 'to hurt'), women's expressions show more diversity and variation.
- Women produce a higher number of relativizing temporal qualifiers (often, sometimes ...) than men, who more frequently use the absolute qualifier 'always'. This can also be interpreted in the sense that female patients appear to produce more differentiated representations.

Overall then, representations of pain appear to exhibit more variation and diversity when produced by women than by men. However, some medical studies (Penque et al., 1998; Shaw et al., 1994) have pointed out that it may in fact be due to these divergences in strategies for the representation of pain that certain syndromes like coronary heart disorders are more frequently overlooked in female patients than in males, which in turn increases women's mortality rate. Because the description of pain is a central diagnostic tool

used to distinguish severe from less harmful complaints and thus to assess the necessity of (life-saving) measures, verbal representation plays a central role that is not to be underestimated. Differences in verbal expression occur notably in the following four areas (Menz and Lalouschek, 2006; Vodopiutz et al., 2002):

- 1 Women tend to downplay their pain (making light of it or focusing more on the psychological and social context); men, by contrast, tend to overstate their pain (taking it seriously, showing they are interested and well informed).
- 2 From an interactional perspective, women are more likely to view themselves as being able to endure the pain (passively, and ready to delegate and entrust the treatment to the medical institution), while men tend to present themselves interactively as mastering the pain (actively, and to undertake therapy).
- 3 Men tend to show a stronger wish to know the cause of pain than women.
- 4 Men tend to describe pain in (very) concrete terms, by providing ample descriptions of symptoms, while women's descriptions of pain tend to be more contextualizing, showing little focus on symptomatic aspects and frequently using markers of diffusion as well as metacommunicative remarks that topicalize the impossibility of providing an exact description of the pain.

The reason why such divergences are important issues for study within doctor – patient communication is that the linguistic enactments typically found with men correspond more closely to doctors' expectations with regards to providing the desired information than do women's enactments. Doctors require and demand symptomatic descriptions of pain, which means as exact an indication of the locality, intensity, duration and frequency of (e.g. chest) pain as possible. Thus, patients who themselves prefer and pursue a diagnostic path of investigating causes and producing symptomatic descriptions of pain are more readily regarded as precise, informative and cooperative by doctors. This mainly applies to male patients. Furthermore, due to the fact that the majority of cardiologists to this day are male and that, historically, descriptions of symptoms and clinical differential diagnoses in the realm of coronary heart disorders were developed mainly with male patients, the bias may actually be immanent in the system (Menz and Lalouschek, 2006; Vodopituz et al., 2002).

23.4 APPLICATIONS: TEACHING/EDUCATION

In recent years, an increasing number of linguistic findings in the area of DPC have given rise to considerations of transference to and practical applicability within medical practice. Here, different theoretical models lead to preferences for different propositions. From a conversation analytic perspective, sequential turn-by-turn analyses lend themselves readily to the comparative study of, and ultimately to the differentiation between, successful and less-than-successful interactions, underlining the notion that both (all) conversational parties share equal responsibility in the co-construction of a setting. Thus, conversation analysis (CA) is particularly conducive to findings in the context of patient-centred and biopsychosocial approaches (Maynard and Heritage, 2005). Discourse analytic approaches take up another focus, integrating more strongly theme-oriented aspects such as frames, footing and face-work, but also content-related aspects such as shared decision-making into their propositions (Roberts and Sarangi, 2005). Considerations of grammar, intonation, vocabulary, as well as of rhetorical processes of facework, are all integral parts of discourse analytic models.

Proposals growing out of the 'Vienna School' (see e.g. Lalouschek, 2004; Menz and Nowak, 1992; Wodak, 1996) are more strongly oriented towards practice and the development of specific training programmes.

Furthermore, Menz et al. (2008a), using an innovative two-phase study design, report validated results for a set of communication characteristics that proved to be salient. Data from a first series of recordings formed the basis for a short (and thus easily implemented) one-hour training programme focusing on two areas that analysis had shown to be significant: **orientation** with regards to the local interactional process as well as the global context of the treatment and also transparency with regards to laying out the conversation. A second set of recordings served to test the effectiveness of the training programme. Compared to the first data-set, the second set attested to clear modifications in the participating doctors' conversation design: doctors provided more orientation for the patients regarding the course of the conversation that was to be expected; there were fewer topic jumps, and doctors reacted more sensitively towards indications of patients' concerns, while nevertheless adhering more closely to their original mapping of the conversation. Thus, even short-term didactic intervention was shown to have noticeable ramifications for conversational conduct. It would be desirable for similar programmes, addressing further linguistic processes such as the use of relevance markers (Sator et al., 2008: 169), to be introduced into the medical curriculum.

Also of great importance is the work on seizure disorders (epilepsy, dissociative disorders, etc.) conducted by a research group around Elisabeth Gülich and Martin Schöndienst. Their work is not only relevant to focusing and improving doctors' communicative competence but also on a more immediate level for the development of diagnoses. Thus, Gülich and her collaborators, in a series of conversation analytic studies (Furchner, 2002; Furchner and Gülich, 2001; Gülich and Furchner, 2002; Gülich and Schöndienst, 1998, 1999) have provided evidence for the fact that different subtypes of epilepsy can be distinguished on the basis of the forms of representations of seizure attacks and so-called auras. Hesitation phenomena, reformulations, elaborations on the description of auras, as well as the use of adversative structures and of ready-made phrases, were all shown to be discriminatory features of certain types of epilepsy and dissociative attacks. Thus, the generation of findings, which in traditional medicine would have taken up long periods of observation during hospitalization or even invasive measures such as surgery, can now be elicited in more straightforward and comparatively easy ways in the course of careful anamnesis, due to the parameters established. (For similar results in the context of chest pain, see Vodopituz et al., 2002.) The work of Sator (e.g. 2009) promises to yield results of comparable significance with regards to

the differentiation of headaches, the classification of which has, until now, proved impossible using medical testing and machinery. Here too, careful and precise anamnesis is of vital importance.

Differently cast, but also of increasing significance, are discussions following Roberts and Sarangi's (2003) treatise that problematizes attempts to disseminate discourse analytic findings among medical practitioners in the form of academic publications. In particular, potential clashes of inherently different methodological paradigms (quantitative vs qualitative), the presentation of qualitative conversational data, as well as issues of academic writing style warrant reflection in view of a dissemination via out-of-discipline (i.e. medical) scientific journals. Such discussions vividly illustrate both the opportunities afforded by and the limits imposed on inter-/trans-disciplinary research (see also Menz et al., 2008b; Nowak, 2009).

23.5 TRENDS AND FUTURE RESEARCH: INTERDISCIPLINARITY, CONSOLIDATION, GENERALIZATION

Research on doctor – patient interaction is an area of analysis approached from the perspectives of a variety of disciplines (medical psychology, medical sociology, medical science per se, sociolinguistics) using a variety of methods and research questions. As the analysis of medical communication is, by definition, located on the interface of two fields, the interdisciplinary approach will continue to gain importance. This is likely to have direct bearings on methodological and topical issues and concerns, which shall be briefly considered in the following.

From a methodological perspective, medical and sociolinguistic research on doctor – patient communication developed out of two very different scientific paradigms. In sociolinguistics/conversation analysis (CA)/discourse analysis (DA), the qualitative approach dominates, which treats comparatively small corpora of data in depth and great detail. By contrast, medical research, including research on communication and interaction, is traditionally rooted in, and thus held accountable to, the standards of evidence-based medicine, whose findings primarily grow out of statistical calculations of probabilities and significances. Thus, detailed analyses that do not lend themselves easily to broad generalization are not necessarily considered reliable from this perspective.

Overall, three approaches can be discerned that attempt to bridge or at least narrow this perceived gap and prepare the ground for sociolinguistic research to be more readily integrated into medical

and medico-social work. First, within discourse analysis, there appears to be a noticeable trend towards combining genuinely qualitative analysis with quantification of observations (see, for example, a recent collection by Heritage and Maynard, 2006b; see also, for example, Haakana, 2002; Menz and Al-Roubaie, 2008; Stivers, 2001). Such combinations of different empirical methods (Wodak, 1997) is conducive to giving sociolinguistic studies more prominence within the field of medical science and to bringing it in closer contact with well-established medical research.

Secondly, modern approaches to the aggregation and dissemination of scientific data and findings are continually gaining importance in general. A first step here is the compilation of a database registering all linguistic studies on the topic of German-based doctor – patient communication that have been published (see Menz et al., 2008b). It is hoped this database will contribute to the internal consolidation and theoretical development of the research area and, ideally, constitute a pivotal point of reference for future sociolinguistic studies. To this end, the primary studies captured in the database, along with the concomitant systematized metadata and individual analyses, were made publicly and freely accessible to the scientific community in an open-access-database format. At the same time, all interested researchers and scholars are invited to become involved in the critical assessment of the database as well as its development and expansion. In that sense, the database partakes in an international trend towards open access to scientific data and findings generated on the basis of public funding. Through systematic, comprehensive presentation and electronic accessibility, such findings are henceforth available for research and discussion far beyond the linguistic discipline and tradition. This is in line with a strong desire within sociolinguistic and discourse analytic research to establish close linkages with other scientific discourse communities in the realm of medical and health communications. As a third point, so-called **metastudies** must be mentioned as a further method of generalizing and systematizing research findings, along with comprehensive bibliographies (see, for example, Nowak and Spranz-Fogasy, 2007). The purpose of metastudies is to collect and evaluate individual studies systematically. This method of generating scientific insight is well established within quantitatively-oriented disciplines such as psychology or medical science, and plays an important role with regards to the generalization and validation of results there. In a more recent development, the methodology of metastudies has been adapted for qualitatively-oriented disciplines as well. Here, Nowak's (2009) work is pioneering in the context of DPC, showing how systematic metastudy of

comprehensive analyses of conversational components of DCP can supplement or even replace entire collections of individual studies.

Beyond methodological innovations and trends, it can be predicted that, from a content-oriented perspective, attention will increasingly focus on multilingual, inter- and transcultural settings and issues (see Section 23.3.2 above). It is in this area in particular that doctors face special challenges, and here interactional sociolinguistics has much insight to offer by virtue of its long-standing and rich tradition (see also the chapters on multilingualism in this handbook).

Last but not least, a notable trend within the development of medical science itself should be mentioned. The traditional paradigm of Western medicine is gradually being supplemented with, or partially even replaced by, alternative, more holistic conceptions of illness and health, which may to some extent be due to the fact that within alternative forms of medicine such as homeopathy (Konitzer et al., 2002; Ruusuvoori, 2005), psychosomatic approaches, bio-psychosocial medicine (Lalouschek, 2005), or Traditional Chinese Medicine (TCM), different, and unconventional, forms of communication pertain that may be more conducive to patient satisfaction. The global development in the direction of post-bureaucratic forms of organization (Iedema, 2003), in the course of which communication and negotiation are increasingly gaining in importance, is another factor contributing to the high significance accorded to communicative needs and demands today. This situation will continue to call for and challenge sociolinguistic research on doctor – patient communication in the years to come.

NOTE

1 By contrast, Heath (1989) shows that forms of expressions of pain such as groaning, whimpering, or interjections can actually be inhibiting in the medical setting. Doctoral diagnosis relies on an exact description of pain, while the acute expression of pain is diagnostically not helpful or even a hindrance in the sense that other witnesses have to be consulted for the description of pain in cases where patients are themselves unable to provide an 'objective' assessment (Heath 1989: 114).

REFERENCES

- Angelelli, C. V. (2004) *Medical interpreting and cross-cultural communication*. Cambridge: Cambridge University Press.
- Atkinson, P. and Heath, C. (eds) (1981) *Medical work: realities and routines*. Farnborough: Gower.
- Becker-Mrotzek, M. (1992) *Diskursforschung und Kommunikation in Institutionen*. Heidelberg: Groos.
- Blasch, L., Menz, F., and Wetschanow, K. (2010) 'Texttypspezifische und gendertypische Unterschiede in der Darstellung von Kopfschmerzen', in F. Menz J. Lalouschek, M. Sator and K. Wetschanow (eds), *Sprechen über Schmerzen*. Duisburg: Universitätsverlag Rhein-Ruhr (UVR). pp. 225–94.
- Bolden, G. B. (2000) 'Toward understanding practices of medical interpreting: interpreters' involvement in history taking', *Discourse Studies: an Interdisciplinary Journal for the Study of Text and Talk*, 2: 387–419.
- Bot, H. (2007) 'Dialogue interpreting as a specific case of reported speech', in F. Pöchhacker and M. Shlesinger (eds), *Healthcare Interpreting: Discourse and Interaction*. Amsterdam: Jon Benjamins. pp. 77–99.
- Brünner, G. and Gülich, E. (2002) 'Verfahren der Veranschaulichung in der Experten-Laien-Kommunikation', in G. Brünner and E. Gülich (eds), *Krankheit verstehen. Interdisziplinäre Beiträge zur Sprache in Krankheitsdarstellungen*. Bielefeld: Aisthesis Verlag. pp. 17–94.
- Buchholz, M. B. (1998) 'Die Metapher im psychoanalytischen Dialog', *Psyche*, 545–71.
- Bühlig, K. (2001) 'Interpreting in hospitals', in S. Cigada, S. Gilardoni and M. Matey (eds), *Communicare in Ambiente Professionale Plurilingue*. Lugano: Università della Svizzera italiana. pp. 107–9.
- Bühlig, K. and Meyer, B. (2004a) *Ad hoc-interpreting and the achievement of communicative in specific kinds of doctor-patient discourse*. (Rep. No. 57). Hamburg: Universität Hamburg: Sonderforschungsbereich Mehrsprachigkeit.
- Bühlig, K. and Meyer, B. (2004b) 'Ad-hoc-interpreting and the achievement of communicative purposes in doctor-patient-communication', in J. House and J. Rehbein (eds), *Multilingual communication*. Amsterdam: Benjamins. pp. 43–62.
- Byrne, P. S. and Long, B. E. L. (1976) *Doctors talking to patients: a study of the verbal behaviour of general practitioners consulting in their surgeries*. London: HSMO, Royal College of General Practitioners.
- Campion, P. and Langdon, M. (2004) 'Achieving multiple topic shifts in primary care medical consultations: a conversation analysis study in UK general practice', *Sociology of Health and Illness*, 26: 81–101.
- Candlin, S. (2006) 'Constructing knowledge, understanding and meaning between patients and nurses', in M. Gotti and F. Salager-Meyer (eds), *Advances in medical discourse analysis: oral and written contexts*. Berne: Peter Lang. pp. 65–86.
- Collins, S. (2005) 'Explanations in consultations: the combined effectiveness of doctors' and nurses' communication with patients', *Medical Education*, 39: 785–96.
- Deppermann, A. (2003) 'Wenn Semantik zum praktischen Problem wird: Divergierende Schmerzkonzepte von Ärztin und Patientin in der psychosomatischen Exploration', *Psychotherapie und Sozialwissenschaft. Zeitschrift für qualitative Forschung*, 5: 165–81.
- de Valck, C. and Van den Wostijne, K. P. (1996) 'Communication problems on an oncology ward', *Patient Education and Counseling*, 29: 131–6.

- Diaz, F. (2000) 'The social organisation of chemotherapy treatment consultations', *Sociology of Health and Illness*, 22: 364–89.
- Drew, P. and Heritage, J. C. (eds) (1992) *Talk at work. Interaction in institutional settings*. Cambridge: Cambridge University Press.
- Ehlich, K., Koerfer, A., Redder, A. and Weingarten, R. (eds) (1990) *Medizinische und therapeutische Kommunikation. Diskursanalytische Untersuchungen*. Opladen: Westdeutscher Verlag.
- Fisher, S. and Todd, A. D. (eds) (1983) *The social organization of doctor patient communication*. Washington, DC: Center for Applied Linguistics.
- Fritzsche, K. and Wirsching, M. (2005) *Psychosomatische Medizin und Psychotherapie*. Berlin: Springer.
- Furchner, I. (2002) 'Keine absence gleicht der anderen.' Die Darstellung von Bewusstseinslücken in "Anfallsbeschreibungen", in G. Brünner and E. Gülich (eds), *Krankheit verstehen. Interdisziplinäre Beiträge zur Sprache in Krankheitsdarstellungen*. Bielefeld: Aisthesis Verlag. pp. 121–42.
- Furchner, I. and Gülich, E. (2001) 'L'expertise des patients dans l'établissement d'un diagnostic médical', *Bulletin VALS-ASLA*, 74: 83–107.
- Gotti, M. and Salager-Meyer, F. (eds) (2006) *Advances in medical discourse analysis: oral and written contexts*. Berne: Peter Lang. p. 148.
- Gülich, E. and Furchner, I. (2002) 'Die Beschreibung von Unbeschreibbarem. Eine konversationsanalytische Annäherung an Gespräche mit Anfallskranken', in I. Keim and W. Schütte (eds), *Soziale Welten und kommunikative Stile. Festschrift für Werner Kallmeyer zum 60. Geburtstag*. Tübingen: Narr. pp. 161–86.
- Gülich, E. and Schöndienst, M. (1998) Anfallsbeschreibung von PatientInnen mit epileptischen oder pseudoepileptischen Anfällen: Differentialdiagnostische Aspekte und interventionstechnische Implikationen. Bielefeld. 21-2-2007. Unpublished work.
- Gülich, E. and Schöndienst, M. (1999) 'Das ist unheimlich schwer zu beschreiben'. Formulierungsmuster in Krankheitsbeschreibungen anfallskranker Patienten: differentialdiagnostische und therapeutische Aspekte', *Psychotherapie und Sozialwissenschaft, Zeitschrift für Qualitative Forschung*, 199–227.
- Gülich, E., Schöndienst, M. and Surmann, V. (2003) 'Schmerzen erzählen Geschichten – Geschichten erzählen Schmerzen', *Psychotherapie und Sozialwissenschaft. Zeitschrift für qualitative Forschung*, 5: 220–49.
- Haakana, M. (2002) 'Laughter in medical interaction: from quantification to analysis, and back', *Journal of Sociolinguistics*, 6: 207–35.
- Heath, C. (1989) 'Pain talk. The expression of suffering in the medical consultation', *Social Psychology Quarterly*, 52: 113–25.
- Heath, C. (2002) 'Demonstrative suffering: the gestural (re)embodiment of symptoms', *Journal of Communication*, 52: 597–616.
- Hein, N., Hoffmann-Richter, U., Laluschek, J., Nowak, P. and Wodak, R. (1985) 'Kommunikation zwischen Arzt und Patient', *Wiener Linguistische Gazette*, 1–87.
- Herb, G. and Streeck, S. (1995) 'Der Diagnoseprozess bei Spina bifida: Elterliche Wahrnehmung und Sicht des klinischen Fachpersonals', *Praxis der Kinderpsychologie und Kinderpsychiatrie*, 44: 150–8.
- Heritage, J. C. and Maynard, D. W. (2006a) 'Introduction: analyzing interaction between doctors and patients in primary care encounters', in J. C. Heritage and D. W. Maynard (eds), *Communication in medical care: interaction between primary care physicians and patients*. Cambridge: Cambridge University Press. pp. 1–21.
- Heritage, J. C. and Maynard, D. W. (eds) (2006b) *Communication in medical care: interaction between primary care physicians and patients*. Cambridge: Cambridge University Press.
- Heritage, J. C. and Robinson, J. D. (2006) 'Accounting for the visit: giving reasons for seeking medical care', in J. C. Heritage and D. W. Maynard (eds), *Communication in medical care: interaction between primary care physicians and patients*. Cambridge: Cambridge University Press. pp. 48–85.
- Heritage, J. C., Robinson, J. D., Elliott, M. N., Beckett, M. and Wilkes, M. (2007) 'Reducing patients' unmet concerns in primary care: the difference one word can make', *Journal of General Internal Medicine*, 22: 1429–33.
- Holmes, J. (1992) 'Women's talk in public contexts', *Discourse and Society*, 3: 131–50.
- Hydén, L.-C. and Mishler, E. G. (1999) 'Language and medicine', *Annual Review of Applied Linguistics*, 19: 174–92.
- Iedema, R. (2003) *Discourses of post-bureaucratic organization*. Amsterdam: John Benjamins.
- Iedema, R. (2006) '(Post-)bureaucratizing medicine: health reform and the reconfiguration of contemporary clinical work', in M. Gotti and F. Salager-Meyer (eds), *Advances in medical discourse analysis: oral and written contexts* Berne: Peter Lang. pp.111–31.
- Köhle, K. and Raspe, H.-H. (eds) (1982) *Das Gespräch während der ärztlichen Visite. Empirische Untersuchungen*. Wien: Urban and Schwarzenberg.
- Konitzer, M., Schemm, W., Freudenberg, N. and Fischer, G. C. (2002) 'Therapeutic interaction through metaphor: a textual approach to homeopathy', *Semiotica*, 141: 1–27.
- Kütemeyer, M. (2003) 'Psychogener Schmerz als Dissoziation', *Psychotherapie und Sozialwissenschaft. Zeitschrift für qualitative Forschung*, 3: 203–20.
- Lackner, M., Jäger, B. and Kunsbeck, H. W. (1996) 'Patient – medical staff – consultant triad: Conditions for satisfaction in psychosomatic consultation service (translation)', *Psychother Psychosom Med. Psychol.*, 333–9.
- Laluschek, J. (2002) *Ärztliche Gesprächsausbildung. Eine diskursanalytische Studie zu Formen des ärztlichen Gesprächs*. Radolfzell: Verlag für Gesprächsforschung.
- Laluschek, J. (2004) 'Kommunikatives Selbst-Coaching im beruflichen Alltag. Ein sprachwissenschaftliches Trainingskonzept am Beispiel der klinischen Gesprächsführung', in M. Becker-Mrotzek and G. Brünner (eds), *Analyse und Vermittlung von Gesprächskompetenz*. Radolfzell: Verlag für Gesprächsforschung. pp.137–58.
- Laluschek, J. (2005) 'Medizinische Konzepte und ärztliche Gesprächsführung – am Beispiel der psychosomatischen Anamnese', in M. Neises, S. Ditz and T. Spranz-Fogasy (eds), *Psychosomatische Gesprächsführung in der Frauenheilkunde. Ein interdisziplinärer Ansatz zur verbalen*

- Intervention*. Stuttgart: Wissenschaftliche Verlagsgesellschaft. pp. 48–72.
- Lalouschek, J., Menz, F. and Wodak, R. (1990) *Alltag in der Ambulanz. Gespräche zwischen Ärzten, Schwestern und Patienten*. Tübingen: Gunter Narr Verlag.
- Lehtinen, E. (2007) 'Merging doctor and client knowledge: on doctors' ways of dealing with clients' potentially discrepant information in genetic counseling', *Journal of Pragmatics: an Interdisciplinary Journal of Language Studies*, 39: 389–427.
- Li, H. Z. (1999) 'Grounding and information communication in intercultural and intracultural dyadic discourse', *Discourse Processes: a Multidisciplinary Journal*, 28: 195–215.
- Li, H. Z., Krysko, M., Desroches, N. G. and Deagle, G. (2004) 'Reconceptualizing interruptions in physician – patient interviews: cooperative and intrusive', *Communication and Medicine: an Interdisciplinary Journal of Healthcare, Ethics and Society*, 1: 145–57.
- Löning, P. and Rehbein, J. (eds) (1993) *Arzt-Patienten-Kommunikation. Analysen zu interdisziplinären Problemen des medizinischen Diskurses*. Berlin: de Gruyter.
- Maynard, D. W. and Heritage, J. C. (2005) 'Conversation analysis, doctor – patient interaction and medical communication', *Medical Education*, 39: 428–35.
- Menz, F. (1991) *Der geheime Dialog. Medizinische Ausbildung und institutionalisierte Verschleierungen in der Arzt-Patient-Kommunikation*. Frankfurt am Main: Peter Lang.
- Menz, F. and Al-Roubaie, A. (2008) 'Interruptions, status and gender in medical interviews: the harder you brake, the longer it takes', *Discourse and Society*, 19: 645–66.
- Menz, F. and Lalouschek, J. (2006) ' "I just can't tell you how much it hurts." Gender-relevant differences in the description of chest pain', in M. Gotti and F. Salager-Meyer (eds), *Advances in medical discourse analysis: oral and written contexts*. Berne: Peter Lang.
- Menz, F. and Nowak, P. (1992) 'Kommunikationstraining für Ärzte und Ärztinnen in Österreich. Eine Anamnese', in R. Fiehler and W. Sucharowski (eds), *Kommunikationsberatung und -ausbildung. Anwendungsfelder der Diskursforschung*. Opladen: Westdeutscher Verlag. pp. 79–86.
- Menz, F., Lalouschek, J. and Gstettner, A. (2008a) *Effiziente ärztliche Gesprächsführung. Optimierung kommunikativer Kompetenz in der ambulanten medizinischen Versorgung. Ein gesprächsanalytisches Trainingskonzept*. Münster: LIT-Verlag.
- Menz, F., Nowak, P., Rappl, A. and Nezhiba, S. (2008b) 'Arzt-Patient-Interaktion im deutschsprachigen Raum – eine Online-Forschungsdatenbank (API-on) als Basis für Metaanalysen', *Gesprächsforschung – Online-Zeitschrift zur verbalen Interaktion*, 9: 129–63.
- Merlini, R. and Favaron, R. (2005) 'Examining the "voice of interpreting" in speech pathology', *Interpreting: International Journal of Research and Practice in Interpreting*, 7: 263–302.
- Meyer, B. (2002) 'Medical interpreting: some salient features', in G. Garzone, M. Viezzi, D. C. Snelling, A. Amato, and P. Mead (eds), *Interpreting in the 21st century: challenges and opportunities*. Amsterdam: Benjamins. pp. 159–69.
- Meyer, B. (2004) *Dolmetschen im medizinischen Aufklärungsgespräch. Eine diskursanalytische Untersuchung zur Wissensvermittlung im mehrsprachigen Krankenhaus*. Münster: Waxmann.
- Meyer, B., Apfelbaum, B., Pöchhacker, F. and Bischoff, A. (2003) 'Analysing interpreted doctor-patient communication from the perspectives of linguistics, interpreting studies and health sciences', in L. Brunette, G. Bastin, I. Hemlin and H. Clarke (eds), *The critical link 3: interpreters in the community*. Amsterdam: Benjamins. pp. 67–79.
- Mishler, E. G. (1984) *The discourse of medicine. Dialectics of medical interviews*. Norwood, NJ: Ablex.
- Mondada, L. (2002) 'Die interaktive Formulierung der medizinischen Beschreibung', *Psychotherapie und Sozialwissenschaft. Zeitschrift für qualitative Forschung*, 5: 341–53.
- Morris, G. H. and Chenail, R. J. (eds) (1995) *The talk of the clinic. Explorations in the analysis of medical and therapeutic discourse*. Hillsdale, NJ: Erlbaum.
- Neises, M., Ditz, S. and Spranz-Fogasy, T. (eds) (2005) *Psychosomatische Gesprächsführung in der Frauenheilkunde. Ein interdisziplinärer Ansatz zur verbalen Intervention*. Stuttgart: Wissenschaftliche Verlagsgesellschaft.
- Nowak, P. (2009) *Eine Systematik sprachlichen Handelns von Ärzt/inn/en. Metastudie über Diskursforschungen zu deutschsprachigen Arzt-Patient-Interaktionen*. Frankfurt/ am Main: Peter Lang.
- Nowak, P. and Spranz-Fogasy, T. (2007) *Literatur zur Arzt-Patient-Kommunikation*. Mannheim: Institut für Deutsche Sprache.
- Odebumi, A. (2006) 'Locutions in medical discourse in Southwestern Nigeria', *Pragmatics: Quarterly Publication of the International Pragmatics Association*, 16: 25–41.
- Overlach, F. (2008) *Sprache des Schmerzes – Sprechen über Schmerzen. Eine grammatisch-semantische und gesprächsanalytische Untersuchung von Schmerzausdrücken im Deutschen*. Berlin: de Gruyter.
- Pahta, P. (2006) ' "This is very important": a corpus study of amplifiers in medical writing', in M. Gotti and F. Salager-Meyer (eds), *Advances in medical discourse analysis: oral and written contexts*. Berne: Peter Lang. pp. 357–81.
- Penque, S., Halm, M., Smith, M., et al. (1998) 'Women and coronary disease: relationship between descriptors of signs and symptoms and diagnostic and treatment course', *American Journal of Critical Care*, 175–82.
- Peräkylä, A. (2004) 'Making links in psychoanalytic interpretations: a conversation analytical perspective', *Psychotherapy Research*, 289–307.
- Ploeger, A. (2005) 'Verbale Interaktion im Kollektiv', in M. Neises, S. Ditz and T. Spranz-Fogasy (eds), *Psychosomatische Gesprächsführung in der Frauenheilkunde. Ein interdisziplinärer Ansatz zur verbalen Intervention*. Stuttgart: Wissenschaftliche Verlagsgesellschaft. pp. 285–98.
- Pöchhacker, F. and Kadric, M. (1999) 'The hospital cleaner as healthcare interpreter. A case study', *The Interpreter*, 5: 161–78.
- Pöchhacker, F. and Shlesinger, M. (2005) 'Introduction. Discourse-based research on healthcare interpreting',

- Interpreting: International Journal of Research and Practice in Interpreting*, 7: 157–67.
- Pöchlhacker, F. and Shlesinger, M. (eds) (2007) *Healthcare interpreting: discourse and interaction*. Amsterdam: Benjamins.
- Redder, A. and Wiese, I. (eds) (1994) *Medizinische Kommunikation. Diskurspraxis, Diskursethik, Diskursanalyse*. Opladen: Westdeutscher Verlag.
- Rees, C. E., Knight, L. V. and Wilkinson, C. E. (2007) 'Doctors being up there and we being down here: a metaphorical analysis of talk about student/doctor – patient relationships', *Social Science and Medicine*, 65: 725–37.
- Reisigl, M. (2006). *Semiotik des Schmerzes – Das Medizinsemiotische Framework der Untersuchung*. Wien: Institut für Sprachwissenschaft.
- Roberts, C. (2006) 'Continuities and discontinuities in doctor – patient consultations in a multilingual society', in M. Gotti and F. Salager-Meyer (eds), *Advances in medical discourse analysis: oral and written contexts*. Berne: Peter Lang. pp. 177–95.
- Roberts, C. and Sarangi, S. (2003) 'Uptake of discourse research in interprofessional settings: reporting from medical consultancy', *Applied Linguistics*, 24: 338–59.
- Roberts, C. and Sarangi, S. (2005) 'Theme-oriented discourse analysis of medical encounters', *Medical Education*, 39: 632–40.
- Roberts, C., Moss, B., Wass, V., Sarangi, S. and Jones, R. (2005) 'Misunderstandings: a qualitative study of primary care consultations in multilingual settings, and educational implications', *Medical Education*: 465–75.
- Roberts, F. D. (2000) 'The interactional construction of asymmetry: the medical agenda as a resource for delaying response to patient questions', *The Sociological Quarterly*: 151–70.
- Robinson, J. D. (1998) 'Getting down to business. Talk, gaze and body orientation during openings of doctor – patient consultations', *Human Communication Research*, 25: 97–123.
- Ruusuvuori, J. (2005) 'Comparing homeopathic and general practice consultations: the case of problem presentation', *Communication and Medicine*, 2: 123–35.
- Sachweh, S. (2005) "'Gut Herr Doktor!'" Gespräche mit alten Patientinnen', in M. Neises, S. Ditz and T. Spranz-Fogasy (eds), *Psychosomatische Gesprächsführung in der Frauenheilkunde. Ein interdisziplinärer Ansatz zur verbalen Intervention*. Stuttgart: Wissenschaftliche Verlagsgesellschaft. pp. 339–51.
- Sachweh, S. (2006) "'Noch ein Löffelchen?'" *Effektive Kommunikation in der Altenpflege*, (2., vollst. überarb. und erw. Aufl. ed.) Hans Huber.
- Sarangi, S. and Brookes-Howell, L. (2006) 'Recontextualising the familial lifeworld in genetic counseling: case notes', in M. Gotti and F. Salager-Meyer (eds), *Advances in medical discourse analysis: oral and written contexts*. Berne: Peter Lang. pp. 197–225.
- Sarangi, S. and Roberts, C. (eds) (1999) *Talk, work and institutional order: discourse in medical, mediation and management settings*. Berlin: Mouton de Gruyter.
- Sator, M. (2009) "'Irgendwie schwierig zu differenzieren!'" Schmerzdifferenzierung in ärztlichen Erstgesprächen an der Kopfschmerzambulanz. Eine gesprächsanalytische Untersuchung'. Unpublished work.
- Sator, M., Gstettner, A. and Hladschik-Kermer, B. (2008) 'Seitdem mir der Arzt gesagt hat "Tumor" – Das war's', *Wiener klinische Wochenschrift*, 120: 158–70.
- Schöndienst, M. (2002) 'The Role of psychotherapy in the treatment of epilepsies', in M. R. Trimble and B. Schmitz (eds), *The neuropsychiatry of epilepsy*. Cambridge: Cambridge University Press. pp. 313–23.
- Semino, E., Heywood, J. and Short, M. (2004) 'Methodological problems in the analysis of metaphors in a corpus of conversations about cancer', *Journal of Pragmatics: an Interdisciplinary Journal of Language Studies*, 36: 1271–94.
- Shaw, L. J., Miller, D. D., Romeis, J. C., et al. (1994) 'Gender differences in the noninvasive evaluation and management of patients with suspected coronary disease', *Annals of Internal Medicine*: 559–66.
- Speer, S. A. and Parsons, C. (2006) 'Gatekeeping gender: some features of the use of hypothetical questions in the psychiatric assessment of transsexual patients', *Discourse and Society: an International Journal for the Study of Discourse and Communication in Their Social, Political and Cultural Contexts*, 17: 785–812.
- Spranz-Fogasy, T. (2005) 'Kommunikatives Handeln in ärztlichen Gesprächen – Gespräch – seröffnung und Beschwerdenexploration', in M. Neises, S. Ditz and T. Spranz-Fogasy (eds), *Psychosomatische Gesprächsführung in der Frauenheilkunde. Ein interdisziplinärer Ansatz zur verbalen Intervention*. Stuttgart: Wissenschaftliche Verlagsgesellschaft. pp. 17–47.
- Stivers, T. (2001) 'Negotiating who presents the problem: next speaker selection in pediatric encounters', *Journal of Communication*, 51: 1–31.
- Stukenbrock, A. (2008) "'Wo ist der Hauptschmerz?'" – Zeigen am menschlichen Körper", *Gesprächsforschung – Online-Zeitschrift zur verbalen Interaktion*, 9: 1–33.
- Surmann, V. (2005) *Anfallsbilder. Metaphorische Konzepte im Sprechen anfallskranker Menschen*. Würzburg: Königshausen u. Neumann.
- Tanner, B. A. (eds) (1976) *Language and communication in general practice*. London: Hodder and Stoughton.
- Valero-Garcés, C. (2002) 'Interaction and conversational constructions in the relationships between suppliers of services and immigrant users', *Pragmatics: Quarterly Publication of the International Pragmatics Association*, 12: 469–95.
- Valero Garcés, C. (2005) 'Doctor-patient consultations in dyadic and triadic exchanges', *Interpreting: International Journal of Research and Practice in Interpreting*, 7: 193–210.
- Vodopiutz, J., Poller, S., Schneider, B., et al. (2002) 'Chest pain in hospitalized patient: cause-specific and gender-specific differences', *Journal of Women's Health and Gender-Based Medicine*, 11: 1–9.
- Walther, S. (1997) *Im Mittelpunkt der Patient? Übergabegespräche im Krankenhaus*. Stuttgart: Thieme.
- Walther, S. (2005). *Erstgespräch zwischen Pflegepersonal und Patienten im Krankenhausalltag. Ein Transkriptband*. Radolfzell: Verlag für Gesprächsforschung.
- Watson, B. M. and Gallois, C. (1999) 'Communication accommodation between patients and health professionals: themes and strategies in satisfying and unsatisfying

- encounters', *International Journal of Applied Linguistics*, 9: 167–83.
- Weinhold, C. (1997) *Kommunikation zwischen Patienten und Pflegepersonal*. Berne: Verlag Hans Huber.
- West, C. (1984) *Routine complications. Troubles with talk between doctors and patients*. Bloomington; IN: Indiana University Press.
- West, C. (1990) "'Not just doctors' Orders": directive-response sequences in patients' visits to women and men physicians', *Discourse and Society*, 1: 85–112.
- Wodak, R. (1996) *Disorders of discourse*. London: Longman.
- Wodak, R. (1997) 'Critical discourse analysis and the study of doctor – patient interaction', in B.-L. Gunnarsson, P. Linell, B. Nordberg and C. N. Candlin (eds), *The construction of professional discourse* London: Longman. pp. 173–200.