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Summary

The article is an overview of the relevance of discourse analysis and pragmatics for applied linguistics and particularly for second and foreign language education. It also looks at the influence of these two disciplines on materials design and teaching philosophy.

TEN KEYS TO IMPROVING DOCTOR–PATIENT COMMUNICATION

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Introduction

Looking back to the initial and preparatory stages of myresearch on doctor–patient communication [Černý 2012], it would be right to say that I was bold to choose a research subject of such broad scope. The plan that I devised was to examine communication between doctors and patients during English medical consultations. The first main objective of the study was to explore to what degree the present-day style of doctor–patient communication reflects on-going social transformations; in this way I

planned either to confirm or (rather) challenge the findings arrived at in previous decades. Secondly, I aimed at making an attempt to examine discourse strategies that are capable of conveying empathy and trust between the participants of the medical encounter; in my opinion these two notions form the springboard for the desired improvement of doctor–patient interaction. Thirdly, I hoped to write a text that would meet both scholarly requirements and, at the same time, the requirements for its future application in medical education and practice.

For the purposes of my analysis, in order to adjust the research data and the methodological approach to the research aims, I decided to take advantage of the spoken section of the British National Corpus, which includes 115 annotated medical interviews. Out of this data, I selected 50 medical interactions, with the total extent of text amounting to 34,376 word items. All of the interviews selected were dyads andwere instances of general practice consultations, which gave me access to the most representative type of medical discourse. Having compared and contrasted the most dominant methods of research into doctor–patient interaction (namely the sociolinguistic approach and the medical approach), I adopted a combination of the qualitative aspects of the former approach (representedby ethnomethodological conversation analysis and discourse analysis) with the quantitative perspective of the latter (supported by the calculation of the F-test and the Pearson correlation). The interdisciplinary character of the investigation was supported by anthropologically-oriented field work in the surgery of one Czech general practitioner.

The study was divided into two main parts: theoretical (Chapters 2–6) and practical (Chapters 7–11). Chapter 2 introduced the general practice consultation as a discourse type sui generis. Chapter 3 provided an overview of the significance of corpus linguistics for the analysis of medical interviews. Chapter 4 outlined the role of conversation analysis and its related disciplines. Chapter 5 described the selection of topics central to D–P communication investigation. Chapter 6 defined empathy and trust as key concepts in D–P interaction. Chapter 7 focused on questioning and responding practices of doctors and patients. Chapter 8 examined the sequential organization of speech acts. Chapter 9 revisited the use of interruptions and overlaps. Chapter 10 investigated medical and social topics. Finally, Chapter 11 explored the positive politeness strategies manifested by the interlocutors. As part of the study, to strengthen the illustrational potential of the findings presented, I cited 155 examples of authentic language material, plus 18 charts including a variety of information related to the research topic, 10 tables offering a distributional analysis with respect to dialogue interactants, dialogue sections and selected variables, and 20 figures showing relative distributions within the category of either doctors or patients.

The summary of the research findings that I am about to present below consists of four parts. First of all, I will draw a brief comparison between the findings arrived at in the past and more recent findings of my own. Second, I would like to draw attention to more elaborate quantitative viewpoints on the distributions of particular variables under scrutiny. Then, I will offer results of the qualitative interpretation. The final part will be devoted to practical implications of the research outcomes. Hopefully my conclusions,

though largely limited by the character of the selected material, methods, and my qualification, will be of interest to anybody involved in doctor–patient communication and/or its research.

2. Discourse of Medicine Revisited

Most generally, the findings demonstrate that the traditional model of the doctor–patient relationship, being of distinctively asymmetrical character, has shifted in favor of the patient. It is difficult to assert unequivocally what lies behind such a profound social change, but both the literature cited and the language data investigated suggest that the weakening of hierarchies and the redefinition of roles within medical consulting is, on the one hand, due to recent technical innovations (e.g. the internet) which enable patients to access desired medical information without the assistance of the doctor, and on the other hand, due to a more patient-centered approach on the part of doctors. Naturally, both points of explanation are closely interrelated. At the discourse and pragmatic levels, they are manifested by a variety of communicative practices.

As far as questioning and responding practices are concerned, my findings indicate that there still is an unequal distribution of questions between dialogue participants, with the greater number of elicitations initiated by the doctor. However, the disparity in the number of questions posed by doctors and patients is not as great as it used to be. Patients initiate questions and they do so very frequently. Unlike in previous decades, when the proportion of patient-initiated questions was marginal, in my samples patients are very active questioners. Besides, patients use exactly the same question types as doctors do. Moreover, doctors answer questions initiated by patients. If no answer is given, it is owing to specific circumstances (e.g. a phone call).

Regarding the organization of other speech acts, both similarities and differences can be seen. As is evident from the distribution of speech act types, doctors speak more than patients. Furthermore, the analysis has shown that although both interactants use all the speech act categories, certain speech acts are far more frequently initiated by doctors (directives, reactives) and other by patients (expressives). This unequal distribution of speech acts can be explained by the dissimilar social roles that doctors and patients play in the medical encounter and it prevails as one of the conventional (i.e. asymmetrical) features of the doctor–patient relationship. The inequality of some verbal practices of doctors and patients is further supported by the use of the three-part structural unit of doctor–patient interaction, consisting of the doctor's question, the patient's response, and the doctor's reactive, which enables the doctor to claim his power over the patient and thus maintain control over the interaction.

As for interruptions and overlaps, it has been revealed that there is a tendency towards a more balanced nature of doctor–patient interviewing. Interestingly enough, both interactants are active 'intruders' into the talk of the other, with slight numerical dominance on the part of the doctor. Doctors as well as patients interrupt throughout the medical consultation, and it is also evident that neither doctors nor patients limit

themselves in the use of any type of interruption. Briefly said, overlapping speech is a common interactional pattern.

Moving to the organization of topicality in medical consulting, it needs to be remembered that often it is not clear whether the purpose of topic initiation is medically- or socially-oriented. However, taking into account several criteria, the examination has yielded the following results. Expectedly, medically dominant topics prevail on the part of the doctor, while socially dominant topics prevail on the part of the patient. It should, however, be added that this (at first sight) asymmetrical distribution is not necessarily related to the asymmetrical character of the doctor–patient relationship. Topic transition activities give evidence that doctors prefer to use reciprocal topic shifts, which are capable of conveying power equality. Patients challenge the asymmetry by providing competent and medically relevant contributions, even within doctor-initiated medical frames; they seem to be much more educated than in previous decades.

Though previous investigations into the phenomenon of linguistic politeness manifested during the medical encounter were either vague or rather fragmented, my analysis has at least contested the opinion that politeness forms are almost entirely absent from the speaking practices of doctors. As is obvious from the data presented in this study, doctors (and patients as well) employ politeness strategies quite frequently, throughout the medical interview, and of all selected types. Importantly in relation to my research aims, it is not only negative politeness which is used by doctors, but also its positive counterpart.

3. Statistical Distributions and Relationships

Having outlined the most general findings arrived at during my search for a more current picture of doctor–patient interaction, let me now continue these concluding remarks with information concerning the quantitative perspective of the analysis. Without going into details that are presented within the individual chapters, I will stress especially the changes along the symmetry–asymmetry continuum (or the patient-centered vs. doctor-centered, equal vs. dominant continuum). In this respect, I want to emphasize the delimitation of dominance by Linnel [1990]. In his view, there are four principal types of conversational dominance: (i) quantitative dominance (the number of words); (ii) interactive dominance (e.g. the distribution of initiatives and responses); (iii) semantic dominance (e.g. who chooses topics); and (iv) strategic dominance (who initiates the strategically most important contributions).

Starting with the classification of questions, it is interesting to see that the distributional order of patient-initiated categories of questions (1. information, 2. confirmation, 3. clarification, 4. agreement, 5. repetition, 6. commitment) corresponds, more or less, to the distributional order of doctor-initiated categories of questions (1. information, 2. confirmation, 3. clarification, 4. commitment, 5. agreement, 6. repetition). If the classification based on tenor by Urbanová [2003] is taken into consideration, the data show that the ratio of patient-initiated questions

representing asymmetrical–symmetrical relations (70% : 30%) is approximately the same as the ratio calculated for doctors (74% : 26%). The quantitative analysis has further revealed that unlike doctors, who are more active 'investigators' during the first part of the consultation (during the information-gathering phase), patients make their contributions towards the end of the consultation (during the section of diagnosis and treatment).

As regards the distribution of other speech acts, the most numerous group is the category of statements, while the least numerous group is the category of commissives. Importantly, whereas statements are distributed throughout the consultation, with a slight predominance towards its end, commissives take place exclusively during the treatment phase, regardless of whether they are doctor- or patient-initiated. Also patients' reactives have prevalence in the section of treatment. By contrast, patient-initiated expressives (the second most numerous patient-initiated speech act type) prevail during the information-gathering phase, most often during the section of physical examination. In terms of directives, doctors usually employ directives in their direct form, while patients in the indirect form.

Turning to interruptions, the quantity data shows that the symmetry-oriented interruptions posed by doctors (i.e. neutral interruptions and those expressing relational rapport) prevail over the asymmetry-oriented interruptions (i.e. competitive and power interruptions) by 80% : 20%. Interestingly, exactly the same distribution – based on the functional classification system suggested by Goldberg [1990] – can be found in the proportion of interruptions employed by patients (again 80% : 20%). Even more surprisingly, the numerical order of patient-initiated interruptions from the most numerous category to the least numerous category follows the same numerical order as that calculated for doctor-initiated interruptions (1. rapport, 2. competitive, 3. neutral, 4. power). This suggests that the claim about interruptions correlating with the asymmetry in the distribution of speech during the medical interview cannot be taken for granted. As is obvious, interrupting does not necessarily relate to asymmetry; instead, it can be viewed as a symmetrical feature of the doctor–patient relationship.

As was mentioned above, the quantity data for the distribution of doctor- and patient-initiated topics were not as surprising as the data for the other variables. Doctors are more productive when initiating medically dominant topics, while patients are more productive for other topics. To put it differently, doctors frame the conversation in medical terms, whereas patients do so in more social terms. Nevertheless, there are instances when patients talk within medical frames, and even initiate medical topics. Moreover, contrary to what was suggested in previous decades, the analysis indicates that patients are given opportunities to introduce topics that are of interest to them, and even to expand on topics selected by doctors.

With respect to the distribution of positive politeness strategies, it can be said that both participants prefer the strategies involving 'claiming common ground between speakers and hearers' to the strategies involving 'cooperation of S & H' and 'fulfilling H's wants'. The explanation appears to be closely connected with the number of substrategies embraced by each category and with the dialogue phases in which it is

natural for the particular strategy to be used. As the former category comprises more than half of the total number of the substrategies involved [8 out of 15 – here I am referring to Brown&Levinson 1987], it could be presumed that it is this variability that supports the language choices. However, it must be added that unlike the latter two strategies, which occur almost exclusively in the treatment section, 'claiming common ground between speakers and hearers' is distributed throughout the interview.

Returning to Linnel's types of dominance and taking into account what has been said so far, I believe that my findings allow me to conclude the following. It is the doctor who seizes more dominance over the medical interview. He is more dominant as far as verbosity, the interaction process, topicality, and strategic advances are concerned. In this way, he achieves the main purposes of the medical encounter, that being to examine, to diagnose, and to cure the patient. However, it is clear that these inequivalences or asymmetries tend to be leveled out, and compared to the situation that existed just twenty years ago, the present-day medical environment is much more balanced. How both the doctor and the patient contribute to the atmosphere of equality will be summarized in the next section.

4. Results of the Qualitative Interpretation

Starting with the category of doctor-initiated questions, it seems that medical practitioners are beginning to realize the advantages of open-ended questioning. This strategy enables them to pursue more effective information-gathering, and gives the patient an opportunity to recount what she considers to be important with few or no restrictions on the part of the doctor. Open-ended questions further function as potent devices leading to more subtle communicative strategies. First of all, they enable the doctor to support the narration of the patient's medical story. The doctor may also pose open-ended elicitations which are not directly related to the patient's health but target the talk towards social issues. Also close-ended questions are capable of conveying strategies centered on the empathic relationship with the patient. In this way, doctors can involve patients in the decision-making process, which is viewed as an instance of patient-centeredness, resulting in a more equal relationship between doctors and patients. What is more, the analysis has shown that doctors strengthen empathic ties with their patients by employing questions that incorporate patients' ideas – so-called circular questions.

In order to discern patients' share in the successful origination of an ambience of equality, empathy and trust in the consulting room, we have to take into consideration the way in which patients respond to their doctors (rather than the way in which they ask questions, as is the case with doctors' role). In this respect, there appear to be two relevant discourse strategies worth mentioning. Firstly, the doctor can trust his patient if he knows that his talk is being monitored by her. Secondly, if he finds out that that she complies with his treatment suggestions and advice. As my investigation has shown, the first discourse strategy is dependent on the number of backchannel signals initiated by the patient; these vocal indications inform the doctor that the patient is attentive to what

is being talked about, and thus she is more likely to under-stand the message. The second strategy can be recognized only in the follow-up visit; here, the patient's compliance is expressed and confirmed via relevant and trustworthy answers. Both strategies enhance doctor–patient interaction and contribute to more positive outcomes.

Proceeding now to the domain of other speech acts, the research results show that the most numerous speech act type is that of statements. The main function of statements employed by doctors is obviously that of informing patients. The information-giving of doctors gives preference to its presentational rather than its persuasional form. In addition, the information-giving frequently uses interpreting and clarifying techniques and is provided via accessible terminology. Evidently, doctors are attentive to patients' needs and worries, and they help patients better understand their health problems and the benefit of the proposed treatment. All this is often performed by doctors in a soft, cooperative and reflective manner, in joint production with their clients. The close affiliation with both the rational and emotional world of patients is also created by other speech act types. Doctor-initiated directives are organized in such a way that they either strengthen patient-centeredness or their imposing character is sometimes mitigated by the utilization of their indirect variants. Expressives communicate emotional reciprocity and entail shifts to a more colloquial style of doctor–patient interaction.

As regards patient-initiated speech acts (apart from questions and answers), there is one important strategy that is capable of conveying empathy and trust – so-called health-related storytelling. To put it differently, the data show that patients are able to give their personal perspectives on the medical problems, which allows doctors to gather relevant information for reaching a responsible diagnosis. In my view, such verbal behavior reinforces the confidence that doctors have in their patients. In relation to this, the fact that practitioners grant patients time to share their stories indicates that the originally asymmetrical nature of the doctor–patient relationship has indeed been modified in favor of the latter.

Doctor–patient communication, of course, does not develop as a series of consecutive sequences that have clear-cut boundaries; much more often one can witness overlapping speech, characterized by frequent interruptions. Importantly, only a minority of interruptions are used by doctors in the asymmetrical manner, with the intent to control the medical consultation. More frequently, interruptions function as discourse devices expressing either support and co-operation, or eagerness and/or signs of interest and empathy. Among the most frequent communicative aims accomplished by cooperative interruptions are those intending to elicit either repairs of patients' preceding utterances or repeats for confirmation of what the patient has suggested. The communicative intention hidden behind the employment of empathic interruptions is to signal high involvement and understanding, and to express positive feedback.

In harmony with their doctors, also patients take the advantage of the types of interruptions that could be labelled as empathic, expressing cooperation, or acting as markers of interest, affection, social closeness, and active listenership.

The organization of topicality within the medical consultation suggests that doctors are quite open as far as the content matter of the interview is concerned. Topic transition activities further indicate that doctors prefer to activate topic shifts that are capable of conveying power equality. In addition, doctors empathize with their patients by giving them a chance to talk about their personal feelings and perspectives, while at the same time disclosing their professional experiences from medical practice and sometimes even broaching more delicate issues regarding their private lives. These discourse strategies reflect doctors' empathic attunement and high involvement in patients' treatment situation. In this regard, patients may perceive doctors as more human in the relationship, and less threatening or remote.

Patients, on the other hand, not only share their private, non-medical, problems, but are also active contributors within the medical frames developed by the doctors, or even sometimes initiate medical topics. They seem to be far more educated than in previous decades (probably thanks to technical innovations responsible for the accessibility of medical information). In this regard, doctors may perceive patients as competent partners who are familiar with certain aspects of the health care system, and are more likely to comply with the treatment advice recommended.

The qualitative interpretation of doctor-initiated positive politeness has revealed that by manifesting positive politeness strategies, doctors support courteous and tactful manners, and thus achieve smooth relations with their patients. More specifically, the analysis has indicated that doctors frequently choose a style of language that patients are familiar with; usually they switch from medical jargon to more colloquial expressions. In other words, they try to build an interactional environment in which the delivery of medical expertise does not conflict with the lay perspective of their patients. The positive talk of medical practitioners is further enhanced by the frequent use of laughter, by showing solidarity and approval, releasing tension, displaying optimism and involving a high percentage of communication with positive content, giving re-assurance and offering support, calming patients and promoting trust, initiating safe topics and using informal address forms. Of course, these discourse practices do not occur in isolation; they overlap and combine with each other.

Also the positive talk of patients involves a range of diverse forms. Patients, for example, ask their doctors quite personal questions concerning their family life or the way they feel. Sometimes they tease doctors, thus showing friendliness, initiate humorous atmosphere, resulting in laughter, and make social (non-medical) and informal remarks. Similarly to doctors, the patient-initiated positive politeness strategies enter into a number of varied combinations.

5. Conclusion

Taking into account everything that has been observed so far, I am inclined to conclude that general practice consultation is a dynamic interaction influenced by multiple factors. Though there is a significant degree of uniformity, resulting from the primary function of any medical interview – that being to diagnose and treat responsibly

– the mutual interaction of doctors and patients takes a variety of forms and styles, and the interactants employ a variety of discourse strategies, corresponding to their various interests. Whereas some of the strategies result in conflict, other should be viewed as instances of an empathic relationship.

As the focus of the present study has been placed on the latter, it may wrongly appear that doctor–patient interaction, at least in a general practice environment, is harmonious. In fact, the reality is much more complex. Medical interviews still suffer from deficiencies, misunderstandings, and communicative disturbances on both sides of the interaction. As communicative competence should be a social desideratum in all spheres of human life, including the health care system, educating people about competent verbal behavior as one element of medical practice is a must. It is for this reason that I will now list ten key 'summary' suggestions which, in my opinion, contribute to empathic and trusting communication, and support what both doctors and patients long most for – an effective medical process.

(i) INFORMATION – effective general practice consultation requires an abundance of information; both main protagonists of the medical interview, at any stage of the interview, should keep each other informed about their own perspectives of the health problem.

(ii) LUCIDITY – any piece of information should be presented lucidly, in a style of language that is intelligible to both parties; if opacity occurs, it should be given attention and supplemented with explanation and clarification.

(iii) OPENNESS – acquiring the information should be performed in an open, natural, authentic, and transparent manner; both medical and psychosocial issues should be addressed; open-ended questioning is beneficial.

(iv) STORYTELLING – doctor–patient interaction should support narrative aspects of the medical visit; the doctor should motivate his patient to tell the story of her illness, and the patient should be willing to expand on her narration related to health.

(v) LISTENERSHIP – active listenership is a prerequisite for any successful interaction; make sure that you are attentive to what the current speaker is saying; in this way you show interest and compassion; you are also more likely to gain compliance with advice.

(vi) MUTUALITY – or reciprocity, partnership; the doctor and the patient should share similar dominance and control over the interaction. Both participants should have the impression that their contributions are appropriate and appreciated. Shared decision-making is essential.

(vii) CLOSENESS – establishing a partnership is not enough; what is desirable in order to create an atmosphere of empathy and trust is emotional closeness which goes hand in hand with emotional care, understanding, safety, intimacy, and reliance.

(viii) REFLECTION – if a doctor (or patient) wants to be viewed as empathic, he (or she) needs to be able to convey his (or her) emotional experience back to the subject of empathy; it is this re-flection that is still lacking in medical practice.

(ix) TOUCHING – though not given attention in the analytical part of this study, it is without any shade of doubt that nonverbal communication plays a vital role in doctor–patient communication; the literature suggests that haptics is the most relevant type of this communication.

(x) HUMANITY – as the last point let me recall that the main goal of medicine is to treat the patient, not merely to cure the disease; the treatment should be about humans, not about pills; also doctors should be treated as humans, not as gods who can do anything.

Medical education, naturally, cannot limit itself to a mere ten ideas derived from research with a restricted scope. Although my interdisciplinary analysis of English medical consulting confirms some of the findings by Cordella [2004] and Wynn [1999], arrived at using Spanish and Norwegian language material respectively, more investigations of both theoretical and empirical character are needed. Only then will we be able to propose more detailed practical implications of use to all protagonists of the medical encounter.

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Summary

The article presents a summary of findings resulting from a long term project aimed at the inquiry into the field of medical interviewing. More specifically, it deals with the meaning and value of empathy and trust in general practice consultations. A more detailed information can be found in the scholarly monograph “Discourse of medicine revisited” on conveying empathy and trust in English medical consulting (2012).

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СЕМАНТИКА ТА СТИЛІСТИЧНІ ФУНКЦІЇ ПРИКМЕТНИКІВ ЖОВТОГО КОЛЬОРУ В ЛАТИНСЬКІЙ МОВІ

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Постановка наукової проблеми. В ході дослідження якісно нового рівня семантики прикметників кольору в латинській мові класичного періоду як ніколи актуальною постає проблема визначення лексико-семантичного поля певного кольору, яке є складовою загального лексико-семантичного поля прикметників кольору. Основну увагу важливо приділити критеріям формування лексико-семантичного поля.

Стаття присвячена дослідженню семантики прикметників жовтого кольору. **Метою** нашого дослідження є визначення семантичних та стилістичних особливостей прикметників жовтого кольору на матеріалі поетичних творів Горація, Овідія та Вергілія. **Об'єктом** дослідження є прикметники, що позначають жовтий колір у творах даних поетів. **Предметом** вивчення є семантичні особливості та стилістичні функції прикметників, що утворюють лексико-семантичне поле жовтого кольору. Для даного дослідження був використаний матеріал оригінальних пам’ятників [9].

Аналіз останніх досліджень із цієї проблеми. Найяскравіше колористична культура виявилася за доби античності. Про це стверджує Л. В. Бичкова у праці «Колористична культура античного світу». Авторка зосередила увагу на процесах формування і розвитку колірної культури з урахуванням «динаміки політичних та ідеологічних настанов, що панують у суспільстві» [2]. Досліджуючи проблеми функціонування прикметникових лексичних синонімів у старогрецькій мові, О. І. Малиновська зробила вагомий