23 The Discourse of Medical Encounters

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0 Introduction

There is a huge cross-disciplinary literature on medical encounters. Lipkin et al. estimate 7000 titles (1995: ix) overall, and one computerized bibliography contains 3000 articles (Putnam and Sherman 1995). However, as Fleischman (this volume) points out, there are significant differences among the interests, theories, and methodologies brought to bear on talk in medical encounters. In this huge literature, most studies of medical encounters are atheoretical about language. Since most of the linguistically atheoretical studies are oriented toward medical praxis, I will refer to this group as the "praxis literature."

In the praxis literature, talk-as-data usually disappears in the first steps of the research. These first steps involve assigning a single functional meaning (e.g. information-giving, affective display) to each utterance and then coding utterances into functional categories, so that they can be quantified. Language is assumed to be the transparent vehicle of meaning. For these reasons, the praxis literature does not provide discourse data, although it does provide data on speakers' intuitions and it can have tangential bearing upon discourse issues.

The "discourse literature," by contrast, consists of analyses of talk itself. The analyses grow out of contemporary theories about sequential, situated discourse (e.g. conversation analysis, interactional sociolinguistics, the ethnography of communication). The discourse literature is a relatively new one. Although articles date from the 1970s (e.g. Shuy 1976), the major books devoted entirely to the discourse of medical encounters have all been published since 1984 (Mishler 1984; West 1984b; Fisher 1986; Silverman 1987; Davis 1988; Todd 1989; von Raffler-Engel 1990; Fisher and Todd 1993; Weijts 1993; Ferrara 1994; Ainsworth-Vaughn 1998a).

In the praxis literature, and to a large extent in the discourse literature, research has had an explicit or implicit orientation toward the balance of power between patient and physician. An overt or underlying research question is: what is the relationship between the power balance and what participants say?

In order to address this question, we need first to analyze power (see Ainsworth-Vaughn 1995, 1998a, for a complete discussion of power and discourse). Power is

usually defined as implementing one's agenda. Doctor and patient may each have an agenda regarding who will speak, about what, and when; and doctor and patient may each have an agenda regarding treatment. So there are two kinds of power at issue: control over the emerging discourse, and control over future action.

The praxis literature includes discussion of the second type of power, control over future action: what are the outcomes of talk? Do patients follow physicians' recommendations? One striking theme in this discussion is that of improved physical health following upon certain types of talk within the encounter (Kaplan et al. 1989).

The discourse literature, however, is concerned with the first type of power: control over emerging discourse.

In both literatures, researchers have tended to focus upon three dimensions of the discourse organization of the medical encounter: sequential phases of the encounter; its discourse genre (usually, interview vs. conversation); and its major constitutive speech activities. Following is a selective, issue-oriented review organized by these three categories.

1 Sequential Phases

It is in this dimension that the two literatures diverge the most. Much of the discourse literature contains no mention of phases in the overall encounter, focusing instead upon one or a few sequential speech activities. By contrast, in the praxis literature, phases are accepted as fundamental, a given (e.g. Byrne and Long 1976, discussed below). Helman's (1984) description of encounters as "ritualized" refers in part to their organization into phases.

In the study of medical discourse, it is helpful to return to assessment of ritual in both institutional and noninstitutional talk. Though we seldom notice ritual in everyday life, it interpenetrates conversational talk – for example, simply getting through a grocery store checkout line can involve as many as five ritualized routines of greeting, thanking, and farewell. These are ritualized in three ways: the type of speech activity is culturally predetermined, its place of occurrence in sequential talk is prescribed, and its phrasing is routinized. All this operates at such a low level of awareness that we do not normally consider such encounters to have ritualized dimensions.

In the medical encounter, all three of these dimensions show ritualization, but – for physicians and medical educators, at least – there is a conscious attempt to design these ritual aspects of talk. As is the case with religious rituals, the approved speech activities, their phrasing, and their sequence are taught explicitly by the ordained to the neophyte (in medical school). Another similarity to religious rituals is the fact that the design of the discourse is subject to overt debate and change (e.g. Smith and Hoppe 1991, discussed below).

However, conversational discourse co-occurs with ritualized discourse in medical encounters. Medical discourse is unpredictable, and in being so, it is like conversation. Also, many of the constitutive speech activities of medical encounters are shared with conversation – though these speech activities may be modified or restricted differently in the two genres. Relationships between conversation and talk in medical encounters are discussed in section 2.

The model of ritualized phases has been adopted into the discourse literature from the praxis literature. For instance, Heath (1992) cites a phase model drawn from the praxis literature (Byrne and Long 1976). Byrne and Long suggest six phases: "[Phase] I, relating to the patient; II, discovering the reason for attendance; III, conducting a verbal or physical examination or both; IV, consideration of the patient's condition; V, detailing treatment or further investigation; and VI, terminating" (Heath 1992: 237). Note that Byrne and Long name each phase after the physician's activity rather than joint activity. This focus upon the physician and neglect of patients' role in co-constructing the discourse is a significant limitation of both literatures.

Conscious design of the discourse of medical encounters is illustrated by a variation on the phase model in the praxis literature (Smith and Hoppe 1991). This model also illustrates the relationship between this speech event and the larger society. Smith and Hoppe explicitly construe the encounter as sequential phases, but propose that initial phases should change away from the traditional physician-centered history-taking. Instead, they call upon physicians to make the first two phases of the encounter "patient-centered." In the first phase, the physician would not talk beyond an opening remark and occasional back-channels or brief repetitions of the patient's words. In the second phase, the physician would ask questions directed at eliciting the patient's feelings. In this second phase, "When patients redirect conversation away from the personal dimension and begin to give data related to organic disease, the interviewer should try to refocus the patient on the already-developed . . . emotion, as in the following example: 'Before going into your hospitalization, tell me more about what that was like for you to be scared'" (Smith and Hoppe 1991: 474).

Smith and Hoppe's model is a kind of discourse planning that is ongoing in medical education. It illustrates the pitfalls in overt attempts to design the discourse of encounters without understanding the ways power is claimed through discourse. The model is an attempt to respond to the recent well-documented rejection, in American society, of traditional authoritarian roles for physicians (Starr 1982). Ironically, in Smith and Hoppe's model the physician is enjoined to make highly consequential unilateral decisions about topic transitions (cf. West and Garcia 1988). A physician who did this would enact the very authoritarian role the model seeks to subvert, since he or she would be unilaterally choosing topics and enforcing predetermined phases.

If the praxis literature is overinfluenced by the notion of phases, the discourse literature shows a paucity of attention to the notion. One sophisticated analysis which does assert the relevance of a phase model is that of ten Have (1989).

Ten Have's model brings together the phase, genre, and speech activities dimensions of medical encounters. He regards "the consultation as a genre" (the title of his article). For ten Have, this genre is marked by orientation to phases. At the same time, it is realized through locally negotiated speech activities.

Ten Have speaks of medical encounters as organized into an "ideal sequence" of six phases: opening, complaint, examination or test, diagnosis, treatment or advice, and closing. "The sequence is called 'ideal' because one observes many deviations from it that seem to be quite acceptable to the participants" (ten Have 1989: 118).

Shuy's (1983) analysis also bears upon the nature and existence of planned phases for medical encounters. Like ten Have, Shuy (1983) found a great deal of variation in

the sequential organization of encounters. Physicians in Shuy's data apparently were filling out a written questionnaire during the encounter. Shuy expected that the topics of the encounters' discourse would be clearly related to the questionnaire. He reports:

> One startling conclusion faced me at the end of my examination of some 100 interviews: It would be very difficult to reconstruct the written questionnaire on the basis of the tape-recorded interviews. . . . not all interviews cover the same topics and by no means are all questions covered consistently across all interviews. The range of variability was, in fact, gross. (1983: 22).

In other words, in Shuy's data, patients' and doctors' local negotiation changed the encounter away from the doctors' previously established design for the discourse.

Shuy's subsequent discussion casts his results in terms of the possibility that medical encounters can be conversational to a degree. Shuy suggests that patients are more comfortable with encounters that are more conversational. This raises the issue of genre: are encounters fundamentally interviews which can be modified toward conversation, or fundamentally conversations that have been modified to create interviews?

2 Genre

The question whether medical encounters are fundamentally conversational or interview-like appears in several major analyses. Frankel points to early studies in which researchers suggested that the encounter "is essentially conversational in nature" (1979: 232). Frankel remarks that the "case [has not] been made convincingly" (1979: 233).[1] Instead, he suggests, the restricted turn-taking system of the medical encounter is in contrast with that of conversational discourse, especially in regard to questions.

Ten Have's (1989) discussion of genre in medical encounters suggests that there is "simultaneous relevance of several different interactional formats" (1989: 115). Ten Have examines one such format, troubles-telling, a conversational activity. Confusions occur when patients think they are being invited to do troubles-telling. So ten Have sees that conversation can be one of the interactional formats that participants in encounters orient themselves toward, but that this can be "problematic," as physicians resist the format.

Heritage appears to agree with Frankel that institutional discourse is defined by restrictions on speech activities: "Institutional interaction seems to involve specific and significant narrowing and respecifications of the range of options that are operative in conversational interaction" (1989: 34). But, in contrast to Frankel, Heritage's formulation might suggest that he sees medical discourse as essentially conversational in nature.

Both Maynard (1991) and Ainsworth-Vaughn (1998b) identify speech activities which are found in conversation and in the medical encounters the researchers studied. Maynard shows that "doctor–patient interaction involves sequences of talk that have

their home in ordinary conversation" (1991: 449). This sequence is neither problematic, as in ten Have's data, nor peripheral, as in Shuy's. The sequence Maynard finds in both medical encounters and ordinary conversations is a "perspective display series." For instance, a clinician and his team have developed a diagnosis of developmental delay in a child, and the clinician must now convey that diagnosis to the parents. The clinician asks the parents, "What do you see? – as his difficulty" (Maynard 1991: 468). The clinician then uses the parents' perspectives, as displayed in their answers, in co-constructing a formulation of the difficulty. Because the parents helped construct the formulation, they are more easily persuaded of its validity. Maynard suggests that this persuasive power can be abused by clinicians.

Maynard points to the theoretical significance of finding overlap between conversation and medical encounters: "If, at the level of conversational sequencing, we find deep connections between everyday life and the medical encounter, implications [for theories of] clinical and other institutional discourses are vast" (1991: 449). One such implication is that the structures of institutional discourse should be studied in conjunction with those of ordinary conversation, rather than in isolation, as is often the case now.

Ainsworth-Vaughn (1998b) also found a conversational structure fundamental to medical encounters. She studied narratives and stories used by doctors and patients in speculating upon and ruling out possible diagnoses. Three types of narratives appeared in this process: Labovian (Labov 1972), habitual (Riessman 1991), and hypothetical (Riessman 1991). Doctors and patients used these types of narrative to tell what happened (Labovian), what typically happens (habitual), or what might happen (hypothetical), in a story-world embodying a diagnosis. Labovian narratives about what did not happen were used to rule out possible story-worlds that had been offered. Often these Labovian, habitual, and hypothetical narratives were evaluated, becoming stories. These data are particularly significant for the "conversation as fundamental" approach, because narration and stories are often cited as archetypal conversational speech activities.

Psychotherapy sessions are an outgrowth of medical encounters. Ferrara's (1994) list of contrasts between conversation and talk in psychotherapy sessions is relevant to discussion of genre.

Ferrara labels seven differences between conversation and psychotherapy sessions: parity, reciprocality, routine recurrence, bounded time, restricted topic, remuneration, and regulatory responsibility. Three of the seven – routine recurrence, bounded time, and remuneration – are contextual features. These unarguably constitute the event, but they do not directly control or define the speech activities in the event. These three contextual features are found in both psychotherapeutic and medical encounters, but not in ordinary conversation.

The other four features have to do with discourse structure. They often are prominent in medical encounters, but have varying salience. Restricted topic, for instance, is a feature of encounters; but that statement must be qualified, for both topic sequence and topic itself. Shuy's (1983) above-mentioned data show the unpredictability of topic sequences in encounters. In my data on topic in oncology encounters (aspects of which are discussed in Ainsworth-Vaughn 1992), the restriction operated to require discussion of the relevant medical topic, but not necessarily to exclude discussion – even extensive discussion – of other, nonmedical topics.

In reviewing my data on medical encounters (Ainsworth-Vaughn 1998d), I find two more of Ferrara's contrasts to be borne out: lack of reciprocality (e.g. patient and doctor have unequal rights to ask questions) and regulatory responsibility (the physician has an asymmetrical right to initiate and terminate the encounter).

This leaves parity. Parity, or lack of it, in Ferrara's data refers to a client's agreement that the therapist is a helper and that the client needs help, through the discourse itself. Here therapeutic talk can differ from that of medical encounters. Since the discourse itself is treatment, the therapist has rights that may or may not be ceded to physicians in medical encounters.

In psychotherapeutic encounters, patients are presenting themselves for on-the-spot treatment through discourse, including discussion of intimate topics as the therapist deems therapeutic. So parity is relinquished, at least in selection of topics. This is not necessarily the case with medical encounters. This is why the model proposed by Smith and Hoppe, discussed above, is not appropriate for every medical encounter.

In medical encounters, parity is negotiated among participants, apart from the genre (conversational or ritualized talk). When the physician puts forth a diagnosis and treatment plan, this act is sometimes accepted as desired help and is ratified as a plan of action. The sequence of offering and accepting then constitutes lack of parity.

But the same act may be taken as constituting an opinion, and the patient may hold in abeyance any plans for action. In my data, an oncologist suggested that a young man with testicular cancer should have an exploratory operation to see whether cancer was in the nearby lymph nodes. Because the couple had no children, and the operation could lead to impotence, the man's wife suggested a different plan, and her plan was eventually adopted. She had negotiated parity; her plan was on a par with that of the physician.

In sum, we cannot characterize all medical encounters as having a matrix of conversational features, or as having a matrix of interview-like restrictions. We can suggest that encounters exist on a continuum between interrogation, as described in Mishler (1984), and friendly conversation with a small amount of time devoted to satisfying medical goals, as I found in studying unproblematic oncology checkups.

At the interrogation end, the sequence of speech activities is heavily ritualized (primarily questions and answers) and reciprocality is not present. At the conversation end, only a brief part of the sequence of speech activities is ritualized, and reciprocality may be present in varying degrees. Regulatory responsibility (the right of the physician to begin and end the event) is present throughout the continuum. Parity is negotiated locally, apart from discourse genre.

All analogies are deficient, by nature. A continuum metaphor provides for construing two possible directions for the discourse – toward the two ends of the continuum – rather than depicting the possible shifts that actually take place among multiple interactional frames (cf. Tannen and Wallat 1987). Perhaps the emblematic designs in medieval woodcuts would serve better; these web-like designs show connections among a variety of symbols. In an emblem, movement would be possible back and forth in a variety of directions. But the continuum metaphor does allow a representation, however limited, of variation in discourse genre – variation that has not yet received adequate attention in either the medical or the discourse literature on the medical encounter.

3 Constitutive Speech Activities

Framing moves and questions are the constitutive speech activities that have been of most interest to analysis of medical talk. Framing moves are related to the constitution of self in the medical encounter. Questions are the speech activity usually seen as embodying asymmetry in the encounter.

3.1 Frames

Framing is a critical act, because a frame is the definition of the speech activity underway (Tannen 1993). Frames are related to schemas, which are mental constructs, organized chunks of information (Tannen and Wallat 1987). We have schemas about all aspects of our lives, including our and others' social identities, the normal conduct of types of talk, and relationships between the two. I suggest that speakers make attempts to instantiate their schemas for the conduct of speech activities. In my terminology, such an attempt is a framing act, and an instantiated schema for a speech activity is a frame. Frames are constituted by participants' interactive behavior and by the way this behavior indexes the sociocognitive schemas associated with speech activities.

Goffman speaks of "the building up of an information state known to be common to the participants," which is "dependent on the question of the [interactional] unit as a whole" (1981: 131). Theories of frame and schema suggest that by proffering a frame, a speaker attempts to constitute the self. When the doctor–patient encounter is framed as part of the medical institution, participants are constituted as doctors, patients, nurses. But when a friendship frame is invoked, participants are constituted as peers. As frames are offered and ratified, a recursive process takes place. In this process, favorable or unfavorable attributes are added to the cognitive schemas participants can refer to during future constitution of their own and other's social identities.

A great deal of framing takes place at the beginning of an encounter. Introductory talk cannot be dismissed as just a prefatory segment preceding, and walled off from, the real work of the medical encounter. Talk at the first and last of the encounter is rich in meaning; as Ferrara says, "Information about differences is stacked at the edges of events" (1994: 42).

Coupland et al. found framing in physicians' small talk at the first of medical encounters in a small hospital in England. There were greetings and welcomings, apologies, compliments, teases, and other talk that "constitute[s] a predominantly social frame for consultation openings" (1994: 102); "doctors' willingness to pursue non-medical topics [was] strikingly at odds with the findings of most previous studies" (1994: 104). Coupland et al. see these framing gestures in a positive light. However, Cheepen (1988), referring to data on a job interview, suggests that when this early small talk is initiated by the institutional member of the group, it may be patronizing.

Although framing moves are typically proffered at the first of the encounter, they can occur anywhere within it. Tannen and Wallat (1987) studied a pediatrician who

was videotaped for the purpose of teaching medical students how to conduct a medical encounter. The physician joked with the child, addressed her audience of medical students, and spoke to the mother, moving back and forth among frames. Tannen and Wallat locate their study within an extensive, detailed theoretical apparatus, showing that medical discourse (indeed, any discourse) may involve the coexistence of multiple frames.

Ten Have (1989) most likely had framing in mind when he remarked upon "different interactional formats" that can occur during medical consultations (1989: 115). Unlike Tannen and Wallat, who found multiple frames in peaceful coexistence, ten Have was interested in difficulties – "activity contamination" – that might arise from the salience of multiple frames.

Storytelling has been linked with framing in medical discourse. Stories are rich in both referential and social meaning (Schiffrin 1984), and therefore they play an interesting role in constituting frames and selfhood.

3.2 Stories

Sandelowski (1991) provides a masterly review of narrative studies relevant to medicine and medical discourse. In the praxis literature, narration has been linked primarily to patients' histories. "The patient's story," whether told by patient or by physician, usually is a term that conflates localized storytelling with an overview of the illness or of the patient's life history in relation to illness (Brody 1987; Kleinman 1988; Charon 1989; Hunter 1991; Frank 1995). For example, Waitzkin suggests that "doctors should let patients tell their stories, with fewer interruptions, cut-offs, and returns to the technical" (1991: 273). "Story" here refers both to localized talk and to the development of an overarching, abstract narrative.

Analysts of sequential discourse, however, are interested primarily in localized stories. A localized story is talk about a sequence of events. In the cross-disciplinary literature on stories, it is generally agreed that stories function to display core values and thus characterize the storyteller (e.g. Bauman 1986; Josselson and Lieblich 1993; Riessman 1993). Localized storytelling establishes both interactive frames and cognitive schemas important to the encounter.

Localized stories in the medical encounter have been associated with patients and thought of as patient's actions in a fundamentally conflictual relationship with the physician. Davis (1988) and Young (1989) looked at stories being used by patients. The stories they studied had two purposes:

- to define the interaction so that the social distance between patient and physician was reduced;
- to assert a self which had been suppressed in the institutional discourse.

Young (1989) describes encounters in which stories have little overt relation to the patient's presenting illness. Young analyzes both "links and splits" between stories and their surrounding medical context, but her emphasis is on the splits. For Young, stories are "enclaves of the self." The self is "sealed inside a story" (1989: 153).

Ainsworth-Vaughn (1998c) describes storytelling with multiple functions, in the introductory small talk in two oncology encounters. Rather than being the production

of only one speaker, as in Young's study, in these encounters stories – even stories with no direct relation to cancer – were co-constructed, as doctor and patient worked to constitute a valued social self for the patient.

But this willingness to co-construct story and self may be unusual in medical encounters. Like Young, others who write about patient–physician talk have found patients having little success with their attempts to secure respect for their life worlds (Mishler 1984; Henzl 1990). Davis (1988) analyzed storytelling in Dutch medical encounters. In her data, "Myriad instances were available of the patient's 'lifeworld' being 'absorbed' into medical frameworks" (1988: 357). Davis makes it clear that she does not mean this in a positive way – as an enriching integration of the two – but rather as the disappearance of the life world.

The functions of storytelling as described by Davis (1988) and Ainsworth-Vaughn (1998b) are quite complex. Davis chose four encounters which show that patients' storytelling can range from being continuous throughout the encounter (creating and being created by a friendship frame) to being stymied at every attempt (creating and being created by a medical/professional dominance frame). And Ainsworth-Vaughn (1998c) suggested that stories functioned not only to frame but also to mitigate discussion of cancer, introduce a candidate diagnosis, and validate the patient's experience.

Also, as described in the preceding section, Ainsworth-Vaughn (1998b) found encounters in which joint storytelling became a way of constituting a diagnosis. Doctor and patient used narratives and stories to propose, argue against, augment, or accept – i.e. to construct – an overarching diagnostic hypothesis and its associated treatment plan.

Because it can determine diagnosis and treatment, and because it embodies our selves, storytelling claims power. Its presence in medical encounters is rich in significance for discourse theory and also for medical praxis.

3.3 Questions

The study of questions in medical encounters illustrates two fundamental problems with the extant research. One is the difficulty of defining a speech activity, and the other is the difficulty of generalizing on the basis of situated talk, without fully assessing the influence of varying contextual features, such as setting, gender, or diagnosis.

3.3.1 Questions and power

The term *question* sometimes is used to refer only to linguistic form, e.g. inversion of subject and auxiliary verb, or rising intonation at the end of a sentence. However, I follow Stenström (1984), West (1984a), and Frankel (1979) in using "question" to mean "request for information." Stenström shows that linguistic markings alone cannot identify questions (e.g. rhetorical questions are linguistically marked but function otherwise), but that linguistic markings and situational features have some conventionalized relationships which speakers understand as suggesting and confirming question function.

The number of questions doctors and patients ask has been a central issue in research on medical discourse because to ask a question is to claim power over emerging talk. Studies in various cultures (e.g. West 1984b (United States); Hein and Wodak 1987 (Austria); Weijts 1993 (Netherlands)) have shown beyond doubt that medical encounters often consist primarily of doctors asking questions and patients answering. The usual conclusion is that medical encounters are an "interview" genre – highly asymmetrical, with only one person having the right to question.

The relationship between questions and power is important to specify. Questions are directives. By using directives, a speaker proposes to exert control over other conversational participants (Goodwin 1990), i.e. to direct their actions in the discourse. There are several ways in which questions claim power:

- A question addressed to another participant chooses that participant as the next speaker – an obvious exercise of control.
- A question, even an "open-ended" question, always in some way restricts the topic of the response – the referential content of the conversation. This second point is especially important in the medical encounter, because time for the encounter is limited and choice of topic determines which of the patient's problems will be addressed and which will not.
- Some questions entail the expectation that the floor will be returned to the questioner (Frankel 1979: 234), and control of the floor is usually thought to embody the "up" position in conversational asymmetry (Edelsky 1993; James and Drakich 1993).

In institutional dyads (attorney–witness, teacher–student, physician–patient), typically, the speaker who has the power to reward (attorney, teacher, physician) has asked the most questions, and the imbalance in numbers has been dramatic (Dillon 1982, 1986, 1990). In conversational settings, however, questions need not be solely claims to power over the emerging discourse. Sometimes questions also propose to share or give up that power. Notably, a question can hand over the floor to other participants and demonstrate the questioner's interest in the answer (Goody 1978; Fishman 1983).

Questions in medical encounters demonstrate both power-claiming and power-sharing. However, it is power-claiming that has occupied researchers' attention. Comparative numbers and percentages of questions asked have been assumed to be rough indices to the balance of power between doctor and patient (Frankel 1979; West 1984a; Ainsworth-Vaughn 1994; see Ainsworth-Vaughn 1995 for a critique of this assumption). But these quantitative studies often rest upon differing definitions.

3.3.2 Defining and counting questions

Discourse acts depend upon both culturally agreed signals and interpretations made in real time by the participants. Interpretations are made by assessing talk within its local context. So speakers are assessing widely varying combinations of syntactic, referential, discourse, and other features. These combinations cannot be reduced to brief definitions. Referential meaning is particularly difficult to delimit with a definition (Ainsworth-Vaughn 1992).

The problem of definition is central in research on questions in medical encounters, in both the medical and the discourse literature. In the praxis literature, studies often have no articulated definition for questions (Bain 1976; Davis 1971; Korsch and Negrete 1972) or an idiosyncratic definition (Roter 1977, 1984).

In the discourse literature, the best-known article on questions is Frankel (1979). Frankel's definition acknowledges the role of referential content but rests upon the status of the question as the first part of an adjacency pair, itself a controversial concept (Stenström 1984: 24; Tsui 1989).

Frankel studied a very narrow subset of questions, which he called "patient-initiated." In audiotapes of ten ambulatory care visits, Frankel found that fewer than 1 percent of the total number of questions asked by physicians and patients were "patient-initiated." In order to be "initiated" by the patient, the question had to be the first utterance in the turn and also had to introduce new information. In addition, Frankel excluded "'normal' troubles such as requests for clarification, information, etc." (1979: 239).

Frankel's count of "patient-initiated" questions, based upon a well-articulated definition, is an example of quantitative and qualitative methods supporting one another in a productive way. It meets the qualitative demand for a discourse-based definition and the quantitative goal of providing an overview of the occurrence of the activity.

Unfortunately, there has been a widespread tendency to generalize Frankel's 1 per cent finding to all questions, when in fact it only applies to narrowly defined "patient-initiated" ones.[2] This inappropriately generalized finding is probably the best-known result of all research done on medical encounters and has contributed materially to a prevalent stereotype of patients as passive and powerless.

West (1984a, 1984b) also used an adjacency pair definition of questions; however, she placed few restrictions upon it, excluding only requests for repetition, because one person did not hear the other, and markers of surprise ("Oh, really?"). West studied questions in 21 encounters in a clinic whose population was primarily drawn from lower socioeconomic strata. She found 773 questions, of which 91 percent (705) were asked by physicians. Only 9 percent of the questions were asked by patients. West's data may suggest that medical encounters between residents and poor patients in a clinic do in fact belong to the "interview" genre, with doctors asking questions and the patients' role being largely limited to answering. But there is little contextual information on these 21 encounters. West does not say what the diagnoses were or whether the patients and doctors had met before.

She does say that there were 18 physicians, all of whom were white. Fourteen of the physicians were men and four were women. There were nine male patients (five white, four black) and 11 female patients (six white, five black). So both gender and ethnicity are complicating factors in evaluating West's results.

In my quantitative study of questions, I also used an adjacency pair definition, comparable to that used by West. I studied 40 encounters, evenly divided as to gender of both physician and patient. The setting was oncology in 28 of the 40 encounters, but the other 12 encounters were spread over a variety of medical specialties and diagnoses.

Compared with West's (9 percent) numbers, patients in this study asked a high percentage – 38.7 percent – of the 838 questions physicians and patients asked one another. This percentage is not out of line with other research. Roter et al. (1988)

summarize the results of nine quantitative studies of medical encounters in which some form of questioning was studied; by my count of their reported figures, patients asked 25 percent of the questions. In Roter's own 1984 study, patients asked 43 percent of the questions.

Diagnosis, gender, and initial versus repeat visit all appeared to make a difference in the numbers of questions patients asked, in the Ainsworth-Vaughn study. Gender was a particularly interesting issue. When the physician was a woman, male patients asked 10.9 questions per encounter and female patients asked 10.8. When the physician was a man and the patient a woman, the patient asked 8 questions per visit. Finally, the man–man dyad produced only 3.7 patient questions per visit. The percentages of physicians' questions in these same encounters are equally interesting. Overall, when the physician was a woman, she asked 49.9 percent (216) of the 433 questions. When the physician was a man, he asked 73.3 percent (297) of the 405 questions.

Gender has not been well studied in medical discourse. The studies that focus upon gender (West 1984c, 1990; Pizzini 1991; Davis 1988; Ainsworth-Vaughn 1992) have involved small numbers of female physicians (e.g. Davis looks only at the male physician–female patient combination). With these qualifications, it can be said that the studies of gender in medical discourse tend to support the possibility that women are more likely to be cooperative in discourse, while men are more likely to be competitive.

These quantitative/qualitative studies bear directly upon the problem of describing a genre – in this case, the medical encounter. They show that for some patients, the medical encounter was an interview in which physicians asked, and patients answered, questions; but for others, it was not. They suggest that subgenres exist, related to such factors as diagnosis and setting. They call attention to the need for further study of gender. In short, quantitative studies with a strong base in qualitative methods can provide important data on the control of emerging discourse.

4 Conclusion

In sum, research on medical discourse has provided data of great interest for theoreticians and practitioners. The medical encounter is an ideal locus for studies of institutional discourse because of the disparities between doctor and patient and the consequentiality of the talk. Practical problems of recording institutional discourse are minimal in medical encounters because of the temporal and spatial boundaries of the talk – usually 10–15 minutes, in a private room – and the small number of participants.

On the other hand, it is difficult to establish the trust that allows physicians and patients to consent to being recorded. Most studies have been based upon recordings made as part of residents' training, in free or low-cost clinics. In these settings, it is debatable whether patients can freely give consent. Perhaps because of the difficulty of obtaining consent for data other than that on free or low-cost clinics, the discourse literature is fragmentary.

There are several problems with the extant literature: first, we lack broadly tested discourse models of medical encounters. Therefore we cannot assume that phases are

the most salient discourse organization in this speech event. Secondly, the event's constitutive speech activities have often gone undefined – or defined in idiosyncratic ways – and this casts doubt upon many quantitative studies of such critical activities as questions. Other important features of the event also need closer attention; so far we have an inadequate base of data on important discourse features such as contrasting medical settings, characteristics of the illness and patient, and gender. And finally, theories about power – its use and abuse – in relation to institutional discourse have not yet been well articulated, in spite of the centrality of power issues to debates in the literature.

We need research upon talk in a wider variety of medical settings, with balanced numbers of men and women as participants, and with ethnographic observation and attention to the way talk is situated – setting, diagnosis, interactional history, prospective length of the relationship. Research should exploit the creative tension that can exist between qualitative and quantitative methodologies, so that data on both sequence and frequency are represented in the analysis.

Research on medical encounters is used by medical educators, who attempt to design this consequential discourse event. New data on the event and on the attempt will continue to hold an unusual degree of interest for discourse analysts because of its theoretical, practical, and human implications.

NOTES

1 The publication date for this study is variously given as 1979 and 1984. As I read the publication data in Psathas's book, 1979 is the correct date.

2 For example, the phrasing in Beckman and Frankel (1984) allows overgeneralization: "In two studies (Frankel 1979, West 1984) physicians were found to control 91% and 99% of the questions asked in routine office visits to internists and family practitioners" (Beckman and Frankel 1984: 694).

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