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The Discoursal Aspects of Medical Encounters

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ABSTRACT
This paper exclusively deals with medical encounters. . Structurally and thematically, it manifests itself in five parts. The First part deals with medical encounters as well as essential speech activities which cover (a) frames (certain types of talk) (b) the patient's account and the patient's story or more precisely the patient telling his story and (c) the act of questioning the patient.
The Second part revolves round *genre* and *register*. The former, in most cases, suggests that the format of medical encounters is *conversational*. With *register*; we have a converse reality that restrictively tries to narrow things and give them a certain flavor.
The Third part realizes the *technicalities* of medical encounters (a) the setting of an interview realized by the clinical atmosphere which either impedes or facilitates medical interviews (b) the operative parts of medical encounters which involve elements like (i) beginning an interview (ii) the main part of an interview (iii) asking questions (iv) probing questions (v) picking up cues (vi) demonstrating active listening (vii) verbal and non- verbal facilitation (viii) other points including *clarification* , *relevance* and *silent periods* (ix) *summarizing* (c) *introductory and terminating talk in a medical encounter* (d) *ending an interview* and (e) *defense mechanism in a medical interview.*
The Fourth part of my study projects clinical discourse and interpersonal communication relationships.
The Fifth part presents one model of a medical encounter that is evaluated. The model tells us precisely what goes on between the interviewer and the interviewed.
The paper ends with a *conclusion* that sums up the insights gained by the study and that isolates some of the operative perceptive points for our inspection.
A questionnaire has been conducted to explore the physicians' and the patients' attitudes, knowledge and emotional aspects. The results with this questionnaire have been analyzed and then confirmed in my conclusion.
Key words and phrases: medical encounter, medical interview, clinical discourse, the interviewer, the interviewed, patient, physician, care giver, care seeker, frame, register, empathy, telling a story.

PROCEDURE

An illustrative plan, utilizing the assessment is conveyed all through the current investigation to assess the physicians' and the patients' attitudes, knowledge and emotional aspects. My method in this research centers on what really goes between the doctor and his/her patient. For this purpose, I have shown the operative factors leading to successful or inchoate interviews. To prove my point of view, I have dealt with one model taken from a reliable source to show through my linguistic analyses what finally supports my conclusion, the pivotal point of which is the unpredictability of medical encounters due to what goes between the questioner and the questioned or that which transpires when the patient is allowed to tell his/her own story.
To be more pragmatic about medical encounters, I have had a questionnaire choosing a specimen of (100) participants in terms of (30) physicians and (70) patients. A pilot study is done from January seventh 2019 to February twentieth 2019 to decide the inside consistency unwavering quality and substance legitimacy of the examination instruments.

The inward consistency dependability of the surveys is resolved using split-half procedure and the calculation of Cronbach alpha connection coefficient. The outcomes show that the relationship coefficient is (r = 0.87) for the doctors' poll and (r = 0.88) survey to the patients' survey. Such scores uncovering the examination instruments are sufficiently solid measures for the ideas basic the current investigation.

Content legitimacy of the investigation instruments is dictated by board of (12) specialists. These specialists are employees at the University of Baghdad. They are furnished with duplicates of the surveys and requested to audit and assess the examination instruments for content clearness and sufficiency. Their reactions portray that the examination instruments are substantial measures for the basic the investigation.

Information is gathered by using the investigation instruments and the organized meeting strategy as means for information assortment for the time of February 21st 2019 to March twentieth 2019.

Information is dissected by applying illustrative measurable information investigation approach which incorporates the recurrence, rate, mean of scores , complete score and reach.

1- MEDICAL ENCOUNTERS AND ESSENTIAL SPEECH ACTIVITIES

Vaughn alerts us (2003:459-465) to constitutive speech activities that assert themselves in medical encounters. These are projected in terms of the four categories of (a) framing (b) stories (c) questions and (d) conclusion.
These categories would be closely adhered to in my paper.

a. Frames

Frames may be defined as chunks of informative or certain types of talk realized by the participants' behavioral interaction. In a more general sense, they could be realized as a focused discourse that is designed to perform a variety of actions. *Goffman*, who theoretically underpins framing likes to suggest (1986: 21) that frames allow their users to "perceive, identify and label" events.

Becker looks at a frame (2001:319) as an arrangement of connections, to show how things balance together in a net of shared impact or backing or reliance. Ten Have refers (1989:115) to the act of framing by remarking on "different interaction formats" occurring in medical discourse. Goffman sees (1981:131) frame – the act of "building information "as being independent on the *questions* of the unit as a whole."

Generally speaking, frames allow us to carry out various activities. Snow and Benford like to speak (1988:200-201) of three types of frames. These are (1) diagnostic frames that involve blame and causality (2) prognostic frames that identify targets and solutions and (3) motivational frames that compel people to take action.

In a more specific sense, frames describe a system of interdependent relationships filtered through the physician's questions and the patient's responses. This particular frame of clinical discourse establishes participants as doctor versus patient whereas a *friendship frame* is a non-professional frame realizing its participants as equals.

b. The patient's account

Every patient has his own story. A wise physician must allow his patient to tell his story without being interrupted. Waitzkin warns (1991:272) against the patient being thwarted. His advice is to allow patients recount their accounts with less interferences only to return, later, "to the technical" aspect of their encounters. This kind of localized talk is apt to allow the suppressed reality of the patient to assert itself, to intensify personal interaction between patient and doctor and, consequently, to bring them closer to each other. Young observes (1989:153) that the patient's self is "sealed inside the story." The basic function of storytelling is to allow the physician to specify the patient's predicament.

On occasions, we have in the act of the patient telling his story what is known as panic disorders. *Radley et al* (2008:1494) maintain that sickness stories are developed reflectively, thinking back from their endings. Labor looks at the types of narrative in medical interviews (1972: 354-94) as "habitual" and Riessman (1991:41-68) as "hypothetical." Hunter notes (1992:89-116) that the doctor's responsibility is to change the patient's language which demonstrates his fear and suffering into technically structured and relevant clinical language.

C. The act of questioning the patient

Questioning is an essential component of a clinical discourse. One of the basic roles of questioning is that it allows the interviewer (in this case the physician) to get the necessary information about the interviewed. Moreover, through a question, the physician asserts his power over his patient. This *exertion* of control should be subtly delicate. The kinds of questions that should be asked are those that eventually succeed in determining the patient's basic problem(s).If the patient wants to ask some questions, he should be allowed to do so. This will put him / her at ease and convinces him / her that he / she shares power with his interviewer.

2- MEDICAL ENCOUNTERS: GENRE AND REGISTER

Kress defines genres (1985:19) as "conventionalized forms of texts". In dealing with medical encounters the term "genre" asserts itself in the sense that it realizes the kind of the format used in clinical discourse. Frankel looks at medical encounters (1979:232) as being "essentially *conversational* in nature". Ten Have, who also discusses genre in medical encounters points out (1989:115) to "several different interactional formats". This only means that the conversational activity is one of the formats involved in. Heritage seems to be aware (1989:34) of the restrictions on the conversation of clinical interviews which involve narrowing … of the scope of choices that are usable in

conversational association. Maynard notes (1991: 449) the similarity between the sequences of medical encounters and those of ordinary conversation: specialist – sick person communication includes succession of talk that have their home in common discussion .

Ferra projects (Vaughn, 2003:457) seven distinctions among discussion and psychotherapy meetings. These are *equality, correspondence, routine repeat, limited time, confined subject, renumeration and administrative duty.*

Halliday et al define register (1964:47) in terms of grammatical and lexical differences as the classification of register is proposed to represent how individuals manage their language .When we notice language activeness in the different settings in which it happens, we discover dissimilarity in the kind of language chosen as suitable to various sorts of circumstance.

In a relevant sense, the model I want to introduce in this paper emphasize its conversational nature. It is apt to narrow things and give them a certain colour. So at this particular point, we would be in the realm of *register*.

3- MEDICAL ENCOUNTERS: TECHNICALITIES

a. The Setting of an interview

The setting of an interview plays a telling role in making things go right or wrong. Positively, an important point is to cause the patient to feel calm by the interviewing doctor who often faces the patient across a desk. Another facilitating point is the right distance between the doctor and the patient. Interpersonal relationships are often valued by patients over professional expertise. Ten Have's planned phases of medical encounters seem to be quite operative in this respect. He discusses clinical experiences (1989:118) as though being sorted out into an ideal arrangement covering the six stages of *opening, objection, assessment, diagnosis or test, treatment or guidance and closure.*

Significantly the atmosphere where an interview takes place is important .It either impedes or facilitates a medical interview. Lloyd and Bor assume (2009:11) that most discussions happen in a medical clinic ward, an outpatient health center or a GP's medical procedure.. They argue that one could discern certain points that have to be considered in a medical interview. These could be summed up as (a) arrangement with the patient and (b) the arrangement to make the patient feel at ease, a thing which makes him more communicative.

In a more specific sense, the right way the physician's consulting room is organized certainly contributes to a positive atmosphere that relieves the patient's stress , and encourages him / her to be more communicative.

The *setting* and the way in which an interview is conducted have a profound effect on the success or failure of a medical interview. From a practical point of view , the distance between the interviewer and the patient plays a decisive role in a clinical discourse. Thus , placing the seats of the interviewer and the interviewed too close may have a negative impact on the patient who may feel threatened. Certainly the place in which the patient is examined and the way the examiner acts exercise influence on an interview.

Here is an instance when things in an interview go wrong .This is the story of Mrs. Francis, a shop associate. She went to clinical outpatients at her neighborhood emergency clinic and stated that at the point when she went into the room, which was huge and exposed, she felt lost. She didn't have the foggiest idea where to sit, the specialist had his head down and was composing , the attendant was on the phone and there were some clinical undergraduates conversing with one another. She stuck around and needed to run out the entryway. After what seemed like ages, the specialist instructed her to have a seat and asked what wasn't right. She didn't have a clue about his name and she doesn't know that he knew hers. She'd been contemplating her issues and what she needed to tell the specialist yet she overlooked everything – he didn't appear to be intrigued at any rate (Lloyd and Bor, 2009:13).

Obviously the bare room in which the interview takes place and the way the doctor acts have their negative impact on Mrs. Francis. The doctor, so it seems, has ignored what makes the beginning of an interview successful by an interviewer: greeting the patient , introducing himself or herself and the encouraging act of orienting the patient.

Interrupting patients at the beginning of an interview should also be avoided. Beckman (1964, 101:693-96) notes that physicians frequently interrupt their patients at the beginning of an interview, a thing which prevents patients from expressing their major concerns.

There are also those interviewers who like to *repress* their patient. Putnom Stiles, Jacob and James warn (1985:75) against repressing the patients who like to cooperate with an understanding physician: **"Patients want to be understood sometimes even more than they want to be cured, yet numerous studies have documented how rarely physicians allow patients to express their concerns."**

One has also to be flexible. Shuy enlightens us (1983:22) to the fact that the doctor's previous design for the discourse of a medical encounter would be changed through doctor-patient negotiation. He states that not all

interviewers talk about similar subjects and in no way are all questions dealt with from all interviewers. The scope of unevenness was, indeed, large.

b. **The Operative Parts of Medical Interviews**

Lloyd and Bor talk (2009:13-21) of certain points that define the strategy of conducting an interview. These points could, thus, be summarized (my numbering and italics).

(i) *Beginning an interview*

Here, certain strategies must be observed such as providing a comfortable setting, greeting the patient, showing him where to sit, orienting him or her.

(ii) *The main part of an interview*

Here the physician has to ask appropriate questions, listening attentively and demonstrating an interest.

(iii) *Asking questions*

The physician has to ask 'open' questions that enable him to obtain more useful information. 'Closed questions' must be avoided because they elicit a 'yes' or a 'no' answer.

(iv) *Probing questions*

To clarify and justify things and to check accuracy, probing questions by the physician would help the patients to think more clearly. Complex questions should be avoided.

(v) *Picking up cues*

The physician has to pick up the patient's oral and gestural cues which reveal the patient's real concern.

(vi) *Demonstrating active listening*

The physician has to listen carefully to the patients and to encourage them through nodding and / or some other encouraging gestures.

(vii) *Verbal and non- verbal facilitation*

This facilitation is *verbally* achieved through effective listening to the patient and *non-verbally* through the physician's eye contact and posture.

(viii) *Other points*

These can be summarized in terms of *clarification* (asking patients to clarify things , helping the patient to be *relevant* , making the patient feel comfortable through effecting *silent periods.*

(ix) *Summarizing*

The physician has to summarize things at the end of an interview to inspect the precision of the patient's story , to reveal that he / she has listened carefully to the patient , to keep the patient on track.

c. Introductory and terminating talk in a medical encounter

Obviously, prefatory and final conversational bits in a clinical discourse are highly important in the sense of being meaningfully rich. Ferra recognizes (1994:42) that these segments are far from being peripheral and data about contrasts is piled up at the borders of occasions.

d. Ending an interview

The communication techniques adopted by the physician is critically important. Before closing an interview, a competent physician has to ask the patient if he or she has anything to discuss. If he is able to deal successfully with certain emotional concerns that are raised by the patient at this point, the interview would be successfully terminated.

Lloyd and Bor speak (2009:21) of essential features of ending an interview. These are exactly realized by the following points. (My numbering)

a. summarizing the patient's problems.

b.. requesting the patient to check the precision of what he / she has stated and if he/she has left any important information.

c. asking the patient if he/she likes to add anything.

d. thanking the patient or announcing the end of the session 'our time is now up'.

e. Defence Mechanism in a Medical Interview

Tamparo and Lindh realize (2000:70-74) defence mechanism on the patient's part in terms of ten acts. These are (1) *regression* (the client's attempt to go back to an earlier stage to escape fear ,anxiety or conflict (2) *repression* (forgetting or experiencing temporary amnesia (3) *sublimation* (involving redirecting a socially desirable behavior) (4) *projection* (attributing one's thoughts or impulses to another person (5) *displacement* (shifting the emotional element of a situation from a threatening object to a non- threatening one (6) *undoing* (cancelling out a behavior) (7)

compensation (overemphasizing a characteristic to compensate for a real or imagined deficiency) (8) *identification* (mimicking another's trait to cope with feelings of inferiority) (9) *denial* (unconsciously refusing to acknowledge painful realities and (10) rationalization (justifying behavior by trying an explanation other than a truthful one).

4. CLINICAL DISCOURSE AND INTERPERSONAL COMMUNICATION RELATIONSHIPS

Care givers play a decisive role in realizing positive clinical relationships .Ruben argues convincingly (1993:106) that a group of healthcare staff participate in making the encounters that are generally essential and unforgettable to patients. Kreps also speaks (1988:351) of the positive role of the interaction between the patient and care professionals. Lazare , Putnam and Lipkin (1995:11) also emphasize the importance of these relationships between health givers and health seekers in the sense of facilitating several clinical objectives, one of which is the patient's desire to turn into a functioning and helpful member in the demonstrative and treatment method. Riley also seems to be quite interested in building relationships between the physician or a care giver and a patient or a car seeker. In her *Communication in Nursing* , she has assigned (2004:93-218) chapters to talk about some basic elements such as *warmth* , *respect* , *genuiness* ,*empathy* (telling the fellow human that you understand how he/she feels) *self-disclosure* , *specificity* and *humour*.

5. A MODEL OF MEDICAL ENCOUNTERS

A video taped conversation which occurs in Tannen and Wallat (1986) is that of the mother who seems to be worrying about her daughter's noisy breathing in her sleep. The daughter's name is Jody and in this clinical discourse, the mother raises the issue as the doctor starts examining her daughter.

(1) Mother: She stresses me around evening time.
Since uh… when she's sleeping
I continue keeping an eye on her so she doesn't
Specialist:
As you probably are aware the
Significant
Mother:
I continue believing she's not breathing appropriately.
Specialist: As you probably are aware
It is not easy for her to use her muscles
(2) Specialist: … And I think what I attempted to clarify…
Um to Mrs. Jones, Mrs. Jones,
[Father goes to doctor]
was that u:m … thE … her muscles
at the point when they're impacted,
they don't … simply impact the arm and leg.
They influence the muscles … u:m … of the tongue,
What's more, the mouth, and the … neck,
what's more, thE um vocal chords,
… a:nd … thE.. lungs,
There are tubes in our lungs
likewise have muscle around them,
… so every one of these muscles are impacted.
Furthermore, the muscles, small muscles between our ribs,
…..… so … there's a … grouping.
… And afterward when I hear Jody's chest,
… her breathing sounds … harsh.
… everything sounds sort of … loose.
… in there … as … thE … lung enlarges … and diminishes.
Thus her loud breaths … u:m … truly … will be …

because of a similar method.
There's nothing … else going on.
That you should be concerned about.

(3) Mother: No:, aside from …… with this … uh…
about the hard …wheezy sound ,
Specialist: mhm]
would a specialist be capable … to say …
in the event that it's a blockage she's having →
Specialist: right
or
Specialist: She has clear lungs..
… In spite of the fact that she sounds … rough when she draws breath.
…….. the air going in and out.
She doesn't have wheezes

Analysis

It is quite clear that in the first excerpt the doctor explains that the noisy breathing has to do with the muscle weakness. As the doctor continues her examination, she is often interrupted by the mother who observes the sort of sound that she hears when her daughter is sleeping.

In the second excerpt, the doctor summarizes things for the parents, concluding that nothing is abnormal about her noisy breathing and that they should not worry about this particular reality. She ends by asking the parents if they have any questions.

In the third excerpt, the mother is still worrying about Jody's "heavy … wheezing sound" and the doctor assures the mother that Jody "has no wheezes".

The model makes it obvious that communication difficulties often arise in medical encounters , a thing which is observed by Landlin , Brauton and Leather suggest (1974:10) that the problematic issue is between the specialist and the patient.

Linguistically speaking, the interview does not take the form of a question by the doctor and an answer by the patient's mother. It wholly occurs in short, sometimes disconnected language .The (u: m) a device used to announce a new point of departure is repeated four times in the doctor's lengthy explanation and the other technical devices of the dots (…) which are silent periods and the four [E]s are to realize reflective periods providing a platform handy enough to give the doctor time to assume his clinical discourse.

Results

Table (1): Overall Evaluation for Physicians' Questioning (N=30)

Items	Poor (5 – 8.3)	Fair (8.4 – 11.7)	Good (11.8 - 15)
Physician's Attitude	**0**	**0**	**30**
Physician's Knowledge	**0**	**0**	**30**
Emotional Aspect of Physicians	**0**	**0**	**30**

This table illustrates that all physicians have encountered a good degree de of physicians' questioning 100 %.

Table (2): Mean of Scores for Physician's Attitude (N=30)

List	Items	Always	Sometimes	Never	Mean of Scores	Evaluation
1	You greet the patient at the beginning of a medical encounter and make him /her feel at ease.	28	2	0	2.8	High
2	You encourage the patient by telling him/her that things will be all right for him/her at the end.	30	0	0	3.0	High
3	You avoid interrupting the patient's story about his/her illness or try to listen to his/her full story.	30	0	0	3.0	High
4	You try to spend the time needed to examine your patients carefully.	27	2	1	2.8	High
5	You end the medical interview by summarizing things for your patients.	25	4	1	2.8	High

Low: (≤ 1.6); Moderate: (1.7 – 2.3); High: (≥ 2.4)
The table shows that the entire physicians have experienced high level of attitude.

Table (3): Mean of Scores for Physician's Knowledge (N=30)

List	Items	Always	Sometimes	Never	Mean of Scores	Evaluation
1	You meet the patient first to know at what he complains.	28	2	0	2.9	High
2	You recourse to reliable medical texts to enlighten yourself concerning the patient's state.	27	2	1	2.8	High
3	You contact your colleagues to consult them on the subject of treating your patient.	30	0	0	3.0	High
4	You ask the patient for his social status.	27	2	1	2.8	High
5	You refer the patient to another physician when you feel perplexed about the patient's case.	28	2	0	2.8	High

Low: (≤ 1.6); Moderate: (1.7 – 2.3); High: (≥ 2.4)
The table presents that all of the physicians have experienced high level of knowledge.

Table (4): Mean of Scores for Emotional Aspect of Physicians (N=30)

List	Items	Always	Sometimes	Never	Mean of Scores	Evaluation
1	You feel uneasy if the patient interrupts you.	30	0	0	3.0	High
2	You let the patient tell his story without interrupting her/him.	27	3	0	2.9	High
3	You let the patient feel that she/he is at home.	26	2	2	2.8	High
4	You get easily bored when the patient continues complaining from what he suffers.	28	2	0	2.8	High
5	You always encourage your patient to be optimistic.	30	0	0	3.0	High

Low: (≤ 1.6); Moderate: (1.7 – 2.3); High: (≥ 2.4)

This table indicates that all of the physicians have experienced high level of emotional aspect.

Table (5): Overall Evaluation for Patient's Questioning (N=70)

Items	Poor (5 – 8.3)	Fair (8.4 – 11.7)	Good (11.8 - 15)
Patient's Attitude	0	0	70
Patient's Knowledge	0	0	70
Emotional Aspect of Patients	0	0	70

The table presents that all of the patients have experienced good level of patient's questioning 100%.

Table (6): Mean of Scores for Patient's Attitude (N=70)

List	Items	Always	Sometimes	Never	Mean of Scores	Evaluation
1	You like to cooperate with your physician and establish a positive relation with her/him.	62	6	2	2.8	High
2	You sometimes feel frightened in the physician's clinic and in this case, the physician tries to put you at ease.	67	2	1	2.9	High
3	The physician encourages you to tell your story or does he try to interrupt you.	65	3	2	2.9	High
4	You feel tense when you encounter your physician for the first time.	63	4	3	2.8	High

5	**You tell your physician the whole story of your illness or try to repress certain parts of it.**	**64**	**2**	**4**	**2.8**	**High**

Low: (≤ 1.6); Moderate: (1.7 – 2.3); High: (≥ 2.4)
This table shows that all of the patients have experienced high level of attitude.

Table (7): Mean of Scores for Patient's Knowledge (N=70)

List	Items	Always	Sometimes	Never	Mean of Scores	Evaluation
1	**You know exactly from what you complain.**	**66**	**2**	**2**	**2.9**	**High**
2	**You go to the physician who is a specialist in your case.**	**68**	**2**	**0**	**2.9**	**High**
3	**You change your physician if your case does not improve.**	**64**	**3**	**3**	**2.8**	**High**
4	**You pay attention to your physician's explanation about your medicine.**	**68**	**1**	**1**	**2.9**	**High**
5	**You take your medicine exactly as the physician instructs you.**	**66**	**3**	**1**	**2.9**	**High**

Low: (≤ 1.6); Moderate: (1.7 – 2.3); High: (≥ 2.4)
The table reveals that all of the patients have experienced high level of knowledge.

Table (8): Mean of Scores for Emotional Aspect of Patients (N=70)

List	Items	Always	Sometimes	Never	Mean of Scores	Evaluation
1	**You feel uneasy when you meet your physician.**	**62**	**6**	**2**	**2.8**	**High**
2	**You think that the physician does not give the time necessary for you to explain your case.**	**68**	**1**	**1**	**2.9**	**High**
3	**You do not feel at home when you meet your physician.**	**66**	**2**	**2**	**2.9**	**High**
4	**You feel depressed if your case does not improve.**	**67**	**2**	**1**	**2.9**	**High**
5	**You try to listen to what your physician says about your case.**	**65**	**5**	**0**	**2.9**	**High**

Low: (≤ 1.6); Moderate: (1.7 – 2.3); High: (≥ 2.4)
The table presents that all of the patients have experienced high level of emotional aspect.

CONCLUSION

One could conclude that medical encounters are unpredictable in the sense of their ultimate outcome. Their success largely depends on the tactfulness of the physician .We have also seen that the orientation of the physician and the patient to each other is a major component of a successful interview.

The paper has shown that to succeed, doctors have to be resourceful. They should not ask more questions than needed. The physician does well if his questions are relevant and if they elicit the desired response from the patient.

It has also transpired that the physician's warmth and posture often result in creating the desired atmosphere that helps making the patient feel at ease.

The model of the medical interview cited in my paper has turned out to be quite indicative. It has an explanatory nature.

Significantly, the model succeeds in projecting a physician who is quite confident and reassuring. She has been able to put things right as she encounters communication difficulties with Jody's mother.

In terms of statistics, the results of the questionnaire conducted on the specimen of participants show the dependability of the examination instruments for the concepts informing this study. Panel of experts chosen to determine the content validity of the study have verified the adequacy and the clarity of the measures exploring the phenomena underlying the study.

REFERENCES

Becker, A. (2001). *Populärmedizinische Vermittlungstexte*. Studien zur Geschichte und Gegenwart fachexterner Vermittlungsvarietäten. Tübingen: Niemeyer.

Beckman H.B, Frankel R.M (1984) "The effect of Physician behaviour on the collection of data" *Ann Intern Med.*; 101 : 693-96 [PubMed].

Ferra , Katherine Warden (1994) "Therapeutic Ways with Words" , *Oxford Studies in Sociolinguistics*. New York : Oxford University Press.

Frankel,Richard (1979) "Talking in interviews : a dispreference for patient – intiated questions in physician–patient encounters" in *Everyday Language : studies in Ethnomethdology* , ed. George Psathas , 231-62. New York : Irvington.

Goffman , E. (1981) "Footing" in *Forms of Talk* . Philadelphia : University of Pensylvania Press.124-59.

_____ (1986) "An Essay on the Organization of experience" , *Frame Analysis* .Boston , Massachusetts : Northeastern University Press.

Halliday , M.A.K. , McIntosh , A. and Strevens , P. (1969) *The Linguistic Sciences and Language Teaching* . London : Longman.

Have , Paul ten (1989) " The consultation as genre" , in *Text and Talk as Social Practice*, ed. Brian Torode 115-35. Dordrecht: Foris.

Heritage , J (1989) "Current developments in conversation analysis" in *Conversation* ,eds. D. Roger and P.Bull , 21-47 .Philadelphia : Multilingual Matters.

Hunter , K.M.(1992) "Patients,physicians and red parakeets" , *Hospital Practice* 27 (2) :89-116.

Kreps, Gary L.(1988) Relational commuincation in health care .*Southern Speech Commuincation Journal* ,53,344-359.

Kress ,G. (1985*) Linguistic Processes in Sociocultural Practice*. Paris: Seuil (tranlated as *Desire in Language : a semiotic approach to Literature and art* , edited by L.S. Roudiez , translated A.Jardine , T.A. Gora and L.S. Roudiez . Oxford : Blackwell.

Labov , William (1972) "The transformation of experience in narrative syntax" , in *Language in the Inner City* , 354-96 , Philadelphia.

Landlin , C.N. Bruton C.J., and Leather , J.H. (1974) "Doctor – patient communication skills" , *Working Papers* 1-4 .Lancaster , University of Lancaster Institute for English Laanguage Education.

Lazare Aaron , Putnam Samuel .M and Lipkin Mack. Jr, (1995) *The Medical Interview . Clinical Care, Education, and Research.* New York : Springer.

Lloyd, Margaret and Bor, Robert (2009). *Communication Skills for Medicine.*Churchill Livingstone :Elsevier.

Maynard , Douglas W. (1991) "Interaction and asymmetry in clinical discourse " *American Journal of Sociology* 97 : 448-95.

Putnam , S. Stiles , W. , Jacob , M. and James , S. (1985) "Patient exposition and physician explanation in initial medical interviews and outcomes of clinic visits" *Medical Care* , 23(1), 74-83.

Radley A. Mayberry J. and Pearce M. (2008) "Time , Space and Opportunity in the Outpatient Consultation : ' the doctor's story' " , *So.Sci .Med*. 66 : 1484-96.

Riessman , Catherine Kholer (1991) "Byond reductionism : narrative genres in divorce accounts" , *Journal of Narrative and Life History* 1 (1): 41-68.

Riley , Julia Balzer (2004) *Communication in Nursing* . Fifth Edition . St. Louis, Missouri : Mosby.

Ruben , Brent D. (1993) What patients remmber: A content analysis of critical incidents in health care. *Health Communication*, 5 (2) , 99-112.

Shuy, Roger W. (1983) "Three types of interference to an effective exchange of information in the medical interviews" in *Social Organization of Doctor – Patient Communication* , eds. Sue Fisher and Alexandra D. Todd , 189-202. Washington DC: Center for Applied Linguistics.

Snow .DA , Benford RD (1988) Idealogy , Frame , Resonance , and Participant Mobilization *Int. Soc.Mov.*

Tamparo , Carol and Wilburta Q. Lindh (2000) *Therapeutic Communications for Health Professionals*. Second Edition. Canada : Thomson Learning.

Tannen Deborah and Cynthia Wallat (1986) "Medical Professionals and parents: A Linguistic analysis of communication across contexts" in *Language in Society* 15:3 .Cambridge University Press.

Vaughn , Nancy Ainsworth (1998b) "Diagnosis as Storytelling", in *Claiming Power in Doctor- Patient Talk*, 147-71. New York: Oxford University Press.

---------- (2003) " The Discourse of Medical Encounters" 453-469 in Schiffrin , Deborah , Deborah Tannen and Heidi E. Hamilton (eds.) *The Handbook of Discourse Analysis.* Maldon , Oxford ,Melbourne and Berlin : Blackwell Publishing Ltd.

Waitzkin , Howard (1991) *The Politics of Medical Encounters*: *How Patients and Doctors deal with Social Problems* . NewHaven , CT : Yale University Press.

Young , Katherine (1989) "Narrative Embodiments : enclaves of the self in the realm of medicine" in *Texts of Identity* , edited by John Shortler and Kenneth Gergen , 152-65: Newbury Park , CA :Sage.