Any Questions?

An analysis of questions initiated by native and non-native English speaking patients and their parents during paediatric consultations

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ABSTRACT

Good medical care depends on effective communication between patient and health professional. Misunderstandings can occur in any medical setting but can be further compounded by language and cultural factors in those interactions which occur in a cross-cultural context. The medical consultation is an institutional interaction and as such can involve additional, taken-for-granted evaluative and interpretive criteria which are applied by interactants automatically, without conscious reflection. Non-native speakers who may have a good functional control of the language and have few problems at the level of propositional content may experience significant difficulties at the necessary interpretative level.

Questions act to allow the questioner a degree of interactional control and when patients ask questions they not only increase their access to information but also indicate to the doctor that they wish to play a more active role in the consultation. This thesis examines the discourse of doctor-patient interactions and in particular the ways in which questions are framed and presented by patients and, because the patients in this case are children, their parents. Fifty three medical consultations were observed from both public and private pediatric clinics with patients and their parents comprising 33 native and 20 non-native speakers of English. Data for the study comprise 28 of those consultations. The data include post-consultation interviews with patients and their parents, and interviews with the treating doctors.

The analysis indicates that there are considerable differences in the patterns of questioning behaviour of native speakers and non-native speakers, and that the questioning behaviour of patients and parents seems to be influenced by the communication style of the doctor.
These findings indicate that the questioning behaviour of non-native speaking parents in medical consultations has the potential to lead to less access to information, fewer explanations about their child's condition and a less active role overall in the medical consultation. This in turn can lead to different outcomes for those parents such as lower levels of satisfaction and, potentially, lower levels of compliance with medical advice and directives. These findings also indicate that the needs of non-native speakers in such circumstances are more successfully addressed by a doctor-centred approach.

Finally, this study argues that the observed differences in the patterns of questioning behaviour between native speakers and non-native speakers is more than simple lack of linguistic resources but rather is a result of the clash between the often subtle differences in communicative competence of non-native speakers and the specialised inferential frameworks inherent in institutional discourse.
AUTHOR’S DECLARATION

This is to certify that:

i. The thesis comprises only my original work

ii. Due acknowledgement has been made in the text to all other material used

iii. The thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies, appendices and footnotes.

Anne Kanaris

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CHAPTER 1 Introduction

Talk is central to most interactions in most social contexts. Meaning in such interactional situations is negotiated by participants, based on feedback and cues given to each other during conversational turns, through shared background knowledge, and through participants’ pragmatic, sociocultural, and sociolinguistic abilities. The ways in which participants approach interaction depend on the ideas, beliefs, attitudes and expectations they have about that interaction, about communication, and about language itself. In order to function effectively, people have to make links between each new event, or situation and their past experiences of such events or situations. These connections are learned as children grow up and live in a given culture and it is these connections that lead us to have certain expectations of how an event should look, or what it means (Tannen, 1993). When people interpret the discourse of others, it is through the cultural norms of their own system and is often based on the assumption that the interaction carries the same meanings for all participants. It is in this way that misinterpretations can occur and judgements based on such misinterpretations are made. As Jones (1996) points out such problems can be further compounded when the topic of interaction is one which is sensitive or emotionally charged such as in matters of ill health, or as is the case in the present study, the illness of one’s children.

Capturing the relationship between discourse and social life, Candlin (1997) describes discourse as referring to language in use: as a process which is socially situated. He says: “we may go on to discuss the constructive and dynamic role of either spoken or written discourse in structuring areas of knowledge and the social and institutional
practices which are associated with them.” (Candlin, 1997: vii). Medical discourse is socially situated and talk between patients and doctors in the medical setting is an “essential and critical component of clinical practice” (Mishler, 1984:8) and is the “fundamental instrument by which the doctor-patient relationship is crafted and through which therapeutic goals are achieved” (Roter and Hall, 1993:3). Talk therefore plays a vital role in the medical setting. Misunderstanding, or lack of effective communication is a threat to any form of interaction, but in the medical setting poor communication can have very serious consequences. The ultimate goals of the medical interaction can range from the restoration of health to the preservation of life (West and Frankel, 1991) so the talk between doctor and patient has very real consequences for the diagnosis and treatment of the patient’s illness. These consequences can include patient dissatisfaction, feelings of powerlessness and anxiety, confusion, and ultimately non-compliance with medical advice, which has the potential to then lead to actual physical harm for the patient (Mishler, 1984, Wodak, 1996). Communication difficulties, which can occur frequently in doctor-patient interactions where both participants share a common language and cultural background are further exacerbated and compounded by language and cultural misunderstandings in those interactions which occur in a cross-cultural context. In such a context the beliefs and values of the participants may be at variance, instrumental goals may be in conflict, perceptions of the event and each participant’s role may also vary and power differences are likely to be heightened (Candlin, 1987).

Although there is a considerable body of research into doctor-patient communication (e.g. Korsch, and Negrete, 1972: Ben-Sira, 1980: Cicourel, 1981, 1992: West, 1984a, 1984b: Tuckett, Boulton, Olson and Williams: 1985: Buller and Buller, 1987:}
Silverman, 1987: Wodak, 1996) which is discussed in detail in Chapter 2, there are fewer studies which examine the doctor-patient interaction in cross-cultural contexts. Those studies which have been conducted indicate that many of the difficulties relating to the provision of appropriate health care to people from a non-English speaking background arise from, or are compounded by the linguistic and sociolinguistic barriers between the health professional and the patient, as well as a general lack of understanding of different cultural perspectives on health and health care (e.g. Pauwels, 1990, 1995, Chesher, 1988, Loustanau and Sobo 1979).

A number of studies have found that the level of patient satisfaction is one of the important factors in compliance with medical directives, and that satisfaction with the doctor’s communication correlates strongly with the patients’ level of satisfaction with the treatment (Ben-Sira, 1980, Korsch and Negrete, 1981, Buller and Buller, 1987). Ben-Sira (1980) found that the doctor’s affective behaviour was a crucial factor in the patient’s evaluation of the medical treatment itself, while Buller and Buller (1987), in their study of 219 patients found that patients rely heavily on the doctor’s mode of communicating when evaluating the care given by the doctor. They also found that communication style was more important to those patients who see doctors less frequently. Pauwels (1995) points out that there is a tendency amongst migrants from a non-English speaking background in Australia to avoid doctors and to minimise communication with health professionals: given the findings of Buller and Buller described above, the doctor’s mode of communication becomes a significant factor in health care provision to people of non-English speaking backgrounds.
Medical discourse is located in an institutional context and many of its institutional practices are made visible in the talk between doctors and patients. Wodak (1996, 1997) describes the everyday life of institutions as “being characterised by conflicts, by disorders in discourse, and by contradictions which are mystified through myths and other symbols of the institution” (1997:175). She uses medical discourse to illustrate the notion of institutional myths, referring to the constructed and naturalised reality of the supposed infallibility of doctors and the vast technical knowledge that they are supposed to possess. She argues that institutions have their own value systems with organisational power being constructed and reproduced in the institutional hierarchies and in access to certain discourses and information. In the outpatients’ section of her hospital, for instance, doctors never have enough time, doctors are never wrong, and there is no better way to do things. Both insiders and outsiders are supposed to know, understand, and believe these myths.

To demystify these hidden presuppositions and world-views against which meanings are co-constructed by participants in institutional discourse, Candlin (1987) proposes that we seek to illustrate the degree to which our use of language, the way we make meaning, and our perceptions of role-relationships are determined by the social situation, its unstated values and interests and the degree to which such use “determines the value of the conversational goods which are being exchanged” (Candlin, 1987:25).

In such institutional contexts talk is again a central activity. Gumperz argues that “the interpretation of what a speaker intends to convey at any one point rests on socially constructed knowledge of what the encounter is about, and what is to be achieved”
(Gumperz, 1992:303). He calls this process of context-bound interpretation ‘conversational inference’ and argues that institutional processes such as the job interview, which is a goal oriented, instrumental encounter, involve additional, taken-for-granted evaluative and interpretive criteria which are applied by interactants automatically, without conscious reflection.

In cross-cultural institutional encounters, non-native speakers who may have a good functional control of the language and have few problems at the level of propositional content may experience significant difficulties at this interpretative level. In interpreting what is conveyed in any encounter participants draw on indirect inferences based on their background knowledge and understandings of what the event is about and how it should work. Gumperz argues that where participants in an interaction rely on different, taken-for-granted inferential strategies they may be unable to negotiate shared understandings about the interaction. His research indicates that in cases of differential power such problems can be seen as reflecting the non-native speaker’s ability, truthfulness, or trustworthiness, and that such speakers tend to encounter much more difficulty in their institutional contacts.

In recent years a great deal of the research carried out on the sort of talk that takes place in institutional settings such as courtrooms, classrooms, police stations, job interviews, and medical encounters has been conducted by Conversation Analysts (CA) which makes CA a particularly relevant approach to the data in this study. CA research is based on the realisation that ordinary, or mundane conversation is the predominant medium of interaction in the social world, as well as being “the primary form of interaction to which a child is exposed and through which socialisation
occurs" (Drew and Heritage, 1992:19). While Conversation Analysis is discussed more fully in Chapter 3 the following is a brief description of its relevance to institutional talk.

Research into the nature of institutional talk in the CA arena uses ordinary conversation as the benchmark, and comes from the view that institutional forms of interaction will show systematic variations and restrictions on their design, relative to ordinary conversation. These variations are summarised by Drew and Heritage (1992:22) as follows:

1. Institutional interaction involves an orientation by at least one of the participants to some core task, or goal (or set of them) conventionally associated with the institution in question.
2. Institutional interactions may often involve special and particular constraints on what one or both of the participants will treat as allowable contributions to the business at hand.
3. Institutional talk may be associated with inferential frameworks and procedures which are particular to specific contexts.

Levinson (1992) also argues that in institutional interactions where participants depart from the ordinary rules of conversation there will also be specialised aspects of the reasoning, inferences and implicatures that take place. These interpretive issues become even more complex where the participants in an institutional interaction, for instance, a medical encounter, do not share common cultural or linguistic resources. The institutionalised reductions and specialisations of interactional options found in institutional conventions are culturally variable, and are associated with differing
participation frameworks, different footings (Goffman, 1981) and different patterns of interaction.

Like other institutional encounters, the medical consultation is strongly influenced by structural and organisational matters and involves special and particular restraints on what either participants may contribute to the interaction. Evidence of such restraints emerged from my data and became the focus of this research. The research was conducted within a constructivist paradigm so starts with an area of study and, rather than pre-supposing what the important aspects and dimensions will be, approaches the study inductively, without pre-conceived theories, categories and hypotheses, allowing the theory to emerge from the data. Accordingly, there were no research questions as such to lead the analysis of these data in any pre-determined direction, but rather patterns and themes were examined as they emerged from the examination and re-examination of the data. Two of the most striking patterns to emerge from these data involve the effect that individual doctors have on the occurrence of patient-initiated questions and the differences in the ways in which native speakers and non-native speakers framed and used questions during their consultations.

The elicitation of information through a series of questions and answers is an important and accepted aspect of the western biomedical model of medical consultation. A pre-designated person, usually the doctor, asks the questions and the patient provides the answers. Such question-answer structures often leads to a marked asymmetry between doctors' and patients' contributions, with the doctor generally taking control of the interaction by primarily asking questions, introducing and changing topics and making decisions about what can and can not be talked
about. Doctors' attitudes and beliefs about the interaction and their styles of communication play are crucial to the ways in which the interaction is managed. Questions and questioning behaviour is discussed more fully in Chapters 2 and 7.

Good medical care depends on the doctor's ability to elicit details of medical history, descriptions of symptoms, pain, and so on, and to answer questions and give advice and treatment directives. It also depends on the patient's ability to provide those details and to ensure that the doctor has access to the information on which the medical diagnosis is made. The patient must also indicate to the doctor the extent to which they wish to be actively involved in the clinical process and one of the most powerful ways the patient can achieve this is by asking questions.

This thesis therefore examines the discourse of doctor-patient interactions and in particular the ways in which questions are framed and presented by patients (and parents, since these consultations are paediatric medical triads which include parents). The purpose of the analysis is to examine the questioning behaviour of both native English speaking (NS) and non-native English speaking (NNS) patients in order to identify any differences in questioning patterns for NS and NNS patients or parents which emerge from the data.

There is a vast body of research on medical discourse and Chapter 2 provides a review of the literature which is most relevant to the present study. Chapter 3 explains the methodology of the present study, including a description of a software analysis tool which was developed by the researcher to store, code, and analyse the data. The study is a qualitative one, and Chapter 4 contextualises the research by
providing a thick description of the settings and participants. This chapter also
contains a discussion of the language background of the patients and parents and the
controversies raised by the use of such terms as native and non-native speaker.

Another controversial issue in the literature on the doctor-patient relationship is the
description of doctors' communicative style in terms of being doctor-centred or
patient-centred. This issue has also emerged from these data, so the implications of
the doctor's style for NS and NNS patients or parents are discussed in Chapter 5.
Chapter 6 analyses the structure of the medical consultation and relates this to the
communicative style of the two doctors in the study, while Chapters 7 and 8 look
specifically at the occurrence of patient/parent-initiated questions in the data in terms
of the number, type, timing, and goals of the questions asked by NS and NNS
patients/parents. The findings of these chapters are discussed in Chapter 9, while
Chapter 10 contains the conclusions reached as well as a discussion of the limitations
of the study and recommendations for further research.
CHAPTER 2  A review of the literature on medical discourse

Research into the communication, or lack of communication, between patients and doctors can be found as early as the 1940s and 1950s (Zborowski, 1952, Pratt, Seligman and Reader, 1957, Fox, 1959) but as most current reviews of the medical literature point out, (Ley, 1983, West and Frankel, 1991, Roter and Hall, 1993) it was in the 1960s that it became clear that poor communication was a major factor in poor outcomes, as measured by two of the most significant practical problems in medicine; patient dissatisfaction and patient failure to follow medical advice (Kincey, Bradshaw and Ley, 1975). Researchers in several disciplines, particularly in the field of sociology, began to focus seriously on the problem of miscommunication in the medical encounter (Davis, 1960, Elling, Whittemore, and Green, 1960, Roth, 1963, Cartwright, 1964, Hugh-Jones, Tanser and Whitby, 1964, Skipper, 1965a, 1965b, Ley and Spelman, 1967, Raphael, 1969). This chapter provides a review of the literature on doctor-patient communication from that time.

2.1 Assessing Outcomes: patient satisfaction and compliance

2.1.1 Patient Satisfaction

The level of patient satisfaction with the medical consultation is one indicator of the success (or otherwise) of the communicative process between doctor and patient. Lebow (1974) argues that the major flaw with most studies focusing on patient satisfaction is that they measure patients’ subjective perceptions, however their subjective perceptions are the basis of patients’ beliefs about what occurred and what was achieved in the consultation and as such must surely be just as crucial to the
doctor-patient relationship as any other factor (King 1983). Lebow also suggests that the processes, structure, outcomes and impact of care on the patient should also be assessed in order to evaluate the quality of the interaction between doctor and patient, a suggestion which, as Pendleton (1983) points out, has rarely been followed. Nevertheless, the question of patient satisfaction has been extensively examined and is important because of its clear links to another critical patient outcome, namely, compliance with medical directives. While the range of methods and definitions used throughout the literature may make comparisons difficult, there is no doubt that the sheer weight of findings of these studies, flawed or not, represents a valuable component in the research on medical interactions (Locker and Dunt, 1978).

Early empirical studies in British hospital settings in the 1960s focused on short-term outcomes by examining the level of satisfaction among patients either still in hospital or immediately after discharge. They found that many, if not most, patients were dissatisfied with one or more aspects of their medical care. Two major factors identified as contributing to patient dissatisfaction were the amount of information provided by medical professionals and the manner, including the language, in which it was presented.

2.1.1.1 Amount of Information

Cartwright, (1964) interviewed 739 people who had recently been hospitalised and found that more patients expressed dissatisfaction with the information they received from their doctors than with any other aspect of their medical care. She reported that obtaining information was the most difficult task patients faced in the hospital. Hugh-Jones, Tanser and Whitby (1964) surveyed 174 patients of a London public hospital
and found that 61% were dissatisfied at some level with either the amount or the clarity of information they were given.

Klein’s (1979) survey of 788 patients revealed that almost half wanted to know more about their condition but felt they could not ask the doctor. Others (Ley and Spelman, 1967, Raphael, 1969) confirmed that most patients wanted much more information than they were given, while McIntosh (1974) found that even though most patients wanted to know as much as possible about their illness and treatment, most doctors avoided telling them. Doctors offered many reasons for this lack of information-sharing including the belief that patients did not truly want to know (Ley and Spelman, 1967), the view that patients should only be told enough to ensure compliance (Bard, 1970), the doctor’s own uncertainty about the diagnosis (Roth, 1963), and doctors’ general predisposition to restrict information available to patients in order to minimise opportunities for evaluation and criticism of their role and authority (McIntosh 1974).

Research in the United States offered support for the findings of these British studies. Davis (1960) found in his longitudinal study of 14 polio patients and their parents that parents were deliberately kept in the dark. Doctors answered questions in a way that was evasive, hedged, or couched in unintelligible technical terms. As one hospital staff-member said “we try not to tell them too much. It’s better if they find out for themselves in a natural sort of way” (Davis 1960: 44). Skipper (1965a) found that poor explanations were the most criticised aspect of medical care, adding that the provision of appropriate information was a critical issue as “patients needed to secure
information about what was supposed to be happening to them so they would have more control over the situation” (1965a : 64).

Seeman and Evans (1962) identified lack of information as a significant factor in creating a sense of powerlessness in what they called ‘alienated patients’. Many patients in Raphael’s (1969) study complained about the lack of information they were given, making comments such as “I was told nothing about my treatment and this worried me” and “doctors would not give even elementary information any reasonably intelligent patient wants to know” (1969: 37). Ley and Spelman (1967) argued that lack of adequate and appropriate information led to anxiety and feelings of isolation and Reynolds (1978) pointed out that the inevitable consequences of lack of information are anxiety and fear. These fears often led to patients making considerable efforts to obtain information from other sources, sometimes by extreme or devious methods (Suchman, 1972), resulting in misconceptions and misinformation which could result in patients refusing treatment or even discharging themselves from hospital (Taylor, 1979).

On the other hand, Pratt, Seligmann and Reader (1957) established that patients who were given more thorough explanations were more likely to be cooperative and to participate more effectively in their treatment and Fox (1959) pointed out that information about the cause of a symptom, by itself, can reduce anxiety, even if nothing can be done about it. In their study of pediatric surgery patients Skipper and Leonard (1968) found that providing information and emotional support to the mother could reduce her level of stress and improve her attitude to the experience, which in turn tended to reduce the child’s stress, resulting in sometimes profound effects on their psychological and physiological responses to hospital and surgery, while in a
similar finding Wasserman et al (1984) described how supportive statements and provision of general information in pediatric consultations led to greater satisfaction and reduction in the levels of concern for the mothers. In further studies which support the significant finding that more information leads to more satisfied patients, Stoekle and Barsky (1980) argue that a causal explanation of their symptoms to patients gives them some sense of control, while Hulka (1979) also demonstrated the importance of good information with her finding that better communication and greater patients’ satisfaction led to higher compliance with prescription directives and lower rates of medication errors.

Given patients’ desire for more information about their conditions, treatments and prognoses, it could be expected that visit time would be positively correlated with patient satisfaction, since patients would be more satisfied with doctors who spent more time communicating and giving them more information. However Korsch and Negrete (1972) found that there was no significant relationship between these two factors. Patient satisfaction did not improve with longer visits since longer visits did not necessarily mean more information was provided. Indeed, they argue, longer visits were often indicative of communication failures which took extra time to resolve. This finding has been challenged more recently by Howie et al (1999) who found that patient satisfaction, or what they call ‘enablement’, was strongly correlated with duration of consultation and they suggest that in fact it is time “to reward doctors who have longer consultations” (1999:738). In one of the few studies that specifically consider the language background of patients and is therefore particularly relevant to the present study, Howie et al also found that patients who spoke languages other than English at home were generally more satisfied in spite of having shorter consultations.
In their revealing analysis of 201 English-speaking parents of seriously ill children in an American Children's hospital, Kupst, Dresser, Schulman, and Paul (1975) found that the actual amount of medical information given was not significantly related to parent satisfaction. In fact, they found that the major factor in satisfaction was the parents' *perception* (my emphasis) that they had been given adequate information, whether or not they actually understood or remembered the information.

Korsch et al (1968) also found that patients' perception of the doctor was a factor in patient satisfaction, with only 36% of those parents who had not received reassurance from the doctor expressing satisfaction with the consultation. Korsch and Negrete (1972) reported further that the most frequent cause of dissatisfaction for mothers was that the doctor showed little interest in their concern about their children. In a similar finding Ben-Sira (1980) found that there was a strong correlation between patients' level of satisfaction with the consultation and the affective component of the doctor's behaviour, in other words, if the doctor was perceived by the patient as interested or if he or she offered emotional support the patient felt more satisfied with the consultation. Ben-Sira showed that the doctor's mode of presentation not only affected patients' level of satisfaction with the consultation but their assessment of the efficacy of the treatment itself. Larsen and Rootman (1976) linked patient satisfaction to the degree to which the doctor's behaviour corresponded to the patient's expectations of the doctor's role.

2.1.1.2 Language used to convey information

The second major factor leading to patient dissatisfaction in the medical setting was the concern that providers often used difficult language and specialised jargon that was not readily understood by their patients. Samora, Saunders and Larson (1961)
tested 125 patients on their knowledge of fifty medical terms, including words such as relieve, abdomen, fatal, bacteria and therapy. A panel of doctors had previously been consulted and indicated that they would ordinarily use the words on the list when talking with patients. When the word abdomen was used, respondents identified their side, back, buttocks, heart, and in one case, the entire area below the waist. Let me feel your pulse led to patients identifying temperature, fever, sickness and ‘a bad hurt’. Samora et al concluded that ‘practitioner-patient communication is rendered difficult .... by the tremendous and probably increasing differences in conceptualisation and knowledge of normal and pathological processes that exist between professionally trained persons and even well informed laymen’ (1961: 92).

Boyle (1970) found that only 20% of the 234 patients surveyed at a general hospital in Scotland could define the word stomach. Of even greater concern is the finding by Mazzullo et al (1974) that even a simple word like for is ambiguous and can be misunderstood in the medical context, for instance, a tablet for pain is designed to reduce pain, while a tablet for sleep is taken to increase sleep. They found that 52% of the patients in their study believed that a tablet for fluid retention would cause fluid retention and they point out that this would lead to the patient taking the medication in entirely the wrong way, avoiding it when they saw symptoms of retention. Klein’s (1979) survey of hospital patients indicated that even when the doctor did provide information, about 15% had difficulty understanding the explanations because of the medical terminology used, and Korsch et al (1968) found that although 76% of patients were generally satisfied with other aspects of their visits, the use of medical terms (e.g. peristalsis, edema) and routine technical jargon (work-up, history), “represented an outstanding barrier to communication” (1968:862). This barrier to
communication is strikingly illustrated by Shuy (1976:381) who offers the following remarkable example of a report sent to a patient: "there is reflux in the terminal ileum which appears normal. There are multiple nontender diverticula, predominantly involving the descending colon and sigmoid portion of the colon". Shuy adds that this patient received no other information or explanation of her condition. This example clearly demonstrates the alienating and potentially damaging effect of a doctor's inappropriate use of technical language.

McKinley (1975) however, disagreed with this position, finding that "physicians consistently and markedly underestimated the level of word comprehension among their lower-class respondents" (1975: 9). This echoed Pratt et al's (1957) finding that 81% of the doctors in their study consistently underestimated patients' knowledge, even when that knowledge was poor. Aasterud (1965) also argued that failure to comprehend medical explanations need not be attributed to patients. She found that fault may lie not so much in ignorance as in the fact that patients and doctors may attribute different meanings to terms used. This was supported by Boyle (1970) who found very significant differences between doctors' and patients' definitions of commonly used medical terms. Ley and Spelman (1967) demonstrated in their study of 215 volunteers and patients at a general hospital in Liverpool that even the names of common illnesses (such as arthritis and diabetes) often meant something different to patients than to doctors and had potential to cause misunderstandings and dissatisfaction with advice given. This difficulty is further illustrated by Skopek (1979) who demonstrated how miscommunication occurred because of the doctor's and patient's different understanding of the terms hypertension and what the patient called high blood.
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The gap in this research, from the point of view of the current study is the lack of information about, or attention, to language background of the patient. Most of these studies are based on large numbers of patients and although many do provide some details of patients’ backgrounds (usually gender, age and social class) very few refer to the language background of the patient or consider the effect that background might have on the doctor-patient communication. Boyle (1970) for example described the gender and social class of his 234 patients, but not their language. Samora et al (1961) in their study of medical jargon described the ethnic background of their participants (native-English speaking white, Spanish-American, and Negroes) but do not describe their language skills. Similarly, Korsch and her colleagues (1968, 1972) again describe the ethnic background of the patients, dividing them into Anglo-American, Spanish-American, Negroes, and others, but once again do not discuss language and do not correlate their findings with ethnic background. Kupst et al (1975) specifically exclude patients who are non-English speaking but they do not define this category so it is not clear if patients for whom English is a second language were included or excluded. As the study by Howie et al (1999) shows, the language background of the patient can be a critical factor in the patients’ levels of understanding and satisfaction, and as demonstrated below, subsequent compliance with medical instructions. This is an area which requires further investigation and it is this aspect of the doctor-patient interaction which is the focus of the current study.

2.1.2 Compliance

A critical point was reached in the research on medical discourse when studies began to link low levels of patients’ satisfaction to their failure to comply with medical
advice. Compliance usually refers to the extent to which patients follow the advice and directives of doctors and is a useful indicator of intermediate-term patient satisfaction (Pendleton, 1983) while non-compliance can lead to medical complications, further periods of hospitalisation and increased costs, both to the individual and to the health care system (Ley, 1988). It also has implications for the future relationship between the doctor and the patient, as Fineman (1991) found in his examination of the subjective construction of non-compliance by a range of health care workers. He found that practitioners interpreted the meaning of their patients’ non-compliance with their subjective assessment of the patient as either unwilling or unable to comply. Unwilling patients were perceived to be trouble makers who abused the medical service, a position which led to poor relationships and even resulted in patients leaving the clinic. Patients categorised as unable were seen as helpless victims and though troublesome their noncompliance was seen to be unintentional and involuntary and they were often subjected to strategies which took control of their regimes and in some cases led to a significant loss of autonomy for the patient. Non-compliance, which Hulka (1979) argues is a term which implies a pejorative affect toward patients, includes failure to keep medical appointments, take prescribed medicine or adhere to recommended treatment or preventative measures, and has therefore been the focus of extensive research. Ley (1988:53) points out that in the 1950s there were 25 publications on the subject of compliance, in the 1960s there were 168 publications, 810 in the 1970s, and in fact there is now a journal, The Journal of Compliance in Health Care, devoted entirely to the topic.

Ley and Spelman (1967:37-43) provide a comprehensive review of British research between 1954 and 1965 which shows that many patients clearly do not follow advice
given to them, take less medicine than is prescribed, and fail to attend follow-up appointments. Roth et al (1962) found that patients’ lack of understanding of the causes of their condition (peptic ulcers) led to their failure to understand the therapeutic value of the recommended treatment and subsequent failure to comply with their doctors’ instructions. Elling, Whittemore, and Green (1960) assessed compliance, or what they called participation, by measuring the regularity with which patients took medication and kept appointments. They analysed 118 pediatric consultations and showed a strong statistical relationship between the mothers’ understanding of their child’s illness and the degree of participation. For example, they found that when a mother had a good understanding of the role of penicillin in her child’s treatment plan she would be a high participator and that in contrast, when a parent had a poor understanding, the child was generally a low participator. They also reported a significant tendency for high participators to report positive relations with doctors in general and low participators to show mistrust and suspicion of any medical relationship. Although family income and social class were considered as factors in this study, language background was not.

The link between level of understanding of instructions and compliance was also investigated by Hulka et al (1975) who found that compliance, in terms of following medication regimes, was linked to the frequency and specificity of the advice given by the doctor. Again Hulka et al considered socioeconomic variables amongst their patient sample, but in spite of the fact that the research focused on understanding complex drug regimes, there is no mention, or assessment of the patients’ language background. Hulka’s finding on compliance is supported by Ley (1983) who also argues that satisfaction is linked to compliance, and that a factor in satisfaction is the
patient’s understanding of, and ability to recall advice given. He also pointed out that specific advice is more accurately recalled by the patient than general advice.

Korsch, Gozzi and Francis (1968) observed and audio-recorded consultations between 800 patients and 64 pediatricians in the emergency clinic at the Children’s Hospital of Los Angeles. Interview responses indicated that patients who thought of the doctor as being friendly and those who felt the doctor understood their concern had a significantly higher level of satisfaction. Freemon, Negrete, Davis and Korsch (1971) used two case studies from these same data to illustrate the link between communication, satisfaction, and compliance. One case illustrated active two-way communication with the mother contributing 55% of utterances and the doctor frequently indicating interest, attention, and understanding. This mother was both very satisfied with the consultation and highly compliant with the medical advice given. In sharp contrast, their second case clearly illustrated a situation where the mother made few utterances and perceived the doctor as showing no interest and doing nothing to relieve her anxieties. This mother reported that the doctor was “lousy”, (Freemon et al, 1971:304) and subsequently she was only partially compliant with the doctor’s advice.

In a later analysis of the same data, Korsch and Negrete (1972:66) commented that “the quality of medical care depends in the last analysis on the interaction of the patient and the doctor, and there is abundant evidence that in current practice the interaction is all too often disappointing to both parties”. They reported that 20% of mothers in the study felt that they had not received a clear statement of what was
wrong with their children, and in nearly half of the cases mothers were not aware of what had caused their child’s illness (Korsch and Negrete, 1972: 69).

Compliance continued to be the focus of much research in the 1970s and early 1980s, (Bard, 1970, Sackett and Snow, 1979, DiMatteo and DiNicola, 1982) with research findings indicating that between 20% and 80% of patients do not follow their doctor’s recommendations and that on average one patient in two does not do so (Ley, 1983). The links between communication, patient understanding and recall, patient satisfaction and patient compliance were now well established so it became important to identify those factors contributing to poor communication which could be addressed in order to achieve better outcomes, namely, increased levels of patient satisfaction and subsequent improved rates of patient compliance. Researchers now focused more closely on attributes of the participants: the doctors and the patients.

2.2 Assessing participants.

When researchers turned their attention to assessing the role of each participant in the medical interaction, one of the first aspects they considered was who was to blame.

2.2.1 Attributing blame

As seen in the discussion on medical jargon above, most early studies attributed the blame for communication problems to the patient. Roth (1963) argued that patient dissatisfaction with the amount of information provided cannot be attributed to doctors’ poor communication skills. He attempted to dispel two assumptions commonly held about doctor-patient communication; that doctors have reliable means
for obtaining information from patients who are willing to be cooperative and provide such information, and that doctors are the ones to provide all relevant information to patients who in turn are willing to accept it. Based on his research in a tuberculosis ward in a public hospital, he argued that patients are never satisfied with the information they receive from doctors and therefore work at getting information, often conflicting information, from other sources, for example, other patients and newspaper or magazine articles. He also argued that in fact doctors often have difficulty obtaining relevant information from patients because patients are often uncooperative and resistant, and because of the ways in which they can manipulate which and how much information will be provided.

This view is also found in Samora et al (1961) who opened their discussion of medical communication by pointing out that the many barriers to ideal communication “arise out of such factors as the physical inability of the patient to hear what is said to him, his psychological unwillingness to receive unpleasant information or to impart information about private matters, anxieties and inhibitions stemming from perceived status differences or from uncertainties about the clinical situation and his ability to remember clearly past experiences or to formulate and relate what he does remember” (1961: 83).

Ley and Spelman (1967) also focus on patient shortcomings. They concluded that “even when wishing to cooperate with the doctor, patients will fail to do so because they do not really understand what the doctor is saying” (1967: 57). They also suggested that patients forget what their doctor tells them for a number of reasons, for example they attach a different degree of importance to different types of medical
statements, and “some attempt should be made to educate patients” (1967 : 76) to pay attention to the really important things.

However, as Kupst et al (1975) point out, it is unreasonable to expect patients to retain a clear understanding of what they have been told when they are frequently given such a wealth of information about their condition, symptoms, treatment and prognosis in a very short time and at a time when the patient is often in crisis. They argue that it is the doctor’s responsibility to use more effective communication techniques to ensure that the patient does understand and can recall details. They found that the parents in their experiment did record higher levels of satisfaction based on the perception that the doctor took time to ensure their understanding.

Zola (1963) accepted that the doctors’ clinical training is at least in part responsible for difficulties with patients, while Davis (1966) voiced a similar view. Although his survey of doctors showed that most attributed non-compliance to the patient “either because he is unable to understand or is simply an uncooperative personality” (1966 : 1046) Davis himself rejected this, arguing that it is the doctor’s responsibility to ensure he (sic) is able to establish rapport with his patients. McKinley (1975) also questioned what he called “the bias towards physician imputation of patient ignorance” (1975:10) and argued that instead responsibility should be more correctly attributed to physicians and aspects of their own professionalism than to patients. The question of the doctors’ professionalism was just one of the attributes considered by researchers in the analysis of participants’ attributes.
There is some evidence that doctors are willing to accept some responsibility for the problem however. The majority of participants in the study of 342 Scottish doctors by Bennett et al (1979) believed that there was a need for systematised formal training in communication skills in both undergraduate courses and during vocational training while Lloyd (1974) argued that doctors themselves would be much happier if they examined their own attitudes and attempted to improve the situation between patients and doctors.

2.2.2 Doctors

A number of studies which examined doctors’ attributes focused on professional characteristics such as medical specialty (Zola, 1963), levels of frustration (Mechanic, 1974, Gough, 1977, Cartwright and Anderson, 1981), job satisfaction, (Mechanic, 1974), consulting style (Lloyd, 1974), and affective behaviour (Ben-Sira, 1980) while others focused more directly on the doctors’ personal and situational characteristics (Waitzkin and Stoeckle, 1976, Rhec, 1977, Waitzkin, 1985).

Mechanic (1974) linked doctors’ level of job satisfaction with the extent to which they perceived patients’ problems as non-trivial. Gough (1977) also investigated factors which influenced doctors’ attitude to triviality and concluded that those doctors who saw many patients, those who viewed medicine as a strictly biological discipline and those who were older at entry to medical school were more likely to see consultations as trivial.
Waitzkin and Stoeckle (1976) examined a range of doctors’ characteristics including demographic factors (age, sex, religion, race, income), professional experience, professionalism (attitudes about the profession, satisfaction in professional accomplishments, attitudes towards chronically ill or elderly patients and satisfaction from caring for patients), political ideology, perception of patients’ information needs, need for power, and general attitudes about information sharing. In a later analysis, Waitzkin (1985) found that doctors’ own social class and their perceptions of patients’ desire for information were important factors in the amount of information the doctor gave in the consultation and concluded that “physicians’ political ideology and need for power were significant explanatory variables in doctors’ information-giving behaviour” (Waitzkin, 1985:95). In an investigation of factors that determine the quality of medical care, Rhee (1977) used a framework which assumed that the quality of the doctors’ performance would be jointly determined by internal (personal) and external (situational) factors. He gathered data from 454 doctors in 22 hospitals in Hawaii to assess the relative importance of personal and situational characteristics and concluded that doctors’ external, situational factors have much more influence on their performance than their internal characteristics.

A study of British doctors by Cartwright and Anderson (1981) also examined a number of factors, looking at, among other things, doctors’ age, sex, country of qualification, specialist training and patient list sizes. They found that female doctors tended to have fewer patients, that those patients believed female doctors were more likely to rush them and reported they would be less likely to consult their doctor on a matter that was not strictly medical. They found little difference between older and younger doctors, other than in a commitment to health education and prevention.
However, they found that country of qualification was significant. Asian doctors perceived a higher proportion of consultations as being for trivial, unnecessary or inappropriate matters. Patients of Asian doctors were more likely to be critical of their doctor, particularly over communication issues and were more likely to have reservations about the level of their care.

One of the most substantial studies of doctors was undertaken by Byrne and Long (1976a, 1976b) in their analysis of the behaviour of over 70 doctors in more than 2500 consultations. Byrne and Long described the range of behaviours they observed then clustered those behaviours to describe doctors' consulting styles on a scale ranging from a doctor-centred approach to a patient-centred approach. At the doctor-centred end of the scale typical behaviour would involve the doctor making their decision and announcing it to the patient. As doctors moved along the scale towards a more patient-centred approach their behaviour would become more collaborative, involving the patient more for instance by asking for suggestions, until at the extreme patient-centred end of the scale the doctor would permit the patient to make their own decision.

Byrne and Long found that most doctors operated at the doctor-centred end of the scale. They also found evidence that once doctors have developed a set of behaviours they remained relatively inflexible tending to use the same patterns with most patients in most situations with very little variation. Doctors' style did not appear to be influenced by the degree to which the problem was non-organic in nature or by the social class or verbal skills of the patient. However there was evidence in the study that it could be influenced to a certain extent by the number of patients waiting to be
seen, and the degree to which the problem was perceived by the doctor to be urgent as well as several patient characteristics like the sex and age of the patient (Byrne and Long, 1976a).

Doctors’ consulting style has been directly linked to the level of patient satisfaction in several recent studies although with quite different findings. In their examination of over two hundred patients Savage and Armstrong (1990) compared levels of satisfaction from patients who had been seen by either a ‘directing’ or a ‘sharing’ doctor, their terms for doctors with either a doctor-centred or patient-centred approach. They found that a significantly higher number of those patients who had consultations with the directing, authoritative doctor were very satisfied with their visit, reporting that the doctor understood their problem, provided good explanations, and believed that they had been greatly helped by the doctor. In contrast, Roter and Hall (1993) claim that physicians who used a patient-centred style of communication left a more positive impression on patients. They describe a patient-centred approach as being characterised by more open-ended questions, a greater level of information-giving, paraphrasing to ensure understanding, requests for patient’s own opinions, reassurance, and statements of concern, agreement and approval, and argue that such an approach maximises the collaboration between doctors and patients. This important aspect of the medical consultation is further explored in the current study.

2.2.3 Patients

Studies investigating patient attributes have focused on a range of characteristics including age (Henley and Davis, 1967, Coope and Metcalfe, 1979, Hooper et al,

Coburn and Pope (1974) considered a number of patient socioeconomic factors, including education, age, income and social participation and found that these factors combine to have an impact on patient preventative health measures. Studies examining patients' social and educational background have suggested that patients from higher social classes recall information better than those from lower classes (Bain, 1977) and lower class and less well educated people were less familiar with medical terminology (Samora, et al, 1961, Boyle 1970) and less likely to listen to their doctors (Bochner, 1983). However, Banks and Keller (1971) found that prior experience with the symptoms of a given disease resulted in those symptoms being given a lower 'concern' rating and concluded that knowledge gained from personal experience offset lack of formal education and functioned to reduce uncertainty and anxiety and reduce the perceived seriousness of the symptom.
Social class appeared to have emerged as a significant factor in many of these studies. Bain (1976), in an audit of 480 of his own consultations, found that he spent significantly more time in consultations with patients of higher social class and argued that social class was a key factor in the amount of information provided in the medical consultation. Coope and Metcalfe (1979:485) claimed that “there is a social class gradient whereby level of knowledge descends in parallel with social class”, and Pendleton and Bochner, (1980) suggested that “since most doctors have high socioeconomic status it is not surprising that consultations with working-class patients present more communication difficulties than consultations with middle class patients” (1980:669). They found that social class was a significant predictor of how many explanations were offered by doctors. Lower class patients did not receive as much information or as many explanations as higher social class patients, and this group also expressed lower levels of satisfaction and displayed lower levels of compliance.

However, no direct, causal link between socioeconomic or educational factors and outcomes has been established. Korsch and Negrete (1972) found that college-educated mothers were no more satisfied with their consultations than those who were less well-educated. Roth (1963) suggested that, rather than actual socioeconomic factors, it was doctors’ perceptions of patients’ socioeconomic status that was a factor in how much they were told; the way patients presented themselves influenced the kinds of information they received. Steele and McBroome (1972) concluded from their analysis of over 3,000 participants that there was only a low positive association with socioeconomic status, while Moody and Gray (1972) argued that associations between socioeconomic factors and health behavior as demonstrated by polio
immunization may be spurious, concluding that "the supposition that social class has
an independent influence on preventative health care is not supported by this study"
(1972 : 251). King (1983) concluded that social class could best be considered a risk
factor for non-compliance, in that it helps to identify groups or individuals who are
likely not to comply with medical advice.

2.2.3.1 Patient gender

Other patient characteristics which were explored included gender. Coope and
Metcalfe (1979) found that female patients tended to have a higher level of
knowledge about health matters than male patients, while a number of researchers
have found that female patients ask more questions (Wallen et al, 1979, Pendleton
found that doctors’ responses to questions were more or less detailed depending on
the gender of the patient, with female patients being given more information than
male patients, a similar finding to that of Hooper et al (1982) who found that doctors
were more empathetic and provided more information to female patients and also
interrupted female patients less frequently than they did male patients. Waitzkin
(1985) also found that female patients tended to ask more questions than male patients
and generally engaged in more verbal interaction.

2.2.3.2 Cultural factors

One patient characteristic examined by a small number of researchers which is
particularly relevant to the present study is the patient’s ethnicity and the effect of
cultural factors on the medical consultation. The significance of pain, which plays an
important role in the diagnostic and treatment process (Koopman et al 1984) was examined by Zborowski, (1952) and Zola, (1963). In his much-cited study of pain and ethnicity, Zborowski (1952) found that patients responses to spontaneous pain (meaning pain as a result of injury or illness, which he differentiates from self-inflicted and other-inflicted pain), their interpretations of such pain, and their expectations of pain control varied widely across ethnic groups. He found that Italian and Jewish patients were very emotional in their response to pain, and tended to exaggerate their pain experience.

Despite these similarities however, Zborowski found that the underlying attitudes to pain were quite different: Italian patients were more concerned with the actual experience of pain and consequently sought and were satisfied by immediate pain relief. Jewish patients on the other hand were more concerned about the significance of their pain and resisted pain relief for fear it would mask a significant symptom. Jewish and Italian patients manifest similar behaviours in their reaction to pain, talking and complaining a great deal, groaning, moaning unashamedly. Zborowski points out that such behaviour, approved and accepted by the Jewish and Italian cultures, is in conflict with the American norm, and as such can lead to distrust and unsympathetic assessments from American doctors.

American patients in Zborowski’s study tended to view pain in an objective and rather unemotional way, often commenting that “there is no point in complaining and groaning and moaning because it won’t help anybody” (1952:24). Such patients seek to avoid being a nuisance in hospital and tended to withdraw, preferring to be alone when their pain became unbearable. American patients tended to feel reassured when
tests and procedures were administered and generally displayed a confidence in the
skill and knowledge of their doctors.

Ethnic origin and cultural background contribute not only to what symptoms are
regarded as important but also how those symptoms are presented to the doctor and
how and when a patient decides to go to the doctor (Stoeckle, Zola and Davidson
1963). Zola (1963) found that Italian patients were much more likely than Anglo or
Irish patients to be labeled as having psychiatric problems by their doctors.
Differences were found in how the Italians presented their chief complaints, reporting
more pain, more symptoms overall and in more bodily locations, more consequent
dysfunction. Zola speculated that Italians and Irish have ways of reporting illness that
reflect ways of dealing with problems within the culture itself. The Italians tend
towards drama and exaggeration as a way of dissipating and coping with anxiety
whereas the Irish have a tradition in which control and denial are foremost.

In a study developing the work carried out by Zborowski (1952) and Zola (1963),
Koopman, Eisenthal and Stoeckle (1984) found similar differences in pain reporting
between the Italian and Anglo-American patients in their study, however they found
that the differences were more marked in the older age category. Pain was more
likely to be reported by Italian older females and least likely to be reported by older
male Anglo-Americans. For second and third generation Italians the process of
acculturation seemed to have diminished the effects of the patient’s ethnic
background.
In other studies which specifically focus on ethnicity, Hooper et al (1982) found that Anglo-American doctors demonstrated better questioning and facilitating skills and were more empathetic with Anglo-American patients as compared with Spanish-American patients. In an analysis of cross-cultural medical encounters between white American doctors and native American patients, Kaplan (1989) describes how the different discourse styles of white Americans and native Americans, who talk much less than white Americans and speak very indirectly and impersonally, can lead to significant confusion and resentment in the medical encounter and eventually non-compliance with medical advice. This study stands out as one of the very few which directly considers the language background of the interactants and acknowledges the role of sociopragmatical failure in medical miscommunication.

Many of the studies discussed so far which address outcomes and participant characteristics have based their analysis and conclusions on information gained retrospectively, by questionnaires administered (usually by post) to doctors (Gough, 1977, Bennett et al, 1979), by questionnaires administered to patients in hospital or recently discharged from hospital (Cartwright, 1964, Hugh-Jones et al, 1964, Skipper, 1965a, Raphael, 1969, Boyle, 1970, Reynolds, 1978) or attending general practice surgeries or outpatients clinics (Coope and Metcalfe, 1979) or in some cases to random samples of the general public (Suchman, 1972, Coburn and Pope, 1974, McKinley, 1975, Larsen and Rootman, 1976). Other studies were based on information obtained from interviews with patients about their medical visits after the event (Elling et al, 1960, Ley and Spelman, 1965, Henley and Davis, 1967, Mayou et al, 1976, Koopman et al, 1984) or from patients who had at some time been in hospital (Skipper, 1965b). Some used a combination of interviews and questionnaires.
(Kincey et al, 1975, Hulka, 1979) or a combination of questionnaires to both doctors and patients about the aspect being examined (Pratt et al, 1957, Hulka, 1979).

There are obviously a number of problems with studies of this kind since patients’ retrospective reports of what was said and done in the interaction can provide different kinds of information to that obtained from a direct observation of the interaction itself. Pendleton (1983) argues that such studies have not contributed much to the understanding of communicative behaviours, which he argues is something which can best be achieved through the observation, examination and analysis of the actual interaction which occurs during the consultation. Stiles (1989) argues that such studies, which are usually reliant on statistical associations do not allow for the specific context of the interaction or for the individual needs and requirements of participants. Using the example of patient-initiated questions to illustrate his point, he argues that while determining the number of questions used may provide an indirect measure of patients’ ability to express their concerns, it cannot locate specific communication problems in the context of their occurrence. West and Frankel (1991) argue that these types of studies have focused on isolated variables and have “led to a general neglect of issues of context, sequence, and interpretation” (1991:178). They agree with Pendleton’s position that a better approach is to focus on communication in context, that is, as it actually happens during the consultation. My study attempts to address these issues by examining when and how questions are framed and what types of information patients attempt to elicit when they ask questions. It is not dependent on statistical analyses, other than those used to identify the level of significance of differences between NS and NNS patients which emerge from the data.
In a related criticism, Mishler (1984) details a number of methodological problems with some early research, especially the different studies carried out by Korsch and her various colleagues and the studies by Waitzkin and colleagues. Mishler is particularly concerned by the lack of attention to, or description of, the procedures and conventions used for the transcription and coding of data gathered from the medical consultation. He argues that talk is a core component of the clinical interaction, one that has real and significant consequences for the well-being of the patient, and as such warrants close and systematic investigation. Such investigation requires transparent methods for recording, transcribing and analysing that talk. These comments have informed the methodology of my study at every level.

2.3 Examining the interaction in context

The focus of much research into communication in the medical setting moved from examining the medical consultation in terms of large numbers of reported outcomes to studies that were based on the observation and analysis of actual interactions, thereby "bridging the micro-macro gap" (Fisher and Todd, 1993a:3). Such studies focus on close analysis of what actually happens between the doctor and the patient, and address the concerns raised about the methodological issues by Mishler (1984) by basing their findings and conclusions on the analysis of actual observations and detailed transcripts of audio-taped or videotaped consultations.

Issues of asymmetry, power and control in the medical consultation became the focus of many studies. As Todd and Fisher (1993) explain it: "communication between doctors and patients seems an ideal site to explore the relationship between social
structure and social interaction now redefined, to see how power is exercised and resisted, how social structure is implicated and transformed as doctors and patients communicate” (1993: vi).

Researchers using a range of theoretical frameworks including Discourse Analysis, Frame Theory and Conversation Analysis, all of which allow for the close analysis of the talk between doctors and patients, were able to move beyond findings that patients were dissatisfied with the amount of information they received to demonstrate how the patient and doctor jointly construct and contribute to the asymmetry of the consultation on a number of levels.

One of the earliest studies which focused directly on how doctors and patients communicate and what they actually say to each other is Coulthard and Ashby’s (1975) analysis of 24 consultations which they tape recorded but did not directly observe. Coulthard and Ashby were particularly interested in how topics were introduced and closed, how turns were distributed or negotiated, what verbal strategies participants used to achieve their goals and how utterances were interpreted in context. They defined three types of utterances (or moves as they refer to them): initiating, responding and follow-up moves, and determined that the development of the doctor-patient discourse was tightly controlled by the doctor who initiated the majority of information-seeking moves while the patient was generally limited to providing responses. They demonstrated how doctors were able in this way to create an asymmetrical relationship which in turn allowed them to limit and control what topics were discussed and to what extent they were developed.
Todd (1993) also demonstrates how doctors use third turns, or what she calls reactivities, to control the interaction by regaining control of the floor after each sequence. She argues that doctors’ institutional power is reflected in their domination of questioning and directive strategies and of the sequencing of turns in the interaction. Maynard (1991) however, compares the discourse of a clinical pediatric interview with ordinary conversation and argues that asymmetry in the consultation is not totally a product of the doctor’s institutional power, but is negotiated and interactively achieved in the consultation.

Rather than the doctor’s behaviour, Boreham and Gibson (1978) focus on patient behaviour. They observed the questioning behaviour of 80 female patients during their interviews and were then able to demonstrate through a close analysis of the questions they asked that it was largely due to their own passivity and the type of questions they asked that patients gained little additional information from the doctor. In another study highlighting patients’ contributions Clark and Mishler (1992) analyse a patient’s efforts to tell their story. They show how the patient’s story emerges through a series of requests, expansions, acknowledgements and elaborations, and so represents the joint effort of the patient and doctor. They also demonstrate how doctors adopt specific alignments, either hindering or facilitating, with respect to the emerging story, and how these alignments are related to patient outcomes and clinical decisions.

Mishler (1984) argues that medical discourse involves a dialectic between two voices, the voice of medicine, expressing the technical, biomedical frame of reference, and the voice of the lifeworld, which reflects the patient’s personal “contextually
grounded experiences of events and problems" (1984:104). Medical discourse could also be described as a dialectic between institutional frames and socio-relational frames of talk (Coupland et al, 1994). The term ‘frame’ and related terms such as ‘script’ and ‘schema’ have been used interchangeably in the literature to describe the basis on which participants’ expectations are used to predict and interpret interactions. Tannen (1993:53) describes frames as “structures of expectation based on past experience which serve to filter and shape perception”. Goffman (1981) uses the term ‘footing’ as a way of talking about the way interactants move between frames in an interaction and manage talk in different contexts. Many of the examples of miscommunication discussed earlier in this review, for example the mismatch of patients’ and doctors’ understanding of technical vocabulary and the miscommunication of instructions about medication could be attributed to the conflicting frames of the interactants. The notion of frames is also particularly relevant to any discussion of interactions which occur in cross-cultural contexts and is taken up further in Chapter 9.

Frame theory has been used by a number of researchers to examine and explain communication and miscommunication in the doctor-patient relationship. Evans et al (1986) point out that the fundamental starting point of diagnosis and treatment is comprehension (their emphasis) of the patient by the doctor and of the doctor by the patient. Such comprehension requires an understanding of the conceptual structure which supports the participants’ perceptions and expectations. They claim that the lack of shared frames is one of the most significant factors in miscommunication between doctors and patients. Frame theory is also used by Tannen and Wallat (1983, 1986, 1999) in a series of studies based on a single pediatric case over five different
settings involving different family members and various health professionals. In the first study (1983) they show how the mother’s participation in the consultation presented the doctor with conflicting frames and required him to make frequent shifts in footing (Goffman, 1981) between examining the child and consulting or advising the mother. By focusing on the actual talk between the health professionals and patients Tannen and Wallet (1986) also found that the kinds of information exchanged between family members and health professionals differed depending on the context of the interview, that is, whether it was the intake interview, the pediatric examination or the social work session. They also demonstrated how the conflicting frames of the doctor and mother accounted for many of the doctor’s lengthy explanations, the mother’s apparent discomfort and her recurrent questions (1999).

Coupland et al (1994) also highlight the importance of frame negotiations in medical encounters in their study of 85 geriatric consultations. In a contradictory finding however, they show that, unlike other findings in the literature, there was little evidence of frame conflict and patients and doctors each played a significant role in the negotiation of the relatively smooth movement from a social frame to a medical one, with patients in some cases making the first move into medical talk.

Frame analysis also allowed Coupland and Coupland (2000) to clearly demonstrate the importance of the multi-party context in the framing of participation in geriatric medical consultations (although they try to avoid the use of the word ‘geriatric’ because they see it as generally pejorative) where a third person, usually a son or daughter, is present. Coupland and Coupland build on Silverman’s (1987) notion of the ‘chauffeur role’ assigned to parents in pediatric consultations (where the parent
equates to the driver, the doctor is the mechanic and the child is the car), They argue that this is a unitary role-based concept which under-represents the diversity and subtlety of triadic relationships, and show that the relational frames between doctor, patient and third party in geriatric consultations are complex, interdependent and negotiable. By focusing on the use of pronouns in the interactions Coupland and Coupland show how the institutional practices that define ‘geriatrics’ as socially structured and socially structuring are made visible in the talk.

There has also been a growing interest from researchers working with Conversation Analysis as a framework for describing and examining the structure of interactions between doctors and patients. Conversation Analysis (CA) developed from the work of Sacks, Schegloff and Jefferson (1974) and is primarily concerned with how participants in ordinary conversation “manage and accomplish the sequential order of talk-in-interaction” (Hutchby and Wooffitt, 1998: 75). CA’s basic position is that social actions are meaningful for those who produce them and that they have a natural organisation that can be discovered and analysed by close examination. CA researchers have shown how the asymmetrical nature of the doctor-patient relationship is achieved and maintained through a number of linguistic means.

CA studies have shown not only that doctors ask most of the questions in the consultation and at the same time restrict patients’ opportunities to ask questions, but also demonstrate how doctors achieve and manage this through control of the turn-by-turn development of the interaction. (West, 1983, 1984a, 1984b, Todd, 1984, Frankel, 1984, 1990). West (1983, 1984a) and Frankel (1990) have demonstrated how patients’ questions are dispreferred in the medical consultation, while ten Have (1991)
shows that the dispreference for patient-initiated questions is much stronger in some stages of the consultation than others. Frankel (1984) has also demonstrated how doctors’ use of a third turn following doctor-initiated question-answer adjacency pairs allows them to assess and evaluate information given by the patients. He divides doctors’ third turns into two categories: acknowledgments, which Frankel argues are neutral and operate functionally to invite the speaker to continue, and assessments, which indicate the speaker’s reaction to or interpretation of the information being provided. He shows how by this simple mechanism doctors are able to determine which topics will be taken up and explored and which will be ignored. Similarly, ten Have (1991) shows how the use of third turns by doctors varies with what he calls ‘episodes’ within the consultation and how doctors use third turns in very specific ways to construct and maintain the asymmetrical nature of doctor-patient discourse.

Using CA to analyse 32 gynaecological consultations Weijts et al (1993) demonstrate how issues relating to sexuality are largely avoided in discussion and how doctors avoid using terms for female genitalia, making it more difficult for female patients to raise questions about aspects of their sexuality and reproductive capacities. Doctors’ use of leading questions which display their own sense of what is normal regarding sexual behaviour and patients’ general reluctance to ask questions results in many issues of sexuality remaining unaddressed. Also focusing on women’s health and reproductive issues, Fisher’s (1993) research examines gender ideology and institutional power and how each is socially accomplished in discourse. In her analysis of consultations and processes in two clinics in the Department of Reproductive Medicine over two years she found that young Caucasian single or divorced women who were referred by private doctors to clinics staffed by
gynaecological oncologists were more likely to receive conservative treatment, while older Mexican or Mexican-American women, married or divorced, referred to public clinics staffed by a rotating roster of medical residents were more likely to have radical treatment, namely, hysterectomies. She argues that decisions about who should and should not have hysterectomies were not based solely on either medical grounds nor on social criteria but on the structural and organisational features of the clinical experience. The doctor-patient relationship is an asymmetrical one but, Fisher argues, that asymmetry increases when the patients are poor and powerless and, in the case of her data from public clinics, the medical practitioners need surgery experience.

Many of the studies which examine power in the consultation are doctor-focused and patients are often considered only inasmuch as they respond to or react to the doctor. However the patient can play a significant role in the negotiation of power in the interaction in a number of ways, by the number and type of questions they ask, by the way they tell or do not tell their story, and by providing or withholding information. Patient contributions play a central part in what information is made available to the doctor and therefore in what is diagnosed and how (Sarangi, 2001). Some very recent studies have focused specifically on the ways in which patients initiate and solicit actions in the medical consultation (Gill et al, 2001, Robinson, 2001). Again using CA as the analytical framework, Robinson (2001) shows how a patient successfully negotiates a renewal of a prescription and Gill et al (2001) show how a patient who thinks an HIV test is warranted is able through indirect and oblique hints to request and initiate that action. Gill et al demonstrate the subtle complexities of the negotiations which occur between doctor and patient when patients initiate requests.
Sarangi (2001:9) argues that encouraging patients "to become more active stakeholders in their overall well-being" empowers the patient in the interaction and privileges a shared decision-making framework which brings about changes in the way consultations are organised. One of the many layers of asymmetry identified in the doctor-patient relationship which challenges the shared decision framework is the degree of interactional control each participant is able to exercise. A particularly powerful means for participants of attaining or maintaining that control is through the use of questions (West, 1984a, 1984b, Frankel, 1984, 1990, Roter and Hall, 1993).

2.4 Patient-initiated questions


Pratt et al pointed out as long ago as 1957 that patients waited for the doctor to take the initiative in explanations. They recognised even then that doctors interpreted patients' lack of questioning to indicate either a lack of interest or inability to understand what was going on, and used this as a reason for not providing explanations and additional information to their patients. Korsch et al (1968) found that 24% of the parents of pediatric patients in their study did not ask the doctor questions even though they wanted more information. They also found that 76% of
the parents' main worries and 63% of their expectations about treatment were not communicated to the doctor.

Bain (1976, 1977) noted the relatively small number of questions asked by the majority of patients except those in the higher social categories who generally better articulated their problems and asked significantly more questions than lower class patients (1977:349). In a large-scale British report Klein (1979) found that almost half of those patients who wanted to ask questions failed to do so, while in their study of 80 consultations with 4 doctors in Australia, Boreham and Gibson (1978) found that the great majority of the patients in their study failed to ask questions about significant areas of diagnosis and treatment. For example, 37% of the patients in Boreham and Gibson’s study had not been given specific instructions about treatment by the doctor, yet none of those patients asked questions about that topic. Patients also rarely asked the doctor about their diagnosis, so as Boreham and Gibson point out, what patients found out in their consultations depended entirely on what the doctor offered. Given the finding of Wallen, Waitzkin, and Stoekle (1979) who report that less than 1% of the total time spent in information exchange is spent on doctors' explanations to parents, it is clear that patients were not often offered substantial amounts of information.

The situation does not seem to have changed a great deal in the last twenty years. Although Cartwright and Anderson (1981) found that both patients and doctors believed that patients were more likely to question their doctor than they were ten years earlier, the results of more recent studies continue to support the findings of earlier reports. Waitzkin (1985) found that patients still spent on average only 1% of
total time available in consultations in asking questions while Roter and Hall (1993) found that only 6% of time is taken up with patients asking questions. Tuckett et al (1985) argue that even under the best of circumstances, patient questions are still infrequent, and doctors are still routinely skeptical about whether patients are really interested in obtaining more information. This supports West (1983, 1984a, 1984b) who found that in the twenty one consultations she examined only 9% of a total of 773 questions identified were initiated by patients, while other studies puts the percentage of questions asked by patients as low as 1% (Frankel, 1990, Ibrahim, 2001).

The gender of the doctor may be a factor in patient questioning behaviour. In their examination of 537 medical consultations Roter et al (1991) demonstrated that the gender of the doctor affected the length, content and structure of the medical consultation. They found that both male and female patients were likely to talk more and ask more questions in consultations with female doctors than with male doctors. Ainsworth-Vaughn (1998) reports a similar finding from her analysis of forty consultations selected specifically from her larger database of 101 consultations to provide gender balance. Both male and female patients asked slightly more questions of the female doctor with a female doctor-female-patient dyad producing the greatest number of questions and the male-doctor-male-patient the least.

Ainsworth-Vaughn’s findings also suggests therefore that whether a patient does or does not ask questions is strongly influenced by their own gender. A number of other researchers have found that women patients’ tendency to ask more questions in general and to ask more questions following the doctor’s explanations generally
results in women receiving greater amounts of information in their consultations (Wallen at al, 1979, Pendleton and Bochner, 1980). Waitzkin (1985) found that women tended to ask more questions than male patients and generally engaged in more verbal interaction. They found that female patients were therefore given more information than male patients, but also that the information was given in more comprehensible manner; that is technical matters were explained or reworded in simpler language. They also identified a tendency for doctors to match their responses to patients’ questions in terms of technical sophistication, consequently avoiding the impression of talking down or talking up to them.

A number of studies have also found that different cultural groups have different perceptions about what doctors themselves should need to ask in a consultation, and whether or not it is appropriate for the patient to ask questions of the doctor. Mori (1991) compared the expectations of four Japanese and four American students about what doctors and patients should do in medical consultations. She found that while all the native English speakers in her study believed it was entirely appropriate to ask the doctor questions, the Japanese students thought that doctors do not like patients questioning them, because asking questions “damages the doctor-patient relationship”, and that it is “better for the patient to show that they trust the doctor” (1991:9).

These findings are similar to those of Ranney (1992) who examined the notion of the medical consultation using script, or schema theory as her framework. She conducted a series of interviews and elicitation tasks with nine English-speaking and nine Hmong students who were fluent speakers of English, at an American university. She
found that the English speakers thought it entirely appropriate for the patient to question the doctor, using terms like “sure”, “definitely” “absolutely”, and comments such as “I keep asking everything I can think of” (1992:38). The Hmong students, however, were reluctant to ask questions, believing it to be disrespectful, and commenting that “the doctor won’t like it” (1992:38). Ranney also points out that while the English speakers are comfortable with, and expect the question-answer structure of history taking, many South East Asians believe that doctors should be able to recognise problems and diseases by simply looking at the patient, leading some Hmong patients to interpret the doctor’s questions and use of diagnostic tests as a sign of laziness or incompetence.

These studies have highlighted some of the reasons given for why non-native speakers of English do not question their doctor. A number of reasons for the reluctance of patients in general to ask questions have also been identified in the literature and are discussed below.

2.4.1 Reasons for patients’ reluctance to ask questions

Many of the reasons identified for patients’ diffidence about asking questions in the medical interview reflect the asymmetry of power which exists in the medical consultation and the patients’ perception of the doctor as a busy and powerful figure. Patients are reluctant to ask questions because it could be seen to indicate a lack of confidence in the doctor (Coe, 1970, Boreham and Gibson 1978) or because “the doctors are all so busy” (Mayou et al, 1976: 1578), or it would make the doctor angry (Wodak, 1996). Tagliacozzo and Mauksch, (1972) found that patients are reluctant to
bother the doctor or delay what they consider to be critical services to other sick patients. They found that patients constantly expressed doubts about taking up the doctor’s time, no matter how sick they are themselves. This view is reflected in Roter (1984) who argues that patients may be discouraged by doctors from asking questions through a variety of time-watching cues such as looking at their watch, or by their own reluctance to “bother” the doctor (1984:403) and Ley (1988) who suggests that the reluctance of patients to ask questions probably stems from an overly deferential attitudes towards doctors.

Tuckett et al (1985) found that the majority of patients did not ask questions because they were afraid of the doctor’s reaction and were afraid of humiliation by the doctor. Patients did not want the doctor to think badly of them, or misunderstand their motives for questioning and indicated that they believed the doctor didn’t want them to ask questions. Many patients also felt anxious about the time they were taking from really needy patients or felt rushed which interfered with their ability to gather their thoughts and clearly articulate their questions. Crystal (1976) points out that it is not unusual to find people who are simply not used to asking questions and this is reflected by Tuckett and his colleagues who argue that the lack of questions from patients indicates a lack of question-asking skill rather than lack of interest.

Patient reluctance to ask questions is particularly problematic since many studies have demonstrated that patients often have questions they would like to ask but simply do not (Roter and Hall 1993). For example, Mayou et al (1976) found that 70% of the 40 coronary inpatients in their study did not intend to ask questions even though 76% of patients in the coronary care unit did not understand their treatment and many of them
CHAPTER 2 - A review of the literature on medical discourse

wanted more information (1976: 1578). Klein (1979) found that almost half of those patients in his study who wanted to ask questions failed to do so, and Tuckett et al (1985) found that 75% of the 98 patients interviewed in their study had specific doubts or questions which they had failed to raise during their consultations. This reluctance to ask questions leads to a number of negative outcomes for patients including the patient being less well informed about their condition than they might otherwise be, the absence of feedback to doctors about the adequacy of their performance as communicators, and doctors continuing to believe that patients do not want information (Ley 1988).

Asking questions in the consultation is a powerful indicator that the patient wishes to be active and involved in the medical interaction (Roter and Hall 1993) and there is considerable evidence that a more active role in a visit to a doctor may relate to a greater sense of control over the disease and therefore a better health outcome (Skipper and Leonard, 1968, Hulka, 1979, Wasserman et al, 1984, Greenfield et al 1985). There is some conflicting evidence about whether patients’ questions are answered by doctors, for example Korsch et al (1968) found that mothers’ questions to doctors were frequently ignored or given vague answers, but the most consistent finding in the literature is that in fact when patients do ask questions doctors virtually always provide them with answers (Boreham and Gibson, 1978, Roter, 1977, Roter and Hall, 1993).
2.4.2 NS and NNS interactions in the medical setting

There are several studies which focus on particular ethnic groups or examine specifically cross-cultural medical interactions. Mori (1991) and Ranney (1992) discussed above focused on patients from a single ethnic group. Cameron and Williams (1997) examined a cross-cultural interaction where the health professional, a nurse, is a non-native (Thai) English-speaker. They conclude that successful communication was achieved through her use of “ordinary inferential responses, .... her use of a variety of communication strategies .... And the nurse’s own emerging professional competence” (1997:438).

Pauwels (1990) examined the perceptions of health professionals and patients of communication difficulties experienced in health care contexts. All medical participants in her study had their medical training in Australia and most had English as their first language and had had contact with either patients, students or colleagues from a non-English speaking background. Communication difficulties were attributed by participants to non-linguistic causes such as patients having different perceptions about the role of Western medicine in the treatment of illness, to culturally different attitudes to the concepts of illness and health, to the influence of religion on medical treatment and to differences in non-verbal behaviour (1990:99).

The role of language in cross-cultural miscommunication was not prominent in participants’ comments, but those comments that were made fell into two categories: difficulties arising from the lack of a shared language, and difficulties resulting from cultural and linguistic differences in the use of the same language. Difficulties were also identified with the lack of appropriate vocabulary for patients from a non-English
speaking background (NESB) to talk about medical problems and their use of the colloquial register which often caused embarrassment to the health professional who had to respond in a similar vein. A particularly interesting aspect of this finding is that the use of such language did not stigmatise the patient when there were clear ‘foreignness’ markers such as a heavy accent while the lack of such markers led to the patient being regarded as rude, uneducated or impolite.

Pauwels also identified instances of sociopragmatic failure, which is a term borrowed from Leech (1983) by Thomas (1983) and used to describe the type of pragmatic failure which stems from “cross-culturally different perceptions of what constitutes appropriate linguistic behaviour” (1983:99). Thomas differentiates this type of pragmatic failure which is a social problem from pragmalinguistic failure, which is essentially a linguistic problem. Pauwels speculated that such sociopragmatic failures which were manifested primarily in patient reluctance to answer questions, arose from different cultural beliefs about the role relationships of doctors and patients, with doctors being considered more in some cultures as an expert who should not need information from the patient who consequently adopts a very passive role. The extreme politeness or the lack of politeness of some patients was also interpreted by the researcher as demonstrations of sociopragmatic failure.

While these studies are extremely useful, they tend to foreground language or cultural differences and attribute communication difficulties to those differences. For example, there are patients who are native speakers of English who are extremely polite or extremely impolite in any given circumstance: how would such a patient be judged? A comparative analysis of such patients could shed further light on any
findings about cross-cultural miscommunication. There are very few studies which offer a direct comparison of consultations between doctors and NS and NNS patients. Such a study would afford the opportunity to examine the interactions of both and to use consultations with NS patients as a baseline against which to compare any communication difficulties identified in NNS interactions. In this way it can be demonstrated that any patterns which occur only, or to a greater extent, in one group or the other are related to the language background of the patient rather than to the general difficulties associated with the doctor-patient relationship. This is the contribution that the current study is designed to make to the body of knowledge on medical discourse.

2.5 Summary of Chapter

This chapter has reviewed the literature on medical discourse and has identified and discussed several themes which emerged from that review. There is a clear link in the literature between patients' perceptions of the amount and type of information made available to them, patient satisfaction, and subsequent compliance with medical advice. Another major theme throughout the literature is the issue of power and control. It is clear that there are several dimensions to the asymmetry that exists in doctor-patient interactions, an asymmetry of knowledge and expertise, an asymmetry of authority, and an asymmetry of discourse control. The literature, particularly that within the framework of CA has shown how asymmetry is interactively achieved. In a medical consultation it is primarily the doctor who introduces and changes topics, who therefore decides what will be talked about and who determines the direction of the consultation. This control is achieved largely through the use of questions, and
the literature has clearly established that doctors ask many questions and patients ask very few.

There is considerable research which has examined this aspect of patient behaviour and which has identified several factors which seem to influence the degree to which patients will or will not ask questions. Gender, for example, seems to be a significant factor, with female patients generally asking more questions than male patients and all patients tending to ask more questions of female doctors than of male doctors. It also seems that the cultural background of the patient may be a factor, but there has been little work done which compares the questioning behaviour of those patients who are native speakers of English and those who are not.

This aspect is the focus of the current research project which examines doctor-patient interactions and in particular the ways in which questions are framed and presented by both native speaking (NS) and non-native speaking patients/parents (NNS), to determine if there are differences in the patterns of questioning behaviour for NS and NNS patients/parents.
CHAPTER 3  Methodology

This chapter describes the methodological design of the study. It begins with a brief discussion of the philosophical perspectives informing the study and provides a rationale for the use of the chosen paradigm and the naturalistic approach taken. It then provides a description of and a rationale for the methods used to collect and analyse the data. Tools used for storing, coding, and analysing data are a significant part of any methodology. A software tool has been developed as part of the methodology of this study and is briefly introduced in this chapter, while its development and functionality are fully described and discussed in Appendix 4.

Much of the criticism leveled at naturalistic research is based on the perceived lack of objectivity, and perceived problems with validity. This chapter therefore concludes with a discussion of those issues and the ways in which they are addressed in this study.

3.1 Philosophical Perspectives

Significant debate continues to take place on the contentious issue of the relative merits of various research paradigms which are seen as being fundamentally different in terms of their ontology, (view of reality), epistemology, (the way in which we know the world, or the relationship between the inquirer and the known), and methodology (or the ways in which we gain knowledge of the world) (Guba, 1990, Denzin and Lincoln, 1994). The term ‘paradigm’ may be defined in this context as “a basic set of beliefs that guide action” (Guba, 1990:17), “a world view, a general
perspective, a way of breaking down the complexity of the real world" (Patton, 1990: 37), or "a set of basic beliefs (or metaphysics) that...represents a world view, that defines, for its holder, the nature of the 'world', the individual's place in it, and the range of possible relationships to that world and its parts" (Guba and Lincoln, 1994:107).

While Guba identifies and discusses four paradigms, (Guba, 1990) I have limited my discussion to a comparison of the basic beliefs of the dominant paradigms of positivism and post-positivism, and those of constructivism, the paradigm within which the present study is situated.

3.1.1 Positivism and Post-Positivism

Research within the dominant positivistic and post-positivistic paradigms is based on the belief that reality and truth exist, somewhere, are knowable, (albeit imperfectly in the post-positivist ontology), and measurable. This type of research uses quantitative, experimental and quasi-experimental methods to manipulate variables and control conditions in order to develop and test causal hypotheses (Schwandt, 1990).

Epistemologically, researchers in this tradition see themselves as uninvolved, removed from their research setting and subjects: such research therefore claims to be objective, and free from the researchers' own values and biases. Emphasis is therefore on rigorous guidelines, empirical measures, correlations, reliability, and validity (Glaser and Strauss 1967). Results are reported in such a way that experiments can be
replicated and findings can lead to empirical generalisations (Edge and Richards, 1998).

3.1.2 Constructivism

The constructivist, or interpretivist, paradigm is based on the view that reality, or truth, is "apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature, (although elements are often shared among individuals and even across cultures), and dependent on the individual persons or groups holding the constructions". (Guba and Lincoln 1994: 110-111).

Research within the constructivist paradigm does not manipulate or control the setting, but rather emphasises the socially constructed nature of reality and aims for a naturalistic perspective by using primarily, but not exclusively, qualitative data, such as observations, interviews, field notes and document analysis. Since reality is seen as being constructed by individuals in interaction, researchers in the constructivist paradigm eschew the notion of objectivity, acknowledge that "observations are not independent of the observer" (Firestone 1990:111) and therefore acknowledge their own subjectivist position (Guba,1990).

Such research aims to understand and describe as accurately as possible some aspect of human experience as it is experienced or understood by the participants in that experience. The goal of such research is an emic, or insider, understanding of meaning as it is constructed in a particular place, at a particular time, by particular actors (Denzin and Lincoln 1994).
As such, the researcher starts with an area of study and, rather than pre-supposing what the important aspects and dimensions will be, approaches the study inductively, without pre-conceived theories, categories and hypotheses, allowing the theory to emerge from the data. Glaser and Strauss (1967) argue that theory derived or elaborated from data in such a way, what they call ‘grounded theory’, is “destined to last, despite its inevitable modification” (1967:4) while Strauss and Corbin (1998:12) claim that it is “more likely to offer insight and enhance understanding”. This study aims to move inductively from the data to capture and elaborate the emerging theory, and in that sense can be said to be ‘grounded’. Accordingly, there were no research questions as such to lead the analysis of these data in any pre-determined direction, but rather patterns and themes were examined as they emerged from the examination and re-examination of the data. The most striking patterns to emerge from these data involve the occurrence of patient/parent-initiated questions. These patterns have therefore become the focus of, and have determined the direction of this research.

Research using qualitative methods conducted in the constructivist paradigm aims to gain a holistic view of the context, logic and rules of a given situation through intense or prolonged contact with that situation. It is interpretative, reflective and flexible, with an emphasis on discovery and exploration. Such research allows greater focus and attention on nuance, setting, interdependencies, complexities, idiosyncrasies and context (Patton 1990: 49). For these reasons it is important for the researcher to engage with the research setting and to present as detailed as possible descriptions of the setting, context and participants of the research. Such descriptions can be found in Chapter 4 of this study.
3.2 Qualitative Methods

Within a constructivist framework, an ethnographic methodology focuses on the routine details of everyday settings, and allows the researcher to get at the norms, understandings, and assumptions that are taken for granted in those settings (Patton, 1990). It allows the opportunity to observe the negotiation and co-construction of the speech event by all the participants, by emphasising the investigation of contextualised experience, and taking account of the interpretations and constructions of those involved in the context being studied (Edge and Richards, 1998).

Ethnographic research in linguistics and applied linguistics has its roots in anthropology and grew out of the work of Hymes (1972) who argued that “there are rules of use without which the rules of grammar would be useless” (1972:278). In other words, a speaker needs to know not only the grammar of a language, but also a system of use, or, what can appropriately be said to whom, under what circumstances. He called this knowledge ‘communicative competence’. This research has come to focus on a comparison of native and non-native speakers of the language, so the notion of communicative competence is particularly relevant.

While there are now many branches of ethnography, including (but not limited to) ethnographers of communication, ethnographers of speaking, educational ethnographers and critical ethnographers (Davis and Henze, 1998) they all share the belief that realities are multiple, constructed, and holistic, and focus on how meaning is constructed by participants in a given context. This study is ethnographic inasmuch
as it is concerned with the description and interpretation of the lived experience and individual realities of the participants.

Data for the study was collected using a range of ethnographic techniques, such as observation and interviewing. These methods provide for non-experimental, non-manipulative procedures which aim for the collection of authentic examples of language use and behaviour from a variety of sources and involves both the description and explanation of observed behaviour. These data collection methods are discussed in detail below.

3.2.1 Sampling

While the term ‘sampling’ may have a positivist ring to it, researchers in the constructivist paradigm still need to make decisions about who and what to observe, how many interviews to conduct, and how participants will be selected. However, selection in a constructivist sense does not need to be done in a way that ensures that the sample is representative of some particular population, or in a way that ensures randomness since such research does not necessarily aim for results that can be replicated or generalised (Guba and Lincoln, 1989).

Patton (1990) points out that the focus of sampling in qualitative research, which may be based on very small numbers, or even single cases, is on selecting information-rich cases for examination. This type of sampling is called ‘purposeful sampling’ and can be implemented in a number of ways, including, among others, criterion sampling, which allows the researcher to include all cases which meet previously specified criteria, extreme or deviant case sampling, which focuses on highly unusual cases in
the data, maximum variation sampling, which includes a range of diverse cases and can be useful for identifying common patterns, intensity sampling, which require the identification of information-rich cases, and opportunistic sampling, which allows the researcher to pursue new leads and follow-up on the unexpected (Patton, 1990; Miles and Huberman, 1994).

Criterion sampling allows the researcher to specify a particular criterion that participants must meet, for example, being from a non-English speaking background. When combined with intensity sampling, which provides for choosing a source of rich, but not unusual cases, it is possible to identify sources of a number of cases which will manifest the particular behaviour or feature to be examined. Data collected from a sample selected in such a manner can then be further enriched by an examination of deviant or disconfirming cases. The sample selected for this study is discussed in 3.4.2 below.

3.2.2 Qualitative observation

Qualitative observation is essentially naturalistic and occurs in the natural setting under study where the observer is unobtrusive and inconspicuous, neither manipulating nor controlling the situation. Observational research can vary widely, with the researcher assuming a role that can range anywhere between the hidden, or absent observer, who may watch from outside or with a passive presence, to the active participant who is involved in the setting and who acts as a member rather than a researcher (Denzin 1989a, 1989b, Adler and Adler, 1994).
The extent to which he or she will be a participant in the setting represents one of the first decisions to be made by the observer. In some cases, the extent to which it is possible to become a participant will be limited by the situation. As Patton (1990) points out, it can be difficult for a researcher to become a participant in settings where the social and political factors preclude participation, for example, where the other participants know each other well, or where there are marked social class differences, or where the setting is designed for specific groups, such as children.

It was not possible for the researcher to assume a role of participant, or participant-observer in the context of the medical setting being observed in this study since there was no natural role that could be assumed. Observations were therefore carried out in as unintrusive, inconspicuous manner as possible. Adler and Adler (1994) point out that since the role of observer does not require interaction with the participants it also has the advantage of minimising the potential for observer effects.

Observers can not, and should not, be expected to observe or notice everything which occurs, even within the context of attempting to achieve a holistic sense of the situation. Patton (1990:216) recommends using what he calls 'sensitising concepts' to help make the situation manageable and to determine those aspects which will be the focus of each observation. Sensitising concepts can provide a framework and give the analyst a "general sense of reference" (Patton, 1990:390) Some sensitising concepts were initially identified by the researcher and the health workers in the study, for example, the language background of the parents but others, such as whether the visit was a first or subsequent visit, or the fact that the nature of the
child's illness would play a role in the conduct of the consultation, emerged from observations and member-check discussions as the study progressed and developed.

### 3.2.3 Interviewing

Interviewing is one of the most common tools for naturalistic data-collection because of its interactional nature. Interviews can take the form of face-to-face interactions or can be conducted over the telephone. They can be one-on-one discussions, or group interviews with naturally occurring groups or specially gathered focus groups. The interview itself can range from **highly structured**, during which the interviewer asks respondents a series of pre-determined questions, in exactly the same sequence, usually with a limited range of possible responses, to **unstructured**, which, because of its open nature, provides an opportunity for greater breadth and depth of discovery (Fontana and Frey, 1994).

The purpose of interviews is to find out those things which we cannot observe directly; a representation of what someone else is thinking. Qualitative interviewing therefore starts with the assumption that "the perspective of others is meaningful and able to be made explicit" (Patton, 1990:278). The purpose of unstructured, open interviews is to access the perspective of the person being interviewed, without imposing any preconceived categories or limits on the discussion.

Patton (1990:280) identifies three types of what he calls open-ended interviews, although the third type is in fact a very structured interview:
• The informal conversational interview: the interviewer wants to maintain maximum flexibility and does not know beforehand what is going to happen or how the conversation will develop

• The general interview guide approach, which has as its base a set of general issues to be explored which can act as a checklist for the interviewer to ensure all relevant topics have been covered, and

• The standardised open-ended interview, which usually consists of a set of pre-determined questions asked in the same order and in the same words, and is very focused and systematic.

To address questions about an individual’s experience with pain (or illness) and to identify the important themes which emerge from patients’ stories and experiences, it is essential to have an open-ended, individual, in-depth interview strategy (Miller and Crabtree, 1994). The general interview guide approach is the one employed in this study, as it combines a basic framework of information to be addressed with the flexibility to adapt each interview to the needs of the individual participant, and the freedom to develop and pursue particular issues in greater depth as appropriate.

3.2.4 Field Notes

The researcher in the field cannot rely either on their memory, or necessarily on their electronic equipment, to capture all the relevant details of what is being observed. It is essential that observations and interviews be captured in clear, detailed, and descriptive notes. The most important goal of such notes is “to record as thoroughly as possible what is happening in the observed context” (Lynch, 1996:116).

Since the purpose of any observational data is to take the reader into the context being studied, field note descriptions need to be factual, accurate, and thorough, while
avoiding labels and terms that are ambiguous, emotive, or judgmental. Direct quotations from participants are important as they can assist the researcher to capture a truly emic perspective on what is happening, by capturing the participants' own words and terms. Field notes should contain either the actual quotes or some quick form of reference so that the relevant quote can be retrieved from the tapes at a later stage.

Field notes should also contain the researcher's own reflections, impressions and interpretations, and as the study progresses, insights, beginning analyses and working hypotheses (Patton, 1990:242). However, it is important that these be identifiable as such, and clearly distinguishable from the purely descriptive content. Field notes in this study also helped keep track of more administrative information such as appointment times, any delays, length of appointments, and number of patients waiting. During data collection it is not always possible to determine what data will or will not be crucial for examination and analysis. Field notes are just one source of data and may not in fact feature largely in analyses but nonetheless they serve to focus the researcher at the time of recording, provide a 'safety net' in case of equipment failure, and can be used to check interpretations or impressions which emerge during analysis.

3.2.5 Triangulation

The term triangulation is used by Denzin to mean "the use of multiple observers, methods, interpretative points of view and levels and forms of empirical materials in the construction of interpretations" (1989a: 270). He argues that triangulation, or the use of multiple methods, helps to overcome the inherent weaknesses of a single
measurement and "is the plan of action which raises researchers above the personal biases that stem from single methodologies" (Denzin, 1989a: 236)

Denzin (1989a) has identified four of basic types of triangulation:

- *data triangulation* for example, comparing observational data with interview data, or comparing what participants say over a period of time, or perhaps comparing what people say in different physical contexts or sites.

- *investigator triangulation*, which involves the use of multiple investigators which can expand the interpretative base of the research and reveal elements of the phenomenon that would not necessarily be seen by just one observer.

- *theory triangulation*, which requires researchers to compare subjects’ accounts of their experiences with alternative theoretical schemas, and

- *methodological triangulation*, which requires the researcher to consider and use a number of methods to manage and analyse data. This includes *with-in method, and between, or across-method*, which is seen as the more satisfactory form of method triangulation since it combines dissimilar methods to examine the data. Since the flaws of one method are often the strengths of another by combining methods researchers can achieve the best of each while overcoming their unique deficiencies. (Denzin, 1989a: 237-244).

Guba and Lincoln (1989: 240) argue, however, that the notion of triangulation has very positivist implications and deliberately avoid referring to it as a technique in qualitative research, other than as a means of cross-checking specific factual data items. Lynch, (1996) agrees that validity, (itself a positivist notion), can be enhanced through the inclusion of multiple data sources and perspectives, but only to the degree that the researcher can reasonably construct meaningful conclusions from these data. He emphasises that triangulation in itself cannot guarantee validity and argues that the
use of triangulation “needs to be accompanied by a clear elaboration of the process that the researcher followed in triangulating the data and in deciding on interpretations” (1996: 60).

Patton (1990: 60) discusses triangulation by drawing on the metaphor of the triangle as the strongest of all geometric shapes and argues that triangulation adds strength to the design of a study. He maintains that studies which rely on only one method are more vulnerable to the weaknesses and biases inherent in that method, and argues that it is possible to achieve triangulation within a qualitative inquiry by combining different qualitative methods, mixing purposeful samples, and including multiple perspectives.

Triangulation, then, in spite of its positivist implications, is a useful tool to ensure that a study is not too reliant on single methods and the weaknesses of those methods, and encourages the researcher to explore multiple approaches and analyses when examining the data. Used in this way, triangulation does not claim to establish validity, but can be, as Lynch points out “a tool for providing the audience with richer and clearer information’ (1996: 60). It is in this sense that the notion of triangulation is employed in this study which is based on data gathered in a variety of settings from a range of participants using a number of collection methods, then analysed from various perspectives.
3.3 Data Collection

Data were collected from a range of participants, using a range of collection methods as discussed above, from several sites. The following section describes the various techniques employed to select participants and collect data, and discusses the ethical issues of human research. It also discusses the notion of triangulation, and describes its role in this study. As mentioned earlier, the research sites are described in detail in Chapter 4.

3.3.1 Ethical Issues

Ethical issues are intrinsic in research design and the collection of data from human subjects. This is particularly so where the research involves children, as it does in this study. It is important that every participant is fully informed of the purpose of the research and the extent of their role, and that they, or their parent or guardian, gives written consent to participate in the research.

In the medical setting, patients must be under no obligation to participate, and it needs to be emphasised that consent is entirely voluntary, can be withdrawn at any time, and that refusal to participate will not affect their treatment or relationship with the doctor in any way. Participants need to be assured that their privacy will be protected and that confidentiality will be maintained. They need to be aware that the researcher has considered any potential risks, and has taken all possible steps to minimise such risks, and it should be clear that the researcher will treat them fairly and relate to them with integrity and honesty.
Since this research involved both the hospital and the University of Melbourne, it was necessary to obtain approval from the Ethics Committees of both institutions. The two Ethics Committees have a reciprocal agreement, so once approval was obtained from one, the other agreed to accept that their requirements were met and issue their approval. It was decided that initial ethics approval should be obtained from the hospital since observations were to take place there. The hospital has very strict guidelines about informed consent, and specific requirements for the information sheets and consent forms to be used. The Ethics application forms, informed consent forms, patient and parent information sheets and the research proposal were submitted on the 19th of May, 1999, and approval was received on the 29th July, 1999. Approval was subsequently obtained from the University of Melbourne Ethics Committee three months later. Copies of the relevant forms can be found at Appendix 1.

3.3.2 Participants

The sample for this study is a purposeful sample based on a combination of criterion and intensive sampling as described in 3.3.1. above. The participants are doctors, orthoptists, child patients and parents (or guardians) at the hospital and at two private metropolitan clinics. The hospital was chosen on the basis that it could provide a rich source of participants who meet the essential criteria for this study, namely, being:

- From either an English or a non-English speaking background, and
- a child (and/ or their parent) who needs to consult with a doctor, or
- a doctor or other health professional who interacts with patients/parents from both English-speaking and non-English speaking backgrounds.
The private clinics are those with which participating doctors are associated. Data were collected from both the hospital and private rooms to provide as wide a patient base as possible by including both private and public patients/parents.

3.3.2.1 The health care professionals

The doctors and orthoptists in the study agreed to participate after being fully informed about the goals and methodology of the study by the researcher at a staff meeting of the Ophthalmology Department at the hospital. The two doctors who volunteered, one male and one female, are both ophthalmologists, or eye specialists, and were observed during consultations at both the hospital and at their respective private rooms.

The consultations between orthoptists and patients/parents were included in the data collection since they are part of the consultation process and, like the post-consultation interviews with the the patients and their parents and the doctors, provide another source of relevant data. The orthoptists involved in the study were also those who volunteered to participate.

Orthoptists are university trained allied health professionals who work closely with ophthalmologists, usually seeing all patients and carrying out necessary vision tests and preliminary examinations before the patient sees the ophthalmologist. Four female orthoptists were observed, two at the hospital and one each at the two metropolitan private clinics. There are no male orthoptists at the hospital or at either private clinic, although on two occasions there was a male orthoptic student doing field work at the hospital. A full description of the health professionals involved is provided in Chapter 4, ‘The Research Setting’.

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3.3.2.2 The patients and their parents

Patients and their parents were also fully informed about the purpose and aims of the study, in accordance with both hospital and university ethics requirements, and were asked to provide written consent before being observed or interviewed. A purposeful sample of patients was selected, consisting of those patients at both the hospital and the private clinics who had appointments on days the researcher was present, and who agreed, or whose parents agreed, to participate and who gave the appropriate written informed consent.

As the study evolved it came to focus on a comparison of consultations with native speaking and non-native speaking patients and their parents. Accordingly, the daily appointments lists were scrutinised and the initial selection of patients was made on the basis of names so that patients from both English-speaking backgrounds and non-English speaking backgrounds were included. Language background was assessed by asking the participants what their first language was, and if they were not native speakers of English a range of questions about their first language and their exposure to English were asked at the post-consultation interview. This native-speaker/non-native speaker dichotomy is problematic for several reasons and is therefore discussed fully in Chapter 4.

Participants were given a plain English explanation of the purpose of the research study and advised that they could withdraw their consent at any stage. They were also advised that refusal to participate in the study would not affect their treatment in any way. In the early stages of data collection the refusal rate was quite high, particularly among patients from a non-English speaking background. It had been decided that
the doctors themselves would play no part in the selection process, or at the request stage, since this could be seen as putting the patients/parents under some pressure to participate. Patients/parents were notified of my presence and the purpose of the study by the medical receptionist, who also handed them the information sheets and consent forms. If patients/parents indicated they might be willing to participate, I approached them and introduced myself, explaining in more detail what would happen and inviting questions. However, most refusals were made at the stage where the receptionist initially explained the project and I was reluctant to approach the patient/parent after they had already declined to be involved.

It appeared that most refusals were made because the papers handed to the patient/parent made a quite daunting pile, particularly for someone from a non-English speaking background. For many patients or parents it was just easier to say no. The procedure was therefore amended so that the receptionist simply informed the patient/parent who I was, where I was from, and that I would be talking to them about my research project. I then approached the patient/parent, introduced myself and gave a very brief outline of the project, explaining what participation in the study involved, and handling questions and objections on the spot. If the patient/parent agreed to participate, I then gave them the information sheets, to read at their leisure, and then obtained their signature on the consent form. The number of refusals dropped from as many as half of those approached in the first few sessions to no refusals at all.

Sample size in qualitative research depends on the purpose of the research, and can be very small, sometimes a single example, as in a case study. An initial sample base can be identified, but the sample can be added to or varied as the project develops: for
instance an interview with a participant in the initial sample may lead to
'snowballing', where other information-rich cases are identified and pursued during
the data collection and analysis stages. There were no pre-determined notions about a
suitable sample size for this study but as it became clear that something interesting
was emerging from a comparison of native and non-native questioning behaviour it
became important to obtain sufficient data for meaningful patterns to be observed.

A total of fifty-three consultations were observed and recorded during eighteen
sessions over a period of ten months. This includes twenty-six consultations at the
hospital and another twenty-seven at the two private clinics. One of the doctors held a
clinic at the hospital on only one afternoon a month, during which he often saw
patients with complex genetic eye diseases on an on-going basis and in association
with the hospital’s genetics department. These consultations were not observed and
the number of observations obtained from consultations at the hospital with this
doctor was therefore limited. The data-set contains consultations with thirty-three
native speakers of English and twenty non-native speakers. The gender of the patients
or parents was not a factor in selecting participants and there was no attempt to
balance male and female participants. The data-set also contains a mix of initial and
follow-up visits at both the hospital and each of the clinics.

3.3.2.3 Observations

Non-participant observations, as described in 3.3.2 above, were carried out during
consultations between doctors, orthoptists, and patients and their parents at the public
eye clinic at the hospital. Observations were carried out on those consultations where
informed, written consent had been given by the patient and/or their parent or
guardian, and included consultations between the health professional and both native
English speakers and non-native speakers. Similar observations were also carried out on consultations between doctors, orthoptists, and patients and their parents or guardians at two private practices in the Melbourne metropolitan area.

It was explained to the patients and/or their parents that participation in the project meant that I would be present during their consultation and would be recording it. When the patient was called in by the doctor, I accompanied them into the consulting room and in order to remain as inconspicuous as possible sat beside or behind them, depending on the configuration of the room. On no occasion did I sit next to or near the doctor. I remained silent throughout and as described below, the recording equipment used was all but invisible to the patients and parents. Dr. Colson did not remark on my presence in any of her consultations, however, Dr. Maxwell referred to me in every case, usually with a casual remark such as “and you’ve met my friend Anne who’s with us today?”. At the end of the consultation I left the room with the patient and parent(s), thanked them for allowing me to sit in, and then conducted the post-consultation interview.

All observations were tape-recorded to help capture as accurately as possible the linguistic and paralinguistic features of the interactions. These paralinguistic features include tone, pitch, and volume of speech, as well as non-verbal vocalisations such as laughter, sighs, crying, and so on (Beisler, Scheeres and Pinner, 1993). As Patton points out, “tape recorders do not ‘tune out’ of conversations (or) change what has been said because of interpretation” (Patton, 1990:348). Audio-recording substantially enrich the data, in a relatively unobtrusive manner, since it accurately
records everything which is said, while freeing up the researcher to be more attentive to what is going on.

Notwithstanding extensive testing of the equipment, the audio taping process was not trauma-free. In order to keep the recording process as unobtrusive as possible a ‘bug’ style microphone was used. This microphone is tiny and was pinned to the lapel of my jacket where it was completely invisible, while the tape recorder itself was concealed in a small black shoulder bag which I carried. The advantages of this system were that it was very unobtrusive, and that the recording equipment was completely self-contained so that the researcher could enter and leave the various consulting and examination rooms with the patient without having to set up or move the equipment each time. There were however several disadvantages. This type of microphone is extremely sensitive and it was able to pick up conversations in the next room or at the reception desk, so a number of consultations were very difficult to transcribe due to excessive background noise, or extraneous noise from siblings during the consultations. The microphone also had its own battery and on three occasions the microphone battery proved to be dead even though the recorder was operating normally, so those consultations were not actually recorded. However the researcher’s presence at those consultations served to enrich the opportunity for thick description and the researcher’s ability to contextualise the data.

The option of video-taping observations was considered but, given the potentially stressful environment of a children’s hospital, the intrusiveness of a video-camera, and the one-off nature of most of the observations it was considered neither desirable nor feasible in this case.
3.3.2.4 Interviews

Qualitative researchers need to be able to choose from a range of effective data-collection techniques, particularly in the clinical or medical setting, where ethical issues and the importance of avoiding harm or distress is especially important (Miller and Crabtree, 1994). For this reason, observations were combined with a range of interviews, as described below.

Interviews were conducted with both participating doctors and orthoptists before observations began to:

- gather necessary information for the contextual description of the study;
- allow the participants to become more comfortable with the researcher, and with the idea of being observed;
- answer any questions and address any concerns they may have about the process, confidentiality etc; and
- obtain participants' views and impressions about their own communicative style and any perceived problems they have, or have observed, or are aware of, with cross-cultural communication.

The general interview guide approach to interviewing, which provides a framework for questioning but allows for individual variations, was used to conduct interviews after the consultation with the patient (and parents, where relevant), to provide an opportunity for patients/parents to evaluate the consultation and for each party to discuss their understanding of what had happened, what decisions were made, by whom and for what reasons, and their perceptions of the success or otherwise of the communication process. Since the patients themselves were children, interviews were only conducted with those who are old enough to understand the process (the hospital regards children of thirteen years of age as able to give informed consent, and
therefore it seems reasonable to regard them as being capable of forming and expressing an opinion about the medical consultation and its outcomes).

Debriefing and evaluation interviews were also conducted with the doctors and orthoptists after each observation session. These interviews provided an opportunity for participants to express their views on what occurred during the various consultations, whether any misunderstandings occurred and, if so, what factors they thought may have contributed to those misunderstandings, as well as their own observations on the success or otherwise of the consultation and any other matters they wished to discuss. These interviews also functioned as ‘member-checks’ in the ongoing analysis of the data and development of the findings. Member checks require the ongoing involvement of participants in the development of findings and are a valuable way of enhancing credibility in qualitative research. They are discussed more fully in Section 3.6.1 below.

The initial interview framework was designed as a starting point and aimed to ensure that the interview addressed the most important topics and areas, as anticipated by the researcher, however this framework changed and evolved as the data collection proceeded and as issues, patterns, and trends began to emerge from the data. As with observations, all interviews were audio-taped.

3.3.2.5 Field Notes

Detailed and extensive field notes were maintained throughout the data collection phase. These contain information such as: descriptions of the physical environment, the location of participants in the room, description of any interruptions, evidence of participants’ awareness of the observer, and details of paralinguistic and non-verbal communication such as eye contact, gestures, silences, use of space and time. Given
the potential and actual difficulties with audio-recording equipment, the field notes have also provided a valuable back-up to help capture fragments of actual discourse, as well as providing a means of recording relevant details of time, for instance, the duration of consultations, length of delays, and comparison of appointment times with actual times of consultations.

As outlined in 3.2.4 above, these notes also contain the researcher’s comments, impressions and interpretations as they developed. A sample of the field notes can be found at Appendix 2.

3.3.2.6 Summary of participants

As discussed above, some consultations were not suitable for analysis for reasons such as the failure of the recording equipment, or transcription was rendered impossible by the presence of siblings or other intrusive noise levels. Of the fifty-three consultations observed, a sub-set of complete and transcribable recordings was selected to provide equal numbers of consultations with NS and NNS patients/parents. This resulted in a total of twenty eight consultations comprising sixteen (eight NS and eight NNS) consultations with Dr. Maxwell\(^1\) and twelve (six NS and six NNS) with Dr. Colson for analysis. These consultations are summarised in Table 3-1 below.

To protect the identity of participants, each consultation was allocated a unique identifier (1, 2, 3, etc) at the time of observation. This identification code appears in column 2 of the table. Each of the four sources of data collection for each patient have also been identified in the ID code as follows:

---
\(^1\) Pseudonyms adopted for all participants to protect their identity
A. Orthoptist consultation  
B. Doctor consultation  
C. Parent interview  
D. Doctor’s debriefing

Data taken from an interview with, for example, Dean’s mother would be coded as 31C, while Dean’s consultation with the doctor would be coded as 31B.

The table also shows details of the age and gender of each patient, the gender of the parent who attended the consultation, whether the consultation took place at the hospital or at one of the private clinics, and whether the visit was an initial or follow-up visit.

**Table 3-1: Summary of patient sample**

<table>
<thead>
<tr>
<th>Obs</th>
<th>ID</th>
<th>Doctor</th>
<th>Age of child</th>
<th>Gender of child</th>
<th>Gender of parent</th>
<th>NS/ NNS</th>
<th>Site (hospital/ clinic)</th>
<th>Initial/ follow-up visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11</td>
<td>Maxwell</td>
<td>5</td>
<td>M</td>
<td>F</td>
<td>N</td>
<td>C</td>
<td>F</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>Maxwell</td>
<td>5</td>
<td>F</td>
<td>F</td>
<td>N</td>
<td>C</td>
<td>F</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>Maxwell</td>
<td>7</td>
<td>M</td>
<td>M</td>
<td>NN</td>
<td>C</td>
<td>F</td>
</tr>
<tr>
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<td>Maxwell</td>
<td>4</td>
<td>M</td>
<td>M</td>
<td>NN</td>
<td>C</td>
<td>F</td>
</tr>
<tr>
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<td>Maxwell</td>
<td>6</td>
<td>M</td>
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<td>NN</td>
<td>C</td>
<td>F</td>
</tr>
<tr>
<td>6</td>
<td>18</td>
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Several of these variables, in particular the variables of doctor and speaking background (NS:NNS) of parents, have emerged from these data as being important in terms of their effect on patient/parent questioning behaviour. Their significance is analysed and discussed in chapters 5 to 8.

3.4 Transcription and analysis of the data

3.4.1 Transcription

Transcribing talk is the process of creating a written representation of speech so as to make it accessible for analysis (Du Bois et al 1993). It involves capturing as accurately as possible not only the lexical content of the talk, but also all the complex features of talk as interaction, such as pauses, overlapping speech, false starts, tone and other paralinguistic cues, in a manner which remains readable and meaningful within the context of the interaction with the text.

Patton (1990) points out that a full transcription of the raw data gathered during interviews and observations, while the most useful, is not always practicable, and that it is often sufficient to work between the recordings and transcribed sections of the most relevant and rich data. It is important to recognise, however, that the very act of deciding what content or aspects of talk to transcribe or not transcribe is a major step in beginning to analyse the data, and is part of an interpretative process which is influenced by the researcher’s assumptions about language, whose point of view should be represented, and what is perceived as being meaningful (Green, Franquiz, and Dixon, 1997).
The researcher must also make decisions about the general design of their transcript, including the spatial organisation and descriptive categories to be used. Edwards (1993) argues that these decisions should be informed by two general goals of transcribing:

- that the transcripts preserve the information needed by the researcher in a manner which is true to the nature of the interaction itself, and

- that its conventions be practical with respect to the way in which the data are to be managed and analysed, for example, that they are easy to read, can apply to new data sets, and can expand if needed for other purposes (Edwards, 1993: 4).

There are a number of conventions for the spatial representation of discourse, each with its own strengths and weaknesses. For example, talk can be represented vertically, or in a linear fashion. The latter is the mostly commonly used format, since it facilitates comprehension (Tannen and Wallat, 1986) but tends to give the impression of symmetry and equality, (Edwards, 1993) which may be appropriate in some interactions but may also be very misleading in others where there is some distance or unequal power between the speakers. Talk can also be represented in columns, one column for each speaker, which in fact emphasises the asymmetry of the interaction, and allows for a clear display of simultaneous or overlapping talk. The format used should depend on the purpose of the transcript and the focus and theoretical framework of the analysis.
While the particular strengths of the column format make it suitable for use in the present study, with its focus on interactions often characterised by social distance and unequal power, there are other considerations. As Edwards points out, "in approaching a transcript, readers necessarily bring with them strategies developed in the course of extensive experience with other types of written material (e.g. books, newspapers, … personal letters). It makes sense for transcripts … to draw on reader expectations in their choice of conventions" (1993:6). The practical consideration of improving the readability of the transcripts and the need for flexibility in the way the data are to be managed make a linear transcription the most appropriate for these data.

Levinson (1983) and Atkinson and Heritage (1999) present a framework for discourse transcription based on the work carried out by Gail Jefferson, which incorporates basic transcription information such as the words spoken and who said them, conventions for indicating the division of chunks of discourse into units or turns, intonation contours, pauses, overlapping, and indecipherable words. This framework is well established and widely accepted in the field of linguistics and applied linguistics and provides a sound basis for the transcription of the data in this study. Additional symbols have been created as required, for instance, the use of square brackets [ ] to indicate that the speaker is thinking out loud, for example, [now, where did I see those notes] and no response is required. The transcription conventions employed in this study are detailed in Appendix 3.

Finally, Roberts (1997) highlights the difficulties faced by a transcriber in producing transcriptions which are accurate and readable, but also make explicit to the reader the constructed and political nature of transcribed talk. She recommends a number of
practical strategies for managing the tension between accuracy, readability and the political issue of representation, including:

- Where appropriate, using standard orthography even when the speaker is using non-standard varieties to avoid stigmatisation and to evoke the naturalness of their speech, and to never use ‘eye dialect’, for example “hwaryuh” for “how are you”
- Using a layered approach to transcription, offering different versions and different levels, some using fine-grained widely-accepted transcription systems to give different readings, and
- Being more reflexive about the whole process of transcribing (1997:170).

Roberts urges us to remember that when we transcribe talk we transcribe people and to be constantly aware of the ideological, political, situated nature of any transcription.

These strategies seem particularly relevant to the present study, which involves transcribing talk from participants who are non-native speakers of English and who may use non-standard varieties of English. Inappropriate transcription of such talk could lead to ambiguity, stigmatising or pejorative stereotyping. Transcriptions have therefore as far as practicable used standard orthography and the only time abbreviations and slang are used is for everyday words commonly shortened by most people, for instance cos rather than because since it is commonly accepted in spoken discourse and is not pejorative in any way. An exception to this is in cases where data extracts from other researchers are used to illustrate a discussion point. In such cases the transcription conventions used by the researcher have also been retained.
3.4.2 Analytical Tools

A thick description of the setting, participants, and the interactions has been provided, which will facilitate transferability of the results of this study, and the research process has been fully documented (see 3.6 below for further discussion on these points). A range of analytical tools and theoretical frameworks have been used to identify and describe any patterns or trends emerging from the data. These include a range of features from discourse analysis, conversation analysis, frame theory, pragmatics, and cross-cultural and interlanguage pragmatics. Frame theory is discussed in Chapter 2 (see 2.3) and the key elements of the other approaches are discussed below.

Discourse Analysis is sometimes used as an inclusive label for a wide range of approaches in disciplines such as cognitive psychology, post-structuralism and literary theory as well as in linguistics as a general term which can encompass speech act theory, pragmatics, and sociolinguistics (Potter, 1997). One approach with roots in sociology and social psychology sees talk as a social practice. Discourse Analysis in this sense pays particular attention to linguistic content such as topics and meaning, rather than linguistic forms such as grammar, and seeks to answer social questions rather than linguistic ones (Potter and Wetherall, 1994). Discourse Analysis can be seen therefore as not only a method designed for the close analysis of talk but also as a perspective on the nature of language itself and as a powerful conceptual framework for the analysis of human behaviour (Wood and Kroger, 2000).

Conversation Analysis (CA) is based on the realisation that ordinary, or mundane conversation is the predominant medium of interaction in the social world, as well as
being "the primary form of interaction to which a child is exposed and through which socialisation occurs" (Drew and Heritage, 1992:19). CA provides a means by which we can understand the sequential organisation of utterances in dialogue and how the orderliness of conversation is achieved by speakers and hearers adhering to procedural 'rules' (Sacks, Schlegoff and Jefferson, 1974). CA practices which are particularly relevant to medical contexts include the analysis of adjacency pairs and in particular question and answer sequences, the organisation of turn-taking, the notion of preference, repair, and topic management.

The boundary between CA and DA is becoming increasingly blurred as a number of CA researchers move beyond the analysis of ordinary conversation to focus on the ways in which talk is constructed in institutional settings such as classrooms, courtrooms and medical consultations (Heritage and Greatbach, 1991). Some of the features of institutional discourse which are particularly relevant to the analysis of medical interactions are discussed more fully in Chapters 1 and 9. The overlap between CA and DA is made explicit by Wood and Kroger (2000), who include CA in their discussion of "varieties of Discourse Analysis" and argue that "CA has contributed major insights to our understanding of talk in both everyday and institutional contexts" (2000: 205). It is at this nexus of CA and DA that the present study is located.

Other theoretical frameworks which inform the present study include cross-cultural pragmatics, which contrasts the ways in which specific speech acts such as apologising, thanking and requesting are realised in various cultures (Blum-Kulka, 1989, Bardovi-Harlig and Hartford, 1991, Houck and Gass, 1996) and interlanguage
pragmatics, which looks at the pragmatic and discourse knowledge of second language learners, and is concerned with explaining the differences between NS and NNS pragmatic performance in terms of producing (Blum-Kulka, 1989) and, more recently, interpreting various speech acts (Cook and Liddicoat, 2002).

Finally, the analysis is informed by Pragmatics, which “allows a fuller, deeper and more reasonable account of human language behaviour” (Mey, 1993:7) by focusing on the relationship between meaning and context. Pragmatics, for Mey, is about what the speaker means, not what the words mean, and is therefore concerned about the relationship between interlocutors and how meaning is negotiated and achieved.

Features of pragmatics which are particularly relevant to the present study include the notions of appropriacy (Hymes, 1972), relevance (Sperber and Wilson, 1986) politeness (Leech, 1983,: Brown and Levinson, 1987, Grundy, 2000), indirectness (Searle, 1976, 1979) and implicature (Grice, 1975, Levinson, 1983).

This use of a number of frameworks and methods, or triangulating, in the data analysis stage, has several advantages, highlighting and examining different aspects of the data from different philosophical viewpoints and dealing with the different strengths and weaknesses of each approach. Revisiting and re-analysing the data from different approaches also helps to minimise researcher subjectivity and can provide valuable confirmation and credibility for initial findings.

3.4.3 Coding

The qualitative analysis of verbal interactions is a complex task due mainly to the high volume of data which results upon transcription. The transcribed data for this study comprise approximately 200,000 words. A detailed inspection of the
transcribed data was first required, to highlight useful and relevant aspects of the data, while discarding other data. The task then facing the researcher was to synthesise these useful and relevant aspects, in all their forms, into interesting and meaningful groupings, in order to draw conclusions with respect to the original interactions. Coding is one way of reducing the volume of data and preparing it for further analysis and classification.

A brief survey of currently available tools determined that existing tools are generally expensive, they generally require extensive training and experience to gain any real benefits, and are often relatively inflexible. I felt that a need existed for a more appropriate computer-based tool to assist me with the capture, organisation and analysis of my data. The key requirement for such a tool was flexibility; the flexibility to decompose text into user-defined units, the flexibility to organise these units into user-defined patterns, the flexibility to assign multiple codes to a particular utterance and ultimately the flexibility to ask ‘what-if’ questions on the resulting data set.

To meet this need, the Discourse Analysis And Reporting Tool (DART) was developed by the researcher and was used to code, store and analyse the data. A key, and particularly useful, feature of DART is that it allows simultaneous visual and audio presentation of any selected excerpt of data which facilitates the visiting and revisiting of the original audio recording as the primary data at the same time as the matching transcription as the written representation of that data. As part of the commitment to thick description, the key features of DART are fully explained in Appendix 4.
3.4.4 Statistical Analysis

The decision to conduct qualitative research does not preclude the use of quantitative methods and as this study developed it became clear that some of the patterns which emerged from the data lent themselves to statistical analysis. Strauss and Corbin (1998) argue that “a researcher should make use of any and every method at his or her disposal keeping in mind that a true interplay of methods is necessary” (1998:33). Strauss and Corbin point out that as relationships emerge from data during qualitative analysis the researcher needs to make decisions about appropriate methods for analysing those relationships. The need for statistical analyses was not anticipated or planned for this study, but rather, like other key patterns and themes, emerged from the data and such analyses were therefore subsequently incorporated into the study.

As the data sample is small, a normal distribution can not be assumed and the non-parametric Mann-Whitney test and Spearman’s rank correlation were therefore used to conduct the statistical analyses. These tests are univariate, in the sense that they look at one explanatory variable at a time. In any statistical analysis of data containing a number of variables it is possible that some of the effects of the explanatory variables are confounded by virtue of their association with other variables. Accordingly, it is desirable to apply statistical models which examine the simultaneous effects of explanatory variables on the outcomes.

As illustrated in table 3.1 above, there are seven independent or explanatory variables which could potentially influence the patterns of patient/parent-initiated questioning behaviour which have emerged from these data. These are:

– the doctor (2 doctors participated in the study)
- age of patient
- sex of patient
- parent(s) attending with the patient: mother, father, both or neither
- speaking background of the parent (native or non-native speaker)
- whether the visit took place at the hospital or at a private clinic
- whether the visit was an initial or follow-up visit

To address the issue of confounding variables a multivariate analysis of variance was required. In this case a general linear model was fitted to the square root of the total number of questions, with the seven variables listed above as potential explanatory variables. The square root transformation was used so as to make the assumptions of the analysis of variance valid. The outcomes of these statistical tests are presented where appropriate in chapters 5 to 8.

It must be stressed that the formal statistical analyses carried out on these data should be interpreted cautiously and considered as indicative only. The original design of this study made no attempt to meet the most basic requirements for quantitative studies, for example, as mentioned earlier, the sample is very small and it was not randomly selected from a wide population basis. It is therefore not intended that these statistical findings should be generalised in any way, but rather used to strengthen the claims made about the patterns that have emerged from the qualitative analysis of these data.

3.5 Trustworthiness Criteria

A very important aspect of qualitative research is the way in which the data are evaluated. Guba and Lincoln (1989) highlight the positivistic nature of the traditional notions of validity and reliability, and have instead identified a set of criteria which they consider more appropriate for the evaluation of naturalistic investigation: they
refer to these criteria as trustworthiness criteria, and describe them as “paralleling the criteria traditionally used within the positivist and post-positivist paradigms” (1989: 233).

These criteria refer to credibility and transferability, which parallel internal and external validity respectively, dependability rather than reliability, and confirmability instead of the positivistic notion of objectivity. Each of these criteria is discussed below.

3.5.1 Credibility

Guba and Lincoln (1989) identify a number of ways to enhance credibility, including peer debriefing, which involves extensive discussions of findings, evaluations, conclusions and tentative hypotheses, with a disinterested peer, and ‘member checks’, which requires the ongoing involvement, either formally or informally, of members of the study in the development of findings.

Both of these techniques were used in this study, in the form of on-going consultations with other researchers, and with the two medical participants in the study. It was not feasible to include patients/parents in this stage, unless they specifically requested such involvement, (which none did) because of the difficulty of follow-up contact created by the confidentiality measures taken to meet the hospital and university ethics requirements. Other credibility measures, such as prolonged engagement, which involves immersion in the setting of the study, and persistent observation were built-in to the design of the study.
3.5.2 Transferability

Transferability refers to the degree to which findings or working hypotheses from the particular study can be transferred to other contexts. It is therefore necessary for the researcher to provide “as complete a data base as humanly possible in order to facilitate transferability judgments on the part of others who may wish to apply the study to their own situations” (Guba and Lincoln 1989: p242). This is achieved through thick description. Thick description is an extensive, careful and detailed description which goes beyond surface appearances and records as much as possible the depth, density, context, and emotion of the observed context, and captures the meanings people bring to their experiences. “In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard” (Denzin, 1989b: 83). Chapter 4 of this study provides a rich, thick description of the culture, context, participants, and interactions under observation, allowing readers the best possible opportunity to make their own, informed judgments of the transferability of the findings.

3.5.3 Dependability and Confirmability

Dependability is parallel to the notion of reliability, and is concerned with the stability of the data over time. In any naturalistic inquiry, shifts and changes in constructions can be expected, and in fact are desirable as indicators of a maturing investigation. The important point is that such changes are tracked and documented in such a way that readers can follow the processes and decisions that are made.

Finally, confirmability, which parallels the positivistic notion of objectivity, has the basis of its integrity in the data themselves. It is necessary that data of all types can be
traced to their original sources and the processes and logic used to compress the data are available for inspection (Guba and Lincoln 1989: 243). This study has been designed to account for these requirements but has also been informed by Guba and Lincoln’s (1989) notion of ‘authenticity’.

3.6 Authenticity criteria

Guba and Lincoln point out that the above criteria are still “rooted in positivistic assumptions” (1989:244) and have attempted to move beyond the parallel nature of those criteria by developing what they call authenticity criteria, a new set of criteria based specifically on the assumptions and beliefs inherent in the constructivist paradigm. They have defined five criteria as follows:

- **fairness**: this refers to the extent to which the various participants and their individual constructions are represented and taken into account in the study.
- **ontological authenticity**: this refers to the extent to which participants are able to use any new information to improve and expand their own constructions.
- **educative authenticity**: this refers to the extent to which the study has facilitated participants’ understanding of and appreciation of the constructions of those outside their group.
- **catalytic authenticity**: this means the extent to which action is actually stimulated and effected as a result of the study, and
- **tactical authenticity**: this builds on the previous criterion and refers to the extent to which participants are actually empowered to act.

These criteria highlight the relativist ontology and the transactional epistemology of the constructivist paradigm. They indicate, as Guba and Lincoln point out, that it is neither necessary nor appropriate to apply positivistic goodness criteria when
evaluating constructivist research. These criteria will not guarantee authenticity, but will encourage the "honest presentation of what is, finally, the record of experience, perception and interpretation for which the researcher seeks to take responsibility" (Edge and Richards, 1998: 351).

The principles of representativeness, enhanced understanding, and participant empowerment embodied in these authenticity criteria informed the design of the present study at every level.

3.7 Summary of Chapter

This chapter has located the study in the constructivist paradigm and has provided a description of and rationale for the methodology including: participant selection, data collection methods, and the role of triangulation in the study's design. It has discussed the transcription protocol used and introduced the theoretical tools used for analysis. Finally, it has discussed both the trustworthiness criteria and the authenticity criteria identified by Guba and Lincoln (1989), and described how they have been applied in this research.

Chapter 4 provides a key aspect of the research, the thick description of the participants and settings which contextualises the study.
CHAPTER 4  Research Setting

It is important for a researcher in the constructivist paradigm to provide “as complete a data base as humanly possible in order to facilitate transferability judgments on the part of others who may wish to apply the study to their own situations” (Guba and Lincoln 1989: 242). This can be achieved through what is known as thick description. Geertz (1973) goes so far as to claim that what defines ethnographic study as an intellectual effort is “the elaborate venture in thick description with the object of a stratified hierarchy of meaningful structures within which activities are produced, perceived and interpreted” (1973:6).

This chapter aims to provide a thick description for the study by presenting a detailed description of the patients and professional staff involved in the study and providing information about their background, qualifications, experience, and their reasons for agreeing to participate in this study. The chapter also describes the data collection sites, which I have called the City Hospital, the Ivandale Eye clinic and the Watsville Eye clinic. Finally the chapter also provides a detailed discussion of the constructs of native speaker and non-native speaker and discusses the ways in which those categories have been applied in this study.

4.1 The Health care providers

This section describes the various medical staff who participated in the consultations which were observed during the data collection phase of this study.

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2 Names of all collection sites and suburbs have been changed
4.1.1 Ophthalmologists

Ophthalmologists are doctors who have undergone extensive training as specialists in the anatomy, functions and diseases of the eye. The doctors in this study are both pediatric ophthalmologists, specialising in the treatment of children with eye problems. Children are usually referred to an ophthalmologist by their family doctor or school nurse for problems ranging from persistent watery eyes to short-sightedness and strabismus, which is usually associated with crossed eyes but in fact covers any condition where the eyes are not parallel. Referrals are also made to ophthalmologists when serious eye problems result from illnesses such as cerebral palsy, diabetes, and Down Syndrome or from accident or trauma.

The two pediatric ophthalmologists who participated in this study are described in detail in the next section. As is the case with all patients in the study, the names of all doctors and orthoptists have been changed to preserve confidentiality.

4.1.1.1 Dr. Susan Colson

I first met Dr. Colson when she approached me at a conference after I had presented a paper on some earlier research. She was interested in my work and after some discussion, she offered me access to her medical practice and invited me to contact her should I decide to do further research. I contacted her early in 1999 with my proposal for this research project and she agreed to participate.

Dr. Colson is an Australian-born paediatric ophthalmic surgeon interested in public health, women's health, and medical education. She graduated with an MBBS in

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1 This information was obtained from Dr. Colson’s CV and from personal interviews with the researcher.
Melbourne in 1975. In 1976 Susan completed her internship at a women’s hospital in Melbourne and in 1983 became a Fellow of the Royal Australian College of Ophthalmologists (FRACO) and Royal Australasian College of Surgeons (FRACS). She recently completed her Master of Public Health and at the time this research was conducted was working on a Master of Education at the University of Melbourne. She holds several senior professional positions and chairs a number of professional committees.

Dr. Colson has special interests in research methods applicable to the analysis of diagnostic screening tests in childhood, and the medical curriculum as a determinant of the professional identity and practices of doctors. She has had ten years experience applying public health principles to problems in health policy-making in medical colleges and reports “an enduring interest in working at the vital interface between public health and clinical care”.

Dr. Colson has participated in a number of professional conferences and has significant medical teaching and research experience. She is currently coordinator of ophthalmology post-graduate teaching at a large public hospital in Melbourne. This includes teaching sessions for surgeons, neurologists, physicians, endocrinologists, accident and emergency physicians, psychiatrists, physician trainees, and general practitioners.

Dr. Colson also has a private practice in paediatric ophthalmology in Ivandale, Victoria, and is a senior Consultant at City Hospital in Melbourne. She has been involved in this research project from its very beginning, having offered the researcher access to her medical practice for further research. Although initially she
had her own research agenda for the project, she has supported this research and
agreed to participate because of the potential benefits to herself and her patients of
increasing her knowledge of what she referred to as culturally appropriate language
and approaches.

4.1.1.2 Dr. Brian Maxwell

Following Dr. Colson’s agreement to participate in the project, I was invited to
present my research proposal to the staff of the ophthalmology department at City
Hospital. As a result of that meeting, Dr. Maxwell also volunteered to be a participant
and offered me access to his consultations at both the hospital and his private clinic.

Dr. Maxwell\(^4\) was born in and grew up in Tasmania in an environment where he says
he had little exposure to people from non-English speaking backgrounds. His father
was a doctor and so he reports that he too was always going to be a doctor. He is now
a consultant ophthalmologist at three large public teaching hospitals in two states. He
holds a number of academic posts, and is a Fellow of the Royal Australian College of
Ophthalmologists and the Royal Australasian College of Surgeons.

Dr. Maxwell has a strong academic background. His initial medical training was in
Tasmania, deciding on ophthalmology in his final year of medical school. He
undertook two years further training in the USA and six months in the UK. He holds a
MD (a clinical PhD) in genetic eye diseases and continues to conduct research in this
field.

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\(^4\) The information contained in this section was provided by Dr. Maxwell in a personal interview with
the researcher.
Dr Maxwell agreed to participate in this project partly because of his general interest in what he calls ‘the culture of research’, particularly the issues of consent and ethics in medical research. Another reason given for his participation was that he could see that being observed, or audited, would provide him with a very valuable opportunity to learn more about his own clinical practices and to help raise his awareness of language and cultural issues. He also raised the fact that he had suffered a very serious illness himself and pointed out that he had therefore been ‘on the other side’, where he learned first hand about the importance of effective communication from medical professionals.

4.1.2 Orthoptists

Orthoptists are university trained allied health professionals who specialise in disorders of the eye and are trained in diagnostic procedures and treatment for a number of eye abnormalities. Orthoptists usually work closely with ophthalmologists, seeing patients and carrying out necessary vision tests and preliminary examinations before the patient sees the ophthalmologist.

Both La Trobe University in Victoria and the University of Sydney in New South Wales offer an Orthoptics degree as well as a range of post graduate diplomas and degrees. The degree course is three and a half years and students may complete the fourth year as an Honours year. A number of currently practicing orthoptists completed their studies when the course was still a Diploma course, and so the universities also offer bridging courses for those orthoptists wishing to upgrade their formal qualifications.
Orthoptists work in private and public eye clinics, often in practice with an ophthalmologist, and in hospitals, community health centres, and rehabilitation centres. They also provide vision screening tests in schools, pre-schools, day care centres and the work place.

In most circumstances, and in all cases observed, patients are seen by the orthoptist before being seen by the ophthalmologist. On the patient’s first visit, the orthoptist discusses the reasons for the referral and any concerns the child or parent has, and takes a full medical history. A range of eye and vision tests are then conducted, and if required, drops are administered so that the pupil dilates and the doctor can examine the back of the eye.

All the orthoptists observed were very experienced in working with children, and were able to create a relaxed and non-threatening atmosphere in the examination room. They used various techniques including toys, games, and a running patter to help carry out their tests, and were very supportive and positive about the children’s attempts to read letters or identify pictures. Children were usually invited to sit up ‘in the big chair’ for the tests, but could stay on the parent’s lap if too young or too nervous, and one test was even conducted with the child in his pram because that was where he felt secure.

### 4.2 Data Collection Sites

The following section describes the three medical sites where consultations were observed. These are City Hospital in Melbourne, and the two private clinics in
Ivandale and Watsville. Each site is described in terms of location and accessibility, physical layout and features, staffing, and patient management procedures.

4.2.1 City Hospital

4.2.1.1 General

The hospital is a large public hospital (330 beds) in the city of Melbourne, providing specialist pediatric services for sick children from both Victoria and Tasmania, and for a number of overseas patients, particularly from South East Asia. The hospital is located 2 kilometres from the city centre and can be easily accessed by public transport. Its location is also very close to several suburbs which have high migrant and refugee populations. Overall, the Melbourne and Inner Melbourne local government statistical area has a population of 48,560. Thirty percent of the local population (14,824) were born overseas, and twenty two percent (10,848) speak a language other than English (ABS, 1999). The hospital’s patient records indicate that thirty percent of their patients come from a non-English speaking background.³

The Hospital is affiliated with the University of Melbourne and is actively involved in and committed to ongoing research in a number of areas. This involvement and commitment to research is reflected in the hospital’s Mission Statement which identifies its mission, values and key strategies. The hospital has identified its mission as:

"In partnership with other health providers and the community, to improve the health outcomes of women and children by providing

³ Figures provided in personal correspondence from Manager, Outpatients Services, City Hospital, 22.9.2000
and promoting innovative services, research, education and advocacy" 6.

Strategies to achieve this mission include “integrated research and clinical care”, and a commitment to ensuring that “patients and patient’s (sic) parents understand condition and treatment options so they can make informed decisions about their own care, or that of their children”.7

4.2.1.2 Outpatients

This study is located in the Ophthalmology Clinic which is part of Outpatients Services. Outpatients Services provides clinics in a range of specialist areas including orthopedics, diabetes, speech pathology, audiology and ENT (ear, nose and throat).

Table 4-1 below summarises the number of appointments in all Outpatients departments over the last 5 years.

<table>
<thead>
<tr>
<th></th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>96/97</td>
<td>97/98</td>
</tr>
<tr>
<td>new</td>
<td>61,346</td>
<td>57,754</td>
</tr>
<tr>
<td>review</td>
<td>42,453</td>
<td>43,175</td>
</tr>
<tr>
<td>total</td>
<td>103,799</td>
<td>100,929</td>
</tr>
<tr>
<td>Fail to attend</td>
<td>5,530</td>
<td>4,793</td>
</tr>
</tbody>
</table>

6 Hospital web page, 1998.  
7 Hospital web page, 1998  
8 Data provided in personal correspondence from Manager, Outpatients Services, PHC, 22.9.2000
4.2.2 The Ophthalmology Outpatients Clinic

Patients require a referral letter from either their family doctor or from a doctor in the hospital’s own emergency clinic before an appointment can be made in any of the Outpatients’ clinics. Waiting lists for appointments average two to three months, but urgent or emergency referrals can be triaged by the Chief Orthoptist and be seen much more quickly if necessary.

The clinic is on the 6th floor of the hospital, sharing space with private Ophthalmology rooms and a Medicare/accounts office. The clinic operates two sessions daily, 9.00am to 12.00 and 1.00pm to 4.00pm. There are usually three appointment lists, with 12 to 15 appointments on each list. Appointments are made for two visiting consultants and one Registrar. A Registrar is a ‘specialist-in-training’, having completed the requisite six years of medical school, one year as an intern, and two to three years of residency.

Appointments are usually made at 15 minute intervals, but the later appointments in the session often have multiple appointments, for example, 3 names listed for 10.45 or 11.00 a.m. slots. This is to ensure that patients, even if late, will be seen before the clinic session ends, and to minimise any loss of time due to patients who fail to attend (FTAs).

Clinics are organised on a four-weekly rotating schedule with a range of specialist clinics each week. There are specialist clinics for Cerebral Palsy, Genetics, Diabetes, and Glaucoma and Cataracts. Patients are scheduled whenever possible into the
appropriate clinic, but can be given appointments in any clinic if a particular day or date is required.

4.2.3 Management of Patients

There are four distinct phases in the clinical process and patient movement is managed and tracked by the movement of their medical files. On arrival patients report to the reception desk, check in and hand in their referral letter if this is their first appointment. They are then directed to the Medicare office to complete the necessary paperwork and sign claim forms before being seen by the doctor. The receptionist places the patient’s file in the orthoptists’ pile on the reception desk in the order in which they arrive, which is not necessarily the order of their appointment time. All patients at the hospital’s clinic are first seen by an orthoptist who takes the medical history, conducts a range of eye tests and administers eye drops if required. Patients are then asked to return to the waiting area, their file is placed on the appropriate doctor’s pile, and they are then called in to the examination rooms by the doctor when he or she is ready. If patients have had eye drops their file is placed in a separate pile until their pupils are checked, then their file goes onto the doctor’s pile. Finally patients queue at the Outpatients Appointments desk to make their next appointment, if required, and their file is returned to registry.

The clinic has a small waiting room decorated with cartoon characters and equipped with magazines, children’s books, a television, VCR, a collection of children’s videos, and a Nintendo game set. This area is usually crowded and noisy, since patients and families wait here not only on arrival but between seeing the orthoptist and seeing the
doctor, and while waiting for eye drops to take effect. At 10.00 am on the first Wednesday morning of data collection there were 14 children and 18 adults already in the waiting area. Because the area is crowded, patients also wait on chairs along the corridor, and even sometimes in the waiting area of another clinic further down the hall. Orthoptists and doctors, who may not always know their patients by sight, often need to spend some time trying to find their next appointment, which over the course of a clinical session can contribute significantly to delays.

4.2.4 The Interpreter Service

Those patients who consulted the doctor with the assistance of an interpreter present a different range of interactional dynamics and issues which are not considered in this study and were therefore excluded from the sample of patients selected. However it is important to note that the Hospital does provide an interpreter service in 16 languages in-house and can access professional interpreting in 92 languages, including Auslan. Interpreting services are available 7 days a week, and once a patient has been identified as requiring an interpreter a booking is automatically made whenever that patient makes a clinical appointment. This continues until such time as the patient or their parent elects not to use an interpreter. This means that patients and their parents who see the doctors without a medical interpreter have chosen to do so, usually on the basis of their assessment of their own ability to cope with the consultation.

Vietnamese is currently the most frequently required language, closely followed by Chinese, Arabic and Turkish, while demand for Somali and other African languages is rapidly increasing. The service currently provides interpreters in fifteen to twenty
languages per day for both inpatients and outpatients. Statistics are not available for outpatients, however, of 29,369 admissions in 1999, 18,281 were children who had one or both parents born outside of Australia. (Director, Interpreter Services, 2000)

The service also provides training for medical, nursing and allied health staff in working with interpreters, and presents sessions on all staff intake and orientation programs.

4.2.5 The Private Clinic at Ivandale

Dr. Colson has private consulting rooms in several locations, including a practice in Ivandale which she shares with three other ophthalmologists. Appointments can normally be made to see Dr. Colson here within one to two weeks. Patients again need a referral letter, usually from the family doctor, but often from the school medical service.

Ivandale is located in the Northern districts local government area and has a population of 59,871. Twenty two percent of the population (13,506) were born overseas and nineteen percent (11,201) speak a language other than English (ABS, 1996).

The clinic is located in a converted old house near the main shopping area of Ivandale, within easy walking distance of the railway station. Patients enter the building directly into the reception area and report to the receptionist. The front desk has recently been equipped with a computer and specialised appointments and billing
software so the practice is in the process of changing over from paper cards and files to the computerised system. The reception staff believe that this has been a smooth transition from the patients’ point of view and has generally improved service to the patients. Although the practice has several part-time reception staff members they generally work with the same medical staff and feel they have established a good working relationship with those particular doctors and orthoptists.

In the reception area there is a small waiting area equipped with eight upright chairs, a low table with a large toy box filled with lego and plastic and wooden blocks. Magazines are several years old and consist of National Geographic, House and Garden and Country Living. There is another waiting area in the front room of the building which is furnished with a range of upright chairs and armchairs and has another toy box.

The procedure for managing patient movement is very similar in both private clinics. On arrival patients report to the receptionist who annotates the appointments book and places the file in a basket outside the orthoptist’s room. Patients are seen by the orthoptist, then return to the waiting room while their file goes into a basket outside the doctor’s room. They are then called in by the doctor. Accounts are issued and/or settled and new appointments are made at the reception desk after the patient has been seen by the doctor.

The clinic has one full-time orthoptist who works with three of the four doctors. The fourth doctor does not use an orthoptist. The orthoptist’s room in the Ivandale clinic is very small, measuring 2.7 metres by 3 metres, with four doors opening into it. The
room is close to the reception desk, so telephone and other conversations at the desk are audible in the room, while discussions in the consulting room are also audible in the waiting area. The orthoptist's desk is against the wall in a corner between two doors, with the examination chair next to it. There is an eye chart on the wall above the examination chair with a mirror on the opposite wall. Eye tests are conducted by having the patient view the chart through the mirror to give the requisite testing distance of 6 metres.

The doctor's consulting room is larger than the orthoptist's room, with the desk against a back wall and the doctor seated on a stool where she can work at the desk or swing around to face patients and parents when they enter the room. There is a large toy box in the room and after examination most children gravitate to that while the doctor talks to the parent(s). This room is also quite noisy as telephone calls and conversations at the reception desk or in the waiting area can be heard. Some observations carried out in this room were not able to be transcribed because of the noise caused by patients and/or young siblings playing with blocks and squeaky toys in the toy box and the level of general background noise from the reception area. The doctors in this practice were very aware of its shortcomings and relocated to new premises in the same general area very shortly after data collection was completed.

4.2.6 The Private Clinic at Watsville

Dr. Maxwell also conducts private consultations at several locations, including a clinic in Watsville on a very busy major thoroughfare close to a major suburban shopping centre and a large train station. The Watsville local government area has a
population of 112,934. Thirty two percent of this population (36,515) were born overseas, and 29,767 people speak a language other than English (ABS, 1999).

This clinic has also been established in a converted house, but it was purposefully converted and modernised two years ago, with walls of glass bricks, a large, bright waiting area, spacious reception area and large consulting rooms. The waiting room is equipped with matching chairs, a low table with magazines and a toy box containing a range of soft building panels and some educational toys. At the time of data collection the clinic had a new receptionist who had only been there for three weeks. The reception system is fully computerised and works very smoothly.

These rooms are shared by 2 pediatric ophthalmologists and 3 retinal specialists. Dr. Maxwell has 3 full day sessions and 2 afternoon sessions a month, and appointments can usually be made to see him there within 2 weeks. As with all specialist consultations, patients need a referral letter, usually from the family doctor.

Appointments are made at ten or fifteen minute intervals for the full day sessions from 9.00am to 4.30pm, with an hour scheduled for a lunch break. No double bookings are made, so patients generally do not have to wait long and the waiting room is usually not crowded.

The procedure for managing patients here is the same as at the Ivandale clinic and is achieved by managing the movement of the patient’s file. Files are passed from the receptionist to the orthoptist, then to the doctor, each of whom comes into the waiting area and calls the patient by name then escorts them and their family into the
consulting room. This system works more efficiently in the private clinics than in the hospital since there are significantly fewer people in the waiting room at any one time and everyone is waiting to see the one doctor.

There are two orthoptists in the practice, both of whom work part-time. The orthoptist's room is large, bright and uncluttered, and is equipped with a range of modern testing equipment which allows the orthoptist to project letters and images onto a screen during consultations without moving from her desk. The doctor's consulting room is large and uncluttered, with the desk facing another wall of glass bricks. The doctor sits on a stool which allows him to swivel around to face patients as they enter. There is a large Wiggles poster on the wall, a glass jar of jelly snakes on the desk, but no toy box or squeaky toys in the room. The atmosphere is calm and unhurried and there is no leakage of noise into the room from the reception area or waiting room.

4.3 The Patients

The participating doctors in this study are both pediatric specialists which means that the patients are children who attend either the hospital or the private clinics with their parent or parents. Parents were approached before their child's consultation began and were invited to participate in the study which was explained in full to them. Participants were both native speakers of English and those from a non-English speaking background. Language background was assessed by initially considering the names of the children, then asking the participants what they considered their first language to be. A range of questions about language and exposure to English were
asked at the post-consultation interview. Patients and their parents were selected as far as possible to provide a good balance of both native speakers of English and those from a non-English speaking background. As mentioned earlier, patients who use an interpreter when consulting the doctor present a different range of interactional dynamics and issues which are not considered in this study and were therefore excluded from the sample of patients selected.

Since the data were collected from pediatric consultations, one or both parents also attended the consultation in all cases but one. This creates a situation similar to that found in many geriatric consultations where an adult child accompanies the patient during medical consultations (Coupland and Coupland, 2000). This requires that the normal patterns of communication between the doctor and patient be adapted to accommodate the routine presence of a third person. Parental involvement in pediatric consultations places further demands on the doctor who is required to shift from examining and dealing with the patient to consulting and interacting with the parent (Tannen and Wallek 1983). This can create different and additional difficulties for the doctor who may be required to change footing (Goffman, 1981) more frequently and for the parent who needs to re-negotiate their role as either primary or overhearing addressee. The additional stress and distress associated with being the parent of a sick child also plays a role in the communicative process adding another dimension to these data. As one NNS mother explains:

Data Fragment 4-1 :(29C)⁹

M because I like to know, every parent likes to know, who’s, um, you know, why they’re looking at her, and, you know, for what they’re looking for and so on, so that you can understand the situation better

⁹ information regarding the age, gender, language background, and so on of patients referred to in this and all further data fragments can be found in Table 3.1 on page 89
I do you think it’s different being here with your child than it would be if it was for yourself? You say every parent likes to know.

M um, yes, it, it, it is in a sense, because a child can’t tell you what’s happening, um whereas you, you can always, you know you can always ask them if there is, you know, anything you don’t understand about your own body, but a child cannot tell you that, let alone a doctor to look at it and say, okay what’s wrong with you and so on,

I mmm, right

M And I can’t, she doesn’t often tell me what’s wrong with her, and she can’t explain, so yeah, that’s, that’s the only thing that I see is different, for her, rather than for me,

I so what, how does that affect you when she’s with the doctor?

M um, well, If the doctor’s not explaining what he’s doing then I don’t know if um, he’s sort of cover, what, I might have missed, or I probably see something that’s she’s doing, but she doesn’t have, I don’t know what’s wrong, but it hasn’t, it, it, he didn’t explain, I wouldn’t know that he, sort of, look into that area?

The interactive patterns in the consultation are further complicated by the presence in many cases of younger siblings. Doctors and parents try to communicate about a child who may be quite ill in an environment where the parent is trying to listen while soothing the patient and trying to entertain or control a baby. Very often the extra children are playing with toys that squeak or whistle and almost invariably end up crying. Dr. Maxwell, commenting on this situation, said: yeah, it does make it very difficult, often, it’s interesting, you will ask questions like, ‘is there anything else you want to ask’, you know, ‘do you have any other questions’, and I’ll often do that again when there’s been that distraction and I think that the number of times parents say ‘that’s fine, see you later’, you know, they’ve got that, ‘I’ll get rid of this other child and I’ll ask you next visit’ sort of tone in their voice.

Children attend specialist ophthalmologists for various reasons and for a variety of conditions. Some children are referred because they failed or did poorly on a routine
eye test at school, others suffer from short or long-sightedness, amblyopia (reduced vision in one eye, sometimes called lazy eye), or strabismus (misaligned eyes, commonly referred to as a turn or squint). Some children have eye infections, or damaged eyes or sight as a result of accident or trauma, while for others loss of vision or potential loss of vision is just one symptom of more serious diseases or genetic conditions such as diabetes, Down Syndrome or cerebral palsy. Treatments can range from a program of patching or drops, to prescribing glasses to surgery.

Both doctors see the full range of conditions at both the hospital and at their clinics, although the more serious cases of cerebral palsy for instance tended to attend at the hospital since, as one father who had just seen Dr. Maxwell and was on his way to the cardiology unit told me, they usually need to see the full spectrum of specialists and the hospital has them all under one roof.

4.3.1 Patients/parents’ language background.

As discussed above, participants in this study are both native speakers of English and those from a non-English speaking background, or non-native speakers. The terms ‘native speaker’ and ‘non-native speaker’ are widely used in the fields of applied linguistics and language pedagogy, often with little or no attempt to define them. As the distinction between these two categories is crucial to my study this section discusses the often controversial nature of the terms and provides a definition of the terms as they are used in the present study.
In the context of the internationalisation of English and in these times of high population mobility, the concept of the ‘native speaker’ has become problematic, and the debate over the use of these terms has raised a number of controversial issues. These issues are particularly prevalent in the area of English Language Teaching (ELT) where the debate is focused on teachers rather than learners, and particularly on the relevant worth, or value of native English speaking teachers and non-native English speaking teachers.

The English language has now become an international language for communication in business and banking, advertising, popular music, tourism, and diplomacy, and has become the major language used for scientific and technological research and publications (Platt, Weber and Ho, 1984, Medgyes, 1994). English is now an official language in many countries in the world including Singapore, PNG, the Philippines, Hong Kong, Bangladesh and Sri Lanka. In many of these places English has become (or is becoming) nativised, or indigenised, acquiring relatively consistent, fixed, local norms of usage (Trudgill and Hannah, 1994).

Kachru (1985) uses the imagery of three concentric circles to classify what he sees as the three types of English speakers in the world today. The first of these is described as the Inner Circle, which includes those speakers for whom English is the first, and often only, language. These are native speakers who generally live in countries such as Britain, America, Australia and new Zealand where the dominant culture is based around English. Kachru’s Outer Circle includes speakers for whom English is a second or additional language. Countries in the Outer Circle include India, Pakistan, Singapore and Nigeria, where speakers might use both a local form of English but
may also be fluent in international varieties. Finally the Expanding Circle includes the
growing number of people learning English as a foreign language (EFL) in countries
like China or Brazil, or in fact, as Medgyes (1994) comments, the rest of the world.

The global spread and nativisation of English have raised questions about
intelligibility, acceptability, and appropriate teaching models, as well as the more
fundamental question articulated by, for example, Davies (1991): what is a native
speaker?

In the context of ELT, Medgyes (1994:9) argues that the native speaker/ non-native
speaker distinction is one of the most complex and elusive areas in applied linguistics,
and describes it as a "hornet’s nest fraught with ideological, socio-political and
stinging existential implications". Nayar (1994: 3) pulls no punches when he suggests
that “the native/non-native paradigm is not only linguistically unsound and
pedagogically irrelevant, but also politically pernicious, as at best it is linguistic
elitism and at worst an instrument of linguistic imperialism”. Researchers in this
arena argue that the construct of a native speaker is not a linguistic construct but a
socially constructed identity based on cultural assumptions of who conforms to a
preconceived notion of a native speaker, and that it is a dichotomy established to
define and create the Other (Brutt-Griffler and Samimy, 1999). Others suggest new
terms in preference to what they see as the value-laden labels NS and NNS; for
instance Rampton (1990) proposes the notions of language expertise, language
affiliation and inheritance to describe the connection between speakers and languages.
In the wider context, many researchers also claim that attempts to define the native speaker are futile. Cheshire (1991) argues that with the globalisation of English, the distinction between native and non-native speakers has become blurred and increasingly difficult to define. Liu (1999) argues that the dichotomy of NS versus NNS is as complex as that of literacy versus illiteracy and that the labels in both cases are both simplistic and reductionist. He claims that identifying an individual as a native speaker or non-native speaker is a difficult, if not impossible, task (1991:101). Kachru (1983, 1985) claims that the dichotomy of the native and non-native speaker has become irrelevant and must be seriously challenged while Ferguson (1982) suggests that both the terms ‘native speaker’, and ‘mother tongue’ “should be quietly dropped from the linguist’s set of professional myths” (1982: vii).

These views are in sharp contrast to that expressed by Quirk (1985), that the distinction between native and non-native speakers remains a significant one. Quirk and Stein (1990) argue that “the English of most Britons and Australians is native, the English of most Malaysians, Ghanaians, Japanese and Pakistanis is non-native. ….

Broadly speaking, native speakers have an equally competent command of English, whether they are Americans or British or New Zealanders; by contrast, non-native speakers vary enormously in their command of the language and indeed a Nigerian or a Japanese sounds less identifiably Nigerian or Japanese the better the command is.” (Quirk and Stein, 1990:50). Davies (1991) would see this as an example of what he calls the inherent racism of what is often meant by the term native-speaker, which he claims is a deliberate attempt to exclude speakers of, for example, Singapore English, or Indian English, who may see themselves as native speakers of English.
Bloomfield (1933/1984:43) offers a simple definition of the term native speaker, arguing that a speaker is a native speaker of the first language they learn. Davies also acknowledges the possibility of definition but maintains that the notion of a native speaker as one who can lay claim to being a speaker of a language by virtue of place or country of birth, is too narrow. He believes that a native speaker can be characterised by a number of qualities, including:

- he acquired the language in childhood
- he has intuitions, in terms of acceptability and productiveness, about grammar
- he has the capacity to produce unique, fluent, spontaneous discourse and exhibits communicative competence in both production and comprehension
- he has a unique capacity to write creatively and
- he has the unique capacity to translate into the native language (Davies, 1991: 148).

This view echoes Tay (1982) who argued that a native speaker of English need not be someone who was born in one of the traditionally English-speaking countries, but is someone who learnt English in childhood, and continues to use it as their dominant language, and has reached a certain standard of fluency. Liu (1999) argues that social identity and cultural affiliation are important psychological factors in the NS-NNS debate, agreeing with Davies (1991) who argues that the native speaker/non-native speaker dichotomy is as much about issues of power and identity as it is about language, and identifies acceptance, not knowledge, as the most critical issue in the debate. He maintains that it is up to the individual to identify him or herself as a native speaker, but that in so doing the speaker must identify with other native speakers, and be accepted by them. (1991:7-8).
Medgyes (1994) also argues emphatically that the distinction between native speaker and non-native speaker is a reality that should not be "rejected, overlooked or blurred simply because it runs in the face of certain theories or ideologies" (1994:14). He points out that difficulties with defining a category do not challenge the existence of that category, and that the concepts of native speaker and non-native speaker are still legitimate. Davies (1991) also concludes that "the concept of the native speaker is not a fiction but has the reality that membership, however informal, always gives" (1991:164).

Davies goes on to use Saussure's notion of 'langue' as a metaphor for the sense of 'native speakerness', in that it represents the shared competence of the community, not just the individual. He argues that it is because of langue that one native speaker can address another and make assumptions about his/her language understanding (1991:70). He also uses the idea of 'membership' as a suitable model for native speakerness, and points out that membership of the same cultural group means an assumption of behaviours from other members as well as a knowledge of how to behave in the normal range of situations of daily life (1991:95).

It is this aspect of the debate which informs the categorisation of participants as native-speaker or non-native speaker in this study. Whether a non-native speaker can or cannot achieve near-native proficiency or whether that proficiency should be more or less valued is not the central issue. Rather, belonging to, and being identified as belonging to, the same cultural group as the institutional representative (in this case, the doctor) is the critical point. Can the doctor and patient/parent make valid assumptions about each other in terms of their cultural understandings, knowledge
and behaviours? Is the patient/parent likely to have gaps in their referential knowledge which could disadvantage them in an institutional exchange? As Medgyes (1994) points out, the native/non-native distinction does not normally pose problems and for the sake of convenience we should accept Halliday’s paradox “the native speaker is a useful term precisely because it is not too closely defined” (Medgyes, 1994: 12).

In this study the labels of native speaker and non-native speaker provide a convenient means of differentiating those patients, or more specifically, their parents, who are likely to have significant cultural overlap with the doctor and those who are not, even if they have achieved near-native English language proficiency. The non-native speaking parents in this study have elected to see the doctor without the assistance of an interpreter, and in most cases, believe their language skills equal to the task. This essentially backgrounds the potential for misunderstandings caused by language and cultural differences, but certainly does not mean that it does not exist.

Nayar (1994) provides a very useful list of defining features which he claims can be used in any combination to identify a native speaker. The list contains such features as order of acquisition, acculturation, phonological, linguistic and communicative competence, dominance, frequency and comfort of use, ethnicity, self-perception and other-perception of linguistic identity, and monolingualism. He argues that monolingualism is the only single feature which guarantees native speakerness as the speaker has no other language to be a native speaker of. The native-speaker category in this study therefore has been defined to include all and only monolingual English speakers.
Tajfel (1981:317) argues that “minorities are often defined on the basis of criteria originating from and developed by the majority. They are different from something which, in itself, need not clearly be defined”. The non-native speaker category in this study has been defined as broadly as possible to include anyone who does not fit the monolingual native speaker category and therefore to include everyone who may approach the medical encounter with differing knowledge, expectations and assumptions.

Given these definitions, categorisation of most participants was straightforward. The native-speaker category contains the monolingual English speakers, all of whom were born in Australia or the United Kingdom and who self-identified as native speakers. Everyone who did not fit the native speaker category, or in other words, everyone who has another language, regardless of factors such as dominance, or age of acquisition, was placed in the non-native category. A typical example is Grigor’s father (data fragment 4-2):

data fragment 4-2: (18C)

I okay, er, what is your first language?
F er, Yugoslavian, Serbian
I Serbian, Yugoslavian, and does Grigor speak both languages?
F yeah, actually he speak better that one, because grandfather he’s not very good in English actually
I oh, right, okay [and his mother?]
F but he’s getting better, yeah she’s the same, yeah
I okay, so what do you speak at home?
F er. Serbian
I Serbian, so and when Grigor goes to school
F next year
I good, good, and how long have you been in Australia?
F six years
I and did you know any English when you came?
F er, yes I did
F did you learn it at school?
F yeah, learnt it at school
I for how long?
F oh, for I think, eight years
I okay, so would you describe yourself as fluent in English?
F oh, I don’t have too much problems, yeah

While the allocation of most participants was unproblematic, several warrant further discussion. For example, Costas, 4 years old, attended the clinic with his father. They were approached on the basis of their Greek name, and following initial contact, were allocated to the non-native category. However, the post-consultation interview took an interesting turn:

**data fragment 4-3: (14C)**

I good, okay, now what is your first language?
→ F my first language? Um Greek, we’re Greek but I speak English,
I what language do you speak at home?
F both, um both
I both?
F yeah
I what about Costas,
F he speaks English, but he knows, he knows, understands what you are saying in Greek,
I hmm hmm
F he speaks back to you in English
I right, and your wife?
F she’s Greek
I so would you tend to speak Greek more at home or English?
F umm, a bit of, a bit of both,
I okay, have you, how old were you when you came to Australia?
→ F I was born here
I oh, you were born here, right, okay, so you tend to speak Greek with your parents, [with your family]?
F [yeah, my, my, yeah]

Although this parent was born in Australia, he does not identify as a native speaker of English. Given that he self-identifies as Greek, his wife is Greek and the fact that he speaks Greek at home with his family, he has been placed in the non-native category. Another potentially contentious example is Carlos, whose father initially identified his first language as English, but later changed his mind.

data fragment 4-4: (25C)

→ F Yes, see, if we were, the thing is even my, you know, my first language is English so that may be
I Your first language?
F Is English
I Is English?
F So, I speak three languages personally
I What languages do you speak?
F I speak Spanish, and Sinhalese, and obviously English, which is the language that I can read, write and communicate in a professional manner, I can speak read and write in the other two languages but I am not qualified to do so in a professional manner.
I Good. Do you all speak English at home?
F For the most part. She speaks in English now and we have the 3 languages spoken at home, I insist on speaking Sinhalese to the children, so that they actually speak at least two languages
I That’s English and Spanish, or Sinhalese?
F I don’t care, even if it’s Chinese I don’t mind, as long as they speak two, so I speak mainly Sinhalese, they understand Sinhalese very fluently, or very well, I would say, Lauren used to speak to them in Spanish but now she has given up and speaks to them in English so she can pick up more English too, (speaks to wife: the children no longer know Spanish, is that right?) I don’t think they know Spanish any more, no, they used to know Spanish, but not any more
M Some words, only, some
F But they are ( ) in English
I So you communicate with the children in English, what do you two use
to communicate with each other?
F  Spanish
I  And how long have you been in Australia?
F  Seven, now, seven and a half years
I  And you came here from?
F  USA, we have lived all over the place, she is from Mexico, I was born in Sri Lanka, and lived in the States for a long time
I  Where did you learn, so you learnt English from birth, in .... ?
→ F  Er, I would say, around about five, six, so the first language would be Sinhalese, and that's what my parents speak, I still speak Sinhalese to them, and whenever we wrote letters to each other, but my, growing up was in an English school, it was a private school, ( ) so it was actually English was the main language of communication ( )

Even though this parent initially self-identified as a native speaker of English, it is more appropriate to place him in the non-native category as defined for this study.

His early acquisition of Sinhalese, his frequent use of both Spanish and Sinhalese and his very proficiency in English blur his language status and obscures the very real potential for cross-cultural mis-communication.

It is evident that there are real political and pedagogical problems with the constructs of native speaker and non-native speaker. However, the focus of this research is on identifying difference, and providing an analysis of such differences in order to empower all participants in institutional encounters. As such, the categories of native speaker and non-native speaker provide a useful dichotomy to collapse the data and locate behaviours that are significant to the research.
4.4 Summary of chapter.

This chapter has provided a richly detailed thick description of the physical locations, context, and participants that make up the setting for this research. Such description allows readers the best possible opportunity to make their own, informed judgments of the transferability of the study’s findings.
CHAPTER 5  Doctors’ style of communication

5.1 Background

One of the recurring themes to emerge from a sustained examination of these data is the effect that the individual doctor seems to have on questioning patterns of both NS and NNS parents. This chapter examines the communicative style of the two doctors involved in this research and identifies a number of differences in the ways their consultations are structured and managed.

Individual doctors have their own styles of communication which contribute to a range of different behaviours in the medical consultation. Tate (1983) argues that a doctor’s style is influenced by his (or her) personality, attitudes, skills, experience and training. Roter and Hall (1993) support this claim, arguing that doctors’ consultation styles are strongly influenced by three classes of factors; their sociodemographic characteristics, general attitudes and personality orientation, and the nature of their medical training experience. Tate (1983) also claims that although individual variations may be infinite certain broad categories of behaviour are recognisable, as clearly demonstrated by Byrne and Long (1976a, 1976b) in their analysis of the behaviour of over 70 doctors in more than 2500 consultations.

Byrne and Long described the range of behaviours they observed in specific stages in those consultations. They then clustered those behaviours to describe styles on a scale ranging from a doctor-centred approach to a patient-centred approach and found that most doctors operated at the doctor-centred end of the scale. The doctor-centred
approach is the more traditional authoritarian approach which is based on the assumption that the doctor is in charge, in control, and responsible for his patient's health. There are a number of reasons why doctors cluster at this end of the scale, the most fundamental being that this is the traditional paternalistic model, described by Parsons in 1951, which defines the medical relationship in terms of the passive, dependent patient and the dominant, autonomous doctor. It is designed to meet the doctor's agenda of gathering sufficient information to test hypotheses in order to make a diagnosis and recommend treatment, and his/her need to have the visit proceed quickly and efficiently (Roter and Hall, 1993).

On a practical level the traditional approach allows the doctor greater control: control, for instance, of what is talked about, control of the amount of information which is shared with the patient, control of the overall structure of the consultation and control of the doctor's time (although there is some debate about whether this approach is in fact time-effective in the long term (Tate, 1983)). As in any institutional interaction medical interactions are goal-oriented and must meet institutional requirements, including time-frames. The need to meet institutional time-frames was summed up very bluntly by one doctor in Byrne and Long's study who made the following comment:

The doctor's primary task is to manage his time. If he allows patients to rabbit on about their conditions then the doctor will lose control of time and will spend all his time sitting in a surgery listening to irrelevant rubbish. Effective doctoring is characterised by a 'quick clean job' (Byrne and Long, 1976a:93).
CHAPTER 5 - Doctors' style of communication

The doctor-centred approach maximises the doctor's own input to the consultation and is characterised by series of closed questions and direction giving. A patient-centred approach, on the other hand, is characterised by a range of features including more open-ended questions, a greater level of information-giving, paraphrasing to ensure understanding, requests for patient's own opinions, reassurance, and statements of concern, agreement and approval (Roter and Hall, 1993).

Byrne and Long (1976a, 1976b) also found evidence that once doctors have developed a set of behaviours they tend to use the same patterns with most patients in most situations with very little variation. For example they found that most of the doctors they observed used no more than three forms of words to cover the initial opening stage of the consultation in almost 90% of all the situations they encountered. The most typical opening was "good morning/afternoon Mr./Mrs./Miss ---, and what can we do for you today?".

A particularly interesting finding from Byrne and Long's (1976a) study is that doctors tend to maintain their own relatively inflexible style while patients seem to adjust their own behaviour to accommodate the doctor's style of communication. This was demonstrated when four patients in the study were unable to see their own doctor for various reasons and saw alternative doctors. In every case the patient's behaviour changed from that exhibited with their regular doctor. For example, two of the four patients seemed much more inhibited and less communicative than normal. The new doctor who saw these two patients was much more controlling than any other doctor in the practice and both patients reacted to his style, adjusting their own behaviour accordingly. The other two patients were regular patients of this controlling doctor.
and they were also observed to adjust their behaviour to suit their new doctor’s style, and in contrast became much more open and talkative with their substitute doctor.

Byrne and Long found that doctors’ style did not appear to be influenced by the degree to which the problem was non-organic in nature or the social class or verbal skills of the patient. However there was evidence in the study that the doctors’ style could be influenced to a certain extent by several factors. These include the sex of the patient, the patient’s age, the number of patients waiting to be seen, and the degree to which the problem was perceived by the doctor to be urgent. (Byrne and Long, 1976a).

5.2 Doctors’ style in the present study

The two doctors involved in the present study exhibit quite different interactional styles. The most striking difference is that Dr. Maxwell primarily interacts with the child, with occasional comments or questions directed to the parent, whereas Dr. Colson principally interacts with the parent and generally only addresses the child during the examination and closing stages of the consultation. In effect then, each doctor’s style is affected by, or adjusted to accommodate interactants of quite different age groups.

Their different styles also contribute to a number of differences in the way their consultations are managed. An examination shows differences between the two doctors in both the length of their consultations and the number of turns in each consultation. As well as differences between the two doctors, there are also
significant differences between the consultations each doctor has with their NS and NNS patients/parents.

5.2.1 Number of turns

A count of all turns by all speakers in the consultations shows that there were a total of 1590 turns in Dr. Maxwell’s 16 consultations, giving an average of 99 turns per consultation, while Dr. Colson’s 12 consultations contained a total of 2471 turns, with an average of 205 turns per consultation. Table 5-1 below shows the number of turns in each of Dr. Maxwell’s consultations.

<table>
<thead>
<tr>
<th>Consult no.</th>
<th>NS patients/parents (n=8) no of turns</th>
<th>NNS patients/parents (n=8) consult no. no of turns</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>48</td>
<td>13</td>
</tr>
<tr>
<td>12</td>
<td>83</td>
<td>14</td>
</tr>
<tr>
<td>19</td>
<td>206</td>
<td>15</td>
</tr>
<tr>
<td>26</td>
<td>64</td>
<td>18</td>
</tr>
<tr>
<td>27</td>
<td>87</td>
<td>20</td>
</tr>
<tr>
<td>31</td>
<td>222</td>
<td>28</td>
</tr>
<tr>
<td>32</td>
<td>66</td>
<td>30</td>
</tr>
<tr>
<td>41</td>
<td>92</td>
<td>33</td>
</tr>
<tr>
<td>Average</td>
<td>108</td>
<td>Average</td>
</tr>
<tr>
<td>Adj. average</td>
<td>114</td>
<td>90</td>
</tr>
</tbody>
</table>

The number of turns in consultations with NS patients/parents ranged from 48 to 222, with an average of 108. It should be noted however that consultation number 32 was already in progress when the researcher entered the room, and it is therefore impossible to accurately estimate the length of that consultation. Removing it from calculations gives an average of 114 turns for the remaining consultations with NS patients/parents.
The number of turns per consultation in consultations with NNS patients/parents fell in a narrower band, ranging from 52 to 153 turns, with an average of 90 turns. Given an average for all consultations of 102 turns, NS consultations contained about 10% more turns than average, and NNS about 10% fewer than the average with this doctor.

The average number of turns in Dr. Colson’s consultations was 206.

Table 5-2 below summarises the data on the number of turns in each of her consultations.

**Table 5-2: Number of turns in consultations with NS and NNS: Dr. Colson**

<table>
<thead>
<tr>
<th>NS patients/parents (n=6)</th>
<th>NNS patients/parents (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>consult no.</td>
<td>turns</td>
</tr>
<tr>
<td>1</td>
<td>282</td>
</tr>
<tr>
<td>2</td>
<td>229</td>
</tr>
<tr>
<td>22</td>
<td>292</td>
</tr>
<tr>
<td>47</td>
<td>450</td>
</tr>
<tr>
<td>48</td>
<td>209</td>
</tr>
<tr>
<td>49</td>
<td>255</td>
</tr>
<tr>
<td>average</td>
<td>286</td>
</tr>
</tbody>
</table>

The number of turns in Dr. Colson’s consultations with NS patients/parents ranged from 209 to 450, with an average of 286. As with Dr. Maxwell, the number of turns per consultation with NNS patients/parents occurred in a narrower band, in this case ranging from 63 to 179 turns, with an average of 126. Given an average for all consultations with this doctor of 206 turns, NS consultations contained about 40% more turns than average, and NNS about 40% fewer turns than the average with this doctor.
5.2.2 Duration of the consultation

The number of turns does not tell the full story, however, and needs to be considered in conjunction with the length, or duration, of the consultation. There is also evidence in the data of disparity in the duration of consultations for each doctor, and again, between NS and NNS patients/parents for each doctor.

Table 5-3 below shows the duration of each of Dr. Maxwell’s consultations.

Table 5-3: Duration (in minutes and seconds) of Dr. Maxwell’s consultations.

<table>
<thead>
<tr>
<th>NS patients/parents (n=8)</th>
<th>NNS patients/parents (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>consult no.</td>
<td>duration</td>
</tr>
<tr>
<td>11</td>
<td>3.28</td>
</tr>
<tr>
<td>12</td>
<td>6.23</td>
</tr>
<tr>
<td>19</td>
<td>17.06</td>
</tr>
<tr>
<td>26</td>
<td>6.26</td>
</tr>
<tr>
<td>27</td>
<td>6.46</td>
</tr>
<tr>
<td>31</td>
<td>13.20</td>
</tr>
<tr>
<td>32</td>
<td>3.06</td>
</tr>
<tr>
<td>41</td>
<td>14.15</td>
</tr>
<tr>
<td>average</td>
<td>8.43</td>
</tr>
<tr>
<td>adj. ave.</td>
<td>9.53</td>
</tr>
</tbody>
</table>

The duration of Dr. Maxwell’s consultations with NS patients/parents ranged from 3 minutes, 6 seconds to 17 minutes, 6 seconds, with an average length of 8 minutes, 43 seconds. Three consultations exceeded 10 minutes in length. As noted above however the recording of consultation number 32 is incomplete. Removing it from calculations gives an average duration of 9 minutes, 53 seconds.

The duration of his consultations with NNS patients/parents fell into a narrower range than those with NS patients/parents. Times ranged from 4 minutes, 55 seconds to 15 minutes, 11 seconds, with an average duration of 8 minutes, 12 seconds. Only one consultation exceeded 10 minutes, and it is important to note that this consultation,
consultation number 33, which took place between the doctor and the 9 year old patient, his mother and his elder sister, involved the patient being asked to leave the consultation for a test to be conducted by the orthoptist in another room. The family returned to the doctor’s room after the test and the consultation was resumed. This means the consultation was unusually extended by the doctor leaving the room to arrange the test, by explaining the need for the additional test and by a pseudo-closing at the end of the first part of the consultation before the family left the room. Apart from this consultation, all other NNS consultations seem to cluster closely around the 7 to 8 minutes mark, whereas there is no such clear tendency with the NS consultations.

The average consultation for all patients with Dr. Maxwell lasted 9 minutes, 2 seconds, and contained 102 turns (these figures again exclude consultation no. 32). The corresponding figures are quite different for Dr. Colson.

Table 5-4 below presents the duration (in minutes and seconds) of each of Dr. Colson’s consultations.

<table>
<thead>
<tr>
<th>NS patients/parents (n=6)</th>
<th>NNS patients/parents (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>consult no.</td>
<td>duration</td>
</tr>
<tr>
<td>1</td>
<td>13.20</td>
</tr>
<tr>
<td>2</td>
<td>16.36</td>
</tr>
<tr>
<td>22</td>
<td>12.38</td>
</tr>
<tr>
<td>47</td>
<td>25.00</td>
</tr>
<tr>
<td>48</td>
<td>9.28</td>
</tr>
<tr>
<td>49</td>
<td>15.30</td>
</tr>
<tr>
<td>average</td>
<td>15.25</td>
</tr>
</tbody>
</table>

The duration of consultations with NS patients/parents ranged from 9 minutes, 28 seconds to 25 minutes, with an average length of 15 minutes, 30 seconds. Five of the
six consultations exceeded 10 minutes. As with Dr. Maxwell, there was also a narrower range of times for consultations with NNS patients/parents. The duration of consultations ranged from 5 minutes, 19 seconds to 15 minutes, 45 seconds, with an average duration of 9 minutes, 58 seconds.

5.2.3 NS and NNS patients/parents

There are two significant points of comparison in these data. First, there are clear differences between the two doctors, and secondly, there are considerable differences in each individual doctor’s consultations with NS and NNS patients/parents.

Table 5-5 below compares the number of turns per consultation both between doctors and between NS and NNS patients/parents. The table is rank ordered by number of turns. As with earlier analyses, consultation no. 32 with Dr. Maxwell has been removed because of its incomplete nature. This leaves a total for comparison of 15 consultations with Dr. Maxwell and 12 with Dr. Colson.

Table 5-5: Comparison by doctor of the total number of turns by all speakers in NS and NNS consultations

<table>
<thead>
<tr>
<th></th>
<th>no. of turns with NS patients/parents</th>
<th>no. of turns with NNS patients/parents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dr. Maxwell</td>
<td>Dr. Colson</td>
</tr>
<tr>
<td>11B</td>
<td>48</td>
<td>48B</td>
</tr>
<tr>
<td>26B</td>
<td>64</td>
<td>2B</td>
</tr>
<tr>
<td>12B</td>
<td>83</td>
<td>49B</td>
</tr>
<tr>
<td>27B</td>
<td>87</td>
<td>1B</td>
</tr>
<tr>
<td>41B</td>
<td>92</td>
<td>22B</td>
</tr>
<tr>
<td>19B</td>
<td>206</td>
<td>47B</td>
</tr>
<tr>
<td>31B</td>
<td>222</td>
<td>-</td>
</tr>
<tr>
<td>32B</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>114</td>
<td>286</td>
</tr>
</tbody>
</table>
As we can see from the table, Dr. Colson’s consultations with both NS and NNS contained more turns than Dr. Maxwell’s consultations in either category. Both doctors averaged more turns per consultation with NS patients/parents than with NNS patients/parents, but the difference between NS and NNS was greater for Dr. Colson than for Dr. Maxwell. Dr. Colson averaged more than twice as many turns per consultation as Dr. Maxwell with NS patients/parents.

There are also striking differences in the duration of consultations with NS and NNS patients/parents between the two doctors.

Table 5-6 below summarises the data on the duration of consultations with each doctor and compares the duration of consultations for each doctor with NS and NNS patients/parents. Again, the table has been rank ordered by duration.

Table 5-6: Average duration of all consultations: a comparison of NS and NNS

<table>
<thead>
<tr>
<th>Duration of consultations with NS patients/parents</th>
<th>Duration of consultations with NNS patients/parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Maxwell</td>
<td>Dr. Colson</td>
</tr>
<tr>
<td>3.28</td>
<td>9.28</td>
</tr>
<tr>
<td>6.23</td>
<td>12.38</td>
</tr>
<tr>
<td>6.26</td>
<td>13.20</td>
</tr>
<tr>
<td>6.46</td>
<td>15.30</td>
</tr>
<tr>
<td>13.20</td>
<td>16.36</td>
</tr>
<tr>
<td>14.15</td>
<td>25.00</td>
</tr>
<tr>
<td>17.06</td>
<td>-</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9.53</td>
<td>15.25</td>
</tr>
</tbody>
</table>

As we can see from this table, both doctors averaged longer consultations with NS than with NNS patients/parents, with the difference between NS and NNS again being greater for Dr. Colson than Dr. Maxwell. Dr. Colson’s consultations with both NS and NNS are longer than Dr. Maxwell’s in either category.
5.3 A comparison of the doctors

On average, Dr. Colson’s consultations were longer than, and contained considerably more turns than those of Dr. Maxwell. These data have been collected from consultations with Dr. Maxwell and Dr. Colson in ophthalmology clinics at both the public hospital and their private rooms. Both doctors see a very similar mix of patients presenting with the same problems and following very similar treatment plans. Nonetheless, even when the doctors had consultations of similar duration, Dr. Colson’s consultations contained many more turns. For example, each doctor has a consultation of exactly 13 minutes and 20 seconds with a NS patient/parent. Dr. Maxwell’s consultation contains 222 turns, and Dr. Colson’s has 282 turns. A consultation of 6 minutes and 15 seconds with Dr. Maxwell and a NNS patient/parent contained 52 turns, while one of similar length (6 minutes and 16 seconds) with Dr. Colson and a NNS contained 117 turns. Dr. Maxwell had one consultation of 15 minutes and 11 seconds with a NNS patient/parent which contained 84 turns. The closest time-frame with Dr. Colson and a NNS patient/parent was 15 minutes and 47 seconds, which contained 179 turns and one with a NS patient/parent of 15 minutes and 30 seconds which contained 255 turns. These data are summarised in Table 5-7 below.

Table 5-7: Comparison of number of turns in consultations of similar length

<table>
<thead>
<tr>
<th>Dr. Maxwell</th>
<th>Dr. Colson</th>
<th>Patient/parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>duration</td>
<td>turns</td>
<td>duration</td>
</tr>
<tr>
<td>13.20</td>
<td>222</td>
<td>13.20</td>
</tr>
<tr>
<td>6.15</td>
<td>52</td>
<td>6.61</td>
</tr>
<tr>
<td>15.11</td>
<td>84</td>
<td>15.47</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15.30</td>
</tr>
</tbody>
</table>
This is one indicator that Dr. Colson’s consultations are more interactive, with more frequent changes of speaker, which is compatible with the notion that she tends more towards the patient-centred end of Byrne and Long’s (1976a) scale in her communication style than does Dr. Maxwell. It would be reasonable therefore to expect further support for this in the data in the form of more of the patient-centred characteristics identified by Byrne and Long (1976a) and Roter and Hall (1993) such as more requests for patients’ own opinions, statements of reassurance, paraphrasing of questions or information-giving to ensure that the patient understands, statements of concern, agreement and approval and empathy, and more frequent use of open questions. More of the doctor-centred characteristics identified by Byrne and Long (1976a), such as a more tightly controlled structure and more frequent use of closed questions could also be expected from Dr. Maxwell.

5.3.1 Style features

The notions of doctor-centred and patient-centred approaches represent the two extremes of a continuum. The data here indicate that features from both ends of the scale are present in both doctors’ consultations. For example, both doctors use numerous closed questions, which is a feature of a doctor-centred approach, yet the data show that both doctors are willing to provide information and explanations to patients and parents when required, a feature more often associated with a patient-centred approach. Both also frequently offer statements of support and reassurance, as in data fragment 5-1 below which is from a consultation with Dr. Colson, and data fragment 5-2 which is taken from one of Dr. Maxwell’s consultations.

data fragment 5-1 (4B)

165 M okay. [thank you
\[\rightarrow 166 D \quad [so\ I\ think\ he’s\ alright

- 145 -
167 M yeah well that’s good ((laughs)) that’s good to know

data fragment 5-2 (14B)

1 D hi, Mr. Michael how are you today?
2 C good
[6 lines omitted]
9 D and Michael you look like you’ve been very good too haven’t you? How did you do with your vision test next door?
10 C good
11 D did you see well out of both your eyes? That’s terrific, isn’t it?

However, many of the patient-centred features mentioned above occur more frequently in Dr. Colson’s consultations, as predicted by the analysis of number of turns and duration of consultations, while more examples of the more doctor-centred features can be found in Dr. Maxwell’s consultations. Examples of some patient-centred features to emerge from Dr. Colson’s consultations include statements of reassurance as above, statements of approval (data fragment 5-3), empathy (data fragment 5-4) and evidence of paraphrasing to ensure that her questions have been understood data fragment 5-5.

data fragment 5-3 (25B)

106 D I’m pleased you’re doing well (. ) you did well on your vision test today

This data fragment contains a clear statement of approval from the doctor directed towards the child.

data fragment 5-4 (51B) statement of empathy

22 D good, good and has it been active?
23 M not at the (. ) no, not so far, we’ve been really lucky. they seem to come hand in hand anyway
24 D yes to the extent that we sometimes don’t know when to stop
→ seeing you ((laughs)) but that (. ) that’s a good decision to have to make
25 M yeah, that’s a good sign, we don’t mind coming once a year just for that reason

In this fragment, the doctor indicates her empathy with the mother’s feelings.

data fragment 5-5 (4B) paraphrasing

28 D hmm hmm, okay, and do you think you see double?
29 C no
→ 30 D no? do you know what I mean by that, like you see two things one next to the other?

This data fragment is a good illustration of the doctor paraphrasing her question to ensure that the patient has understood. This is one of the few examples in the data where this particular doctor questions the child directly rather than directing questions at the parent.

5.3.2 Patterns of questions

In the initial stages of the consultation Dr. Colson frequently uses open questions to elicit from the parent the progress of on-going treatment or the reason for the visit, as in data fragment 5-6 and data fragment 5-7 below. This style of opening immediately gives the floor to the parent and allows them to voice their own observations and their concerns. This style of opening can however create problems for NNS parents who may have limited vocabulary and find it difficult to frame an appropriate response (Pauwels, 1995).

data fragment 5-6 (50B) NNS

3 D okay. So how’s he going?
data fragment 5-7 (49B) NS

69  D  I’m having a think about you. (28.0) okay. so what’s your concern today, sir? why (.). why are you wanting her checked out?

Data fragment 5-7 is also noteworthy because the doctor addresses this NS parent as ‘sir’. There is no other example of such an address form in the entire data-set.

In contrast to the openings described above, Dr. Maxwell is much more likely to open with a series of statements and closed questions addressed to the child which allow him to maintain control of the interaction, as in data fragment 5-8 below.

data fragment 5-8 (13B)

1  D  oh, this one, do you want to sit in the big chair there, and dad can sit over there, and you’ve met my friend Anne,
2  F  Oh yes [ ( )
→ 3  D  [( )] and you saw (.). Dr. Wendy last time, is that right?
4  C  yes
5  D  and you’d seen me a while back, the last time I saw you was way back in (2.0) October last year, so you’re a year older, you must be seven, is that right?
→ 6  C  nods
7  D  And we saw you a long time before then at the Blackburn clinic, and I gave you some glasses to wear so that your eye didn’t turn in. And how did you go with your visual test next door with Barbara, did you see well out of both your eyes?
→  C  yeah
   D  hmm hmm, [good

In this type of questioning the patient is usually required to, and able to, provide only single word answers, while questions such as ‘how did you …’ which might elicit more are usually reformulated, as in turn 7. This allows the doctor to maintain much tighter control of the information flow and the direction of any discussion. It also simplifies the exchange, a strategy commonly found in NS-NNS interactions (Long,
1983) thereby assisting those NNS parents with limited linguistic resources who may find it difficult to articulate an appropriate opening turn.

5.3.3 Seeking the patient's opinion

Dr. Maxwell often asks for information about what the parent may have noticed (*does mummy notice your eye turning a bit?*), but there are no examples at all of him asking for a parent's opinion of diagnosis or treatment.

In contrast, Dr. Colson frequently expects the parent to exercise agency by asking for the parent's opinion about various aspects of their child's condition, progress or proposed treatment. This is illustrated by the three examples below.

**data fragment 5-9 (2B)**

→ 31 D okay, and if I gave you the letters to try at home do you think that would help?

In data fragment 5-9, Dr. Colson is seeking the parent's opinion of a proposed treatment plan, while in data fragment 5-10 and data fragment 5-11 below she is asking for the parent's assessment of the child's progress.

**data fragment 5-10 (40B)**

→ 6 D so how's she going? from your point of view?
    7 F yeah, she's okay

**data fragment 5-11 (52B)**

→ 11 D um(.) let's see it's not a big difference(.) um wh- did you have an impression on the(.) test today yourselves? whether she'd be better with a new lenses or the old ones? What do you think?
    12 M um, I didn't see much because er(.) with the new lens she(.) she was a little bit wrong, but a little bit
In most cases where the doctor seeks the parent’s opinion the parent responds in one or two turns, as in data fragment 5-10 and data fragment 5-11, but on occasion it can lead to the parent holding the floor for an extended period, as in data fragment 5-12 below.

data fragment 5-12 (25B) NNS

→ 9 D okay. alright. and on the test (. ) today’s test he seems to be seeing well? (. ) do you think the same between the two eyes?
   10 F I think he’s improved
   11 D [hmm
   12 F [in the past (. ) he could er ((laughs)) read only the letter
   13 D yes
   14 F now I think he’s er (. ) improved significantly
      ((3 lines omitted))
→ 18 D a::nd h::is left eye (3.0) looks okay (. ) and do you think he needs a glass for his left eye?
   19 F not really Susan, very well, [because you know today
   20 D [okay
   21 F He ( ) I think he can see,
   22 D Yes, yeah
   23 F There’s, er,(.) two letters, the X he improved that on both eyes,
   24 D [Yes, yeah, oh good,
   25 F [I was not sure about the er, to see what he can see from afar,
   26 D yeah
   27 F But I think his left eye seems to be okay, that is my main observation.
   28 D Hmm hmm
   29 F But the right eye,
   30 D [Yes
   31 F [Keep in mind that’s er with the (. ) glass on,
   32 D That’s correct, yes
   33 F [But er,
   34 D [We haven’t tested him with the glass off,
   35 F no
→ 36 D so:o, is he, hap, happy to keep wearing them? do you think?
This exchange is quite extraordinary for several reasons. First, apart from a series of minimal responses, the doctor’s only significant contributions in this passage of 28 turns are three utterances which solicit the parent’s opinion (turns 9, 18, and 36). The parent, on the other hand, contributes a sustained series of comments, assessments and observations. In this text the doctor’s and parent’s utterances sound as if they are the wrong way round. It would be very easy for anyone reading this text without having heard or observed it to imagine that the speakers’ labels had been accidentally reversed.

Even more unusual is the fact that, when replying to one question, the parent uses the doctor’s first name (turn 19), an occurrence which the doctor admitted she was uncomfortable with, and which raises the issue of address terms.

5.3.4 Address terms

One way that professional distance, the gap which exists between the authority, knowledge, and expertise of the doctor and the patient, is maintained by both participants in a medical consultation is by the use of names and titles. This aspect of the medical encounter has not been extensively researched but there is sufficient evidence to suggest that a patient’s use of the doctor’s first name, particularly when it has not been sanctioned or invited by the doctor, is an extremely unusual occurrence and one which can make both the doctor and the patient feel uncomfortable (Vafiadis, 1999). West (1983) points out that in 532 pages of medical consultation transcripts she found no incidences of a patient using a doctor’s first name. She also found that while doctors and patients tended to avoid the use of address terms wherever possible,
when doctors did introduce themselves to patients it was usually in a formal manner, using title and last name.

Dr. Maxwell explained his policy on the use of titles and names as follows:

I’m an Associate Professor, so I can be called Professor, I’m a surgeon so I can be called Mister, I can be called Doctor, I can be called Brian, and I don’t, really, mind so much, but, there are a few patients that, one lady was calling me Brian, and you know, I thought that was very familiar and things, um, with children I, with some of them introduce myself as Dr. Brian and sometimes it’s Dr. Maxwell, it varies a bit, but I’ve decided not to care what people call me, and not to correct people and let them decide.

When asked if he thought it changed the relationship if a patient or a parent addressed him as Brian, Dr. Maxwell replied:

I have found that there are a few patients who have been overly, familiar, inappropriately, and I think it has gotten my back up a little bit, and I have been a little bit irritated by them, and it affects the interaction, long term.

He concluded by pointing out that he thought the clever way around the issue is to informalse it and make it friendly.

I find being called Dr. Brian is a nice, I can do it with the children, you know, will you do this for Dr. Brian, and that again is this, you’ve got a bit of formality there, and informality.

Notwithstanding this stated approach, in these data, Dr. Maxwell introduced himself to new patients/parents on two occasions, each time as Dr. Maxwell. Dr. Colson introduced herself to patients or parents in 4 of her 12 consultations, 3 times as Dr. Colson, and once as Sue Colson. When asked how she felt about Carlos’ father’s use of her first name she replied: “it’s just totally alien”, but when asked if it made her uncomfortable she said ’no, not uncomfortable’. However, she then went on to say that she felt the issue of names was an important one and said that generally she did not agree with the use of first names, even though it was an issue in the hospital, because:
I think, as a doctor, emphasising that you've got a first name is not always comfortable if you are talking about big time things like cancer, serious surgery, risk of death in surgery, I feel uncomfortable with those personal details being in the space, in the talk, in that situation.

Overall there was a marked avoidance of address terms by both patients/parents and doctors. There were no instances of either doctor addressing any parent by name, although Dr. Maxwell almost always addressed the children by name in a joking manner (hullo, there, Mr. Marcus) and in one instance addressed a NNS parent as 'dad', which seems to be part of his strategy, as discussed fully in section 9.2, of designing his communicative style to suit his child addressee.

As illustrated in data fragment 5-7 above, Dr. Colson addressed one parent as 'sir'. Only one patient/parent addressed Dr. Maxwell by title in the opening stage of the consultation, and two patients used the title 'doctor' in the closing stage (alright, thanks doctor, bye). There were no cases of patients/parents addressing Dr. Colson by title in either the opening or closing stages of her consultation, the only example of any term of address in her consultations being the one in data fragment 5-12 above where the parent used her first name. This parent explained that his decision to use the doctor's first name is a deliberate strategy to reduce the distance between the doctor and himself.

The examples discussed above illustrate the differences in the communication style of the two doctors and support the notion that Dr. Maxwell adopts a more doctor-centred approach than Dr. Colson. There is evidence that Dr. Maxwell maintains a greater level of control in his consultations, whereas parents (rather than patients) play a more active role in Dr. Colson's consultations, sometimes to the extent that they seem to disrupt the traditional power hierarchy of the consultation and take control. One of
the myriad factors in the construction of power in face-to-face encounters is gender, and it does seem that some of the significant disparities found between Dr. Maxwell and Dr. Colson in these data could be attributed to gendered language practices.

5.4 Gender as a factor in communication style

There are many social practices which play a role in shaping gender, and of these, language is one of the most important. Christie (1990) points out that language, like any other symbolic system, is not, and can never be, neutral since it is centrally involved in the ways in which information, values and beliefs are established and transmitted in society. Cameron (1997) maintains that gender is not so much what we are as what we do, and that gender needs to be constantly re-affirmed and displayed by performing acts which define masculinity and femininity according to the cultural norms. This means, among other things, using gender-specific language. Being linguistically competent means adopting gender-appropriate language which in turn effectively perpetuates the social order which creates gender distinctions (Coates, 1993). Davies (1989) agrees, but adds that “the essence of the male-female dualism is that power resides with the male” (1989:138). Gender differences can therefore be seen as part of a larger power differential.

5.4.1 Gendered language

There is no doubt that males and females use language differently and for different purposes. A considerable body of research, dating from Lakoff (1975), demonstrates that there are significant gender-differences in the use of language, particularly in
such linguistic features as hedges, intensifiers, qualifiers, interruptions, tag questions, minimal responses and certain prosodic features. Women are said to use language to build and maintain relationships, and as such women's talk is seen to use more polite forms and to be based on mutual support and cooperation, as opposed to competitiveness, which is an observed feature of men's verbal interaction. West and Zimmerman (1983) for example found that although interruptions were rarely initiated in same sex conversations, they were a striking feature of mixed-sex conversations, with men repeatedly interrupting women in conversation.

A number of studies have identified gender differences in talk in various contexts, for instance in private conversations between couples as mentioned above, (West and Zimmerman, 1983, Fishman, 1983, DeFrancisco, 1998), in classrooms, (Maltz and Borker, 1982, Swann, 1988, Graddol and Swann, 1989, Grant, 1992, Kanaris, 1999) and in medical consultations (Cypress, 1980, West, 1983, 1998, Pendleton and Bochner, 1980, Wallen et al, 1979, Waitzkin, 1985, Roter et al 1991). There is clear evidence of gender differences in the literature on medical discourse. Cypress (1980) found that female doctors spend more time with patients than do male doctors. In her data, female doctors averaged almost five minutes more than male doctors per consultation with patients overall, and six minutes more than male doctors with female patients. This is consistent with the present findings that the male doctor, Dr. Maxwell, averaged 9 minutes per consultation while the female doctor, Dr. Colson, averaged 12 minutes, 41 seconds per consultation, with an even greater difference between the doctors in duration of those consultations with NS patients/parents.
Also relevant to the present study is the finding by Wassermann et al (1984) that female doctors expressed significantly more statements of empathy to mothers of patients in pediatric visits. More recently, a study by Roter et al (1991) of 537 medical consultations also revealed that female doctors in the study spent more time with patients, especially female patients, than did the male doctors. They found that talk during the early part of the consultation accounted for much of the difference in length of the consultations. They also noted that female doctors engaged in more positive talk, question-asking and information-giving. Roter et al argue that these features are more patient-centred and claim that they are more positive (1991:1092). Finally, they found that both male and female patients were likely to talk more and ask more questions in consultations with female doctors than with male doctors. An analysis by Howie et al (1999) of almost 26,000 consultations adds weight to these results with their finding that female doctors spent more time with their patients than male doctors do, particularly when the patient was not well known to the doctor.

5.4.2 Giving orders

West (1998) found that there were striking differences in the ways in which male and female doctors formulated directives to patients. Directives are speech acts designed to get someone to do something, and include verbs such as ask, request, suggest, advise, order, demand (Searle, 1976). Searle also points out that the way in which a speaker orders, commands, or requests a hearer to do something expresses the speaker’s attitude to the propositional content of the utterance. Directives can be framed in a number of ways, ranging from ‘need statements’ (I need you to come back in 6 weeks), bald imperatives (give this to the receptionist) and embedded imperatives
(could you give this to the receptionist) to permission directives (I'll let you give this to Margaret) and hints (Margaret will need that), all of which "reflect the relative power of speaker and addressee in conventional usage" (Ervin-Tripp, 1976:29).

In her study of 21 consultations in a family practice clinic, West (1998) found that male doctors typically gave directives in the form of bald imperatives, for example: take yer trousers off and TAKE OFF YER SHOES AN' SOCKS (West, 1998:333). Other typical formulations used by male doctors involved telling the patients what they needed to do, or ought to do: I think yuh need duh try: duh ged out, and statements describing what the doctor wanted: whud I wan'cha tuh do: fer me: is I wan'cha duh keep a goo:d record ... (West, 1998:333). 'Need' and 'want' statements commonly occur in situations where there is a power differential, and, as Ervin-Tripp (1976) argues, are used not only to make it very clear who is to do what but that there is an obligation on the part of the subordinate to do what is 'needed'.

Another common formulation used by male doctors is what West calls permission provisions which involved the doctor giving permission for an action, you cun start on a three-month supply: an' yih cun refill that three times (West, 1998:337) and which she distinguishes from the permission directives identified by Ervin-Tripp (1976) which request permission by the speaker, as in may I have that back?.

West found that 81% of directives male doctors used fell into the above categories, and argues that such commands emphasise the hierarchical nature of the relationship between the doctor and patient and characterise the inherent authority of the doctor.
In contrast with the male doctors, the female doctors in West’s study rarely issued directives baldly but rather used a range of mitigating strategies to get their patients to do something. The most common form of this was a ‘Let’s do X’ format: okay, well let’s make that our plan and let’s stay on uh::: what we’re doin’ right now. Okay? (West, 1998:340). While West found the ‘let’s do X’ structure in some consultations with male doctors she describes these as ‘false collaboratives’ arguing that the actions proposed are not ones that can be done jointly, but rather, in such contexts the use of ‘let’s …’ implies a form of pseudo-participation in joint action which parodies a proposal for joint action (West, 1998:339). Ervin-Tripp’s own example makes this distinction clear:

nursery-school teacher: “let’s all take our naps now” (Ervin-Tripp, 1976:48)

Clearly, the teacher is not going to take a nap, so the action is not truly collaborative. However, West’s examples are less clear. She cites the following as an example of a false collaborative:


West argues that this is not truly collaborative as it is only the patient who can do the action, that is, return in two weeks. She claims that this directive is different to the genuinely collaborative ones made by female doctors which require action by both parties. However, it seems that any difference between the female doctor’s let’s stay on what we’re doing right now and the male doctor’s let’s have you come back in about 2 weeks is debatable and both utterances could be interpreted as either collaboratives, or false-collaboratives: in the first example it can be argued that it is the patient who must continue with whatever action has been decided, while a
reasonable interpretation of the second example is *let's meet in 2 weeks*, since it is likely that the purpose of getting the patient to return is to see the doctor again, making the plan a collaborative one.

Another frequent construction used by female doctors to formulate directives is also based on the notion of a joint plan and referred to what 'we' could or should do: *okay, so: whadda yuh thin', maybe wih'd jus take the top of yer yer dress off*? as well as what 'we' ought to or had to do: *maybe what we ought to do is – is stay with (.2) .h the do:se yer on* (West, 1998:340). West argues that such formulations are proposals for genuine joint actions between the doctor and patient, and as such underline the more symmetrical relationship female doctors build with their patients (although, again, unless the doctor actually helps the patient undress, the action is not joint).

There are a number of differences in the way the two doctors in the present study formulate directives, but those differences are not nearly as clear-cut as West seemed to find, and there is a significant overlap in these data of the categories she identified as being used by predominantly one gender or the other. For example, West did not report any bald directives being used by female doctors in her study, but in the present data, both the male and the female doctors used a large number of bald imperatives while addressing the child during the physical examination stage. It should however be remembered that West was not analysing ophthalmological data which by its very nature may require more directives. The use of bald directives is illustrated in data fragment 5-13 below:
data fragment 5-13 (4B)

76  D  Eyes forward, (3.0), Look straight here for me, that's it, eyes forward, 
(2.0) as wide as you can, look straight at me, (3.0) okay, good, rest
back please, (5.0) now I want you to ((gaze)) in the distance, so, about
where my flower is up there, can you see my flower, in the mirror?
there, see it right up there, can you see where the mirror is?

77  C  yeah,

78  D  yeah okay, look up there in that direction, I'm just going to have a
look at the back of your eye, (11.0) looking at my shoulder now, (31.0)
looking in the distance again, I'm going to bring these lenses close to
you, like this, okay? I just want you to look way in the distance for
me, and just relax your eye, (31.0)

A simple count of such imperatives reveals that Dr. Colson used almost three times as
many as Dr. Maxwell, but as can be seen above, Dr. Colson talks constantly while
conducting the physical examination. Dr. Maxwell's examinations tend to be shorter
overall, and he is much more likely to engage the child in general conversation to
distract them. However, as the following example shows, even with a long
examination, Dr. Maxwell talks less and uses fewer imperatives than Dr. Colson. In
the consultation below with Dr. Maxwell there are several periods of silence
exceeding 60 seconds and one of over 3 minutes.

data fragment 5-14 (33B)

D  at the library. (2.0) Okay, (2.0) let's have a look with my light, you have a
look at me, (1.0) so what grade are you in at school?

C  um grade one, next year, this year,
(18.0)

D  let's take your glasses right off, (7.0) we are going to measure you here so
we can see exactly what power of glasses,
(3.32.0) (testing with various lenses)

D  open wide, keep looking at me,
(65.0)

D  nearly finished, (6.0) okay,
(62.0)

D  okay, so you're definitely short-sighted, we might be able to fine tune your
glasses just a little bit, I’ll just have a look at the back of your eyes,

There were no examples of Dr. Maxwell, the male doctor, using a bald imperative with any parent, although Dr. Colson, the female doctor, did use them with parents on several occasions. However, as can be seen in data fragment 5-15 below, her use of the imperative again allows the parent to take the floor and tell her story.

**data fragment 5-15 (47B)**

61 D  er, I gather she’s got a watery eye?
62 M  yes,
→ 63 D  okay, so tell me about it.
64 M  well it just happened, most of the time it’s watery ((beeper going off)) and there will be occasions when it won’t,
65 D  hmm hhm
66 M  water, but just with the constant dripping, you know, on her, eye she’s always got a red, she’s even red at the mo, moment,
67 D  hmm hhm
68 M  she does suffer from sinus as well, it seems to happen at the same time
68 D  hmm hhm
   M  and she’s just getting tired of it now she’s at school and she’s getting lots of questions from other kids, so she’s really, (. ) conscious of it now, and she’d really like, you know, something, we, we’ve tried massaging it as well, over the years, but, um, [yeah

‘I’d like to’ and ‘I’d like you to’ formulations were commonly used by both doctors but permission directives were used much more frequently by the male doctor (Dr. Maxwell, 20: Dr. Colson, 8). These directives include permission tokens such as ‘you can …’ and ‘I’ll let you …. ’ as illustrated in data fragment 5-16 below.

**data fragment 5-16 (33B)**

→ 52 D  I’ll let you take a seat outside and we’ll do this other test =
53 S  yep
54 D = and then I’ll bring you back in and have a talk with you after that. Barbara will call you through shortly. (3.0) thank you, ta.

Interestingly, although Dr. Colson used permission tokens much less frequently than Dr. Maxwell, she was usually very direct when she did use them. In one example, a child asks for and is granted permission to do something, (data fragment 5-17), and on several occasions she actually uses the word ‘permission’, as illustrated in data fragment 5-18 and data fragment 5-19 below.

data fragment 5-17 (49B)

59 C can I put my glasses on?

→ 60 D yes, you can put them on, yes.

data fragment 5-18 (22B)

→ 142 D and I’ll give you permission to ((laughing)) to use the atropine, if you don’t know (.) just leave it go otherwise ....

data fragment 5-19 (50B)

And then that way he doesn’t complain so much. Umm, it’s (.) up to you, we probably will get it up with just increasing the patching but it’s hard work and it’s slower that way but if you wanted to do it fast, and did the patching every day for about three or four days during the holidays, you may find that’s enough to get the vision up, and you’ve got my permission [to do that if you feel that].

Ervin-Tripp (1976) uses the term ‘embedded imperatives’ to describe those directives where the agent and action are explicit but embedded in a frame which can carry social meaning in itself. For instance, embedding with the modal ‘can’ usually occurs when the directive interpretation is the only one possible regardless of the relationship between speaker and hearer: *can you keep your voices down* (Ervin-Tripp, 1976:34)
while other forms of embedding carry different social interpretations and usually
reflect the difference in rank or power between speaker and hearer, for instance there
is greater social distance encoded in the embedded imperative *could I trouble you to
open the window* than in *why don’t you open the window?* (Ervin-Tripp, 1976:33).

Embedded imperatives were used by both doctors in the current study, although more
frequently by Dr. Maxwell (31 cases) than Dr. Colson (15 cases). However there were
significant differences in the way commands were embedded. The most common
forms used by Dr. Maxwell were ‘can you ...’ and ‘could you ...’, but he also used
such formulations as ‘I’ll just get you to ...’ and ‘if you’d like to ...’ as illustrated
below:

data fragment 5-20 (13B)

→ 38  D  Right, oka :y, (4.0) and Barbara thought you were pretty straight
with your glasses, I’ll just get you to look at my dinosaur here,
what sort of dinosaur is that?

data fragment 5-21 (19B)

→ 1   D  Hi, I’m Brian Maxwell, if you’d like to take a seat there, g’day.
(1.0) and you know Anne.

When Dr. Maxwell uses an embedded imperative structure there is no doubt that the
utterance is a direction from the doctor to the patient (or parent) to do something and
that there is an expectation that it will be done. Dr. Colson uses this structure less
often (about half as frequently) and her embedded imperatives can appear to be quite
tentative, because of frequent hedging and the ellipsis of the performative verb, as in
data fragment 5-22 and data fragment 5-23 below.
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data fragment 5-22 (1B)

→ 102 D yes, okay, fine. (1.0) I almost think no patching at the moment

data fragment 5-23 (40B)

→ 37 D okay? um (7.0) I'm thinking um (6.0) I think two drops per day

This pattern occurs in most of Dr. Colson's treatment directives, and in many cases involves an even more tentative approach which requires the parent to play a role in the decision about what to do. This can be a simple exchange, as illustrated by data fragment 5-24 or it can be a relatively lengthy negotiation, as in data fragment 5-25 and data fragment 5-26 below.

data fragment 5-24 (52B)

→ 64 D so I think if you were happy to give it a try
  65 M [yes
  66 F [yes

→ 67 D [I would like to encourage you to give (.) to give it a try
  68 F okay
  69 D okay, and usually what we do is get you to do that say three times a week which would be the equivalent of about twenty to thirty hours
  70 M [hmm hmm
  71 F [yes

data fragment 5-25 (47B)

→ 353 D I'm thinking 3 times a day for 5 days?
  354 M hmm hmm

→ 355 D Do you think that will be long enough to get a feel for whether it would (.) be better, or not?
  356 M um (0.5) 5 days?
    [two lines omitted]
I don’t mind if it’s a little bit longer

yeah, I’d prefer to use them a bit longer, [yeah

right, that’s fine so

what would you say? how long would be enough to (. ) to give her a test?

[[laughing]) I don’t know?

Like for ten days?

yeah, probably ten days, would be better,

okay

more time.

so, I’ll put three times a day

hmm

for ten days,

okay

In the example above, the doctor tries to actively involve the mother in the decision about how long to use the drops. Even when the mother says she doesn’t know (turn 362) Dr. Colson makes another suggestion (ten days?) rather than making the decision herself and issuing a directive.

The example at data fragment 5-26, from a consultation with a NNS parent, is an even more extreme example of this type of negotiation, and in fact is another example of the parent taking control of the negotiation.

data fragment 5-26 (50B)

[okay, yes, right, yeah, okay, s: o are you happy then to resume? To go back [to patching?

[oh yeah, yeah, yeah

[2 lines omitted]

Do you think three hours ( . ) a day is ( . ) possible? (0.5) (laughs)

three or two? (((laughing)) I try

[It’s um, ( . ) it depends on how much you’ve been doing, and how it’s led it to going backwards?
20 M Yeah, can I like doing, um, five days a week, so, if I do it five days a week for how long? ( )
21 D [Well, the total number of hours per week that matters.
22 M Okay
23 D So um mm
24 M So two hours a day five days a week, that enough, or not?
25 D U:um
26 M Ten hours a week
27 D Um, (4.0)
28 M Or you want some more?
29 D So he’s been doing (0.5) four (.) four hours a week, is that right?
30 M [yeah, yes
31 D U:um, what about in the past, how much have you done?
32 M Oh about two hours a day
33 D Two hours a day, every day?
34 M Yes, every day
[6 turns omitted]
34 D So it’s possible that ten hours would be enough, so my usual suggestion is to say do ten hours per week, and we’ll see him in about six to eight weeks to check [the vision
36 M [yes
37 D If that’s not enough we’ll have to put it up to say fourteen, or even more, okay? So, in an individual child we don’t know exactly how much.
38 M okay
39 D Okay, now it can be, all in one day, it can be all together rather than (0.5) separated.
40 M Yeah but he need to go to school
41 D [Okay, so you
42 M [And we do only after school, yeah
43 D Okay, so after school, what about weekends?
44 M Er, if it ten hours, he will miss out the weekends, because we got Monday to Friday so will have free (.) eye patch on Sunday and Saturday
45 M Okay, so you would prefer that (.) to doing it after school
46 M Yes on Sunday and Saturday he goes to his grandmother’s house and his (.)
Dr. Colson initially asks the mother if she is happy to embark on a treatment plan of patching (turn 13) then asks if a proposed treatment schedule is possible (turn 17). From this point on, the mother takes control of the exchange. In turn 18 she attempts to reduce the number of hours of daily patching, then in turn 20 tries to limit it to 5 days a week. Dr. Colson hesitates (turn 23) so the mother summarises her minimal position so two hours a day 5 days a week, that enough or not? (turn 24). Somewhat incredibly, Dr. Colson still hesitates (turn 25) and the mother restates her position (turn 26). Dr. Colson still delays her response and after a 4 second pause the mother takes the initiative again and asks or you want some more? (turn 28). This is followed by some clarification of previous treatments, and Dr. Colson regains control (turns 41 and 43) only to lose it again in turn 46 when the mother objects to what Dr. Colson has said and again takes the lead in determining which days and at which times patching will be done (turns 46-52). The negotiation concludes with Dr. Colson agreeing with the mother’s various suggestions.

The examples provided in this section illustrate the considerable differences in the communicative styles of the two doctors and provides some evidence to support a claim that gender could be a factor in those differences. Differences have been identified in the duration of consultations, with the female doctor’s consultations being longer and more interactive (more changes of speaker) than those of the male doctor. Dr. Colson’s consultations contain more statements of reassurance, approval, and empathy and more attempts to paraphrase her statements than those of Dr. Maxwell. There are differences in the opening moves of the doctors, with Dr. Colson more likely than Dr. Maxwell to use open questions, and differences in the ways in
which each doctor formulates directives, with Dr. Maxwell using more permission
tokens and embedded imperatives.

These findings add to the literature on gender specific language use in various
contexts, particularly in medical discourse.

5.5 Summary of Chapter

This chapter has discussed doctors’ communication styles in terms of Byrne and
Long’s (1976a) scale of doctor-centred and patient-centred behaviour, and has
described a number of observable differences between the two doctors in this study.
Differences have been identified between the doctors in terms of duration of and
number of turns in consultations, types of questioning behaviour used and the
formulation of directives. It has been claimed that, while there is some overlap, the
behaviour patterns of Dr. Colson places her at the patient-centred end of the scale,
while locating Dr. Maxwell closer to the doctor-centred end. Roter and Hall (1993)
argue that a patient-centred approach maximises the collaboration between doctors
and patients, while doctor-centred exchanges maximise the physician’s input and
minimise the value of patient input. They also claim that physicians who had a
patient-centred style of communication left a more positive impression on patients.
These claims are not supported by the findings of this study and are discussed further
in Chapter 9.

The role of gender in the observed differences in style was also discussed. There is
only one male and one female doctor in the present study and observed differences
could be due to individual personality differences, so there is no warrant for a more
generalised claim based on these data that gender plays a significant role in the doctor-patient relationship. However it does seem clear from the way differences identified in these data map onto the research findings on gender that the gender of the doctor has had some role in creating those observed differences.

While this chapter provides some explanation for the differences observed between the behaviour of the two doctors, it does not explain the differences found at a deeper level, that is, the differences observed between the doctor's consultations with NS and NNS patients/parents. These differences are found with both doctors, the male and the female, the one with the more doctor-centred approach and the one with the more patient-centred approach. It seems therefore that other factors must play a role. Medical consultations, like any other interaction, are influenced by the range of beliefs, values, expectations, and behaviours brought to the consultation by both the doctors and the patients/parents. As we have seen, consultations can be affected by characteristics of the doctor such as their communicative style, so it is possible that other doctor characteristics, such as their perceptions of the patient (Davis, 1963, Roth, 1963) also influence the progress and development of the consultation.

However, patient characteristics also play an important role. Doctors and patients both come to the consultation with a range of beliefs and views about health, illness, their own role and the other person's role in the consultation. Pendleton (1983) argues that the situational influences on the doctor includes patient behaviour. As Jaspars et al (1983) point out, patients' characteristics, views and behaviour affect the progress and outcome of the consultation just as definitely as the nature of the complaint and the doctor's expertise.
One important theme which has emerged from these data is that patient behaviour, particularly whether or not the patient asks questions, has a significant effect on the development of the consultation. The questioning behaviour of NS and NNS patients and their parents is therefore the primary focus of this research study, and the following chapters examine the number, type, timing and purpose of questioning patterns to determine if there are differences between NS and NNS patients/parents, and to analyse the effect such, if any, differences have on the development of the consultation and the success or otherwise of the questioning behaviour.

Chapter 6 begins this analysis by examining the structure of each doctor’s consultations and identifying a model of the consultation. Chapter 7 then identifies and examines the patient/parent-initiated questions in these data, and maps the occurrence of such questions across the various stages of the consultation.
CHAPTER 6  The Structure of the Consultation

One of the themes to emerge from these data is that the shape, or structure of the consultation itself is a very important aspect of the medical interaction which can have a significant influence on the questioning behaviour of patients. In this chapter the consultations with both doctors are analysed to reveal their structures, and the model of the consultations which emerges from this process is described. The widely accepted behavioural model of the medical consultation proposed by Byrne and Long (1976a) is described and discussed and the two models are compared.

The new model appears to be robust and forms a solid framework on which to map the occurrence of patient/parent-initiated questions in order to compare any differences between NS and NNS patients/parents in terms of the timing of their questions

6.1  The stages of the consultation

Byrne and Long (1976a, 1976b) have argued that there is a standard accepted model of medical consultations with four stages of history taking, examination, diagnosis and treatment. While this describes in medical terms the medical procedures being followed, they argue that it actually says very little about the interaction that goes on between the doctor and patient (1976a:19). Ten Have (1991) points out that medical consultations are tightly organised events which display clear phases devoted to the specific tasks of symptom presentation and history taking, physical examination, diagnosis and treatment, prescription and advice (1991: 139). He supports Byrne and Long’s approach, arguing that in order to understand the relationship between doctors
and patients it is necessary to analyse the consultation at a more detailed level where
the overall organisation is achieved through a series of concerted activities which are
sequentially organised.

6.1.1 The Models

In one of the most substantial published works on medical communication Byrne and
Long analysed over 2500 general practice consultations in the United Kingdom,
Australia, New Zealand, Holland and Ireland in order to discover what patterns of
behaviour doctors appeared to follow in their consulting rooms and the degree to
which the patterns were repetitive among doctors (1976a:21). They described a very
specific set of steps in a fairly fixed sequence which they found was followed by most
doctors most of the time although with some variations and, in some cases, omissions.
Their extended and refined model consisted of six behavioural stages which are
presented and described in Figure 6-1 below (Byrne and Long, 1976a:21).

Figure 6-1: Byrne and Long’s Model of consultations

<table>
<thead>
<tr>
<th>Stage No.</th>
<th>Stage</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Relating</td>
<td>The doctor establishes a relationship with the patient.</td>
</tr>
<tr>
<td>2</td>
<td>Reasons for attendance</td>
<td>The doctor attempts to discover the reason for the patient’s attendance.</td>
</tr>
<tr>
<td>3</td>
<td>Examination</td>
<td>The doctor conducts a verbal and/or physical examination</td>
</tr>
<tr>
<td>4</td>
<td>Consideration of future</td>
<td>The doctor, or the doctor and the patient, or the patient, in that order of probability, consider the condition.</td>
</tr>
<tr>
<td>5</td>
<td>Treatment</td>
<td>The doctor, and occasionally the patient, detail treatment or further investigation.</td>
</tr>
<tr>
<td>6</td>
<td>Terminating</td>
<td>The consultation is terminated, usually by the doctor</td>
</tr>
</tbody>
</table>
This model is based on the verbal behaviour patterns exhibited by doctors in general practice consultations.

General practitioners are usually very busy, seeing a wide range of patients with a very wide range of concerns every day. Visits can vary considerably in duration but are usually quite brief, for example, in their analysis of 79 general practice consultations, Pendleton and Bochner (1980) found that the average duration of a consultation was six minutes. There are several differences between general practice consultations and the consultations which make up the data for this study. The doctors in this study are specialists in pediatric ophthalmology so the range of presenting conditions and symptoms is restricted. In every case the specialist is supported by an orthoptist who conducts the necessary eye tests before the patient is seen by the doctor, and in every case the patient has been referred to the specialist by a treating doctor who explains the reasons for the visit in a referral letter.

A preliminary attempt to map these specialist consultations onto Byrne and Long’s (1976a) model proved unsatisfactory. In stage 1, for example, the doctor did take steps to establish a relationship with the patient but it was clear that ‘relating’ was not the only component of the opening stage of these consultations. It also became clear that different types of interactions were taking place regularly in these consultations which could not be explained by, or fitted into the Byrne and Long model.

The next step in my analysis therefore was to map and identify the various stages, or phases, of the consultations in these data with both doctors in terms of the activities which take place. The model which emerged from this process is described in Figure
6-2 below with a brief description of the content of each stage. Labels draw on and reflect the nature of the linguistic interaction and activities that occur in each stage, as well as defining the sequential structure of the consultations.

**Figure 6-2: Model of consultations based on current data**

<table>
<thead>
<tr>
<th>Stage No.</th>
<th>Stage</th>
<th>General Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Opening</td>
<td>Greetings, introductions if a new patient</td>
</tr>
<tr>
<td>2</td>
<td>Case review</td>
<td>Doctor-initiated questions about symptoms, tests, glasses, progress, etc.</td>
</tr>
<tr>
<td>3</td>
<td>Physical Examination</td>
<td>Doctor examines patients</td>
</tr>
<tr>
<td>4</td>
<td>Diagnosis/Treatment discussion</td>
<td>Doctor provides diagnoses, treatment plans, instructions</td>
</tr>
<tr>
<td>5</td>
<td>Pre-closing</td>
<td>Offer of a reward to child, references to next visit, note to take to the receptionist</td>
</tr>
<tr>
<td>6</td>
<td>Closing</td>
<td>Thanking, Leave-taking</td>
</tr>
</tbody>
</table>

The 6-stage model which emerged from my data initially appears very similar to Byrne and Long’s model however there are several important differences. The two models are compared in Figure 6-3 and the various stages are analysed and discussed below.

Stages 1, 2, 3 and 6 in each model are closely related, but stages 4 and 5 differ significantly. Stage 2 of my model contains the elicitation of the reason for the visit (stage 2 in Byrne and Long) as well as a verbal examination, so it can overlap on some occasions with stage 3 of Byrne and Long’s model, however, both models allow for a physical examination in stage 3. The most striking difference is that stage 4 (consideration of the future) of Byrne and Long’s model does not exist as a separate stage in my model. When stages 4 and 5 (treatment) of Byrne and Long’s model are
conflated this then closely resembles stage 4 (discussion/treatment) of my model which is where any consideration of the future is likely to occur.

Figure 6-3: The Structure Of The Consultation: A Comparison Of The Two Models

<table>
<thead>
<tr>
<th>My model</th>
<th>Byrne and Long</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage No.</td>
<td>Stage</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Opening</td>
</tr>
<tr>
<td>2</td>
<td>Case review</td>
</tr>
<tr>
<td>3</td>
<td>Physical Examination</td>
</tr>
<tr>
<td>4</td>
<td>Diagnosis/Treatment discussion</td>
</tr>
<tr>
<td>5</td>
<td>Pre-closing</td>
</tr>
<tr>
<td>6</td>
<td>Closing</td>
</tr>
</tbody>
</table>

The similarities and differences of the various stages of the models are identified and discussed fully in section 6.2 below.

6.1.2 Routines

As in any institutional interaction medical interactions are goal-oriented. Ten Have (1991) argues that the organisational goal of the medical consultation is clearly revealed in its structure. Heritage (1997) refers to the ‘wind-tunnel effect’ of institutional agent-client interaction, where the institutional representative has a repetitive set of tasks to be worked through and has developed routines to maintain control and effectively minimise the chances of client resistance. These routines illustrate the tension between the organisational perspective of the consultation as a routine case, and the perspective of the client, for whom the experience is personal, unique, and sometimes frightening. Also contained in the analysis below therefore is
a discussion of a number of routines which have emerged from this mapping process, particularly with Dr. Maxwell. It is interesting to see how he utilises his routines to mark the stages in the consultation and control the movement from one stage to the next.

Figure 6-4 below maps the consultations with Dr. Maxwell contained in these data and provides examples from one of his consultations which clearly illustrate his use of routines in the goal-oriented structure of the consultation.

**Figure 6-4: Map of Dr. Maxwell’s Consultations: (11B)**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Name</th>
<th>Content</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Opening</td>
<td><strong>greeting and seating routine:</strong></td>
<td>Hullo Mr. Marcus, do you want to hop up on the big chair there, and you’ve met my friend Anne, haven’t you?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>introduction/reference to researcher</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Case review</td>
<td>Vision test, sight, age, glasses, patches,</td>
<td>Do you like wearing your glasses? How did you go with your vision test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>school issues, other problems.</td>
<td>next door? And do you have any problems with your eyes, or are they good?</td>
</tr>
<tr>
<td>3</td>
<td>Physical Exam</td>
<td>Window, lights, dinosaur routine</td>
<td>Alright, can you see my dinosaur What sort of dinosaur is that one?</td>
</tr>
<tr>
<td>4</td>
<td>Diagnosis/</td>
<td>Vision, current situation, continue/discontinue patching, glasses, future testing,</td>
<td>Good, so we just need you to keep wearing your glasses.</td>
</tr>
<tr>
<td></td>
<td>Discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Preclosing</td>
<td><strong>Jelly-slime routine.</strong> Next visit, note to Margaret</td>
<td>Would you like a jelly snake for being a good boy today? Now I’ll just give you a note to take to Margaret, and we’ll see you in six months.</td>
</tr>
<tr>
<td>6</td>
<td>Closing</td>
<td>Thanking, farewells</td>
<td>M: That’s lovely, thanks very much, bye bye. D: We’ll see you then.</td>
</tr>
</tbody>
</table>
All of Dr. Maxwell’s consultations contain these very clear stages and most or all of these routines are used to signal the transition from one stage to another. Dr. Colson’s consultations also exhibit all of the stages described in Figure 6.4 but they are generally more fluid and less well-defined than those of Dr. Maxwell. Dr. Colson does not employ the range of strategies used by Dr. Maxwell to move from one stage of the consultation to another and there are no examples of recurring routines in her data.

The consultations of each doctor are analysed and discussed in the stage by stage analysis below.

6.2 A comparison of the models

The following section provides a detailed comparison of the two models of consultation. Section sub-headings refer to the six stages identified in my model. The content of these stages is described and then compared to the typical content of the appropriate stages in Byrne and Long’s (1976a) model.

6.2.1 The first stage (opening)

In Byrne and Long’s model the first stage, which was found in all of their consultations, is very brief, usually only a few seconds, and contains a greeting, an introduction if the patient is new, and often an invitation to move straight into stage two in their model, the presentation of the problem. Byrne and Long found a great deal of consistency in the language used by doctors in this stage. Most doctors used the same standardised greeting with up to 70% of their patients: good morning/afternoon, Mr. Mrs. Miss X, what can we do for you today? (Byrne and
Long, 1976a: 32). They observed changes only when the patient was new or if a third person was present, for instance the consultation was with a mother and child. In this case the most common practice was to relate to the child first, then the mother: hello, Jimmy, my, you’re growing into a big boy! And what is it brings you both here today Mrs. X? (Byrne and Long, 1976a: 33).

An examination of data gathered from consultations with the two doctors in the present study reveals a similarly consistent use of a limited range of openings in most cases. In Dr. Maxwell’s case stage 1 occurred in all but one of consultations and it is likely that in that case, which involved a patient seen earlier in the day, the greeting stage would have occurred at the earlier meeting. The following examples clearly demonstrate that Stage 1 of my model is more than simply establishing a relationship with the patient and illustrate how Dr. Maxwell opens the consultation in a way that allows him to take control and achieve several interactional goals in just one or two short utterances by using his ‘greeting and seating’ routine. The label ‘opening’ covers this range of activities in a way that Byrne and Long’s term ‘relating’ does not. As discussed in Chapter 5, Dr. Maxwell interacts primarily with the child and this may have contributed to the development of this distinctive pattern.

**data fragment 6-1 (11B)**

1  D Hullo Mr. Marcus, do you want to hop up on the big chair there, and you’ve met my friend Anne, haven’t you?

In this example, Marcus is attending for a follow up visit. In one utterance, the doctor has greeted the patient, directed him to where the doctor wants him to sit, and introduced the observer.
The routine is used with each patient with minor variations, depending on factors such as the age of the patient, the number of parents accompanying the child, and whether the patient is new to the practice. In data fragment 6-2, the child is only five years old so the doctor varies his routine slightly to give the child the option of sitting alone on the examination chair, or sitting on her mother’s lap. In data fragment 6-3 Melanie is a new patient but even so the pattern does not vary substantially as the doctor greets both parents, directs them to sit and again introduces the observer:

**data fragment 6-2 (12B)**

1  D  How are you, and you’ve met my friend Anne who is watching us today? Would you like to sit up on the seat on your own or would you like to sit up with mummy?

**data fragment 6-3 (19B)**

1  D  Hi, I’m Dr. Maxwell, if you’d like to take a seat there, g’day. And you know Anne? Alright, how old is Miss Melanie?

There is no evidence of a routine of any description in Dr. Colson’s openings. She does not introduce or explain the presence of the researcher, and she does not indicate any preference or directions for seating when patients and parents enter the room. Dr. Colson’s first stage more closely resembles the first stage of Byrne and Long’s model in that it is very brief, usually only a few seconds, and contains a greeting, an introduction if the patient is new, and often an invitation to move straight into stage two in their model, the presentation of the problem. Stage 1 is also usually very brief, sometimes containing only a cursory greeting before moving straight into Stage 2, as in data fragment 6-4 below which shows stage 2 commencing in turn 3.

**data fragment 6-4: (1B)**

1  D  Hi, how are you?
2  M  hi (2.0) come on William come on
so how did you go with the (0.5) test patching?

Occasionally there is some brief social chat but it does not tend to extend the stage significantly. This is illustrated in data fragment 6-5 below.

**data fragment 6-5: (4B)**

1  D  Hi, so how are you going? I haven’t seen you for a while
2  M  yes indeed
3  D  okay (9.0) okay (0.5) you’re here about his vision, is that correct?

There are also examples in Dr. Colson’s data of stage 1 containing no greeting as such at all, as in data fragment 6-6 below. Her comment let’s get settled is an oblique reference to the need for five people in the room to find seats, but she still does not direct any one to a particular seat. In this fragment Doctor Colson moves straight into stage 2 in her first turn.

**data fragment 6-6: (25B)**

1  D  come in, yes. (2.0) now let’s get settled (2.0) let’s see what we need today (3.0) okay, so you’ve been doing some patching?

There is a minor variation when the visit is the first one and Dr. Colson needs to introduce herself (see data fragment 6-7 below) which she does in one utterance (turn 1) before moving quickly into stage 2 in turn 3.

**data fragment 6-7: (2B)**

1  D  My name’s Sue Colson, (and you’ve) seen our orthoptist?
2  M  hmm hmm
3  D  now you’re concerned that his left vision isn’t as good as his right according to a school test?

As with Dr. Maxwell, stage 1 occurred in most of the consultations observed. One consultation was already in progress when recording commenced and in one other
case there was a pre-consultation examination in another room which involved the
doctor, patient, parent and observer moving back and forth several times and so stage
1 did not occur in the normal fashion when everyone finally entered the consulting
room although there was a discussion about seating initiated by the father.

As in Byrne and Long's (1976a) data, both doctors in this study moved fairly quickly
through the first stage with quite standard openings and only minor variations.

6.2.2 The second stage (case review)

Byrne and Long (1976a, 1976b) describe the second stage of their model in terms of
the doctor's behaviour which consists of his attempt to discover the reason for the
patient's attendance. In the third stage of their model the doctor conducts a verbal
and/or physical examination. This is not the case in my model where the physical
examination occurs in the third stage while the second stage focuses on the function
of reviewing the case, and usually consists of both a series of question and answer
sequences which provides the doctor with a medical history if the patient is new,
information on the nature of the patient's symptoms, and a discussion of the progress
of any on-going treatment. As was the case with stage 1 of the model, the label used
by Byrne and Long for stage 2 of their model did not capture the full range of
activities which could occur in this stage of the consultations in these data.

In most medical encounters the doctor does not know the reason for the visit until the
patient announces it, so the second stage is usually signaled by an open question such
as *what brings you here today?* or *what seems to be the problem?* Byrne and Long
found that this stage did not necessarily occur in all cases, for instance when a patient was returning for a repeat prescription or for a post-natal visit the attempt to ascertain the purpose of the visit was clearly not necessary. When this stage did occur a number of factors seemed to affect its progress, including, critically, the degree to which the doctor was prepared to accept the first thing a patient may say, the degree of clarity with which the patient presented symptoms, the number of patients already seen and the number still waiting.

However there are several differences between a general practitioner's office and a specialist clinic. In the specialist clinic the nature of complaints and the reasons for visits are very limited and the doctor has usually seen a letter of referral from the patient's general practitioner which details the purpose of the visit. Appointments are generally made weeks, if not months in advance and schedules and waiting rooms tend to be much less crowded.

6.2.2.1 Dr. Maxwell's case review stage

As a specialist consultant, Dr. Maxwell's approach does not seem to be particularly affected by any of the factors mentioned by Byrne and Long. The consultation proceeds in the same structured way regardless of the age of the child, whether the parent is NS or NNS, or the number of patients seen or still waiting to be seen. The case review stage was not observed in one consultation which had already reached stage 4 (diagnosis/treatment discussion) by the time the observation began, however the content of the first recorded utterance (see data fragment 6-8 below) indicates that a case review question-answer exchange (*I've just been talking to mum*), and probably a physical examination (*her eyes are much straighter*) had taken place.
data fragment 6-8: (32B)

1   D   ... without Anne knowing you're here, so ((laughs)), so, I've just been 
talking with mum about the operation, and, hh her eyes are much 
straighter, there's a little bit of a turn, and therefore there's (.) a 
possibility that we might need to do something else but we need to 
really wait until about six months after the operation to know exactly 
how straight things are

Stage 2 occurred in all other consultations with Dr. Maxwell. Throughout this stage
Dr. Maxwell uses a series of closed questions, and as discussed in section 5.3.2, when
he does frame an open question he usually reformulates it immediately as a closed
question without waiting for a response. This is illustrated in data fragment 6-9, turns
3 and 7, and data fragment 6-10, turn 9. In this way he directs the flow of information
and maintains very tight control of the structure of the consultation.

data fragment 6-9 (11B)

→ 3   D   How have you been since I saw you last time? Have you been
       wearing your glasses?
        4   C   mmm
        5   D   You've been wearing them all the time?
        6   C   Yeah
→ 7   D   And how did you go with your test next door? Could you see all
       the little letters really well?

data fragment 6-10 (28B)

5   D   Last time I saw you I wanted you to wear a patch, like a pirate,
is that right?
6   C   ((nods)).
7   D   And have you been wearing your glasses all the time?
8   C   ((nods))
→ 9   D   And what about the patch? Do you like wearing the patch?
10  C   ((nods))
One very interesting feature of this second stage in Dr. Maxwell’s consultations is what happens when the doctor asks the child a question clearly intended for an overhearing audience, in this case the parent. The following three examples all occurred in consultations with NS parents.

**data fragment 6-11 (11B)**

23 D Is mum noticing any problems?
24 M no

**data fragment 6-12 (12B)**

9 D ... and the main thing we check you for wearing your glasses is to make sure your eyes are straight. And does mummy notice your eyes turning in a bit?
10 M A little bit, when she’s tired.

**data fragment 6-13 (26B)**

20 D What does mum think?
21 M Oh, well, I think that’s the way it looks, I’m sure that there’s anything in that inability to discern colours...

In each of these three examples where the parent is a NS, the doctor asks the child a question which is clearly directed at the parent. In each case the parent recognises their role as intended audience and responds appropriately to the question with no further prompting. The situation is quite different in the following 3 examples, also from Dr. Maxwell’s consultations.

**data fragment 6-14 (14B)**

15 D Do daddy and mummy notice anything about them?
16 C ((nods))
17 D What do they notice about your eyes?
18 C Um, (1.0) that I go to the eye doctor and I check my eyes.
19 D Right. Can I ask dad about your eyes? Okay? do you still notice them turning in a little bit?
20 F Er, sometimes, not all the time, just sometimes.
The examples given in data fragment 6-14, data fragment 6-15 and data fragment 6-16 are all taken from consultations with NNS patients/parents. In each case the doctor again asks the child a question that is clearly directed at the parent. However, unlike the NS examples above, in every case the parent fails to correctly interpret the pragmatic force of the question and the doctor has to reframe his question directly to the parent, in some cases after seeking permission from the child to do so (data fragment 6-14, turn 14 and data fragment 6-15, turn 13). There are no cases of a NS parent failing to correctly ‘read’ and respond to these types of questions, and no cases of a NNS parent correctly doing so.

Interestingly, there is also one example of an utterance intended for an overhearing audience made by a patient. In data fragment 6-17 below, the NS patient addresses a remark about his success with a friend’s goggles to his mother (turn 73), who makes a fairly non-committal response. There is no comment from the doctor, so the child follows up with more information (turn 75) and the mother again makes a vague
response. In turn 77, the child tries again, and finally the intended hearer, Dr.

Maxwell responds (turn 78).

**data fragment 6-17: (31B)**

73 C er, mum, er what, when, um, I use um Joe's goggles at Rinley park when I went under, right, yeah, under the water, with just his, his normal goggles, yeah I could actually see better than without my glasses, ^above^ water.

74 M oh:h?

75 C like we, with my goggles, with his goggles on, above water, no difference, but under water I could see, like, almost perfectly.

76 M ohhh, that's really interesting, isn't it?

77 C just normal goggles.

78 D you must have had just the right power using them on the water.

79 M mmm

80 D okay, let's have a look at the rest of your eye we didn't put any drops in today,

6.2.2.2 Dr. Colson's case review stage

As discussed in Chapter 5, section 5.2, Dr. Colson has a fundamentally different style of communication to Dr. Maxwell in that she primarily interacts with the parent, not the child. There are no examples in her data of utterances intended for an overhearing audience.

Stage 2 also occurs in every consultation with Dr. Colson who uses several quite different strategies to open the discussion. In exactly half of the consultations observed, Dr. Colson demonstrated a very patient-centred approach by using an open question which allows the parent to decide what or how much to say. This is illustrated in data fragment 6-18 below, where Dr. Colson invites the mother to give her own view (turn 15).
This approach is not particularly successful as the mother seems unsure what to say, and needs to be prompted by the doctor (turn 16) before continuing. It takes several more turns before this NS parent finally gives her opinion (turn 20).

In most of those cases where Dr. Colson uses an open question at the beginning of stage 2, the parent is usually hesitant about taking the opportunity to elaborate, regardless of whether they are NS or NNS. In data fragment 6-19 and data fragment 6-20 below, both with NNS parents, the open questions again fail to elicit a substantial response from the parent.

**data fragment 6-19: (40B)**

<table>
<thead>
<tr>
<th>Turn</th>
<th>Speaker</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>D</td>
<td>so how’s she going, from your point of view?</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>yeah, she’s okay</td>
</tr>
<tr>
<td>8</td>
<td>D</td>
<td>yep?</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>(10.0)</td>
</tr>
</tbody>
</table>

**data fragment 6-20: (50B)**

<table>
<thead>
<tr>
<th>Turn</th>
<th>Speaker</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>D</td>
<td>okay, so how’s he going?</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>okay, he’s ( )</td>
</tr>
</tbody>
</table>
CHAPTER 6 - The Structure of the Consultation

5 D and (.) the difference between the two eyes? do you (.) is it noticeable in the exam to you?

(2.0)

6 D he sees differently, one eye's better than the other, his left one is better than his right one?

7 M mm (1.0) yes that's right

Another approach used frequently by Dr. Colson is to state the reason for the visit and invite agreement, as in data fragment 6-21, a consultation with a NNS patient/parent.

data fragment 6-21: (4B)

3 D okay (9.) okay (0.5) so: o you’re really here about his vision, is that correct?

4 M well it's more or less a [check up really

5 D [yes]

6 M and I've noticed that his eye's started drifting a little bit, but not a major (.) concern

7 D yes

8 M not a major concern .hh and he also has mentioned a couple of times that he felt one eye doesn't see as well as the other

It is interesting to note that this approach generated more information than did any of the open questions above. This is not typical however, and most such openings were responded to very briefly, whether with a NS or a NNS parent, as in data fragment 6-22 (NS) and data fragment 6-23 (NNS) below.

data fragment 6-22: (2B)

5 D no:w you’re concerned that his left vision isn’t as good as his right, according to a school test?

6 M Right

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data fragment 6-23: (51B)

9 D okay, so what do you need today? you’re here for a check up aren’t you.

10 M yes

11 D alright

In this example Dr. Colson uses a technique commonly used by Dr. Maxwell, framing an open question (what do you need today?) then immediately reformulating the inquiry as a closed question (you’re here for a check up aren’t you?).

However even when Dr. Colson uses this type of reformulation to open stage 2, she usually continues to ask open questions and to encourage the parent to voice their own opinions. For example in data fragment 6-24 below, Dr. Colson continues by asking another open question in the next utterance.

data fragment 6-24: (52B)

7 D okay, so tell me what you need today. She’s come for a check up?

8 M yes

[2 turns omitted]

11 D U:um, and she did seem to be slightly better with a slightly different script, so I’m just trying to decide whether it’s enough to make the change, ((laughs)) or not. U:um, let’s see, it’s not a big difference, um, wh-, did you have an impression on the (.) test today yourselves? Whether she’d be better with new lenses or with the old ones? What do you think?

12 M Um, I didn’t see much because er (.) with the new lens she, she was a little bit wrong a bit

These examples further illustrate Dr. Colson’s tendency to use open questions and to try to encourage the patient or parent to tell their story, adopting an approach which seems more patient-centred than that employed by Dr. Maxwell whose strategies in this stage provide him with maximum control over the direction of the discussion throughout this stage.
Byrne and Long claim that there were consultations in which stage 2 did not occur, for example when the visit was for a repeat prescription or for an ante-natal or post-natal visit. In such cases, they say, the “doctor seems to have a pre-set agenda” (Byrne and Long, 1976a:22). They do not offer any data samples to illustrate how this actually occurs, but it seems unlikely that even in such circumstances as they describe the doctor would not make some inquiry, even of a minimal nature, to confirm the reasons for the visit. In fact it is difficult to imagine how the consultation could proceed without some confirmation of the patient’s needs. This analysis also indicates that, unlike Byrne and Long’s model, this stage occurs in every consultation and is therefore not an optional one in my model. The consultations in my data always contain a statement or question to confirm the reasons for the visit, even when the doctor knows exactly why the patient is there.

6.2.3 The third stage (physical examination)

The third stage is described in Byrne and Long’s model as the stage where the doctor conducts a verbal and/or physical examination and is another optional stage in their model. Those consultations which could be described as straightforward and procedural, for example, requests for repeat prescriptions or follow-up of previous treatment directives, often do not require a physical examination and therefore the third stage is omitted. However, Byrne and Long found that most patients presenting with new symptoms will be examined by the doctor. Time required for such an examination can range from only a few seconds to many minutes. Although Byrne and Long conflate the verbal and physical examination into one stage (stage 3 of their
model) in the data analysed here there is a clear distinction between the two.

Although some questioning can occur in stage 3 of my model it is incidental to the physical examination which is the defining feature of this stage in my model.

In the data for the present study it is important to remember that before seeing the doctor, every patient is seen by the orthoptist who carries out a series of eye and vision tests. Nonetheless, a physical examination was also conducted by Dr. Maxwell in all but one case. This was with a NNS who was regularly attending on a three-monthly basis and whose vision was demonstrably better on the tests conducted by the orthoptist. The doctor went straight from stage 2 to stage 4 in this case without conducting a further physical examination himself. In all other cases a physical examination took place, some lasting just a matter of seconds, and others continuing for an extended period and using various pieces of equipment.

In most cases the third stage of Dr. Maxwell’s consultations was signaled by the dinosaur routine. This doctor has a toy dinosaur which he uses to attract the child’s attention while observing eye movements and he maintains a running commentary to distract the child while the physical examination proceeds, as illustrated in data fragment 6-25 below.

data fragment 6-25 (11B)

30 D Alright, can you see my dinosaur there?
31 C ((Nods))
32 D What sort of dinosaur’s that one?
33 C A long-neck
34 D A long neck dinosaur. Do you know the proper name for a dinosaur? Where could you find out the names for a whole lot of
Sometimes the doctor gets more than he expected from his routine, as in data fragment 6-26 below.

**data fragment 6-26 (13B)**

38  D  I’ll just get you to look at my dinosaur here. What sort of dinosaur is that?
39  C  Umm, a brachyosaurus or a brontosaurus
40  D  [Oh, very good
41  C  [I can never tell the difference between them
42  D  Oh, I think it’s the same thing
43  C  No they’re different
44  D  are they?
45  C  The brachyosaurus is
46  F  ( )
47  D  they’re not the same?
48  C  no, they’re not the same, ( )
49  D  okay, (3.0) because we used to call them all brontosauruses and now hardly any of them got called that, they changed all the names. (6.0) So where did you learn all about dinosaurs?
50  C  um
51  D  have you got a few books about them?
52  C  yeah, we’ve got a few, a big book about this thick about them
53  D  great, can you look at me, that’s great. So are you going to be, become a paleontologist and go and dig up dinosaur bones?
54  C  oh, I don’t think so
55  D  right
56  C  no, ( )
57  D  It’s an interesting subject
58  C  one of my favourite subjects is reading, so
59  D  great, and you get to see dinosaurs on television too, did you see Jurassic Park?
60  C  Um, a little bit of it,
61  D  It might have been a bit violent, maybe when you’re a bit older,
62  C  But I don’t (.) it’s not my favourite movie
oh, okay, can you take your glasses off for me? (.) can I get you to look at my ear, and I’ll have a look at the back of your eye, you’ve been very (...), look at my other ear. (4.0) terrific, you can pop your glasses back on now, well your vision is good and your eyes are straight, with the glasses that you’re wearing at the moment, I think we can just keep you just wearing glasses all the time and see how you go.

In this example the child evidently knows a little bit about dinosaurs (turns 39, 43, 45) but the doctor continues his routine without really listening to what the child is saying. When the child indicates he is not particularly interested in dinosaurs but that one of his favourite subjects is reading (turn 58) the doctor maintains the dinosaur discussion (turn 59). He then ignores the child’s protest at turn 62, and moves into Stage 4 with well your vision is good (turn 63).

On some occasions the dinosaur routine was replaced with a ‘special light’ routine, depending on the nature of the examination.

**data fragment 6-27 (15B)**

Let’s have a look at you with my special light

The age of the patient was the major factor in determining the use of either the dinosaur or light routines. They did not appear when the child was older, for example twelve or thirteen years or generally if the child was under two years old, although in fact the dinosaur routine was used once with an infant of nine months.

The situation was slightly different with Dr. Colson. There were two consultations which did not contain any physical examination, both with NNS patients. In both cases, Dr. Colson bases her discussion on treatment on the notes made by the
orthoptist on the tests she conducted immediately prior to the doctor’s consultation.

In data fragment 6-28 Dr. Colson makes two references to the orthoptist’s tests.

**data fragment 6-28: (25B)**

9  D  okay, alright, and on the tests today he seems to be seeing well  
(29 turns omitted))

38 D  okay, okay, now I’m just looking at Mary’s notes here (0.5) I agree with what she said (.) I’d like him to continue …

There is no consistent approach to stage 3 in Dr. Colson consultations. On some occasions she signals verbally that she will do a physical examination, as in data fragment 6-29 below, while in others, such as data fragment 6-30 below, the first verbal indication that a physical examination is occurring or has occurred is when the doctor makes an observation.

**data fragment 6-29: (4B)**

73  D  let me have a look to see if there is anything else to fine, alright, so come and sit up here. (1.0) and have a look at my light first

**data fragment 6-30: (1B)**

88  D  she’s got a tiny turn in her left eye there (3.0) can I get you to hold her head straight?

In this case, there was no verbal announcement that an examination was going to take place; the doctor simply leaned in towards the child.

While there is clearly a physical examination in most of Dr. Colson’s consultations it is sometimes difficult to delineate the 3 stages of case review/physical examination/ diagnosis and discussion since she does not signal the end of one stage and the
beginning of the next, and can appear to revisit a stage, for instance, reverting to the case review stage after doing a physical examination. As a result her consultations are much more fluid than those of Dr. Maxwell and do not necessarily progress through these three middle stages as clearly as those of Dr. Maxwell. Although this stage occurred in all of Dr. Maxwell’s consultations, given the absence of an examination in two of Dr. Colson’s consultations, this stage cannot be said to be obligatory in my model.

6.2.4 The fourth Stage (diagnosis / discussion)

It is at the fourth stage that the two models diverge most significantly. Byrne and Long’s model describe this stage as ‘consideration of the condition and of the future’. The purpose of the fourth stage in their model is to allow the doctor to provide as much information as possible to the patient in order to reach agreement (my emphasis) about the future management of the patient’s condition. Byrne and Long give several examples of the types of doctors’ behaviour found in this stage: one they call ‘predirectional probing’ such as if it is true that you are pregnant again, what would you want to do about it? (1976a:51) and another they refer to as ‘summarising established positions to open up’ which they illustrate with the following: now then, you have got all sorts of odd aches and pains in your chest. You have infections of the bronchus time and time again. You cough your heart out every morning. Every time you light up in the morning your heart starts to thump. I mean, apart from suggesting that we sit here waiting for a fall of soot, what should we talk about now? (1976a:52). Byrne and Long describe this stage as “optional under all circumstances” (1976a:25), and found that it did not occur at all in 30% of their consultations, and in another 48%
lasted less than 10% of the total consultation time. They also found evidence that
even those doctors who do use the approach consistently do not use it with patients
who have poor English skills, although reasons or an explanation for this are not
provided.

This stage does not exist in its own right in my model. There could be several
explanations for this, although none are particularly clear from the data. One possible
explanation is that because the doctors in my data are specialists they are less inclined
to negotiate treatment options with patients than are general practitioners, who would
tend to be involved in more general health and illness prevention strategies with their
patients. Another explanation could lie in the fact that the doctors in this study are
pediatric specialists and their patients are children, although this would not prevent
the doctor from attempting to negotiate an agreed position with the parents.

The fourth stage in my model is the diagnosis/discussion stage and it occurs in every
consultation. It therefore more closely resembles stage 5 of Byrne and Long's model.
All of the characteristics of Byrne and Long's fifth stage can be found here. Their
fifth stage, detailing treatment or further investigations, generally consists of the
doctor providing advice, prescriptions, instructions and explanations. Stage 4 of my
model does occasionally contain information and a discussion about future treatment
similar to that described by Byrne and Long in the fourth stage of their model, but the
only attempts to negotiate an agreement about such treatment are found in
consultations with Dr. Colson and are generally based on the doctor making the
decision about treatment and involving the parent in the detail of how treatment will
be conducted, rather than in the more significant decisions about what treatment will
or will not be undertaken. This is illustrated in data fragment 6-31 below, where Dr. Colson has decided that patching needs to be done, but involves the mother in the decision about how long to do it.

data fragment 6-31:(47B)

→ 353 D I'm thinking 3 times a day for 5 days?
354 M hmm hmm
→ 355 D Do you think that will be long enough to get a feel for whether it would (. ) be better, or not?
356 M um (0.5) 5 days?
   [two lines omitted]
359 D I don't mind if it's a little bit longer
360 M yeah, I'd prefer to use them a bit longer, [yeah
→ 361 D what would you say? how long would be enough to (. ) to give her a test?
362 M [((laughing)) I don't know?
363 D Like for ten days?
364 M yeah, probably ten days, would be better,

This is quite different to the process that Byrne and Long describe as occurring in stage 4 of their model, a process which, as we saw earlier, requires a deeper involvement by the patient in the whole management of their illness and future treatment options.

The duration of stage 4 of my model is variable. In Dr. Maxwell’s case, it can range from a large number of turns to a single turn, as in data fragment 6-32 below. In this example the directions for treatment occur immediately after the physical examination. There is no other discussion about the child’s condition either before or after this one utterance.
data fragment 6-32 (11B)

40     D     Good, so we just need you to keep wearing your glasses, we don’t 
need you to have any patches or any operations and we can see you in 
another six months, will that be okay? Would you like a jelly snake 
for being a good boy today?

The reference to a jelly snake is a clear indication that the doctor has moved into stage 
5, the pre-closing stage. The use of this routine is discussed in more detail in the 
analysis of stage 5.

However, these data show that Dr. Maxwell does usually provides detailed 
explanation to the patient/parent, regardless of whether the patient/parent is a NS or a 
NNS: In data fragment 6-33 below, the doctor explains to the NS mother that her 
daughter’s condition seems well controlled:

data fragment 6-33 (12B)

50     D     ... so the vision’s good
51     M     Mmm
52     D     The turn’s fairly well controlled with the glasses, she’s got a tiny bit 
there which you are noticing but I think with the current glasses 
strength we don’t need to increase that,
53     M     Right
54     D     And we definitely don’t need to do an operation to straighten it, and 
I think we’ll just keep checking her vision, it’s unlikely to drop 
back, it still could a little bit over the next two years, but if we get it 
up to age seven, hold the vision good she should remain with 
excellent vision.
55     M     Excellent
56     D     Okay, would you like a stamp or a jelly snake?

This example is typical of stage 4 with this doctor, covering the present situation, 
proposed treatment, and expected outcomes. However some consultations contained
more general explanations of why things were being done, for example in data

fragment 6-34 below Dr. Maxwell explains his son’s treatment to a NNS father:

data fragment 6-34 (20B)

32 D so we’ve patched him and got him almost the same, but not quite, (.) but both eyes are very good, so we don’t need to worry about that. If he was little, we would need to keep watching him very closely, (1.0) but at the age of seven, he’s finished that stage where his brain is learning how to see, (1.0) he won’t forget how to see, whereas when he was two or three years of age, his brain could forget, and the vision could drop. But now it will stay good for the rest of his life. (0.5) Okay?

Stage 4 can be extended by a number of factors however, including questions from the patient/parent. In data fragment 6-35 below the patient’s NNS father needed to clarify a number of Dr. Maxwell’s utterances and as can be seen this has a significant effect on the length of the fourth stage:

data fragment 6-35 (28B)

22 D that was very good wasn’t it? So we’ve made that lazy eye get a bit stronger, are you pleased about that?
23 C ((nods))
24 D I’m very pleased. hh so that’s really good news. Now, (.) I think we need to keep wearing the patch a little bit longer, (0.5) so:O, would you be happy to wear the sticky on your lens again? would that be alright? so if you go back to just the sticky patch on the lens and not the patch on his eye, (.) okay? (17.0) And what if we do that for half of the time, so m, if he has that on for two days, and then off for two days, or on for one day and off for one day,
25 F you mean er, only the glasses, not this with the other patches on?
26 D the glasses all the time,
27 F yeah
28 D and the sticky patch,
29 F hmm hmm
30 D on the lens,
31 F for two days,
32 D for (.) half of the time, so you could put it on half of every day,
33 F oh but he not using at the school, you know, and er,
Stage 4 can also be extended by a number of other factors. In the following example the mother of the infant patient does not agree with the doctor’s decision, and makes it clear that she wishes to take a different course of action. This is a lengthy excerpt, but
it illustrates how this NS mother resists Dr. Maxwell’s attempts to bring the phase to a
close and is able eventually to achieve her own preferred outcome. There is no
example of such resistance from a NNS parent.

data fragment 6-36 (19B)

40  D  I have *everything* at the ready, and, o:oh, yuk, (. ) yuk, yuk, yuk, so,
     with the eyes, after you’ve cleaned her,
41  M  hmm hmm
42  D  if it’s just the mucus itself is, that’s sticky, (. ) then I don’t think you
     really need to do anything else, but what you’d need to do is a warm
     face washer to soften everything, =
43  M  yeah,
44  D  = clean everything away, =
45  M  yep
46  D  = and then just gently press over the tear duct here, ((baby cries)) I’m
     sorry, (. ) and that just refluxes any of the mucus back up out, and then
     clean that away, and also it might help to push it down a bit so that it
     opens up. (0.5) If after you’ve cleaned her e:yes, and you look and
     everything’s perfectly ok:ay, (. ) then she doesn’t need to have any
     antibiotic drops. (0.5) ((D washing hands)) but if the eyes’ a bit red, or
     the skin’s a bit red,
47  M  she’s had um antibiotic drops already,
48  D  Yeah?
49 (1.0)
50  M  and we’ve been massaging.
51  D  Yeah. (0.5) but what I’m saying though is if, after you’ve washed her
     face,
52  M  Right.
53  D  the skins red, or the *conjunctiva*, the white of the eye’s red,
54  M  Right.
55  D  she needs to go on the antibiotic drops for a short period of time,
     usually about three or four days. The underlying problem is that the
     tear ducts between the eyes and the nose, hasn’t opened up, =
56  M  right
57  D  = that’s normally something that normally happens in the first few
     weeks of life, in about five percent of children it takes a few months, =
58  M  Hmm hmm
D = and in one or two percent of children in six months, it’s still not come right.

M Right.

D it may be up to a year before it can come right on its own.

M hmm hmm

D .hh, now we can do a simple procedure where we pass a little wire from the tear duct opening (. ) into the nose, to open that up, on both sides, however, to do that, (. ) it’s not actually a traumatic procedure in itself, I could do it on the two of you just by putting a drop of local anesthetic in, .hh but she is not going to sit there calmly and say I’m happy to have this done, =

M Sure.

D = and because we risk (. ) injuring her eye if she moved, we’d need to put her to [sleep =

M [to sleep.

D = to do it, and a general anesthetic does carry slight risks, =

M mmm

D = as does getting in a car and driving in (. ) to the hospital does =

M Sure.

D = and because of that we don’t just do it (. ) willy nilly, =

M no.

D = without thinking about it, and given that, at five months of age about (. ) seventy five percent chance she’ll come right on her own, without needing to do that, be inclined to wait.

M Okay.

D okay? Now, it is a real pain, because you’ve got to clean her face [five or six times a day

M [well

D Yeah,

M vile

D ((laughs)) .hh Now what’s happening is that her eyes produce (. ) the tears which overflow and run down, and also some mucus as well, and, the reason it’s all pus-y and gunky is that the normal bacteria that we’ve got on our skin, are growing in there, and there’s a, an overgrowth of that. Now one way to cut that down and to get less of it is to actually use an antiseptic type soap? um you can get that from the chemist shop, um usually it’s a squeeze bottle, and you can get (. ) simpler ones that, you know you just use in the bathroom, or you can get the full, you know, ones, that surgeons use if they’re scrubbing up
to do an operation.

80 M right
81 D I'll let you talk to the chemist and see what they've got, and if you (.)
clean all of her,
82 M Yeah.
83 D in it, yourself, your hands, wash your hands, dad, wash your hands, and
try to decrease whatever the (.) current bacteria are that are on your
skin,
84 M okay
85 D you'll find that she gets less infected, cos it's what's on her hands, she
then rubs her eyes, it then grows up again. And let's see if that helps
cut down the, you know, the load there. Now, I think, if you're happy
to keep going for another couple of months and see how she goes, (.)
you, you are doing everything correctly, and I know it's frustrating,
putting up with it, the odds are though it will come right on its own.
86 M Right.
87 D If it hasn't, and you know, you're happy to wait, we could wait until
she's about ten or eleven months of age, and then book her for an
operation then,
88 M Hmm hmm
89 D if you really wanted something done straight away we could arrange to
have it done now. But I would be inclined to wait a bit longer, if
you're happy to do that.
90 F yeah, no worries,
91 D okay? how do you feel about all of that?
92 M I probably would have, I don't know, I probably would have liked it
done, perhaps, only because it's just been going and going and going,
this is a good day, sometimes it's bleeding, [in here, or
93 D [hmm hmm, yeah, if
it's like that then I think she needs to be on the antibiotic drops for a
few days.
94 M she, she has been.
95 D Yeah, but then, that's just to clean the skin up. If I look at her now, I
mean if I wash her face, and we could pass her off and no one would
know there was any problem, she doesn't need to be on antibiotic
drops, =
96 M yeah
97 D = at the moment, so it's just a short burst usually,
98 M no
99 D not a, (.) keep her on it all the time to get rid of all the mucus all the
time because then you do build up resistant [bacteria.
[Well, we’re on new ones now, which we sort of had to stop using, which she was only on them for five or six days, and then I took her back to the GP and he just said you might as well stop it’s just doing nothing.

Dr. Maxwell’s approach in this case is to treat the symptoms, based on proper cleansing and possibly antibiotic drops but in turn 47 the mother resists this, and pre-empts the doctor’s next suggestion in turn 50 by mentioning that she has also been massaging. The doctor restates his position, Yeah. (0.5) but what I’m saying though is ... and goes on to explain the underlying cause of the condition. The mother listens to this making minimal responses until turn 76, when she contradicts the doctor when he suggests that the process is tedious and points out that she has been doing it for some time. This continues until the doctor finally asks, at turn 91 okay? How do you feel about that? The field notes made of this particular consultation indicate that the mother’s facial expression and body language make it clear that she is not satisfied (field notes, 1999). I believe that this question from the doctor was prompted by those non-verbal cues as well as the terse minimal responses given by the mother. The conflict continues in turns 92 and 93, with the mother insisting that she has already tried these remedies: She says I probably would have, I don’t know, I probably would have liked it done, perhaps, only because it’s just been going and going and going, and when the doctor answers that he thinks she needs to be on the antibiotic drops for a few days her response at turn 94 is a curt she has been.

Stage 4 continues for another 90 turns, containing 146 turns in total, considerably longer than other consultations where this stage ranged from 1 to 30 turns. By the end of the discussion Dr. Maxwell had agreed to book the child in for surgery and the mother was satisfied with that decision. It is interesting to note data fragment 6-37
below which took place immediately after the details of hospital admission had been completed and placed in an envelope to send to the hospital. It reveals the mother’s uneasiness with the way the consultation had developed and her awareness of the fact that she had not fully observed the accepted norms of behaviour for doctor-patient interactions.

**data fragment 6-37 (19B)**

165  D  And so I’ll post that in to the hospital.
166  M  so are you happy for it to go like this? You, you,
167  D  yeah, yeah.
168  M  I don’t want you to think I was (.) rushing you or anything.

Dr. Maxwell then brought stage 4 to a close in this case by bringing up the procedure for making a new appointment.

As discussed fully in Chapter 5, Dr. Colson’s directions in this stage of the consultation can appear to be quite tentative, and in many cases she seems to require the parent to play a role in the decision about what to do (see examples given in section 5.4.2). As a result of her communicative style stage 4 tends to be much longer in Dr. Colson’s consultations but despite this there is very little difference in the amount of information conveyed by each doctor in this stage. Both doctors provide comments and explanations about the patient’s progress where relevant and about the future in terms of treatment and long-term results.

### 6.2.5 The fifth stage (preclosing)

Stage 5 of my model does not appear in Byrne and Long’s model but is present in almost all consultations with Dr. Maxwell. The pre-closing stage is used by the doctor to terminate the discussion stage. It is signaled in almost every case by the
‘jelly-snake routine’ which involves offering the child a jelly snake or a stamp, and contains some reference to the next appointment and a note to take to the receptionist to actually make the next appointment. It is a very effective strategy which generally allows a smooth transition into stage 6, the closing stage. Examples in data fragment 6-38 and data fragment 6-39 below clearly illustrate the use of the jelly snake routine to move from the discussion/diagnosis stage:

**data fragment 6-38 (12B)**

56 D  She should remain with excellent vision  
57 M  Excellent  
58 D  Okay, would you like a stamp or a jelly snake?

**data fragment 6-39 (15B)**

49 D  so after seven we probably won’t wear the patches anymore, OK? but a little bit longer if you wear the sticky patch on your lens. (7.0) So I might just see you, (1.0) just before Christmas, just before the (. ) January New Year holidays, (9.0) alright? (2.0) OK. I’ll give you that to hand to Margaret at the desk to say that you need to come back and see me in December. Would you like a jelly snake or a stamp for being good today?

The only occasions on which the doctor did not offer a jelly snake were again when the child was an infant, when the consultation took place in the hospital, and in one case in the private clinic where the child was accompanied by his mother and two sisters. In all other cases the jelly snake was used very effectively to signal that the end of the consultation was approaching.

In Dr. Colson’s case, the pre-closing usually contained a reference to the next visit, as in data fragment 6-40 below.
data fragment 6-40: (1B)

268  D  okay then?
269  M  okay
270  D  alright, we’ll see you in November, perhaps
271  M  okay
272  D  or otherwise in the new year
273  M  yeah
274  D  okay

This stage also often contains a reference to the family GP and an offer to send a letter, as in data fragment 6-41 below.

data fragment 6-41: (50B)

108  D  okay, I’ve put down here eight to ten weeks, okay, now the other thing is your GP? has your GP had a letter from us?
109  M  yeah, I know next month, ( ) next month we got appointment,
110  D  To see your ( ) family doctor?
111  M  Er no, the doctor here,
112  D  Oh, right, no I’m thinking of, about writing to your family doctor to let your doctor know what we are doing?
113  M  Yeah
114  D  I don’t do it every time, me, but just so that, in case you’ve got ( ) questions your family doctor knows why he’s coming to the eye clinic, so it is Doctor Nguyen, N, G, U, Y, E, N, ?
115  M  That’s right
116  D  Yes, Smith Street?
117  M  Yeah
118  D  Okay, it doesn’t sound like he’s had a letter before,( ) from us, yes here we are, in 98 (6.0) okay, alright, (2.0) that’s all I guess [bye bye

Stage 5 occurred in all but one consultation in these data and provided an effective way for both doctors to signal that the end of the consultation was approaching.
6.2.6 The sixth stage (closing)

The final stage in both models involves bringing the consultation to an end. Byrne and Long found that doctors can effectively terminate the consultation non-verbally by simply handing the patient a prescription, by standing up or by walking to the door. Strategies for terminating verbally include the very direct *off you go now* (1976a:28) or the suggestion that the prescription be taken to the pharmacy. It is also interesting to note that they found that patients initiated the termination in about 10% of cases. Byrne and Long found that stage 6 was the only stage where the patient did play a significant role in initiation, either to initiate the termination or to attempt to introduce new information with a question.

My own data reveal a similar pattern, although the percentage of parents who took the initiative was much higher than in Byrne and Long’s finding. In most cases the pre-closing stage leads smoothly into the closing. In approximately 40% of consultations with Dr. Maxwell the parent recognises the pre-closing move and initiates the closing by offering thanks and allowing the doctor to utter a farewell, as demonstrated in data fragment 6-42 below.

**data fragment 6-42 (11B)**

46 D okay, now I’ll give you a note to give to Margaret, and we’ll see you in six months time, (stage 5)

47 M That’s lovely. [thanks very much, bye

48 D [okay, we’ll see you then

In other cases, the doctor the pre-closing move is derailed, usually by a remark of a social nature, by either the parent or the child. When this happens Stage 6 can be delayed quite significantly, as in data fragment 6-43 below. In this example, Stage 5
contains the usual cues, the jelly snake routine, the reference to the next appointment and the note to Margaret, so the consultation should have moved into Stage 6 straight after turn 68. Instead, in turn 69 the mother follows up on an earlier remark about going to the beach for a holiday, and in turn 70 the doctor attempts a closing with ....

\textit{okay, we'll see you then} but loses control of the closing when he adds \textit{I don't know how much swimming you'll do.} It is another 12 turns before the mother re-initiates the closing at turn 82 and Dr. Maxwell is able to complete the closing with a farewell.

\textbf{data fragment 6-43 (12B)}

\begin{verbatim}
58 D  okay, would you like a stamp or a jelly snake?
59 C  umm, a s- ((looks at mother))
60 M  whatever
61 C  umm, a snake
62 D  what colour would you like? A red, [orange =
63 C  [red please
64 D  = green or yellow?
65 C  red please
66 D  a red one. Would this one be good enough?
67 C  thank you
68 D  you're welcome, and I'll give you a note to hand to Miss Margaret at the
desk, and mum can check when you're going to Philip Island, and we'll see
you either a bit before or a bit after in the new year.
69 M  well, we might be going this holidays ((laughs))
70 D  oh, really! This soon, okay, we'll see you then I don't know how much
swimming you'll do
71 C  ((giggles))
72 D  [(   )
73 M  [(   )
74 C  [I've got a surfboard, I've got a surfboard
75 D  are you a good surfer?
76 C  I lie on my tummy
77 D  on your tummy
78 C  and my mum push me
79 D  great, wow, so you'll be a champion surfer in a few years, you'll be able to
\end{verbatim}
take mum to all those exotic [places in Bali [mmmm
81 D and Hawaii and Sth Africa
82 M I'd love that ((laughs)), well, thank you
83 D see you later

In other cases however, the doctor moves quite abruptly from pre-closing to closing.

In data fragment 6-44 below the child has nominated the colour of the jelly snake he would like and the doctor then closes quite bluntly:

data fragment 6-44 (13B)

97 D That one? There you go, see you later, okay. Bye

It may be a coincidence that this consultation is with Robert, the same child who was involved in the dinosaur discussion cited in data fragment 6-26. In other cases, particularly with NNS parents, the closing stage can be extended by repeated thanking. In data fragment 6-45 below Dr. Maxwell has completed stage 5 with his usual reference to the receptionist and a thanking move to initiate stage 6. There are three more thanking moves before the doctor finally explicitly closes with alright, bye (turn 63).

data fragment 6-45 (18B)

57 D Margaret is the lady out at the desk outside in the other room? could you give that to her? (.) Alright then, thank you very much
58 F Thank you
59 D Good, see you later
60 F Okay, thank you. See you
61 D And I'll send Dr. Allan a note.
62 F Yep, okay, thank you
63 D Alright, bye
64 F goodbye
Finally, stage 6 is sometimes deferred significantly when the patient asks what Byrne and Long (1976a) refer to as a ‘Parthian shot’\textsuperscript{10} question, as in data fragment 6-46 below.

**data fragment 6-46 (14B)**

105  D  Alright you hand that to Margaret and you can show her the Captain Feathersword stamp. Okay?
106  F  There’s nothing to worry about now is there?

Turn 105 is the pre-closing signal and should be followed with a goodbye or a thank you, but this NNS parent is still concerned about his son and in turn 106 disregards the cue that the consultation is about to close and expresses his concern. It takes 7 more turns for the closing to get back on track and then the father takes control of the final closing steps.

114  F  Alright. Say goodbye to Dr. Maxwell. Dr. Maxwell
115  C  Goodbye [Dr. Maxwell
116  D  [See you later
117  F  Go and shake his hand
118  D  Okay, good on you mate
119  F  Alright
120  D  Okay
121  F  I’ll catch you later then.
122  D  Alright, in six months or so
123  F  All the best and that

The pattern of interaction in the closing stage is very similar in Dr. Colson’s consultations. In a little over half (58\%) of the consultations, the closing is initiated by the parent. As with Dr. Maxwell the parent could initiate the closing by offering

---

\textsuperscript{10} A hostile remark or gesture delivered while departing. Refers to the archers of Parthia who were skilled at shooting backwards whilst in retreat.
thanks and allowing the doctor to utter a farewell, as in data fragment 6-47 below, or
can in fact make the farewell move themselves, as in data fragment 6-48.

data fragment 6-47: 40B

59 D now
60 C thanks
61 F thank you
62 D and we’ll see you back in 8 weeks (.) okay, bye

In the remaining consultations Dr. Colson initiates the closing, as in data fragment
6-49 below.

data fragment 6-49: (50B)

118 D Okay, it doesn’t sound like he has a letter before (.) from us, yes here
we are in 98 (6.0) okay, alright, (2.0) that’s all I guess (bye, bye
119 M [thank you
very much
120 D so no drops next time, okay, ((laughs)) alright.

Again, as with Dr. Maxwell, the closing can be delayed, usually by a social remark or
in the case of data fragment 6-50 below, by the mechanics of getting the child back
into his pram

data fragment 6-50: (22B)

262 D okay, so:o,
263 (2.0)
M Alright, then.
D alright, good,
M [thank you very much,
D [let’s know how you are going.

(2.0)

Instead of farewells occurring next however, the mother continues to struggle with the pram and, aware of the breach, apologises for the delay in leaving.

M just get, it’s alright, sorry, if I just sit him in it,
D Yeah, that’s fine
M and I’ll do it up outside.

It took another 21 turns before this consultation was finally terminated. During this time Dr. Colson participated in general chat with the mother and child.

C ( )
D you’re talking lots aren’t you?
M absolutely, can I just put him [on the floor for a minute,
D [Sure.
C got the keys.
M (throw the kid) on the floor,
D you’ve got your mother’s keys,
M unceremoniously,
D Yes, that’s right ((laughs))
M oh everything that’s mine is his, (0.5) according to him, ((both laugh)) my dinner, my purse, even my cup of coffee, this morning, he wanted, (0.5) these are going to fall out I guess, say thanks Dr. Colson,
D okay, good,
M thank you [very much,
D [ he’s fine, this is good,
M well it is good,
D yeah
M cos it’s er, you know, we’ve got a few other problems, so that’s one that (.) we can dispense with, for the moment, hullo, is that mine?
There is an example of a similar incident with Dr. Maxwell. The closing stage was initiated in turn 73 and acknowledged by the father in turn 74, but was derailed by the need to load the infant into his carry cot. Dr. Maxwell allowed some delay but when it extended too far he simply left the room.

**data fragment 6-51: (27B)**

<table>
<thead>
<tr>
<th>Turn</th>
<th>Speaker</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>73</td>
<td>D</td>
<td>okay, see you later alligator</td>
</tr>
<tr>
<td>74</td>
<td>F</td>
<td>bye bye</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[4 turns omitted]</td>
</tr>
<tr>
<td>79</td>
<td>D</td>
<td>and we’ll see how you go.</td>
</tr>
<tr>
<td>80</td>
<td>F</td>
<td>yeah, thanks,</td>
</tr>
<tr>
<td>81</td>
<td>D</td>
<td>your big brother’s going to look after you? Hey?</td>
</tr>
<tr>
<td>82</td>
<td>F</td>
<td>he’s got two big brothers, and a big sister</td>
</tr>
<tr>
<td>83</td>
<td>D</td>
<td>Oh (1.0) we’ll see you after Christmas, are you going to come in next time?</td>
</tr>
<tr>
<td>84</td>
<td>F</td>
<td>probably not! you come in lots of times don’t you, we’ll bring, we’ll bring Cordelia in on Friday.</td>
</tr>
<tr>
<td>85</td>
<td>C</td>
<td>yes</td>
</tr>
<tr>
<td>86</td>
<td>D</td>
<td>you’ll know the hospital backwards.</td>
</tr>
<tr>
<td>87</td>
<td>F</td>
<td>Yeah. thanks ((child crying loudly, S talking loudly))</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(11.0) (( D left the room.))</td>
</tr>
</tbody>
</table>

The findings from this analysis indicates that the final stage of consultations follow a similar pattern for both doctors and that the pattern is compatible with Byrne and Long’s findings.
6.2.7 Conclusion

Byrne and Long (1976a) identified two obligatory stages in their model (stage 1, relating and stage 6, terminating), but four stages (1, opening, 2, case review, 4, diagnosis/treatment discussion, and 6, closing) of my model seem to be obligatory. Stage 3 (examination/physical examination) is optional in both models, while my stage 5, (pre-closing) which does not appear in Byrne and Long’s model, is also an optional stage in my model. With few exceptions, each consultation with both doctors features the six stage structure of opening, case review, physical examination, discussion and diagnosis, pre-closing and closing identified in the model.

It is clear from the examples and discussion above that Dr. Maxwell’s consultations are very tightly organised and closely follow the structure identified in this model. He uses a number of routines to facilitate the smooth transition from stage to stage and to maintain control of his consultations. This control of the overall structure of the consultation and of the doctor’s time is typical of the doctor-centred approach described in Chapter 5, which maximises the doctor’s own input and also allows the doctor greater control of both what is talked about and how much information is shared with the patient.

This analysis also supports the notion that Dr. Colson tends more to the patient-centred end of the scale. Her consultations are more loosely structured than those of Dr. Maxwell and the structure is less controlled, with more fluid boundaries between the various stages. Dr. Colson does not use a set of routines to signal stages or to control the progress of the consultation, and she encourages, or even requires in some instances, greater parental involvement in both stages 2 and 4 of her consultations.
which therefore tend to be much longer than Dr. Maxwell’s consultations. This is not
to say that Dr. Colson’s are necessarily more satisfactory or better meet patients’
needs, which is an aspect of the doctors’ different consultation styles which will be
discussed further in Chapter 9.

It is also important to note that the patterns of interaction described in this chapter do
not appear to be affected by the speaking background of the patient/parent. Both
doctors exhibit similar patterns of verbal interaction throughout with both NS and
NNS patients/parents.

6.3 Summary of chapter

This chapter examined the structure of the consultations observed in these data. The
model of the consultation which emerged from this analysis was then compared with
Byrne and Long’s widely accepted model. The new model is robust and can now be
used to map patient/parent-initiated questions in order to compare any differences
between NS and NNS patients/parents in terms of the timing of their questions.

In the next chapter the questions which occur in these data are analysed to reveal
patterns of patient/parent questioning behaviour in terms of the number and timing of
questions, and the way in which questions are framed. The patterns of questioning
behaviour of NS and NNS patients and their parents can then be compared.
CHAPTER 7  Number, timing and type of patient/parent-initiated questions

This chapter discusses some of the difficulties which can be encountered in the
analysis of questions in interaction, and provides a definition of the term ‘question’ as
it is used in this study. A number of important aspects of questioning behaviour have
emerged from the data. This chapter examines the data to reveal patterns of
questioning behaviour in terms of the number of questions asked and the timing of
such questions. Patients/parents’ questions are mapped onto the model of the
consultation described and discussed in Chapter 6, and the potentially significant
effect that patient/parent-initiated questions can have on the structure of the
consultation is demonstrated. The variety of ways in which patients/parents frame
their questions has also emerged as an important aspect of questioning behaviour and
this is also analysed and described in this chapter. The patterns of questioning
behaviour identified as being used by NS and NNS patients (and/or their parents) are
then compared.

7.1  A question of definition

Dictionary definitions of the word ‘question’ can be deceptively simple. For example,
the Macquarie Dictionary gives us “a sentence in an interrogative form addressed to
someone in order to elicit information” (Delbridge et al 1991:1443-1445). The Collins
Dictionary offers “a form of words addressed to a person in order to elicit
information or evoke a response: interrogative sentence” (Collins, 1991:1230).
Questions can therefore be defined not only by their grammatical structure but also by
the function they perform in interaction. This wider definition is supported by Heritage and Roth (1995) who argue that questioning is "an activity that cannot be reduced to grammatical form" and that to attempt to do so 'misses what we have identified as important pragmatic and turn-constructional features of questioning" (Heritage and Roth, 1995:48).

7.1.1 Definitions of questions in the literature

Many of the early researchers on patient-initiated questions provided no definition or description of what they included in their category of 'question' (Pratt et al, 1957, Korsch and Negrete, 1972, Bain, 1976, Boreham and Gibson, 1978). Roter (1977, 1984) does not define questions in her 1977 study but in her 1984 work she reports that "patient question-asking was conceptualised as a behaviour that reflects information seeking on two different levels, distinguished as direct and indirect question asking forms" (Roter, 1984:396). For her, direct patient-initiated questions are those which seek new information and which give to the patient control of the questioning process and topic change. Indirect questions, on the other hand are seen as those which are intended to elicit repetition, clarification or more detail of an earlier utterance, and as such reflect information already provided by the doctor rather than new information.

West (1983, 1984a, 1984b, 1993) makes a similar distinction in her work and links this to her definition of questions which she gives in CA terms. As discussed in Chapter 3, some of the key findings of CA are the notions of turn-taking, adjacency pairs, preference organisation, repair and topic management. West argues that the
notion of adjacency pairs provides a clear distinction between first pair parts and second pair parts based on the temporal position of each component. Following Goffman's observation that "notwithstanding the content of their questions, questioners are oriented to what lies ahead and depend on what is to come: answerers are oriented to what has just been said, and look backwards, not forwards" (Goffman, 1976:257), West argues that an answer therefore must follow a question in time and sequential position, so that the intelligibility of answers is conditionally relevant on the existence of an earlier question. Like Goffman, she describes questions as "forward looking things" (West, 1993:133) and uses this to argue that interrogatives that are used to initiate repair or repetition of previous utterances cannot therefore be properly defined as questions, since they look backward rather than forward in sequential positioning. She refers to those interrogatives that refer backwards in the text, such as requests for repair or confirmation of a previous turn, as conditionally relevant question types, or quasi-questions and specifically excludes them from the category of 'question' in her 1983 study. However, this distinction seems difficult to sustain when talk such as that presented in data fragment 7-1 below is considered.

**data fragment 7-1: (28B)**

```
24 D  so if you go back to just the sticky patch on the lens and not the patch on his eye (. ) okay? (17.0) And what if we do that for half of the time, so um, if he has that on for two days, and then off for two days, or on for one day and off for one day,

→ 25 F  you mean er, only the glasses, not this with the other patches on?
26 D  the glasses all the time,
27 F  yeah
```

In this data fragment the father's utterance at turn 25 is an example of what West would classify as a request for repair, introduced by *you mean* (Scheglof et al 1977) and seeking a restatement or clarification of the doctor's previous utterance. West
would argue therefore that it is a backward looking utterance, not a forward-looking one, so the utterance would not be considered to be a question. However, this turn clearly constrains the hearer’s choices for the next turn in the same way as any other question would do. The doctor responds appropriately and relevantly with a clarification of his earlier instruction, because a failure to do so would be as marked as any failure to answer a question. Although the content of earlier utterances are often revisited and recycled as a result of requests for repair or confirmation, such requests still constrain the next turn in just the same way as any other type of question, and the absence of an answer or the non-relevance of the next turn is equally noticeable and marked. In this way, such questions have a dual function and are oriented both backwards to a previous utterance and forward to the next one.

The distinction West makes between questions and ‘quasi-questions’ is one which differentiates between backward looking and forward looking utterances. This distinction is not critical in the present study which is interested in the myriad ways patients can frame their requests for the information they need, even if that information has been presented in earlier utterances.

West herself subsequently argues (1984b) that these backward-looking types of utterances are in fact “primary means available to speakers for establishing ongoing hearing and understanding of talk itself” (1984b:109) and subjects them to a separate analysis in her later work. It is clear however that the different types of questions have different communicative goals and achieve different kinds of outcomes as West has shown, and this is discussed in Chapters 8 and 9.
Frankel (1990) includes both of West’s question types when he describes questions in discourse as “utterances which perform various sorts of tasks in requesting of a hearer, for instance, that s/he clarify, reiterate, confirm, supply information and/or repair the content and sense of previously provided talk” (1990:234). Nonetheless, he later excludes, without further explanation or discussion, what he refers to as “‘normal’ troubles such as requests for clarification, information etc.” (Frankel 1990:239) from his analysis.

Ten Have (1991) also points out that the analytical category of ‘question’ is a difficult one, claiming, in his discussion of medical interactions that it is difficult to set clear limits since “patients have a variety of ways in which they can make known to their physician their informational needs” (1991:147-148). He does not specifically define ‘question’ but comments that some of the more covert forms of questioning which would certainly not be eligible for inclusion by West are in fact quite successful ways of obtaining information.

The category of ‘question’ is not specifically defined by Tuckett and his colleagues (1985) but they do describe several types of information a patient may want and might use a question to obtain, and specify ‘clarification’ as one of those tasks that questions are used for. They differentiate between overt and covert questions and offer cases where patients repeat the doctor’s utterance with a rising inflection, such as *rheumatism? and and no after effects at all?* as examples of covert questioning.
7.1.2 Definition of ‘questions’ for the present study

The focus of this study is not so much on what is or is not legitimately definable as a question, but rather on describing, analysing and comparing patterns of NS and NNS questioning behaviour as a means for obtaining information. It is important in this study for the definition of the category called ‘questions’ to be as inclusive as possible to avoid the exclusion of any types of utterances which may ultimately prove to function as a means of soliciting information for one group or the other. The category ‘questions’ therefore follows Tuckett et al (1985) and includes all those forms of utterances which ‘do questioning’, or as ten Have (1991) puts it, any utterance which even though it may not create a conditional relevance for an answer in the next slot “displays what the patient wants to know” (1991:146).

One important exception to this in the present study is the phatic interrogative which appears in greetings such as how are you and how are you going and which is not intended to seek or convey information but rather has the social function of establishing or maintaining social contact (Richards et al 1992:272). These differ of course from the genuine medical inquiry by a doctor about the patient’s well-being and state of health, and the latter have been included in the analysis. A full description of the number and types of questions which emerged from the data is provided below.

7.2 Number of questions

In everyday interactions the type and number of turns available to each participant can vary freely and participant roles are not limited or pre-determined (Hutchby and
Wooffitt, 1998). Questions and answers are a common and important means of exchanging information, so in medical consultations questions play an important role for both doctor and patient in the necessary process of obtaining all relevant information. However, in CA terms, asking a question restricts and constrains the range of utterances possible for the next speaker and questions therefore act to allow the questioner a degree of interactional control.

Previous studies (Mayou et al, 1976, Boreham and Gibson, 1978, Wallen et al, 1979, West, 1983, 1984a, 1984b, Waitzkin, 1985, Frankel 1990) have emphasised the disparity between the number of doctor-initiated and patient-initiated questions and pointed out the relatively small number of patient-initiated questions in medical encounters. Frankel (1990) found that in the 3,517 utterances transcribed from ten medical interviews fewer than 1% of utterances produced by patients occurred in first position slots, in other words, were first pair parts in the adjacency pair ‘question-answer’. West (1983, 1984a) found that in 21 consultations only 9% of a total of 773 questions identified (excluding what she calls ‘quasi-question types as described in 7.1.1 above) were initiated by patients. Both Frankel and West argue that this amounts to a dispreference for patient-initiated questions in the medical consultation.

In her subsequent analysis of the same 21 consultations West (1984b) identified 251 quasi-questions, 138 (55%) of which were initiated by doctors and 45% (113) by patients. West argues that the dispreference for patient-initiated questions did not hold for these quasi-questions and that patients who “may hesitate to ask a direct question exhibit little (if any) reluctance to use interrogative forms for less intrusive purposes” (West 1984b:118), in other words, were less reluctant to clarify or confirm
earlier utterances. As discussed in section 7.1.1 above, this study has not made the
distinction between questions and quasi-questions for the purposes of identifying
questions asked by patients, however different types of questions serve different
purposes and achieve different outcomes and these differences are analysed and
discussed in Chapter 8.

Since the data in my study are based on a category of ‘question’ that combines the
two categories in West’s work, it is interesting to consider the results that would be
obtained from combining her two categories. The table below combines the figures
and shows the results that would have occurred if both types of questions were
considered together under the one heading of ‘questions’. The original set of
questions are labeled as ‘type 1’ and the quasi-questions as ‘type 2’ questions. Table
7-1 and subsequent comments are based on my own interpretation of West’s various
findings and do not appear in her own work.

Table 7-1: An interpretation of the data from West, 1983, 1984a, and 1984b

<table>
<thead>
<tr>
<th>Type</th>
<th>Total</th>
<th>Doctor</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>773</td>
<td>100%</td>
<td>705</td>
</tr>
<tr>
<td>Type 2</td>
<td>251</td>
<td>100%</td>
<td>138</td>
</tr>
<tr>
<td>total</td>
<td>1024</td>
<td>100%</td>
<td>843</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>91%</th>
<th>68</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>55%</td>
<td>113</td>
<td></td>
</tr>
<tr>
<td></td>
<td>82%</td>
<td>181</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9%</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A new analysis of West’s combined data shows that doctors asked 843 (82%) of all
questions while patients asked 181(18%). These figures can now be compared more
meaningfully with my own findings.

7.2.1 Questions in Dr. Maxwell’s consultations

Figure 7-1 below shows the total number of questions by all participants which
occurred in consultations with Dr. Maxwell and illustrates how those questions are
distributed between doctor and patient/parent. A similar pattern emerged from the analysis of the data from the second doctor, Dr. Colson. An analysis of the number of questions which occurred in her consultations is presented in Figure 7-2. Figure 7-3 provides a summary of the findings for both doctors.

**Figure 7-1: Count of all questions by speaker: Dr. Maxwell**

<table>
<thead>
<tr>
<th>Total no. of Questions</th>
<th>505</th>
</tr>
</thead>
<tbody>
<tr>
<td>doctor</td>
<td>446 (88%)</td>
</tr>
<tr>
<td>Patients/parents</td>
<td>59 (12%)</td>
</tr>
<tr>
<td>Not to doctor</td>
<td>27 (3%)</td>
</tr>
<tr>
<td>To doctor</td>
<td>32 (6%)</td>
</tr>
<tr>
<td>20 (NS)</td>
<td>20 (4%)</td>
</tr>
<tr>
<td>12 (NNS)</td>
<td>12 (2%)</td>
</tr>
</tbody>
</table>

There were a total of 505 questions in the 16 consultations with Dr. Maxwell. Of these, 446 (88%) were asked by the doctor, and 59 (12%) were asked by patients/parents. Although 12% of all questions were framed by patients/parents only 32 of those questions (6% of the total) were actually put to the doctor. As these patients are all children a parent was present throughout the consultation and 27 (5%) of patient/parent-initiated questions were part of the interactions between patients and their parents. These questions will not be included or considered in the following analysis, although they provide an interesting aspect of patient behaviour for future research.

---

11 Percentages in figures 7.1, 7.2 and 7.3 rounded up or down to nearest whole number
Thus there were 32 questions (6% of all questions) directed to the doctor by the eight NS and eight NNS patients/parents or parents in these consultations with Dr. Maxwell. Of these, NS patients/parents asked 20 (4% of all questions) and NNS patients/parents asked 12 (2% of all questions). NS patients/parents in other words asked 63% of those questions directed to the doctor, and NNS asked 37%.

7.2.2 Questions in Dr. Colson’s consultations

A similar pattern emerged from the analysis of the data from the second doctor, Dr. Colson. An analysis of the number of questions which occurred in her consultations is presented in Figure 7-2 below.

Figure 7-2: Number Of Questions: Dr. Colson

<table>
<thead>
<tr>
<th>Total no. of Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>485</td>
</tr>
<tr>
<td>doctor</td>
</tr>
<tr>
<td>361 (74%)</td>
</tr>
<tr>
<td>Patients/parents</td>
</tr>
<tr>
<td>124 (26%)</td>
</tr>
<tr>
<td>Not to doctor</td>
</tr>
<tr>
<td>54 (12%)</td>
</tr>
<tr>
<td>To doctor</td>
</tr>
<tr>
<td>70 (14%)</td>
</tr>
<tr>
<td>50 (NS) (10%)</td>
</tr>
<tr>
<td>20 (NNS) (4%)</td>
</tr>
</tbody>
</table>

There were a total of 485 questions in the 12 consultations (six NS and six NNS) with Dr. Colson. In this case however there was a smaller difference between doctor and patient/parent-initiated questions, with 361 (74%) of all questions being asked by the
doctor, and 124 (26%) asked by patients/parents. Of those 124 questions, 70 (14% of all questions) were directed to the doctor by the patient or parent. As with Dr. Maxwell, NS patients/parents asked more than twice as many questions as NNS patients/parents. NS patients/parents asked 50 (71%) and NNS patients/parents 20 (29%) of those questions which were directed to the doctor by either the patient or their parent.

7.2.3 Summary of questions in consultations with both doctors

In summary, there were a total of 990 questions found in the data-set of 28 consultations with both doctors. Of those 990 questions, 807 (82%) were initiated by the doctor, which is remarkably consistent with the combination of West's findings of 82% (see Table 7-1). A total of 183 (18%) of all questions were framed by patients/parents however only 102 (10%) of those questions were actually addressed to the doctor. As discussed in 7.2.1 above, the questions which occur between parents and children (81, or 8% for both doctors) are not included in any of the analyses in the rest of this study. When these questions are removed from the analysis we are left with a total of 909 questions from doctors and patients/parents, and the percentage of all questions which are asked by the doctors increases to 89%. Figure 7-3 below provides a summary of all questions for both doctors.
Although there are fewer questions overall in Dr. Colson consultations there are more than twice as many patient/parent-initiated questions than in those consultations with Dr. Maxwell. This is the case for both questions in patient-parent exchanges and questions directed to the doctor even though there were data from fewer consultations with Dr. Colson. Table 7-2 below contains a summary and comparison of the number of questions put to each doctor by NS and NNS parents.

Table 7-2:  Comparison of questions put by NS And NNS patients/parents to each doctor

<table>
<thead>
<tr>
<th>Doctor</th>
<th>No. of consults</th>
<th>NS questions</th>
<th>NNS questions</th>
<th>Total questions</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Maxwell</td>
<td>16</td>
<td>20</td>
<td>12</td>
<td>32</td>
<td>2</td>
</tr>
<tr>
<td>Dr. Colson</td>
<td>12</td>
<td>50</td>
<td>20</td>
<td>70</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>70</td>
<td>32</td>
<td>102</td>
<td>4</td>
</tr>
</tbody>
</table>

As can be seen from Table 7-2 above, NS patients/parents asked a total of 70 questions while NNS asked 32. Table 7-2 also shows that there were an average of 6 questions per consultation with Dr. Colson, and an average of only 2 questions per consultation with Dr. Maxwell. These findings indicate that there is a greater level of interaction occurring in Dr. Colson's consultations. There are a number of reasons
and possible explanations for this. As discussed in section 2.2.3.1, the literature indicates that female patients are more likely to ask questions of their doctor than male patients are (Wallen at al, 1979, Pendleton and Bochner, 1980, Waitzkin, 1985) and that patients generally are more likely to ask questions of a female doctor than a male doctor (Roter et al 1991). Each or all of these three factors (speaking background of patient, gender of patient and gender of doctor) has the potential to influence the number of questions a patient is able, or prepared, to ask their doctor in a medical consultation.

In these data, the patients are children and in most cases the questions are put to the doctor by the parent, not the child. There are only two examples of children asking questions: a male NS child and a female NS child, both with Dr. Maxwell. There is also one example of a female teenage child interpreting questions for her mother, also with Dr. Maxwell. The gender of the parent is therefore more relevant to this analysis and ‘parent’ will be used generally instead of ‘patient’ in analyses to indicate who is asking the questions.

Both male and female parents attended with their children in the consultations observed in these data. Table 7-3 below summarises the number of male and female parents in NS and NNS consultations for each doctor.

**Table 7-3: Gender of parents attending consultations: by doctor**

<table>
<thead>
<tr>
<th></th>
<th><strong>Dr. Maxwell</strong></th>
<th></th>
<th><strong>Dr. Colson</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male Parent</td>
<td>Female Parent</td>
<td>Both Parents</td>
</tr>
<tr>
<td>NS</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>NNS</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>8</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>
There were 2 consultations which were attended by both parents, one with each doctor. In Dr. Maxwell’s case this was a NS family and the patient was an infant. In the case of Dr. Colson it was a NNS family visiting with their two children who both had appointments with the doctor. There are too few examples of this aspect of the data to draw any conclusions. Of the remaining consultations, more mothers attended overall than fathers (16 mothers: 10 fathers). NS parents were overwhelmingly female, (11 mothers and 2 fathers), but the pattern is reversed with NNS parents (8 fathers and 5 mothers). Table 7-4 below summarises the variables of doctor gender, parent gender, and speaking background of the parent.

<table>
<thead>
<tr>
<th>Gender of doctor</th>
<th>Gender of parent</th>
<th>NS or NNS parent</th>
<th>Relationship: doctor-patient/parent</th>
<th>Total questions</th>
<th>Average questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Doctor</td>
<td>Male</td>
<td>NS (n=1)</td>
<td>male-male (NS)</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Parent</td>
<td>NNS (n=6)</td>
<td>male-male (NNS)</td>
<td>10</td>
<td>1.7</td>
</tr>
<tr>
<td>Female Doctor</td>
<td>Male</td>
<td>NS (n=6)</td>
<td>male-female (NS)</td>
<td>15</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>Parent</td>
<td>NNS (n=2)</td>
<td>male-female (NNS)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Female Doctor</td>
<td>Male</td>
<td>NS (n=1)</td>
<td>female-male (NS)</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Parent</td>
<td>NNS (n=2)</td>
<td>female-male (NNS)</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>NS (n=5)</td>
<td>female-female (NS)</td>
<td>38</td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td>Parent</td>
<td>NNS (n=3)</td>
<td>female-female (NNS)</td>
<td>14</td>
<td>4.7</td>
</tr>
</tbody>
</table>

As can be seen from Table 7-4 above the greatest number of patient/parent-initiated questions (12) occurred in the female doctor-male NS parent category, while the fewest (1) occurred in the male doctor-female NNS parent category. Overall, female patients/parents asked more questions than male patients/parents, however, a two-tailed Mann-Whitney test reveals that the gender of the patient/parent is not a statistically significant factor. Both male and female NS patients/parents asked more
questions than NNS patients/parents of either gender with male NS patients/parents asking four times as many questions as male NNS patients/parents.

As described in Chapter 3, a multivariate analysis of variables was also used to defeat the potentially confounding effect of multiple explanatory variables. This analysis revealed that after controlling for all other variables, the observed difference between the number of questions asked by NS parents and NNS parents is statistically significant ($p = 0.02$), with native speakers asking more questions than non-native speakers.

Table 7-4 shows that overall there are three times as many questions put to the female doctor as to the male doctor by both NS and NNS parents, highlighting the importance of doctor gender as a factor in patient questioning patterns. Again, after controlling for all other variables, the difference between the number of questions directed at each of the two doctors is a statistically significant factor ($p = 0.003$)

It is important to note however that with only one male and one female doctor these findings could be a result of personality and individual idiosyncrasies so it is not possible to generalise, but they do point to an interesting area of further research. However the critical point for this research is that the differences identified in the patterns of NS and NNS questioning behaviour is exactly the same with both doctors, that is, NS patients/parents asked two thirds of all questions directed to the doctors while NNS patients/parents asked only one third. This pattern of questioning remains the case even though there are both gender and discourse style differences between the two doctors. These findings add to the findings in the existing literature on questioning behaviour in medical consultations by identifying a clear and statistically
significant difference in the number of questions asked by NS and NNS patients/parents. Overall, NS patients/parents asked twice as many questions as NNS patients/parents. Seventy (69\%) of those questions addressed by patients/parents to the doctor were put by NS patients/parents, while only 32 questions (31\%) were put by NNS patients/parents.

The next step of the analysis examines the occurrence of questions used by each group in the six stages of the consultation to identify whether there are differences in the timing of questions by NS and NNS patients/parents.

7.3 The effect of patient/parent-initiated questions on the consultation

Before mapping the timing of patient/parent-initiated questions, it is important to determine the effect questions have on the consultation. The following comparison of two patients from Dr. Maxwell's data illustrates the effect questions can have on the structure of the medical interview. There is evidence in the literature (Boreham and Gibson, 1978, Ainsworth-Vaughn, 1998) that the number of questions asked by patients is affected by whether the consultation is an initial or follow-up visit. Both types of consultations appear in these data and a two tailed Mann Whitney test indicates that the average number of questions asked at follow-up visits in these data was 1.7 while the average number asked during initial visits was 0.4. This difference is significant ($p=0.04$). The two examples (11B and 31B) used for the comparison below were therefore taken from two follow-up visits, however the data has not been adjusted or adapted to allow for this difference in any other analyses (see 10.1).
Patient 11B and 31B are both native speakers who have attended the clinic for follow-up visits to check on the progress of their on-going treatment. The only difference between them is that 31B and his mother asked some questions. The effect of those questions is demonstrated in Figure 7-4 below.

**Figure 7-4: Effect of questions on the structure of the consultation**

<table>
<thead>
<tr>
<th>Name</th>
<th>11B</th>
<th>31B</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of questions</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>No. of turns</td>
<td>47</td>
<td>249</td>
</tr>
<tr>
<td>Duration of consultation</td>
<td><strong>3 mins 38 secs.</strong></td>
<td><strong>12 mins. 20 secs.</strong></td>
</tr>
</tbody>
</table>

In the case of 31B, the questions were asked in stages 2, 3, and 4. All three stages were significantly extended by the patient/parent initiated questions, and the structure of the consultation was altered, with the boundary between stages 2 and 3 being initially blurred, and then stage 2 having to be revisited after the physical examination.

It is clear from this simple comparison of two otherwise very similar situations that the occurrence of patient/parent-initiated questions has the potential to significantly deflect, extend and distort the pattern of the consultation. Findings in the literature discussed in section 5.1 could lead to the inference that it is in the interests of the institution to minimise such distortions in order to maintain control of its resources and meet institutional demands. To examine the patterns of questioning behaviour and to assess whether there is a difference between NS and NNS patients/parents in the timing of their questions, the occurrence of questions was tracked across the data set and mapped onto the consultation model (see 6.1.1 fig. 6.2).
Figure 7-5 below shows the distribution of questions in consultations with Dr. Maxwell over the 6 stages of the consultation. Two NS and 3 NNS patients/parents asked no questions at all, and the rest were distributed as shown.

**Figure 7-5: Map of questions occurring in consultations with Dr. Maxwell**

<table>
<thead>
<tr>
<th>Consult no.</th>
<th>NS (20 questions)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total quest</th>
<th>NNS (12 questions)</th>
<th></th>
<th></th>
<th></th>
<th>Total quest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19</td>
<td>26</td>
<td>27</td>
<td>31</td>
<td>32</td>
<td>41</td>
<td>14</td>
<td>15</td>
<td>20</td>
<td>28</td>
<td>33</td>
</tr>
<tr>
<td><strong>Stage 1</strong></td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Stage 2</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Stage 3</strong></td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Stage 4</strong></td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>8</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Stage 5</strong></td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Stage 6</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>20</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Most questions occurred in stage 4, the diagnosis/treatment stage for both NS (8) and NNS (11) patients/parents with this doctor. However, NS patients/parents asked more than half of their questions (55%) in the early stages of the consultation, in the opening and case review stages and even in the examination stage. No NNS questions occurred in these early stages. All NNS questions occurred in the later stages of diagnosis/treatment (11) and pre-closing (1).

Figure 7-6 below shows the distribution of questions in consultations with Dr. Colson over the 6 stages of the consultation. Unlike the situation with Dr. Maxwell, there are no cases in these data with Dr. Colson where a parent did not ask any questions.
Figure 7-6: Map of questions occurring in consultations with Dr. Colson

<table>
<thead>
<tr>
<th>consult no.</th>
<th>1</th>
<th>2</th>
<th>22</th>
<th>47</th>
<th>48</th>
<th>49</th>
<th>Total quest</th>
<th>4</th>
<th>25</th>
<th>40</th>
<th>50</th>
<th>51</th>
<th>52</th>
<th>Total quest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Stage 2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>10</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Stage 3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Stage 4</td>
<td>13</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>28</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Stage 5</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stage 6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>total</td>
<td>16</td>
<td>3</td>
<td>6</td>
<td>10</td>
<td>3</td>
<td>12</td>
<td>50</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>20</td>
</tr>
</tbody>
</table>

As with Dr. Maxwell, most questions again occurred in stage 4, the diagnosis/treatment stage from both NS (28) and NNS (18) patients/parents. NS patients/parents again asked a large number (21, or 42%) of their questions in the early stages of the consultation, in the opening and history taking/question-answer stages and in the examination stage. There was also one NS question which occurred in the pre-closing stage. Only two NNS questions occurred in the early stages of the consultation, both from the same parent. The majority of NNS questions occurred in the later stage of diagnosis/treatment and no NNS questions occurred in the pre-closing or closing stages of the consultations.

Figure 7-7 below summarises these findings about the timing of NS and NNS parents’ questions for both doctors.
Figure 7-7: Mapping the questions: Summary of both doctors

<table>
<thead>
<tr>
<th>Stages</th>
<th>NS</th>
<th></th>
<th>NNS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dr. Maxwell</td>
<td>Dr. Colson</td>
<td>total</td>
<td>Dr. Maxwell</td>
<td>Dr. Colson</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4%</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>10</td>
<td>17</td>
<td>24%</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>9</td>
<td>12</td>
<td>14%</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>28</td>
<td>36</td>
<td>52%</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3%</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>50</td>
<td>70</td>
<td>100</td>
<td>12</td>
</tr>
</tbody>
</table>

Overall, both NS and NNS patients/parents asked most of their questions in Stage 4, the diagnosis/discussion stage. NS also asked 45% of their question in the earlier stages, that is stages 1,2 and 3, while NNS asked only 6% of their questions in those stages. Both NNS and NS patients/parents asked 3% of their questions in the preclosing stage. The implications of these findings on the timing of questions will be discussed in Chapter 8 which examines how the doctors respond to questions in the various stages of the consultation.

7.4 Types of patient/parent-initiated questions

Having now demonstrated that NS patients/parents asked twice as many questions as NNS patients during their medical consultations, this next step of the analysis examines and describes the type of questions used by each group to identify whether there are differences in the ways in which NS patients/parents and NNS patients/parents frame their questions.

As noted above (7.1.1) West (1984b) differentiates between direct questions and quasi-questions and Frankel (1990) excludes what he calls ‘normal’ troubles but
neither have provided a taxonomy of question types found in their data. In order to compare the questioning behaviour of NS and NNS patients/parents however, it is essential to be very clear about how questions are framed and whether there is any difference in what functions as a type of questioning behaviour for each group. Four categories of question-types have emerged from these data: direct questions, indirect questions, tag questions and what I have referred to as inflected fragments. Each category is described, with examples from the data, below.

1) Direct questions:

Questions in this category are formed as interrogative sentence types. The category includes all polar questions such as *Um, does he need to have a script written?*, wh-questions like *when do they trouble you?* and alternative questions such as *would you like a stamp or a jelly snake for being a good boy.*

2) Indirect questions

Speech act theory analyses the way meaning is linguistically communicated. It grew out of the work of two philosophers, John L. Austin and John Searle. Austin’s basic argument was that language was used to *do* things and he identified three distinct acts that a speaker can perform at once in making an utterance: an act of saying something, (the locutionary force) an act of doing something (the illocutionary force) and an act of affecting someone (the perlocutionary force) (Austin, 1975:109). Searle (1979), building on Austin’s work, differentiated between direct and indirect speech acts. In a direct speech act the form and function, or the locutionary and illocutionary forces, match. For example the utterance *turn off the light* is an imperative used to give an order. An indirect speech act, on the other hand, is one in which the form and
function of the utterance do not match. *I wonder when the next train leaves* is a declarative form functioning as a question. The speaker is not simply telling the hearer what she is wondering, she is indirectly looking for an answer to the question *what time does the next train leave?* (Grundy, 2000). Indirect questions therefore can be defined as those utterances where the illocutionary force of questioning does not match the locutionary force, or propositional content of the utterance. Only one indirect question occurs in the data and it is presented by a NS parent: *look, I was wondering if he has his glasses off well I’m not sure if it’s worse but (0.5) the turn in his eye seems to be (0.5) perhaps a little more.*

3) **Tag questions**

Tag questions consist of a verb and a subject, in that order, usually following a declarative sentence, for instance *there’s nothing to worry about now, is there?*. A positive declarative generally takes a negative tag (*you’re well set up, aren’t you*) and a negative declarative is followed by a positive tag (*he won’t need surgery, will he?*). Tags can be uttered with a rising or falling intonation – rising is neutral, inviting the hearer to decide whether the proposition is true, while a falling intonation invites the hearer to agree with the proposition. Sometimes a tag question contains both a positive declarative and a positive tag – *you’re going, are you?* which points to a conclusion that the speaker has already drawn. (Greenbaum 1996:48).

4) **Inflected utterances.**

This category includes all other utterances which do the work of questioning although they are not interrogatives or even necessarily whole sentences. This includes declarative sentences, fragments and single words, usually made with a rising
intonation, to indicate a question. For example but you won’t need drops if that happens?

All questions and questioning behaviour in the data-set have been analysed and summarised by individual doctor and the findings are presented in the following sections.

7.4.1 Types Of Patient/Parent-Initiated Questions In Consultations: Dr. Maxwell

Table 7-5 below summarises the number of questions put to Dr. Maxwell by NS and NNS patients/parents in each of the four categories. Table 7-6 on page 248 summarises the same information from consultations with Dr. Colson.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>NS</th>
<th>NNS</th>
<th>TOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (n=15)</td>
<td>Direct questions</td>
<td>13</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>2 (n=1)</td>
<td>Indirect questions</td>
<td>1</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>3 (n=3)</td>
<td>Tag</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>4 (n=13)</td>
<td>Inflected fragments</td>
<td>4</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>20</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

There are several striking differences in the questioning behaviour of NS and NNS patients/parents with this doctor. NS patients/parents used all four types of questions but were much more likely to use direct questions (65%) than any other type of question. In contrast, NNS did not use any indirect questions and only 17% of their
questions were direct questions. 75% of questions used by NNS were framed as type 4, inflected fragments. These differences are discussed below.

7.4.1.1 Direct Questions

Of a total of 15 direct questions, 13 (87%) were asked by NS patients/parents, and two (13%) by NNS. The direct questions from NS were asked in various stages of the consultation with most (seven) occurring in stage 2 (case review), four occurring in stage 4 (diagnosis/discussion) one in stage 5 (pre-closing) and one in stage 1(opening). The two direct questions asked by NNS both occurred in Stage 4. This information is summarised in Figure 7-8 below.

Figure 7-8: Mapping of direct questions by NS and NNS patients/parents on the stages of consultations with Dr. Maxwell

<table>
<thead>
<tr>
<th>Stage</th>
<th>NS</th>
<th>NNS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>total</td>
<td>13</td>
<td>2</td>
<td>15</td>
</tr>
</tbody>
</table>

Direct questions used by NS were framed as ‘wh’ questions as in data fragment 7-2 and data fragment 7-3 below, and as polar questions as illustrated by data fragment 7-4.

**data fragment 7-2 (19B)**

(4.0)

→ 177 F When we rub her face where should we rub (.) [where
178 D [um (1.0) I’ll do it on you (.) it runs from here down into the nose ……

- 240 -
In this example the NS father uses a ‘wh’ question in turn 177 to elicit information about how to perform a therapeutic treatment on his child.

**data fragment 7-3 (41B)**

61 D Right (2.0) your vision seems good and we put some drops in to dilate the pupils

62 C How bad was the vision?

63 D You were about um a diopter a cylinder in the right eye whereas you were a couple of diopters of short-sightedness and a diopter a cylinder in your left

In this example the patient (a 16 year old NS child) again uses a direct question framed as a ‘wh’ at turn 62 to elicit additional information.

**data fragment 7-4 (26B)**

42 D Where’s my rebooking slip um (.) if you can ring up and say you need to see me in about a year

43 M Yeah

44 D I think they’ll probably [may have started next year

45 M [do I need to book in now? I have [to see

46 D [look (.)

In this example the NS mother uses a polar question in turn 45 to interrupt the doctor and seek additional information.

There are also examples of direct questions framed as alternative questions by NS parents, as in turn 106 in data fragment 7-5 below.

**data fragment 7-5 (19B)**

106 M is it a day surgery or is[ it

107 D [it’s come in in the morning, go home later that morning.
Only two direct questions were asked by NNS patients/parents and they occurred in the one consultation which was attended by the NNS patient, a young Turkish boy, his mother and an older sister. Most of the interaction took place between the doctor and the patient with the sister answering many of those questions directed by the doctor to the mother. The mother indicated by a number of minimal responses that she understood what was being said but when she needed to ask a question she spoke to her daughter in her L1 (Turkish) and the daughter then interpreted the question for the doctor, although she did not subsequently translate the doctor’s responses. The two questions, at turns 72 and 75 in data fragment 7-6 below, occurred in stage 4 (diagnosis/discussion) of the consultation.

**data fragment 7-6 (33B)**

70  D  So we’re going to see you again and we’re going to see if we can pick a pair of glasses that you see best with. Alright? And (.) ((turning to face M)) no questions? [okay

71  M  (((L1 to daughter))

→ 72  S  Yeah (.) yeah (.) she’s just asking um why (.) ‘cos you know how you said it wasn’t round (.) what causes it (.) for it to be [like that

73  D  [oh it’s just the shape of some people (.) some of us are round in our bodies (.) some of us are tall and thin and just like that the eyes can be (.) slightly different shapes in different people

74  M  (((L1 to daughter))

→ 75  S  Um (.) is it because of birth (0.5) or when he was born (.) or?

76  D  Probably not (.) no it’s often something that runs in the family but it can happen just out of the blue

77  S  Okay

As discussed in Chapter 3, consultations which relied on interpreters were specifically excluded from this study however this case has been included for several reasons. The mother seemed to be following the consultation and was able to answer questions from the doctor. She did not need anything else translated other than these two
specific questions and during my interview after the consultation she indicated that she should be interviewed, not the daughter. The two questions framed on behalf of the NNS parent by the (Australian born) sister in this consultation could arguably be regarded as reported speech rather than direct questions, and it would be very interesting to know how the mother herself framed what she wanted to know. However the questions did occur in a NNS consultation and they were put to the doctor as direct questions, so they have been coded as such.

7.4.1.2 Indirect and Tag questions

There was only a small number of both indirect and tag questions in the data. These are mapped in Figure 7-9 below.

**Figure 7-9:** Mapping of indirect and tag questions by NS And NNS patients/parents onto the stages of consultations With Dr. Maxwell

<table>
<thead>
<tr>
<th>Stage</th>
<th>NS</th>
<th>NNS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td><strong>3</strong></td>
<td><strong>1</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

Only one indirect question occurred and this was asked by a NS parent, in stage 3 of the consultation. (see data fragment 7-7 below):

**data fragment 7-7 (31B)**

\[83\] **M** Look (.) I was wondering if he has his glasses off (.) well I'm not sure if it's worse (.) but (0.5) the turn in his eye seems to be (0.5) perhaps a little more.

NS patients/parents also asked two (67%) of the three tag questions. (see turn 162 in data fragment 7-8 and turn 39 in data fragment 7-9 below).
data fragment 7-8 (31B)

D 160 The glass is as good as plastic
M 161 Right
(12.0)
→ M 162 It's a fairly strong glass (. is it? That they
D 163 (0.3) yeah you usually get hardened glass

Data fragment 7-9 below illustrates this doctor's efforts to engage with the child. He has a range of toys and gadgets, one of which is the rattle used in this case to make the baby open and move her eyes. His exclamations refer humorously to the amount of mucus in and around her eyes.

data fragment 7-9 (19B)

37 D Let me see you with my light (2.0) can you see my torch OOH what was that? ((rattles)) (3.0) terrific (. is) and inside her eyes look fine (4.0)
→ 39 F ( all these toys haven't you?
40 D I have everything at the ready (. is) and (. OOOH yuk yuk yuk so (. is) with the eyes after you've cleaned her

Both of these tag questions were asked in stage 3 (physical examination) of the consultation and both were asked after relatively long pauses (12 seconds and 4 seconds). In the first example the mother uses a tag question with both a positive declarative and a positive tag to confirm the conclusion that she has already drawn based on her understanding of the doctor's previous remark about glass being as good as plastic. In the second example the father uses a tag question to make a move that seems to be more social, or conversational, in nature and which does not seek any additional information.
In contrast, the only tag question by a NNS occurred in stage 5 (pre-closing) after the doctor had completed his pre-closing routine and after the father had earlier indicated that he had no questions. This question is at turn 106 in data fragment 7-10 below.

**data fragment 7-10 (14B)**

<table>
<thead>
<tr>
<th>Turn</th>
<th>Actor</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>D</td>
<td>That's alright. Do you have any questions dad?</td>
</tr>
<tr>
<td>102</td>
<td>F</td>
<td>No</td>
</tr>
<tr>
<td>103</td>
<td>D</td>
<td>Okay (.) we'll see you then (1.0) I'll send a new note to Dr. Lewis and let him know that everything is going really well</td>
</tr>
<tr>
<td>104</td>
<td>F</td>
<td>Alright</td>
</tr>
<tr>
<td>105</td>
<td>D</td>
<td>Alright? You hand that to Margaret (.) you can show her the Captain Feathersword stamp (.) okay?</td>
</tr>
<tr>
<td>→ 106</td>
<td>F</td>
<td>There's nothing to worry about now, is there?</td>
</tr>
</tbody>
</table>

This question seems to reveal the father's ongoing concern and need for reassurance but even though he is clearly concerned, he does not voice his need as a direct question even when invited to do so.

**7.4.1.3 Inflected fragments**

The pattern for inflected fragments reverses the trend for the other types of questions, with NS asking many fewer questions framed in this way. Of the total of thirteen inflected fragments, NS asked only four (30%), and NNS patients/parents asked nine, or 70%. It is also important to note that this type of question also represents 75% of all questions of all types asked by NNS patients/parents, while it only accounts for 20% of questions asked by NS patients/parents. This information is summarised in Figure 7-10 below.
Figure 7-10: Mapping of inflected fragments by NS and NNS patients/parents onto the stages of consultations with Dr. Maxwell

<table>
<thead>
<tr>
<th>Stage</th>
<th>NS</th>
<th>NNS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>total</td>
<td>4</td>
<td>9</td>
<td>13</td>
</tr>
</tbody>
</table>

It is interesting to note that all inflected fragments from both NS and NNS parents with this doctor occurred in stage 4, the diagnosis/treatment stage. This is the stage where the doctor pronounces his findings and, where appropriate, gives instructions for ongoing treatment. In data fragment 7-11 below, the NNS father uses an inflected fragment to confirm his understanding of the doctor’s suggestion of another visit:

**data fragment 7-11 (14B)**

49 D But I think it would be worthwhile checking him again (.) probably in another six to eight months time

→ 50 F Next year?

51 D yep

In data fragment 7-12 below, the NNS seems to have some difficulty following the doctor’s explanation and uses an inflected fragment at turn17 to clarify the doctor’s last statement.

**data fragment 7-12 (20B)**

16 D He will always be a little bit better in the left eye (.) hh the left eye is better than average

→ 17 F Um on everybody or just (.) you know how can we say (.) er left eye?
In this example the father uses *how can we say* as a communication strategy to show he is searching for the right words or expression to complete his utterance. Ellis (1985) points out that communication strategies are used by second language speakers when they are faced with a “production problem” (1985: 188) and need to compensate for a lack of means to achieve their communicative goal. Communicative strategies are useful to help keep the conversation going while the speaker tries to find the means to complete his turn. There are a number of L2 communication strategies, including word coinage, paraphrasing, restructuring an utterance, and the one used above: what Ellis calls a co-operative strategy where the speaker appeals to the hearer to provide the word he is looking for or to simply be patient while the speaker attempts to formulate his utterance.

Inflected fragments used by NS patients/parents are illustrated at turn 49 in data fragment 7-13 and turn 175 in data fragment 7-14 below.

**data fragment 7-13 (32B)**

→ 49  M  But you won’t need drops if that happens?
   50  D  Oh no
   51  M  nup

**data fragment 7-14 (31B)**

→ 175  M  Right, right okay (.) and the turn in his eye (.) isn’t worse than it was?
   176  D  Not enough to be concerned about
   177  M  right
As mentioned above, all inflected fragments used by both NS and NNS patients/parents with Dr. Maxwell occurred in stage 4 (diagnosis/discussion) of the consultations. This aspect of the data will be further discussed in the next chapter which looks at what various types of questions achieve for the questioner. The next section of this chapter analyses the types of questions identified in the data from consultations with Dr. Colson.

7.4.2 Types Of Patient/Parent-Initiated Questions In Consultations: Dr. Colson

The same general pattern of questioning found in consultations with Dr. Maxwell is also found in data from Dr. Colson. Those questions types are summarised in Table 7-6 below.

Table 7-6: Summary of question types used by NS and NNS: Dr. Colson

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>NS</th>
<th>NNS</th>
<th>TOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (n=33)</td>
<td>Direct questions</td>
<td>26</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>2 (n=0)</td>
<td>Indirect questions</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 (n=7)</td>
<td>Tag</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>4 (n=30)</td>
<td>Inflected fragments</td>
<td>18</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>20</td>
<td>70</td>
</tr>
</tbody>
</table>

There were considerably more questions by both NS and NNS patients/parents in these consultations than in consultations with Dr. Maxwell, but as with Dr. Maxwell, NS parents asked significantly more questions that NNS parents did. Once again, NS parents were much more likely to use direct questions (52% of their questions) than any other type of question. There were no examples of indirect questions by either NS or NNS parents in these data from consultations with Dr. Colson, and of the seven tag questions, six were asked by NS and one by NNS patients/parents. More than half
(60%) of questions used by NNS were framed as type 4, inflected fragments, while NS used this structure for only 36% of their questions. These differences are discussed below.

7.4.2.1 Direct Questions

There were 33 direct questions, more than twice as many as occurred in Dr. Maxwell’s data, with NS patients/parents asking 26, or 79% and NNS patients/parents asking seven, or 21% of all direct questions. As with Dr. Maxwell, NS patients/parents produced one direct question in stage 1 (opening) of the consultation, and one in stage 5 (pre-closing), but unlike Dr. Maxwell, most of the direct questions, (13) from NS patients/parents in these data occurred in stage 4 (diagnosis/discussion), five questions occurred in stage 2 and six questions occurred in stage 3. Of the seven direct questions asked by NNS patients/parents, the majority (six) were asked in stage 4, as was the case with NS patients/parents, and one was asked in stage 2 of the consultations. This information is summarised in Figure 7-11 below.

**Figure 7-11: Mapping of direct questions by NS and NNS Patients/parents on the stages of the consultation with Dr. Colson**

<table>
<thead>
<tr>
<th>Stage</th>
<th>NS</th>
<th>NNS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>13</td>
<td>6</td>
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<td>5</td>
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<td>1</td>
</tr>
<tr>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>total</td>
<td>26</td>
<td>7</td>
<td>33</td>
</tr>
</tbody>
</table>

The examples at data fragment 7-15 and data fragment 7-16 below illustrate the questions framed as direct questions by NS patients/parents in stage 4 of their consultations:
data fragment 7-15: (1B)

→ 169  M  Right so what do I (0.5) where do I put the drops (.) I put them in the right eye do I to make that blurry?
170  D  That’s (.) that’s correct
→ 171  M  Is that what I do?
172  D  yep

At turn 169 the mother begins with a ‘wh’ question, what do I (0.5), then reformulates as another ‘wh’ question where do I put the drops to ask the doctor for more specific instructions about the treatment she has to carry out on her daughter. At turn 171 she follows up with a polar question to confirm that she has understood the instructions.

In data fragment 7-16 below the NS mother begins her turn as a declarative but reformulates her utterance as a direct question.

data fragment 7-16: (22B)

201  D  That’s a good situation [ swapping
→ 202  M  [and then I should (.) and then should I leave it?
203  D  Yes (.) you can do nothing

The example in data fragment 7-17 below is a NNS mother framing a direct question as a ‘wh’ question to obtain additional information.

data fragment 7-17: (4B)

→ 129  M  when
130  D  Yes?
→ 131  M  will the effects of the drops stop?
132  D  Hmm hmmm the (.) when will the effect? Umm (.) usually a few hours (.) [it starts to wear off
The interaction at data fragment 7-18 below is also an example of a NNS mother asking a direct question, also framed as a ‘wh’ question (turn 59) but it is interesting to note that before asking the question the mother asks permission (turn 55) to ask the question. There were no examples of this in NS consultations with either doctor.

**data fragment 7-18: 50B**

55  M  Can I ask you something?
56  D  Mmm
57  (3.0)
58  D  Go on
59  M  Er, um if he has patching until he is seven, and if after seven say he doesn’t improve anything, what is the next step we do?
60  D  Um, we think if we can get the vision up and equal to the other eye (. ) wh while he’s seven or if you can get up beforehand and keep it with maintenance patching, that is a bit of patching each week, not so much as treatment, then we think if you’ve got good vision when the vision gels, about the age of seven then you’ll keep it even when we stop the treatment. So the, the, um, what we’re trying to do is (. ) get his vision up in the other eye, keep it up that way until he turns seven, and that’s when the vision gels and usually whatever vision you’ve got at that age then you keep [for ever=}

7.4.2.2 Indirect and tag questions

There were no indirect questions with either NS or NNS patients/parents with this doctor. There were a total of seven tag questions, six of which were asked by NS patients/parents and one by a NNS patient/parent. The NNS tag question occurred in stage 4, while four NS tag questions occurred in stage 4 and one each in stages 1 and 3. Figure 7-12 below summarises this information.
Figure 7-12: Mapping of indirect and tag questions by NS and NNS patients/parents on the stages of the consultation with Dr. Colson

<table>
<thead>
<tr>
<th>Stage</th>
<th>NS</th>
<th>NNS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>0</td>
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<td>4</td>
<td>4</td>
<td>1</td>
<td>5</td>
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</tr>
<tr>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>total</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

The NS tag question in stage 1 (data fragment 7-19 below) is similar to the example in Dr. Maxwell’s data and seems to serve a purely social purpose rather than being an attempt to obtain information:

**data fragment 7-19: (22B)**

1. D  how are you?
2. M  Good thanks [God, you’re flat out aren’t you=  
3. D  [good  
4. M  = [just for a change ((laughs))  
5. D  [yes, um ((closes door)) now

The tag questions which occurred in stage 4 are illustrated below in data fragment 7-20 which is with a NS parent, and data fragment 7-21 with a NNS parent.

**data fragment 7-20: (47B)**

263 M  it doesn’t, like, clear it, it just (. ) it er (. ) alleviates it doesn’t it?  
264 D  yes, okay so when she’s having the Demazin her eye does seem to be a little less wet?

**data fragment 7-21: (51B)**

52 M  that’s with (. ) with the (. ) coming with the arthritis, isn’t it? around that time?  
53 D  yep, that’s right.
Unlike the examples in Dr. Maxwell’s data where the tag questions occurred after long pauses, both of these examples occurred after the doctor had asked a question about earlier occurrences of symptoms and both the doctor and the mother became involved in a lengthy process of working out and negotiating dates and time-frames to arrive at the correct answer. Most of the tag questions by both NS and NNS patients/parents in stage 4 of Dr. Colson’s consultations are similar, occurring during lengthy exchanges about earlier treatment or symptoms, or prolonged explanations about future treatment.

7.4.2.3 Inflected fragments

Unlike the findings from Dr. Maxwell’s data, the trend for NS parents to ask a greater percentage of the questions in a given category is not reversed in the category of inflected fragments with Dr. Colson. In the case of this doctor, NS patients/parents asked 18 (60%) of the questions framed as inflected fragments, with NNS asking 12 (40%). Both NS and NNS asked the majority of their inflected fragment question in stage 4 of their consultations, (NS:11 and NNS:10) with the rest of NS fragments occurring in stages 2 (five questions) and 3 (two questions). The rest of the inflected fragments from NNS patients/parents occurred in stages 2 (one question) and 5 (one question). This information is summarised in Figure 7-13 below.

Figure 7-13: Mapping of inflected fragments by NS and NNS patients/parents on the stages of the consultation with Dr. Colson

<table>
<thead>
<tr>
<th>Stage</th>
<th>NS</th>
<th>NNS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>5</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>total</td>
<td>18</td>
<td>12</td>
<td>30</td>
</tr>
</tbody>
</table>
The examples at data fragment 7-22 and data fragment 7-23 below illustrate the inflected fragments from NS parents.

**data fragment 7-22: (2B)**

222 D okay.
→ 223 M so it's got all of that in there?
224 D It's got (.) um I've got some information about how to patch, about the alternatives, about eye protection which probably applies to you (.) too
225 M yeah

**data fragment 7-23: (48B)**

186 D alright? [okay
187 M [okay. that's it
188 D good! okay
→ 189 M and they'll stay dilated for the [rest of the day?
190 D [yes, usually for a few hours
191 M okay

Inflected fragments used by NNS in stage 4 are illustrated by data fragment 7-24 and data fragment 7-25 below.

**data fragment 7-24: (40B)**

37 D okay? u:mm (.) now I think (.) um (6.0) two per day
→ 38 F two?
39 D two drops per day

**data fragment 7-25: (40B)**

20 D when was the last time she had the drops?
→ 21 F sorry?
22 D did she have some drops today?
Although the examples above are all inflected fragments it is interesting to note the difference in the amount of new information they elicit from the doctor. Fragments at data fragment 7-22 and data fragment 7-23 from NS parents both result in additional information being provided, while data fragment 7-24 and data fragment 7-25 from NNS parents function as requests for clarification and simply result in the same information being restated. The aim, or purpose of the questions put to the doctor by NS and NNS patients/parents is examined in detail in the next chapter.

7.4.3 Summary of question types by NS and NNS patients/parents: both doctors.

Although there are considerably more questions in the data from consultations with Dr. Colson than from those with Dr. Maxwell, it is clear that the pattern of questioning is very similar for both. Table 7-7 below summarises the findings on question types derived from consultations with both doctors.

### Table 7-7: Summary of all question types by NS and NNS for both doctors

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>NS</th>
<th>NNS</th>
<th>TOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Direct questions</td>
<td>39</td>
<td>56%</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>Indirect questions</td>
<td>1</td>
<td>1.5%</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Tag questions</td>
<td>8</td>
<td>11.5%</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Inflected fragments</td>
<td>22</td>
<td>31%</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>70</strong></td>
<td><strong>100%</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

NS patients/parents asked a total of 70 questions. There were a small number of indirect questions (1) and tag questions (8) but most NS questions (56%) were framed as direct questions, while 31% (22) were framed as inflected fragments. NNS patients/parents, in contrast, asked a total of 32 questions. There were no indirect
questions and only two tag questions from NNS patients/parents in these data. In an almost exact reversal of the pattern for NS patients/parents, most of the questions (66%) asked by NNS patients/parents were inflected fragments, while only 28% of NNS questions were framed as direct questions.

Table 7-7 above shows each question type as a percentage of the speaker’s total questions. An even more revealing way of looking at these data is to examine each question type and compare the figures from NS and NNS consultations. Table 7-8 below presents the data in this form.

Table 7-8: Comparison of question types by NS and NNS in all consultations.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>TOT</th>
<th>NS</th>
<th>NNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Direct questions</td>
<td>48</td>
<td>39</td>
<td>81%</td>
</tr>
<tr>
<td>2</td>
<td>Indirect questions</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>3</td>
<td>Tag questions</td>
<td>10</td>
<td>8</td>
<td>80%</td>
</tr>
<tr>
<td>4</td>
<td>Inflected fragments</td>
<td>43</td>
<td>22</td>
<td>51%</td>
</tr>
</tbody>
</table>

NS patients/parents asked most questions in all categories. The greatest difference was in the category of direct questions. Of a total of 48 direct questions NS patients/parents asked 39 (81%) and NNS patients nine (19%). A two tailed Mann-Whitney test reveals that this difference is significant ($p=0.03$). NS also asked more indirect and tag questions, although the numbers in both these categories are small.

The graph at Figure 7-14 below illustrates the differences in the patterns of question use by NS and NNS patients/parents.
Figure 7-14: Comparison of question types by speaker: all consultations

This finding clearly identifies a significant difference in the type of questions asked by NS and NNS patients/parents.

7.5 Summary of chapter

The findings presented in this chapter reveal considerable differences in the questioning behaviour of NS and NNS patients/parents. NS patients/parents ask more questions overall than NNS patients/parents and tend to ask their questions throughout the course of the consultation, whereas NNS rarely ask questions in the early stages of the consultation. NS ask considerably more direct questions than NNS while 66% of questions asked by NNS are framed as inflected fragments.

In the next chapter differences in the purpose, or function, of the questions asked by NS and NNS patients/parents are examined. There has already been some indication that this may result in a difference in the amount of information elicited by NS and NNS patients/parents (see 7.4.2.3 above), so the next chapter will also examine the success or otherwise of the various types of questions identified in this chapter in achieving their purpose.
CHAPTER 8  Aims and functions of patient/parent-initiated questions

A very important aspect of the speech act of questioning is the questioner's purpose, or aim when asking a question. As discussed in 7.1, questions can be used in interactions for a number of purposes, for example to elicit new information, to request confirmation or clarification of a previous utterance, to establish control of the interaction or just to make social contact. This chapter is based on the textual evidence of the data and focuses on what it is that patients are trying to achieve when they ask their doctor a question, whether there any differences in the goals and outcomes of questions posed by NS and NNS patients/parents and how successful questions are in terms of eliciting answers. As with other analyses, data from each doctor are examined separately, then an overall analysis is presented.

8.1  Function of questions: Dr. Maxwell

The analysis of questions directed to Dr. Maxwell revealed attempts by patients/parents to achieve one of three main interactional goals: to introduce a new topic into the interaction, to seek additional information from the doctor on an existing topic, or to seek clarification of, or confirmation of their understanding of, a previous utterance. Each of these goals is illustrated in the three examples below:

data fragment 8-1: (31B) introduce a new topic

142  D  and because your vision’s on the borderline anyway, you (.) you wouldn’t want to risk losing [that little bit
143  M  [no, no
145  D  so that’s one of the issues
CHAPTER 8 - Aims and functions of patient/parent-initiated questions

146  M  [right
147  D  [you have to go through with that
→  147  M  When it comes time to (.) to (.) for driving for him (.) is he going to get a licence?

In this example the subject of a driving licence had not previously been raised or discussed. The doctor's reference to the child's borderline vision (turn 142) seems to have triggered the thought for the NS mother who then framed her inquiry as a direct question.

data fragment 8-2: (19B) additional information on an existing topic

101  D  do you have health insurance?
102  M  no
103  D  okay so if you wanted to pay for it to be done privately it would be in the order of seven or eight hundred dollars (.) um (.) Medicare covers a little bit of the doctors and a bit of the anesthetist's fees but none of the hospital?
104  M  hmm hmm
105  D  um some people would prefer [to pay
→  106  M  [Is it a day surgery procedure [or is it

In data fragment 8-2 the doctor and mother have already been discussing surgery for the child for some time when the doctor moves on to the issue of cost. However the NS mother wants more information about the surgery not previously provided by the doctor and interrupts him with a direct question to elicit the additional information.

data fragment 8-3: (28B) Clarification of a previous utterance

24  D  I'm very pleased. .hh so that's really good news. Now, (.) I think we need to keep wearing the patch a little bit longer, (0.5) so:O, would you be happy to wear the sticky on your lens again? would that be alright? (.) so if you go back to just the sticky patch on the lens and not the patch on his eye, (.) okay? (17.0) And what if we do that for half of the time, so mm, if he has that on
for two days, and then off for two days, or on for one day and off
for one day,

25  F  You mean er only on the glasses (.) not this with the other patch
on?

In the example at data fragment 8-3 the doctor gives quite complicated directions for
future treatment. The NNS parent is not clear about what he has to do and uses an
inflected fragment to frame his request to the doctor for clarification.

As we have seen (7.4.1.2), there is also one example in the data of a question which
seems to serve a purely conversational goal, as shown in data fragment 8-4 below.

data fragment 8-4: (19B) social interaction

35  D  ((whispering)) let me see you with my light (.) can you see my
torch? OOOOH hey what was that? ((D rattles toy)) (3.0)
TERRIFIC and inside her eyes looks fine
((4.0))

→ 36  F  (     ) all these toys, haven’t you?

37  D  I have everything at the ready and o::oh yuk (.) yuk yuk yuk so
with the eyes after you’ve cleaned her (.)

The tag question in this case does not seek information but rather seems to express the
NS father’s need to break the lengthening pause. The doctor responds briefly to the
tag question in a similarly casual conversational manner and then moves straight into
a discussion about treatment.

Table 8-1 below summarises the interactional goals of the questions occurring in Dr.
Maxwell’s consultations.
Table 8-1: Function of patient/parent-initiated questions in consultations: Dr. Maxwell

<table>
<thead>
<tr>
<th></th>
<th>New Topic</th>
<th>Additional Information</th>
<th>Clarification</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NS</td>
<td>NNS</td>
<td>NS</td>
<td>NNS</td>
</tr>
<tr>
<td>Direct (n=15)</td>
<td>6</td>
<td>0</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Indirect (n=1)</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tag (n=3)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fragments (n=13)</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total (32)</td>
<td>8</td>
<td>0</td>
<td>9</td>
<td>4</td>
</tr>
</tbody>
</table>

It is clear from these figures that NS and NNS parents used different types of questions to achieve quite different interactional goals with this doctor. The most striking finding is that no NNS parent used a question of any type to introduce a new topic or place new information on the floor. NS parents on the other hand used eight (40% of their total questions) to introduce new topics. In contrast to NS parents, NNS parents overwhelmingly used questions to seek clarification of previous utterances made by the doctor and they did this primarily with type 4 (inflected fragment) utterances (8 questions, or 67% of their total questions). Each of these categories of questions is discussed below.

8.1.1 Introducing a new topic

NS parents used eight questions, six direct questions, one indirect question and one inflected fragment, to introduce a new topic. For example, in the consultation from which data fragment 8-5 below is taken, (see data fragment 6.63 for a longer transcription of this consultation) there had been a very long negotiation between the doctor and the mother about whether or not the patient, who is an infant, would be
admitted to hospital. The doctor’s initial decision was to review the child if the condition worsened, but the mother appeared determined to have a more immediate resolution. Having eventually succeeded in getting the doctor to agree to surgery, she asks the following direct question, introducing the new topic of the doctor’s feelings:

**data fragment 8-5: (19B)**

→ 166 M So are you happy for it to go like this? You (. ) you
167 D Yeah (. ) yeah
168 M I don’t want you to think I was (. ) rushing you or anything

Another example of direct questions being used to introduce a new topic comes from Dr. Maxwell’s consultation with Dean. In this example, Dean uses several direct questions to introduce some quite large topics into the discussion. The following example occurs in stage 2 of the consultation:

**data fragment 8-6: (31B)**

D most boys tend to faint when you put anything near their eyes.
M ((laughs)) yes, I think we might wait a little while then, ((laughs)) will he get (. ) better vision if he (. ) uses contacts?
D possibly.
M right.
D sometimes yes, sometimes no,
M right.
D umm, it would vary, (.2) but we’d need to wait and [see
103 C [Excuse me, how old do you have to be before you can have that laser thing so you don’t need glasses or contacts and can see normally?
104 D Er at the moment we really need people to be over 18 and they can decide for themselves. Alright?
→ 105 C Er you just said they can decide for themselves, can you have it when you are younger and your parents decide?

This discussion continues for another 50 turns, and is followed up with a new discussion about whether the child will be able to obtain a driver’s licence when the
time comes (see data fragment 8-1 above), also introduced by a parent-initiated direct question.

In every case where a direct question was used by a patient/parent to introduce a new topic the question was responded to by Dr. Maxwell in the next turn. In some cases, the response was relatively brief, as in data fragment 8-7 below, but in others the response was more extensive, as in data fragment 8-8 below.

**data fragment 8-7: (31B)**

147   M   When it comes time to (.) to (.) for driving for him (.) is he going to get a licence?
→ 148 D   hmm hmm
149   M   Right
150   D   Yeah, but you are a fraction less than average but not (0.2) below a licence level (that would be one of the issues [of
151   M   [mmm
152   D   You know, dropping a line of vision, how could that affect me, well it might take him below [that standard
153   M   [yes, yes

In this case, the mother then takes this discussion onto another topic with a comment about her optometrist. In data fragment 8-8 below the direct question at turn 166 leads initially to a brief response from Dr. Maxwell (*yeah, yeah*) but the mother pursues the issue and finally elicits a lengthy and detailed response.

**data fragment 8-8: (19B)**

→ 166 M   So are you happy for it to go like this? You (.) you
167   D   Yeah (.) yeah
168   M   I don’t want you to think I was (.) rushing you or anything
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>169</td>
<td>D</td>
<td>No, well the thing about it is that (.) it's best to wait, you're going to wait, if you said you've got private insurance and you want it done tomorrow, I'd sort of go, (.) that's a bit rushed ((laughs))</td>
</tr>
<tr>
<td>170</td>
<td>M</td>
<td>Right.</td>
</tr>
<tr>
<td>171</td>
<td>D</td>
<td>but you know if we're looking at a baby eight nine months old, that's fine, and the thing, we used to do them routinely at six months, and then we did this big audit and worked out that three quarters of them got better anyway, so, (.) why not just wait, but, (.) you might have a bad relationship with her later in life because she grizzled every time you washed her face five times a day for three months, and so if you were sick of doing that, um we'd be happy to do it earlier.</td>
</tr>
<tr>
<td>172</td>
<td>M</td>
<td>fine, that's fine.</td>
</tr>
<tr>
<td>173</td>
<td>D</td>
<td>so it's not something that I'm very fussed about, but =</td>
</tr>
<tr>
<td>174</td>
<td>M</td>
<td>okay</td>
</tr>
<tr>
<td>175</td>
<td>D</td>
<td>= um you know, it's going to be a couple of months before, anyway, so that's quite appropriate. (4.0)</td>
</tr>
</tbody>
</table>

As mentioned in section 7.4 there is only one example of an indirect question in the complete data set and this is used by a NS parent in an attempt to raise a concern about the turn in her son's eye (data fragment 8-9 below):

data fragment 8-9: (31B)

→ 83 | M  | look, I was wondering if he has his glasses off well I'm not sure if it's worse but (0.5) the turn in his eye seems to be (0.5) perhaps a little more. |
| 84 | D  | Your old glasses aren't too bad power respect, can you slip your glasses off for me? (6.0) no other troubles at school with your eyes? |
| 85 | C  | er no, no troubles at school |

This question (turn 83) was completely overlooked by the doctor, however, nearly 100 turns later the mother tried again, using a different type of question (an inflected fragment) and this time receiving a satisfactory response: (data fragment 8-10).
CHAPTER 8 - Aims and functions of patient/parent-initiated questions

data fragment 8-10: (31B)

→ 175  M  Right, right, okay, and the turn in his eye isn’t worse than it was?
176  D  Not enough to be concerned about.

Where a direct question is used by a NS to introduce a new topic it is responded to in every case by Dr. Maxwell. The only example of an indirect question was ignored by the doctor and not answered, but the mother tried again and the topic was later introduced by an inflected fragment, this time successfully eliciting the information the parent was seeking.

8.1.2  Seeking additional information on an existing topic

Direct questions were used by both NS (7) and NNS (2) to elicit additional information on existing topics and were answered by the doctor on every occasion. The example at data fragment 8-11 below is typical of the exchanges of this nature between Dr. Maxwell and NS patients or parents.

data fragment 8-11: (41B)

60  D  Right (2.0) your vision seems good and we put some drops in to dilate the pupils ( )
→ 61  C  How bad was the vision?
62  D  You were about um a diopter a cylinder in the right eye whereas you were a couple of dioptrers of short sightedness a cylinder in your left eye. Just turn the lights (0.3) off,

This example is also atypical of the data in that it is one of only two cases where a question is asked by the child and not by the parent. This example is taken from a
consultation with Emma who is a 16 years old NS, and is in fact the only child in the entire data set to attend without the support of a parent or guardian. She has been having treatment for many years and is very familiar with her condition and its effects. Her familiarity with her condition is illustrated by the extremely technical nature of the doctor’s response which is in itself unusual and does not happen in any other consultation.

In data fragment 8-11, the question is answered immediately and fully. This is also the case with the two direct questions asked in a NNS consultation. Both are illustrated in data fragment 8-12 below.

data fragment 8-12: (33B)

70  D  okay, I’ll send a copy to them. (3.0) Alright? so three weeks time, do you have any questions? So we’re going to see you again and we’re going to see if we can pick a pair of glasses that you see best with. Alright? And, no questions? ((to M)) [okay

71  M  [speaks to daughter in L1

72  S  yeah, yeah she’s just asking, um, why, ‘cos you know how you said it wasn’t round, what causes it, for it to be [like that?

73  D  [oh, it’s just the shape of some people, some of us are round in our bodies, some of us are tall and thin, and just like that the eyes can be (. ) slightly different shapes in different people.

74  M  ((speaks to S in L1))

75  S  um, is it because of birth, or when he was born, or?

76  D  probably not, no. (1.0) it’s often something that runs in families, but it can happen just out of the blue.

77  S  okay.

(3.0)
In every case of a direct question being used to seek additional information on an existing topic by both NS and NNS patients/parents, the question was answered in the next turn.

There were two examples of tag questions being used to seek additional information on an existing topic, one in a NS and one in a NNS consultation. In each case the question elicited an immediate answer with which the parent seemed to be satisfied. The NS tag question is presented at data fragment 8-13 and the NNS example at data fragment 8-14 below.

**data fragment 8-13: (31B)**

160  D  The glass is as good as plastic
161  M  right
162  (12.0)  
→  163  M  It's a fairly strong glass, is it? That they use
164  D  (3.0) yeah, you usually get hardened glass
165  M  Right
166  D  I think that we might be able to let you go for another eighteen months (.) how would that be?

In this example the mother uses a tag question with both a positive declarative and a positive tag to confirm the conclusion that she has already drawn. The doctor dealt with the question succinctly, confirming her statement, then moved straight on to the next stage of the consultation.

The tag question in data fragment 8-14 below creates a response on different levels. The doctor provides an immediate answer which addresses the propositional content of the question then goes on in a way that recognises and addresses the illocutionary force of the question by providing the reassurance that the father is seeking.
data fragment 8-14: (14B)

105 D alright? You hand that to Margaret, you can show her the Captain Feathersword stamp. (. ) Okay?

→ 106 F there’s nothing to worry about now, is there?

107 D no, and the older he gets, the less likely there is to be any problem. When he was very little we had to watch him very closely, now that he’s older we have to check him less often, cos the chances of the vision dropping, decrease the older he gets. [Alright

[5 turns omitted]

113 D alright? So you’re going well, you’re controlling it all by yourself,

114 F alright. (0.5) Say goodbye to Mr. Maxwell, Dr. Maxwell.

There are two examples of inflected fragments being used to ask for additional information on an existing topic. One was by a NS (data fragment 8-15 below) and one was by NNS parent (data fragment 8-16).

data fragment 8-15: (32B)

46 D You’ll find even though it’s quietened down now if anything irritates her eyes, for instance if you went swimming in the pool and got chlorine in them the area where we operated would get reddest first

→ 47 M But you won’t need drops if that happens?

48 D Oh no

49 M nup

As with the tag question asked by a NS parent, this inflected fragment from a NS required additional information from the doctor to confirm the mother’s understanding of the situation and needed only the brief answer it received. The example in data fragment 8-16 below however revealed that the NNS parent was concerned about the future and the doctor attempted to give him the information he needed.

data fragment 8-16: (20B)

12 D Okay, so I think it’s very unlikely that the vision will drop down any
more and so we’re probably not going to have to have him wear a patch ever again

→ 13  F  You think how he grow up
14  D  Yep
→ 15  F  It will er (.) it will improve or?
16  D  It will stay about the same, he will always be a little bit better in the left eye, .hh the left eye is better than average

However, the parent in this example became confused by the doctor’s answer and needed to use a series of inflected fragments to seek clarification (turns 17 and 25 in data fragment 8-17 below).

**data fragment 8-17:(20B)**

→ 17  F  um, on everybody, or just, (.) how, how we can say, er left eye?
18  D  okay, this left eye
19  F  yes
20  D  sees better (.) than the average person’s left eye, (0.5) okay? His right eye (.) is (.) average (0.5) [for his age
21  F  [average
22  D  okay? So when you look at a chart, (4.0) okay, if you were sitting (.) where he is looking [at that chart
23  F  [yeah
24  D  that’s what most people can see, alright? And he’s seeing that. Most people have a bit of trouble reading those two lines, and he’s able to see that line with his better eye. He can’t read that line but most people can’t, (.) alright? So, he’s got one very good eye, and an excellent eye.
→ 25  F  um, for example, people will be always will be, you know, one stronger, one weak eyes, =
26  D  = most people are equal in both their eyes.
27  F  most are equal
28  D  yeah, and what we’ve done with him when he was younger there was a bigger difference =
29  F  Yeah
30  D  = between the two eyes?
31  F  Yes there was
32  D  so we’ve patched him and got him almost the same, but not quite, (.)
but both eyes are very good, so we don’t need to worry about that. If he was little we would need to keep watching him very closely, (1.0) but at the age of seven he’s finished that stage where his brain is learning how to see, (1.0) he won’t forget how to see, whereas when he was two or three years of age, his brain could forget, and the vision could drop. But now it will stay good for the rest of his life. (0.5) Okay? So, I’ll just have one look with this and just check that everything else is in order, (11.0)

In this example the NNS parent’s questions led to a full explanation of how and why the child’s condition had been addressed.

8.1.3 Clarification of previous utterances

As illustrated in data fragment 8-17 above, NNS used inflected fragments as their primary means of obtaining additional information and clarification. NNS parents used four times as many questions as NS parents did to seek clarification of previous utterances made by the doctor and they did this exclusively with type 4 (inflected fragment) utterances. Both NS and NNS fragments were answered immediately by the doctor. For example, in data fragment 8-18 below the NS mother seeks clarification of what the doctor means by different:

data fragment 8-18: (26B)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>D</td>
<td>So your vision today is excellent and all your other tests look pretty good you’re colour vision’s a little bit different</td>
</tr>
<tr>
<td>2</td>
<td>C</td>
<td>yeah</td>
</tr>
<tr>
<td></td>
<td></td>
<td>((4 turns omitted))</td>
</tr>
<tr>
<td>→</td>
<td>7</td>
<td>M</td>
</tr>
<tr>
<td>8</td>
<td>D</td>
<td>Well, it’s variant of normal which it was last time</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>Oh, right</td>
</tr>
</tbody>
</table>

All questions framed as inflected fragments by NNS parents were also answered immediately by this doctor, as illustrated in data fragment 8-19 below.
data fragment 8-19:(15B)

36 D I think I might get you to wear the sticky patch all the time? For the next few weeks? could you do that? (2.0) so we’ll get him to wear that, put it on and leave it on ALL the time.

→ 37 F The patches?

38 D The sticky contact, the sticky back, I’ll write that down for you.

39 (2.0)

→ 40 F Every day?

41 D Every day. (2.0) So wear the glasses (1.0) all the time.

This fragment includes two of the 12 questions put to this doctor by NNS patients/parents. As can be seen from this example, even when they do ask questions, NNS patients/parents do not ask the type of questions which leads to new or additional information being provided as a result of their questioning behaviour.

8.1.4 Summary: functions of patient/parent-initiated questions: Dr. Maxwell

This analysis has demonstrated the different goals of questions put by NS and NNS parents to Dr. Maxwell. The graph at Figure 8-1 below clearly illustrates these differences.

Figure 8-1: Function of patient/parent-initiated questions in Dr. Maxwell's consultations
The patterns which are illustrated so clearly in this graph show NS patients/parents using questions primarily to elicit new and additional information with occasional requests for clarification. NNS patients/parents on the other hand, use questions to seek clarification of the doctor’s instructions and treatment directives, and less frequently to obtain additional information. Only one question, an indirect question, did not elicit an immediate response from the doctor. In every other case when patients/parents asked questions they were answered by Dr. Maxwell.

8.2 Function of questions: Dr. Colson

Analysis of the data from Dr. Colson reveals all of the categories found in the data from Dr. Maxwell as well as an additional categories of work done by questions: what West (1983) called comprehension checks, which seem to be used by the patient to elicit reassurance or confirmation of understanding from the doctor. Framed as interrogatives, they were responded to in every case by the doctor. An example of this is at data fragment 8-20 (1B) below.

data fragment 8-20 (1B)

→ 33  M  I noticed that this one would like roll up and you know sit right in the corner, do you know what I mean?

34  D  yes, hmm hmm’

Table 8-2 below summarises the interactional goals of questions which emerged from Dr. Colson’s consultations. There were no indirect questions in these data.
Table 8-2: Function of patient/parent-initiated questions in consultations: Dr. Colson.

<table>
<thead>
<tr>
<th>New Topic</th>
<th>Additional Information</th>
<th>Clarification</th>
<th>Social</th>
<th>Confirmation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NS</td>
<td>NNS</td>
<td>NS</td>
<td>NNS</td>
</tr>
<tr>
<td>Direct</td>
<td>(n=33)</td>
<td></td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Indirect</td>
<td>(n=0)</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tag</td>
<td>(n=7)</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fragment</td>
<td>(n=30)</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>(n=70)</td>
<td></td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

The patterns illustrated by these figures are generally consistent with those found in consultations with Dr. Maxwell, however there are several important differences. Once again, there are no cases where questions are used by NNS to introduce new topics. However it is striking that, even though there are more than twice as many questions with this doctor, NS parents were much less likely to use questions of any type to introduce new topics than they were with Dr. Maxwell (8 out of 20 questions (40%) with Dr. Maxwell, but only 2 out of 50 (4%) with Dr. Colson). It is also interesting to note in this case NS patients/parents used slightly more questions to clarify previous utterances, or confirm their interpretation of previous utterances, than NNS patients/parents did whereas with Dr. Maxwell NNS patients/parents asked many more questions in this category than did NS patients/parents. Each category is discussed more fully below.
8.2.1 Introducing a new topic

There were only two questions in this category, both by NS patients/parents. A very significant difference between the findings for the two doctors in this category is that the topics introduced by patients/parents in consultation with Dr. Maxwell tended to be substantial, for example, the question of laser surgery illustrated at data fragment 8-6 on page 262. This is not the case with Dr. Colson, as illustrated in the following examples. In data fragment 8-21 below the doctor has given the mother directions about treatment and in handing the script to the mother signals that the consultation is about to end. The next appointment is one topic typically covered in the pre-closing stage and the mother takes the opportunity to introduce the question of which clinic to attend.

data fragment 8-21: (22B)

252 D okay (. ) so: o one drop fortnightly ((hands script to M)) there you go
\rightarrow 253 M thank you (. ) now which ( . ) what's the best clinic to come to? which is
254 D (    )((laughs))
255 M no they're all pretty horrible
256 D I'll say in February 2000 and leave it up to you, I'm not going to say the general one, I think, you've been to either one haven't you?
257 M yeah
258 D Yeah, you went to the CP clinic, it's actually lighter (. ) lighter booked in the CP clinic but they can take longer
259 M Yeah and also yeah (. ) the (. ) the waiting room gets a bit cramped with all the (0.5) paraphernalia
260 D That's [right
261 M [yeah
262 D Okay, so
263 (2.0)
264 M Alright then
Alright, good

Thanks very much

In this example the mother asked the doctor a direct question (turn 253) but the doctor does not answer immediately, then in turn 256 tells the mother that she will not in fact answer, but leave the decision up to her. This announcement is followed by some general discussion about the clinics then after a two second pause at turn 263, the mother seems to realise that she is not going to get an answer to her question and initiates the closing stage of the consultation by thanking the doctor.

There is only one other instance of a question of any type being used to introduce a new topic (data fragment 8-22) below. In this case, a physical examination of the child was carried out in another room by the doctor, who then directs everyone to move back into her consulting room. This physical examination is not part of the consultation and can be characterised as a type of 'pre-consultation examination' similar to the examination conducted by the orthoptist, since the actual consultation is complete in its own right and follows the 6 stages of the model as discussed in Chapter 6.

**data fragment 8-22: (49B)**

63 D okay, so we're going to go next door (I'm just getting this (1.0) printout

64 F okay, let's go

(6.0) (( while everybody moves into the consulting room))

→ 65 F ( ) a lot of people through today. (4.0) where would you like us to sit?

66 D Okay, so:0 um come up here so I can see you, that's good

67 (24.0)

68 D I'm having a think about you (28.0) okay, so what's your concern today sir? why (.) why are you wanting her checked today?
CHAPTER 8 - Aims and functions of patient/parent-initiated questions

The father and child entered the consultation room with the researcher and doctor. The father made a conversational remark, (turn 65) then after a 4 second pause during which everyone stood around, asked where the doctor would like them to sit. It is interesting to note that such a question would never be necessary in a consultation with Dr. Maxwell because of his ‘greeting and seating’ routine. The use of this routine allows Dr. Maxwell to seat patients and their parents quickly and efficiently and they are never left in a position where they are unsure of what is expected of them at this early stage. In this example the parent was put in a position by the doctor where he was not sure what to do, possibly because of the number of people in the room, and was forced to ask where to sit. In this case however the direct question did succeed in eliciting an answer from the doctor in the next turn.

8.2.2 Seeking additional information

The finding on questions which seek additional information on an existing topic follows a pattern similar to that which emerged from the consultations with Dr. Maxwell. There are again many more NS than NNS questions in this category. In Dr. Maxwell’s case, there are more than twice as many NS as NNS (9 NS and 4 NNS) while in Dr. Colson’s consultations there are more than three times as many NS as NNS questions used to elicit additional information (24 NS and 7 NNS).

There were 15 direct questions from NS parents and six from NNS parents in this category. In every case the questions were answered immediately by the doctor. However, some of these questions occurred in a way which altered the flow and seemed to change the pattern of control usually associated with medical consultations.
In data fragment 8-23 below, for example, it is the NS mother who seems to
determine the direction of the discussion with her use of frequent questions.

data fragment 8-23: (1B)

<table>
<thead>
<tr>
<th>Turn</th>
<th>Role</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>102</td>
<td>D</td>
<td>yes, OK, fine. (1.0) I almost think no patching at the moment, don’t, don’t throw away the ( ) we might do it next year</td>
</tr>
<tr>
<td>103</td>
<td>M</td>
<td>hmm hmm</td>
</tr>
<tr>
<td>104</td>
<td>D</td>
<td>and I think just want to test her vision early in the new year is what I want to do ( )</td>
</tr>
<tr>
<td>105</td>
<td>M</td>
<td>[so is her, is it getting worse now, like, she’s still, she’s been the same since the operation hasn’t she it’s no worse?</td>
</tr>
<tr>
<td>106</td>
<td>D</td>
<td>well, the turn in fact is showing up as a flick so it is slightly worse</td>
</tr>
<tr>
<td>107</td>
<td>M</td>
<td>[is it</td>
</tr>
<tr>
<td>108</td>
<td>D</td>
<td>[whereas she’s perfectly straight on our tests</td>
</tr>
<tr>
<td>109</td>
<td>M</td>
<td>so does that mean that she could, that her eye could go back?</td>
</tr>
<tr>
<td>110</td>
<td>D</td>
<td>could drift, that’s why I want to do patching if it does drift more, um, and if you’re finding that it is drifting more you could even start, restart the pa- treatment patching off your own back</td>
</tr>
<tr>
<td>111</td>
<td>M</td>
<td>yeah</td>
</tr>
<tr>
<td>112</td>
<td>D</td>
<td>I, as I say, I’m not one hundred percent certain she needs it at the moment, but if the turn is getting worse, it is very likely that that vision will drop down a little bit in which case I will get you to patch</td>
</tr>
<tr>
<td>113</td>
<td>M</td>
<td>so if I do start patching [her again</td>
</tr>
<tr>
<td>114</td>
<td>D</td>
<td>[yep, yep</td>
</tr>
<tr>
<td>115</td>
<td>M</td>
<td>like if her eye goes back, what happens then, like if her eye turns back the way that it was? does that mean that you’d operate again or just patch it?</td>
</tr>
<tr>
<td>116</td>
<td>D</td>
<td>[well, um, I would do (. ) patching before I did surgery</td>
</tr>
<tr>
<td>117</td>
<td>M</td>
<td>hmm hmm</td>
</tr>
<tr>
<td>118</td>
<td>D</td>
<td>and, once again, by the same principle as before that is, that we want her vision to be good</td>
</tr>
<tr>
<td>119</td>
<td>M</td>
<td>yeah</td>
</tr>
<tr>
<td>120</td>
<td>D</td>
<td>and if, if she drifts, sometimes it’s because the vision isn’t as good, so I’d do patching first, and if she doesn’t straighten with that, then further surgery</td>
</tr>
</tbody>
</table>
In this example, the doctor uses several markers (yes, okay, fine, turn 102) to indicate that she wants to bring the previous discussion to a close and move on to the treatment plan. She then announces her plans for treatment (turns 102 and 104) and raises the issue of the next visit, which is usually a signal that the consultation has moved into the 5th (pre-closing) stage. The mother then asks another direct question (with an embedded tag question) seeking additional information, an overt statement from the doctor on her child’s progress (turn 105). Further questions from the mother at turns 109 and 115 keep the discussion on the topic she has chosen and in fact it is not until turn 144 that the doctor wrests back control by referring once again to the next visit (see data fragment 8-24 below).

data fragment 8-24: (1B)

\[\rightarrow\]

144 D Um (.) so (.) perhaps next time we’ll [check if it’s getting worse
142 M [check it again

This consultation continued for some time after this exchange and in fact did not end until 140 turns later.

There are numerous other examples of direct questions from NS parents being used on one level to obtain additional information but also serving to take control of the consultation. In data fragment 8-25 below, the mother appeared quite impatient with the doctor’s communicative style. She does not engage with the doctor other than with a series of minimal responses and finally used a direct question to interrupt the doctor and get her to come to the point.
(5.0) I’ve just got a brochure behind here that gives you, (49.0) ((searching))

okay, so, with the letters, I think it is a good idea if you satisfy yourself that the vision is different or not. On our test it is only a couple of letters, but often with repeat tests it’s a little bit less difference than in the initial test, so I don’t want to miss, since you bothered to follow that up,

MM

and it is important to maximise the chance of having a spare eye,

Yeah

I think it is important too for you to be satisfied that there is a difference and getting a feel for how much there is,

hmm hmm

if you’re satisfied that there is a difference you might as well get started with some patching if you’re happy to do it, or we can do the testing and come back and report

Yeah

I don’t mind which one you do, um, what I am going to give you is like a package of background information tells you a bit about patching,

hmm hmm

some alternatives to patching, which is drops in the eyes, which we sometimes use instead of patching,

hmm hmm

um, and my job then is I guess to convince you, and you to convince him, and also to try and adapt what he will tolerate, um, with what needs to happen, so he needs to have at least twenty hours patching,

mmm

of his right eye, per week

right, so how long?

so, usually what I’d say is do it for, six weeks, then we’ll review his vision and see if it’s any different, it can be enough to improve it

Yeah

um, usually it’s at least three cycles, in fact, of at least six weeks, to er, once we start the treatment.

right
This seems to be another example of the doctor’s communicative style forcing patients/parents to ask questions to obtain clear information. The mother’s direct question in this case elicited an immediate response, giving the mother the information she wanted, however, the doctor then continued talking at length, presenting the patient with options for treatment, timing, and subsequent visits (data fragment 8-26). The mother continued making minimal responses until she signaled the end of the consultation herself, first with a question framed as an inflected fragment (turn 223) and then with an explicit statement to the child (turn 227) while physically moving to the door (shown in data fragment 8-26 below).

data fragment 8-26: (2B)

→ 223 M So it’s got all of that in here?
224 D It’s got (. ) um I’ve got some information about how to patch, about the alternatives, about eye protection which probably applies to you (. ) [too
225 M [yeah
226 D So (. ) [alright
227 M [come on darling we’re going home ((moving to door))
228 D So I would say in a few weeks, give you time to patch [ and ( )
229 M thank you
This mother declined to be interviewed after the consultation, saying only that she was unhappy with the whole process.

Examples of direct questions from NNS parents seeking additional information on an existing topic indicate that the questions are answered but that they do not generally tend to significantly deflect the consultation or shift the locus of control. In data fragment 8-27 below, the mother asks a direct question about the level of her son’s vision and when the question is answered to the mother’s obvious satisfaction (turn 23) the doctor resumes her own series of questions and answers which characterise this stage (stage 2) of the consultation.

**data fragment 8-27: (4B)**

<table>
<thead>
<tr>
<th>Turn</th>
<th>Speaker</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>D</td>
<td>Okay. A:::md, okay, s::o, well on our tests, there wasn’t an obvious difference, = ((4 turns omitted))</td>
</tr>
<tr>
<td>21</td>
<td>M</td>
<td>so, (0.5) what about the level of his vision, though, is it, (.) is it okay, or?</td>
</tr>
<tr>
<td>22</td>
<td>D</td>
<td>yeah, it’s normal.</td>
</tr>
<tr>
<td>23</td>
<td>M</td>
<td>oh good!</td>
</tr>
</tbody>
</table>

Similarly with data fragment 8-28 below, once the direct question from the NNS parent has been answered fully the doctor continues briefly with a discussion of alternative treatments and then quickly closes the consultation.

**data fragment 8-28: (52B)**

<table>
<thead>
<tr>
<th>Turn</th>
<th>Speaker</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>67</td>
<td>D</td>
<td>≈I would like to encourage you to give (.) to give it a try</td>
</tr>
<tr>
<td>68</td>
<td>F</td>
<td>[okay</td>
</tr>
<tr>
<td>69</td>
<td>D</td>
<td>[okay, and usually what we do is get you to do that say three days a week which would be the equivalent of about twenty to thirty hours</td>
</tr>
<tr>
<td>70</td>
<td>M</td>
<td>[Hmm hmm</td>
</tr>
<tr>
<td>71</td>
<td>F</td>
<td>[ ( ) Yes</td>
</tr>
</tbody>
</table>
72  D  [Do you think
→ 73  M  [How do we have to do it?
74  D  So you’d need to get contact that’s used to cover books, I’ll show you and stick it on the lens of the glasses, and it’s on the good eye
75  M  Okay
76  D  It’s on her left eye?
77  M  Hmm hm
78  D  And (.) do that for (.) eight weeks and then we see her again and test the vision for you
79  M  Alright
80  D  okay?
81  M  Okay

However, there is one example of a NNS using a series of direct questions and inflected fragments to take control of the consultation in the way that several NS parents did. As we saw in Chapter 5 (section 5.4) consultation 50B (data fragment 8-29 below) is an example of the parent taking control of the negotiation. Dr. Colson initially asks the mother if she is happy to embark on a treatment plan of patching (turn 13) then asks if a proposed treatment schedule is possible (turn 17). From this point on, the mother takes control of the exchange (turns 18, 20, 26, 46-52). This negotiation concludes with Dr. Colson agreeing with the mother’s various suggestions.

**data fragment 8-29 (50B)**

13  D  [okay, yes, right, yeah, okay, so are you happy then to resume? To go back [to patching?
14  M  [oh yeah, yeah, yeah

(2 lines omitted)

17  D  Do you think three hours (.) a day is (.) possible? (0.5) ((laughs))
→ 18  M  three or two? (((laughing)) I try
19  D  [It’s um, (.) it depends on how much you’ve been doing, and how it’s led it to going backwards?
→ 20  M  Yeah, can I like doing, um, five days a week, so, if I do it five
days a week for how long? [( )] Well, the total number of hours per week that matters.

22 M Okay

23 D So: u:mm

24 M So two hours a day five days a week, that enough, or not?

25 D U:um

26 M Ten hours a week?

27 D Um, (4.0)

28 M Or you want some more?

29 D So he’s been doing (0.5) four (. ) hours a week, is that right?

30 M [yeah, yes

31 D U:um, what about in the past, how much have you done?

32 M Oh about two hours a day

33 D Two hours a day, every day?

34 M Yes, every day

[10 turns omitted]

35 D Okay, now it can be, all in one day, it can be all together rather than (0.5) separated.

36 M Yeah but he need to go to school

37 D [Okay, so you

38 M [And we do only after school, yeah

39 D Okay, so after school, what about weekends?

40 M Er, if it ten hours, he will miss out the weekends, because we got Monday to Friday so will have free (. ) eye patch on Sunday and Saturday

41 D Okay, so you would prefer that (. ) to doing it after school

42 M Yes on Sunday and Saturday he goes to his grandmother’s house and his (. )

43 D Yes, yes, okay, sure, okay.

The examples given above illustrate the use of direct questions and in some cases, inflected fragments, by NS and NNS parents. In all cases the questions were used to elicit additional information on existing topics, and in all cases the direct questions were answered although the fragments were not, largely because of the rapid-fire
approach of the mother and the delayed responses from the doctor. In many cases however the questions seemed to serve a secondary purpose of bringing the doctor to the point and as illustrated in data fragment 8-29 above resulted in control of the discussion shifting from the doctor to the patient/parent.

There were three tag questions in this category of seeking additional information, all by NS patients/parents. One tag was answered but the remaining two, while acknowledged, do not seem to have elicited appropriate answers. In data fragment 8-30 below, for example, it is not at all clear whether the doctor is agreeing with the mother or contradicting her, while in data fragment 8-31, an example taken from the same consultation, the mother uses a tag question to obtain additional information about the medication she has been using (turn 263) and again the doctor’s response is ambiguous, it is not clearly an answer, and is just as likely to be an acknowledgement token, like her earlier yes token in turn 262.

**data fragment 8-30: (47B)**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>391</td>
<td>D</td>
<td>Um (.) er (.) can you be bothered? [I mean there’s no hurry</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[well I mean it’s not as if I have to record every minute, do I?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>392</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>393</td>
<td>D</td>
<td>yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>394</td>
<td>M</td>
<td>yeah</td>
<td></td>
<td></td>
</tr>
<tr>
<td>395</td>
<td>D</td>
<td>Okay, well why don’t we try to do it every (.) every day or so because you’ll probably remember, for a month?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>396</td>
<td>M</td>
<td>okay</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**data fragment 8-31: (47B)**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>260</td>
<td>D</td>
<td>Does the Demazin help?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>261</td>
<td>M</td>
<td>Well it does but (.) I mean I continuously have to give it to her all the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>262</td>
<td>D</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 8 - Aims and functions of patient/parent-initiated questions

→ 263 M It doesn’t (.) like (.) clear it, it just (.) it er (.) alleviates it, doesn’t it?
264 D Yes, okay, so when she’s having the Demazin her eye does seem to be a little less wet?

Tag questions seemed to be easily ignored and were not generally successful in eliciting appropriate answers or the required additional information from this doctor.

NS parents also framed more questions as inflected fragments than NNS did to obtain additional information from Dr. Colson (NS, 6, NNS, 1). An example of an inflected fragment from a NS parent is included in data fragment 8-26 on page 280 (turn 223). As illustrated in data fragment 8-32 below, these questions always elicited an answer from the doctor.

data fragment 8-32: (48B)

        188 D Good, okay
→ 189 M Good man. And they’ll stay dilated for [the rest of the day?  
        190 D [yes usually for a few   
hours
        191 M okay

Only one inflected fragment was used by a NNS parent in this category (illustrated in data fragment 8-29 on page 282 (turn 18). This was also answered by the doctor but as we have already seen this consultation involved a great deal of negotiation and the answer to this particular question led to further questioning by the parent using further fragments to clarify the situation, some of which did not result in answers.

Overall, both NS and NNS parents used direct questions successfully to elicit additional information from this doctor, although they often led to considerable shifts in the power base of the consultation, particularly with NS parents. Tag questions
were not successful for the NS parents who used them, and inflected fragments proved an effective means for NS parents to elicit brief, immediate answers from the doctor.

8.2.3 Clarification (and confirmation) of previous utterances

There were a total of 28 questions, 15 by NS and 13 by NNS parents, used to clarify previous utterances with this doctor. These include two direct questions from NS parents and one direct question from a NNS parent. This is in stark contrast with Dr. Maxwell’s consultations, where a total of 10 questions, all inflected fragments, and framed mostly by NNS parents (80%), occurred in this category.

Both NS direct questions in this category occurred in the same consultation, and were used by the mother to clarify and confirm her understanding of the doctor’s earlier treatment directives, as illustrated in data fragment 8-33 below.

data fragment 8-33: (1B)

\[
\begin{align*}
\rightarrow & 169 & M & \text{So what do I (.) where do I put the drops, I put them in the right eye to make that blurry?} \\
& 170 & D & \text{That’s (.) that’s correct} \\
\rightarrow & 171 & M & \text{Is that what I do?} \\
& 172 & D & \text{Yes, all the treatment’s for the right eye} \\
& 173 & M & \text{Yep}
\end{align*}
\]

In this example, the mother frames a direct question then recasts it as a fragment to restate her understanding of what she has to do, and even though the doctor says quite clearly that she is correct (turn 170) the mother asks another direct question to confirm her understanding. In data fragment 8-34 below, the NNS does something
similar, using a direct question to confirm that her interpretation of what the doctor is saying is correct.

**data fragment 8-34: (51B)**

33 D All she's got is those signs of old activity in the right eye that she's had for a long time

→ 34 M Is that say (.) like scars [is that like scarring that remains there because of that (.) what the cells (.) you know?

35 D yeah, yes, yeah, that's right it's from (.) yeah from old uveitis

In this example the doctor has referred to evidence of old activity and the mother clarifies this by checking that they are talking about what the mother understands as scars. In all cases where a direct question was used to clarify or confirm a previous utterance it was answered by the doctor in the next turn.

There were 2 tag questions, one by a NS and one by NNS parents, in this category. In data fragment 8-35 below the NS mother uses a tag to interrupt the doctor and attempt to confirm her understanding of the doctor's earlier explanation.

**data fragment 8-35: (1B)**

186 D So::: why don't we make it er November and put it off until the new year ( )

((5 turns omitted))

192 D so, now ((I'm looking )

→ 193 M so she tilts her head because she can't see out of her left eye, is that right?

194 D er, I don't know, but lots of kids do it so that they can (.) see better,

195 M mmm

196 D and lots of kids do it to compensate for the turn, so if it's getting worse I'd say well the turn may be getting worse

197 M yeah

198 D um, because sometimes it's (.) it's more comfortable to hold your
eyes straight if you've got a slight tilt
199 M yeah
200 D so let her do it, don't stop her doing it if [ ok ]
201 M [okay]
202 D Now, how old is she?

In this case the mother had raised the issue of her daughter tilting her head very early in the consultation (turn 18 in the transcript) but it was not taken up by the doctor who chose instead to pursue the problem of a turn in the child's eye. The mother brought up the issue of tilting again at turn 84 and this time the doctor offered a brief explanation but the discussion then reverted immediately to the problem of the turn in the eye and how to deal with that. In turn 186 (data fragment 8-35 above) the doctor introduced the topic of a new appointment which usually signals that the consultation is nearly over, so the mother revisited her initial concern about the tilt and used a question to try to confirm that she has in fact received an explanation (turn 193 above) and that she does understand why her child is tilting her head. The question finally elicits an admission from the doctor that she does not know the answer, and a reassurance that it is not however a major problem.

The tag question used by NNS in this category also served to confirm the parent's understanding of the situation, as illustrated in data fragment 8-36 below.

data fragment 8-36: (25B)

42 D And, I would just like to see him maybe six, how long had it been this time? Was it six months?
43 F I'm sorry, they asked for, we were supposed to come and see you in September, you know, we just er forgot, about it, completely, you know, it's just er
44 D yep
45 F Now you're doing a six month cycle are you? [because ( ] so
46  D  [yeah, that’s right. Okay so I’m happy to leave it for six months again, um and I would just, I’d be encouraging him to wear the glasses if you can, do you think there’s going to be any problem?]

Tag questions used by both NS and NNS in this category were responded to by the doctor.

There were a total of 23 inflected fragments used with this doctor to clarify or confirm previous utterances. Unlike the findings with Dr. Maxwell, where NNS used 4 times as many inflected fragments as NS did, with this doctor NS and NNS parents used approximately the same number of fragments (NS 12, NNS 11). In one case (data fragment 8-37 below) a NS parent became bogged down in his own answer to a question from the doctor and used an inflected fragment to explicitly clarify the doctor’s earlier utterance.

**data fragment 8-37: (49B)**

```
158  D  Was she prem, do you know?  
      ((15 turns omitted)
→ 173  F  And um (1.0) that’s (2.0) er the original question again was?  
      D  Oh whether she was prem
```

Other NS fragments were straightforward attempts to clarify or confirm the doctor’s instructions. In data fragment 8-38 below, the mother simply restates the doctor’s instruction, while in data fragment 8-39 the mother uses a fragment to check that her interpretation of what the doctor has been saying is correct.

**data fragment 8-38(1B)**

```
186  D  so-o-o, (3.0) why don’t we make it er November and put it off until the new year if she wants to (   )
→ 187  M  so make an appointment in November?
```
yes, do that, and then we can defer it if she is OK

**Data fragment 8-39: (22B)**

219 M  No it's certainly been in the fridge for [three months
220 D  [yeah that's right so probably better to (  )
221 M  Because it's been how long probably since I last saw you and it was (. ) I had it before then so I think I probably should turf it
222 D  yeah
223   (6.0)
→ 224 M  So it's only after it's open though [that it starts?
225 D  [that's correct

Four of the eleven NNS inflected fragments in this category occurred in the same consultation. Three are contained in data fragment 8-40 below.

**Data fragment 8-40: (40B)**

33  D  okay, so she's not (. ) not having quite enough?
34  F  I see
35  D  so I want to think of how we can increase it a little bit.
36  F  alright.
37  D  okay? um, (7.0) now, um, (6.0) I think two per day.
→ 38  F  two?
39  D  two drops, per day.
→ 40  F  two drops a day?
41  D  yeah.
→ 42  F  in both? Both [eyes?
43  D  [that's correct, yes, um, so that's, is that one in the morning and one in the afternoon? Is that what she's been having?

In every case NNS questions framed as inflected fragments received an answer in the doctor's next turn, but as illustrated in this fragment, NNS parents do not receive new or additional information as a result of their questioning behaviour.
8.2.4 Social

As with the social tag question used in Dr. Maxwell’s consultations, there were two tag questions in these data which seem to serve no other purpose than social comment. This is illustrated in data fragment 8-41 below.

data fragment 8-41: (22B)

1   D   How are you?
2   M   Good thanks. [God, you’re flat out, aren’t you?
3   D   [good
4   M   [=just for a change
5   D   [yes .) um ((closes door)) now

In this example the mother follows up the doctor’s greeting with an appropriate second pair part (good thanks) then uses a tag question to continue the social exchange. This is overlapped by the doctor’s feedback (turn 3) but the mother continues on without pause and the doctor finally responded to the tag and then indicated that it was time to move on (turn 5: now).

8.2.5 Confirmation

This category occurred exclusively with Dr. Colson and this type of question was found in only two consultations. There were 5 instances during the course of one consultation where the mother frequently asked the doctor if she understood what she (the mother) was saying. This appears to be an idiosyncrasy of this particular NS mother’s speech, however, the doctor treated the utterances as questions and responded to them on every occasion so they have been included in these data even though they do tend to distort the overall pattern of what NS parents do with questions
in consultations. The example in data fragment 8-42 below is typical of these exchanges.

data fragment 8-42: (1B)

46 M but like maybe if she just gets to the telly you know as soon as she looks at it she'll squint and then I'll look at her later and her eyes are normal

47 D yes

→ 48 M do you know what I mean?

49 D yes, yes

8.2.6 Summary: functions of patient/parent-initiated questions: Dr. Colson

This analysis has demonstrated the different goals and functions of the patient/parent-initiated questions put by NS and NNS patients/parents to Dr. Colson. The graph at Figure 8-2 below clearly illustrates the different patterns which emerged from this analysis.

Figure 8-2: Function of questions (Dr. Colson)
The patterns which have emerged from the analysis of data from Dr. Colson show NS patients/parents using questions primarily to elicit additional information from the doctor and to clarify or confirm previous utterances. NS patients/parents also used questions on occasion to introduce new topics into the discussion or engage in social interaction. NNS patients/parents, on the other hand, did not introduce new topics or use questions for a purely social purpose. They overwhelmingly used questions to seek clarification of doctor's instructions and treatment directives, and less frequently to obtain additional information.

There was little difference between questions from NS and NNS patients/parents in terms of success in eliciting answers. All 33 direct questions from both NS and NNS were responded to by Dr. Colson, although one, a question from a child about why she was having a test that day was brushed off by the doctor with because you're having all your tests today, and one other direct question from a NS parent was responded to but not answered, in other words, the doctor declined to answer, leaving the decision up to the parent. The seven tag questions had mixed success in eliciting answers, with two from NS patients/parents being ignored completely, one being answered in a very ambiguous manner and the rest being answered. However inflected fragments were generally successful with only two of the thirty fragments used failing to elicit an answer from the doctor.

8.3 Function of questions: summary of both doctors

This analysis has revealed a total of five categories of aims and functions of patient/parent-initiated questions. Four of these categories, introduction of a new
topic, eliciting additional information on an existing topic, clarifying or confirming previous utterances, and social remarks, are found in the data of both doctors. The remaining category, confirmation, occurred only in data from Dr. Colson. Table 8-3 below summarises these findings.

**Table 8-3:** Function of patient/parent-initiated questions in consultations with both doctors

<table>
<thead>
<tr>
<th></th>
<th>New Topic</th>
<th>Additional Information</th>
<th>Clarification</th>
<th>Social remarks</th>
<th>Confirmation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NS</td>
<td>NNS</td>
<td>NS</td>
<td>NNS</td>
<td>NS</td>
</tr>
<tr>
<td>Direct (n=48)</td>
<td>8</td>
<td>0</td>
<td>22</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Indirect (n=1)</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tag (n=10)</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fragment (n=43)</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Total (n=102)</td>
<td>10</td>
<td>0</td>
<td>33</td>
<td>11</td>
<td>17</td>
</tr>
</tbody>
</table>

These data identify a clear difference in the function of questions asked by NS and NNS parents. NS parents used questions to introduce new topics: NNS parents did not. NS parents used three times as many questions as NNS parents to seek additional information from the doctor. NNS parents used more questions than NS parents to seek clarification of previous utterances from the doctor. NS parents used questions for social purposes: NNS parents did not. Only NS parents used questions to seek reassurance from the doctor that their utterances were understood by the doctor. The graph at Figure 8-3 below clearly illustrates these different patterns.
The analysis also shows that there is very little difference between questions from NS and NNS parents in terms of being answered. The type of question is a better indicator of success. Only one indirect question was asked and was completely ignored by the doctor. Of the 10 tag questions, seven from both NS and NNS parents were answered and the remaining three, all from NS parents were either ignored or answered in an ambiguous manner. Direct questions were generally successful, with none being ignored, and only two (of the 48) not being answered appropriately. Inflected fragments were also successful in eliciting answers from both doctors.

Questions occurred in five of the six stages of the consultation (no questions occurred in stage 6: closing) but there was no evidence to indicate that the success or otherwise of questions in generating appropriate responses was affected in any way by the timing of the question.
8.4 Summary of Chapter

This chapter has examined the patient/parent-initiated questions in these data and has identified a number of differences in the aim and function of questions used by NS and NNS parents. The analysis shows that NS patients/parents use questions to elicit new and additional information from the doctor, and to express additional concerns about their child’s condition or treatment. In contrast, NNS patients/parents are more likely to use questions to clarify previous utterances by the doctor, or to confirm their understanding of a previous utterance. The analysis also shows that while these patterns are found in consultations with both doctors, patients and parents in consultations with Dr. Colson are more likely to ask questions to obtain information that is routinely made available to patients/parents in consultations with Dr. Maxwell, and questions which seem to also have a secondary function of trying to bring the discussion back to the point.

Finally, the analysis shows that when parents (or patients) do ask questions they are answered by both doctors in nearly every case. When questions are not answered it seems to be the type of question which is the most relevant factor. These findings are discussed fully in Chapter 9.
CHAPTER 9 Discussion

This chapter discusses the findings that have emerged from the analyses described in Chapters 5, 6, 7, and 8. These analyses have identified clear differences in the patterns of questioning behaviour of NS and NNS parents in terms of the number of questions asked, the timing of questions, the types of questions used, and the goal, or type of work done by patient/parent-initiated questions.

9.1 Number of questions

Whether or not the patient asks questions is an important aspect of patient behaviour which can strongly affect the development of the consultation and patient outcomes. As illustrated in Chapter 7 the occurrence of patient/parent-initiated questions has the potential to extend the consultation considerably, and it is therefore in the interests of the doctor as the institutional participant to minimise patient-initiated questions in order to maintain control of resources and meet institutional demands. Dr. Maxwell’s tightly structured consultations and his use of routines to move smoothly through the consultation results in fewer questions from his patients/parents. His consultations are consequently much shorter than those of Dr. Colson which contain many more questions.

However, question-asking is a powerful indicator of patient activity and involvement in the interaction (Roter and Hall, 1993) and there is evidence that a more active role in a visit to a doctor may relate to a greater sense of control over the disease and therefore a better health outcome (Hulka, 1979, Wasserman et al, 1984, Greenfield et
al 1985). Early studies (Pratt et al 1957, Cartwright, 1964) observed that doctors tend to see patients' passive behaviour and failure to ask questions as an indication of lack of interest or incompetence, however it has been argued that many people are simply not used to asking questions (Crystal, 1976) and that the lack of questions from patients reflects a lack of question-asking skill rather than lack of interest (Tuckett et al, 1985). The notion of skill both in framing and in using questions appropriately becomes particularly pertinent in any discussion of non-native speakers attempting to interact in an institutional setting.

More recent studies indicate that patient-initiated questions are increasingly seen by doctors as an indicator of the level of patient assertiveness in information seeking (Greenfield et al 1985) and as the expression of a desire for greater participation (Roter and Hall, 1993). Cartwright and Anderson (1981) found that both patients and doctors believed that patients were more likely to question their doctor than they were ten years earlier, and that there was evidence of a change to less passive and more knowledgeable patients, however patient-initiated questions are still relatively rare (West, 1984a, 1984b, Tuckett et al, 1985, Frankel, 1990, Ibrahim 2001), a very small percentage of available time is spent on them during the consultation (Waitzkin 1985, Roter and Hall, 1993) and there is evidence that patients have questions which they do not ask (Mayou et al 1976, Klein, 1979, Tuckett et al, 1985).

The analysis of patient/parent-initiated questions occurring in consultations with the two doctors in my research reveals patterns which generally support the findings in the literature. Patients/parents asked 6% of a total of 505 questions identified in consultations with Dr. Maxwell and 14% of a total of 485 questions in consultations
with Dr. Colson. This represents an average of 6 questions per consultation with Dr. Colson, and an average of 2 questions per consultation with Dr. Maxwell. The study provides further support for the evidence of gender differences identified in the literature on medical discourse which indicates that patients generally and female patients in particular, ask more questions of female doctors than of male doctors (Cypress 1980, Wassermann et al, 1984, Roter et al, 1991, Howie, 1999).

These findings extend the work on patient questioning behaviour and have identified a clear difference in the number of questions asked by NS and NNS patients/parents. It is evident that while patients/parents in general ask few questions, the situation is more severe for NNS patients/parents. Overall, NS patients/parents asked twice as many questions as NNS patients/parents. In the case of Dr. Maxwell, NS patients/parents asked 20 (63%) of those questions directed to the doctor, while NNS asked only 12 (37%). A similar pattern was observed in consultations with Dr. Colson, although the gap between NS and NNS patients/parents was slightly greater, with NS patients/parents asking 50 (71%) and NNS patients/parents 20 (29%) of those questions directed to the doctor.

However, contrary to the findings in the literature that patients had questions which they did not ask (Mayou et al, 1976, Klein, 1979, Tuckett et al, 1985) Dr. Maxwell’s patients/parents who were interviewed for this study claimed that they felt completely comfortable about asking questions and none indicated that they had questions which they wished to but did not ask. In the case of Dr. Maxwell, there were five patients/parents, 2 NS and 3 NNS, who did not ask any questions in their consultations. The two NS patients/parents each said in their post-consultation
interviews that they had been coming to Dr. Maxwell for years, and that they did not ask questions because they did not have any to ask. Both indicated that they would be comfortable asking questions if necessary and one mother commented that she had no questions because *he really explains things, a couple of years ago I asked him questions and there was a lot more explaining to do* (11C).

The three NNS parents who asked no questions during their consultations also said that they would feel comfortable about asking questions, but one pointed out there was no need to do so because the doctor explained everything so that he (the parent) understood everything. However, one NNS mother said she tried to ask questions but it was not easy because she had difficulty formulating the question: *I can’t make properly the sent (.) the sentence to ask him* (30C). This NNS mother said that her husband had come to the first few consultations to *be sure to understand* but that now it was only regular checkups she could manage herself because *I understand enough (0.5) it’s easy to understand when the doctor talking you know because (. ) I think I understand him better because he (. ) when he’s talking he talk properly, not some people when they’re talking talk fast, or like that.*

Those NNS parents who did ask questions in their consultations also pointed out that Dr. Maxwell always explained things clearly and fully and patient/parent-initiated questions were therefore often not necessary. For example, one NNS father who had asked two questions in the consultation commented in his interview that *there was nothing else to ask because he’s answered them anyway I was going to ask the same things he’s already told me so there’s nothing (.) nothing to ask* (14C). Another pointed out that the doctor was *understandable, he try to make you understand, he*
talk very slowly, and that he would of course (20C) ask questions if he needed to. One NNS mother who had asked questions but had relied on her daughter to translate them reported that one problem she usually has is that doctors do not explain anything, but she liked that Dr. Maxwell explained, mostly, all of it, and especially that he asked if I had any questions (33C).

This pattern was also found in interviews with the NS parents who had asked questions in their consultations. All indicated that they were very comfortable asking questions of Dr. Maxwell. For example one parent (19C) said he thought the doctor was very open to questions and another (32C) said she felt confident about asking questions no matter how stupid they might be. This NS mother went on to comment that, he sort of explains things for us to understand, like, medical sort of terms where it’s a bit harder to understand, you don’t know what’s going on. This was a common thread throughout the parent interviews, both NS and NNS, with many parents indicating that Dr. Maxwell’s style of communication facilitated their understanding of what was going on, that he was easy to understand, and that he was unlike a lot of doctors who you don’t, treat you as though you don’t know anything (27C).

One NS mother (26C) made the interesting comment that she was confident about asking questions because I am a professional myself and added that she fully understood that the doctors were very busy so I wouldn’t be pressing them to spend more time with me as I’ve been given good hearings in the past and had things explained to me. This comment reveals her awareness of the perceived difficulty that patients/parents, especially less-well educated ones, experience in asking questions as well as revealing the widely held notion among patients that doctors are busy,
important people whose time should not be taken up unnecessarily (Tagliacozzo and Mauksch, 1972, Mayou et al, 1976, Tuckett et al, 1985).

The situation was a little different with Dr. Colson. Patients/parents asked 14% of a total of 485 questions in her consultations. There were 70 questions from her 12 consultations, which represents an average of 6 questions per consultation with Dr. Colson compared with 32 questions from 16 consultations with Dr. Maxwell and an average of 2 questions per consultation. Unlike the situation with Dr. Maxwell’s consultations, there were no consultations with either NS and NNS patients/parents which contained no patient/parent-initiated questions. The comments from parents in their post-consultation interviews were also quite different from those made by parents of Dr. Maxwell’s patients, with mixed responses from both NS and NNS parents.

Of the six NS parents, one declined to be interviewed (2C), saying on her way out that the doctor was ‘abrupt’ and that she (the mother) was unhappy about the whole process and did not want to talk about it. One other mother (47C) also used the word ‘abrupt’ to describe Dr. Colson, adding that she did not like her, she could have put in a bit more effort to be friendly, and was very, very quick to get to the tests. Both consultations described above were very long, the first being over 16 minutes and the second 25 minutes, so this appears to confirm Korsch and Negrete’s (1972) finding that longer consultations do not necessarily mean more satisfied patients. It is interesting to speculate on whether the parent’s view of this doctor could in fact be based on an expectation of how a female doctor should act and whether a male doctor with a similar approach would be assessed in the same way.
One NS father (49C) said that he felt uncertain about what he had to do and that there had been a lack of communication about a test his daughter was expected to undertake. He commented that the doctor had not explained what the test was for or how it would work, or, more importantly for him, how the equipment could be manipulated to physically accommodate his daughter. He made several comments during the examination to indicate that he was not sure the child was positioned correctly, for example *I don't know, her eyes are actually above the level of the machine*, and *it's, it's still a bit low, that's the only thing*. At the completion of the examination he said to the doctor: *I don't know if she was far enough forward do you think everything was ...* and was interrupted by the doctor who assured him it all seemed okay. As a result of this, he said, he felt nervous about whether the test results would be correct.

In contrast to these comments, three NS parents described Dr. Colson as easy to talk to, nice, friendly, and commented that she explains things really well and listens well, and one parent added that she did not feel rushed like she did with other doctors. All NS parents interviewed indicated that they were comfortable about asking questions and none had questions that they wanted to, but did not, ask. The issue of the level of patient/parent education was raised again with this doctor, with one NS mother (22C) pointing out that *I can ask questions because I'm well-educated, but someone else might not*, and one NNS father (25C) drawing my attention to the fact that he had a PhD himself and was not going to be intimidated by anyone calling themselves 'doctor'. This is the same parent who addressed Dr. Colson by her first name, which he explained was a deliberate policy he employed *because people in this country,*
they use this title, doctor, to (get big height) and I’m determined not to let that happen.

There were also mixed comments about Dr. Colson from NNS parents. Again one parent declined an interview but in this case it was because she had been waiting so long at the hospital and was now late for another appointment. She commented that she thought Dr. Colson communicated well and added that she (the mother) was always happy to ask questions if she had any. Another parent found the doctor informative, easy to get along with, straightforward and relaxed, which is an interesting contrast to abrupt. One NNS parent thought that Dr. Colson was not very clear, and a bit fast, but okay, and commented that when you ask questions then she explains, while another described her as a bit quick but okay, and also added that if you ask her again she explains it.

9.2 Doctor-centred and patient-centred approaches

This indication that the doctor is always happy to explain things when questions are asked makes an interesting contrast to the comments made by Dr. Maxwell’s patients/parents which indicate that they do not have to ask questions because he always explains things clearly. One explanation for this difference lies in the communication styles of the two doctors. As discussed in Chapter 5, Dr. Colson’s consultations were longer than and contained considerably more turns than those of Dr. Maxwell. Dr. Maxwell’s consultations are very tightly organised and closely follow the organisational structure of the consultation as identified in Chapter 6. He uses a number of routines to facilitate the smooth transition from stage to stage and to
maintain control of his consultations. This control of the overall structure of the consultation and of the doctor’s time is typical of the doctor-centred approach described in Chapter 5, which maximises the doctor’s own input and also allows the doctor greater control of what is talked about and control of the amount of information which is shared with the patient.

In contrast, Dr. Colson’s consultations have been identified as containing a number of the features associated with a more patient-centred approach. Such features include, among others, information giving, counseling, open-ended questions, requesting patient’s opinion, confirming comprehension, reassurance and statements of concern, agreement and approval (Roter and Hall 1993). This is not to say that none of these features appear in Dr. Maxwell’s consultations, since they clearly do, but simply that more of them appear more often in Dr. Colson’s. Her consultations are closer to the patient-centred end of the spectrum. They are more loosely structured than those of Dr. Maxwell and the structure is less controlled, with more fluid boundaries between the various stages. Dr. Colson does not use a set of routines to signal changes in stages or to control the progress of the consultation, and she encourages, and in some instances even requires, greater parental involvement throughout the consultation but particularly in the diagnosis and discussion stage (stage 4). Dr. Colson interacts primarily with the parent and addresses her questions, comments and instructions in a manner and at a level suitable for an adult hearer. She rarely interacts directly with the child other than in the physical examination stage, or in some general pleasantries in the opening or closing stages.
Dr. Maxwell on the other hand, focuses on the child as the primary addressee and
designs his style of speech accordingly. As such he speaks slowly and clearly and
explains things in a way that the child will be able to understand. Parents, by virtue of
being auditors or “ratified as participants but not directly addressed” (Bell, 1984:159)
are also able to access this simplified style which is designed by the doctor
specifically for children. Such simplification, which includes shorter utterances,
lower syntactical complexity and avoidance of low frequency lexical items, is one of
the strategies commonly found in the modified input found in NS – NNS interactions
(Long, 1983). Although there is no evidence in the data to indicate that Dr. Maxwell
adjusts his style to directly accommodate NNS parents, his practice of addressing the
child as the primary interactant could also contribute to increased levels of
comprehension for NNS parents.

Dr. Maxwell’s utterances also have what Candlin et al (1976) refer to as multiple
address articulation. The parents in these interviews are cast very much in the role of
an overhearing audience, or what Aronsson and Rundstrom (1989) refer to as side-
participants. Aronsson and Rundstrom point out that side participants can play a very
important role in the shape of the discourse, particularly if they are imbued with some
special authority, for example a member of the jury in a legal interaction, or a parent
in a pediatric medical examination. The findings described in Chapter 6 show that NS
parents recognise when the doctor’s remarks are intended for them and respond
appropriately when required but NNS parents do not recognise the appropriate cues
for them to respond in this context (see 6.2.2.1). However in each case where the
NNS parent missed the cue that they were the intended audience and should respond
the doctor was able to identify the failure and then simply reformulate the question,
addressing it directly to the parent. This aspect of Dr. Maxwell’s communicative style therefore does not represent a significant disadvantage to NNS parents. On the contrary, these findings indicate that there are specific advantages for NNS parents in Dr. Maxwell’s style, as discussed above.

Despite the fact that all NS and NNS parents in this study claim to be happy and comfortable asking questions of both doctors the data clearly show that neither group ask many questions, and that the situation is worse for NNS parents who ask even fewer questions than NS parents. Overall in these data, NS asked 71% of patient/parent-initiated questions and NNS patients/parents asked only 29%, less than half the number of questions asked by NS patients/parents.

In any medical encounter it is likely that those patients (or parents) who ask questions are going to have different outcomes to those patients who do not (Boreham and Gibson, 1978, Pendleton and Bochner, 1980, Waitzkin, 1985, Roter and Hall, 1993). Parents who asks few questions, but particularly NNS parents who ask very few questions, are clearly going to receive only as much information as the doctor chooses to make available to them. Shuy (1993) argues that parents do not ask questions because they are less comfortable with the interview frame than they are with the discourse structure of normal conversation. He argues therefore in support of a more relaxed, friendly, patient-centred approach. Roter and Hall (1993) also argue for a patient centred approach, claiming that it maximises the collaboration between doctors and patients, while doctor-centred exchanges maximise the physician’s input and minimise the value of patient input. They go on to say that “although doctor-centred communication may be more effective in maintaining the doctor’s control of
the visit, this type of communication is less successful in meeting patients’ needs” (Roter and Hall, 1993:89). However there is clear evidence that this is not always the case. In their study of overseas-trained doctors in America, Erickson and Rittenburg (1987) found that doctors (particularly those trained in Asia and Europe) saw their authority as absolute and legitimised by the possession of esoteric knowledge which is viewed as professional expertise. Such doctors are trained to expect that it is their right and duty to determine what is wrong with the patient and it is the doctor’s role to ask questions and the patient’s role to answer. It is reasonable to expect that patients from those cultures have similar role expectations. There are environments therefore, including those in which the patient has different cultural expectations of the medical encounter, in which an authoritative doctor who uses a doctor-centred approach is more reassuring for the patient (Ibrahim 2001) and where the patient feels more satisfied with their consultation and their treatment (Savage and Armstrong, 1990).

Roter and Hall (1993) criticise the doctor-centred approach on the basis that it minimises the value of patient input. Such criticism is less relevant when a patient (or parent) is not willing to or perhaps not able to provide that input. In such cases patients’ needs are better met by the doctor providing a clear and recognisable structure and taking control of the flow of information. Controlling the amount of information shared with the patient does not necessarily mean limiting or restricting that information and it is clear that the NNS parents in this study felt advantaged and better informed by Dr. Maxwell whose consultations moved smoothly through that orderly and identifiable structure and who explained everything fully in the first instance, without waiting for parents to ask questions in order to provide necessary information.
NNS parents were less likely to ask questions and so were less likely to achieve access to a full range of information with Dr. Colson who may be more patient-centred in her approach but whose consultations are more fluid and less structured, and who is described by patients/parents as quick, but happy to explain things when questions are asked: a doctor who, in other words, expects patient/parent involvement and relies on patient/parent-initiated questions as prompts to provide information. This analysis suggests that the needs of the NNS patients/parents in this study were more successfully addressed by the doctor who employed a more doctor-centred approach.

9.3 Types and goals of questions

The analysis of these data has also revealed considerable differences between NS and NNS parents in terms of the types of question used and in the interactive goals of their questions.

Chapter 8 defines and discusses the four question types which emerged from the analysis of these data: direct questions, indirect questions, tag questions and inflected fragments. NS patients/parents asked more questions than NNS patients/parents in all categories, although in the category of inflected fragments the difference was minimal, with NS patients/parents asking only slightly more (51%) than NNS (49%) of the 43 questions in this category. NS patients/parents also asked more indirect and tag questions, although the numbers in both these categories are small. The greatest difference between NS and NNS patients/parents was found in the category of direct questions.
When patients ask any type of question they are able to demonstrate to the doctor that they wish to be more actively involved in the medical consultation but it is in the use of direct questions that patients exert some measure of control and influence on the development of the consultation and on the topics raised and discussed. Of a total of 48 direct questions identified in these data, NS patients/parents asked 81% (39) and NNS patients/parents asked 19% (9). NS patients/parents in these data are clearly playing a more active role in their consultations than NNS patients/parents and are taking more opportunities to influence the content and direction of the consultation. These differences identified in the number and type of patient/parent-initiated questions have the potential to lead to different outcomes and different levels of access to information for NS and NNS patients/parents.

There were also differences observed in the timing of direct questions from NS and NNS patients/parents in these data. When patients ask questions early in the visit, the doctor is more likely to accept that the patient wishes to be more involved in the consultation and decisions and therefore to provide more detailed answers and explanations as the consultation proceeds (Roter, 1977). Overall, both NS and NNS patients/parents asked most of their questions in Stage 4, the diagnosis/discussion stage, however NS patients/parents asked more than 50% (20) of their direct questions in the first three stages of the consultation, thereby setting the stage for the benefits of greater participation in the consultation. Only one direct question from a NNS patient/parent occurred in these early stages of the consultation so once again, the patterns of questioning behaviour exhibited by NS patients/parents provides them with greater access to information than that available to NNS patients/parents.
It is also clear from the analysis that NS and NNS patients/parent used questions to achieve different interactional goals. Five goals, or categories of work done by patient/parent-initiated questions have emerged from these data. Four of these categories, introduction of a new topic, eliciting additional information on an existing topic, clarifying or confirming previous utterances, and social remarks, are found in the data of both doctors. The remaining category, confirmation, occurred only in data from Dr. Colson.

NS patients/parents used questions to elicit new and additional information from the doctor, and to express additional concerns about their child’s condition or treatment. They were much more likely than NNS patients/parents to achieve these goals by using direct questions. Rather than using direct questions to introduce new topics, NNS patients/parents were much more likely to use questions to seek clarification of the doctor’s instructions and treatment directives, and less frequently to obtain additional information, and they did this overwhelmingly with inflected fragments. More than 60% of NNS questions were framed as inflected fragments while only 31% of NS questions were framed in this way. Many of these sought clarification or confirmation of earlier utterances. Such requests for clarification or confirmation are those utterances defined by West (1983, 1984a, 1984b) as ‘quasi-questions’ (see section 7.1.1) and she argues that while patient-initiated questions are strongly dispreferred in medical consultations, such quasi-questions are not, providing instead an alternative method for establishing understanding between the doctor and the patient (West, 1984b:126). However, since such questions call for reiteration or repair of previously supplied information they do not provide opportunities for NNS parents
to introduce new topics for discussion or shift the locus of control from the doctor to
the patient, even temporarily.

9.4 Questions and answers

There are conflicting findings in the literature about how successful patient-initiated
questioning is, with some researchers reporting that questions to doctors were
frequently ignored or given vague or heavily hedged answers (Davis, 1960, Korsch et
al, 1968) and others reporting that doctors nearly always answer questions when they
are asked by patients (Roter, 1977, Boreham and Gibson, 1978, Roter and Hall,
1993). My analysis supports the latter finding, and reveals that when parents (or
patients) do ask questions they are answered by each doctor in nearly every case. The
analysis also shows that there is very little difference between questions from NS and
NNS parents in terms of being answered; however, the type of question used can be a
factor in its success or otherwise.

Only one indirect question was asked and was completely ignored by the doctor. Of
the ten tag questions, seven from both NS and NNS parents were answered and the
remaining three, all from NS parents were either ignored or answered in an
ambiguous manner. Direct questions were generally successful, with none being
ignored, and only two (of the 48) receiving a dispreferred response, with the doctor
declining to answer in one case and brushing off the question in the other. Inflected
fragments were also successful in eliciting answers from both doctors.
Questions occurred in five of the six stages of the consultation (no questions occurred in stage 6: closing) but there was no evidence to indicate that the success or otherwise of questions in generating appropriate responses was affected in any way by the timing of the question.

Put simply, when patients or parents ask direct questions they receive answers. NS parents used direct questions to raise additional concerns about their child, NNS did not. This however does not mean that NNS parents do not have additional concerns but rather that such concerns can be missed by the doctor as Frankel (1990) has suggested. This point is clearly illustrated in the following extract taken from stage 3 of a consultation with a NNS parent:

**data fragment 9-1 (15C)**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>31</td>
<td>D</td>
<td>Oka:y let's have a look with my special light, (8.0) right (3.0) look at me (14.0) good, look at me (17.0) good look again (9.0)</td>
</tr>
<tr>
<td>→</td>
<td>32</td>
<td>F</td>
</tr>
<tr>
<td>33</td>
<td>D</td>
<td>[hmm hmm</td>
</tr>
<tr>
<td>34</td>
<td>F</td>
<td>[and use the oth () the other eyes. (10.0)</td>
</tr>
<tr>
<td>35</td>
<td>D</td>
<td>Okay. (9.0) we won't change your glasses, hh but I think I might get you to wear the sticky patch all the time?</td>
</tr>
</tbody>
</table>

The NNS father here is obviously concerned about an aspect of his son’s vision which has not been previously discussed. His attempt to introduce the topic is followed by a 10 second pause, then the doctor resumes his routine, giving directions for future treatment, without even acknowledging the comment made by the parent.

The great majority of the 48 direct questions analysed in this data elicited a direct answer commencing in the next turn, some of which extended over a series of turns.
Had this father framed his concern as a direct question such as *in the morning specially in the morning when he wake up* (.) *when he watch the TV he try to move to his head to one side ... is it a problem?* the data indicate that he may have been able to successfully elicit an answer and possibly a more satisfying response from the doctor.

A similar example of a concern being overlooked occurred in a NS consultation, in this case when the mother used an indirect question to raise a concern about the turn in her son’s eye:

**data fragment 9-2 (31B)**

→  83  M  look, I was wondering if he has his glasses off well I’m not sure if it’s worse but (0.5) the turn in his eye seems to be (0.5) perhaps a little more.

  84  D  Your old glasses aren’t too bad power respect. Can you slip your glasses off for me? (6.0) no other troubles at school with your eyes?

It is clear that the mother’s indirect question was completely overlooked by the doctor, however, some time later she tried again, this time eliciting a satisfactory response in the form of a direct answer:

**data fragment 9-3 (31B)**

→  175  M  Right, right, okay, and the turn in his eye isn’t worse than it was?

  176  D  Not enough to be concerned about.

The concern raised by the NNS father about his son’s vision in data fragment 9-1 was not raised again so the concern was either missed or ignored by the doctor and consequently the father did not receive the information or reassurance he was so clearly seeking.
At the post-consultation interview this incident was raised for discussion by the researcher and the father’s responses are very revealing (see data fragment 9-4 below):

**data fragment 9-4 (15C)**

36  I  Okay, and did you ask all the questions you had?

37  F  Yes, I think, any problems we come up, you know, watching TV using the other eye, come up.

38  I  Uh-huh, and did he answer that problem for you?

→ 39  F  (5.0) er, but I think you know he probably didn’t answer but you know I think you know he asked me to use the patches, I think that is the answer.

The NNS father thought that he had managed to raise his concern (turn 37) but although he acknowledged that the doctor did not provide a direct answer he believed that he had received an answer. By not framing his concern directly as a question this NNS father was denied access to information he might otherwise have received and was forced to make assumptions about the purpose of the treatment prescribed for his child.

### 9.5 Institutional talk and non-native speakers

The findings discussed above reveal significant and serious differences in the patterns of questioning behaviour of NS and NNS patients and their parents. These findings indicate that the behaviour of NNS parents in medical consultations has the potential to lead to significantly different outcomes for those parents such as less access to information, fewer explanations about their child’s condition and a less active role overall in the medical consultation which, as clearly demonstrated in the literature (Kincey et al, 1975, Taylor, 1979, Stoeckle and Barsky, 1980, Ley, 1983) can lead to
the patient or parent feeling less involved and having less control in the consultation, resulting in lower levels of satisfaction leading, potentially, to lower levels of compliance with the medical advice and directives provided.

Why is the behaviour of NNS parents so different to that of NS parents? The study of cross-cultural pragmatics offers one possible explanation. Cross-cultural pragmatics, in the sense in which it is widely used in the literature, looks at and contrasts the linguistic resources available to speakers of various languages to achieve specific speech acts such as apologising, thanking and requesting. There is a considerable body of research on the native-speaker and non-native speaker performance of specific speech acts, particularly refusals (Beebe, Takahashi and Uliss-Weltz, 1990, Houck and Gass, 1996), apologies (Holmes, 1989, Rintell and Mitchell, 1989, Olshtain and Cohen, 1983, Olshtain, 1989, Bergman and Kasper, 1993), compliments (Herbert, 1989, Holmes and Brown, 1987), rejections (Bardovi-Harlig and Hartford, 1991), complaints (Olshtain and Weinbach, 1993, Boxer and Pickering, 1995), and requests (Rintell and Mitchell, 1989, Blum-Kulka, 1989, Weizman, 1993, Cook and Liddicoat, 2002), and to a lesser degree on such acts as expressing gratitude (Eisenstein and Bodman, 1993), greeting, (Eisenstein-Ebsworth, Bodman and Carpenter, 1996) and correction (Takahashi and Beebe, 1993).

This research provides one possible basis for an explanation of differences that might be identified between the native speakers of one language and another. However, as discussed in Chapter 4, the category of ‘non-native speaker’ has deliberately been defined to be as broad as possible to include any participant who was not defined as a native speaker. As a result the NNS participants in this study come from a range of
speaking backgrounds and display a variety of English language proficiency levels. The patterns of questioning behaviour identified in my study apply to Kao and his father, whose first language is Chinese and to Josef and his mother, whose first language is French. The patterns are found in patients and parents in this study whose first languages are Vietnamese, Serbian, Tamil, Greek, Croatian, Sinhalese, Cambodian, Turkish and Portuguese. They were also found in participants who had been in Australia for six years, twenty years, thirty years, those who came as adults with no English, those who came as children and who had their education in English, and even, as we saw in Chapter 4, one, self-identified non-native speaker who was born in Australia. These participants do not share a common first language, they do not share a particular level of proficiency in English: what they do share is the requirement to function in the language of the medical interaction, English, and their non-nativeness in that language.

Any analysis of situated interaction needs to be considered in the context or contexts within which the interaction occurs. The process of talk itself creates a context in the sense of locally organised and negotiated interaction, and it is within this context that this study has looked at the construction of these medical consultations. However, in bureaucratic exchanges the context can also include the institutional setting of the interaction. Cicourel (1992) describes this broad context as “encompassing the group-derived prescriptive norms that pressure and/or channel people with designated titles, presumed competencies, duties or responsibilities into certain physical spaces at certain times in order to engage in a finite number of specifiable activities” (1992:294-95).
It is within this broader context that Bourdieu (1993, 1999) situates another concept which is particularly relevant to the present discussion: the notions of the linguistic market and linguistic capital. He argues that a linguistic exchange is also an economic exchange which is established within a power relation between a producer who has a certain linguistic capital and a market: utterances receive their value only in relation to the market which is a particular social situation, more or less ritualised, with a particular set of interlocutors situated at a particular level of the social hierarchy. Bourdieu argues that every interaction is in a sense a micro-market which always remains dominated by these overall structures. Linguistic capital, as the production of utterances which conform "not only to the immanent rules of the language, but also to the intuitively grasped rules that are immanent in a situation, or rather a certain linguistic market" (1993: 79) is power which confers on the speaker authority to speak. Linguistic power is not determined by linguistic forces alone, Bourdieu argues, but by virtue of the languages spoken, the speakers who use them and the groups defined by the possession of the corresponding competence, the whole social structure is present in each interaction (1999:503). Just as in an economic market there are monopolies which means that all producers do not start out equal so too in the linguistic market the power relations which dominate the market ensure that certain speakers are privileged.

Similarly, Cicourel (1992) argues that both the narrow and broad sense of context is needed for the analysis of language use and that the exclusion of details extraneous to the actual talk, that is, details of the situation, can obscure information that is relevant to the exchange being observed. Apart from looking at such aspects of the interaction as turn-taking and topic control the analysis needs to be located in the wide variety of
social activities that are implicitly and explicitly known to the participants and the researcher (1992:296). The critical detail known to the participants and researcher in this study which provides the broad context for these interactions is that they are located in the wider context of medical discourse, which is itself located in the context of institutional discourse. The frames used to interpret what can or should occur in the context of medical discourse however may be different for each participant (see data fragments 9.5 and 9.6 below).

As discussed in Chapter 1, institutional discourse differs from ordinary, mundane conversation in a number of ways. Institutional talk is goal oriented and the institutional participant’s conduct is shaped by organisational and institutional constraints and accountabilities which may not be apparent to or understood by the lay participant (Drew and Heritage, 1992). As in any other institutional interaction medical interactions are goal-oriented and must meet a range of institutional requirements, including restrictions on time-frames. The comparison discussed in Chapter 7 (section 7.3) of two consultations, one with and one without patient/parent-initiated questions, clearly illustrates how the occurrence of such questions has the potential to significantly deflect, extend and distort the structure of the medical consultation. The comparison demonstrates why it is in the interests of the doctor to minimise such distortions in order to have the visit proceed quickly and efficiently and to satisfy patient’s needs while still being able to maintain control of institutional resources and meet institutional demands.

The literature makes it clear that participants organise their conduct by reference to general features of the task or functions of particular institutions as they understand
them. In an institutional interaction such as a medical consultation, participants draw on two types of interactional knowledge to construct the interaction, the turn by turn conduct of the talk, and their frame of expectations for the event as a whole (Erickson and Rittenburg, 1987). In medical consultations patients are orienting to their own goals which are almost inevitably different to those of the doctor (Drew and Heritage, 1992) and in cross-cultural institutional encounters, doctors and non-native speaking patients are also almost inevitably operating from different frames of what a medical consultation should be like (Candlin, 1987, Erickson and Rittenburg, 1987) and the ways in which power is both constructed and resisted (Todd, 1984, Fisher, 1993, Fisher and Todd, 1993b) in discourse.

There is evidence in these data of the different frames of expectations with which some NNS patients/parents might approach a visit to a doctor. One NNS parent explained the difference between visiting the doctor in Australia and in her country of origin thus:

**Data Fragment 9-5 (30C)**

M I didn’t very often go but I don’t know, in our country it’s a little bit different, you know, you can buy something for the doctor and he will look after you maybe better than the other person, but here I think the doctor here work for everyone the same, you know?

Another NNS father reported that:

**Data Fragment 9-6 (18C)**

F Well, it’s a bit different, but I don’t know, how you say, it’s a bit more um it’s more friendly here I’d say, in terms of kind relations, but over there you’d see people more professional but I don’t know if they are, doctor wouldn’t be in a shirt he would probably be in a or um um white coat and things like that, it’s more like if you go to hospital here I’d say that you wouldn’t have such practices here.
This father went on to point out that it was too difficult to compare what happens in his country at the moment because of the very bad situation there but that certain things would be better in Australia. The point here of course is not whether things are better or worse, but crucially, that they are different.

Chapter 5 (section 5.3.4) discusses the way in which professional distance is maintained by both participants in a medical consultation through the use of names and titles and argues that a patient/parents’s use of the doctor’s first name, particularly when it has not been sanctioned or invited by the doctor, is an unusual occurrence and one which can make both the doctor and the patient feel uncomfortable (Vafiadis, 1999). Even though he stated that it was a deliberate attempt to address the asymmetry of the interaction, the example cited in data fragment 5.12 where a NNS parent addresses Dr. Colson by her first name could also be interpreted as an interesting example of the NNS interactant misreading the norms of the medical encounter since it resulted in the doctor feeling uncomfortable.

A second feature of institutional discourse is that it often involves special and particular constraints on what one or both of the participants may contribute to the interaction, constraints which commonly reduce the range of options available to a participant and specialisations and re-specifications of the interactional functions (Drew and Heritage, 1992). These institutionalised reductions and specialisations of interactional options found in institutional conventions are culturally variable (see data fragments 9.5 and 9.6 above), and are associated with differing participation frameworks, different footings (Goffman, 1981) and different patterns of interaction (Gumperz, 1992). This means that an individual who may be familiar with the
specific requirements of an institutional interaction in one culture may not necessarily
be equipped to function effectively in the same institutional encounter in another
culture.

Finally, institutional talk may be associated with inferential frameworks and
procedures which are particular to specific contexts (Drew and Heritage, 1992).
Levinson (1992) also argues that in institutional interactions where participants depart
from the ordinary rules of conversation, there will also be specialised aspects of the
reasoning, inferences and implicatures that take place. NNS patients/parents may
have a good functional control of the language and have experienced few problems
functioning at the level of propositional content in ordinary conversation. This is
clearly the case with all the NNS patients/parents in this study who had eschewed the
option of having an interpreter to assist them during their consultations. Non-native
speakers however may experience significant difficulties at the specialised
interpretative level of institutional discourse since in interpreting what is conveyed in
the encounter participants draw on indirect inferences based on their background
knowledge and understandings of what the event is about and how it should work.

Gumperz (1992) has pointed out that where participants in an interaction rely on
different, taken-for-granted inferential strategies they may be unable to negotiate
shared understandings about the interaction. This aspect is illustrated in the
discussion in section 6.2.2. above on multiple address articulation (Candlin et al 1976)
and the role of side-participants (Aronsson and Rundstrom 1989). The parents in
these pediatric interviews are cast in the role of an overhearing audience and the
findings described in Chapter 6 show that in every case NS parents correctly
interpreted that the doctor’s remarks were intended for them and responded appropriately whereas in every case NNS parents fail to recognise the appropriate cues for them to respond indicating that they lack the specific inferential strategies required in this context. Institutional talk differs from ordinary talk in significant ways and has a number of specialised and restricted aspects of inferences and implicatures. NNS patients/parents may have different frames of reference and different, taken-for-granted inferential strategies when they attend a medical consultation.

The overlap and combined effect of these conflicting frames means that the potential for miscommunication is compounded for NNS patients/parents, particularly in light of Pauwels’ (1995) finding that there is a tendency amongst migrants from a non-English speaking background to avoid doctors and to minimise communication with health professionals. The observed differences in the patterns of questioning behaviour between NS and NNS parents is more than a simple difference in linguistic resources but rather is a result of the clash between the subtle differences in communicative competence, or linguistic capital, of non-native speakers (Gumperz, 1992, Bourdieu, 1993, 1999) and the specialised inferential frameworks inherent in institutional discourse (Drew and Heritage, 1992, Levinson, 1992).

9.6 Summary of chapter

This chapter has discussed the three major findings to emerge from this research: that NNS parents ask significantly fewer questions than NS parents, that NS and NNS parents use different question types, and they use them to achieve different interactional goals. The research has shown that NS patients and parents use direct
questions to obtain new information or raise additional concerns. NNS patients/parents do not use direct questions but rather tend to frame their questions as inflected fragments, and when NNS patients/parents do question the doctor it is to seek clarification of information already provided, not to obtain new information or raise additional concerns, even though there is evidence that they have those concerns.

The chapter has also shown that when patients and parents do ask questions they are usually answered by the doctors, with only the single indirect question and some tag questions being overlooked or avoided by the doctor. There are some differences in the timing of patient-initiated questions by NS and NNS patients/parents but there is no evidence in these data that the timing of questions has any effect on whether they are answered or not. The timing of questions however does have the potential to influence the degree of involvement the patient achieves in the consultation and the amount of information and explanation the doctor provides, particularly in the case of the doctor who has a more patient-centred approach. The timing of NS patient/parents -initiated questions in particular leads to greater opportunities for involvement.

The chapter has also argued that these differences in their patterns of questioning behaviour can result in NS and NNS patients/parents achieving different levels of access to information and as such NNS patients/parents are more advantaged by a doctor-centred approach than they are in more patient-centred consultations.

Finally, this chapter has presented the argument that the observed differences in the patterns of questioning behaviour between NS and NNS patients/parents is more than
simple lack of linguistic resources but rather is a result of the clash between the subtle
differences in communicative competence, or linguistic capital, of non-native
speakers and the specialised inferential frameworks inherent in institutional discourse.
CHAPTER 10  Conclusion

There is a considerable body of evidence that the medical encounter can be the site of miscommunication and that such miscommunication can have serious implications for the health and wellbeing of patients in Australia today. Mishler (1984) discusses the medical interview in terms of the conflict between the voice of medicine and the voice of the lifeworld (1984:14) and argues that the voice of medicine objectifies the patient and strips away the lifeworld context of their problems (1984:128). In 1977 Engel proposed a new model of medical care, a biopsychosocial model, as a challenge to the prevailing biomedical model which he argued was too restrictive and reductionistic. He acknowledged the importance of patients' social and emotional needs and argued that such needs must be considered within the goals of medicine. His argument echoes and revitalises the notion "it is not a question of what sort of disease the patient has, but what sort of patient has it" (Ostler, undated, cited in West and Frankel, 1991:194).

The structure of the biomedical model of medical interviews routinely restricts the type and range of speaking opportunities available for patients. This study indicates that the situation is even more difficult for NNS patients/parents, who ask fewer questions overall and when they do ask questions those questions are of a different quality, and used for different purposes.

This analysis shows clearly that both doctors answer questions and are willing to provide explanations to both NS and NNS patients/parents. The difference however between a doctor who uses a more doctor-centred approach and is described by his patients/parents as one who 'explains everything so there is no need to ask questions' and the one who is more patient-centred and 'is happy to explain if you ask' means
that patients/parents who do not ask questions, who are, as demonstrated here, overwhelmingly NNS patients/parents, are more ‘enabled’ to use Howie et al’s (1999) term by a doctor-centred consultation style.

These data show that patients/parents are generally more satisfied with their consultations with Dr. Maxwell, and whether or not they receive quantitatively more information than those patients/parents who see Dr. Colson, they are happy with the amount of information they receive, lending support to the thread in the literature (e.g. Kupst et al, 1975) which indicates that it is not the absolute amount of information that is linked to patient satisfaction, but rather the patient’s perception that they have been listened to, considered, and fully informed. While it is not possible to determine absolutely whether it is Dr. Maxwell’s doctor-centred approach which leads to more satisfied patients/parents or if it is simply a result of his individual communicative ability, there is support in the literature for the assertion that it is the approach itself which is the critical factor (Savage and Armstrong, 1990, Ibrahim 2001).

As we have seen, communication difficulties can occur in institutional interactions where both participants share a common language and cultural background but such difficulties can be further compounded by the different expectations of patients and doctors in those interactions which occur in a cross-cultural context. Australia is one of the most culturally and linguistically diverse countries in the world with over 26% of the population born overseas and more than one hundred languages other than English used at home by members of these migrant populations (ABS 1999). It is therefore essential that health care providers are aware that although some markers of cultural difference are readily apparent, others are not, and the effect that cultural
beliefs can have on communication may remain unrecognised and unacknowledged (Kreps and Kunimoto 1994).

10.1 Limitations to the study and directions for further research

There are a number of aspects of this study which act as limitations on these findings and which warrant further investigation.

Several polar distinctions can be found in the data: data for the present study were collected from both public and private medical sites and while these variables were considered in the statistical analyses they were not otherwise examined. An analysis which compares these two could yield some interesting results. Similarly, the issue of whether the consultation is an initial or follow-up visit could warrant further investigation. Both types of consultations appear in these data but as pointed out in Chapter 7 (7.3) this aspect of the data was not fully explored and further investigation could be fruitful.

Some interesting and statistically significant findings have emerged from these data about the effect of the individual doctors on the questioning behaviour of their patients/parents. While it is tempting to describe these differences as gender based, the consultations analysed for this study were gathered from only two doctors, one male and one female. It is therefore not feasible to generalise these findings as gender differences, since it is not possible to determine if those observed differences are in fact attributable to the gender of the doctor or if they are simply a result of the individual personalities of the two doctors. It would be very useful to replicate this study with a larger number of male and female doctors and/or to conduct a more
quantitative analysis of such a study to determine if the patterns identified here can in fact be attributed to gender differences in the doctors.

Another aspect of these findings which warrants further examination is the amount of information received by patients/parents as a result of their questions. This study has briefly considered parents’ reported levels of satisfaction with their children’s consultations and their perceptions of the amount of information they had received from the doctor. It would be an interesting step to compare the amount of information actually provided by the doctors to determine if there is any quantitative difference.

As discussed in Chapter 4, this study is also based on pediatric consultations which means that the normal patterns of communication between the doctor and patient are distorted in a number of ways. The strategy of child-directed talk used by Dr. Maxwell which seems to assist comprehensibility for NNS parents would of course not be a feature of adult to adult interactions. In pediatric consultations further demands are placed on the doctor who is required to shift from examining and dealing with the patient to consulting and interacting with the parent and on the parent who also needs to negotiate several participant roles. The additional stress and distress associated with being the parent of a sick child plays a role in the communicative process adding another potentially important dimension to these data. For these reasons it would be very valuable to conduct a similar comparative study between NS and NNS adult patients to determine if the differences in questioning behaviour identified in this study apply in other medical encounters.
Finally, given the controversial nature of the native/non-native speaker dichotomy, other researchers might wish to narrow or otherwise adjust my definitions of these categories to then test their findings against the results of this study, or to consider specific cultural expectations of the doctor-patient interaction from the point of view of the patient.

10.2 Implications for doctors and health educators

This study has highlighted several issues which warrant consideration by doctors and health educators. The study indicates that there are two key factors which determine whether or not patients will ask questions: the language background of the patient (or in the case of pediatric consultations, the parent) and the consulting style of the doctor.

It is clear from this study that NS parents are much more likely to ask questions during their consultations than NNS parents, and that their questions are likely to introduce new topics and seek additional information on existing topics. Doctors could reasonably expect that if a NS parent had concerns about their child’s symptoms, condition or treatment they could and would raise those concerns. The same can not be said however of NNS parents. It is clear that such parents will also have concerns about their children, but it is less likely that they will voice those concerns in the form of a question.

Asking questions is an assertive act which may be too direct or threatening for many NNS parents. Rather than asking direct questions they may attempt to use a range of
alternative strategies such as attempting joking remarks about their uncertainties, reporting comments made by others, often family members, or simply hinting at or making oblique references to the cause of their concern. There is evidence in these findings that some may simply fail to raise their concerns at all.

In order to address this problem, doctors need to develop an awareness of the various means available to any patient to display their need to be better informed. It is also essential that health care providers are made aware that cultural and linguistic factors may not always be visible but can play a significant role in the communication between themselves and their NNS patients. Cross-cultural communication should be a feature of the communication skills component of medical training programs.

The second factor in whether or not patients ask questions is the communicative style of the doctor. While it is not possible to generalise from these findings, they do seem to indicate that those patients who are least likely to ask questions, usually NNS patients/parents, will benefit from a more traditional, directing approach. If a patient will not or can not ask questions, for whatever reason, a doctor whose style is co-operative and depends on patient participation may not fully address all aspects of such a patient/parent's concerns. On the other hand a doctor who assumes a more directing role and provides as much information as is feasible regardless of whether there are patient/parent-initiated questions is more likely to satisfy such patients/parents' needs without the patient/parent having to ask questions.
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APPENDIX 1 – Informed Consent Guidelines

PARENT / GUARDIAN
INFORMATION STATEMENT

Project No EHRC 99057A

Lay Title of Project

A linguistic analysis of the communication between doctors and patients and their parents.

Thank you for taking the time to read this Information Statement.
This information statement is 3 pages long. Please make sure you have all the pages.

Your child is invited to participate in a Research Project that is explained below.

What is the Research Project about?

The purpose of this study is to look at the way doctors, patients and their parents talk to each other during medical visits. It will look at visits with patients who are native speakers of English and patients for whom English is a second language, and describe the language and behaviour which occurs to try to identify areas of misunderstanding between doctor and patient, and to examine the causes of those misunderstandings. We hope that the results of such a study will help doctors and patients to understand each other better during a consultation, and therefore improve the quality of medical care provided.

Who are the Researchers?

Ms. Anne Kanaris, is a PhD candidate at the University of Melbourne and is the person who will be carrying out the observations. Dr. Brian Paltridge, (Dept. of Linguistics and Applied Linguistics, University of Melb) is the project’s supervisor. Dr. Senior Ophthalmology Consultant, Hospital is one of the doctors who practices in the hospital and who has agreed to take part in the study.

Why am I and my child being asked to be in this research project?

The project is aimed at finding out and describing exactly what happens between doctors and their patients so that we can identify whether any misunderstandings, or communication difficulties occur, and, if so, what caused them. It is therefore important to observe real consultations with real patients.

What does my child need to do to be in this research project?

With your consent, your child’s consultation will be observed by the researcher, and will be audio-recorded for later analysis. You and your child will also be asked to participate in a short interview after the consultation to talk about it, and to provide some information about your and your child’s first language, if relevant.

Is there likely to be a benefit to my child?
It is not likely that there will be any immediate benefit to your child, although there may be an improvement in the quality of care in future consultations.

Is there likely to be a benefit to other children in the future?

Yes. This study is aimed at improving doctor-patient communication, and improving cross-cultural understanding, which will improve the quality of medical care for other children in the future.

What are the possible risks for my child?

The project involves audiotaping your consultation and does not present any physical risks to your child.

What are the possible discomforts for my child?

It is possible that your child will become embarrassed or uncomfortable during the consultation because of the recording. If this occurs, the researcher will stop recording immediately and will leave the room if necessary.

What are the possible side effects?

There should be no side effects.

What are the likely things that could be an inconvenience for me or my child?

As described above, embarrassment at being observed. Short delays after your consultation to talk to the researcher.

What will be done to make sure the information is confidential?

No identifying details will be recorded at any stage. First names only will be used, and all names will be changed in the report. All data will be kept in a locked cabinet at the University of Melbourne and destroyed after 5 years.

Will I be informed of the results when the research project is finished?

Since personal details will not be recorded, it will be difficult to contact you when the project is finished (approx. 3 years). However, if you wish to be informed, that can be arranged.

You can decide whether or not you give permission for your child to take part in this research project.

You can decide whether or not you would like to withdraw your child from this research project at any time. No explanation is needed.

You may like to discuss your participation in this research project with your family and with your doctor. You can ask for further information before deciding if your child will take part.

The name and telephone number of the person to contact for more information or in an emergency.

Ms Anne Kanaris, 9375 3503

For parents/guardians who speak languages other than English

If you would also like information about the research and the Consent Form in your language, please ask for it to be provided.
What are my child’s rights as a Participant?

1. I am informed that no information regarding my child’s medical history will be released. This is subject to legal requirements.

2. I am informed that the results of any tests involving my child will not be published so as to reveal my child’s identity. This is subject to legal requirements.

3. The detail of the procedure proposed has also been explained to me. This includes how long it will take, how often the procedure will be performed and whether any discomfort will result.

4. It has also been explained that my child’s involvement in the research may not be of any benefit to him or her. I understand that the purpose of this research project is to improve the quality of medical care in the future.

5. I have been asked if I would like to have a family member or a friend with me while the project is explained to me.

6. I understand that this project follows the guidelines of the National Health and Medical Research Council Statement on Human Experimentation (1992).

7. I understand that this research project has been approved by the Hospital Ethics in Human Research Committee on behalf of the Women’s and Children’s Health Care Network Board.

8. I have received a copy of this document.

If you have any questions about patient rights contact

The Secretariat
Ethics in Human Research Committee
Phone
STANDARD INFORMED CONSENT
FOR PARENT / GUARDIAN TO GIVE CONSENT
FOR THEIR CHILD TO PARTICIPATE IN A RESEARCH PROJECT

Lay Title of Project

A linguistic analysis of the communication between doctors and patients and their parents.

Principal Investigator(s)    Ms. Anne Kanaris; Dr. Brian Paltridge (University of Melb); Dr.

Brief outline of research project including benefits, possible risks, inconveniences and discomforts (12 lines maximum)

The purpose of this study is to look at the way doctors, patients and their parents talk to each other during medical visits. It will look at visits with patients who are native speakers of English and patients for whom English is a second language, and describe the language and behaviour which occurs during those visits to try to identify areas of misunderstanding between doctor and patient, and to examine the causes of those misunderstandings. We hope that the results of such a study will help doctors and patients to understand each other better during a medical visit.

If you consent, your child’s visit will be observed and recorded. You and your child may also be asked to take part in a short interview after the visit to talk about what happened. We do not need to see your child’s medical or other confidential material at any stage of the project. If at any stage of the visit you or your child feel uncomfortable, the researcher will stop recording and leave the room.

I (Parent/Guardian name)  
Parent / Guardian of (child’s name) voluntarily consent to him / her taking part in the above titled Research Project, explained to me by Mr / Ms / Dr / Professor  

I have received a Parent/Guardian Information Statement to keep and I fully understand the purpose, extent and possible effects of his/her involvement. I have been asked if I would like to have a family member or friend with me while the project was explained.

I understand that if I refuse to consent, or withdraw my child from the study at any time without explanation, this will not in affect my child’s access to the best available treatment and care from The Women’s and Children’s Healthcare Network. (The Hospital OR Hospital). I understand I will receive a copy of this consent form.

PARENT GUARDIAN SIGNATURE ___________________________ Date ____________

WITNESS ___________________________ Name ___________________________ Relationship ___________________________

WITNESS SIGNATURE ___________________________ Date ____________

RESEARCHER’S SIGNATURE ___________________________ Date ____________
STANDARD INFORMED CONSENT
FOR PARTICIPANT TO
PARTicipate in a research PROJECT

Project No: EHRG 99057A

Lay Title of Project
A linguistic analysis of the communication between doctors and patients and their parents

Principal Investigator(s)
Ms. Anne Kanaris; Dr. Brian Paltridge (University of Melb); Dr.

Brief outline of research project including benefits, possible risks, inconveniences and discomforts (12 lines maximum)
The purpose of this study is to look at the way doctors, patients and their parents talk to each other during medical visits. It will look at visits with patients who are native speakers of English and patients for whom English is a second language, and describe the language and behaviour which occurs during the visits to try to identify areas of misunderstanding between doctor and patient, and to examine the causes of those misunderstandings. We hope that the results of such a study will help doctors and patients to understand each other better during a consultation.

If you consent, your visit will be observed and recorded. You may also be asked to take part in a short interview after the visit to talk about what happened. We do not need to see your medical or other confidential material at any stage of the project. If at any stage of the consultation you feel uncomfortable, the researcher will stop recording and leave the room.

I, ___________________________________________,
voluntarily consent to taking part in this research project, which has been explained to me by

Mr / Ms / Dr / Professor ___________________________________________

I have received a Participant Information Statement to keep and I fully understand the purpose, extent and possible effects of my involvement. I have been asked if I would like to have a family member or friend with me while the project was explained.

I understand that if I refuse to consent, or if I withdraw from the study at any time without explanation, this will not affect my access to the best available treatment and care from The Women’s and Children’s Healthcare Network (The Hospital OR The Hospital)

I understand that I will receive a copy of this consent form.

_________________________________________ Date _______________
SIGNATURE

WITNESS
(not a project investigator) Name __________________________ Relationship __________________________

_________________________________________ Date _______________
WITNESS SIGNATURE

_________________________________________ Date _______________
RESEARCHER’S SIGNATURE

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**APPENDIX 2 – Field Notes Samples**

<table>
<thead>
<tr>
<th>Loss</th>
<th>1/10</th>
<th>0.2 cent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>my name is RC</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>how are the joints going</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>you know what I mean</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>how are you feeling today</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>I think it's going to be OK</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>I'm going to help you relax here, so I can look at your eyes</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>I want to have a think about what you have</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>mouth turned down, yawn</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>red spots on her body</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>alright</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>is that what you would be expecting</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>alright</td>
<td></td>
</tr>
</tbody>
</table>
11/01
10:55

Gen. Assessment & Doctor

- First visit - 'Quick look' thru' history.

Jushte, the oldest one, astigmatism,

(M) she looks to turn - Em moves head

her, you know, what do you call

it? - eyeshine with hands to

indicate 'peripheral vision'

K) sat next to (my) - Still upset after

drops, (D) moved her to exam chair

- Look at my face - bringing things

into range, but 'C' actually looking at

object, not 'D'

- Clair pumped up, 'C' engaged it!

- clown up here - look at my figure,

and now look at my ear

eard. Look at my ear

'Eye wandering - look shinger asked

good, rest back - (no response)

rest back

another test & lining out - 6 lenses

- Lining back on - Big smile from 'C'

- Silence maintained while 'D' wakes up

- hemi pleasia?

- measured bed & hit - why?
APPENDIX 3 – Transcription Conventions and Sample Transcripts

Transcription Conventions

The transcription conventions used in this study are based on those of Gail Jefferson which are commonly used in discourse and conversation analysis. (Levinson, 1983, Hutchby and Wooffitt, 1998, Atkinson and Heritage, 1999)

<table>
<thead>
<tr>
<th>Convention</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>So she[may go yes</td>
<td>Opening square brackets indicate where overlapping talk commences</td>
</tr>
<tr>
<td>Go::d</td>
<td>Colons indicate the elongation of the syllable. The number of colons indicate the extent of the elongation</td>
</tr>
<tr>
<td>YES</td>
<td>Words in capital letters indicate that the word(s) are spoken more loudly than the surrounding speech</td>
</tr>
<tr>
<td>You have been very good</td>
<td>Italic indicate that the word has been emphasised</td>
</tr>
<tr>
<td>(2.0)</td>
<td>Numbers in brackets indicate the duration of pauses (in seconds and tenths of seconds)</td>
</tr>
<tr>
<td>.</td>
<td>Indicates a hesitation of less than one tenth of a second, other than a pause caused by the natural rhythm of the speaker’s speech</td>
</tr>
<tr>
<td>(fluent)</td>
<td>Indicates that the word is not clear to the transcriber – best approximation of what is heard</td>
</tr>
<tr>
<td>( )</td>
<td>Unable to transcribe the contents</td>
</tr>
<tr>
<td>((closes door))</td>
<td>Double brackets contain descriptions or researcher’s comments about what is happening</td>
</tr>
<tr>
<td>Patches?</td>
<td>Punctuation marks used to indicate intonation and natural speech rhythms</td>
</tr>
<tr>
<td>.hh</td>
<td>Audible inwards breath</td>
</tr>
<tr>
<td>hh</td>
<td>Audible outwards breath</td>
</tr>
<tr>
<td>= the next six months</td>
<td>= indicates that the utterance is latched to the speaker’s previous utterance without pause, even if there is an attempt to interrupt</td>
</tr>
<tr>
<td>→</td>
<td>This symbol in the left-hand column is used to highlight a feature of interest and features being discussed in the text.</td>
</tr>
<tr>
<td>[ now, where is that file ]</td>
<td>Square brackets indicates that the speaker is thinking aloud or speaking to themselves</td>
</tr>
</tbody>
</table>
Sample Transcriptions

Transcript 12B: Marcus. Dr. Maxwell: NNS

1  D  hullo Mr. Marcus, do you want to hop up on the big chair there, and you’ve met my friend Anne, haven’t you?
2  C  mmm
3  D  And, you can sit, you are going to share a chair. How are you today, are you good? And how have you been since I saw you last time? You’ve been wearing your glasses?
4  C  mmm
5  D  you’ve been wearing them all the time?
6  C  ((nods))
7  D  That’s good. And does anyone say anything about your glasses?
8  C  ((nods))
9  D  Do you like wearing your glasses?
10 C  ((nods))
11 D  Does, anyone at school wear glasses too? Or are you the only person in your class?
12 C  only me
13 D  only you! Well you are so very smart. And how did you go with your eye test next door with Barbara? Could you see all the little letters really well? That’s terrific. That’s the main reason we get you to come back, is to check that you can see well with both your eyes.
14 C  ((nods))
15 D  With both eyes?
16 C  ((nods))
17 D  And how old are you now?
18 C  five
19 D  five! So you’re growing up very quickly aren’t you?.
20 C  mm
21 D  and your vision’s equal, so did you have any problems with your eyes at all? Or are they good?
22 C  good
23 D  right. Is mum noticing any problems?
24 M  no,
25 D  Okay, I’ll have a quick look at your eyes and then we might just give you a pat on the back and check you in another six months, how old will you be then?
26 C  I don’t know
27 M  ((laughs))
28 D  what comes after five?
29 C  six?
30 D  six, and, it won’t quite be your birthday, so you’ll be five and a half, still. Alright, can you see my dinosaur there?
31 C  ((nods))
32 D  what sort of dinosaur’s that one?
33 C  a long-neck
34 D  a long-neck dinosaur, and do you know the proper names for long neck dinosaurs?
35 C  no
36  D  how would you find out the name of a dinosaur? (2.0) where could you find out the names of a whole lot of dinosaurs just look up there, good, look there, look here, you could find it in a book, where would you get a dinosaur book from?
37  C  from the library?
38  D  yeah! So next time you go to the library, you see if you can get a book on dinosaurs and you can tell me next time you come what the names are. which they’re all changed since I was a little boy. Can you look through my window?
39  C  yeah
40  D  good, so we just need you to keep wearing your glasses, we don’t need you to have any patches, or any operations, and we can see you in another six months, will that be okay? Would you like a jelly snake for being a good boy today?
41  C  ((nods))
42  D  alright, do you think you need one for anyone else?
43  C  yeah, (laughs)
44  D  there’s a spare one ( )
45  C  thank you ((both children together))
46  D  okay, now I’ll give you a note to give to Michelle, and we’ll see you in six months time,
47  M  (   ) he’s got his snake, he’s off. That’s lovely, [thanks very much, bye  
48  D  [okay, we’ll see you then
Transcript 13B: Robert. Dr. Maxwell: NNS

1  D  oh, this one, do you want to sit in the big chair there, and dad can sit
over there, and you’ve met my friend Anne,

2  F  Oh yes [ (  )
3  D  [ ( )and you saw (. ) Dr. Wendy last time, is that right?
4  C  yes
5  D  and you’d seen me a while back, the last time I saw you was way
back in: (2.0) October last year, so you’re a year older, you must be
seven, is that right?
6  C  nods
7  D  And we saw you a long time before then at the Blackburn clinic, and
I gave you some glasses to wear so that your eye didn’t turn in. And
how did you go with your visual test next door with Barbara, did
you see well out of both your eyes?
8  C  yeah
9  D  hmm hmm, [good
10  C  [um, just, maybe, when I, the left eye, um I’m a bit, I’m
a bit, um badder on the left, than on the right.
11  D  you are, just a fraction
12  C  yeah
13  D  It’s not too bad now, and because you’re aged seven I don’t think
we need to get you to wear a patch, (2.0) you’re right eye is better
than average and your left eye is [about average
14  C  [yeah, um, usually, but um
15  D  did we ever get you to wear a patch before?
16  C  yeah
17  D  how long has it been since you wore the patch last time?
18  C  er, it was about time I was going to [(  )
19  F  [but he never wore a patch at
20  D  home
21  F  he never wore a patch at home
22  D  right
23  F  maybe [just a tissue
24  D  [okay, right, okay, so, good, (4.0) the current glasses(.) have
been pretty much the same since Dr. Marshall did them in June? Did
you get a new pair then, or are they the old ones?
25  F  well, we got a new lens in
26  D  right
27  F  to change ( (  )
28  D  Right, hmm hmm, (6.0) and any problems with your eyes?,
29  C  no
30  D  does dad thing there are any problems with your eyes?
31  C  I don’t think so
32  D  and are they nice and straight when you keep your glasses on?
33  C  yeah
34  D  you haven’t noticed he’s still turning with the glasses on?
35  F  no, not since June
36  D  right, and with the glasses off, has anyone noticed?
oh he does turn

Right, oka ;y, (4.0) and Barbara thought you were pretty straight with your glasses, I’ll just get you to look at my dinosaur here, what sort of dinosaur is that?

[oh, very good,
[I can never tell the difference between them
oh, I think it’s the same thing, (.) [when you
[no, they’re different
are they?
The brachyosaurus is
( )
they’re not the same?
no, they’re not the same, ( )
okay, (3.0) because we used to call them all brontosaurus and now hardly any of them got called that, they changed all the names. (6.0) So where did you learn all about dinosaurs?

um
have you got a few books about them?
yeah, we’ve got a few, a big book about this thick about them
great, can you look at me, that’s great. So are you going to be, become a paleontologist and go and dig up dinosaur bones?
oh, I don’t think so
right
no, ( )
It’s an interesting subject
one of my favourite subjects is reading, so
great, and you get to see dinosaurs on television too, did you see Jurassic park?

Um, a little bit of it,
It might have been a bit violent, maybe when you’re a bit older,
But I don’t, it’s not my favourite movie
oh, okay, can you take your glasses off for me?, can I get you to look at my ear, and I’ll have a look at the back of your eye, you’ve been very ( ) today, look at my other ear, (4.0) terrific, you can pop your glasses back on now, well your vision is good and your eyes are straight, with the glasses that you’re wearing at the moment, I think we can just keep you just wearing glasses all the time and see how you go.

yeah
so you can take them off for the bed, the bath and the beach,
yeah
and when you go on the trampoline or any other very active sports, but I’d like you to keep wearing them all the time until you’re about eight and a half,

yeah
alright? And then after then you can be in charge,
yeah
and if your eyes are straight with them on it would probably be a good idea to keep them on, so we are getting to the end stage of all of the treatment process where his brain and visual systems are
fairly mature, and (walking around) isn’t going to cause any harm to
his vision. I think it would be worth while checking him in about
four months time, do you want to come back and see me, [or Dr.
Marshall

72  F  [yes ( )
73  D  ( ) that’s fine, (1.06) so if we see you in January or February,
that will be at the beginning of your school year next year, what year
are you going to be in then?
74  C  year three
75  D  okay, so four months time,
76  C  and it’s going to be my birthday and I’ve going ( )
77  D  okay, so you will be eight then
78  C  yeah, ( ) for my birthday
79  D  Okay, well, you’ll be a real grown up then
80  C  yeah
81  D  can you give this to Margaret, the lady at the desk =
82  C  yeah
83  D  = and she’ll, I think we may have to pop your name in the reminder
book, I don’t know if we’ve opened up the appointments for
February yet, but we’ll check you then.
84  C  yeah
85  D  okay, have you got any questions?
86  C  no
87  D  no? any questions from dad?
88  F  that’s fine
89  D  We’ll see you later.
90  C  bye
91  D  do you want a stamp or a jelly snake?
92  C  a jelly snake.
93  D  what colour would you like?
94  C  er, (.) a yellow
95  D  a yellow
96  C  yeah
97  D  that one, there you go,(.) see you later, okay, bye.
Transcript 31B: Dean. Dr. Maxwell. NS

1. D how are you going?
2. M [fine
3. D [Hi, how are you today?
4. C good
5. D do you want to have a seat in the big chair? And you’ve been chatting with Anne? And Barbara (0.5) checked your glasses, do you think that the new lenses that Barbara put up were better than the ones that you’re wearing?
6. C oh, (0.3) a bit, a bit better
7. D a bit better, how old are the ones you’ve got on at the moment?
8. C um,
9. M gosh, they’d be a few years, we thought that his frames were getting a bit small for his head, [so
10. D [ hmm hmm
11. M yeah, we thought it might be time [for a new
12. D [I’ll write out a new prescription for you then. Okay. (0.2) And have you had any troubles with your eyes since I saw you last?
13. C um, no, no
14. D how’s school going?
15. C good
16. D what year are you in next year, coming up?
17. C oh, grade five
18. D mmm, an old, (0.2) student at the school
19. C [mmm
20. M [mmm/
21. M we were also wanting him to get some goggles for swimming with prescriptions,
22. D hmm hmm
23. M and I’ve been to a few places to try to get some off the shelf
24. D yeah
25. M sort of with the highest, but they’re not stocking them,
26. D mmm
27. M um, does he need to have a script written? = They said they’d need to send away, and, get some made for him.
28. D um, the problem is you’re getting a bit out of my depth in knowing what the power to prescribe is,
29. M right
30. D the (0.2) problem with prescribing, um, goggles is, that you can’t really get any power out of the front surface, you’ve got to get it all out of the back surface and the side and for such a high power it may not be, (0.2) possible, right
31. M right
32. D um (0.2) so, are they optometrists you’re going to [for goggles?
33. M [yes, I went to OPSM and
to where my daughter goes to her optometrist.
34. D right, so I think, (0.4) he was wearing one sixes wasn’t he, off the shelf, before?
35. M uh, he hasn’t worn any before, when I was speaking to you last time I was going to get some, um, but he stopped his swimming lessons, um but he’s having to start them again this year, so, (0.2) I really need to get him some
soon, so he hasn’t actually had any prescription ones before. (0.5) I think that perhaps they just weren’t stocking them in if I asked for a certain, um, measurement, they [would]

[ mmm

36 D get it in
37 M mmm, right, yeah, although (0.4) we’d probably not treat the astigmatism.
39 M right
40 D I’d just give him the cylinder, er the sphere component,
41 M right
42 D um, (13.0), um, so I’ll let you talk to the optometrist about that, they may work out what power
43 M so they’ll be able to just look at his script for his glasses [and
44 D out a (0.2) compromise
45 M yeah
46 D what’s feasible
47 M right
48 D I’m pretty sure they’d never be able to give him that script
49 M no, no
50 D on a goggle, but if you speak with them and say, well, you know, can we just do a spherical equivalent,
51 M right
52 D without the cylinder component,
53 M right
54 D or even if, you know, both eyes are virtually identical
55 M right
56 D that’s sometimes easier, but they may be able to make it up
57 M right
58 D it depends on how much you want to pay,
59 M right
60 D and, you know, what level you go to.
61 M right
62 D ideally, as he gets older, wearing a pair of contact lenses under his goggles would probably be the best (0.3) [compromise
63 M [yes
64 D and ideally, probably using the disposable type of contact lenses
65 M yeah
66 D so if you lose them, [it’s not a big deal
67 M [that’s what my daughter is using, yeah
68 D yep
69 M yeah
70 D so, I’ll give you that,
71 M thank you
72 D I’d better check I put the date on it, [I keep forgetting how to write the date these days
73 C [ er, mum, er what, when, um, I use um Joe’s goggles at Rinley park when I went under, right, yeah, under the water, with just his, his normal goggles, yeah I could actually see better than without my glasses, above water.
74 M oh, h?
75 C like we, with my goggles, with his goggles on, above water, no difference, but
under water I could see, like, almost perfectly.
76 M ohhh, that’s really interesting, isn’t it?
77 C just normal goggles.
78 D you must have had just the right power using them on the water.
79 M mmmm
80 D oka:y, let’s have a look at the rest of your eye we didn’t put any drops in
today,
81 M no
82 D we don’t need to do that every time, you come, okay, now
83 M look, I was just wondering if he has his glasses off, well I’m not sure if its
worse, but, (0.5) the turn in his eye seems to be (0.2) perhaps a little more?
84 D your old glasses aren’t too bad power respect, can you slip your glasses off for
me? (0.6) no other troubles at school with your eyes?
85 C er, no, no troubles at school.
86 D can you see the board okay?
87 M yes, he sits up towards the front, we’ve spoken to the teacher
88 D ‘cos even with your glasses on you’re a little less than average, look at my ear,
(3.0) good, (.5.0) look at my ear. And his sister wears contact lenses some of
the time or all of the time?
89 M all of the time.
90 D and does she find that she sees better with her contacts than with her glasses?
91 M I think she does, yeah, she’s taken to them, no troubles at all, she’s been
wearing them two years, she started in grade five,
92 D hmmm mmm
93 M um, [Drew
94 D [how do you reckon you’d go?
95 C um,
96 M with contacts
97 C oh, with contacts? Um, I don’t really want to use um, use contacts, so,
98 D its up to you, it has to be something you want to do ‘cos you’re the person
who has to put them in and take them out and keep them clean, so, its just as
long as you know about it, see what you think, (0.5) in general, girls tend to do
it a little bit, earlier than boys, because its part of the, knowing how to put on
eye make up, [and
99 M do things around their eyes,
100 D [yes
101 M mmm
102 D most boys tend to faint when you put anything near their eyes.
103 M ((laughs)) yes, I think we might wait a little while then, ((laughs)) will he get(.
.) better vision if he (. ) uses contacts?
104 D possibly.
105 M right.
106 D sometimes yes, sometimes no,
107 M right.
108 D umm, it would vary, (0.2) but we’d need to wait and [see
109 C [um, excuse me, um how
old do you have to be before you can have that laser thing so you don’t need
glasses or contacts and you can just see normally?
110 D er, at the moment we really need people to be over eighteen, and they can
decide for themselves,
111 M hmm hmm
so it’s a few years to go yet.

uh-huh,

alright?
er, you just said they can decide for themselves, you can have it when you’re younger and your parents decide on?

well, at the moment we’re not (.) tending to do that because, we don’t know what’s going to happen in thirty or forty years time? ‘cos they’ve only been doing it now for ten years, (0.2) and how much longer do you plan to stay alive for? (4.0) how old do you think you are going to live to?
er

what’s the average boy going to live to? How old?

don’t know the average age, but I’d want to live to, (0.2) a hundred and twenty.

uh, that’s a long time, you’d be breaking world records a bit with that,

[([laughs])]

[((laughs))]

um, most people you’d want them to be able to see pretty well until they’re about eight^{a}, so that’s at least ooh, another, seventy years for you?

mmm

and we’d want to know that if we’d do the laser on your eyes it would be alright in thirty or forty years, and fifty or sixty years, and at the moment we don’t quite have that information, (0.3) so we tend not to do new things on young people, ‘cos they’re going to have to live with it for a lot longer.

so I can’t get them until I’m over eighteen

d when you’re eighteen and you’re in total charge of what you want to do with your body, then you can decide if you want to have it done, but at the moment we’re tending not to do it on young people, (0.3) alright?

there was an operation I heard of where they um, put contact lenses [into the eye

[inside the eye

is that the same situation, or not?

yeah,

right.

although that’s a: (.) far more reversible procedure,

right.

but its ([2) more experimental.

oh, right, okay.

but one of the (.) issues with all of this is that most people with the laser don’t get vision better than they had with their best glasses.

right, right,

and you do actually risk dropping the vision, the best vision with glasses.

right.

and because you’re vision’s on the borderline anyway, you, you wouldn’t want to risk losing [that little bit

[ no, no

so that’s one of the issues.

[right

you have to go through with that

when it comes time to, to, for driving for him, is he going to get a licence?

hmm hmm.
right,
yeah, but you are, a fraction less than average but not (.2) below a licence level, that would be one of the issues [of

| mmm |

you know, dropping a line of vision, how could that affect me, well it might take him [below that standard.

| yes, yes |

so,
‘cos I was speaking to the optometrist where my daughter goes, when I had her last script done, and they said they could get a thinner one but it would be in glass but I was very nervous about glass, at his age, um,

| yeah, its not really that big an issue. |

| right |

as long as you’re sensible about (.) sport and things,

| yeah |

the glass is as good as plastic

| right |

(12.0)

it’s a fairly strong glass, is it? That they?

| (3) yeah, you usually get hardened glass. |

| right, |

(6.0) I think that we might let you go for another eighteen months, how would that be?

| okay |

| alright, so I’ve given you the prescription. |

| yes, thank you. |

| if you decide you want contact lenses, who fitted your sister’s contact lenses? |

| um, Freeman and Smith at Kilburn |

| okay, so you could go back and see them, you could actually do that directly (.) |

| [right |

| without having to see me. |

| right, right, okay, and the turn in his eye, isn’t worse than it was? |

| not enough to be concerned about. |

| right |

| it measures about twenty prism diopteres, which is the amount that we usually wouldn’t do anything. |

| right |

| and with the (0.2) prism effect of the lenses you don’t really notice it |

| no, no, if he goes to contacts, will you notice it then? |

| possibly, |

| right |

| but I suspect it would be (0.2) quite mild. There’d be far more people noticing, gosh you look different without your glasses. |

| yeah |

| than actually going, oh, you’ve got a slight turn in your eye. |

| right, right, |

| so, |

| okay, [good, |

| [ okay, any more questions? |

| nup |
192 D are you happy with that?
193 C yep
194 D alright? So I might check you in about a year and a half?
195 M okay,
196 C yeah
197 D and, (6.0) I might pop some drops in next visit.
198 M right
199 D just to check the back of the back of your eye, and, we'll see how you go,
[and
200 M [ good
201 D I'll drop Dr. Timson a note.
202 M okay.
203 D and we'll see you then.
204 M great
205 D if you hand that to the ladies at the desk, and I'll see you later.
206 C okay.
207 D do you want a jelly snake?
208 C yes please.
209 D to everyone, what colour?
210 C red please.
211 D a red one
212 M doesn't want to come ((laughs))
213 D alright
214 M [thanks very much
215 C [that's the second one today
216 D you're doing well, ((laughs)) [okay
217 M [ ((laughs)) thanks
218 D see you later.
219 M say thank you.
220 C thank you.
221 M see you later.
222 D bye.
Transcript 22B: Declan. Dr. Colson. NS

1  D  How are you?
2  M  good thanks, [God, you're flat out aren't you,=
3  D  [Good.
4  M  [=just for a change, ((laughs))
5  D  [yes, um, ((closes door)) now,
6  M  do you want to say hullo?
7  D  Hiii, do you want to come and sit down, hullo, I like your
8  C  smile, I was moving very fast then, wasn't I?
9  D  want to sit down?
10 M  okay, you can sit down,
11 C  you can sit there, just let mummy unhinge the bag, now, I've,
12 M  (.) you'll have to sit on my knee,
13 D  who?
14 M  That's your friend Dr. Colson.
15 D  Yes.  (1.0) okay, so: o, I'm just looking at, um your,
16 C  orthoptist's notes
17 M  Yeah, right,
18 D  what do you think?
19 M  Ooh, (.) I dunno, I'm not, it might, (0.5) still
20 D  Umm, I think what you said ( ) there, ((both laugh))
21 M  er, yeah, look, I think they're, um, both, they are still both
22 D  turned,
23 M  yes
24 D  I think the left one's worse,
25 M  yes, hmm hmm,
26 D  (6.0)
27 M  because, in fact, I thought (2.0) um, now what did I do, no,
28 D  what, no, what actually happened was, that the right one was
29 M  going in, so I put a drop,
30 D  [hmm hmm
31 M  [and this, this is the only drop he's had in since we last saw
32 D  you,
33 M  hmm hmm
34 D  Ee, I put a drop in, (2.0) the left eye,
35 M  yes,
36 D  A:nd, that was only, probably last Thursday?
37 M  yes
38 D  and, now I think, the left eye's turning.
39 M  hmm hmm
40 D  Soto, and that was only [a matter of a day, so,(1.0) I'm a bit
41 M  confused.
42 C  [De da, de da, de da de da, de da,
43 M  It's a (0.5) light, that's what it is, that's what you say when
44 D  you (don't know what it is)
45 M  teddy bear.
46 C  [good.
47 D  it is, [I bet you it still hasn't been fixed, either. ((laughs)) so,
48 M  mmm, mmm, mmm ((laughs)) it's impossible to fix.
49 D  (1.0) I'm told. Okay, now, so, let me think, so you put, so he's
had left atrophine, (2.0) and
er, yeah, but only once, only one drop,
hmm hmm
and it was only a week ago
hmm hmm
Because, I kept, I couldn’t make up my mind, because they,
one day it seemed to be one (. ) eye and then(. ) soon after it
would be the other one, so I thought, well it can’t, I didn’t
know what else to do, so maybe,
That’s a light
hey look, the light, wow, (3.0) ( ) play with that?
(yells))
((laughs))
((laughs)), oh really, who taught you that one?
Yeah, that’s really, he might have heard that from another
child.
yeah,
Oh, Declan
Oh, Declan. ((laughs))
Yeah.
Bandaid?
It’s not a band aid, it’s a bat. (1.0) it flies, at night.
okay, now the (. )angle of the turn, how do you think that is
now compared to, say, (. ) six months ago?
my memory’s not that good
okay, [and
um but look, I don’t think it is, I, no, I don’t think it’s
as (. ) (extreme as it was
[ oh, okay
but it’s, (. ) it still [goes in,
in May, this year,
mmm
and we, I’ve got here that he was stryb with a small angle, that
was getting worse, it was about ten to fifteen degrees in (. )
June, he was swapping from one to the other, (4.0) then I’ve
got that he was straight, but I gave, oh, so, and after that
you’ve done, after that, previously you’d done some right
atropine, [because you must have thought
[Yes, yeah, yes,
because it was more the left eye turning
yep
Yes?
oh look, [for a while there I thought they were pretty good, but
I think they have gone,
[yes, yeah,
they have deteriorated a bit.
Yeah. okay and, (4.0) so, (4.0) and so, (2.0)
now? Now?
So at that stage he was, the left eye was turning more also,
Appendix 3 – Transcription Conventions and Sample Transcripts

77    D  U: um, and you did the left atropine because you thought he was, the right eye was turning more than the left, [is that right?][this was just the other day?]
78    M  yeah.
79    D  Yeah.
80    M  Yeah.
81    D  yeah, okay,
82    M  but, (.) obviously I'm wrong,
83    D  Oh, okay.
84    M  cos [the left is]
85    D  [what about if you stopped it all, and we’ll see what he does?]
86    M  well I had [I had stopped, [I mean,
87    D  [yes, okay
88    M  [he’s only had the one drop in all the time
89    D  [yes, yeah
90    M  since I last saw you.
91    D  yep
92    M  and in fact I don’t know if it wore off, (0.5) [probably it almost has,
93    D  [ No:o, (0.5) as far as the pupil’s concerned?
94    M  [ yeah.
95    D  still, the pupil still looks bigger that side to me, [now most people are slightly different anyway
96    M  [ yeah, so
97    D  which is [(]
98    C  [light on?
99    D  yeah, we're going to put the light on, here we go.
100   C  is the light on?
101   M  ( )
102   D  okay, so that pupil is still larger,
103   M  Yeah, I don't know
104   D  but it’s definitely reacting now, so it’s starting, it’s definitely wearing off,
105   C  lights on
106   D  and to me they don’t look too bad [as far as the turn’s concerned
107   M  [ good
108   D  um, and, I want you to keep your (. ) bottle at the ready,
109   M  [yeah,
110   D  [and stop for a while now and just see what happens
111   M  yeah, okay
112   D  and if he goes back to turning, one much more often that the other, basically I think you should do what you’ve done in the past,
113   M  yeah
114   D  put the drop in the other one =
115   M  yep
116   D  = to get them even
117   M  yeah ((toys banging))

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I'm happy sw (.) swapping over, his angle just looking at him doesn't look too bad [to me, oh good,
It's certainly no worse than before, I'm just moving back here, Anne, ((laughs)) so I can have a look at him, umm, he's got the little folds here which are likely, which he's likely to grow out of, which will make the turn look, make him [look as if = yeah
= he's more turning than he really is?
Yeah.
so, I would have to say I am happy with him,
oh great
um, I think[ we talked about glasses, if he was getting worse?
[ I'm happy if you're happy. Yeah, yeah.
um, [ but, I don’t think you need them for the turn at the moment.
[ I mean, I'd be, I'm glad I didn't get them.
[ no
[ no I think
and you'll know that I'll start talking again if he starts getting worse I'll talk about
[oh yeah, but I mean, I, I don’t want to get them [ unless he really
[ yeah, that's fine
I'm sure he really needs them, [because
[ yeah, that's fine, and
keeping him alternating is good [insurance
[ yeah
because usually if it's just one eye the angle overall is worse, right
so that's the other reason why I want you to keep up
yeah, okay
and I'll give you the permission to, ((laugh)) [to use the atropine, if you don’t know, just leave it go, otherwise
[ the atropine
I've got it's been in the fridge for months [you know,
[ yes, that’s fine
yeah, well that's what, I thought,
yes
you said to [just keep it in the fridge and it should be alright
[um yes, it's safe,
yeah
yeah, have you got a spare script?
(1.0) I may not have.
do you want me to give you [one?
[ yeah, that would be good okay,
um and I think,(.) um, so, looking at him at the moment I don’t think he needs any atropine,=
excellent
= more atropine at the moment,
good
I would just let it all wear off and decide in another few weeks, =
hmm hmm
= and if you think he’s swapping be himself =
okay
= you don’t need to use and more
alright
if you think he’s stopped swapping and you’re sure that it’s just one eye, you might want to try and do it again
[ alright, yep
um, and I’m thinking (.) February, just to have another look at how he’s fixing
okay, yep, excellent
um (3.0) and I’m just looking,
(3.0)
[(
( ) before, haven’t you, eh ((laughs))
C
It’s stuck,
It’s stuck? but I think you’ve got it out, good, ( )Dr. Colson ( ) ((whispering to child))
do, do you re, I was just looking to see whether he originally was one eye or the other? (1.0) Is it, or was it both? [My memory of it is that it went from one eye to the other.
I think it was, the left
was, was, definitely worse.
okay, sometimes if you stop everything, that’s the one it goes back to?
yeah,
[so
well the thing is, his um, (0.5) CP’s worse I think too,
is it?
[so whether that, yeah, I don’t know,
I don’t know, [(
maybe, maybe not, yeah,
(10.0)
What, ( )
yeah, left viso since birth, so,
mmmm
that’s, I’ve got ( ), so you’d think that if anything that’s the way it would go,
mmmm
so if anything he hasn’t had quite enough,
right
on balance
yeah
as far as the atropine [for his right eye?
[ right, okay
uum, but (.) from time to time it may well swap over, and sometimes it just seems to do it by itself, [for a few days and
swaps backwards? And I think
[ well, I, I was just a bit confused.]
199 D yeah, well if you can’t decide which one it is =
200 M [no
201 D [= that’s a good situation, ( swapping )
202 M [ and then I should, and then should
203 D I leave it?
204 M yes you can do nothing,
205 D yeah,
206 M and leave it, um
207 D well that’s why I stopped the last of the drops ( ).
208 C light on.
209 M Light on, sit there, have a look at the bear, it’s meant to play
the drum, (0.5) but it doesn’t matter,
210 D so what if I write right in the script, because that’s the one
we’re more likely to need, ((laughs))
211 M oh, yeah, okay
212 C there’s a TV in the cupboard.
213 M it is, it’s a TV in the cupboard with a (troll?)
214 D and do you think one drop, just one drop, did it, so what if I
say one drop [( ]
215 M yeah well so that seems to last for about a week, or,
216 D yeah, it definitely can =
217 M or so
218 D = that’s right, that’s our usual dose, (3.0) and I’m deliberately
leaving it up in the air about how, when you change over the
bottle, I suppose after three months it’s reasonable to ask [you
to change over .hh
219 M [ no, it’s certainly been in
 the fridge
[ for three months
220 D [yeah that’s right, so probably better to ( ]
221 M because it’s been, how long, probably since I seen you and it
was, I had it before then, so, I think I probably should turf it.
222 D yeah,
223 (6.0)
224 M so, it’s only after it’s open though [that it starts
225 D [that’s correct
226 M so if I get a script made up, =
227 D that’s right
228 M = and I kept it in the fridge
229 D [yes that’s right
230 M [it would be okay
231 D yes that’s right
232 M until I need a dose
233 D but you may not need it again.
234 M ((coughs)) oh, oh well, I’ll,
235 D and if you do need it, like, in the next few weeks you could
certainly use your old bottle,
<table>
<thead>
<tr>
<th>Line</th>
<th>Time</th>
<th>Speaker</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>236</td>
<td>M</td>
<td>M</td>
<td>oh, okay</td>
</tr>
<tr>
<td>237</td>
<td>D</td>
<td>M</td>
<td>It’s really more the idea that I want you to have a supply, if you happen to touch the tip of the bottle on his lashes for example, that would be the time to chuck it out.</td>
</tr>
<tr>
<td>238</td>
<td>M</td>
<td>D</td>
<td>right</td>
</tr>
<tr>
<td>239</td>
<td>D</td>
<td>M</td>
<td>because it, occasionally the germs will grow on the drops?</td>
</tr>
<tr>
<td>240</td>
<td>M</td>
<td>D</td>
<td>[yeah, oh okay,</td>
</tr>
<tr>
<td>241</td>
<td>D</td>
<td>D</td>
<td>[but the, the, the actual atropine itself, stays and it lasts forever,</td>
</tr>
<tr>
<td>242</td>
<td>M</td>
<td>D</td>
<td>okay</td>
</tr>
<tr>
<td>243</td>
<td>D</td>
<td>D</td>
<td>the only reason to change the bottle over is in case it’s got infection =</td>
</tr>
<tr>
<td>244</td>
<td>M</td>
<td>D</td>
<td>[yeah</td>
</tr>
<tr>
<td>245</td>
<td>D</td>
<td>M</td>
<td>[= growing in it, and [th</td>
</tr>
<tr>
<td>246</td>
<td>M</td>
<td>D</td>
<td>[okay, contaminated</td>
</tr>
<tr>
<td>247</td>
<td>D</td>
<td>D</td>
<td>that’s right and you don’t want to be putting that back into his eye, (. ) again,n um but I would think, (. ) I would wait (. ) and not get the other bottle.</td>
</tr>
<tr>
<td>248</td>
<td>M</td>
<td>D</td>
<td>[okay, fine</td>
</tr>
<tr>
<td>249</td>
<td>D</td>
<td>D</td>
<td>[would be my suggestion, because I would be expecting that you’ll just come in February not having done anything else, [unless the situation was obviously different</td>
</tr>
<tr>
<td>250</td>
<td>M</td>
<td>C</td>
<td>[ well I, yes</td>
</tr>
<tr>
<td>251</td>
<td>C</td>
<td>D</td>
<td>( )</td>
</tr>
<tr>
<td>252</td>
<td>D</td>
<td>D</td>
<td>Oka:y, so one drop fortnightly (( hands script to M)) there you go,</td>
</tr>
<tr>
<td>253</td>
<td>M</td>
<td>M</td>
<td>thank you, now which, what’s the best clinic to come to? Which is the,</td>
</tr>
<tr>
<td>254</td>
<td>D</td>
<td>M</td>
<td>( ) ((laughs)),</td>
</tr>
<tr>
<td>255</td>
<td>M</td>
<td>M</td>
<td>no, they’re all pretty horrible, (both laugh)</td>
</tr>
<tr>
<td>256</td>
<td>D</td>
<td>D</td>
<td>I’ll say in Feb 2000 and leave it up to you, I’m not going to say the general one, I think, you’ve been to either one haven’t you,</td>
</tr>
<tr>
<td>257</td>
<td>M</td>
<td>M</td>
<td>yeah</td>
</tr>
<tr>
<td>258</td>
<td>D</td>
<td>D</td>
<td>yeah you went to the CP clinic, it’s actually lighter, lighter booked in the CP clinic but they can take longer.</td>
</tr>
<tr>
<td>259</td>
<td>M</td>
<td>M</td>
<td>yeah and also, yeah, the, the waiting room gets a bit cramped, with all the, (0.5) paraphernalia,</td>
</tr>
<tr>
<td>260</td>
<td>D</td>
<td>M</td>
<td>that’s [right</td>
</tr>
<tr>
<td>261</td>
<td>M</td>
<td>D</td>
<td>[yeah,</td>
</tr>
<tr>
<td>262</td>
<td>D</td>
<td>D</td>
<td>okay, so:o,</td>
</tr>
<tr>
<td>263</td>
<td>D</td>
<td>M</td>
<td>(2.0)</td>
</tr>
<tr>
<td>264</td>
<td>M</td>
<td>D</td>
<td>Alright, then.</td>
</tr>
<tr>
<td>265</td>
<td>D</td>
<td>M</td>
<td>alright, good,</td>
</tr>
<tr>
<td>266</td>
<td>M</td>
<td>D</td>
<td>[thank you very much,</td>
</tr>
<tr>
<td>267</td>
<td>D</td>
<td>M</td>
<td>[let’s know how you are going.</td>
</tr>
<tr>
<td>268</td>
<td>D</td>
<td>M</td>
<td>(2.0)</td>
</tr>
<tr>
<td>269</td>
<td>M</td>
<td>D</td>
<td>just get, it’s alright, sorry, if I just sit him in it,</td>
</tr>
<tr>
<td>270</td>
<td>D</td>
<td>M</td>
<td>Yeah, that’s fine</td>
</tr>
<tr>
<td>271</td>
<td>M</td>
<td>M</td>
<td>and I’ll do it up outside.</td>
</tr>
<tr>
<td>272</td>
<td>C</td>
<td>C</td>
<td>( )</td>
</tr>
<tr>
<td>Line</td>
<td>Transcript</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>273</td>
<td>D you’re talking lots aren’t you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>274</td>
<td>M absolutely, can I just put him [on the floor for a minute,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>275</td>
<td>D [Sure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>276</td>
<td>C got the keys.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>277</td>
<td>M ((throw the kid)) on the floor,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>278</td>
<td>D [you’ve got your mother’s keys,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>279</td>
<td>M [Unceremoniously,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>280</td>
<td>D Yes, that’s right ((laughs))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>281</td>
<td>M oh everything that’s mine is his, (0.5) according to him, ((both laugh)) my dinner, my purse, even my cup of coffee, this morning, he wanted, (0.5) these are going to fall out I guess, say thanks Dr. Colson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>282</td>
<td>D okay, good,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>283</td>
<td>M thank you [very much,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>284</td>
<td>D [ he’s fine, this is good,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>285</td>
<td>M well it is good,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>286</td>
<td>D yeah</td>
<td></td>
<td></td>
</tr>
<tr>
<td>287</td>
<td>M cos it’s er, you know, we’ve got a few other problems, so that’s one that (.) we can dispense with, for the moment, hullo, is that mine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>288</td>
<td>C lady’s on the chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>289</td>
<td>M well she is on the chair, mummy’s going to talk to her in a minute,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>290</td>
<td>I bye bye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>291</td>
<td>M bye bye, thanks very much,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>292</td>
<td>D bye bye</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Transcript 25B: Carlos. Dr. Colson. NNS

1  D  Come in, yes, (2.0) ((door banging)) now let's get settled? (2.0) let's see what we need today. (3.0) okay, so you've been doing some patching?
2  F  no
3  D  [no, okay
4  F  [no, we stopped it, er some time back now
5  D  yes
6  (3.0)
7  D  Just the glasses?
8  F  yes
9  D  Okay, alright. A:nd on the test (.), today's test he seems to be seeing well? (.), do you think the same between the two eyes?
10  F  I think he's improved,
11  D  [hmm
12  F  [in the past he could, er, ((laugh)) read only the letter
13  D  yes
14  F  now I think he's er (.), improved significantly
15  (21.0) (paper shuffling))
16  D  Okay, so I'm just really looking at his history, he originally came because his right eye wasn't, (.), as good as his left? And now we've had a several tests where they've been equal, today it's equal, that was just with glasses,
17  F  good
18  D  a::nd h::is left eye (3.0) looks okay, and do you think he needs a glass for his left eye?
19  F  Not really, Susan, very well [because you know today
20  D  [okay
21  F  He ( .) I think he can see,
22  D  Yes, yeah
23  F  There's, er, (.), two letters, the X he improved that on both eyes,
24  D  [Yes, yeah, oh good,
25  F  [I was not sure about the er, to see what he can see from afar,
26  D  yeah
27  F  But I think his left eye seems to be okay, that is my main observation.
28  D  Hmm hmm
29  F  But the right eye,
30  D  [Yes
31  F  [Keep in mind that's er with the (.) glass on,
32  D  That's correct, yes
33  F  [But er,
34  D  [We haven't tested him with the glass off,
35  F  no
36  D  so:0, is he, hap, happy to keep wearing them? do you think?
37  F  Yes.
38  D  Okay. okay, I'm just looking at Sandra's notes here, I agree with what she said, I'd like him to continue with the glasses if you can, I'll leave him uncorrected in the (.), left eye (.), at the moment, but later on he may want correction in his left eye. What I'll say is we're getting to a different phase now, I'm happy with his right eye,
39  F  hmm
40  D  Now I have to say does he need glasses for schoolwork and other things like

- 378 -
that for the left eye? And it sounds as though you’re happy to leave it as is at the moment, and we’ll just get him, keep him going with the glasses,

41 F Hmm hmm
42 D And, I would just like to see him maybe six, how long had it been this time? Was it six months?
43 F I’m sorry, they asked for, we were supposed to come and see you in September, you know, we just er forgot, about it, completely, you know, its just er
44 D yep
45 F Now you’re doing a six month cycle are you? because ( ) so
46 D [yeah, that’s right. Okay so I’m happy to leave it for six months again, um and I would just, I’d be encouraging him to wear the glasses if you can, do you think there” going to be any problem?
47 F No, not at all, [I mean he understands
48 D [okay
49 F that he has to wear [the glasses
50 D [Yes okay
51 F And eventually he, promise at least that ( ) [And eventually he may not have to wear the glasses,
52 D [That’s correct
53 F So he’s aware(.) of that er
54 D [okay
55 F So he he’s determined he’ll have the glasses, so that you know (2.0) that he will not have to wear the glasses .) later [on.
56 D [Later on.
57 D (3.0)
58 D Okay, and I notice, I’ve given you a script at one stage for his left eye,
59 F Yes.
60 D There , that one,
61 F Yes [( )
62 D um, so I’ve just got in the back of my mind that he might need that at some stage,
63 F okay
64 D but I don’t think he needs it yet, he seems to be seeing well and ((background noise, child speaking)) I take it that he’s reading well? Is that right?
65 F Especially now, the, er the, the magnification of the right eye is it the same lens?
66 D Yes, keep him going the same,
67 F [( )
68 D [yes that’s right, and, there’s pros and cons of putting some on his other eye and I’m happy for it to be left out at the moment. And in some ways I would be waiting for you to say oh I think we should try it for reading? Rather than me saying he’s got to have a change in the left eye? because I don’t know [if he needs it
69 F [what he needs, he’s er, he has no problems reading,
70 D Right, [okay
71 F [he has no problems and (anything like that)
72 D Yep
73 F I know for a fact that er you know, he draws, all the, all he’s and exceptionally good (. ) [artist, for his age
D and that’s all he does, so I mean we don’t have any problems about anything he just keeps on working, so I have no problems

F alright

D so as long as he can see (  )

F okay, no, I’m happy to leave him without the glasses, it’s not a strong lens in the left eye, and he’s wearing the right one, so I’m happy. Alright.

D For swimming obviously he has to take the glasses off (  )

F That’s right, yeah.

D One of the things I may have mentioned is there’s no hard and fast rules that tell us when to stop? We know when to start the treatment, but we don’t know when to stop?

F yes

D it’s quite a hard decision, and its mainly personal preference, we think ( ) that it’s a good idea to keep wearing the glasses as long as possible, at least towards the end of primary school if we can, but if you’re finding that he absolutely refuses or its too difficult to keep them available I’d just watch his vision closely and make sure it didn’t go backwards,

F Hmmm hmm

D Sooo, I think keep going with the glasses and we’ll see you six months

F okay

D Okay?

C ( oh:h, that means we’re coming again)

D ((mother re-enters room with younger sibling, children talking, some explanation to mother))

F ( see him again in six months make another appointment)

D Okay, so that’s, for doing that, okay? and his vision seems to be good in both eyes

M Yeah? (  )

D Good, alright

F ( organising )

D [Yeah, I’d rather

D ((child whining, background noise))

F Okay,

D Okay?

F thank you very much, [Susan

D Alright, good, you’re doing well

C Bye

D [Okay, good

F (  )

C [I’m doing well

F thank you Susan ((to child))

C Thank you

D That’s okay. I’m pleased you’re doing well, you did well on your vision test, (1.0) okay.

C ( and the lady ) ((everybody laughs))

I I’m coming out with you to talk to you

D That’s right [yeah

F thanks Susan

D Okay, good
112  F  so hopefully we’ll see you in six months =
113  D  yes
114  F  = and we won’t forget this time
115  D  Oh that’s alright, its not a hard and fast, bye
116  I  Bye bye
117  D  okay
APPENDIX 4 – Discourse Analysis and Reporting Tool (DART)

As discussed in Chapter 3, the Discourse Analysis and Reporting Tool (DART) was developed and used for all data storage, coding, and analysis in this study. This appendix provides a full description of the package. DART was developed using Microsoft Access, which was chosen for its ability to support rapid prototyping and flexible query and reporting capabilities. The program was developed in parallel with the research and evolved to meet requirements as the research project proceeded. Its key features are as follows:

a. Allows the direct transcription of primary audio data into the database as text, and linkage to the audio data for later playback during analysis.

b. Ability to enter and store all observation master data relating to subjects and interviews, and link to subsequent analyses.

c. Ability to define and amend analysis parameters as patterns emerged and to answer ‘what-if’ questions.

d. Ability to present in one screen all relevant data pertaining to each consultation, including the primary audio data, and assign various user-defined codes as required on a turn-by-turn basis.

e. Ability to generate analysis reports in ‘real-time’ from the analysis screen in order to review any emerging trends.

These features are discussed in more detail below.
Transcription – the capture of raw data

The data editing and transcription screen, shown above, facilitates the transcription of primary audio data into tables within the database, and stores this data as “turns” - a sequence of interactions characterised by a change in speaker. This has been selected as the most appropriate device for segmenting the data in this particular study, however, this feature is completely flexible and can be redefined as required by the researcher.

This module also allows the recording of all the vital identifying data associated with the text, including:

a. Observation Id – A unique identifier allocated to an observation. This identifier is used as a link to the table which stores details of the subject, such as name, age, gender, first language and second language.

b. Interview Type – A unique user-defined code representing the nature of the interview, or source of the data, as follows:
<table>
<thead>
<tr>
<th>IV_Code</th>
<th>IV_Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Orthoptist Consultation</td>
</tr>
<tr>
<td>B</td>
<td>Doctor Consultation</td>
</tr>
<tr>
<td>C</td>
<td>Parent Post-Consultation Interview</td>
</tr>
<tr>
<td>D</td>
<td>Doctor Debriefing</td>
</tr>
</tbody>
</table>

c. **Provider Id** – A unique user-defined code for each of the participants in the interview, whether doctor or parent, for example:

<table>
<thead>
<tr>
<th>Name Code</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Child</td>
</tr>
<tr>
<td>D1</td>
<td>Dr. XYZ, Private Rooms</td>
</tr>
<tr>
<td>D2</td>
<td>Dr. ABC, Private Rooms</td>
</tr>
<tr>
<td>D3</td>
<td>Dr. XYZ, RCH</td>
</tr>
<tr>
<td>D4</td>
<td>Dr. ABC, RCH</td>
</tr>
<tr>
<td>F</td>
<td>Father</td>
</tr>
<tr>
<td>G</td>
<td>Guardian</td>
</tr>
</tbody>
</table>

d. **Interview Date** – The date on which the interview was conducted.

e. **Media Id** – Identification of the medium on which the interview was recorded, such as Tape Number.

f. **Audio Duration** – The duration of the primary audio data for this interview.

g. **Filename & Sound Filename** – The locations of the primary text and audio data for this interview.
Analysis - Decomposition of Data into Analysis Units

This module, shown below, assists with the process of decomposition of the transcribed text into the units of analysis selected by the researcher.

This screen features the following sections:

1. **Observation Selector** - The ‘drop-down’ control presents the reference numbers of all observations which have been imported, and loads the observation ready for analysis. Below this is a ‘check-box’, which, once ‘checked’, limits the turns displayed in the data area to only those which have had some analysis performed on them.

2. **Observation Details** - Summary of the details associated with the selected observation.

3. **Observation Data** – The transcribed data for each observation is presented in this area, a number of ‘turns’ at a time. This allows the researcher to focus on a small section of text, but also to see each utterance in context. Each turn is divided into four boxes – top left is the turn sequence number in the observation, next right is the code for the turn speaker, and, the lower area is
the time-stamp at which the turn starts in the audio. The large area on the right
is the transcribed utterance.

4. **Analysis Code Selector** – This set of controls provides the ability to select the
type of analysis to be conducted on the observation. The Code is set by using
the drop-down controls for each of the Type, Feature and Attribute settings in
turn. The resulting analysis code and description are displayed to the right and
beneath the Code Selector controls. The Enter control attaches the Analysis
Code to the segment of text currently highlighted in the Observation Data area.

5. **Analysis Results** – This area presents a list of the data fragments as they are
coded, for the currently selected turn. As different turns are selected in the
data area, this window changes to display the analysed fragments for the
selected turn.

6. **Play Turn** – This button plays the selected turn from the time indicated in the
time-stamp, until the beginning of the next turn.

7. **Enter Turn into Selected Sequence** – In DART it is possible to define key
sequences of turns which reflect patterns as they are identified in the data.
This button adds the selected turn into a user-defined sequence, created using
the Turn Sequencing control (See Item 8 which follows).

8. **Turn Sequencing** – This area provides a mean for identifying and recording
emerging sequences. It is possible to define any number of sequences, and as
turns are encountered which fit the sequence, they can be added to the
sequence of interest (See Item 7 above).

9. **Audio Playback** – This control allows the selected sample to be played back
for review in recognition of the fact that the audio recording, not the transcript,
is the primary data and to prevent glossing or mis-interpretation.

10. **Analysis Reports** – Once the data have been imported these controls can be
used to produce a range of useful reports, as follows:

    a. **Create Worksheet** – A work sheet which can be printed out and used in
       hard copy for analysis (See below for sample). Although it is possible to
code straight into DART, coding is only one step in the analysis process
and it is sometimes necessary, and desirable, to engage more closely with
the data, to be able to take a more global view of the entire transcript and
to be able to work freely with a number of analysis tools. The worksheet
presents the transcript in full, with turns numbered, speakers identified,
and ample space for drafts, notes, and comments. Any number of worksheets can be generated for a particular transcript, so if desired, a clean sheet can be used for each type of analysis. When analysis is complete, the transcript can be coded into DART.

b. **Update Task Status** – This control can be used to update the status of tasks for the currently selected observation (see also Section *Task Management* later). The dialog box shown below is presented and this then allows the user to indicate which tasks have been completed.

c. **Speaker/Provider Report** – For a user defined code, this will produce a query result showing coded utterance counts by speaker and speaking background.
<table>
<thead>
<tr>
<th>Analysis Code</th>
<th>SpeakerX</th>
<th>L1X</th>
<th>D1</th>
<th>D2</th>
<th>D3</th>
<th>D4</th>
</tr>
</thead>
<tbody>
<tr>
<td>346</td>
<td>D</td>
<td>English</td>
<td>30.25</td>
<td>25</td>
<td>30.8</td>
<td>17.333</td>
</tr>
<tr>
<td>346</td>
<td>D</td>
<td>Non-English</td>
<td>27</td>
<td>2975</td>
<td>635</td>
<td></td>
</tr>
<tr>
<td>346</td>
<td>ND</td>
<td>English</td>
<td>9.5</td>
<td>3.8</td>
<td>17.4</td>
<td>1.3333</td>
</tr>
<tr>
<td>346</td>
<td>ND</td>
<td>Non-English</td>
<td>4</td>
<td>609</td>
<td>105</td>
<td></td>
</tr>
</tbody>
</table>

d. Code by Speaker/L1 Report – For a user defined analysis code, this will produce a graphical presentation of the breakdown of allocated codes by speaker, and then by speaking background.

**Reports**

The DART package provides a number of standard reports which are available at the push of a button. These reports provide quick access to summarised data in a structured form. These reports currently includes the following:

a. Summary Data by Analysis Type
b. Summary Data by Observation and Type and Provider
c. Observation Task Summary

**Performing Queries on the Analysed Data**

In addition to the above standard reports, it is possible to perform ad-hoc analysis when required, by utilising the automated ‘query-builder’ provided by Microsoft Access.

This query tool allows completely flexible reporting of data, not only within a single table, but across a number of tables.
Task Management

By its very nature, discourse analysis of a large number of samples involves the tracking and organisation of many elements. DART offers a utility, shown below, to assist in the organisation of the gathering and analysis of the many samples of data.

![Obs Task Status](image)

This screen provides a checklist against which progress during the acquisition and analysis phases of the project can be measured. The primary features are:

a. Tracking of any number of samples

b. Samples are automatically included in the list upon import, and the ‘Import’ column is automatically ticked.

c. A formatted report can be produced, as shown below, summarising the analysis process for progress reporting to 3rd parties or for visual scanning.
### Analysis Task Summary

**Saturday, 19 February 2000**

<table>
<thead>
<tr>
<th>Observation</th>
<th>Imported</th>
<th>Fine Transcript</th>
<th>CA</th>
<th>Speech Act</th>
<th>Pragmatic</th>
<th>Lexical</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 B</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 C</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
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Author/s: Kanaris, A.

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