

ABSTRACT

PORTER, HEIDI ANNETTE. Discourse Means of Jointly Produced Asymmetry and Symmetry in Physician-Patient Conversation. (Under the direction of Dr. David Herman.)

Studies have found that during medical interview physicians tend to dominate the conversation through questioning, controlling topic and topic development, and interrupting and disregarding patients' contributions to the conversation (Hyden and Mishler 1999). Other studies have demonstrated how important a thorough knowledge of patient's psychosocial circumstances is for determining the causes and subsequent treatment of illness (Waitzkin 1991; Hyden and Mishler 1999). Thus, it is important to allow the patient to be heard in medical encounters. As part of the medical encounter, "patients and physicians both have discourse recourses upon which they draw in seeking control over the encounter and over the plan of treatment" (Ainsworth-Vaughn, 1994).

This thesis seeks to contribute to discourse analysis research on how power asymmetries are located in conversations between physicians and patients. As a consequence of the different views and positions of physicians and patients, there can be a battle of voices between "the medical view" and the "view of the lifeworld." What is more, as a consequence of the shared expectations about their respective roles, patients might not "introduce new topics or ask questions even when physicians seem to give them permission to do so" (Heath 1992 in Mishler 1999:79). There is an asymmetry in physician-patient communication that is the result not simply of one-sided discourse production, but also of the participants' jointly produced conversational strategies.

Although many studies have focused on analysis of one or two discourse moves and their resulting affect on asymmetry or symmetry, I concur with Ainsworth Vaughn's (1998) emphasis that many discourse moves can be used to consolidate power. This paper therefore explores many discourse moves of asymmetric interactions between physicians and their patients and the role that each play in this dissonance. However, these discourse moves may have multiple meanings and the interpretation of power is very complex (Ainsworth-Vaughn 1998).

Ainsworth-Vaughn (1998:43) further writes, "participants' personal, social, and professional histories are brought into the event and serve as bases for the power negotiation that takes place there." Consequently, I provide an overview of research on discourse moves and their affect on asymmetry and symmetry in encounters. I also review in more detail one particular high-level asymmetry factor, that of gender. Yet, the results of my analysis provide an interesting look at other power differences, besides gender, that come into play.

Samples of physician-patient discourse were analyzed in the context of discourse analysis to highlight areas where both asymmetry and symmetry are located. My results reflect Ainsworth-Vaughn's (1998) conclusion that "each medical encounter is a micropolitical achievement" in which the prejudices of the institution, society, and individuals shape the form of the doctor-patient encounter. The high-level asymmetry of the context takes shape in the asymmetry of the words and the conversation, which in turn reproduce and reinforce the asymmetry of the context. However, the results in my 4 samples showed race and socioeconomic status playing a more important role than

gender in producing asymmetry. Thus, it seems there is some hope that certain power differences can be overcome.

In conclusion, I summarize ways in which doctors can redress asymmetry and patients can promote symmetry in order to effectively shift this typically asymmetrical relationship. However, I also discuss the many barriers to achieving an egalitarian conversation within the medical encounter. And, I propose areas for future research that could aid in more equality in the doctor-patient relationship, leading to better health and satisfaction in life.

DISCOURSE MEANS OF JOINTLY PRODUCED ASYMMETRY AND
SYMMETRY IN PHYSICIAN-PATIENT CONVERSATION

by
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BIOGRAPHY

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1. INTRODUCTION

Doctors' visits are a fundamental part of most Americans' lives. People visit the doctor in order to protect against and fix health problems. As patients, people want doctors to hear their health problems and make recommendations for a solution. Hyden and Mishler write that "talk is the main ingredient in medical care and is the fundamental instrument by which the doctor-patient relationship is crafted" (Roter and Hall, 1992 in Hyden and Mishler, 1999:174). Therefore, one could argue that good communication between doctor and patient is fundamental to good medical care. Consequently, many studies have been conducted on different aspects of doctor-patient communication.

The first studies of doctor-patient communication focused on how doctors should ask for and give information and what styles of communication help or hurt patient satisfaction or compliance (Hyden and Mishler, 1999). However, these studies took the perspective of the biomedical model of care, giving doctors all the power and not examining the broader cultural or social contexts of illness and care (Hyden and Mishler, 1999). The next wave of studies looked at how social background factors affect the communicative process, as well as the outcome of medical care (Hyden and Mishler, 1999). These studies also relied on the biomedical view of care and analyzed speech that was removed from the "structure and flow of discourse" (Hyden and Mishler, 1999:176). In other words, these studies analyzed speech without regard to the context in which the speech was produced.

More recent studies have taken sociolinguistic approaches, such as discourse and conversational analysis, to study doctor-patient communications. These studies have shown that physicians "dominate and control the doctor-patient conversation by asking

questions, controlling topics and topic development, interrupting, and disregarding patients' efforts to contribute something new" (Hyden and Mishler, 1999:177). In addition, doctors' use of other conversational moves, such as informal address terms, medical terminology, and directives, further underscore doctors' control within the interaction. Thus, asymmetry is one of the hallmarks of medical conversation.

Furthermore, patients can contribute to this asymmetry (e.g. by not asking questions). One must study both participants' speech, because the study of "how asymmetrical relations of power are interactionally produced and reproduced is incomplete without taking into account all the ways participants also go about undermining them" (Dundas-Todd, 1989:256). Ainsworth-Vaughn writes that as part of the medical encounter, "patients and physicians both have discourse strengths on which they draw in seeking control over the encounter and over the plan of medical treatment" (Ainsworth-Vaughn, 1998:124). Those who believe in the Parsons, or doctor-centered model of medical care, in which the doctor is powerful, detached, godlike and knows best, say that the asymmetry is necessary for an effective medical encounter (Roter and Hall, 1992; Dundas-Todd, 1989). Other studies, however, have demonstrated how important a thorough knowledge of patient's psychosocial circumstances is for determining the causes and subsequent treatment of illness (Waitzkin, 1991; Hyden and Mishler, 1999). Dundas-Todd (1989) proposes that an egalitarian relationship is necessary to health. Two active participants problem-solve and make decisions as they work towards ways of addressing the health problem (Dundas-Todd, 1989). Thus, it seems important to allow the patient to be heard in medical encounters.

If an egalitarian relationship is best, then asymmetry within the encounter needs to be redressed. Before the doctor-patient conversation begins, however, each person enters the encounter influenced by many extralinguistic or extradiscursive factors. Doctors and patients have asymmetrically structured access to resources for influencing what happens in any encounter (Ainsworth-Vaughn, 1998). Ainsworth-Vaughn (1998) writes that medical encounters are “micropolitical achievements” in which the prejudices of the institution, society, and individuals shape the form of the doctor-patient encounter.

This thesis concerns itself with the linguistic means by which asymmetry and symmetry are created in the medical encounter. The premise of my thesis is similar to that underlying Ainsworth-Vaughn’s work in *Claiming Power in Doctor-Patient Interaction*. The goals of medical encounters are better health outcomes. Her purpose is to increase doctors’ and patients’ awareness of how “power is claimed and ratified,” so that “they can do a better job pursuing the goals of the event” (Ainsworth-Vaughn 1998:26). Likewise, Norman Fairclough, another linguist who studies discourse practices of power, writes that “from awareness and critique arise possibilities of empowerment and change” (Faircloth 1989 in 1995:83).

Many studies have looked at one or two discourse moves between doctor and patient to show where asymmetry resides. Ainsworth-Vaughn (1998:10), however, says that in fact not one or two but “several major speech activities and discourse features are used to claim [this] power “or promote asymmetry.” Ainsworth-Vaughn (1998:42) further writes that “power is constructed moment-to-moment during interaction, with all participants being involved, in turn, as either its claimers or its ratifiers.” In *Claiming Power in Doctor-Patient Talk*, Ainsworth-Vaughn looks at interruptions, questions, topic

control, and associations with Aesculapian, or biomedically based knowledge within the doctor-patient conversation (Ainsworth-Vaughn, 1998). This thesis builds on Ainsworth-Vaughn's approach of considering how the use of technical terms, formal or informal address terms, reciprocated or nonreciprocated greetings, directives, and address pronouns can all produce asymmetry or else work towards creating symmetry within the medical encounter. In addition, I will show how two overall constraints, politeness and the dominant medical view of illness affect the use (and abuse) of particular discourse moves, such as direct questioning and topic control.

Ainsworth-Vaughn (1998) emphasizes that although many discourse moves can be used to consolidate power, discourse moves can also have multiple meanings, and must be kept in perspective in analysis as part of a "complex theory of power." The effect of the discourse moves is thus dependent on the contextual properties of the interaction. Accordingly, I seek to understand how each discourse move may promote or redress asymmetry within the doctor-patient interview, keeping the perspective that there is not a one-to-one relationship between discourse means and the amount of asymmetry produced or redressed; contextual matters must be taken into account. For example, when a patient asks a question, the questioning does not claim as much power, or promote as much asymmetry, as when a doctor asks a question. One must understand the context in order to understand the effect a move has on asymmetry within the conversation. To complicate matters further, a discourse move can promote both power and solidarity at the same time (Ainsworth Vaughn 1998).

In order to better understand how contextual variables may affect asymmetry, I review some literature on gender differences and discourse moves in medical

conversations. However, keep in mind that other contextual variables such as race, socioeconomic status, and age, although not thoroughly reviewed here, may also affect discourse moves. One can never exhaustively analyze all contextual variables; this is one reason why interpretation of discourse is open to error. But, by attempting to understand how asymmetry or symmetry is promoted, one may hope to make gains towards outlining the basis for a more egalitarian conversation between physicians and patients.

2. THEORETICAL FRAMEWORK

2.1 Power Distribution and Desired Outcome of Medical Encounter

First, what is the desired outcome of a more egalitarian and symmetrical doctor-patient relationship? If people visit doctors in order to gain or keep good health, then both better health outcomes and satisfaction with the visit are the desired outcome of the medical encounter. Ainsworth-Vaughn (1998) writes that patients have better health outcomes if they are assertive within the medical interview. Also, with regard to satisfaction, more satisfaction has been shown in medical encounters where patients are informed of all options and have input into decision-making (Roter and Hall, 1992). So, as far as the desired outcome of a medical visit is concerned, what happens when the conversation is mainly asymmetrical? In order to understand the importance of symmetry within the medical encounter, I first examine how asymmetries affect not only health outcome (including patient compliance) and satisfaction, but also joint decision-making and information within the medical encounter.

2.1.1 Less Information

When doctors dominate the medical encounter through questioning, interrupting, and directing, patients' questions, concerns, and ideas are not heard and less information comes out during the interview. Also, when patients, through politeness or submission, do not question doctors, then the information that could be elicited by their questions is eliminated. Patients who are assertive and who use questioning techniques may cause providers to detail other possible medical interventions, thereby allowing the patient to gain more knowledge about the treatment of their illness, and promoting symmetry in the encounter (Dundas-Todd and Fisher, 1993). Grace (1995) writes that inadequate

information regarding the meaning of a diagnosis or the results of surgery, as well as inadequate information about side effects of prescribed medication, can mean that no other options are given besides surgery.

2.1.2 Less Joint Decision-Making

If it is mainly the doctor's voice that is heard and the biomedical institution's concerns that are seen as valid, then the patient's values and wishes are sometimes not heard. Katz (1984) says that there may be a conflict between a physician's personal and professional ethics and experience and the patient's needs, wishes, and expectations. Thus, the patient's interests need to be heard. Furthermore, Freidson writes "[W]hen decisions are at bottom more evaluative rather than substantive, laymen have as much if not more to contribute..." (Freidson in Katz 1984:98). In this case, the patient's ideals MUST be heard. The doctor's presentations of options may originate from different values than the patient's values, such as those of the medical institution (Katz 1984). For example, whereas the doctor may value quantity of life, or longevity, the patient may value quality of life. Politeness and socialization into doctor-patient roles, plus the doctor's means of controlling the conversation, may jeopardize patients' participation in decision-making (Aronsson and Satterlund-Larrson 1987). Roter and Hall (Stewart 1983 in 1992:44) write, however, that male patients show higher scores (than females) of patient-centered behavior, such as "giving suggestions, opinions, information, and orientation to the physician, as well as more negative verbal behaviors, including disagreements and antagonisms."

Another effect of patients' silence or being silenced within the conversation is that the misunderstandings, such as those caused by too much technical jargon, may not allow

them to be heard (Jones, 1988). These misunderstandings also affect joint-decision making. But, most importantly, when the patient's voice is not heard, actions may be taken against his or her wishes, or he or she may not take actions that support the doctor's treatment wishes.

2.1.3 Patients' Refusals Are Not Heard/Less Compliance

Katz (1984) writes that outright refusals are rare in doctor-patient conversations. A "yes" can really mean "no." Dundas-Todd and Fisher (1993) studied women patients who made their own decisions behind doctors' backs; these women would therefore be labeled as non-compliant. These women may then not be receiving what they paid for in their medical treatment; a better health outcome through diagnosis and treatment. The asymmetry in doctor-patient encounters therefore affects compliance with the doctor's recommended treatment. West (1984) writes that patients often do not do as they are told. Furthermore, Street (1985) writes that the way the doctor talks is directly related to compliance. West supports this finding by noting that within the interview, the "more aggravated the directive [by the physician], the less likely it was to elicit a compliant response" (West 1990:108). This result was true for both men and women physicians. Women physicians, however, used fewer aggravated or baldfaced directives in prescribing treatments, thus enjoying more patient compliance overall (West 1990). Furthermore, Street (1995) found that the more time physicians spend asking questions, the more the patient's understanding is diminished, thereby affecting compliance.

2.1.4 Doctor and Medical Uncertainties of Medical Interventions Not Heard

Another outcome of asymmetrical conversations is that the doctor's and the biomedical institution's view are seen as more certain and rational than the patient's

view. Since the biomedical view is the dominant view, many treatments that appear to be necessary, may actually cover over uncertainties about the usefulness of the treatments and problems with side effects (Katz 1984). Thus, due to the dominant doctor and biomedical view, non-acknowledgement of treatment uncertainties leads to more interventionist treatments (Katz 1984). Katz (1984:113) also writes that ignorance and misconceptions about treatments can cause “magical hopes about diagnostic tests and therapeutic interventions.” Katz (1984:193) writes that doctors need to acknowledge uncertainty, while reassuring and offering hope. Conversing can help patient understanding and influence treatment (Katz 1984).

2.1.5 Biomedical Voice Heard/Dominant Social Ideologies Reinforced

If the patient’s voice is mostly ignored (Borges and Waitzkin 1995), the biomedical view of illness is the main voice that is heard. The biomedical view sees illness as mainly organic and thus controllable through modifying diet, modifying personal habits such as smoking or drugs, and using medication and technical interventions. By contrast, as Waitzkin (1991) notes, patients’ contextual concerns are ambiguous and difficult to define. Thus, they are hard to fit into any model. In general, people see the biomedical model with its symptoms and diagnoses as a rational, effective way to deal with illness and conduct treatment. Thus, concerns that do not lend themselves well to the medical institution’s technical lexicon become marginalized (Dundas-Todd 1989).

However, Borges and Waitzkin (1995:41) write that the purpose of medical discourse is to find a cause or diagnosis, and the patient’s narrative, which includes contextual items, such as life stresses, focuses on the “meanings and tensions of lived

experience.” Within this dialogue between doctor and patient, though, the “ideologic assumptions are unexplored and roles remain unexamined” (Borges and Waitzkin 1995:41). Doctors want patients to fit their social life to their bodies not their bodies/medicine to their social lives (Dundas-Todd 1989). More and Milligan (1994:137) write that the “ non critical nature of medical discourse encourages clients continued functioning in a social system that is often a major source of their problems.” Borges and Waitzkin (1995) found, in one case, that even when a doctor gave a contextually sensitive diagnosis, hence acknowledging the role that life stress is playing in illness, the problem was still medicalized, through medication or advice, and the woman returned to the same social context as before; the woman’s problems derived in part from familial and societal expectations about her roles.

2.1.6 Less Satisfaction and Poorer Health Outcomes

As one would expect, working towards symmetry through partnership building, agreeing with the patient, avoiding interrupts, and soliciting patients’ opinions appears to facilitate patients’ satisfaction and recall (Street 1985). Street (1985:322) also writes that “information giving by physicians modestly but positively related to patients’ satisfaction.” In addition, as mentioned above, patients’ who are more assertive, thus promoting more symmetry in the medical encounter, may have better health outcomes (Ainsworth-Vaughn 1998). Thus, patients’ health may be compromised by asymmetry in the medical conversation.

2.2 Power, Asymmetry, Symmetry, and Talk

According to Fairclough (1995:82), “discoursal practices are ideologically invested in so far as they contribute to sustaining or undermining power relations.”

Accordingly, when we talk about asymmetry in discourse, we are basically talking about the effect of discourse on power, or power relations, as well as the effects of power on discourse moves.

2.2.1 Asymmetry and Symmetry

Linell and Luckmann (1991 in Wynn 1999:4) define asymmetry as referring to “...various sorts of inequivalences in dialogue process.” Linell and Luckmann view such inequivalencies as including “difference[s] in knowledge or status, as emergent in talk” and “differences in participation, for instance in topic control and topic development.” Traditionally, the doctor-patient interaction is one that is intrinsically asymmetrical, given that the patient is visiting the doctor because of his or her power to help the patient and give the patient information. However, if, as some studies propose, health resides in a more egalitarian relationship between doctor and patient (Ainsworth-Vaughn 1998), and if the knowledge that the patient brings is equal to though different from the knowledge the doctor brings, then the doctor-patient relationship needs to move towards greater symmetry.

2.2.2 Asymmetry, Symmetry, and Conversation

Some asymmetries occur in all conversations (Linell and Luckmann 1991:4 in Wynn 1999). Yet some conversations are more asymmetrical than others. Despite the asymmetry inherent in the medical encounter, both asymmetry and symmetry can exist within the encounter (Ainsworth-Vaughn 1998). Furthermore, whether a particular discourse move promotes asymmetry or symmetry is dependent on a number of contextual and interactional factors, which I go on to examine in the following sections.

2.3 Asymmetrically Structured Encounters

Before even entering the medical encounter, doctors and patients are influenced by the asymmetrically structured roles of the institution, their roles within the institution, and also their individual characteristics and individual roles within society. The medical encounter is further formed by the time and budget constraints of the health-care system, as well as the traditional role and conversation of the doctor and patient within that institution. In addition, interactional factors overlap with contextual factors to form the power structure of the encounter. According to Ainsworth-Vaughn (1998:89), medical encounters fall on a continuum stretching from interviews to consultations to conversations. The position of an encounter on this continuum is produced interactionally by both the physician and patient, through the use of different sorts of discourse moves. Thus, each participant may affect how the other participant interacts in the conversation. For example, Ainsworth-Vaughn (1998:93) writes that the participation by patients is affected by the “amount of information and positive talk” provided by the doctor.

The medical encounter is also shaped by the social class, gender, race, and age of the doctor and patient. Mishler (1999) suggests that asymmetry in physician-patient communication can be located on three different planes: that of the social class structure of society; that of the shared expectations of the appropriate roles of the physician and patient; and that of the views and positions of physicians and patients. The social structure includes beliefs about occupation, class, gender, race, and age. The medical care structure promotes the dominant role of the doctor, through the traditional

knowledge, questioning, and treatment-giving roles assigned to participants in the doctor-patient encounters. Furthermore, the individual characteristics and beliefs of both doctor and patient influence how that encounter is carried out.

2.3.1 Patient

With regards to the patient, besides usually having a lower-status occupation than the physician, the person may have any combination of lower-power characteristics, such as those pertaining to class, race, gender, or age. These traits influence how the patient acts towards the doctor and also how the doctor treats the patient. Ainsworth-Vaughn (1998:35) reports that non-whites “received less info and less positive talk than whites.” Also, gender affects the length, the general content, and the treatment that results from the encounter (Roter and Hall, 1992). In general, more social power may be a “basis for asking more questions” (Ainsworth-Vaughn, 1998:90).

Furthermore, if a person is ill, he or she is already in a position of lower power due to the weakness or oppression suffered during the illness (Brody, 1992). In addition, a patient may become more dependent and passive due to a psychological transference onto the doctor as an authority figure, protector, or fixer of ills (Katz, 1984). Also, how much faith the patient places in the medical system and medical interventions as a source of cures, influences the encounter. A further personal factor that can influence the doctor-patient interaction is the amount of education a patient has with respect to medical terms or understanding. Likewise, the patient's personal characteristics in turn affect how a doctor reacts to and treats a patient because the doctor's individual traits and beliefs affect the conversation.

2.3.2 Doctor

A doctor's power is a product of his or her own personal characteristics, the status of his profession, and the dominant medical belief in biomedicine. For example, the gender of the doctor influences the asymmetry in the encounter. Hall and colleagues (Hall and colleagues 1993 in Roter and Hall 1992) found that doctors liked patients of their own gender better. Furthermore, the doctor's personal beliefs about race, class, age, and gender affect the interaction. Doctors' beliefs about a particular gender (and most likely a particular race and class also) affect the way they treat a patient of that type (Katz, 1984). If a doctor holds the view that women are generally silly complainers, the doctor may not take a woman's complaint seriously. Also, Katz (1984) believes that when patients come in with a childlike trust in authority, doctors act out on this belief and are more authoritarian, thus promoting asymmetry in the encounter.

The doctor has power within the medical interview due to his or her technical knowledge and training and the dominance of the biomedical view within the health-care encounter. The voice of the "medicine" is dominant over the voice of the "lifeworld" (Waitzkin, 1991). All of these factors contribute to the diminished power of the patient within the doctor-patient encounter, constraining the conversation within the medical encounter and thereby influencing health care, sometimes for the worse.

2.3.3 Biomedical View of Gender (or Lifestyle or Race)

The biomedical view and its medical language influence asymmetry by sometimes promoting a view of certain physiologies, such as women's physiology, as inherently diseased. This view may cause doctors to exaggerate problems and stigmatize women (Dundas-Todd, 1989). In the conversations between male doctors and women

patients, general attitudes towards women and reproduction come out (Dundas-Todd, 1989). For example, women's physical complaints are often not taken as seriously as men's complaints (Dundas-Todd, 1989).

Furthermore, Dundas-Todd (1989) writes that the biomedical view often neglects the fact that women are a part of a larger context, even though it is evident that one cannot separate one's body from who one is. This one-sided view influences the structure of the medical interview, enforcing the question-answer mode, where the doctor and biomedicine dominate, versus a story-telling mode, where the women's life story and its effect on the body are important (Dundas-Todd, 1989).

2.3.4 Roles in the Doctor-Patient Encounter

The logistics of the medical encounter influence asymmetry in the conversation. If the medical encounter is in a public instead of a private clinic, the patient may not feel the right to participate more, since he or she is not paying the full fees (Ainsworth-Vaughn, 1998:94). Again, this points to the fact that context is important in understanding conversation in the moment. Furthermore, the timing of the encounter has an effect on the conversation. Ainsworth-Vaughn (1998:94) found that questions are more common in initial versus subsequent treatments. Also, the length of the visit determines how much room is allowed for questions. Hence, both doctors and patients enter and interact within the encounter through an already asymmetrically filtered relationship.

2.3.5 Female Physicians and Medical Interviews

Some of the problems in doctor-patient communication are exacerbated when the patient is a woman. The good news is that some women doctors use conversational

means to mitigate some of the conversational asymmetries in doctor-patient communication. More and Milligan (1994) write that women physicians are often more responsive to emotional or relational content than men physicians and offer more comprehensive information.

Furthermore, women doctors tend to dominate less frequently and to offer socioemotional support (More and Milligan, 1994). One reason may be that female physicians are better able to deal with the ambiguity inherent in contextual considerations of illness (More and Milligan, 1994). Also, women physicians are more egalitarian in allowing joint decision making (More and Milligan, 1994). And, in the studies conducted by Ainsworth-Vaughn (1998) and West (1990), women were more egalitarian in their use of directives and their methods of changing and controlling topics. Furthermore, female physicians tend to spend more time conversing with the patients (Roter and Hall, 1992). Roter and Hall (1992:63) also found that female physicians “engaged in more positive talk, partnership building...and information giving.” So these women physicians show that there is hope for the doctor-patient encounter to become more egalitarian and for the knowledge and speech of both participants in the interview to be equally highly valued.

2.4 Studied Effects of Discourse Means in the Doctor-Patient Encounter

I turn now to the current literature on particular discourse moves and their effects on asymmetry and symmetry in the medical encounter. My review of the literature covers both qualitative and quantitative findings providing background for the analysis of the samples that I discuss in Chapter 3, 4, and 5. In order to shed light on how contextual factors may affect the use of discourse moves, I highlight studies that showed the effect gender has on the use of the discourse moves. However, it is important to keep in mind

that, although evidence is not provided in this theoretical overview, other aspects of power, such as race, socioeconomic factors, and age, may also affect use of a discourse move.

2.4.1 Asymmetry in Medical/Technical Jargon

One area where there is disparity in the doctor-patient conversation is in the use of medical jargon and knowledge. For example, doctors sometimes use technical vocabulary with patients who do not share their knowledge of the term in question (Roter and Hall, 1992). Doctors therefore provide information that is not understood by the patient (Jones, 1988), thus creating a lack of understanding and an asymmetry in communication.

Furthermore, patients may not have adequate expressive resources to describe their problem if they are trying to use the same medical language (Jones, 1988). Because knowledge is power, the doctor thus has a more powerful position with regard to the kind of language that can be used with optimal effectiveness in the doctor-patient interview. Because medical language is based on the dominant biomedical view of the medical institution, it is considered of higher prestige, and the inability of the patient to fully utilize power creates asymmetry in the conversation.

In addition, Dundas-Todd found that when the patient is female, doctors talked down to them (Dundas-Todd, 1983). (This reference did not give numbers for the ratio of male to female doctors in the study; however, in general, the majority of physicians are male). Even when patients have knowledge, doctors err in underestimating levels of knowledge if patients are female, members of a marginalized group, or members of a lower social class (West, 1984). Thus, regardless of the patient's actual knowledge, West

found that an asymmetry is promoted in that the doctor assumes that people of different ethnicities, females, and people of the lower classes do not have the proper kind of knowledge, i.e. the knowledge of the dominant biomedical view.

Conversely, Waitzkin found differing results suggesting “the tendency for physicians to match their response to female patients’ questions in terms of technical sophistication, consequently avoiding the appearance of talking up or talking down to them” (Waitzkin 1985 in Roter and Hall 1992:43). This difference in findings could be a function of contrasting investigative foci: Dundas-Todd explored physicians’ directives and explanations instead of their answers to patient’s questions about technical terms or procedures; therefore, the doctors might not have had a technical base to start from and assumed a lower knowledge level based on the patient’s layperson status. In any event, because of the doctor’s status and training, they have mastery over technical terms and the knowledge base associated with those terms. Further, such the medical nomenclature is more powerful because it corresponds with the dominant biomedical view of illness and treatment.

Furthermore, the doctor’s voice includes a plurality of voices that encompasses his or her own experience and the collective experience of practitioners of biomedical science (Hyden and Mishler, 1999). Thus it is not only the doctor's authority but also a wider base of authority that enables medical-ese to promote asymmetry in the conversation.

2.4.2 Asymmetry in Address Terms

Within the doctor patient interview, the use of address terms may demonstrate an asymmetry in power. The way that doctor and patient address each other can promote

asymmetry. Addressing a listener with formal terms may imply respect and deference. Conversely, familiar terms of address may show assumed superiority, or at least equality. West (1984:152) says that address practices “follow principles of symmetry between equals and asymmetry between dominants and subordinates.” Aronsson and Satterlund-Larson (1987:6) write that in “more than half the consultations, there is an asymmetry in that doctors but not patients employ the intimate form of address.” Within doctor-patient encounters, doctors tend to use informal terms for patients, and patients tend to use formal terms for doctors (Aronsson and Satterlund-Larson, 1987). Likewise, Jones writes that a doctor's use of a patient's first name is authoritarian in nature (Jones, 1988).

In 17 out of 21 encounters, West (1984) found that either physician or patient used no name at all. In six exchanges, a formal address term was used by patients for physicians. But physicians used patient's first names twice as frequently as they used patient's titles or surnames. Thus, this study found a trend towards asymmetry in the way doctors address patients as opposed to the way patients address doctors. However, in a sample of 4 women physicians, West found that none of the women physicians were addressed formally. And none of the women physicians addressed the patient by first name only (West, 1984). Thus, when the physician was a woman, deference was not shown towards the doctor, perhaps showing that gender influences asymmetry more than (or at least as much as) the status of doctor.

Addressing the patient can co-occur within the greeting that is initiated by either doctor or patient. And, the initiator of the greeting may promote asymmetry by taking charge and talking first. Cassell (1976) writes that when initiating a conversation, the higher-status person usually speaks first. In the medical encounter, when doctor and

patient address each other, it is usually the doctor who makes the first conversational move, thus promoting asymmetry from the start of the interview.

Another means of asymmetry in address terms derives from the use of certain address pronouns, such as “we,” which be seen as promoting false collaboration, or symmetry, when in fact the power lies with the speaker. However, the use of “we” can also be a strategy to create empathy, used to make the procedure seem less frightening, since both participants will be involved. Hence the address pronoun “we” can be seen as promoting asymmetry and/or it can be used for politeness and to produce less threat in proposals for physical exams or other face-threatening sorts of procedures (Aronsson and Satterlund-Larrson, 1987).

2.4.3 Asymmetry in Transition to Task

The transition to task is usually the next action to occur after the greeting (Modaff, 1995). In other words, after the opening address, asymmetry is next produced in the transition to the task of determining what is wrong. Daniel Modaff, in his 1995 dissertation on enacting asymmetry in the opening moments of doctor-patient interaction, discusses this aspect of how asymmetry is produced. Specifically, the doctor normally takes control and asks what is wrong, thereby taking the floor and claiming power with a question.

Opening moves by the doctor can start the already asymmetrical relationship off in an asymmetrical way. Opening moves by the patient can promote some symmetry within the asymmetrical encounter. However, whether the patient initiates description of the problem or the doctor asks for information about the problem, the usual next step after the problem is described is for the doctor to start questioning. This questioning is

inherent to the doctor-patient interview, but it is also a means that can be used to promote more or less asymmetry, or power.

2.4.4 Asymmetry in Questioning

Ainsworth-Vaughn (1998) writes that questions can be used to gain power in doctor-patient settings. Furthermore, she writes that “true” questions are directives that exert control over others through choosing the next speaker, the next topic, what will happen next, and what information must be provided (Ainsworth-Vaughn, 1998:76).

Ainsworth-Vaughn (1998:78) found that patients ask 40% of true questions and proposes that many studies that find patients asking fewer questions are “tainted” by the way that the questions are defined. She says that syntactic, referential, discourse, and other features must be taken into account in order to determine whether a given speech act is a question (Ainsworth-Vaughn, 1998:82)

Likewise, one must look at both the context and the content of questions in order to understand the amount of power they claim (or possibly give). For instance, questioning by the doctor is basic to the doctor-patient encounter and is used to discover specifics about the problem at hand. Many studies find that doctors ask more questions than patients (West, 1984; Fisher and Dundas-Todd, 1993; Ainsworth-Vaughn, 1998). However, too much questioning inhibits the information that the patient may be able to contribute to the encounter. The type of questioning that is used can also promote more or less power imbalance and asymmetry. Many studies have focused on the fact that physicians tend to use closed-ordered (yes-no type) questioning versus open-ended questions (how? why?), thereby limiting patient's responses (Roter and Hall, 1992; Boden, 1986). It may also be true that physicians are reluctant to answer too many

patient questions because the general doctor-patient scenario involves mainly doctor questioning (West, 1984). However, this “questioning” method of conversation tends to curtail patients’ contributions to the conversation.

Physicians tend to disprefer patients' questions through various discourse means (Roter and Hall, 1992; West, 1984). Patient questions may be ignored, given ambiguous responses or left unanswered due to a change of topic (West, 1984). West (1984) found that patient-initiated questions are also ignored by such means as consultations of files or physicians’ responding with questions of their own. Or, due to the inherent asymmetry of the encounter and the authority of physicians, patients might not even attempt to “introduce new topics or ask questions even when physicians seem to give them permission” (Heath, 1992 in Hyden and Mishler, 1999:179). Also, when some doctors make openings, patients do not “make extended responses, ask questions or comment about diagnoses” (ten Have, 1991 in Hyden and Mishler, 1999:179). West (1984) found that some patients even stammer when asking questions, thereby being unable to claim very much power with their questions.

Dundas-Todd and Fisher (1993) write that women need to be less submissive and ask questions so that they can understand diagnoses and possible treatment. However, Dundas-Todd and Fisher also note that doctors view this behavior as assertive and are sometimes not used to or comfortable with so-called assertive women. Curiously, Ainsworth-Vaughn (1998) writes that women do ask more questions than men but still not as many as physicians ask (Roter and Hall, 1992). Again, we need to look at the context and content of the question to see whether these questions from women claim or give power. For example, many of the questions women asked were ones needed to

clarify medical terms or ask permission of the doctor, thereby ceding power to the doctor (Roter and Hall, 1992). Regardless, it seems that contextual variables such as gender and the doctor-patient roles in the medical-care institution affect the amount of asymmetry in the use of questions in conversations between doctor and patient.

However, as evidenced in the above-mentioned literature, the absence of patients' questions cannot simply be blamed on either the doctor or the patient alone. For example, the patient may be acting (or not acting) out of role expectations, e.g. that the doctor is the one who does the questioning. Or, the doctor may ask so many questions that the patient does not feel that he or she has the conversational space to ask his or her own questions.

2.4.5 Asymmetry by Interruption

Besides questioning, another way that doctors can control the conversation within the medical encounter is by interrupting the patient's speech. The amount and quality of interruption is another means by which asymmetry may be promoted in the doctor-patient interaction. Interruptions constrain patient's turns at talk and can be the product of an asymmetric relationship (Jin, 1999). Although doctors may interrupt to get more information, these interruptions may stop them from getting pertinent information from the patient (West, 1984). But again, one must look at both context and content in order to gain the full measure of an interruption.

With regard to gender and interruptions, West (1984) writes that across situations, males interrupt more than females. Males' interruptions of females "constitutes an exercise of power and control" (West, 1984:52). Likewise, Boden (1986) found that doctors interrupted patients more; however, when the doctor was female, the pattern was

reversed. West (1984) also found that there were more interruptions by male doctors, but when the doctors were women, the patients (male and female) interrupted more. Thus, it appears from these studies that gender has more effect than professional status on the number of interruptions and degree of asymmetry in the encounter (West, 1984). This is another disturbing finding with regard to how the doctor promotes power in the conversation. How much is due to the status of his or her medical occupation? And how much is due to other contextual factors, such as gender? It does seem that, with regard to the quantity and quality of interruptions within the medical encounter, women tend to enjoy less power than men, and the asymmetry involved is unrelated to whether the woman is the doctor or the patient.

2.4.6 Asymmetry by Topic Change and Control

One of the reasons that doctors or patients interrupt is to gain control of the topic of the conversation. A topic change through interruption can be seen as a unilateral topic change, initiated by one person without the other person contributing, and one that produces a relatively high degree of asymmetry in the conversation (Ainsworth-Vaughn, 1998). In any conversation, the means of topic transition shows attention or lack of attention to the previous speaker's topic, thereby legitimizing or not legitimizing that speaker's concerns. Thus, methods of topic change can promote asymmetry or symmetry within the doctor-patient conversation.

Topic change can be viewed along a continuum of asymmetry and symmetry, with a unilateral move (made by one speaker) promoting the most asymmetry and a reciprocal topic move (accomplished by both speakers) promoting the most symmetry (Ainsworth-Vaughn, 1998). Thus the way “in which topic transitions are made is part of

the construction of power” (Ainsworth-Vaughn, 1998:72). Unilateral transitions allocate all of the power to the speaker whereas in reciprocal transitions, participants share power (Ainsworth-Vaughn, 1998).

Interruptions for the purpose of topic change are an example of a unilateral topic transition. As I mentioned in the previous section, men interrupt more than women, and one of the reasons for interruptions is to change topic. Therefore, it could be surmised that men use more unilateral topic transitions than women. In support of this hypothesis is Ainsworth-Vaughn’s (1998) claim that the women physicians she studied avoided unilateral types of topic transitions. Furthermore, women physicians change topic similarly to how patients change topic (Ainsworth-Vaughn, 1998), here again showing that some of the power and asymmetry promoted by doctors may be the additive affect of gender and the status of physicians. Roter and Hall (1992) also found that female physicians made more attempts to include patients in discussion. Thus, women physicians seem to have found ways to produce a less asymmetrical power balance by allowing patients to have a share in topic control and development.

2.4.7 Asymmetry of Repetition Feedback

As mentioned above, topical cohesion can be shown through repetition of the previous speaker's discourse. No feedback, minimal, or non-minimal feedback indicate what a respondent/interlocutor views as important and can thereby promote either asymmetry or symmetry in conversational interaction (Aronsson and Satterlund-Larsson, 1987). Repetition is one form of feedback and another means by which asymmetry or symmetry can be promoted in conversation. Repetition can be used to “repeat, rephrase,

and echo other's words” as an “automatic and spontaneous way of participating in conversation” (Tannen, 1989:96).

One function of repetition can be the ratification of another's speech. When the patient repeats and thereby ratifies the doctor, it may promote the power of the doctor and also asymmetry in the conversation. When the doctor repeats and ratifies the patient, it may promote the patient’s power and also redress asymmetry in the conversation. When the patient reinforces the doctor’s view through repetition and ratification, it may show the doctor’s authority, thereby promoting asymmetry. By contrast, the doctor's repetition and ratification of patients’ views may show his or her positive evaluation of the patient’s perspectives, thereby promoting symmetry. Furthermore, when the doctor does not participate in the patient’s speech through lack of repetition and/or ratification, asymmetry can be promoted. One must look carefully at what is and isn’t repeated in order to gain a measure of whether asymmetry or symmetry is promoted. Another cautionary note is that there could be the possibility of non-verbal feedback by the doctor or patient that did not get recorded in the transcripts. Again, even with an attempt to bring in all contextual measures, interpretation of conversational interaction is always open to error.

2.4.8 Asymmetry by Use of Directives

Another mechanism that may promote asymmetry in varying degrees is that of the use of directives. Directives are speech acts that try to get another to do something. Directive forms vary with rank and familiarity (Ervin-Tripp, 1976, quoted in West, 1990). Therefore, different directive forms may promote different amounts of asymmetry in the conversation. However, asymmetry in directives may be conducive to the medical

encounter, given that direction by the doctor is sometimes salient to the goals of the encounter, e.g. direction towards better health. Looking closely at directives within the conversation may reveal the kinds of power produced and required by the use of this discourse means.

As far as different directive forms are concerned, imperatives are a form of directive that implies authority on the part of the speaker (West, 1990). In West's study, men physicians used imperatives in 49 out of the 156 directives. In many of these cases, the imperatives required immediate action on the part of the patients. These imperatives therefore proposed "an asymmetrical alignment between physician and patient, in which the patient 'has no choice but to do whatever told'" (Shapiro, 1978: 170 in West 1990; West, 1990:92).

Other directives that may occur within the medical encounter are those issued by the speaker (doctor) to the listener (patient) stating the listener's (patient's) requirements. This type of directive therefore proposes "the physician's authority to assess patients' needs and determine what is best for them," again promoting asymmetry between physician and patient (West 1990:94). For example, telling the patients what they "need" or "have" to do can propose authority as to what the patient's needs are and determines what they must do (West, 1990), thereby promoting asymmetry.

A third form of directive which may show asymmetry includes those indicating to the patient what the male physician "wanted" or "didn't want" the patient to do, thereby "proposing that the speaker's (physician's) preferences imply an obligation on the part of their addressees" (Ervin-Tripp, 1976:29 in West, 1990:95)

Other forms of directives used by physicians to imply asymmetrical alignment between participants are quasi-question directives such as “Why don’t you,” permission provisions which specify what the patient is permitted to do, directives by example, which specify through example of “what I would do,” imbedded imperatives, and false collaboratives, which are “framed as a proposal for joint action, yet actually propose action to be undertaken by a single individual” (West, 1990:97). False collaboratives show the speaker’s right to propose action, thereby promoting asymmetry (West, 1990).

West found that, paralleling this egalitarianism with respect to topic control, women physicians were also more egalitarian in their issuing of directives, using mitigated forms of directives that proposed symmetrical doctor-patient relationships (West, 1990). This finding again implies that there are means by which physicians can promote a more symmetrical and equal relationship in the conversation between doctor and patient. With regard to directives, then, different forms of directives, like different mechanisms of topic change, can be used with the result that different degrees and types of asymmetry are promoted.

2.4.9 Asymmetry Due to Influence of Politeness

Politeness between doctor and patient can be seen as a constraint on many of the discourse moves that occur within doctor-patient interactions. Although politeness can be seen as an overall constraint on many conversations, the doctor-patient relationship may enable particular types of politeness operative in the medical encounter. One politeness strategy, deference, is an overall conversational factor that promotes asymmetry within the doctor-patient encounter. The patient may defer to the doctor’s questions and opinions and suppress his or her own questions and opinions. This

deference affects the asymmetry in the conversation. Deference can contribute to a lack of direct requests or questioning on the part of the patient (Aronsson and Satterlund-Larrson, 1987). This lack of questioning blurs or softens the participants' role structure by not enabling them to have a significant role in the diagnosis and treatment (Aronsson and Satterlund-Larrson, 1987).

Aronsson and Satterlund-Larrson explore politeness and medical interaction by looking at Brown and Levinson's notion of social distance as negotiated through forms of address, indirectness in requests and questioning, patients' collaboration, feedback, topic shift, repair work, overlapping talk, and decision-making. Likewise, many of the discourse moves or lack of discourse moves in my samples can be interpreted as the result of deference of the patient towards the doctor, due to the asymmetry of their relationship. As mentioned above, assertive women may be viewed or reacted to negatively. In turn, women may orient to this view by not asking questions. This lack of questioning promotes less power and therefore more asymmetry within the doctor-patient conversation because the patient's voice is not heard. Another manifestation of patients' deference is when patients present their problems in ways that will be acceptable to physicians and respond to recommendations in ways that do not contest or undermine the authority of the doctor (Hyden and Mishler, 1999). Deference may also cause a patient not to verbally or outwardly disagree.

Deference by the patient towards the doctor may result as well in ambiguous responses such as "yes" and "uhm" which can mean agreement or not, and also in tokens of agreement even when the patient really is silently disagreeing (Aronsson and Satterlund-Larrson, 1987). The result is asymmetry in conversation caused by the non-

expression of the listener's wishes. Dundas-Todd and Fisher (1993) write that women are socialized to be “good girls”. Therefore, women may silently rebel instead of explicitly stating disagreement (Dundas-Todd and Fisher, 1993). Or, the patient may go along with the doctor’s wishes but through silence, sarcasm, or criticism undermine the doctor’s power (Dundas-Todd and Fisher, 1993). Regardless, deference causes the patient to refrain from directly challenging the doctor “by not voicing his/her disagreement and ‘lying’ through omission” (Aronsson and Satterlund-Larrson, 1987:25). Such politeness constraints promote asymmetry in conversation because the listener’s wishes are not truly expressed.

The doctor might also promote asymmetry through negative deference. Doctors might, through negative deference, avoid direct requests about treatment plans, presupposing patient agreement and thereby promoting asymmetry (Aronsson and Satterlund-Larrson, 1987). Thus, deference between doctor and patient can inhibit joint decision-making in medical encounters (Aronsson and Satterlund-Larrson, 1987). Other politeness phenomena can be a product of asymmetry that do not contribute to the goal of the encounter. Dundas-Todd and Fisher (1993) explore the paradigm of the “nice doctor” who listens to the patient’s troubles, “clucks sympathetically,” and reinforces social ideology with medicalization (e.g. tranquilizers) of problems. In this way, a patient can come in with a physical complaint, only to have it psychologized and socially controlled through medicalization (Dundas-Todd and Fisher, 1993). Thus Aronsson and Satterlund-Larrson (1987:26) write that an interesting question would be to look at what “politeness strategies will be employed under conditions of varying power, as in the case of more or less powerless patients.”

One more area of politeness that may affect asymmetry within the encounter is that of sociability and laughter. West (1984:120) writes that “sociable exchange is organized in asymmetrical distributions between parties in medical encounters.” For example, patients have less acceptance of their laughter from physicians than physicians have from patients (West 1984). The doctor laughs last. However, Roter and Hall (1992) writes that females were responded to with more laughter and positive talk than men. (They did not indicate the gender of the doctor but in general, there are more male doctors than women doctors). Thus, gender may benefit females in terms of sociability and laughter and its effect on asymmetry within the doctor-patient encounter.

2.4.10 Asymmetry by Ignoring Contextual Variables/Patient’s Lifeworld

Another overall constraint on doctor-patient conversation is that the voice of “medicine” is valued more than the voice of the “lifeworld.” Within the medical encounter, there can be what Mishler calls “a battle of voices between ‘the medical view’ and the ‘view of the lifeworld’” (Mishler, 1984 in Hyden and Mishler 1999:178). Within the medical interview, biomedical concerns are dominant and life concerns are considered of a lower order. Therefore, the contextual concerns of the patient take lower priority.

Again, the use of selective feedback, no feedback, minimal, and non-minimal feedback tells what is important by showing attentive interest (Aronsson and Satterlund-Larsson, 1987). In the doctor-patient encounter, the patient usually answers all the doctor’s questions, thereby providing feedback to the doctor’s queries. By contrast, numerous studies have documented that patients feel that many aspects of their speech, especially contextual or relational items, are ignored (Dundas-Todd and Fisher, 1993;

Grace, 1995; Waitzkin, 1991). These contextual or relational items may be significant life events, such as death, divorce, or job loss. Or they may be life strains, within the family job. Borges and Waitzkin (1995:33) write that more attention should be given to elements that appear marginal as they may be crucial elements that convey relevant contextual concerns. Contextual elements reveal themselves in “inconsistencies, breaks in logic, interruptions, silences, and absence of pertinent details” (Borges and Waitzkin, 1995:33).

Dundas-Todd and Fisher (1993) explore several examples of women’s doctor-patient encounters and found that several things happened: women tried to give their stories and they were cut off; women did not give information because they didn’t think the information would contribute anything to the encounter (thus also bowing to the technical trend of medical discourse); or women had their own agenda which they kept to themselves. Regardless of what strategy they employed, these women did not get the effective health care that they thought they sought from the medical encounter.

3. METHODOLOGY

3.1 Scope of Analysis

The premise of this thesis is similar to one informing Ainsworth-Vaughn's work in *Claiming Power in Doctor-Patient Talk*. Ainsworth-Vaughn's goal is to aid both doctors' and patients' awareness of how "power is claimed and ratified," so that "they can do a better job pursuing the goals of the event" (Ainsworth-Vaughn, 1998:26). I add to her work by including analysis of additional discourse moves in doctor-patient conversations, incorporating research such as West's examination of directives. I also extend Ainsworth-Vaughn's work by analyzing more doctor-patient samples, thus providing additional empirical evidence for her claims.

To this end, in chapter 4, I undertake an analysis of four samples and of several discourse moves (or the absence thereof) to examine their effect on asymmetry and each speaker's degree of power within the interaction. Additionally, I show where the patients, as the bottom-player of the asymmetric relationship, try to undermine the asymmetry and thereby make gains towards symmetry in the encounter. Furthermore, I show where doctors' moves can redress asymmetry.

Within the conversation of the doctor-patient interaction, one can look at each of the aforementioned discourse means to see how they interactionally promote or redress asymmetry between physicians and patients. In order to interpret the discourse moves, we must also keep in mind the overall contextual factors discussed in my previous chapter. As I mentioned there, one must always keep in mind how contextual variables influence whether asymmetry is being promoted or redressed.

In Chapter 5, I discuss problems revealed by my analysis. Like Ainsworth-Vaughn (1998), I surmise that since the doctor-patient encounter, although framed by the

institution, is not pre-scripted, it allows room for a re-scripting of discourse moves by both participants and process of rescripting which can potentially shift the interaction towards a more symmetrical conversation. However, I also discuss why this sort of re-scripting is not as simple to accomplish as it might seem.

3.2 Samples

For my thesis, I obtained from University Microfilms International 17 transcripts that were transcribed by Howard Waitzkin and colleagues and referenced in *The Politics of Medical Encounters* (Waitzkin 1991). Waitzkin's book deals with the contextual items that patients bring with them into the doctor-patient encounter. He proposes that doctor-patient encounters become "micropolitical situations that do not typically foster change in contextual sources of patients' difficulties" (Waitzkin 1991:10). Waitzkin found that most medical encounters involve contextual difficulties. For example, a woman may suffer from psychosomatic symptoms due to her gender-related role expectations. The exceptions, where people's contextual difficulties are not related to the visit, typically involved people who lived in line with the mainstream social ideologies or were coming to the doctor for routine visits, such as a physical exam.

Howard Waitzkin's group obtained 336 samples of doctor-patient encounters. These samples were recorded in private practice and hospital outpatient departments in two states. The encounters were originally recorded for a purpose different from the one motivating Waitzkin's book, *The Politics of Medical Encounters* (Waitzkin 1991). They originally meant to provide data for a traditional quantitative research project. For these samples, patients and doctors of internal medicine were recruited randomly. The doctors and patients answered questionnaires providing information about demographics and

social context. The 336 samples were then randomly narrowed to 50 samples. However, the sample of 50 was checked to make sure that the distribution of gender, age, and social class was reasonable. These 50 samples were transcribed by transcriptionists and double-checked by research assistants. The transcription guidelines are presented in Section 7.2. Within these 50 transcripts, Dr. Waitzkin and colleagues divided the transcripts according to what contextual area of the patient's life that the medical conversations focused on: work, family life and gender roles, aging, sexuality, substance use, or emotional problems. They then selected 3-4 transcripts from each contextual area. Unfortunately, none of these "randomly" selected samples involved women doctors. Therefore, I was not able to analyze what kind of speech a woman doctor may use, or how patients tailor their discourse moves to an encounter involving a female physician. I then selected 1 transcript each from 4 of their contextual areas. I chose 2 samples where women were patients and 2 samples where men were patients. These samples were not chosen based on any criteria other than an even gender mix. The full transcripts are provided in Sections 7.2.1, 7.2.2, 7.2.3, and 7.2.4. Table 3.1 summarizes some contextual aspects of these encounters.

	Doctor	Patient	Education/ Occupation	Setting of Encounter	Notes about patient
Sample 1	43-year old White Male	41-year old Black male	HS/ Food Op Mgr	Private Practice	Divorced, father of 3
Sample 2	47-year old White Male	30-year old White Woman	College/ Housewife	Private Practice	Mother of 2
Sample 3	43-year old White Male	52-year old White Male	HS/ Setter/Mfg	Private Practice	First visit
Sample 4	44-year old White Man	62-year old White Woman	Secretary school// Housewife	Private Practice	Doctor and patient have known each other 1 year; mother of 3, 1 retarded child

Table 3.1: Summary of Sample Characteristics

3.3 Qualitative versus Quantitative Methods of Analysis

There is a basic problem with both qualitative and quantitative methods of analysis. Quantitative analysis often ignores context, whereas qualitative analysis may not be totally representative (Ainsworth-Vaughn, 1998). However, even qualitative analysis cannot bring in all contextual matters (Ainsworth-Vaughn, 1998). In *Claiming Power in Doctor-Patient Talk*, Ainsworth-Vaughn's studies are either quantitative (but based on qualitative definitions), qualitative, or a mixture of both. My analysis will be mainly qualitative, though I also make some quantitatively oriented remarks about how much asymmetry or symmetry a discourse move produces within the entire encounter. I also make some similar remarks about the distribution of the discourse move across samples and contexts. However, one must realize that due to the small number of my samples (four), this evidence may not be representative of the greater whole of doctor-

patient conversations. In accordance with the overall purpose of my thesis, though, the analyses do offer evidence where asymmetries and symmetries can be located.

Also, one must also remember that this is one analyst's account, reflecting my own subconscious biases and knowledge. As Ainsworth-Vaughn (1998:25) writes, "analysts inevitable use their own frames and schemas, 'members' knowledge ' of social structure." Nonetheless, I attempt this qualitative analysis in an effort to suggest where further analysis might lead (Ainsworth-Vaughn 1998). Like Ainsworth-Vaughn (1998:17), I seek to contextualize my analysis ethnographically, thereby providing "a sense of the moment, with all of its possible meanings." This method of analysis allows me to include contextual matters not immediately apparent in the local context of an interaction. I therefore include the surrounding discourse to aid in my interpretation of fragments of discourse and to minimize my bias in interpretations (Ainsworth-Vaughn 1998).

3.4 Definitions

Before proceeding to analyze the four samples under examination, I offer brief definitions of the discourse moves studied in the samples. Here I restate synoptically some of the issues already discussed in Chapter 2. I will use Wynn's (1999:121) definition of a question: "a question is an utterance by which an interactant typically asks for information and which typically elicits a response." Within this definition, I include requests for action, instructions, and advice as potential types of questions (Wynn, 1999). In other words, a question is a discourse move which asks for something and which expects a response. An interruption can be defined as "an initiation of simultaneous speech which intrudes deeply into the internal structure of a current speaker's utterance;

operationally, it is found more than a syllable away from a possibly complete unit-type's boundaries" (Zimmerman and West, 1975:113-115 in West 1984:55). An interruption claims the right to speak over the other participant's speech. Topic change is defined by West and Garcia (1988 in Ainsworth-Vaughn 1998: 58) as a move having no "sequential or referential" relationship to the preceding discourse. However, Brown and Yule (1983 in Ainsworth-Vaughn 1992) note that some sort of inference that relates them can bridge almost all gaps in reference between topics. This is especially true within the genre of the medical encounter, where all topics tend to relate to diagnosis and treatment. Therefore, for our purposes we can view topic change as involving surface-level linguistic features instead of the abstract level of relationships between discourse units, or coherence (Ainsworth-Vaughn, 1998). Some additional means of cohesion linking a current turn at talk with the surface linguistic structure of the preceding turn are anaphoric pronouns, repetitions (Tannen, 1989), and the use of synonyms or related terms (Ainsworth-Vaughn, 1998). In my analyses, I will look at how topic shifts use or do not use these means of cohesion and what affect this has on asymmetry or symmetry.

In Chapter 2, Section 2.4.5, I discussed the topic shift continuum shown in Figure 3.1 (Ainsworth-Vaughn 1998). Between the two ends of the topic shift continuum there are what Mishler (1984) calls links, and what Ainsworth-Vaughn (1998) calls minimal links, which exist between reciprocal and unilateral topic transition activities. These links show different degrees of acknowledgment of the previous speaker and lesser or greater displays of power or asymmetry in topic transition.

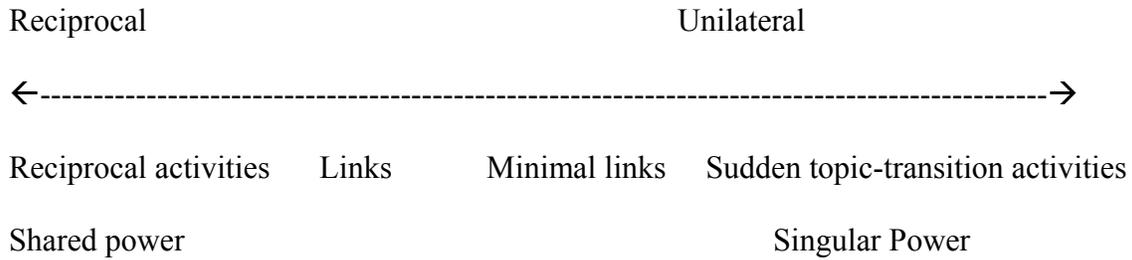


Figure 3.1: Continuum of Topic-Transition Activities

For example, an interruption for the purpose of changing topics would be a sudden topic-transition and give all the power to the interrupter. The use of minimal links like “Well” or “But” would create a less sudden topic-transition and share some power with the interruptee. If one changed topics with a “link,” one would acknowledge the previous speaker’s remarks, and then change the subject. And finally, the most symmetry in topic-transition would be promoted by an agreement between both speakers for a change of topic.

The other discourse moves that I examine were discussed in Chapter 2: use of medical terms, transition to task, address terms and address pronouns, directives, repetition. I also examine constraints imposed by politeness hierarchies and by the dominant biomedical view of illness and treatment.

4. ANALYSIS OF SAMPLES

4.1 Sample 1

This sample involves a patient who comes to the doctor for neck problems. The patient is a 41-year-old African American male who is divorced, a high school graduate, and has 3 children. The doctor is a 43-year-old white male. This is the first visit between the two and it occurs in a suburban practice. The patient's neck problems become worse with work, but he feels he must work. The doctor's diagnosis is "acute muscle spasm." The doctor's treatment plan is rest (as much as possible), pain relievers, a neck collar, and heat.

4.1.1 Asymmetry and Symmetry of Contextual

Besides the asymmetry of the doctor-patient relationship, this encounter involves asymmetry due to racial features; the patient is a 41-year-old African-American male, the doctor is a 43-year old white male. However, both the doctor and patient are close to the same age and both are males. The similarity in age and shared gender could create some solidarity. Furthermore, the encounter is in a private practice. Therefore, the patient must have a high enough socioeconomic status in order to carry health insurance that affords him the privilege of a private doctor's practice. These contextual factors help undercut the asymmetry that might otherwise predominate within the encounter.

4.1.2 Asymmetry and Symmetry of Medical/Technical Terms

In this sample, medical terms are not widely used. Therefore, the asymmetry that can be promoted due to the doctor's frequent use of medical terms and the patient's infrequent use (or non-use) of medical terms does not occur.

4.1.3 Asymmetry and Symmetry of Questioning

When the doctor controls all the questioning and the patient does not question much at all, both the doctor and patient promote asymmetry. In this sample, the doctor controls the questioning from the beginning. The doctor's questions are information-seeking, taking down the patient's history and looking for the cause and solution of the patient's problem. Despite the fact that the doctor's purpose in questioning is closely tied to the nature and goals of the interview, the doctor still claims power by staking the right to question. The only examples of patient questioning are found in lines 227-229, where the patient seeks information about how to ease his pain, and in lines 307 and 335 where the patient asks where he can get a collar and if he needs to buy a neck collar.

- 227 D: I can't image a chest x-ray is gonna be abnormal,
but in the process we can see those vertebrae, that uh...
→ 229 P: Is there anything I can take to relax that, that pain in the
back?

In line 229, the patient's question is in direct line with the medical encounter because it is a direct question about finding relief to the physical pain. However, the question in line 229 claims some power because the patient is proposing a solution to some of his problems, i.e. taking something for the pain.

- 306 D: Okay, just tell me how you're doing.
→ 307 P: Okay. Where do I get this collar?

330 D: They don't cure anything. They simply help ease the pain.
331 But if you can get rid of some of the pain, I think we'll
332 Get rid of some of the spasms. And they'll be labeled....
333 There's that..... You can get these at the same
334 drugstore. And this for the cervical collar, the neck collar.
→ 335 P: The neck collar. You have to buy this?

The questions in line 307 and 335 are seeking clarification about the doctor's treatment plan; therefore, they do not claim as much power as the question in line 229. Overall, the

doctor promotes asymmetry through his many questions and, to a large degree, the patient does not redress this asymmetry because he does not ask many questions.

4.1.4 Asymmetry and Symmetry of Interruptions

When the doctor interrupts, this promotes asymmetry. When the patient interrupts, or continues his line of speech despite the doctor's questions, he promotes symmetry. In lines 118-120, lines 266-269, and also lines 260-264 (not shown), the doctor promotes a large amount of asymmetry when he interrupts in order to finish the patient's speech.

- 118 P: No, that's the work I do, you know. When you're really in (words)
- 120 D: [Throwing kegs of beer around?
- 265: P: Right. And plus the fact that this is (words) tonight,
266 And
- 267: D: Well [
- 268: P: [this afternoon, and
- 269: D: [you've got to compromise. Ideally, you ought to go home and lie on a heating pad...

These interruptions do not change the patient's topic, yet they claim power over the right to speak. The doctor also interrupts to ask a question or make a point in lines 170-175 and in lines 344-345.

- 170 P: Right in the middle, Just a little to the right of that node,
171 (word), okay? My girl was rubbing my neck at, uh, the
172 first part of the week, and there was actually a knot up
173 there. Then when it started going to the back the knot
174 seemed to
- 175 D: [What have you done for it?

343 D: hot water bottle. You have a heating pad like that?

344 P: No, I'll probably have to buy

→ 345 D: [Well you're gonna buy a whole pile

In line 175, not as much power is claimed as in line 345 because the doctor gave the patient a long turn to speak in lines 170-174. But again, these interruptions promote asymmetry by displaying an assumed control over the right to speak. The patient makes some gains towards equality when he interrupts and negates what the doctor is saying in line 204.

202 D: Do you smoke?...It would be nice to stop chewing (word)

203 for the diabetes.

→ 204: [I know, I've been told that.

Likewise, the patient interrupts in line 217, showing assumed control over his right to speak as well.

215 D: And that starts to pull other muscles out of position. Like

216 one wire on a sailing ship being too tight

→ 217 P: [It pulls. Yeoh
I had that once before once before.

The patient claims power when, in line 268, the patient tries to continue his own speech after the doctor's interruption, thereby sticking to his (the patient's) own topic; however, the doctor wins out by continuing the doctor's topic.

266 P: and

267 D: [Well

→ 268 P: [this afternoon, and

269 D: [you've got to compromise. Ideally you ought to go home...

Some of the patient's interruptions can be seen as overlapping speech in which he is agreeing with what the doctor has just said. In line 285, the patient uses a backchannel cue, "Right," to repeat the doctor's directives. The patient also overlaps with the doctor in lines 83-86, lines 110-113 (not shown) and in lines 183 and 253 (not shown).

- 284: D: Put a couple towels. And first don't burn yourself, but
→ 285: P: Right.
286: D: [leave it as the cloth. And do that for an hour
- 83 D: Yeah. Was there any one move that made it worse? Did
84 you reach in
→ 85 P: [No.
86 D: [some funny way and it suddenly hit you, or did this

The doctor promotes much asymmetry through interruptions that propose his authority to speak and question or finish the patient's ideas. The patient promotes some symmetry by also interrupting and tries to promote some symmetry by trying to stick to his topic, even if he does not succeed very well.

4.1.5 Asymmetry and Symmetry of Topic and Topic Change

When the doctor constantly controls the topic and makes unilateral topic changes, he promotes asymmetry. When the patient changes the topic to his or her own concerns, he promotes symmetry. In this sample, the doctor constantly controls the topic in an attempt to discover information and make a diagnosis. For example, in lines 31-41:

- 31 D: All right. Are you a healthy man basically?
32 P: I am.
→ 33 D: Any chronic disease?
34 P: I have uhm, they call it, um, mature diabetes.
→ 35 D: Do you take medicine for that?
36 P: No. I control my weight.

- 37 D: Good. And your weight is pretty well controlled.
- 38 Remember how important that is. You could gain
- 39 50 pounds and have it, and have diabetes that
- 40 would require daily shots of insulin.
- 41 P: Right.

However, the patient rarely changes the topic to any of his (the patient's) own different ideas. One of the patient's topic changes occurs in lines 190-194; the doctor is examining the patient and the patient changes the topic, with no minimal links, to let the doctor know that he (the patient) had a cold last week.

- 190 D: Take a deep breath.
- 191 That doesn't hurt more in the back?...Okay. With your
- 192 Mouth open, take deep breaths. Mouth wide open. Deeper...
- 193
- 194 P: Starting last week, you know, I caught a cold.

This topic change allows the patient to express his own ideas within the medical encounter. The only other times the patient tries to change the topic is when he abruptly asks for something to relieve his pain in line 229 and when he tries to continue on about his work situation for that evening in lines 265-269 (shown above in Section 4.1). These topic changes by the patient allow the patient to speak his thoughts.

- 227 D: I can't image a chest x-ray is gonna be abnormal, but in the process we
- 228 can see those vertebrae, that uh...
- 229 P: Is there anything I can take to relax that, that pain in the
- 230 back?

Thus, the doctor promotes asymmetry by constantly controlling the topic through questioning and through changing the topic to joke about the patient's situation. The patient promotes some symmetry by changing the topic to his concerns with the cold and with pain, thus having some personal input into the diagnosis and treatment.

4.1.6 Asymmetry and Symmetry of Repetition/Feedback

Throughout the sample, the doctor promotes some symmetry by constantly acknowledging the patient's answers with "Allright" and "Good." Also, during the medical encounter, the doctor repeats and acknowledges the patient's physical complaints by asking further questions about them. An example is in lines 82-83.

82 P: Well, I think it got worse when I got to work.
→ 83 D: Yeah. Was there any one move that made it worse?

Throughout the entire encounter, the patient repeats and ratifies the doctor's questions by answering them and staying on topic. This promotes asymmetry because the patient rarely changes the subject to his own concerns or negates what the doctor says.

4.1.7 Asymmetry and Symmetry of Directives

When the doctor uses directives, he promotes asymmetry. When the patient uses directives, he promotes symmetry. In this sample, the doctor issues directives in line with the purpose of offering a diagnosis, but he issues them as imperatives, which claim a high degree of power.

Some examples are in the lines that follow:

43 D: Don't have great big meals.
44 D: Spread out your food during the day.

64 D: Take off your shirt while we're talking.

192 D: mouth open, take deep breaths, Mouth wide open. Deeper...

245 D: Take a little bit of food with it. Half a glass of milk.

306 D: Okay, just tell me how you're doing

In line 356, the doctor also tells the patient what the patient is going to do.

356 D: And sixth, you're gonna call me.

In lines 206 and 255-256, the doctor uses other directives that show his preferences and wants, and imply an obligation for the patient to follow them.

206 D: ..and you don't want to double the effect...

255 D: Two, every three hours, right through the day. I want you to
256 get a heating pad if you don't have one, and you lie on it.

And finally, in line 240, the doctor tells the patient what he is going to do when in actuality the patient is the one who must take the medication.

→ 240 D: Uh, I'm gonna start you with aspirin. High doses.

Thus, there is a high degree of asymmetry promoted through the use of several different types of directives by the doctor. The patient exacerbates the asymmetry by going along with and not questioning the doctor's directives.

4.1.8 Asymmetry, Symmetry, and Politeness

The backchannel cues of "Alright" and "Good" by the doctor and "Alright" and "Yeah" by the patient may simply be moves that are made out of "simulated egalitarianism" towards one either lower status (in the doctor-to-patient case) or higher status (in the patient-to-doctor case). Thus, although the doctor may promote symmetry by acknowledging the patient's speech, he may actually be insincere, thereby lowering the amount of actual symmetry promoted. Likewise, the patient's consistent agreement, while promoting asymmetry through constant affirmation towards the participant of higher status, may actually be a move made only out of deference. Therefore, it may not promote as much asymmetry as the constant agreement with the doctor may seem to promote. Furthermore, deference towards the doctor may constrain the patient from asking questions to the doctor or questioning or interrupting the doctor's statements.

Another aspect of politeness is the sharing of jokes and sociability. The doctor may use jokes and sociability to promote symmetry in the encounter; however, his very dark jokes seem to promote asymmetry by showing the sort of power he could have over the patient. In lines 70 and 137, the doctor jokes, in a dark sense, with the patient.

68 P: This morning when I woke up I just, I just couldn't
69 even lift up off the bed, I had to roll out.
→ 70 D: The toughest men are the biggest sissies.
71 P: heh ha ha

135 D: You haven't been retired too long, have you?
136 P: No, May '72.
→ 137 D: '72. All right, well if I can't cure you, do I have
→ 138 permission to shoot you?
139 P: No, no, please, he heh heh

Also, because the doctor uses jokes and sociability to downplay the patient's concerns, he glosses over the patient's ideas instead of showing solidarity with the patient's thoughts. Thus, the doctor's jokes promote asymmetry within the conversation and the patient does nothing to redress this asymmetry.

4.1.9 Asymmetry and Symmetry of Medical View

When the medical view is relied on for diagnosis and treatment, asymmetry is promoted. When the lifeworld of the patient is involved in the diagnosis and treatment, symmetry is promoted. In this sample, the medical view, expressed as a preference for medication and physical manipulation of the patient's problem, takes precedence over manipulation of possible "lifeworld" solutions to the problem. The doctor holds authority within this medical view. However, the doctor promotes symmetry by bringing in the "lifeworld" of the patient in his diagnosis and in recommending some treatments. The doctor sees that work may exacerbate the problem. However, there seems to be no solution to alleviating the workload. Therefore, both patient and doctor look to medical

interventions, i.e., pills and a neck collar. Again, the focus is on the medical world, because the doctor must find all the solutions from the medical intervention point of view, as opposed to brainstorming with the patient for possible “lifeworld” solutions to the patient’s complaint. This one-sided view of diagnosis and solution promotes asymmetry within the encounter.

4.1.10 Asymmetry and Symmetry of Overall Encounter

The doctor promotes asymmetry through continuous questioning, interrupting, topic control, and use of directives. The patient promotes asymmetry by not questioning or changing the topic, instead letting the doctor determine what treatment he will receive. Politeness may also constrain symmetry because each player may agree due to deference, or simulated egalitarianism, instead of out of a real sense of agreement. With regard to the medical view, the doctor in Sample 1 does promote some symmetry by bringing in the lifeworld situation of the patient and figuring that into his diagnosis of the problem and its treatment. The patient promotes some degree of symmetry by trying to point out his problems and by asking for something to relieve the pain. But, because there is no easy solution to the patient’s problem within the lifeworld itself, the medical-world intervention controls the diagnosis and treatment. Also, the racial, socioeconomic, and educational differences between a white white-collar doctor and a black blue-collar worker may further the patient’s sense of being unable to question or change the topic. Furthermore, this high-level asymmetry may cause the patient to feel that he cannot speak up and ask for time off or perform less physical tasks in his workplace, a solution that could bring him some relief from his physical problem.

4.2 Sample 2

This sample involves a woman who comes to the doctor suffering from general aches and pains, loss of appetite, frequent urination, and itchy skin. She also describes being extremely busy in her role as a housewife in a suburban neighborhood. The doctor's diagnosis is "suburban syndrome," and "acute and chronic anxiety and depression" (Waitzkin 1991:123). His treatment advice is rest and "saying no" to too many activities. At the patient's request, he also prescribes a tranquilizer. The patient is a 30-year old woman who is a college graduate, married, and has two children. The doctor is a 47-year old white male in a private practice. The patient and doctor have had a doctor-patient relationship for 7 months.

4.2.1 Asymmetry and Symmetry of Context

Besides the asymmetry of the doctor-patient relationship, this encounter involves gender-based asymmetry: the doctor is a man and the patient is a woman. Also, the doctor is 47 years old and the patient is 30 years old, a somewhat significant age difference that can be seen as an asymmetry in age status. However, as far as socioeconomic status is concerned, I hypothesize that the patient could be on the same level as the doctor. She does not need to have paid employment and makes references to many suburban housewife activities within her neighborhood. She could be married to a doctor or someone in an equally high-standing profession. The doctor and patient are also both white, so there is no race-based asymmetry. These contextual factors promote some, but not a large amount, of asymmetry within the encounter.

4.2.2 Asymmetry and Symmetry of Medical/Technical Terms

In this sample, medical terms are not widely used. Therefore, the asymmetry that could have been promoted by the doctor's frequent use of medical terms and the patient's infrequent use (or non-use) of medical terms, does not occur.

4.2.3 Asymmetry and Symmetry of Address Terms and Transition to Task

The patient is already familiar with the doctor and vice-versa. The doctor and patient do not exchange any formal or informal greeting. The opening address and the transition to task occur in the same opening move by the doctor, promoting asymmetry.

→ 12 D: ...Talk to me. Why are you here?

Furthermore, the transition to task in line 1 is an imperative, a powerful discourse move that further claims power in the move and in the encounter.

4.2.4 Asymmetry and Symmetry of Questioning

When the doctor asks most of the questions, he promotes asymmetry. If he asks questions and allows the patient space to answer more than yes, no, or one-word answers, he promotes symmetry. When the patient asks some or any questions, and if she expresses herself when answering the doctor's questions, she promotes symmetry. In this interview, after the doctor asks the initial question, he allows the patient a long turn at talk in order to convey her problem. The doctor does break in eventually, but when he questions the patient, he asks her about her opinion concerning the diagnosis. Then, the doctor asks the patient her own personal diagnosis in lines 33-38. This sequence allows the patient to talk, and she does talk.

→ 33 D: You have pretty good insight, huh? Haven't you?

34 P: Well,

→ 35 D: Hmmm?

36 P: Insight into what?

- 37 D: Your story that you give me almost gives the answer with
- 38 it, doesn't it?

As in most medical encounters, the doctor also questions the patient in order to diagnose her problem. However, his questioning claims less power than it might because the patient also questions the doctor in order to understand what he is asking. For example, the patient asks information-seeking questions in lines 219-228:

- 219 P: And what, how does it work?
- 220 D: It's a tranquilizer.
- 221 P: [And what does it
- 222 D: [It's a tranquilizer.
- 223 P: Is it, does it work quickly, or does it over a long period
- 224 of time?
- 225 D: I don't know.
- 226 P: Uhm.
- 227 D: What I mean by that is it depends up on your reaction to it.
- 228 P: In other words?

Thus, the patient asks for information from the doctor, asserting her right to understand. However, because the information the doctor holds has (information about medicine) is deemed more valuable in the medical encounter than the information the patient has (the experience of personal illness), the doctor's information-seeking questions still do more to claim power for the doctor than the patient's information-seeking questions do to claim power for the patient.

But, the patient makes requests of the doctor, in lines 183-192. She asserts her right to ask for what she wants, instead of going along with the doctor's directives.

- 184 P: Okay, but what do I do about this feeling, you know?

- 185 P: I've got
 [
- 186 D: Ignore it
 [
- 187 P: No, I can't, I mean I'm
 [
- 188 D: I have no way of treating you. My answer to you is very
 189 simple. Rest and Bufferin if you want it, or
 190 ignore it, or a hot sauna, or a hot bath, or stay in bed all day, but I
 191 don't find anything organic, I mean (word)
- 192 P: Well is there some kind of sedative or tranquilizer you can give me?

Thus, although the doctor promotes asymmetry through his questioning of the patient, this asymmetry is somewhat redressed by three things: first, he asks the patient for her opinion; second, the patient asks questions in order to better understand the diagnosis and treatment; and third, the patient makes requests of the doctor in order to get what she wants from the encounter.

4.2.5 Asymmetry and Symmetry of Interruptions

When the doctor interrupts, he promotes asymmetry by claiming the right to speak over the patient. When the patient interrupts, she promotes symmetry by claiming the right to speak over the doctor. At the beginning of this sample, the patient is telling the story of her illness.

- 13 P: I'm here because I'm just not feeling well. I um, I feel
 14 exhausted lately. I've been running around doing lots of
 15 things entertaining and lots of committees and so forth, and
 16 lots of social butterfly stuff and I'm just exhausted
 17 Everything hurts me. I don't know whether I have a cold in
 18 my body, my 16 back, muscles. My shoulders hurt, my arms, my
 19 fingers, my wrists. When I wake up my legs hurt and my feet
 20 hurt, and I haven't been walking during the night. And umn,
 21 going along with it I just feel sort of nervous on and (word)
 22 on and off. Loss of appetite at times, frequent urination...
 23 tired. I (words, very softly), and umn, oh. Occasionally I
 24 get this very itchy feeling on my skin when I take my clothes
 25 off. Whether that's due to some kind of nerves or not, I
 26 don't know. And even last week I felt I was hyperventilating

27 a little bit, which uh, stopped after a few minutes, but I
 → 28 D: [You know enough

The doctor interrupts in line 28 in order to move on with the diagnosis. He does not allow the patient to finish her story. However, in the context of the whole conversation, the doctor had allowed the patient a reasonably long turn, enabling the patient to express her ideas. Hence, this particular interaction is only slightly asymmetrical. Other interruptions can be seen in lines 184-192:

184 P: Okay, but what do I do about this feeling, you know?
 185 I've got
 → 186 D: [Ignore it
 187 P: [No, I can't, I mean I'm
 → 188 D: [I have no way of treating you. My answer to you is very
 189 simple. Rest and Bufferin if you want it, or ignore it, or
 190 a hot sauna, or a hot bath, or stay in bed all day, but I
 191 don't find anything organic, I mean (word)
 192 P: Well is there some kind of sedative or tranquilizer you can give me?

In line 186, the interruption can be seen as overlapping speech that answers the patient's question in line 184. However, the doctor again interrupts in line 188 to negate the patient's protests. But the patient then also uses interruption, in line 200 and in line 206.

197 D: You don't need that. Why should you need it? Why should
 198 you need it? You are a very healthy person, with
 199 very normal reactions. They'd be very, it would be
 → 200 P: [You're not making me happy
 201 D: [No, I'm not. Because I know you're pushing me to a tranquilizer
 202 and I don't want you to have one.
 203 P: Well, I don't want to be dependent on one either but I
 204 D: [All right.
 205 Then you and I are talking the same language...
 → 206 P: [But I don't, but

208 P: If I'm stuck one day, and really need one, I want to be
209 Able to have one.

Thus, both doctor and patient interrupt and show a right to take the floor away from the other within the conversation. On the doctor's part, this promotes asymmetry within the conversation. On the patient's part, this promotes symmetry within the conversation, thereby redressing some of the overall asymmetry in the encounter.

4.2.6 Asymmetry and Symmetry of Topic Change

When the doctor controls the topic and topic change, he promotes asymmetry. However, if he makes a gradual topic change, through links or minimal links, he promotes less asymmetry than when he makes an abrupt topic change. When the patient controls the topic and topic change, she promotes symmetry. As noted above, both the doctor and patient use interruptions, which are unilateral topic changes, to change the topic towards their own agenda. With regard to topic control, initially, the doctor allows the patient to tell her story, thereby promoting symmetry in topic development at the beginning of the encounter. Hyden and Mishler (1999) write that "Allowing patients to tell their story breaks free of medical conceptions of illness." These medical conceptions of illness contribute to an imbalance of power in the medical encounter, in that the patient's view, or the "lifeworld" view, is treated as if it were less important than the biomedical view. In addition, in this sample the patient herself initiates topic change. In lines 184 and 192 (excerpted above), she uses the minimal links "Okay" and "Well" to change the topic to her concerns with her feelings and her need for tranquilizers. These minimal links are a more egalitarianism way of changing the topic than abrupt topic changes. But again, the patient at least claims the right to change the topic.

This sample also shows a good example of reciprocal topic-changing activities. Reciprocal activities occur through a closing down of activity by each speaker; a summary or assessment of the topic-in-progress where the other party affirms that summary or assessment; or an arrangement to change topic with an agreement about topic change by the next speaker (Ainsworth-Vaughn 1998). Lines 33 through 38 show reciprocal activity in that the doctor summarizes the problem and the patient agrees (implicitly).

- 33 D: You have a pretty good insight, huh? Haven't you?
34 P: Well.
35 D: Hmm?
→ 36 P: Insight into what?
→ 37 D: Your story that you give me almost gives the answer with
→ 38 it, doesn't it?
→ 39 P: What I'm going through a housewife syndrome?

Also, in lines 192 through 210, although the doctor and the patient don't totally agree, there is an arrangement by the doctor to prescribe tranquilizers and an agreement by the patient on future action in using them.

- 192 P: Well is there some kind of sedative or tranquilizer you
193 can give me? I mean I sometimes feel really really nervous
194 and want something that'll settle me down. And I feel that
195 if I take a drink, which you know, you would think would
196 pep me up, it works the opposite way.
- 197 D: You don't need that. Why should you need it? Why should
198 you need it? You are a very healthy person, with
199 very normal reactions. They'd be very, it would be
[
200 P: You're not making me happy
201 D: No, I'm not. Because I know you're pushing me to a
202 tranquilizer and I don't want you to have one.
203 P: Well, I don't want to be dependent on one either but I
[
204 D: All right.

In line 99, the doctor uses anaphora to repeat the patient's concerns about her achiness, "it," and ratify her need to understand by asking what she thinks "it" is. Also, in line 204, the doctor repeats and ratifies the patient's remarks. In line 209, the doctor repeats the patient's concerns about the pill, "it," and ratifies the patient by going along with the patient's wishes.

- 205 Then you and I are talking the same language...
[
206 P: But I don't, but
→ 207 If I'm stuck one day, and really need one, I want to be
208 able to have one.
→ 209 D; All right. If you're gonna use it very sparingly, and under
210 stand that it isn't going to cure any of your problems.

The patient repeats the doctor's words in answering his questions, but she often does not ratify what the doctor says. For example, in lines 89-91, the patient repeats the doctor's idea of "stopping" but she does not agree with the idea.

- 89 D: Then why don't you stop.
90 P: Okay, so I stop, but I still feel tired now. You know what
I mean?

An interesting piece of non-repetition can be found in lines 75-80.

- 75 D: And what you have to learn is something that you learned many years ago,
76 that is how to say no. Because once there's a willing worker, you then,
77 starting from Welcome Wagon on,
→ 78 P: Hm Hmm.
79 D: All sorts of religious, political and social groups are just going to be
knocking on your door.

The patient ratifies the doctor by agreeing with him in line 78. However, she does not repeat his ideas, instead giving a vague "Hm Hmmm." We find later that the patient was probably only politely agreeing and did not really agree. It would seem that when ratifying, some corresponding repetition is more likely to show honest agreement.

These examples thus show how repetition and ratification of each speaker's discourse can promote asymmetry or symmetry within a conversation. When the doctor and patient repeat one another (without ratifying), they do stay on topic, promoting symmetry with the other speaker, even though they do not agree.

4.2.8 Asymmetry and Symmetry of Directives

When the doctor uses directives, he promotes asymmetry. When the patient uses directives, she promotes symmetry. In lines 12, 148, and 188-190, the doctor uses imperatives, which claim the right to direct the patient.

12 D: Talk to me. Why are you here?

148 D: Or just too much. Sit down.

188 D: I have no way of treating you. My answer to you is very
189 simple. Rest and Bufferin if you want it, or ignore it, or
190 a hot sauna, or a hot bath, or stay in bed all day, but I
191 don't find anything organic, I mean (word)

In line 12, at the initial opening of the encounter, the doctor uses the imperative, "Talk to me." In line 188, the doctor answers the patient's question with the imperative "Ignore it" and furthermore directs her again in line 190 with the imperative to "...stay in bed all day."

But the patient uses directives of her own. For example:

→ 85 P: Right. But I just need something now to, gimme a shot ((laughs))

Yet the doctor proposes what the patient wants in line 201, "I know you're pushing me to a tranquilizer," and asserts his authority with "and I don't want you to have one." In line 192, the patient uses a permission request to ask "Is there some kind of sedative or tranquilizer you can give me" thereby giving authority to the doctor. However, as previously mentioned, she also claims some authority by asking the doctor for medicine.

In line 209, the doctor uses a permission provision, thereby displaying his power in the interaction. In line 209, the doctor gives the patient permission to use the tranquilizers “if you're gonna use it very sparingly, and understand that it isn't going to cure any of your problems.”

Finally, another form of directive used is that of false collaboratives. False collaboratives promote asymmetry by proposing joint collaboration when the actual action is taken by one person. For example, in lines 29, 33, 37, and 205, the doctor says:

29 D: You know enough about that

33 D: You have a pretty good insight, huh?

37 D: Your story that you give me almost gives the answer.

205 D: Then you and I are talking same language

These statements all imply that the patient has authority, whereas the ultimate authority rests with the doctor. However, the patient's authority is shown when the doctor gives in to the patient's request for the use of the tranquilizer. With regard to directives, then, different kinds of directives, like different mechanisms of topic change, produce different claims to power within the encounter. In this sample, the doctor promotes asymmetry in directives by using imperatives and other directives to propose authority over the patient and false collaboratives to pretend the patient has authority. But the patient also uses directives to tell the doctor what she needs to cure her problem, thereby promoting some degree of symmetry.

4.2.9 Asymmetry, Symmetry, and Politeness

In this sample, the doctor and patient could be agreeing with each other only out of deference on the patient's part and “simulated egalitarianism” on the doctor's part.

Line 78 shows the patient agreeing with the doctor, but then later her question in line 184 proposes that she possibly did not agree with the doctor's suggestions.

- 75 D: And what you have to learn is something that you learned many
76 years ago, that is how to say no. Because once there's a
77 willing worker, you then, starting from Welcome Wagon on,
→ 78 P: Hm Hmm.
- 184 P: Okay, but what do I do about this feeling, you know?
185 I've got
[
186 D: Ignore it

Thus, the initial agreement may have been only appearance and may have been due to politeness constraints; the patient may have been agreeing because she was deferring to the doctor and did not want to contradict him. Thus, she promotes asymmetry in the conversation because the patient's real opinion is not heard.

4.2.10 Asymmetry and Symmetry of Medical View

When the doctor and patient rely on the medical view for diagnosis and treatment, some asymmetry is promoted as the doctor holds the authority in this arena. When the lifeworld plays a part in the diagnosis of the encounter, symmetry is promoted because the patient's life contexts are heard. In this sample, the patient is unsure about what is causing pain, a cold or nerves. She owns the information about her own body and life but lacks knowledge about what is more important, namely, the diagnosis. The doctor owns and can give that knowledge, thereby promoting asymmetry within the interview. However, the doctor in this case does view contextual ("lifeworld") information as relevant and gives a diagnosis based on treating the contextual concerns. Thus, the doctor attempts to promote some symmetry between the biomedical world and the

patient's lifeworld. In this case, it is the patient that ignores contextual solutions and proposes that the medical solutions are better

4.2.11 Asymmetry and Symmetry of Overall Encounter

The doctor promotes asymmetry by questioning the patient and by using directives. However, the patient's own questioning redresses the asymmetry caused by the doctor's questioning. Further, the use of interruptions, topic change, and repetition all show some degree of symmetry between doctor and patient. But, politeness constraints may compromise symmetry within the conversation as a whole. In the outcome of the encounter, although the doctor owns the ability to give or deny the patient the treatment she wants, i.e. a tranquilizer, he ultimately gives in to the patient's wishes, thereby promoting symmetry within this interview. One could hypothesize that the patient's class status allows her to buy the things she needs, with the patient viewing tranquilizers as merely another product that can help her out. Therefore, she asserts her rights as a patient and consumer to negotiate the purchase of the product she wants, allowing more symmetry within the encounter, because she has input into the treatment that the doctor prescribes. However, because she is demanding medication, she is, in effect, buying into the biomedical model of the doctor's world.

4.3 Sample 3

This sample involves a patient suffering from a cold that turns out to be bronchitis. The patient is a 62-year old white man who has a high school education and is married with 3 children. The doctor is a 43-year-old white male. This is the first visit between doctor and patient. The doctor diagnoses the patient with bronchitis. He also

diagnoses the patient with “alcoholism in remission” (Waitzkin, 1991:191). The doctor’s treatment is a shot of penicillin and oral penicillin pills.

4.3.1 Asymmetry and Symmetry of Context

Besides the asymmetry of the doctor-patient relationship, this encounter involves race-based asymmetry; the patient is a 52-year old white male, the doctor a 43-year old white male. Contextually, there is asymmetry between the doctor and patient in terms of socioeconomic status, white collar to blue-collar worker. However, both doctor and patient are male and white, enabling gender and racial symmetry. These contextual factors promote a large amount of high-level asymmetry within the encounter.

4.3.2 Asymmetry and Symmetry of Medical/Technical Terms

In this sample, the doctor uses medical terms in presenting the diagnosis. For example, in lines 111-122:

- 111 D: bronchitis. It’s not productive of phlegm, which means,
- 112 this amount means you got an exudates, some secretions
- 113 down there in the lungs. You might heal this yourself.
- 114 Not everyone dies of these things obviously, before we
- 115 Invented antibiotics....

The doctor thus promotes asymmetry by using medical terms whereas the patient does not.

4.3.3 Asymmetry and Symmetry of Address Terms and Transition to Task

In line 8, the patient promotes symmetry both by introducing himself and by immediately making the transition to task. The patient states his problem without being asked.

- 8 P: I’m ... I have a .. started out with a bad cold

4.3.4 Asymmetry and Symmetry of Questioning

When the doctor questions the patient, he promotes asymmetry. If the patient does not ask questions of the doctor, the patient does not redress this asymmetry. After the patient starts out by stating his problem, the doctor then starts his questions, which are basic yes-no or one-word-answer questions. Furthermore, the doctor places an obstruction in the patient's mouth and continues his yes-no questioning. These actions claim more power than the typical questioning of a patient by a doctor because the patient cannot elaborate on his answers or express his ideas easily due to the obstruction in his mouth.

During the entire encounter, the patient asks only two questions, both information-seeking, in lines 31 and 172.

31 P: What do you mean by a teaspoon?

172 P: Now, startin' today? Or tomorrow?

Information-seeking questions by the patient claim some power by redressing some of the imbalance caused by the doctor's information-seeking questions. However, the patient does not question much. In fact, in lines 173-174, which occur at the end of the encounter, the doctor asks if the patient has any questions and the patient answers that he has none.

173 D: Tomorrow. The shot takes care of today. Have any questions?

→ 174 P: None whatsoever

Thus, the doctor promotes asymmetry by questioning the patient, even when he cannot freely answer. The patient does not try to redress this asymmetry by also asking questions.

4.3.5 Asymmetry and Symmetry of Interruptions

When the doctor interrupts, he promotes asymmetry. If the patient interrupts, he promotes symmetry. In line 93, the doctor interrupts the patient in order to finish the patient's sentence, thus claiming the right to speak for the patient.

92 P: But I only take it, Christmas time, you know...
→ 93 D: [On the wet
→ 94 times of the year.

And, in lines 124-130, the patient would like to explain why he shouldn't quit smoking but the doctor continues on with his own idea, claiming the right to speak over the patient by interrupting and finishing the patient's ideas.

124 D: Incidentally, doctors will probably tell you to stop smoking
125 all the time. I'm..I'm not sure you should. Let me tell
126 you why.
127 P: I'm going to tell you why
128 D: Well, you tell me.
129 P: I quit drinking, and I got..
→ 130 D: That's enough.

The patient does interrupt the doctor once in order to explain himself, in lines 83-85.

83 D: Good for you. That's marvelous. But you don't..
→ 84 P: [Of course
→ 85 I take Antabuse itself every once in awhile.

Most of the other simultaneous speech can be seen as overlapping speech by the doctor or patient. For example, the doctor overlaps with the patient in lines 143-145.

142 P: Well my dad said, "Gee," this is about a year, year and a
143 half after I
→ 144 D: [Tell me.
145 [stopped drinking, he was in his late 80's, he said "Now

The patient's speech overlaps the doctor's speech in lines 161-164

161 D: Stand up and lean over. I'll give you this in the
162 butt. Lean over the
→ 163 P: [OK

So, the doctor promotes asymmetry by interrupting the patient in order to finish the patient's sentence. The patient only interrupts once, therefore not redressing much of the asymmetry that was caused by the doctor's interruption.

4.3.6 Asymmetry and Symmetry of Topic Change

When the doctor controls the topic and topic changes, he promotes asymmetry. When the patient changes the topic, he promotes symmetry. The doctor controls the topic from lines 1-77. Then, from lines 77-105 the patient, and, to some extent, the doctor, stay on the patient's topic of the patient's alcoholism and subsequent treatment at a clinic. Thus, the patient claims some power by keeping to his own topic. The doctor does change the topic, somewhat unilaterally, in lines 105 by going back to the topic that was under discussion when the patient and doctor started talking about the patient's alcoholism. The doctor's topic change claims power because it is a sudden topic change by the doctor, proposing the right to control the subject.

104 D: And it has turned better, hasn't it?
105 P: Beautiful, beautiful.
→ 106 D: No allergies to penicillin specifically?

In lines 139-140, the patient again tells a side-story about other people's remonstrations to quit smoking. However, the patient only tells the story after he is given the go-ahead to tell it by the doctor. Thus, the topic change is achieved through links by the patient from one topic to the other and does not claim as much power for the patient as a more unilateral topic shift might have claimed.

- 136 D: It's just a little too much of a burden on you to stop
 137 alcohol and tobacco. So let me be one doctor to tell you
 → 138 that you probably ought to keep smoking
 → 139 P: No, no. This is a (words).
 → 140 D: That's all right. No, I don't know; this is confidential.
 141 Go ahead.

Thus, although the doctor mainly controls the topic, the patient does bring some of his story into the encounter. However, when the doctor changes topics, as in line 105, he does so abruptly, promoting more asymmetry in the method of topic change than the patient's gradual method of topic change in lines 139-140.

4.3.7 Asymmetry and Symmetry of Repetition

When the doctor repeats and ratifies the patient's words, he promotes symmetry. When the patient repeats and ratifies the doctor's words, he promotes asymmetry. The patient repeats and ratifies almost all of the doctor's questions. The only time the patient does not repeat and ratify the doctor's statement is in lines 124-127 (cited above), when the patient wants to tell the reason he shouldn't quit smoking. The doctor does acknowledge the patient. For example, in lines 79-81, the doctor repeats and ratifies the patient and the patient's topic of alcoholism and quitting smoking.

- 79 P: I'm an alcoholic.
 → 80 D: Oh, Good for you, in the sense that you were a former
 81 alcoholic? Do you still drink?

Thus, the doctor promotes some symmetry in repeating the patient's words. The patient promotes asymmetry by repeating and ratifying the doctor's statements all but once.

4.3.8 Asymmetry and Symmetry of Directives

When the doctor uses directives, he promotes asymmetry. If the patient uses directives, he promotes symmetry. In lines 11, 39, 161, and 168, the doctor uses imperatives that claim a significant amount of power. These imperatives direct action

towards finding and curing the patient's problem, but the doctor claims power by directly demanding authority over the patient's actions.

11 D: Take off your shirt.

39 D: Mouth open, take deep breaths...deeper...all right,

161 D: Stand up and lean over. I'll give you this in the
162 butt. Lean over the

168 D: And don't take any more pills if
169 it starts that way.

Furthermore, the doctor directs the patient to answer questions while holding an obstruction (thermometer) in his mouth.

43 D: I'll ask you some yes and no questions that you can answer
44 D: with your mouth...occupied? Do you smoke?

In line 15, the doctor tells the patient what the patient wants.

15 D: Well, you're here to enjoy yourself, not to have a cold.

Furthermore, during the diagnosis, the doctor tells the patient that he is going to give him a shot, as opposed to asking or discussing this solution with the patient.

→ 119 D: ...And I'm
120 going to start you off with a shot which is a quick way to
121 do it, and then I'll have you follow it up over a period of
122 time with pills.
123 P: OK

Likewise, the doctor tells the patient what the patient will do:

→ 169 it starts that way. Now this shot takes care of today. You
170 can get dressed..we'll give you a prescription for some
171 medicine you will take for 6 more days after this.

And, the doctor continues with more imperatives directing his treatment.

175 D: Take it easy today...

178 D: you can do anything you want to do.

184 D: All right. Do it. But don't do it all tomorrow. Do it
185 slowly....All

Thus, the doctor promotes asymmetry by using imperatives to direct diagnosis and treatment. The patient exacerbates the asymmetry by simply agreeing with the doctor's commands. Thus, the patient does not take part in determining and understanding his treatment, leaving it all to the doctor's authority.

4.3.9 Asymmetry, Symmetry, and Politeness

Politeness may be the reason for the appearance of some of the symmetry in this encounter. The doctor may be only showing deference by listening to the patient's story about the people who helped him cure his alcoholism and those who laughed at his attempts to contain his disease. If so, the doctor may not promote much real symmetry in the encounter. However, even if the doctor does listen out of deference, allowing the patient to speak allows more of the patient's history and "lifeworld" to enter the encounter, thus allowing some symmetry in the contributions by the doctor and the patient.

4.3.10 Asymmetry and Symmetry of Medical View

When the doctor and patient rely on the medical view for diagnosis and treatment, asymmetry is promoted. When the "lifeworld" plays a part in the encounter, symmetry is promoted. Both the doctor and patient see both the patient's past problem, alcoholism, and current problem, bronchitis, as mainly due to biomedical causes instead of problems in the "lifeworld" of the patient. The ways in which the patient may have exacerbated a cold into bronchitis are not explored, thereby giving the doctor and the medical view authority. For example, perhaps the patient overworked himself in cold weather right up to the point he was to leave on vacation. This could have contributed to his illness and

awareness of this fact could lead both doctor and patient to caution against this kind of activity in the future. Also, possibilities of prevention and cures within the “lifeworld” would promote some symmetry in the encounter because the patient would have more agency in helping with prevention, diagnosis, and cure.

4.3.11 Asymmetry and Symmetry of Overall Encounter

The doctor promotes asymmetry through questioning, topic control, and directives and the patient further promotes this asymmetry by answering, repeating, and ratifying almost everything the doctor asks or directs. Politeness and the medical view also constrain symmetry and promote more asymmetry. Again, this asymmetry may reflect some of the contextual aspects of the interview, such as the higher social status of the doctor. Also socioeconomic and educational differences between a white-collar doctor and a blue-collar worker may exacerbate the patient’s feeling of relative powerlessness; thus, the patient may feel unable to question, change topics, or not follow the doctor’s directives.

4.4 Sample 4

This sample involves a woman who is coming to the doctor for a follow-up appointment and suffering from muscle disease and psychological distress. The patient is a 62-year old woman who is a high school and secretarial school graduate, and mother of 3 adult children, 1 of whom is retarded. The doctor is a 44-year old white male. The doctor and patient have had a doctor-patient relationship for 1 year and meet in a suburban office. The doctor’s diagnosis is muscle disease and “cortisone reaction.” The doctor takes the patient’s suggestion to prescribe her a different drug prescription.

4.4.1 Asymmetry and Symmetry of Context

Besides the asymmetry of the doctor-patient relationship, this encounter involves gender asymmetry: the patient is a woman and the doctor is a man. But, the doctor and patient are both white and could possibly be on the same socioeconomic level. Also, the patient is senior in age to the doctor, 62 years old as compared to 44; therefore the patient has a higher age, which can promote symmetry or asymmetry depending on both the doctor's and patient's personal views of age. The doctor and patient have known each other for a year so some of the asymmetry that otherwise could be operative may be offset by familiarity. These contextual factors promote some symmetry within the encounter.

4.4.2 Asymmetry and Symmetry of Medical/Technical Terms

The doctor uses the medical jargon that is part of his profession: in lines 55-56 (“adrenal gland”), lines 79-80 and 84-84 (“adrenal dysfunction, muscle disease”), line 260 (“blood pressure”), and line 343 (“methylprednisolone”). As one might expect, the patient has trouble with one of these medical terms, thus promoting some asymmetry in the use of the encounter.

343 D: Uh, you can take three of the methylprednisolone also, but um
344 if you feel you're not doing well, maybe you call me first and
345 we'd talk over what you should do.
→ 346 P: OK. I can't say that so well, now.

However, the patient's use of some medical terms helps to redress some asymmetry. In line 2, the patient uses a technical term when asking for the medicine she wants:

2: P: Just give me permission to take two Decadron a day. I can't
go on with one.

She also questions a blood pressure reading (line 261), thereby participating more fully in the medical encounter.

261 P: You call that fine, a hundred forty was it over eighty-six?

Thus, there is some asymmetry in the use of medical terms, but the patient redresses some of this asymmetry through her own use and understanding of some of the medical terms.

4.4.3 Asymmetry and Symmetry of Address Terms

In lines 59-61, the doctor seems to use the term “we” to promote asymmetry; however, this interpretation can be questioned.

59 D: Sure, but your, you see, when we give you the Decadron we're
60 giving you, we're treating a disease, we're not just keeping it
61 at a normal level. We're giving you big levels of cortisone.

The doctor could be using “we” to say that both he and the patient are treating the disease together. Or, he could be using “we” in the asymmetrical sense, saying that the doctor and patient together are using the medicine when in reality it is the doctor who feels like he is actually giving the medicine and treating the disease. It is therefore difficult to make a precise determination of whether asymmetry is promoted or redressed in the use of the address pronoun “we.”

4.4.4 Asymmetry and Symmetry of Transition to Task and Questioning

When the doctor questions the patient, he promotes asymmetry. When the patient questions the doctor, she promotes symmetry. In this sample, the patient takes charge of the encounter and immediately asks for more medicine. By making a request, this patient promotes symmetry right at the start of the encounter.

2 P: Just give me permission to take two Decadron a day. I can't go on with one.

When the patient starts the encounter off with a request, the doctor does not immediately start his questioning. The doctor's typical information-seeking questions start in line 25 and claim power at that point.

- 25 D: when, when we're, uhm, while we're talking about the Decadron
→ 26 let me ask you one other thing and that is, you remember you
→ 27 were taking two tablets every other day.
28: P: And you changed it to one a day.
→ 29: Right. Now are you just as bad? Worse? Better? Does
30: [I'm
31: worse, it's getting worse the longer time (words)
→ 32: D: So it's worse on one tablet a day.
33: P: Because it's like more length of time, you see, it's two and
34: a half months since I was on two a day.
→ 35: D: You mean two every other day.
36: P: No.
→ 37: D: Oh, you mean back when you were taking two a day? Yeah.
38: P: [when I was back when I was taking two a day.
39 That seems to be it, now, whether it shortens the lifespan
41 or not, I'm going to take a chance.

But, the patient also claims power by questioning the doctor, in an information-seeking way. For example, in lines 21, 62, and 66:

21: P Have you got a stronger one, they're no good.

62 P: That's a big level?

66: P: What are you treating, the inflammation?

The patient further questions the doctor in lines 48, 68, 119, 122-123, and 261. These numerous questions by the patient also claim a high degree of power due to the content of the question; the patient is questioning the diagnosis, or word, of the doctor. Further, the sheer number of the questions asked by the patient promotes symmetry in the conversation.

45 D: Well, uhm, you know there's another possibility and that is,

- 46 uh, rather than taking two every day, you can try three
 47 every day.
- 48: P: What would be the point of that?
- 66 P: What are you treating, the inflammation?
 67 D: Yeah.
- 68: P: Why don't we skip that and just stick to the gland? Let's get
 69 that straightened out.
- 116 D: Sure. But don't you see that the only way to get around that
 117 is to get off Decadron or get on a dosage of Decadron that isn't
 118 uh, too large.
- 119 P: Wouldn't three every other day be larger than—
- 122 P: one day (words) functioning
 → 123 in one day?
- 260: D: Well, your blood pressure's always been fine.
 → 261: P: You call that fine, a hundred forty was it over eighty-six.

Thus, although the doctor questions the patient for information, the patient promotes a lot of symmetry by also seeking information and by questioning the information she is given.

4.4.5 Asymmetry and Symmetry of Interruptions

When the doctor interrupts, the doctor promotes asymmetry. If the patient interrupts, she promotes symmetry. Also, if the patient continues her line of speech after the doctor has interrupted, she promotes symmetry. For example, the doctor interrupts in lines 3-5. But in line 5, the patient continues her line of speech.

- 2 P: Just give me permission to take two Decadron a day. I can't
 3 P: go on with one.
- 4 D: [I'll
 5 P: [I'm half dead most of the time.

In line 83, the doctor again interrupts.

- 82 P: You should know of course. But
 → 83 D: [Well, you haven't had a- nobody was treating adrenal disease

- 84 in you, ever.
 85 P: No, it started treating the muscles, of course-
 → 86 D: Fine.
 87 P: But the adrenal then works on, I mean the Decadron then works
 88 on the adrenal, which stops that from functioning.

And again, the patient keeps to her line of thinking instead of letting the doctor's interruption change her subject. A similar example is in lines 218-221 (not shown).

The patient also abruptly interrupts the doctor's speech several times. For example, in lines 49-51, the patient interrupts to finish the doctor's idea.

- 49 D: Well, it's the same point as every other day therapy in
 50 general. You remember we went through
 []
 → 51 P: Yeah you were trying to get them

This move claims power because the patient proposes the right to finish the doctor's contribution. And, in lines 120-123, the patient interrupts in order to negate what the doctor is saying, claiming the right to express her opinion within the medical encounter.

- 120 D: Well, but the point of every other day therapy is that it
 121 allows your own adrenal gland to keep functioning.
 []
 → 122 P: one day (words) functioning
 → 123 P in one day?

In lines 138-141, the patient interrupts in order to interject an opinion about changing medicines, thereby delving into the doctor's area of expertise.

- 138 D: If, yeah, if you had recently been on ah Decadron to the point
 139 that your own adrenal had been suppressed
 []
 → 140 P: Are you, T---, do you think it makes any difference, is it
 141 time to change brands so to speak.

Thus, the doctor and patient both use interruptions in order to interject their own ideas or negate or question the other's ideas. The doctor's interruptions promote asymmetry and the patient's interruptions help to redress some of this asymmetry.

4.4.6 Asymmetry and Symmetry of Topic Change

When the doctor controls the topic and topic change, he promotes asymmetry. When the patient changes topic, she promotes symmetry. The patient starts off on the topic of her medication and the doctor takes over the topic from there. In line 23, when the patient tries to change the topic to the subject of her mental state, the doctor claims power by continuing with the questioning about the medication.

- 22 D: Uh huh, well, uh
23 P: I'm really in a state, I'm in a mental state, there's no doubt
24 about it.
→ 25 D: When, when we're uhm, while we're talking about the Decadron
→ 26 let me ask you one other thing and that is, you remember you
→ 27 were taking two tablets every other day.

In line 68, the patient abruptly changes to the subject of her glands, claiming power by making a unilateral topic change to switch to her own ideas.

- 66 P: What are you treating, the inflammation?
67 D: Yeah.
→ 68 P: Why don't we skip that and just stick to the gland? Let's get
→ 69 that straightened out.

The patient continually talks about the possibility of problems with her adrenal gland, despite the fact that the doctor does not agree that there are problems in her adrenal gland. Even though the doctor appears to be right, the patient still promotes symmetry by continuing on her line of topic until her questioning is satisfied. The topic then continues on the subject of adrenal issues and the proper drug therapy. In line 206, the patient abruptly switches the topic again, expressing her own ideas and asking questions.

- 203 D: Uh, you can use it every day, too, if we get back in that
204 difficulty about, uh, what we're striving to do is of course
205 every other day.
→ 206 P: Have you ever thought, did you, that possibly I was born
→ 207 with that, problem.

The patient switches the topic again, in line 251, to her own and her son's blood pressure.

- 248 P: but, uh, even so. Now, well that's why I ask some of these
249 questions. That's always in the back of my mind.
250 D: Yeah.
→ 251 P: So, I hope the blood pressure's down.

Eventually, the doctor changes the topic, using a minimal link, and then a strong link, to transition back to the topic of medication. This type of topic change acknowledges the patient even though it closes down the patient's topic.

- 266 D: pressures of a hundred fifty, but even that isn't really high.
267 P: I think it ought to be down, however.
→ 268 D: Well, [OK, uh, let's weigh you
269 and then uh, we'll check your blood pressure, and we will be
270 changing your Decadron to Medrol, it's a methylprednisone.

The patient then shifts the topic to talk of a psychiatrist and her eye problems and then finally the doctor gets back to checking her weight and talking about medication. In line 390, the patient again abruptly changes back to the blood pressure topic, asserting her right to change the topic unilaterally.

- 388 P: OK. Oh, I think that was all I had in mind.
389 D: OK.
→ 390 P: Long as the blood pressure stays down there.

So, the doctor and patient promote symmetry in topic control and topic change because the doctor links his topic changes to the patient's contributions and the patient makes topic changes, asserting her right to speak and introduce topics within the conversation.

4.4.7 Asymmetry and Symmetry of Repetition

When the doctor repeats and ratifies the patient's words, he promotes symmetry. When the patient repeats and/or ratifies the doctor's words, she promotes asymmetry. If either repeat but do not ratify the other, they promote less symmetry or asymmetry than if

they did ratify the other. In this sample, the doctor repeats what the patient says by following and answering her questions. Sometimes the doctor repeats and answers the patient but does not ratify what she has to say. For example, in line 119-121, the doctor answers the question but does not ratify the patient's point of view.

- 119 P: Wouldn't three every other day be larger than-
→ 120 D: Well, but the point of every other day therapy is that it
121 allows your own adrenal gland to keep functioning.

The doctor's non-ratification claims some power as he has the authoritative medical opinion on the matter. This medical authority is part of the nature of the encounter--to come to a medical expert in order to diagnose, understand, and treat a problem.

Sometimes, however, the doctor promotes repeats and ratifies what the patient says with regard to treatment options. For example, in line 188, the doctor repeats and ratifies the patient's suggestion to use different medication (from line 140-141).

- 188 D: to produce that state of affairs. But your point about a
→ 189 different drug, uh, is is, uh, a good one, particularly if we
190 going to try every other day, uh, uh.

The patient's idea is taken in and used for the diagnosis, a move by the doctor that gives the patient power. Throughout the encounter, the patient answers the doctor's questions but often does not ratify what the doctor says. For example, in lines 9-10:

- 9 D: Uhm how much Decadron are you taking?
→ 10 P: One. Can't do it though, Hm.

In lines 51-54 (not shown), 71, 80, and 106, the patient also repeats but does not ratify what the doctor says.

- 70 D: Well, there's nothing wrong with your adrenal, you see.
→ 71 P: Isn't working

78 D: You see, no, it's not a question of that. Your trouble is
79 your muscle disease, right?

→ 80 P: I don't think so.

104 D: You have muscle disease. If you, if you didn't have
105 muscle disease then we'd stop your Decadron.

→ 106 P: And we'd have, still have no ambition, and stuff. ...

Thus, the doctor promotes symmetry by repeating and sometimes even ratifying the patient's questions and ideas. The patient promotes symmetry by not ratifying everything the doctor says.

4.4.8 Asymmetry and Symmetry of Directives

When the doctor uses directives, he promotes asymmetry. If the patient uses some directives, she promotes symmetry. In lines 204 and 367, the doctor uses imperatives that propose authority over the patient's wishes and the patient's actions.

204 D: ... what we're striving to do is of course
205 every other day.

367 D: I know, uh, what we got to do is get you feeling better, and

In line, 370, the doctor uses a mitigated imperative, claiming power but not as much as a baldfaced imperative would claim.

370 D: Call me next week, anyhow, if you would, and let me know

The only time the doctor uses a baldfaced imperative is in line 387.

387 Stick to the amitriptyline at the moment.

Thus, the doctor does use some directives that promote asymmetry; however, he does not use a lot of directives and some of them are mitigated in their use. The patient does not use any directives.

4.4.9 Asymmetry, Symmetry, and Politeness

The patient is suffering a lot of stress in her personal life; this may be causing or exacerbating some of her physical problems. The doctor does not elaborate on possible

personal changes or cures for these problems. He may not propose possible personal remedies out of deference. He may be drawing a line between business, i.e. medical concerns, and personal, or “lifeworld,” concerns. However, this type of deference promotes asymmetry because the “lifeworld” is ignored as a means to help further healing.

4.4.10 Asymmetry and Symmetry of Medical View

In this sample, “medical science explains the patient’s experience mainly as a psychologic manifestation of physical disease and medication toxicity” (Waitzkin, 1991: 226). The medical view and the doctor’s authority take precedence in the cure. But, the patient participates in this world by knowing the medications and suggesting different solutions for medical interventions in her illness, promoting some symmetry within the medical encounter.

4.4.11 Asymmetry and Symmetry of Overall Encounter

In this encounter, the doctor promotes asymmetry through questioning and directives but the patient promotes much symmetry by using medical terminology, questioning the doctor, repeating but not ratifying the doctor’s ideas, and changing the topic to express her own thoughts and ideas. This assertiveness may be a reflection of a full lifetime of dealing with doctors, for herself, and for her retarded son. This assertiveness may help with her satisfaction with the interview and willingness to make another appointment (lines 420-428) and to continue her relationship with the doctor.

5. CONCLUSIONS

In this chapter, I discuss the results of my analysis and draw some conclusions from my research and analysis. I also address areas for further research.

5.1 Summary of Analyses

	Sample 1	Sample 2	Sample 3	Sample 4
Medical Terms	N/A	N/A	D: Asym P: Asym	D: Asym P: Sym
Transition to Task	N/A	D: Asym P: Asym	D: Sym P: Sym	D: Sym P: Sym
Questions	D: Asym P: Asym	D: Asym- P: Sym+	D: Asym P: Asym-	D: Asym P: Sym+
Interruptions	D: Asym P: Sym-	D: Asym P: Sym	D: Asym P: Asym-	D: Sym P: Sym
Topic Control and Change	D: Asym+ P: Sym-	D: Asym- P: Sym	D: Asym+ P: Sym-	D: Sym P: Sym
Directives	D: Asym+ P: Asym	D: Asym P: Sym	D: Asym P: Asym	D: Sym P: Asym
Repetition	D: Sym P: Asym	D: Asym P: Sym	D: Sym- P: Sym	D: Sym P: Sym
Politeness/Sociability	D: Asym P: Asym	D: Asym P: Asym	D: Asym P: Asym	D: Asym P: Asym
Medical vs. Lifeworld View	D: Sym. P: Asym+	D: Sym+ P: Asym	D: Asym P: Asym	D: Asym P: Asym
Overall	Asym+	Asym-	Asym+	Sym-

Table 5.1 Summary of Analyses

In Table 5.1, I have labeled each of the discourse moves discussed in this study as asymmetrical or symmetrical. The labels reflect whether, within the entire conversation, the doctor or patient used the moves to promote asymmetry or symmetry. A “+” or a “-” indicate whether the participant promoted a high or low degree of asymmetry or symmetry. These labels take into account how contextual matters and the use of the same discourse moves by the other participant affect asymmetry and symmetry. From a strictly quantitative view, it is difficult to gauge the amount of symmetry and asymmetry promoted by each discourse move, even with all known contextual factors taken into

account. However, I propose some hypotheses about each move's effect within the entire conversation, suggesting ways in which the overall use of this discourse move affects asymmetry or symmetry in the encounter.

In Table 5.1, I have also attempted to label the overall encounter as more asymmetrical than symmetrical or more symmetrical than asymmetrical. In providing these designations, I had to conjecture how much the use of each discourse move affected the overall conversation. This type of deduction is mainly interpretive guesswork. But I also consider the overall influence of doctor and patient within the diagnosis and treatment. For example, in Samples 1 and 3, the results of the encounters, diagnosis and treatment, were mainly determined by the doctor without much input from the patients. In Samples 2 and 4, the patients had input into the diagnosis and the treatment. As I discussed in Chapter 2, these results affect patient compliance, satisfaction, and, ultimately, patient health.

Within the entire conversation, then, there are many different moves that promote and redress asymmetry. If a researcher looks at only one move and how it is used within the conversation and oriented towards the outcome of the encounter, the analysis ignores the effect that other moves may have on total asymmetry or symmetry. The discourse moves in themselves become another contextual factor within the conversation. For example, if the doctor asks all the questions within the conversation but the patient interrupts all of the questions that the doctor asks in order to change the topic, the asymmetry of control by the doctor's questioning is somewhat redressed by the patient's interruptions. To take as a concrete example of this phenomenon, in Sample 1, if one were to analyze only directives, one could see that the doctor uses them (albeit in

mitigated form) and the patient does not. Therefore, the conversation is asymmetrical as far as directives are concerned. However, the use of interruptions and topic change by the patient contribute to some overall symmetry in the conversation.

A closer look at the many discourse moves that promote or redress asymmetry thus yields some interesting insights with regard to the contextual aspects of the participants and how much asymmetry or symmetry is present in conversation. The asymmetry of each participant's place in society, in terms of sex, race, class, and age, is somewhat mirrored in the way the conversation is produced. The African American blue-collar man and the white blue-collar man of Samples 1 and 3 have less symmetrical conversations than the white, possibly upper class woman of Sample 2. Although the woman's gender may weaken her claim to power, her socioeconomic status seems to enable her to claim more power than the men. As both Waitzkin (1991:10) and Ainsworth-Vaughn (1998) write, it is "micropolitical" achievement. The anomaly in this deduction is the woman in Sample 4; she appears to be financially strained and furthermore, as a woman, has a lower status than the doctor. However, this woman still contributes much to make the conversation more symmetrical than it would be otherwise. One possible reason for this is a lifetime of constant interactions with figures of authority, such as doctors and institutional personnel. She may have learned to claim power over time. Thus, this exception may be an example of how, despite one's gender and socioeconomic status, one can learn to change the equilibrium of the doctor-patient conversation. We could extrapolate that this equilibrium may also be able to be obtained despite other contextual factors such as race and age.

From this multidimensional method of analysis, one thing becomes evident. There are a number of discourse moves that promote and redress asymmetry and also a number of contextual factors that determine whether a given move promotes or redresses asymmetry. In the following sections, I discuss the difficulties in analyzing power and discourse moves. Nevertheless, my analysis suggests possible strategies for a more egalitarian doctor-patient conversation.

5.2 Effect of Norms of Conversation Within the Medical Encounter

Particular types of conversations have particular norms that affect the way the participants speak (Ainsworth-Vaughn 1998). These norms affect the amount of asymmetry or symmetry promoted. Consequently, the “norms” muddy the interpretation of power within the encounter. In the medical encounter, questioning by the doctor is the norm. Because this questioning is expected in the medical interview, it may not promote as much asymmetry as one might expect. The doctor may not actually use the question as a means to claim power; rather it may be used as a tool of his trade, just as the teacher must claim the floor and lecture to a classroom. One must therefore take a closer look at the manner of questioning. Does the doctor question (as in Sample 3) while the patient’s speech is obstructed? Does the doctor ask only “yes,” “no,” or “one-word-answer” questions? These types of questions promote a high degree of asymmetry because the doctor does not leave the patient room to answer. The content of the question can further affect the amount of asymmetry promoted. For example, in Sample 3, if the doctor is asking questions that solicit the patient’s opinion, these questions may promote symmetry. But, in general, since the doctor’s questioning is the norm and is expected, the questioning in a medical encounter may not generate as much asymmetry as questioning in general.

Likewise, the medical encounter involves certain norms for topic sequences, which the doctor tends to control. For example, the doctor may direct the topic to determine a diagnosis and recommend treatment. Again, the method by which the topic change is accomplished affects the asymmetry; unilateral changes are the most asymmetrical. Also, other discourse moves, such as directives to sit down or to take off one's clothes, may be deemed as normal and central to the purpose of a medical encounter. However, if again we take a look at content, when directives are phrased as imperatives ("Sit down! "Take off your clothes!"), the directives claim more power and cause the patient to be more passive within the encounter in general. Thus, norms of questioning, topic control, and directives may not promote as much asymmetry or symmetry as they would in another context; but the manner in which they are used does help determine the power that they claim.

5.3 Inclusion of Contextual Matters

Another factor that makes interpretation difficult is the inability to surface all of the contextual matters relevant to interpretation. Even qualitative studies ignore context to some extent (Ainsworth-Vaughn 1998). In order to understand how much asymmetry a move promotes, before even one word is uttered, one must understand all of the contextual factors that influence high-level asymmetry. However, although it may be easy to know many of the contextual factors, such as race, gender, and education, other contextual factors may not be so evident. For instance, psychological issues can affect the interactional asymmetry. If a patient views the doctor as all-knowing and not-to-be-questioned, then this factor will contribute to the general asymmetry of the conversation and will be evident in the absence of questioning and other discourse moves that could promote symmetry. Samples 1 and 3 could be cases where the patients do not feel that

they have appropriate knowledge or the right to question. When the patient asks a question within this context, less symmetry is promoted because the differences in contextual power are so pronounced. Also, if the illness is debilitating or chronic, the patient may feel less personal power when entering the encounter, thus the symmetrical moves he or she might have used and the amount of symmetry promoted by the use of a given move. In order to understand exactly how much asymmetry or symmetry is promoted, one must take into account as many contextual matters as possible.

5.4 Effect of Content

As mentioned in section 5.2, another factor that affects interpretation is the content of a discourse move. In addition to bringing in contextual factors to analyze whether a move promotes or redresses asymmetry, we saw that one must also look at the content of the discourse move. For example, I showed where a doctor's questions may promote asymmetry due to their close-ended nature. Likewise, the patient's questions may not promote as much symmetry as possible due to the content of the patient's questions. If a patient is asking questions because he or she does not understand what the doctor says, less symmetry is promoted than if the patient is questioning the doctor's opinion. And, doctors may promote more asymmetry in interruptions if the interruptions are used to abruptly change the topic, instead of being used to understand what the patient is saying. This same point about content can be made for all of the discourse moves; the complexity of technical terms, the types of directives, the method of topic change, and the amount of deference shown towards the doctor and towards the medical view all depend on content for their effect on asymmetry or symmetry.

5.5 Possible Different Analyses and Outcomes

Due to the complications in analysis mentioned in 5.2 through 5.4, there can be misinterpretation vis-à-vis both the effects of discourse moves and the outcomes of conversations. First, there can be different ways to interpret discourse moves. For example, an observer may interpret something as a topic change when the participants would not view it as a topic change (Ainsworth-Vaughn 1998). Thus, in Sample 2, when the doctor asks the patient her opinion about the diagnosis (lines 33-38), he could be acting patronizingly instead of wanting and respecting her opinions and insight. Likewise, in Sample 1, when the doctor makes negative jokes towards the patient (lines 68-71 and 135-139), he could be trying to promote solidarity as opposed to flaunting power over the patient. Secondly, another effect of asymmetry in the conversation is that the outcome of the medical encounter could be different than what seems to occur. For example, in Sample 1, the patient was concerned about buying the neck brace. He may not have been able to afford it and may not have expressed this concern. He therefore might not buy the neck brace, thereby not completing the treatment as prescribed from the doctor. If he had felt that he could ask the doctor about cheaper alternatives and gain some advice, he might have had more satisfaction and possibly a better health outcome. Likewise in Sample 4, the woman may not agree and may not comply with the doctor's recommendations on the number of pills to take, or the type of medicine he has given her (because she does not know the medicine). This disagreement or misunderstanding may not have been heard due to some of the asymmetry in the conversation and the outcome would then not match the desired goal of patient compliance. Or, the patient's agreement to the doctor's prescription may have been made because of the asymmetry in medical knowledge. The patient may leave the office, research the prescription herself, and not

follow the doctor's diagnosis. Thus, lack of information about outcomes can hinder interpretation.

5.6 Gaining Symmetry in Doctor-Patient Conversations

In my analysis of the 4 samples, the samples do not show the same amount of symmetry or asymmetry in of each of the discourse moves. Therefore, these discourse moves can be used in different ways to produce medical encounters that are not interactionally asymmetrical. Below is a list of the discourse moves that could be used by doctors to redress asymmetry within the encounter.

1. Doctors could refrain as much as possible from using highly technical medical terms.
2. Doctors could leave conversation space for patient's questions and even ask for patient's questions.
3. Doctors could refrain from interrupting patient's speech.
4. Doctors could make topic changes in a more symmetrical way, with links or minimal links. Doctors could refrain from completely controlling the topic.
5. Doctors could couch directives in different terms, instead of using imperatives or other highly asymmetrical directives.

However, it takes two participants to generate the egalitarian conversation. What discourse moves can be used by patients to gain and balance power within an encounter?

1. Patients could ask questions, whether information-seeking or information-questioning.
2. Patients could make topic changes towards their concerns.
3. Patients could be more honest about agreement or disagreement.
4. Patients could bring into the conversation pertinent information from their "lifeworld" that would aid in diagnosis and treatment options.

However, if a doctor and a patient make these discourse moves towards equality in conversation, is the resultant conversation just some sort of simulated egalitarianism in that they are consciously “making moves” to promote symmetry as opposed to doing this at some basic level? And what is the effect of such “simulated egalitarianism?” These are interesting questions and are topics for further research.

5.7 Complications with Helping Patients Claim Power (Gain Symmetry)

Regardless of whether symmetrical discourse moves produce a simulated or real egalitarianism, there are still barriers that inhibit people from acting more symmetrically within a conversation. If one’s personal, social, and professional circumstances are “bases for power negotiation,” it then takes a change in perspective to change one’s interactions. For example, those patients who can afford private practice medical encounters may feel more right to claim power within the conversation. They are paying more of their own money and money is power. Those who participate in public health encounters may already have lower social prestige and need more to encourage them to gain equality in the conversation. Likewise, personal views about doctor-patient encounters can be hard to change. A patient may have an idealized view of the doctor’s Aesculapian power to cure all ills. Therefore, the patient may not feel the need or not want to participate equally in the doctor-patient conversation. The patient may not want to question the power of the physician. Furthermore, one may want the doctor to control everything and make all the decisions. Some patients want to be directed and told what to do. Direction is what some people want and expect from a doctor and for them, a doctor-controlled conversation gives them satisfaction with the medical encounter. Also, the patient may not want to bring the “lifeworld” into the encounter, either due to privacy issues, or because the patient may not feel that he or she can remedy anything in this

aspect of his or her life. Another variable that can have an effect on whether symmetry is promoted is the length of the relationship (Ainsworth-Vaughn 1998). With familiarity, the doctor may allow the patient more input and the patient may feel more comfortable in giving input towards diagnosis and treatment. Finally, the rules of the institution, such as those concerning patient consent, may play a part in how much symmetry is gained in reality.

5.8 Women Patients in This Study

As far as power and status are concerned, women, in general, have a lower status than men. Although not a statistically significant sample, the two women patients in this study do not act as submissive patients. They assert themselves through the various discourse means discussed above. Women have gained more power in the last few decades and these two samples may reflect some of this increased power within the way they interact in doctor-patient conversations. Or, conversely, perhaps women have gained more power by promoting more power in arenas such as the medical encounter. Further research with bigger samples could help clarify the above speculations. Perhaps as people of various ethnicities gain more power, they will also see more balance in the medical encounter. Or, perhaps, as they promote more power within areas such as medical encounters, they will gain more power. This paradigm could also hold true for people of lower socioeconomic status.

5.8 Differences between Men and Women Doctors

In the samples that I analyzed, there were no women doctors. Just as it is interesting to look at an individual's past history to determine what shaped his or her personality today, it is also interesting to think about how the larger number of men doctors compared to the number of women doctors may have shaped some of the

asymmetry in doctor-patient communication today. I have cited studies that showed how men use more asymmetrical discourse moves, such as directives and imperatives, than women. I have also cited studies and showed samples of how doctors use more asymmetrical discourse moves than patients. It could be that the greater number of men within the profession has shaped the manner in which doctors speak. Now that there are more women becoming doctors and practicing medicine, if these women speak in more egalitarian ways, perhaps doctors' speech will move towards symmetry with that of their patients.

5.9 Implications for Practice

My research, analysis, and conclusions have the following implications for general medical practice:

1. For doctors, implementation of the suggestions in Section 5.6 would require extra training.
2. For patients, implementation of the suggestions in Section 5.6 would require either the initiative to get communication training for medical encounters or information from the health care provider on how to better facilitate communication in one's health care encounters.
3. With regard to interaction within medical encounters, changes in asymmetry could result in better communication and cooperation between doctor and patient, thereby promoting an open and positive teamwork approach towards diagnosis and treatment.
4. With regard to outcomes of medical encounters, changes in asymmetry could result in better understanding of treatment directions by patients and,

consequently, lower accidental deaths due to the erroneous use of prescription medications.

5. Within the health care system, changes in asymmetry could help patients to better assess different physicians' opinions and second opinions.

5.10 Further research

My research, analysis, and conclusions highlight the need for further research:

1. On egalitarian discourse moves (such as reciprocal topic transitions and muted directives) made by women versus men doctors.
2. Conversations in feminist and other contemporary clinics that mandate patient rights and stress good communication skills between doctors and physicians.

Many clinics strive for an egalitarian conversational relationship and it would be interesting to document asymmetry or symmetry of discourse moves within their encounters.

3. On "simulated egalitarianism." Does "simulated egalitarianism" make for more balance in doctors' and patients' influence on diagnosis and treatment?

5.11 Thesis Conclusion

Finally, I come back to one of the base premises of this thesis: for an effective medical encounter to occur and the goals of the encounter to be met, both doctor and patient must be able to speak their knowledge. Doctors must speak their medical expertise and communicate to understand the patient's world. Patients must speak their personal information and communicate with the doctor in order to understand the medical expertise. The medical encounter should be one of partnership, in which an egalitarian conversation and treatment decision is the goal. In this way, patients can equally participate in the care of their bodies, moving towards the goal of better personal health.

6. LIST OF REFERENCES

- Ainsworth-Vaughn, Nancy. "Topic Transitions in Physician-patient Interviews: Power gender, and discourse change." *Language in Society*. 21(1992): 409-426.
- Ainsworth-Vaughn, Nancy. *Claiming Power in Doctor-Patient Talk*. New York: Oxford UP, 1998.
- Aronsson , Karin and Ullabeth Satterlund-Larsson. "Politeness Strategies and Doctor-Patient Communication. On the Social Choreography of Collaborative Thinking." *Journal of Language and Social Psychology* 6.1(1987): 1-27.
- Boden, Deirdre. "Talking with Doctors: Conversation Analysis in Action." *Contemporary Sociology* 15.5(1986): 715-718.
- Borges, Stephany, and Howard Waitzkin. Women's Narratives in Primary Care Medical Encounters. *Women & Health* 23.1(1995): 29-56.
- Brody, Howard. *The Healer's Power*. New Haven: Yale UP, 1992.
- Brown, Penelope and Steven Levinson. "Universals in Language Use. Politeness Phenomena." In E.N. Goody (ed.), *Questions and Politeness*. Cambridge: Cambridge UP, 1987.
- Brown, Gillian and George Yule. *Discourse analysis*. Cambridge: Cambridge UP, 1983.
- Cassell, Eric J. *Talking with Patients: Volume 2: Clinical Technique*. Cambridge, MA: The MIT Press, 1985.
- Ervin Tripp, S. "Is Sybil There? The Structure of Some American English Directives." *Language in Society* 5 (1976): 25-66.
- Hall, J.A., Epstein, A.M., Decioantis, M.L., and McNeil, B.J. "Physicians Liking for their Patients: More Evidence for the Role of Affect in Medical Care." *Health Psychology*, forthcoming, 1993.
- Heath, C. "The Delivery and Reception of Diagnosis in General-Practice Consultation." In P. Drew and J. Heritage (eds.) *Talk at work. Interaction in institutional settings*. New York: Cambridge UP, 1992: 235-267.
- Hyden, Lars-Christer and Elliot G. Mishler. "Language and Medicine." *Annual Review of Applied Linguistics*. 19(1999): 174-192.
- Jin, Jiang. "The Use of Maxims for Cooperation in Chinese Medical Interviews." *Health Communication* 11.3(1999) :215-222.

- Jones, J. Alfred and Gerald M. Phillips. *Communicating with your Doctor*. Carbondale: Southern Illinois UP, 1988.
- Katz, Jay. *The Silent World of Doctor and Patient*. New York: Free Press, 1984.
- Kleinman, Arthur. *The Illness Narratives*. New York: Basic Books, 1988.
- Mishler, E.G. *The Discourse of Medicine. Dialectics of medical interviews*. Norwood, NJ: Ablex, 1984.
- Modaff, Daniel Paul. "Enacting Asymmetry in the Opening Moments of the Doctor-Patient Interview." *Dissertation Abstracts International*, 1995.
- Platt, Frederic W., M.D. *Conversation Failure: Case Studies in Doctor-Patient Communication*. Tacoma, WA: Life Sciences Press, 1992.
- Roter, Debra L. and Judith A. Hall. *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*. Westport, CN: Auburn House, 1992.
- Scollon, Ron and Suzanne Wong Scollon. *Intercultural Communication: A Discourse Approach*. Oxford: Blackwell, 1995.
- Street, Richard L. "Communication in Medical Consultations: A Review Essay." *Quarterly Journal of Speech* 76 (1990): 315-357.
- Tannen, Deborah. *Talking Voices. Repetition, Dialogues, and Imagery in Conversational Discourse*. Cambridge: Cambridge UP, 1989.
- Todd, Alexandra Dundas and Sue Fisher. *The Social Organization of Doctor-Patient Communication*. Norwood, NJ: Ablex Publishing Corporation, 1993.
- Todd, Alexandra Dundas. *Intimate Adversaries*. Philadelphia: University of Pennsylvania Press, 1989.
- Waitzkin, Howard. *The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems*. New Haven: Yale UP, 1991.
- West, Candace. "Not Just 'Doctors' Orders': Directive-Response Sequences in Patients' Visits to Women and Men Physicians." *Discourse and Society* 1.1(1990): 85-112.
- West, C. And A. Garcia. "Conversational Shift Work: As Study of Topical Transitions Between Women and Men." *Social Problems* 35(1988): 551-573.
- West, Candace. *Routine Complications: Troubles with Talk Between Doctors and Patients*. Bloomington: Indiana UP, 1984.

Wynn, Rolf. "*Provider-Patient Interaction-A Corpus-Based Study of Doctor-Patient and Student-Patient Interaction.*" Kristiansand: Norwegian Academic Press, 1999.

Zimmerman, Don. H. and Candace West. "Sex Roles, Interruptions, and Silences in Conversation." In B. Thorne and N. Henley (eds.). *Language and Sex: Difference and Dominance*. Rowley, MA: Newbury House, 1975: 829-939.

7 APPENDICES

7.1 Transcription Conventions

Waitzkin and colleagues used the following transcription conventions to transcribe the data.

<u>Transcription</u>	<u>Description</u>
Line Number	001 002...999 Typescript lines are numbered sequentially from the first line of the transcript.
Speaker	D P D is doctor, P is patient. Speaker is noted at the first line of an utterance and at overlap points.
Turn/Utterance Location	Each new turn, that is, the beginnings of utterances by speakers in a sequence, generally starts at the beginning of a line in the transcript. Gaps and overlaps are indicated by appropriate markers.
Overlap	[If a speaker begins to talk while the other is still talking, the point of beginning overlap is marked by a bracket [between the lines; when a bracket appears below the end of the line or above the beginning of the line, the last word transcribed overlaps the first word of the next line.
Silence	...(34) Silences within speaker utterances and between speakers are marked by a series of dots; each dot represents one second. Long pauses are denoted by number of seconds in parentheses. These silences are assigned to the previous speaker if they occur between speakers – that is, they are given the meaning of a post-utterance pause.
Unclarity	(cold)/(...) Where a word(s) is heard but remains unclear, it is included in parentheses; if words are heard that cannot be distinguished, they are indicated by the notation “(words)”; if there are speaking sounds that are unintelligible, this is noted as dots within parentheses.

Speech Features	<p>?/. Punctuation marks are used when intonation clearly marks the utterance as a question or as the end of a sentence.</p> <p>: If a word is stretched, this is marked by a colon as in “Wel:l.”</p> <p>- If a speaker breaks off in the middle of a word or phrase, this is marked by a hyphen-, as in “haven’t felt like-.” ((softly)) Double parentheses enclose descriptions, not transcribed utterances.</p> <p>.hh, hh, eh-heh, engh-henh These are breathing and laughing indicators. A period followed by “hh’s” marks an inhalation. The “hh’s” alone stand for exhalation. The “eh-heh” and “.engh-henh” are laughter syllables (inhaled when preceded by a period).</p> <p>Italics or CAPS Italics or capital letters are used if there is a marked increase in loudness and/or emphasis.</p>
Names	<p>-----(blanks) To protect confidentiality, blanks substitute for proper names.</p>
Deletion in Excerpt	<p>*** (asterisks) Within excerpts from transcripts, three asterisks signify a passage from the original transcript that has been deleted from the excerpt.</p>

Table 7.1 Transcription Conventions (Waitzkin 1991: 66-67)

7.2 Samples

7.2.1 Sample 1

- 1 D: All right. It's on and we're being recorded for history
2 now. Let me get your last name.
- 3 Patient: -----.
- 4 D: First name?
- 5 P: -----.
- 6 D: What's your permanent address, ((patient's first name))?
- 7 P: Well, I, I'm living in -----, apartment ----, Home from
8 the Sea.
- 9 D: Does that mean you are home from the sea, you've been a seaman?
- 10 P: No, no, no, That's the apartment, the name of the
11 apartments. (words) name, I swear (words) a cartoon.
- 12 D: That's an elegant name. I just wondered if you
13 were a retired seaman. Hh heh ha.
- 14 P: I (words) Air Force.
- 15 D: Any telephone number?
- 16 P: -----.
- 17 D: That's your permanent address, year round.
- 18 P: Right, right.
- 19 D: Okay, how old are you?
- 20 P: 41.
- 21 D: Married, single?
- 22 P: Ah, a single man. I mean... divorced ..hh heh
- 23 D: Right. Ah, date of birth?
- 24 P: -----.
- 25 D: You sound like an old service man.
- 26 P: -----.
- 27 D: All right. And you're working somewhere?
- 28 P: At the -----...(words)
- 29 D: What's your job there?
- 30 P: I'm the assistant food and beverage manager.
- 31 D: All right. Are you a healthy man basically?
- 32 P: I am.
- 33 D: Any chronic diseases?
- 34 P: I have uhm, they call it, um, mature diabetes.
- 35 D: Do you take medicine for that?
- 36 P: No. I control my weight.
- 37 D: Good. And your weight is pretty well controlled.
38 Remember how important that is. You could gain
39 50 pounds and have it, and have diabetes that
40 would require daily shots of insulin.
- 41 P: Right.
- 42 D: As long as you are willing to keep your weight trim, and

43 exercise, and eat evenly. Don't have great big meals.
44 Spread out your food during the day. Ah, you may
45 postpone the onset of diabetes for so to speak the (word),
46 uh, for years, and maybe your whole lifetime. Plus the fact
47 You'll feel better. So it's all in the right direction.
48 P: Well I lost the weight after I lost the (word). The
49 doctors there to be very careful, you know, took
50 care of course (words)
51 [D: yeah, okay, all right. How are we doing, all right?
52 Woman's voice: Quite all right.
53 D: Uh....so you're taking no medications, normally?
54 P: No.
55 D: All right, and what happened then with uh, what was the
56 first thing that happened to your neck?
57 P: Well, it just, it started right at the base of the neck,
58 right on the side here. And then the, I guess the second
59 or third day, I think around Wednesday, it started going
60 down my back. You know, the, uh, the
61 D: Between your shoulders?
62 P: Right, between the shoulders. And then I was using uh,
63 Bengay all the time.
64 [D: Take off your shirt while were talking.
65 P: I was using Bengay, and uh, and seemed like it was
66 getting ready to leave, this morning, ah! There.
67 Women's voice: (words) Let me do it, let me do it.
68 P: This morning when I woke up I just, I just couldn't
69 even lift up off the bed, I had to roll out.
70 D: The toughest men are the biggest sissies.
71 P: heh ha ha.
72 D: Um, and when did that start, how many days ago?
73 P: Monday.
74 D: Today's Sunday, so it's been five or six days.
75 P: Right.
76 D: And you kept working?
77 P: Right.
78 D: And were you working this morning?
79 P: Right.
80 D: Hm hm. And was it worse when you got up or worse after
81 you were at work?
82 P: Well, I think it got worse when I got to work.
83 D: Yeah. Was there any one move that made it worse? Did

84 you reach in
 [

85 P: No.
 [

86 D: some funny way and it suddenly hit you, or did this
 87 gradually get worse?

88 P: It just gradually got worse.

89 D: Any cough?

90 P: No, when I do cough it does hurt.

91 D: Sore throat?

92 P: No.

93 D: Earache?

94 P: No.

95 D: If it wasn't for the neck thing, you'd feel fine.

96 P: Neck and back.

97 D: Neck and back.

98 P: Right, right.

99 D: It's not in your lower back.

100 P: Not below the belt.

101 D: No.

102 P: No.

103 D: Doesn't go in the legs.

104 P: No.

105 D: Does it go down your arms.

106 P: It feels like it's in my arm, but I'm not, you
 107 know, I can't tell the difference between the,
 108 you know, just how much pain it is, and
 [

109 D: uh, hum. But your fingers don't hurt, or your
 110 elbow, or biceps or
 [

111 P: No
 [

112 D: something
 [

113 P: No, uh uh.

114 D: And you actually have full movement.

115 P: Hm hm.

116 D: You've got some very good muscles. Uh, do you
 117 exercise?

118 P: No, that's the work I do, you know. When you're
 119 really in (words)
 [

120 D: Throwing kegs of beer around?

121 P: Right. Stuff like that, you know. And uh

122 D: What's you do in the service.

123 P: I was a procurement specialist.
124 D: In what?
125 P: Uh, purchasing contracts (word)
[
126 D: Navy, Army, Air Force?
[
127 P: Air Force.
128 D: So much the same kind of work.
129 P: Right.
130 D: But you can have a bigger mustache now.
131 P: Oh, yeah .hh heh heh ha
132 Woman's voice: .hh heh heh ha
133 D: You don't have to wear a wig on your off-duty hours?
[
134 P: No, no.
135 D: You haven't been retired too long, have you?
136 P: No. May '72.
137 D: '72. All right, well if I can't cure you, do I have
138 permission to shoot you?
139 P: No, no, please. .he heh heh
140 D: A horse gets this way, I don't waste much time on him.
141 Is it more on the right side?
142 P: Right side. Nothing up there. Thi-There.
143 D: Does it hurt when I press?
144 P: Oh, yeah.
145 D: Now is it easing up?
146 P: Easing up.
147 D: Right in this area.
148 P: Right.
149 D: That's unusual. It's not something I get neck back pain.
[
150 P: a::::gh
151 D: Whereas it doesn't hurt out here.
152 P: No.
153 D: Not even here.
154 P: No.
155 D: It seems to focus there. You it began up higher.
156 P: It's still, as a matter of fact, it's still up in that
157 area, too. But, not so that it's more than, than it
158 is down (.)
159 D: Does it feel tight to you?
160 P: I can't really tell, to tell you the truth. I know that
161 I can't move.
162 D: Uh huh..... Now where's the worst pain? Tell me where
163 it's at.

164 P: Not that far over, oi, right there, just right, right.
165 D: Right here?
166 P: Right.
167 D: Right here.....is it the side? Or right in the middle?

168 P: Mmm, it's not so much on that side. A bit over there.

169 D: [(word) there

170 P: Right in the middle. Just a little to the right of that node,
171 (word), okay? My girl was rubbing my neck at, uh, the
172 first part of the week, and there was actually a knot up
173 there. Then when it started going to the back the knot
174 seemed to

175 D: [What have you done for it?

176 P: Just used the Bengay.
177 D: Did you try heat?
178 P: No.
179 D: What about aspirin?
180 P: No.
181 D: Are you exposed to odd environment? Do you have a chilled
182 room where you keep wine or something that you might get
183 chilled in.

184 P: [No...No.

185 D: You don't have a heavy fan blowing over your neck when
186 you're in bed.
187 P: No, no.
188 D: Your breathing's all right?
189 P: Yes.
190 D: Take a deep breath.
191 That doesn't hurt more in the back?...Okay. With your
192 mouth open, take deep breaths, Mouth wide open. Deeper....
193Okay....

194 P: Starting last week, you know, I caught a cold
195 D: What, what does a cold mean to you?
196 P: Well, it was in my head at first, as a matter of fact I still
197 have it, you know.
198 D: No fever with this, no?
199 P: No.
200 D: Your ears are perfectly normal.....Mouth open. Say ah.
201 P: Ah:::h.
202 D: Do you smoke?.. It would be nice to stop chewing (word)
203 for the diabetes.

204 P: [I know, I've been told that.

205 D: The effects of diabetes are much the same as the effects of
206 smoking, and you don't want double the effect. Ah, it's bad
207 enough to have a tendency toward diabetes, you can't give that
208 up. But you can't give up smoking because then you'd get fat.
209 Ah, so you have to be tough enough to stop smoking and not
210 Eat, ah suck on too many all day suckers, and steaks, and ice
211 cream cones. Ah, what you have is the size of like a crick in
212 the neck. Nothing fancier than that. Except it's unusual to
213 have it down this low. And my guess is, what happened is you
214 got an old fashioned pulled muscle in the neck, uh, spasm.
215 and that starts to pull other muscles out of position. Like
216 one wire on a sailing ship being too tight

217 P: [It pulls. Yeoh
218 I had that] once before once before.

219 D: It's even hard to raise your head off the pillow sometimes
220 in the morning when you have it. I assume that that's
221 gotten better slowly, but the process of that pulling on your
222 check, you pulled, you've moved awkwardly in some fashion, or
223 other muscles have been pulled out of position. And so now
224 you've got the same thing down between your shoulder blades.
225 Uhm when was the last time you had a chest x-ray?

226 P: Uh, I guess ah when I left the service.

227 D: I can't imagine a chest x-ray is gonna be abnormal, but in the
228 process we can see those vertebrae. That uh....

229 P: Is there anything I can take to relax that, that pain in the
230 back?

231 D: Yes and no. We can give you medicine for pain, uh
232 and I'll

233 P: [All right [right

234 D: talk about what we're gonna do in a minute, but, relaxing, to
235 get relaxing you get heat and when you get some pain relievers.
236 Keep it warm, between the heating.

237 P: Having a very bad time, it's true.

238 D: Yeah. I honestly feel that the x-ray of the chest isn't very
239 necessary at this point. I want to stay in touch with you.
240 Uh, I'm gonna start you with aspirin, High doses. It's the
241 old fashioned simple medicine. Harmless medicine. Some
242 people get irritation of the stomach from it. Have you ever
243 had that?

244 P: No.

245 D: Take a little bit of food with it. Half a glass of milk,
246 or a little crust of bread or something (word). Now, take
247 two of them, every three hours. If you end up taking too many,
248 your ears will ring a little bit. That's not harmful, it's a

249 sign to ease off and take it every four hours, or a half hour.
 250 But take two often. Plain old cheapest aspirin you can buy
 251 In a drugstore, You don't need a prescription. They're all
 252 essentially the same in spite of what the advertisements say.
 253 Um
 [

254 P: Yeah
 [

255 D: Two, every three hours, right through the day. I want you to
 256 get a heating pad if you don't have one, and you lie on it.
 257 You go home and you may not be able to work today. Um, is
 258 the whole Sheraton Hospital chain gonna stop if you weren't
 259 working today.
 260 P: Well, see the thing is, the food and beverage manager is gone, he
 261 won't be coming back until Tuesday night, and we
 262 have the Seagram's auction of (word) and
 [

263 D: Yeah, and you're the
 264 liquor man for Seagram's.
 265 P: Right. And plus the fact that this is (words) tonight,
 266 and
 [

267 D: Well
 [

268 P: this afternoon, and
 [

269 D: you've got to compromise. Ideally you ought to go home
 270 and lie on a heating pad. You probably can't do that, because
 271 (words). I will give you some other pains, other pills for
 272 pain. And this will be codeine. Can you take it?
 273 P: Yes.
 274 D: No irritation from that, huh. Ah, this is strong. It may
 275 make you a little bit dizzy, some people are. But the back.
 276 If you can't, will you have any time during the day that you
 277 can lie down, even on the job, lie on a heating pad?
 278 P: Well, once I get this bar set up this afternoon, I think
 279 basically they should (words) me on leave.
 280 D: Well, I would like to have you away as much as possible. At
 281 home, lying down on a flat bed. Don't lie down on a hammock.
 282 Make it a flat bed, and if it's not very flat, lie on the
 283 floor. And put the heating pad on the floor and lie on it.
 284 Put a couple towels. And first don't burn yourself, but
 [

285 P: Right
 [

286 D: leave it as the cloth. And do that for an hour

287 or two. And then some warm clothing over your back so it
288 doesn't uh, get chilled after. And the final thing is, that
289 you will benefit by a collar. Wearing a high collar around
290 your neck. Even though the pain is a little bit lower than
291 that right now, you've got neck residual distress here at the
292 side muscles, and if we can hold that immobile, you can work
293 with the collar on.
294 P: Right.
295 D: Ah, it will help to get the spasm (words). Now that, those
296 are the first steps, and I do not guarantee that you are
297 going to be all better when you've done those things. We may
298 have to get a chest x-ray on you if this thing persists. All
299 right?
300 P: All right.
301 D: But that's the first thing you do. You can call me this
302 afternoon or tonight, or even tomorrow morning. I won't be
303 here later on, ah, but I will be back here Friday. And for
304 my peace of mind, I wish you would call me Friday.
305 P: Right.
306 D: Okay, just tell me how you're doing.
307 P: Okay. Where do I get this collar
308 D: [or your widow can call me,
309 okay. Where do you get the collar?
310 P: Yeah.
311 D: -----pharmacy in ----, and they will fit you with
312 it. I'll call up and tell them you're coming.
313 P: All right.
314 D: And I'll give you the prescriptions for these, um-
315 P: Thank you.
316 D: Give me a blank piece of paper and some note paper, will you?
317 P: (words)
318 D: You can be getting dressed.
319 Woman's voice: (words)
320 D: 15th today, S--?
321 Woman's voice: Ah yes.
322 D: Thank you. I'll give you enough codeine so you can keep it
323 around the house. It's a useful medicine to have for pain.
324 Tear your fingernail, or a bad burn or something. They are
325 Very small little pills, but don't minimize their powers
326 Because they are small. And I'll write, now, one tablet
327 Every three to four hours.. as needed.. for pain. You don't
328 take them unless you need them.
329 P: All right.
330 D: They don't cure anything. They simply help ease the pain.
331 But if you can get rid of some of the pain, I think we'll

332 get rid of some of the spasms. And they'll be labeled.....
333 There's that..... You can get these at the same
334 drugstore. And this for the cervical collar, the neck collar.
335 P: The neck collar. You have to buy this?
336 D: Yes, you have to buy it.
337 P: (words)
338 D: I would keep it around. You may have more troubles like
339 this. It isn't terribly expensive, but it's something you
340 have to through. You don't have any here. Now,
341 the first thing, aspirin. Two tablets, every three or every
342 four hours. All right? Second, heat. The heating pad, or
343 hot water bottle. You have a heating pad like that?
344 P: No, I'll probably have to buy
[
345 D: Well you're gonna buy a whole pile
346 of things. Just a small one, one by one foot is all you need.
347 Heat. Third thing is the codeine as needed. But you take the
348 aspirin even if you don't need it.
349 P: Right.
350 D: Um, fourth thing is a flat sleeping surface. And if your
351 bed really is too soft, you may want to put your mattress on
352 the floor and sleep on your mattress on the floor for a while
[
353 P: All right
[
354 D: and later we can get a bed board and put it under. And five,
355 you can swear all you like. It might make you feel better.
356 And sixth, you're gonna call me.
357 P: Friday.
358 D: Friday, and call someone here sooner if you have too much
359 trouble. They'll have the record even though I'm not here.
360 P: Okay.
361 D: And don't get that way in the future.
362 P: Oh, I don't want to ever get this way. This is worst (word)
363 I've ever been.
364 D: All right, okay. Good to see you.
365 P: Thank you very much.
366 D: Yup.

7.2.2 Sample 2

- 1 D: This is one of the first times. Did anybody say anything
2 about the recording to you?
3 P: Yeah.
4 D: That all right with you?
5 P: Sure
6 [Fine.
7 P: I'm Dr. ----.
8 P: I'm ----. I have a .. started out with a bad cold
9 yesterday morning. And not it's gone down into my chest.
10 [Yep
11 D: Take off your shirt..
12 [And uh...
13 P: Uh, it killed me and I figured I'm on vacation, I might as
14 well get it taken care of right away.
15 D: Well, you're here to enjoy yourself, not to have a cold
16 [Yeah
17 P: Right here
18 D: Think you got fever?
19 P: Yes
20 D: Uh, you haven't taken it I assume, taken your temperature.
21 P: No. But I can..
22 [Uh
23 D: You felt hot... for how many days?
24 P: Uh, yesterday and today.
25 D: Any cough with it?
26 P: Yes.
27 D: Do you bring up much phlegm with the cough?
28 P: Uh, I started this morning to bring up phlegm.
29 D: What color is it?
30 P: Uh, sort of a greenish.
31 D: Is it a teaspoon or a cup?
32 P: What do you mean by a teaspoon?
33 D: In 24 hours did you bring up a teaspoon of that stuff
34 or a cup?
35 [Oh, I just started this morning.
36 D: Sore throat?
37 P: Yes.
38 D: Earaches?
39 P: No.

39 D: Mouth open, take deep breaths.....deeper.....all right,
40 now breathe quietly.....Let me put this thermometer in your
41 mouth.
42 P: ----- it just don't do any good. ((Sound of nose blowing))
43 D: I'll ask you some yes and no questions that you can answer
44 with your mouth... occupied. Do you smoke?
45 Do you get hiccups very often?
46 P: Nope.
47 D: You have a long hair in your ear canal, and rarely that
48 will irritate the
49 P: [Is that right?
50 D: canal and lead to hiccups. If you ever get a bad case of
51 hiccups that won't stop, you tell the doctor to, uh, pull
52 a hair out of your.. it's about an inch long inside the
53 canal. I've always been waiting for someone with hiccups
54 to cure them that way, but I guess I haven't found it even
55 in you. Your ears are fine. Do you take any medicines
56 everyday? Do you have any chronic diseases, diabetes,
57 high blood pressure, meanness? No meanness. What kind
58 of work do you do?
59 P: Ah unh, I work in, uh, ---- (name of factory)). I'm a setter.
60 D: Been working there a long time, haven't you?
61 P: Oh, eleven..
62 D: ---- ((patient's name)).....No vomiting, no diarrhea?
63 Appetite fairly good? Have you had any actual chills?
64 P: Mmmm.....
65 D: Have you had any aspirin today?
66 P: No, uh, I took a Contac last night about three o'clock.
67 D: Your temperature is 99 this morning which is borderline,
68 but probably there's evidence of fever. This afternoon
69 it may be 100, 101 or so. Temperature 99, ears OK. Your
70 chest is clear in the sense that there's no deep pneumonia,
71 no signs of asthma. (To woman:) Where's the earache?
72 Woman: In your office.
73 D: ((To woman:)) We'll fix him up. ((To patient:) OK. Your
74 throat looks sore and boggy. There's no what we call exudates,
75 the sore that you get with strep throat. Do you have any
76 allergies to medicine?
77 P: No. The only thing I have an allergy to is... Antabuse.
78 D: Antabuse.
79 P: I'm an alcoholic.
80 D: Oh. Good for you, in the sense that you were a former
81 alcoholic? Do you still drink?
82 P: No. Ten years.

83 D: Good for you. That's marvelous. But you don't..

84 P: [Of course

85 I take Antabuse every once in a while.

86 D: What happens if you do?

87 P If you take it? And take a drink?

88 D: Well, I know that. But if you, do you have an allergy

89 just to the Antabuse itself? I see.

90 P: No. But I can't take any medication with it.

91 D: I see.

92 P: But I only take it, Christmas time. You know..

93 D: [On the wet

94 times of the year.

95 P: Right.

96 D: Well, I certainly respect you for it. Getting that disease

97 under control

98 P: I went to a ..We have in --- ((state name)) a ---- ---- Clinic

99 in ---- ((city name))

100 D: I know that clinic.

101 P: And, uh, I was there for 3 weeks. And I had a little

102 Jewish social worker that got it across to me that the

103 world turns better without alcohol.

104 D: And it has turned better, hasn't it?

105 P: Beautiful, beautiful.

106 D: No allergies to penicillin specifically?

107 P: No.

108 D: All right. You're not dying, but you're miserable. This

109 is the story of a

110 P: [Yeah

111 D: bronchitis. It's not productive of phlegm, which means,

112 this amount means you got an exudates, some secretions

113 down there in the lungs. You might heal this yourself

114 Not everyone dies of these things obviously, before we

115 invented antibiotics. But I think having a 2 or 3 day

116 history of it now, having productive phlegm coming up

117 now, you'd be better off and get better faster, especially

118 since you're smoking which tends to irritate it a little

119 bit, um, if you, uh, if we gave you penicillin. And I'm

120 going to start you off with a shot which is a quick way to

121 do it, and then I'll have you follow it up over a period of

122 time with pills.

123 P: OK.

124 D: Incidentally, doctors will probably tell you to stop smoking

125 all the time. I'm..I'm not sure you should. Let me tell
126 you why.
127 P: I'm going to tell you why.
128 D: Well, you tell me.
129 P: I quit drinking, and I got..
130 D: That's enough.
131 P: That's enough.
132 D: That's exactly my thinking. Now tobacco isn't the best
133 thing in the world for you, but you don't have emphysema,
134 and you don't have any serious complications of it.
135 P: But I, uh, have cut down.
136 D: It's just a little too much of a burden on you to stop
137 alcohol and tobacco. So let me be one doctor to tell you
138 that you probably ought to keep smoking.
139 P: No, no. This is a (words).
140 D: That's all right. No. I don't know; this is confidential.
141 Go ahead.
142 P: Well my dad said, "Gee", this is about a year, year and a
143 half after I
144 D: [Tell me.
145 P: [stopped drinking, he was in his late 80's, he said, "Now
146 you've stopped drink-
147 D: [Yeah
148 P: [-ing, why don't you stop smoking?" And I says, "Well, Christ,
149 next year you'll want me to stop having sex." ((laughs))
150 D: OK. Fair enough. I think it's important... Give me the...
151 syringe.. Uh, I think that's.. I think your logic is correct,
152 and, uh, I'm with you on that, and you're to be greatly
153 respected for stopping alcohol.
154 P: Wasn't easy. And I have a sister-in-law who laughed at me.
155 D: Why?
156 P: Because I was going up..
157 D: Is she a drunk?
158 P: Six or seven years later she was up there herself. And
159 afterwards she apologized and said that she wished she had
160 gone when I had.
161 D: Stand up and lean over. I'll give you this in the
162 butt. Lean over the
163 P: [OK
164 D: [table here. I could give you the shot anywhere, but you

165 have more tissue to shoot it in through here. Every so
166 often, people get an allergy to penicillin. You may get
167 a rash, you may get all kinds of things, if you do, we
168 want to know about it. And don't take any more pills if
169 it starts that way. Now this shot takes care of today.. you
170 can get dressed.. we'll give you a prescription for some
171 medicine you will take for 6 more days after this.
172 P: Now, startin' today? Or tomorrow?
173 D: Tomorrow. The shot takes care of today. Have any questions?
174 P: None whatsoever.
175 D: Take it easy today, it's a rainy day anyway. After that, as
176 far as I'm
177 [Right.
178 D: [concerned, you can do anything you want to do.
179 Uh, even though you're taking the penicillin, you can go
180 swimming. Or you can do whatever makes sense. Uh, don't
181 push yourself, don't get chilled, don't get fatigued, don't
182 miss a meal.
183 P: I have a half an acre of land to clear.
184 D: All right. Do it. But don't do it all tomorrow. Do it
185 slowly... All
186 P: [No, no
187 D: [right, I'll write the prescription
188 for you, and we'll have you on your way.
189 P: All righty.

7.2.3 Sample 3

- 1 D: This is one of the first times. Did anybody say anything
2 about the recording to you?
3 P: Yeah.
4 D: That's all right with you?
5 P: Sure
6 D: [Fine.
7 D: I'm Dr. ----.
8 P: I'm ----. I have a ..started out with a bad cold
9 yesterday morning, and now it's gone down into my chest.
10 D: [Yep
11 Take off your shirt..
12 P: [And uh...
13 Uh, it killed me and I figured I'm on vacation, I might as
14 well get it taken care of right away.
15 D: Well, you're here to enjoy yourself, not to have a cold.
16 P: [Right here [Yeah
17 D: Think you got fever?
18 P: Yes
19 D: Uh, you haven't taken it I assume, taken your temperature.
20 P: No. But I can..
21 D: [Uh
22 D: You felt hot... for how many days?
23 P: Uh, yesterday and today.
24 D: Any cough with it?
25 P: Yes.
26 D: Do you bring up much phlegm with the cough?
27 P: Uh, I started this morning to bring up phlegm.
28 D: What color is it?
29 P: Uh, sort of a greenish.
30 D: Is it a teaspoon or a cup?
31 P: What do you mean by a teaspoon?
32 D: In 24 hours did you bring up a teaspoon of that stuff
33 or a cup?
34 P: [Oh, I just started this morning.
35 D: Sore throat?
36 P: Yes.
37 D: Earaches?
38 P: No.

39 D: Mouth open, take deep breaths.....deeper.....all right,
40 now breathe quietly.....Let me put this thermometer in your
41 mouth.

42 P: ---- it just don't do any good. ((Sound of nose blowing))

43 D: I'll ask you some yes and no questions that you can answer
44 with your mouth... occupied. Do you smoke?
45 Do you get hiccups very often?

46 P: Nope.

47 D: You have a long hair in your ear canal, and rarely that
48 will irritate the
[

49 P: Is that right?

50 D: canal and lead to hiccups. If you ever get a bad case of
51 hiccups that won't stop, you tell the doctor to, uh, pull
52 a hair out of your.. it's about an inch long inside the
53 canal. I've always been waiting for someone with hiccups
54 to cure them that way, but I guess I haven't found it even
55 in you. Your ears are fine. Do you take any medicines
56 everyday? Do you have any chronic diseases, diabetes,
57 high blood pressure, meanness? No meanness. What kind
58 of work do you do?

59 P: Ah umh, I work in ,, uh, ---- ((name of factory)). I'm a setter.

60 D: Been working there a long time, haven't you?

61 P: Oh, eleven..

62 D: ---- ((patient's name))..... No vomiting, no diarrhea?
63 Appetite fairly good? Have you had any actual chills?

64 P: Mmmmm.....

65 D: Have you had any aspirin today?

66 P: No, uh, I took a Contac last night about three o'clock.

67 D: Your temperature is 99 this morning which is borderline,
68 but probably there's evidence of fever. This afternoon
69 it may be 100, 101 or so. Temperature 99, ears OK. Your
70 chest is clear in the sense that there's no deep pneumonia,
71 no signs of asthma. ((To woman:)) Where's the earache?

72 Woman: In your office.

73 D: ((To woman:)) We'll fix him up. ((To patient:)) OK. Your
74 throat looks sore and boggy. There's no what we call exudates,
75 the sore that you get with strep throat. Do you have any
76 allergies to medicine?

77 P: No. The only thing I have an allergy to is... Antabuse.

78 D: Antabuse.

79 P: I'm an alcoholic.

80 D: Oh. Good for you, in the sense that you were a former
81 alcoholic? Do you still drink?

82 P: No. Ten years.

83 D: Good for you. That's marvelous. But you don't..

84 P: [Of course

85 I take Antabuse every once in a while.

86 D: What happens if you do?

87 P: If you take it? And take a drink?

88 D: Well, I know that. But if you, do you have an allergy

89 just to the Antabuse itself? I see.

90 P: No. But I can't take any medication with it.

91 D: I see.

92 P: But I only take it, Christmas time, you know..

93 D: [On the wet

94 times of the year.

95 P: Right.

96 D: Well, I certainly respect you for it. Getting that disease

97 under control

98 P: I went to a.. We have in --- ((state name)) a ---- ----- Clinic

99 in ---- ((city name)).

100 D: I know that clinic.

101 P: And, uh. I was there for 3 weeks. And I had a little

102 Jewish social worker that got it across to me that the

103 world turns better without alcohol.

104 D: And it has turned better, hasn't it?

105 P: Beautiful, beautiful.

106 D: No allergies to penicillin specifically?

107 P: No.

108 D: All right. You're not dying, but you're miserable. This

109 is the story of a

110 P: [Yeah

111 D: [bronchitis. It's not productive of phlegm, which means,

112 this amount you got an exudates, some secretions

113 down there in the lungs. You might heal this yourself.

114 Not everyone dies of these things obviously, before we

115 invented antibiotics. But I think have a 2 or 3 day

116 history of it now, having productive phlegm coming up

117 now, you'd be better off and get better faster, especially

118 since you're smoking which tends to irritate it a little

119 bit, uh, if you, uh, if we gave you penicillin. And I'm

120 going to start you off with a shot which is a quick way to

121 do it, and then I'll have you follow it up over a period of

122 time with pills.

123 P: OK.

124 D: Incidentally, doctors will probably tell you to stop smoking

125 all the time. I'm.. I'm not sure you should . Let me tell
126 you why.
127 P: I'm going to tell you why
128 D: Well, you tell me.
129 P: I quit drinking, and I got..
130 D: That's enough.
131 P: That's enough.
132 D: that's exactly my thinking. Now tobacco isn't the best
133 thing in the world for you, but you don't have emphysema,
134 and you don't have any serious complications of it.
135 P: But I, uh, have cut down.
136 D: It's just a little too much of a burden on you to stop
137 alcohol and tobacco. So let me be one doctor to tell you
138 that you probably ought to keep smoking.
139 P: No, no. This is a (words).
140 D: That's all right. No. I don't know; this is confidential.
141 Go ahead.
142 P: Well my dad said "Gee", this is about a year, year and a
143 half after I
144 D: [Tell me.
145 P: [stopped drinking, he was in his late 80's, he said, "Now
146 you've stopped drink-
147 D: [Yeah
148 P: [-ing, why don't you stop smoking?" And I says, "Well, Christ,
149 next year you'll want me to stop having sex." ((laughs))
150 D: OK. Fair enough. I think it's important... Give me the...
151 syringe.. Uh, I think that's all I think your logic is correct,
152 and, uh, I'm with you on that, and you're to be greatly
153 respected for stopping alcohol.
154 P: Wasn't easy. And I have a sister-in-law who laughed at me.
155 D: Why?
156 P: Because I was going up..
157 D: Is she a drunk?
158 P: Six or seven years later she was up there herself. And
159 afterwards she apologized and said that she wished she had
160 gone when I had.
161 D: Stand up and lean over. I'll give you this in the
162 butt. Lean over the
163 P: [OK
164 D: [table here. I could give you the shot anywhere, but you

165 have more tissue to shoot it in through here. Every so
166 often, people get an allergy to penicillin. You may get
167 a rash, you may get all kinds
168 want to know about it. And don't take any more pills if
169 it starts that way. Now this shot takes care of today.. you
170 can get dressed..we'll give you a prescription for some
171 medicine you will take for 6 more days after this.
172 P: Now, startin' today? Or tomorrow?
173 D: Tomorrow. The shot takes care of today. Have any questions?
174 P: None whatsoever.
175 D: Take it easy today, it's a rainy day anyway. After that, as
176 far as I'm
177 P: [Right.
178 D: [concerned, you can do anything you want to do.
179 Uh, even though you're taking the penicillin, you can go
180 swimming. Or you can do whatever makes sense. Uh, don't
181 push yourself, don't get chilled, don't get fatigued, don't
182 miss a meal.
183 P: I have a half an acre of land to clear.
184 D: All right. Do it. But don't do it all tomorrow. Do it
185 slowly... All
186 P: [No, no
187 D: [right, I'll write the prescription
188 for you, and we'll have you on your way.
189 P: All righty.

7.2.4 Sample 4

- 1 D: All right.
- 2 P: Just give me permission to take two Decadron a day. I can't
3 go on with one.
- 4 D: [I'll
5 P: [I'm half dead most of the time.
- 6 D: I'll identify you as ----, Mrs. ----, just
7 for that
8 P: oh, [yeah
- 9 D: Uhm, how much Decadron are you taking?
- 10 P: One. Can't do it though. Hm.
11 D: You taking it every day? Yeah.
- 12 P: Did most the time. Most the...
- 13 D: Do you still have the aching?
- 14 P: Not as much, no that definitely was either a bug or a virus,
15 I don't know the difference, because eventually there was a
16 lot of mucus in the bowel movement. And a regular gruppy
17 feeling of course, so I still have some aches, but, na, this
18 morning I didn't'.
- 19 D: But the main problem now is the weakness?
- 20 P: Yes, just no ambition. Nothing. I started on the uhm, the
21 anitdepressants. Have you got a stronger one, they're no good.
- 22 D: Uh huh, well, uh,
- 23 P: I'm really in a state, I'm in a mental state, there' no doubt
24 about it.
- 25 D: When, when we're uhm, while we're talking about the Decadron
26 let me ask you one other thing and that is, you remember you
27 were taking two tablets every other day.
- 28 P: And you changed it one day.
- 29 D: Right. Now are you just as bad? Worse? Better? Does
30 P: [I'm
31 worse, it's getting worse the longer time (words)
- 32 D: So it's worse on one tablet a day.
- 33 P: Because it's like more length of time, you see, it's two and
34 a half months since I was on two a day.
- 35 D: You mean two every other day.
- 36 P: No.
- 37 D: Oh, you mean back when you were taking two a day? Yeah.
38 P: [when I was back when I was taking two a day.

39 That seems to be it, now, whether it shortens the lifespan
40 or not I'm going to take a chance.

41 D: Ha ha ha ha.

42 P: This is not living.

43 D: Yeah.

44 P: I can't just do anything.

45 D: Well, uhm, you know there's another possibility and that is
46 uh, rather than taking two every day, you can try three
47 every other day

48 P: What would be the point of that?

49 D: Well, it's the same point as every other day therapy in
50 general. You remember we went through
51 [

51 Yeah you were trying to get them- but do you- I don't think
52 that gland's going to come back. We've tried what, three
53 times now.

54 D: Oh, it'll come back. Sure. No, your gland, your adrenal
55 gland does
56 [

56 P: I don't
57 [

57 D: function.

58 P: A little bit.

59 D: Sure, but your, you see, when we give you the Decadron we're
60 giving you, we're treating a disease, we're not just keeping
61 it at a normal level. We're giving you big levels of cortisone.

62 P: That's a big level.

63 D: Sure.

64 P: Five milligrams, point five?

65 D: Sure. Sure. It's a big level. And uh-

66 P: What are you treating, the inflammation?

67 D: Yeah.

68 P: Why don't we skip that and just stick to the gland? Let's get
69 that straightened out.

70 D: Well, there's nothing wrong with your adrenal, you see.

71 P: Isn't working!

72 D: Well, it would work if we didn't give you the Decadron.
73 That's the point.

74 P: I wouldn't live through it toward the end, till it came
75 up to normal.

76 D: Yeah, yeah I know
77 [

77 P: (words) was it?
78 [

78 D: You see, no, it's not a question of that. Your trouble is
79 your muscle disease, right?

80 P: I don't think so.
81 D: Well, it has been.
82 P: You should know of course. But
 [
83 D: Well, you haven't had a- nobody was treating adrenal disease
84 in you, ever.
85 P: No, it started treating the muscles, of course-
86 D: Fine.
87 P: But the adrenal then works on, I mean the Decadron then works
88 on the adrenal, which stops that from functioning.
89 D: It tends to make the adrenal not function. That's true. But uh-
90 P: Well, that seems to be the problem at present.
91 D: Well, not really. If you had no muscle disease, we would stop
92 the Decadron and you'd be normal. But since you have muscle
93 disease, if we stop the Decadron, as you know when we did stop
94 it in the hospital, you were far from normal. And at that time-
95 P: Didn't have much pain.
96 D: Yeah, but you told me, uh, well, we sent you home without
 [
97 P: once in a while
 [
98 D: cortisone and you couldn't keep going without
99 it, right?
100 P: No, because I had to get up to do things. It's the getting up
101 and doing things.
102 D: Yeah. But that is uh:::h not. Uh, really, your adrenal,
103 that's not because you have adrenal disease. You don't.
104 You have muscle disease. If you, if you didn't have
105 muscle disease then we'd stop your Decadron.
106 P: And we'd have, still have no ambition, and stuff. That has
107 nothing to do with you muscles, you ambition, and your desire
108 to do something, your ability to do it.
109 D: Sure it does. You have muscular weakness. You tell me you
110 cannot walk really very much-
111 P: I can't walk, but that's not bothering me, I can't even dust,
112 is more important.
113 D: Hm.
114 P: But I don't want to dust. That's the main thing. It's a,
115 bumped into a mental attitude.
116 D: Sure. But don't you see that the only way to get around that
117 is to get off Decadron or get on a dosage of Decadron that isn't
118 uh, too large.
119 P: Wouldn't three every other day be larger than-
120 D: Well, but the point of every other day therapy is that it

121 allows your own adrenal gland to keep functioning.

122 P: [one day (words) functioning

123 in one day?

124 D: Well, uh:::h that's a good question, but it's been answered.

125 P: Were you able to determine how much functions in that gland?

126 D: Sure. It functions perfectly all right, off Decadron, in the

127 hospital.

128 P: A hundred percent?

129 D: Well, uh, we don't know what the adrenal gland would do if you

130 were under stress, if you were under difficulty, if you had

131 another illness that uh, made the gland function even more.

132 P: [wouldn't work at all

133 D: [Yes it would work.

134 We don't know whether it work. A normal adrenal gland can double

135 or triple its output if it needs to.

136 P: Well I am interested in any kind of stress operation or accident

137 or what all I'd have to have massive does of all.

138 D: [If, yeah, if you had recently been on ah Decadron to the point

139 that your own adrenal had been suppressed

140 P: [Are you, T---, do you think it makes any difference, is it

141 time to change brands so to speak.

142 D: But, ah, my point is, ah, in the hospital, off Decadron, your

143 adrenal function was really quite good.

144 P: Well, I didn't give a hoot about getting out of that bed,

145 now why?

146 D: Well, there are u::h, things that take a good deal of time to get

147 completely back to normal, and the uh, emotional response takes

148 a long time to get back to normal too. That's why we fought

149 so hard to keep you off the steroids.

150 P: Seven weeks and I'm mmmh back in bed.

151 D: Hm hmm.

152 P: For good. Now I'm back in bed again.

153 D: Yeah, but, you see, this is the problem you get into. Right.

154 P: Well, all right, then I can't get rid to he muscle disease.

155 We've got to find.... A happy medium on the cortisone.

156 D: Well, daily, daily cortisone is not a happy medium, you see

157 P: Uh huh.

158 D: No, it just isn't..... Uhm, .. And uh, ... What we're going

159 to do about that problem is uh

160 P: Well, try it any way you want to try it, good Lord, you should

161 know more about it than I do.

162 D: ((laughs)) Yeah, well I don't want you to get the idea that we're
163 treating adrenal disease, uh .. uh

[

164 P: Yeah, and that's what I feel you are at this point.

165 D: Well, the adrenal function certainly comes into it, of course.

166 Uhm, ... I don't know if uhm, ... you realize that, you

167 know, to start with, that uh:::

168 P: No, I didn't think it worked a hundred percent. I thought it
169 just hadn't been paralyzed entirely.

170 D: Well, as I said, I can't tell you that it would work a hundred
171 percent under conditions of another severe illness.

172 P: Uh huh.

173 D: That's what we don't know, but, uh, if we were able to keep
174 you off, uh ah, cortisone drugs, uh, uhm, then, uh, there's
175 every indication that your adrenal would come back a hundred
176 percent.

177 P: And what was that they told me once about a ACTH, ACTH?

178 You didn't think much of that?

179 D: Well, if you give ACTH you are just going to ah, give the ACTH
180 that your pituitary should be producing. That's a pituitary
181 hormone that ordinarily helps control the adrenal some. Well,
182 we're already getting the adrenals into trouble, uh::: we're
183 not really going

[

184 P: half a dozen of one, six of the other, yeah

[

185 D: to suppress the pituitary by giving ACTH but there's, there's
186 no point in it what we really want is when normal ACTH-adrenal
187 relationships be re-established. And giving ACTH isn't going
188 to produce that state of affairs. But your point about a
189 different drug, uh, is, is, uh, a good one, particularly if we
190 are going to try every other day, uh, uh.

191 P: Sometimes a change, just psychologically makes a difference,
192 if nothing else.

193 D: Yeah. Well. Look, but you're taking now

194 P: twenty-five milligrams once a day. Decadron.

195 D: (words)..... The uh actually dexamethasone is not a
196 particularly good cortisone derivative for every other day
197 therapy. And uh, what what we should do is switch you to
198 say, methylprednisolone.

199 P: Heavens, I never had that one.

200 D: Well, it, it's a better drug for every other day therapy,
201 that's all you can say. And uh-

202 P: Do you think so?

203 D: Uh, you can use it every day, too, if we get back in that
204 difficulty about, uh, what we're striving to do is of course

205 every other day.
206 P: Have you ever thought, did you, that possibly I was born
207 with that, problem.
208 D: Which problem?
209 P: The muscle one, the adrenal.
210 D: Well, I don't think you have an adrenal problem.
211 P: You don't think I have it at all.
212 D: No, that's, we went through those tests in the hospital. That's
213 one reason we hospitalized you then. There is no indication
214 that you have adrenal disease as such, no. Adrenal function
215 has been altered by the drugs that you've been given, and that
216 I'll continue to give you. But, uh, that's a different thing
217 from saying there was adrenal disease.
218 P: Well then maybe it was the muscle stuff I was born with,
219 because I had this
220 D: [We::ll,
221 P: [same reaction only not so often in my younger days.
222 D: Yeah, uh, that's harder to say because we don't know a great
223 deal about the causes of this sort of uh, muscle problem
224 anyhow. It's uh, an inflammatory disease of muscle, it is not,
225 you know usually you, felt not to be born with it, but uh, I
226 don't think we can prove that one way or another.
227 P: You mean I could have acquired it?
228 D: Well,
229 P: Anyhow, that's settled on anything now.
230 D: Yeah, we don't know why people acquire it when they do, as a
231 rule. So I don't think it's anything you did or didn't do,
232 at least as far as we know.
233 P: [Y'know, I'm always in the back of my mind trying to
234 find out why the two retarded, ((laughs)) (words) conniptions.
235 D: ((laughs)) I know, ah, if you find out let me know. Uh, yeah.
236 P: They found a lot of them, but not mine.
237 D: Pardon?
238 P: They find out a lot of them, but not mind.
239 D: Yeah, I think in that case, well, off hand, at least, there's
240 no relation I ever heard of between your muscle disease and
241 mental retardation in the children, uh.
242 P: No, well, I was thinking glands, you see.
243 D: Oh, I see. Well, no, even, even if we thought there was adrenal
244 disease, uh, uh, it would be any
245 P: [Well they seem to be finding out more about glands now in
246 connection with it.

247 D: Oh, sure, that's true.

248 P: but, uh, even so. Now, well, that's why I ask some of these

249 questions. That's always in the back of my mind.

250 D: Yeah.

251 P: So, I hope the blood pressure's down.

252 D: OK.

253 P: The retarded that's left has got high blood pressure now, that's

254 enough to let mine up worrying about it.

255 D: Yeah.

256 P: We got his down, but they (words)

257 D: He has high blood pressure?

258 P: He eats like there's no tomorrow. He weighs two hundred and

259 ten pounds.

260 D: Well your blood pressure's always been fine.

261 P: You call that fine, a hundred forty was it over eighty six?

262 D: Yeah, that's normal pressure.

263 P: [I call it high.

264 D; High? No, not really you've had

265 P: [for me.

266 D: [pressures of a hundred fifty, but even that isn't really high.

267 P: I think it ought to be down, however.

268 D: Well, [OK, uh, let's let's weight

269 you and then uh, we'll check you blood pressure, and we will be

270 changing your Decadron to Medrol, it's a methylprednisolone.

271 P: It's still steroid, or, it's still a steroid, uh.

272 D: It still is cortisone, yes.

273 P: [cortisone.

274 D: Yeah, we're not going to get away from that

275 very easily, as you see.

276 P: I don't think I ever had though. I can't, if someday I get

277 to the point that I can have a psychiatrist to help me, he

278 won't solve them, but he might help me in, and like for

279 instance, I have worries like fury and that takes so much out

280 of you, you, you just don't go to sleep just thinking about it.

281 D: Have you thought of seeing a psychiatrist?

282 P: I can't afford one.

283 D: ((laughs))

284 P: That lets that out.

285 D: Yeah, uh, although there, there's an outpatient clinic with

286 the, uh

287 P: Yeah and they send you to a social service psychiatric girl

288 that's a waste of time.

289 D: Well, well, I don't know, It huh,

290 it might be a point when you want to go through
[]

291 P: if Dr. ----, Doctor

292 ---- sent me up to Dr. ----, I think it was, in ----,

293 D: Oh, did he?

294 P: Yeah. It was a waste of an hour.

295 D: Is Dr. ---- a psychiatrist?

296 P: He sent me on to one of these girls, what do they call them,
297 psychiatric workers, or something, and she was as good as
298 nothing, and I went to her a few times.

299 D: ((laughs)) Well, it's difficult. Well, we'll put that in the
300 back of our mind at the moment.

301 P: You know there's nobody's gonna solve these problems, 's gonna
302 help me to live with them, that's about the size of it. And
303 when you're sittin' there looking at nothing, why you, you just
304 don't solve them. I've got spots in front of this eye, now,
305 I've got to have my glasses changed, I read too much.

306 D: Hmm hm.

307 P: I presume that's what it's from. It's time I had them changed
308 anyway.

309 D: Do they uh, come ever time you read? Or-

310 P: Since last night, they're still there now, a little bit.

311 D: Do they drift across your eye?

312 P: They float. They got tails on them ((laughs)). (words) with
313 tails on them!

314 D: OK. Uh, uh, they're uh, actually those so-called floaters are
315 not uncommon, they usually don't mean anything, uh.

316 P: Means I'm reading too much.

317 D: Well, even that, not necessarily.

318 P: Oh really?

319 D: No. But if you haven't had your eyes checked in a while,

320 P: It's time for them, yes, it really is, two years now.

321 D: Well, I'll look at your eyes myself while we have you (words)

322 P: (words)

323 ((tape off and then on again))

324 D: All right. Let's see your weight was still-
[]

325 P: 134.

326 D: Just 134, wasn't it..... OK, uh, uh, the uh, uh,

327 P: (word)

328 D: Yeah, I don't want you to take any more of the Decadron,
329 you're gonna stop that entirely, uh, because the uh,
330 methylprednisolone is taking its place.

331 P: I won't get that till tonight, but will it do any harm

332 take an extra one this afternoon?
333 D: Huh! No, I don't think it will, uh-
334 P: It wouldn't do much good either, probably.
335 D: Right. Uh, I would like to try the methylprednisolone on
336 an every other day schedule, but you can take two of those
337 every other day.
338 P: I thought you said three.
339 D: Well, that's of the uh,
340 P: Oh, I see
341 D: uh, Decadron
342 P: Oh
343 D: Uh, you can take three of the methylprednisolone also, but ah,
344 if you feel you're not doing well, maybe you call me first and
345 we'd talk over what you should do.
346 P: OK. I can't say that so well, now.
347 D: The name?
348 P: Hm Hm.
349 D: The brand name is Medrol. You can call it that.
350 P: Oh, Medrol.
351 D: It's easier to say, certainly.
352 P: Have you got a stronger antidepressant?
353 D: Well how much of the amitriptyline are you taking?
354 P: Well I just started over again the other night, taking one at
355 night and one in the morning.
356 D: Ah, you know that is not going to work for weeks, it's a
357 strong antidepressant, but it won't work
358 level.
359 P: ((in a whisper)) dear God. ((back to normal)) I'll take
360 two of something else beforehand, I'm afraid. ((laughs))
361 Go off, someday, I, really, some days are murder.
362 D: Yeah, I, I think really the best thing is to stick to that and
363 don't stop it. You see if you stop it, you're back at point
364 zero again. And it generally works, but it does take a while.
365 P: Oh, all right. But really, I'm very preoccupied with death.
366 I know there's an awful lot of mental stuff mixed up with that.
367 D: I know, uh, what we got to do is get you feeling better, and
368 then you won't be
369 P: Maybe that is the answer, I hope....
370 D: Well, uh, call me next week, anyhow, if you would, and let me
371 know how you're doing.
372 P: All right. What's the best time to call you.
373 D: Oh, it doesn't really matter.
374 P: (words)
375 D: I'll call you back if you don't-
376 P: Today is what?

377 D: Thursday.

[

378 P: Thursday. Shall I wait a whole week?

379 D: No, call me during the week. We've changed your medicine, we're

380 trying to keep you on an every other day schedule, you're not

381 feeling too well to start with, I, I'd like to hear from you,

382 you know, Monday, Tuesday, Wednesday, somewhere in there.

383 P: All right. And this is a oh, can't read it.

384 D: Well, its methylprednisolone and two tablets every other day

[

385 P: two tablets every other day,

386 OK. Will have to get that tonight.

387 D: Stick to the amitriptyline at the moment.

388 P: OK. Oh, I think that was all I had in mine.

389 D: OK.

390 P: Long as the blood pressure stays down there.

391 D: Yeah, what was it today?

[

392 P: I'm worried about that, you know, it was 140

393 over 70.

394 D: Yeah. All right. There's really nothing wrong with that, is

395 there?

396 P: No. By (word)

397 D: I'm not worried about your blood pressure.

398 P: No, but I can't very easily ((laughs))

399 D: OK.

400 P: ---'s down, but I worry about his.

401 D: Really? Is he doing all right?

402 P: Oh, he's down to 140 over 82.

403 D: Well, that's pretty good pressure.

404 P: Yeah, but you see, they don't put him on any diet, or they, he's

405 on that pill, and (word) or something like that, (words), or

406 something like that.

407 D: For his pressure.

408 P: For his pressure. They brought it right down. But what good's

409 a pill if you're gonna be eatin' like that, he weighs two

410 hundred ten.

411 D: Yeah.

412 P: He's up six feet two.

413 D: Well, they want him to get his weight down too, don't they?

414 P: Uh uh.

415 D: No?

416 P: If the Lord would take him in a massive stroke, that I could

417 take. But being, God just crippled, a half cripple, why,

418 that's worse.

419 D: Let's hope that doesn't happen either, right.

420 P: No, that's what I think. But's those high blood pressure's

421 that go. All right, thank you.

422 D: OK. I'll see.

423 P: I'll make an appointment for a month, anyway.

424 D: Yeah, if you would.

425 P: and then I'll call you first of the week.

426 D: Sure.

427 P: (words)

428 D: OK.