

The (socio)linguistic turn in physician-patient communication research

Richard M. Frankel

*The Fetzer Institute, University of Rochester School of
Medicine and Dentistry*

The interview is the most powerful, encompassing and versatile instrument available to the physician.

—G. L. Engel

Introduction. Communication and relationship have long been understood as important in medical care. For example, Early Greek physicians such as Plato warned that telling bad news to patients should be avoided because it could worsen their condition (Reiser 1980). This view of avoiding certain types of communication continued into the modern era and was reflected in the first code of medical ethics adopted by the American Medical Association in 1847, which stated, “It is a sacred duty [of a physician] to avoid all things which have a tendency to discourage the patient and depress his spirits.” A study by Oken (1961) confirmed that things hadn’t changed much as late as the 1960s.

The healing potential of communication also has a venerable history in medicine. The so-called “placebo effect” has been known for thousands of years and has been used and studied extensively, although the specific mechanisms of linguistic and biological action are poorly understood. In one recent study, a suggestion by the surgeon of an early return of bowel function following abdominal surgery resulted in a 3.9-day difference in experimental versus control subjects (2.6 versus 6.5 days). It also reduced the length of hospital stay by half (from 8.1 to 4.1 days) (Disbrow, Bennett, and Owings 1993). Another study of pregnant women, some of whom received continuous emotional support from a doula (a woman specifically trained to provide such support) and others who received usual care, produced significant differences in a range of outcomes from the duration of labor to neonatal hospitalization (Kennell et al. 1991). Finally, a recent report by Smyth and colleagues (1999), demonstrated that patients with rheumatoid arthritis (RA) and asthma who wrote about the emotional experience of these two

chronic diseases three times a week for twenty minutes got nearly the relief of symptoms that patients taking ingested or inhaled steroids did.

Research demonstrating the effects of communication and interaction on medical care processes and outcomes has drawn increasing interest and attention from linguists, clinicians, medical educators, and policy makers. A body of research representing a new synthesis of basic and applied knowledge of language in the context of clinical practice has emerged as a result. An early paper by Inui and Carter (1985) provides a useful frame of reference for this type physician-patient communication research. They argued that in addition to developing objective scales and measures of communication, it is important to retain the full richness of and complexity of human interaction by exploring it naturalistically and sequentially. At the time they lamented, “the most commonly applied analytic strategy is to develop communicator profiles based on frequencies of behaviors of various types. This approach is analogous to describing ‘Hamlet’ as a play with 21 principal characters, a ghost, a group of players, and various numbers of lords, ladies, officers, soldiers, messengers and attendants—one of whom is already dead, one of whom dies by drowning, one by poisoned drink, two by poisoned sword, and one by sword and drink!” (536). Following Inui and Carter’s analogy, I argue that there is a need to understand communication in medical encounters in its broad sociolinguistic context that is defined by the moment-by-moment organization of interaction in face-to-face encounters.

My goal in this paper is to clarify and refine the contribution of sociolinguistic microinteractional analysis to our understanding of the clinical care process and its outcomes. I use the phrase “sociolinguistic turn” to denote a historical trend within the social and behavioral sciences and a growing recognition within the clinical sciences, that “the doctor-patient relationship is the heart of medical practice” (Glass 1996). The evidence I review is based on this assertion. The paper is divided into three main parts. In the next part I selectively sketch some of the developments in social science theorizing that have led to the current interest in language performance. In the following part I describe a heuristic model of the medical encounter called the Three-Function Model. Using it as a backdrop, I review some of the evidence that links routine communication with outcomes of care. In the last section I suggest some future directions for this research approach and some conceptual and methodological questions that still remain.

The patient in theories of social action.

Sociological theory. Parsons (1951) is credited with first theorizing about the social relation between doctor and patient. In essence, Parsons’ view of the social world of doctors and patients took the perspective of the professional. Disease, the sick role, and less dramatic forms of disequilibrium like failure to follow “doctor’s orders” were viewed as a form of deviance. Doctors were seen as technical experts with high decision-making status. Patients were seen as dependent and

unable to discern the causes of their problems. A quote from *The Social System* is instructive:

The patient has a need for technical services because he doesn't—nor do his lay associates “know” what the matter is or what to do about it. . . . The physician is the technical expert who by special training and experience and by an institutionally validated status is qualified to help the patient. (Parsons 1951: 441)

The trouble with Parsons's formulation as pointed out by a number of critics, such as Szasz and Hollander (1956) and Freidson (1961), was that it reduced the patient's role to being passive and dependent and the definition of the situation as being totally under the control of the physician (professional dominance). Common sense and experience make clear that patients in a medical encounter bring their own thoughts, feelings, experiences, and sense-making practices (lay diagnoses, for example) to bear on whatever ails them. For Parsons, the details of just how lay and professional perspectives come into play in and through face-to-face interaction was de-emphasized in favor of the more abstract concept of how social roles, norms, and institutions exert effects on a particular type of social relation.

Cognitive theory. In the mid-1970s, Becker (1974), Becker and Maiman (1975), and Rosenstock (1974) began to focus on patient perceptions of health and health care as a mediating factor in understanding health behavior. The Health Belief Model focused attention on the influence that perceptions of health and illness, susceptibility, severity, and costs had on outcomes such as adherence to medical recommendations. In a related development Arthur Kleinman (1980), an anthropologist and physician, coined the term “patient explanatory models” to characterize patients' thinking about the causes and consequences of disease and illness. Kleinman's conceptualization, informed as it was by an anthropological preoccupation with understanding the worldview and experiences of patients, was broader and more inclusive than the Health Belief Model.

The concepts of health beliefs and explanatory models as cognitive structures clearly showed that patients' views of themselves and their health status affected subsequent behavior such as following medical recommendations. That this was so was well demonstrated. *How* it was accomplished in the face-to-face meeting of a physician and patient remained a “black box” open to speculation but with very little empirical evidence. From the perspective of cognitive theory, language performance was at best an indirect link to cognition and the processes that underlie it. The representation of the patient was certainly fuller and more complete than it was in Parson's scheme but still lacked the specificity of being able to track and understand the moment-by-moment development of the encounter over time.

Sociolinguistic theory. In the late 1970s, a new view of the doctor-patient relationship began to emerge. In a classic paper in the journal *Science*, Engel called attention to the medical interview as a biopsychosocial event, not merely as a point of information transfer. In Engel's view, a medical model must "take into account the patient, the social context in which he lives, and the complimentary system devised by society to deal with the disruptive effects of illness" (1977: 132). Although Engel was an internist and not a sociolinguist, his emphasis on the social context of the encounter and the biological, psychological, and social aspects of care that converge there quite naturally implicated language and social interaction as the medium through which care is delivered and received. Engel reminded us of a very simple but powerful truth and that is that medicine is practiced one conversation at a time.

During this same time period sociolinguists such as Shuy (1976) and Tannen and Wallat (1983) began to focus on issues of language performance in the medical encounter. Shuy analyzed a number of examples of miscommunication between doctors and patients, for example: "Dr: Has there been any history of cardiac arrest in your family? Pt: No, no one's ever been arrested" (1976: 376). Shuy's analysis invited an appreciation of the "delicate" nature of the doctor-patient relationship, with respect to language, and the ever-present potential for misunderstanding and miscommunication to occur. Tannen and Wallat's study, in a pediatric context, focused on the use of linguistic register to convey meaning differentially. The authors audiotaped a pediatrician talking with a family about a child's medical condition and the same pediatrician presenting the case to her colleagues. They noted that by intonation and other paralinguistic features, the pediatrician conveyed a different impression to the family about the seriousness of the child's condition than she did to her colleagues although the language is much the same.

Within the sociological tradition of symbolic interaction, scholars such as Emerson (1970) focused on the use of language and nonverbal behavior such as eye gaze to analyze how gynecologists and patients sustained definitions of reality in the exam room. Studies like these were useful in calling attention to the moment-by-moment organization and flow of language exchange in and through which speakers construct social reality.

The most sustained and systematic treatment of the doctor-patient encounter as a moment-by-moment language performance comes from the twin sociological traditions of ethnomethodology and conversation analysis. Early work by Cicourel (1983) focused on asymmetries of language in the medical encounter and its textual representation in the patient's medical record. In this important study Cicourel (1983) traced the transformation of a conversational exchange between a physician and patient into a written entry in the patient's medical record. The written entry made clear that much of the patient's perspective and meaning were lost in translation to a clinical description of a particular pathology. Mishler (1984)

argued much the same point from a purely discourse point of view. He distinguished between what he termed “the voice of medicine” and “the voice of the life world,” and argued that physicians routinely fail to respond to the latter and insist upon the former as a frame of reference. As a result, patients are routinely reduced to clinical categories based on a model of pathology.

In the mid-to-late 1980s, studies began to appear, largely in the sociological literature, applying the pioneering work of Sacks, Schegloff, and Jefferson (1974) and Schegloff, Jefferson, and Sacks (1977) on conversational turn taking and repair to a variety of organizational settings. The approach provided a comprehensive conceptual scheme, based on utterance exchanges as the unit of measure, for understanding the interactional dynamics of conversation. Application of the model to understanding medical encounters began in the mid-1980s with the appearance of an edited volume by Fisher and Todd (1983) that blended conversation, and analytic and ethnomethodological studies and continued in the following year with a special issue of *Discourse Processes* (1984) devoted primarily to microanalysis of the physician-patient relationship.

In the decade and a half that has elapsed since the first applied studies using conversation analytic theory appeared, two streams of scholarship have emerged. One is primarily concerned with the sociological or social science implications of micro-interactional analysis of physician-patient encounters; the other with the clinical or educational implications of such analysis. This framing follows a distinction made many years ago by Levine, cited in Freeman, Levine and Reeder (1963), between sociology *of* medicine and sociology *in* medicine. My main focus will be on the latter.

A functional model of communication for the medical encounter. With language exchange as a focus for research on the medical encounter, I now turn to a model for considering the evidence that such exchanges make a difference in the course, direction, and outcomes of care. There is general agreement among scholars of the medical interview (Bird and Cohen-Cole 1990; Cohen-Cole 1991; Lazare, Putnam, and Lipkin 1995) that there are three tasks or functions to be accomplished in each visit.

The first task is data gathering, the goals of which are to establish a diagnosis, be able to recommend treatment, and predict the course of illness. The second task is relationship building; the objectives here are to create a safe environment for the patient to provide diagnostic information and tell his or her story, to relieve physical/emotional stress, and to negotiate an acceptable treatment plan. The third task is sharing diagnostic information (good news, bad news, no news) and educating patients about their conditions and treatment.

With well over three-quarters of a billion ambulatory encounters taking place in the United States each year (National Center for Health Statistics 1996), the implications from scholarship on the three communication functions are enormous.

In fact, when considered as a medical procedure the interview is the one most frequently performed by physicians, who average 140,000–160,000 in a practice lifetime (Lipkin et al. 1995). I briefly review several selected studies relating to each of the functions to demonstrate some of the contributions language and interaction studies are making to our understanding of the medical care process.

Function 1: Data gathering. Many medical interviewing textbooks teach that patients come to a physician with one well-formulated complaint or concern, which is referred to as the “chief complaint.” The physician’s job is to focus on the chief complaint, eventually making a diagnosis and recommendation for treatment. Little attention is paid to the social or linguistic context in which patients experience illness or the linguistic forms of expression these experiences take in the medical encounter.

In an early study of data gathering, Beckman and Frankel (1984) investigated the openings of seventy-four routine encounters at an internal medicine clinic. Our initial interest was stimulated by literature, primarily in psychiatry, that had focused on patients’ “hidden concerns” at the very end of the encounter, where they are typically very difficult for the physicians to deal with. A study by Barsky (1981) is typical of this view and essentially argued that “hidden concerns” or hidden agendas were a characteristic of patients who were hostile, angry at their physicians, or otherwise psychologically distressed. While this might have been true in psychiatry, it did not seem to have a perfect translation into the world of internal medicine. Our point of departure was to look not at the very end of the encounter but rather at its beginning, and to pursue the question on interactional rather than psychiatric grounds by asking whether there was a relationship between interactional “troubles” at the beginning and concerns raised late in the visit.

To do this we transcribed the seventy-four opening segments and subjected them to analysis according to whether the patient’s statement was completed (e.g., the patient said “that is my only concern for today” or an elapsed time of 3.0 seconds) or it was interrupted (either by a physical disruption of the speech stream or by the physician following a patient statement of concern with a narrowly focused, closed-ended question). The following two openings illustrate:

INTERRUPTED SOLICITATION OF CONCERNS

Physician: Hello, Ms. Jones. What problems are you having?

Patient: I have chest pains.

Physician: When did it begin?←—Interruption

Patient: It started about three months ago.

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Physician: Can you tell me more about it?

Patient: It's a gnawing pain that hurts in the center of my chest.

Physician: Does the pain go into the arms or to your neck?

Patient: Yes.

Physician: Is it worse when you exercise?

Patient: Yes.

Physician: Do you smoke cigarettes?

Patient: Yes.

Physician: Are you currently taking any medication?

Patient: No.

COMPLETED SOLICITATION OF CONCERNS

Physician: Hello, Ms. Jones. What problems are you having?

Patient: I'm having chest pains.

Physician: Uh-huh.

Patient: It's a gnawing pain.

Physician: Uh-huh.

Patient: It seems to start in my chest and it goes to my arm and jaw.

Physician: (silence)

Patient: It's really frightening.

Physician: I see.

Patient: You know, my father died from a heart attack and I'm afraid that the same thing may happen to me.

Physician: I can see that you're concerned, and I'll certainly talk with you more about your chest pain. Before we start, however, is there anything else that's bothering you that I need to know about?

Patient: No, that's all.

The results of our analysis were illuminating. In 69 percent of the visits, the patient's statement of concerns was interrupted, primarily by the use of narrowly focused, closed-ended questions. In only one of the interrupted statements did the patient raise additional concerns at the beginning of the visit. In a follow-up study by Beckman, Frankel, and Darnley (1985), they found a strong statistical association between patients who were interrupted early in their statements of concern and concerns raised at the very end of the visit. We concluded that in internal medicine visits it wasn't so much that the concerns or agendas were hidden as it was that interactionally they were prevented from being expressed at the beginning of the visit. A follow-up study of family physicians fifteen years later (Marvel et al. 1999) found essentially the same pattern of interruption; however, the average time to interruption had increased from eighteen to twenty-three seconds.

This finding has several implications. First, it suggests that interruption discourages patients from adding additional concerns at the beginning of the visit. Second, the pattern of interruption, which was generally after the first stated concern and after a mean time of eighteen seconds, suggests that the physicians in the study believed that the patient's first stated concern was the presenting concern and the one of utmost importance from the patient's point of view. Neither of these assumptions appears warranted. When all the concerns, whether they were interrupted or not, were abstracted and reviewed by a group of internists blinded to the research, no association was found between the serial ordering of the concerns and their medical or clinical importance. Another study of older diabetic patients by Rost and Frankel (1993) showed that patients viewed their third concern as being most important. Yet, in 85 percent of the cases studied patients did not get to discuss more than their first stated concern.

The mismatch between patient priorities and problems that actually get discussed is one with several potential consequences for the quality and satisfactoriness of care provided. For example, viewing the three functions as a nested set of communication skills immediately makes obvious that relationship building and diagnostic news delivery, which in turn affect outcomes like adherence with medical recommendations, hinge on agreement or, at least, alignment between the patient's priorities for care and the physician's approach. If diabetic foot care is the first thing mentioned by the patient but his primary concern is impotence, the likelihood of the patient's following the care path recommended for a foot ulcer is diminished. In a significant way the opening of the encounter

and the elicitation of the full spectrum of concerns from the patient at the beginning of the visit is the gateway to effective and satisfying care. It may also have effects of its own. A study by the Headache Study Group at the University of Western Ontario (1986) demonstrated that the single variable most highly associated with the resolution of chronic headache at one-year follow-up was the perception on the patients' part that the physician had listened completely to all of their concerns.

Function 2: Relationship building. The task of function 2 is relationship building and the core skill of relationship building is empathy. While many definitions of empathy exist, they are typically based on cognitive conceptualizations, making their use in social interaction research limited. As well, they are sometimes contradictory. Some authors argue that empathy is having the same emotion as another, "feeling another's pain" as it were. Others argue that empathy is the skill of recognizing and accurately reflecting another's emotions so as to be present to, but not experiencing, the emotion itself. The one element that all definitions included was that empathy was a response to another's emotions.

Given the lack of empirical study of empathy as a communication phenomenon in medical encounters, our research team set out to investigate it (Suchman et al. 1997). We chose a descriptive approach and began by selecting physician-patient videotapes at random from a large corpus. We deliberately limited ourselves to exploring verbal empathy, as this seemed the most basic and straightforward. We reasoned that additional elaborations, incorporating nonverbal and paralinguistic features, could be added to the basic model at a later time.

Our observational strategy was quite simple. We reviewed the tapes looking for words or phrases uttered by the patient that contained positive or negative emotion. Considering the range of assessment terms "horrible," "okay," "great," both horrible and great would be flagged for further review. We then looked to see what the physician's response was to the patient's expression of emotion and labeled that sequential exchange an empathic opportunity since it represented an option for the physician to either respond to or deflect the emotion in some way.

The following exchange between a medical intern and a sixty-five-year-old patient who had returned to the clinic for follow-up care illustrates an empathic opportunity and an empathic response on the physician's part.

EMPATHIC OPPORTUNITY (EO)

Physician: . . . How do you feel about the cancer—about the possibility of it coming back?

Patient: Well, it bothers me sometimes but I don't dwell on it. ←
But I'm not as cheerful about it as I was when I first had

it. I just had very good feelings that everything was going to be all right, you know. But, now I dread another operation.

Physician: You seem a little upset; you seem a little teary-eyed talking about it. (Suchman et al. 1997)

Note the use of emotion words like “bothers me,” “not as cheerful,” and “dread,” all of which convey frank emotion. Note also that the physician’s response is to reflect what he is observing to the patient: “You seem a little upset,” “you seem a little teary-eyed.” Although it is not reproduced in the example, the patient’s response to the physician’s statement is a strong agreement followed by an elaboration of the reason for her dread—a friend of hers had died recently because she didn’t act quickly enough when she began to have symptoms. From an interactional perspective, one test of the accuracy of an empathic response to patient emotion is the extent to which the patient agrees and continues to exhibit the emotion. Educationally, such a principle is important in teaching about the range of possible responses to patient emotion and how to judge their impact.

While empathic responses to patients’ expression of emotion help create and sustain the physician-patient relationship, they did not occur with great frequency in our data. Although this was a descriptive study, we did review upwards of twenty-five tapes and found only one example of empathy, the one reproduced above. Much more frequently we found that the response to patients’ expressions of emotion were “missed” by the physician. We defined these as missed empathic opportunities (MEOs). The following exchange illustrates a missed empathic opportunity.

MISSED EMPATHIC OPPORTUNITY (MEO)

Physician: Does anybody in your family have breast cancer?

Patient: No.

Physician: No?

Patient: Now I just start (unintelligible) after I had my hysterectomy. I was taking estrogen, right?

Physician: Yeah?

Patient: You know how your breast get real hard and everything? You know how you get sorta scared?

Physician: How long were you on the estrogen? ←

Patient: Oh, maybe about six months.

Physician: Yeah, what, how, when were you, when did you have the, uh, hysterectomy? (Suchman et al. 1997)

In this example the patient's response to the physician's question about taking estrogen includes a statement about fear, "You know how you get sorta scared?" In response the physician directs a question to the patient about the length of time she was taking estrogen, thereby either ignoring or choosing not to deal with the emotion.

The pattern of physicians choosing to focus on facts rather than feelings was quite consistent where empathic opportunities occurred. Nevertheless, we were surprised by the relatively small number of instances we found. We hypothesized that there might be more to emotion in the medical encounter than its frank expression. Given the asymmetries of power and status that are claimed to exist in the doctor-patient relationship and patients' potential reticence to "come right out" with emotions, we wondered whether patients might first hint that they had something of an emotional nature to bring up and "test the waters" by hinting at it.

To explore this possibility, we defined what we came to call potential empathic opportunities (PEOs). PEOs are hints about emotion but do not contain the emotion itself. The following exchange contains a PEO in the form of a patient stating that the situation of a relative's illness was "touch and go." While this statement implicates emotion, it does not actually name the emotion itself.

POTENTIAL EMPATHIC OPPORTUNITY (PEO)

Patient: [discussing a relative's illness] The doc ←PEO said it was touch and go, touch . . .

Physician: Yeah.

Patient: . . . and go. (Suchman et al. 1997)

We found two responses to PEOs: exploration or termination. Exploration of a PEO transformed it into an empathic opportunity where the options of exploration or termination applied again. Although exploration of a PEO occurred occasionally, it was far more frequently terminated. The following example illustrates a PEO termination.

PEO TERMINATION

Patient: I'm in the process of retiring . . . ←PEO

Physician: You are?

Patient: Yeah. I'll be sixty-six in February.

Physician: Do you have Medicare?←PEO Termination
(Suchman et al. 1997)

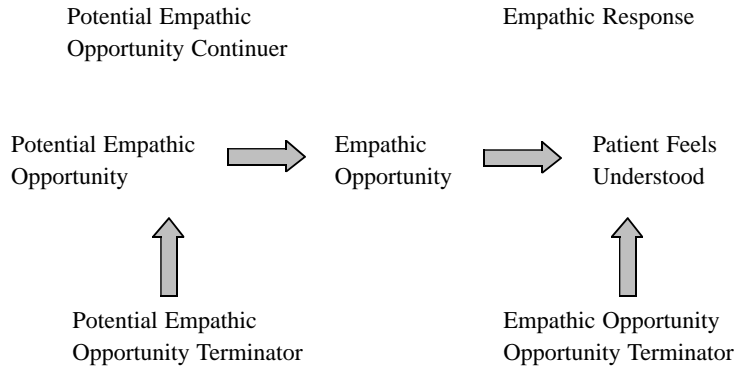
Observe that the patient's statement "I'm in the process of retiring" hints at an issue that has a strong emotional valence (almost everyone has strong feelings about retirement, either positive or negative). The physician's response is to focus on a factual matter: "Do you have Medicare?" As a result the opportunity to explore the potential emotional impact of retirement is terminated.

This particular pattern of patients hinting at emotion followed by a shift in topic away from its further development was the most frequent we found in our data. It may also explain why there was so little expression of frank emotion in the encounters we studied. If the typical approach patients take to discussing emotionally charged issues is to "test the waters" using PEOs, and these are almost without exception terminated in favor of gathering factual information, patients in general are routinely being encouraged *not* to share their emotions in the medical encounter. Based on our analysis we developed the model of empathic communication that appears in Figure 1.

Our study of empathy was designed to describe the communication dynamics around empathy, not to link the presence of empathy with outcomes of care. A recent review of outcome-based communication studies by Stewart (1995) showed a consistent relationship between the presence of empathy and desired outcomes of care, such as satisfaction, adherence, and symptom resolution. An important study by Wasserman et al. (1984) actually showed that empathy is more effective than other forms of supportive communication. Working in a pediatric context, the investigators identified three different types of supportive statements used by pediatricians in talking with parents: encouragement, reassurance, and empathy. Reassurance statements were used most frequently (mean = 16.6 per visit), followed by encouragement (mean = 7.8 per visit). Empathy was used least frequently (mean = 3.1 per visit). In terms of outcomes of care, no association was found to either encouragement or reassurance. By contrast, empathy statements, which were used least frequently, were highly associated with visit satisfaction ($P = .03$) and reduction in maternal concern ($P = < .05$).

This is one of the few outcome-based communication studies to assess the impact of various types of supportive statements made by physicians. It clearly

Figure 1. A model for empathic communication in the medical encounter



Source: Suchman et al. 1997.

lends support to the idea that empathy powerfully affects the physician-patient relationship. It also contains an important clinical lesson for physicians who use reassurance, encouragement, and empathy interchangeably. Empathy, which is used least frequently (as this and Suchman and colleagues' 1997 study showed), is actually the most effective in terms of building relationships and achieving desired outcomes of care.

Function 3: Sharing Diagnostic Information. The third task of the medical encounter is sharing diagnostic information and negotiating treatment plans with patients. Linguistically, it is different from the first two functions that are based on gathering data. While physician questions and patient answers are prototypical of the first two tasks (Frankel 1990; West 1984), information sharing typically takes the form of declarative assertions by the physician followed by elaboration of the news either in the form of response(s) or question(s) from the patient.

The delivery of diagnostic information also comes as the culmination of tasks preceding it and is thus contingent or nested within the overall structure of the encounter. Much like a good novel, the conclusion (the delivery of diagnosis) must be aligned with the characters introduced in the beginning (the elicitation of the patient's concerns). There is evidence that when this alignment is poor or mismatched, the acceptance of the diagnosis by the patient may be jeopardized. One study by Maynard (1991) showed that where diagnostic news was delivered abruptly (noninteractionalized), the diagnosis was more likely to be rejected as compared with news that was aligned with the speaker's state of knowledge (interactionalized). In those cases the diagnosis was better received and accepted. Another recent study by Frankel (forthcoming) analyzes instances where the

diagnosis was rejected by patients. In the cases studied there was a significant disjunction between the patient's statement of concern, the data gathered by the physician in assessing the concern, and the diagnosis rendered. In each case there was a rejection of the diagnosis by the patient followed by a reiteration of information that had already been provided but had been overlooked or de-emphasized in the diagnostic news delivery.

Understanding the interactional dynamics around diagnostic information sharing is complex, in part because of the contingencies that may exist within a single encounter. An added complexity is the diagnostic process on which information sharing depends. It may encompass multiple encounters over a period of weeks, months, or even years, a research challenge that will be addressed in the next section of the paper.

On the clinical side as well, research on the delivery of diagnostic information has been a challenge. For example, a recent review of over 400 studies in this area revealed only a handful that were based on experimental or quasi-experimental methods (Ptacek and Eberhardt 1996). The rest were based on opinion and clinical experience. As well, while guidelines for delivering bad news have appeared recently (Girgis and Sanson-Fisher 1995; Lo, Quill, and Tulsky 1999), these are based on "best practices," not as defined by research but by consensus of groups of clinicians.

Despite its critical importance to patient care, communicating diagnostic information, especially bad news, is not a skill that is widely, or well, taught. A recent newspaper article titled "Apologies to Mr. O: A Doctor Reflects on Delivering the Bad News" bears testimony to this fact.

I began with a confession long overdue, an admission of guilt. Throughout my 10 year medical career, I have repeatedly engaged in a practice for which I have never formally been trained: the delivery of bad news. Not a single hour of medical school or residency was dedicated to the skills necessary to communicate unwelcome news—news that could irrevocably alter the trajectory of another life. (Nahill 1999: C2)

Even where delivering bad news is taught as a communication skill, there is evidence that trainees do less well at it than other skills like data gathering and relationship building. In an important test of the teachability and long-term effects of communication skills training, Maguire, Fairbairn, and Fletcher (1986) demonstrated that first-year medical students randomized to video feedback training as compared with standard paper and pencil instruction retained their skills in all areas five years into practice, except delivering bad news. In this area experimental and control subjects did equally poorly, suggesting that this is a particularly difficult and complex skill to teach. Subsequent work by Maguire and colleagues

(1996) and Fallowfield, Lipkin, and Hall (1998) has shown that significant changes in giving bad news can be made in established practitioners, raising the intriguing possibility that it is a skill that is ideally taught later in training or perhaps even in practice. More research clearly needs to be done in this area both to determine the best ways to deliver diagnostic information and to teach the skills so that they can be put into practice.

Before leaving this topic there is one last study worth mentioning because of its relevance to sequential analysis. It is a study by Ley (1979) on memory for medical information. Most physicians are taught that the logical sequence for the medical encounter begins with a history, physical exam, and laboratory studies if necessary and concludes with the delivery of diagnosis and discussion of prognosis and treatment options. The question raised by Ley was whether the traditional logic of delivering diagnosis, prognosis, and treatment options was actually the most efficacious in terms of information retention by patients. Ley noted, as illustrated below by an excerpt from our own data on an interview with a fifty-nine-year-old cancer patient, that many patients do not remember what is said after bad news is delivered.

The news [that I had gastric cancer] hit me like a bombshell. I was completely unprepared for it. I've been fit and healthy all my life and never had any major health problems. After telling me the news, my doctor gave me a lot of facts and figures about treatments and decisions I had to make. The truth is, I really didn't hear much because I was in shock.

With this in mind Ley designed an experiment in which one group of patients was informed about bad news in the traditional sequence. By contrast, the experimental group was given information in a sequence that reversed the order of presentation so that the prognosis was given first, followed by the diagnosis. Both sets of patients were given the same factual information. In the traditional model it was a statement like, "You have thyroid cancer and in 85 percent of the cases you can expect to make a full recovery." In the experimental manipulation it was, "You do have a medical condition. Eighty-five percent of the time people with this condition make a full recovery. And the name of the condition is thyroid cancer."

After the encounters were concluded patients in both groups were asked to state what they remembered about the diagnostic news that was delivered. In the traditional model group most patients remembered being told that they had cancer and that it would be fatal. By contrast, the majority of patients in the experimental group recalled that they had been told that they had thyroid cancer and that there was a high likelihood (85 percent) of making a full recovery.

The conclusion from this study was that the sequencing of information in the third function exerts a significant effect on the amount and accuracy of

information retained by patients. Unlike other discourse contexts such as aviation, where specific checks and balances on information transfer are routine (a pilot responding to an instruction from air traffic control must restate the instruction and have it acknowledged in order for it to be complete), such checks are relatively scarce in the medical encounter, making the degree of patient comprehension of information difficult to assess.

The future of sociolinguistics in physician-patient communication research. Sociolinguistic microinteractional analysis has already made several significant contributions to our understanding of the dynamics and outcomes of specific communication exchanges involving data gathering, relationship building, and sharing of diagnostic and prognostic information. Several outstanding questions that might usefully be addressed by this approach still remain.

The first has to do with improving our understanding of the impact of the physician-patient relationship over time. At present, virtually all communication research has been cross-sectional. This is an appropriate method for studying encounters between physicians and patients that are episodic. A study of physician-patient communication in the emergency room benefits from a cross-sectional research design, although even in this context it would miss the relationship between the staff and so-called “frequent fliers,” in other words, patients who present to the emergency room frequently. A cross-sectional design might also be appropriate in studying some types of specialty care, for example, an anesthesiologist-patient communication, where the relationship is likely to be limited to a single encounter.

One of the defining features of primary care, which represents the largest source of medical visits in the United States, is that it is continuous. Although patients may experience episodes of illness from time to time, it is assumed that a continuous relationship with one’s own doctor adds value and reduces the costs of care over time. Going to the emergency room for one’s primary care as poor and uninsured in some communities are forced to do is vastly more expensive than having a clinic or a physician of one’s own. Despite the assumption that continuity of care adds value to the processes and outcomes of care, there are almost no longitudinal studies of communication between physicians and patients, and certainly none with a sample size large enough to generalize to the medical care system as a whole.

One tantalizing avenue of study to consider in this area has to do with communication consistency within a single relationship. The question here is, “do physicians consistently respond to the same patient cues?” In the area of relationship building, for example, does the skill of empathy get used consistently over time? A group of colleagues and I recently had occasion to review a series of six videotapes made between a third-year resident in an internal medicine training program and a thirty-seven-year-old patient who had developed gastric

cancer. The first tape involved the resident's delivery of bad news about the cancer. It has been replayed, with permission, at a number of national medical meetings and has been published as a positive example of how to deliver bad news in a humane and empathic way (Frankel 1994).

The next four tapes were routine follow-up visits in which the patient experienced rapid and progressive weight loss, increasing inability to swallow, and back pain. During these visits the patient often referred to his medical problems and his suffering and in several cases also made reference to the fact that he was dying. Just as systematically as he had attended to the psychosocial impact of the news when it was first delivered, the physician avoided engaging in anything but the mechanics of care despite numerous potential empathic opportunities and empathic opportunities.

The last tape, made two weeks before the patient died, was again exemplary. The visit included the patient's sister and contained a sensitive and caring discussion of how the patient wanted to die, the sister's role, and what the physician's own role in the process would be. In addition, the physician touched the patient several times in a comforting, noninstrumental way that is missing from the middle set of visits.

The differences in physician behavior over time in a single relationship are very striking and raise important questions about making general assumptions based on cross-sectional or limited numbers of observations. Certainly, my assumption before watching these tapes was that communication was relatively constant and consistent from visit to visit. In light of the data from an extended case, I am forced to reconsider whether there are certain types of visits rather than relationships with greater and lesser potential for empathic communication. A small field study by Miller (1992) comes to mind in this regard. In it, Miller observed primary care encounters and noted that some events in the encounter were treated as routines or ceremonies; others were treated as dramas. The physician's behavior in these circumstances related to the type of event it was perceived as. Is it possible that the first and last encounters in the videotaped series were treated by the physician as dramas, while the middle four were seen as routine? Research on the ebb and flow of interactions over time would undoubtedly yield important insights into the nature of successful and unsuccessful relationships in primary care. It would be especially interesting to investigate these dynamics as they relate to chronic care, since much of it is highly routinized.

The second area of microinteractional work that lies on the horizon is investigating the effects of computer technology in the exam room and its effects on the physician-patient relationship. Maintaining computerized records and using desktop computers to create them during the course of the medical encounter are growing in popularity. Large health care organizations such as Kaiser Permanente are experimenting with computers in the exam room and have plans to institute paperless medical visits system-wide in the next few years.

There are several overarching questions about computers in the exam room that microinteractional analysis could usefully address. The first is the question of how the presence of the computer affects the relationship between physician and patient. A comparative study of verbal/nonverbal behavior in offices that use traditional charting and those where computers are present would help answer the question of whether the skills necessary to build successful relationships are unique or common to each context. In other words, do physicians with good generic communication skills relate well to patients irrespective of whether they use a paper chart or a computer to record data? If so, the primary communication issue would shift from a consideration of the man/machine interface per se to the more generic question of teaching relationship skills. This is not a trivial question, given the resources that are potentially involved in implementing electronic record keeping. To date there are no studies that have assessed this issue.

Another related issue around electronic versus paper records has to do with the accuracy of information captured in the record. The question of accuracy of medical records has most frequently been studied in the context of quality assurance. Records are reviewed to ensure that all the steps in a care path have been followed appropriately and to identify when errors or omissions have occurred. The standard against which accuracy has been judged in this research tradition has been clearly identifiable biomedical diseases like diabetes, heart disease, or duodenal ulcers. There are no large-scale studies that have investigated accuracy of the medical record when it comes to psychological or social problems. One pilot study (Frankel and Beckman 1995) compared videotapes of encounters with written records of care. For biomedical problems there was a relatively high rate (75 percent) of transfer from a patient having mentioned it during the visit to the problem's recording in the chart. For psychological and social problems the rate of transfer was much lower (33 percent) suggesting that a good deal of important psychosocial information does not ever get recorded on the chart. A study comparing the degree of chart accuracy for psychosocial concerns in office visits where computers are present and where they are not would be an important step in addressing the value of the electronic medical record to all dimensions of the physician-patient relationship, not just disease-based biomedical conditions.

The third area for additional research is time. The average American primary care physician spends, on average, 16.1 minutes per patient visit irrespective of whether it is a new or return visit or how severe the condition is. There is evidence that this amount of time may be suboptimal. A recent study of communication and malpractice by Levinson and colleagues (1997) found that primary care physicians who had been sued at least twice in the past took on average fifteen minutes to see their patients. By contrast those physicians who had never been sued took, on average, 18.3 minutes to see their patients, a mean difference of about one minute less and two minutes more than the national average, respec-

tively. In this study, time was the strongest predictor ($p = .003$) of a physician's history of malpractice. Using malpractice as a measure of extreme patient dissatisfaction, it is fair to say that time and how it is spent is a very important factor in creating successful and satisfying relationships.

Using data from the Medical Outcome Study, Kaplan and colleagues (1995) focused on another dimension of time in the form of joint decision making. The investigators found that visits characterized by joint decision making between the physician and patient generally had better outcomes than those that were physician-centric. For joint decision-making visits the average amount of time spent was about twenty minutes. Interestingly, visits that went much longer than twenty minutes did not show substantially greater effects on outcome, leading Kaplan and her colleagues to conclude that twenty minutes might be ideal in terms of scheduling visits.

From an interactional point of view these studies of time are interesting because they represent a baseline of physician communication behaviors to experiment with. Using the three-function model as a guide, a number of potentially timesaving practices are possible. Eliciting the full spectrum of concerns at the beginning of the encounter and negotiating an agenda to deal with the most pressing from the patient's perspective potentially increases efficiency and optimizes outcome. Similarly, using empathy to increase the patient's experience of being understood may well be more efficient in the long run because it allows the physician to get to "the heart" of the patient's concerns rather than having the concerns unexpressed or remain in the background. As well, communication techniques such as delivering prognostic information before diagnostic information may save time in the short and long run and reduce patient anxiety.

While it may be the case that eighteen-to-twenty-minute visits are ideal under any circumstances, a series of studies based on communication interventions derived from the three-function model could be used to test whether one could achieve in fifteen minutes what currently takes physicians eighteen to twenty minutes to accomplish. One small piece of evidence for this approach comes from a study by Stewart, Brown, and Weston (1989) that compared well-trained practitioners who used either a patient-centered or a narrowly focused biomedical style of interviewing. Stewart found a one-minute time difference on average between practitioners of the two different styles, with patient-centered interviewing taking longer. What is striking in this study is that the magnitude of difference (one minute) is extremely small, suggesting that skills like empathy, finding common ground, and joint decision making have only an incremental time cost.

Conclusion. Language and relationship have always played an important role in medical care. Never has the need and opportunity to understand the intersection of biology, psychology, and language represented by the medical

encounter been greater than it is today. Historically, this is a time when language studies, which typically have their origin in nonclinical disciplines such as linguistics and sociology, are being embraced as a powerful new tool for learning and understanding in medicine. The synthesis that has emerged using functional models of the interview such as the Three-Function Model has already contributed significantly to a range of challenging problems, time, affect, accuracy, etc.

The road ahead is exciting, but it is not without barriers. As time and money become more precious commodities, there will be pressure to bypass the communicative function of the medical encounter altogether. One need only to think of ATMs and pay-at-the-pump gasoline stations to recognize the potential for cost savings to be realized by replacing human interaction with machines. There will continue to be added pressure to reduce, rather than increase, the amount of time doctors spend with patients. A recent cartoon shows two new medical students, one saying to the other, "If the list of procedures insurance companies approve gets any smaller, we'll finish medical school in three weeks!"

On the research side, there will be pressure and increased competition for grant funds. This may make it difficult to maintain ongoing collaborative research partnerships. As well, there is a need for better communication between applied and pure researchers in the collaborating disciplines. There is a tension in most social science disciplines between those who use their craft in the service of another profession (medicine, law, education) and those whose approach is focused on producing discipline-specific knowledge. This is both unproductive and unhealthy and may, in the end, impede progress. These barriers notwithstanding, I believe that we are on the cusp of unlocking some of the most important questions of the new millennium by continuing to pursue the (socio)linguistic turn in physician-patient communication research.

Note

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