Seeking for Effective Strategies at Medical Interviews

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Abstract

Since I started teaching English to the students majoring in the medical filed, I became interested in the discourse analysis of medical interviews – between medical experts such as doctors/nurses and patients. I wonder how medical experts could conduct their interviews with their patients in order to make them feel at ease since the patients usually feel weak and very sensitive in front of the medical experts. It is true that they can professionally handle the physical problems of their patients, but I think they should also be more concerned with their mental aspects in order to recognize how their patients feel at the time of their medical examinations. Thus considering, I have been working on the discourse analysis of Drama ER, and I have studied what kinds of conversational strategies are effectively used at the medical interviews in this drama series, and found the effectiveness of the positive politeness strategies and their basic concepts and characteristics. In this research, based on this findings, I have observed how successfully those strategies actually work or how they fail. Throughout the research, I have noticed there should be another principle in carrying out successful medical interview and found the balance of the two kinds of speech styles – convergence and divergence—are necessary. Finally, I have also made the best use of the findings in the actual English learning situations.

1. Introduction

For the successful communication to be fulfilled, in the medical interviews, the medical expert (referred to as speaker here) should care about the patient (as hearer, here) not just about the professional medical treatment, and the speaker also make the hearer aware of being cared mentally as well as physically. Furthermore, the speaker should appear to be confident as professional so that he/she can be trusted by the hearer. In what way, then can the speaker keep the balance between the care for the hearer and the care for his/her own self-esteem at the time of the medical interview? In order to solve this question and seek for effective strategies at the medical interviews, I would like to observe some the scenes extracted from American Drama Series *ER*., setting the following three goals of the research:

1. To find the conversational strategies suitable in the medical interview context
2. To learn how effective those strategies are for promoting the interpersonal relationship between the medical experts and the patients
3. To make the best use of the findings in English education for the Japanese students

2. Theoretical Framework

2.1 Theoretical Background

Through my observations of the data, I first based on the Politeness Theory (Brown & Levinson: 1987) : analyzing the functions and the pragmatic effectiveness of the politeness strategies. That is, in order to maintain the addressee's (patient's) positive face (the desire to be approved of, to be liked), the speaker (typically, a doctor or a nurse) use positive politeness devices in the ongoing conversation. However, as we observe our data more closely, we have noticed the speaker does not always try to conform to the needs, interests, abilities etc, of the addressee, but he/she also tends to maintain his/her own face; the speaker tends to protect his/her own identity or self-esteem (for instance, to preserve his/her social status as a doctor or a nurse) as well. Accordingly, we also incorporate Accommodation Theory in Giles *et al.* (1991) into our observations.

This theory is originally formulated in the form of Speech Accommodation where Giles proposed that a speaker's choice of speech style is brought about by 'interpersonal accommodation processes': the speaker tends to react, consciously or subconsciously, the addressee's speech style, that is they may be 'accommodating linguistically'. They also propose two types of the speech strategy –convergence and divergence. The former is "a strategy whereby individuals adapt to each other's communicative behaviours in terms of a wide range of linguistic/prosodic/non-verbal features" (Giles *et al.* 1991:7) According to Oatey (2000:191), "the psychological process at the heart of convergence and of 'being accommodative' is 'similarity attraction'". In other words, like one of positive politeness strategies, convergence reflects that speakers want to get closer psychologically to the addressee so that they may be approved of. In our observations below, we will find what sorts of linguistic realizations are effectively selected as showing convergence.

The latter strategy called divergence reflects the speaker's psychological process of being away from the addressee in order to maintain speaker's own social identity or self-esteem. This strategy also plays a key role in some dialogues such as when a speaker (a doctor, for instance) tell the truth which may contain unfavorable information to the address (a patient) and tries to do by putting psychological distance from the patients so that he/she can get trust as a doctor from the patient.

In other words, keeping convergence and divergence in mind, we would say as follows: for the successful communication to be fulfilled, at the medical interviews, the medical expert (speaker) should care about the patient (hearer), not just about the professional medical treatment, and also make the patient aware of being cared mentally as well as physically, and furthermore, the medical expert should appear to be confident as professional so that he/she can be trusted by his/her patient. In relation to positive politeness strategies, we would assume these strategies constitute the convergence speech style, though negative politeness strategies (involving mostly deferent / honorific expressions) are not always constituents of the divergence speech style by which we can maintain our self-esteem and so sometimes sounds challenging for our addressees. In what way,

then, can he/she keep the balance between the care for the patient and the care for his/her self-esteem at the time of the medical interviews? Before observing our actual data, we would like to make a short reference to our key concepts

2. 2 Key Concepts

Taking into the abovementioned theoretical background, I would like to propose the key concepts for as the base for the successful communication. In such conversations as medical interviews between medical experts (defined as Speakers) and patients (defined as Hearers), Speakers need to use positive politeness devices involving the two important concepts: the first concept is the one that we are on the common ground, as shown in, for instance, "I'm with you. You're with me. We are here together", and the second one is that we are cooperators in the same task as in "I'll help you, so trust me". These concepts would be always underlying the successful communication at the medical interview. However, can only the strategies involving these concepts work as the best means of this kind of communication? As mentioned in the last section, we may need something more than these positive politeness strategies. We may as well always consider the balance between convergence and divergence, as hinted above.

3 Observations

3.1 Data

As the data for this study, various medical interview contexts are collected from American Drama Series *ER*I, where the stories are well constructed and show us assumingly ideal human relationship through what is happening at the emergency ward in Chicago County Hospital. Accordingly, we can observe realistic medical interview scenes depicted there as sort of model examples, which might give helpful insights to the students learning medical English. That is why I adopted ER as the source for our research data.

There may be various kinds of the medical interviews shown in ER, but here we would like to focus on the following three kinds which clearly show the importance of the interpersonal relationship:

i) In the cases where the patients are children

ii) In the serious cases such as when informing of the critical disease like cancer

iii) In the cases where the patients are mentally ill or with brain damage such as dementia and autism

From the next section, we will observe, in the actual drama scenes, how well these convergence and divergence speech style work together with positive politeness devices and also discuss in what situation they fail to function successfully. Then, we will consider how we can select an effective speech strategy for the successful communication.

3.2 Observations of Cases in i)

Let us first see Scene A, paying a special attention to the underlined parts.

Scene A [*Dr Ross :Pediatrician, Child :Patient at the age of around 5, Mother :Child's mother*]

Ross: All right. Got some chocolate yogurt for the big guy with the sore clavicle.

Child: Thank you very much.

Ross: You're very welcome….You wanna see why it hurts?

Child: [*Nods*]

Ross: Here. Hop down.

[Showing the X-ray film to the boy] Do you see this line right here? Come here. Take a look. See that? You know what that is? That is your first broken bone. You're officially a man.

Mother: I let him talk me out of bringing him last night.

He said it didn't hurt.

Ross: He's such a tough guy.

Mother: He didn't wanna get in trouble . He isn't supposed to play outside after dark.

Ross: It's tough to stay in when it's this warm …

Child: My mom says I'll get hurt.

Ross: She does? What does your dad say?

Child: I'm a klutz.

Ross: *[Laughing]* He does?

Mother: He gets a lot of bumps and scrapes. His father's quite an athlete, you know?

Ross: *[to Child]* Do you fall down a lot?

Mother: Yeah. I'm not supposed to let him around without watching.

Ross:*[Trying to examine his eyes]* Let's play game. I'll cover my eye. You do the same….

[ER III, Story 20]

As seen from the beginning of this conversation, Dr Ross pretends to regard the child as a man not as a mere child, saying "You're officially a man.", as if they were on the common ground, so that the child can feel proud and be relaxed. In the latter half, Dr Ross is apparently on the side of the child and not of his mother, supporting him as a sort of a cooperator, by using backchanelling and inclusive *we* (as in *Let's*) . Thus, we can find, in this scene, Dr Ross is fairly successful in interpersonal communication with the child by skillfully using positive politeness strategies.

Now let use see Scene B, then, where we can find the differences in the ways where Dr Ross and medical student Tracy deal with their child patient and his mother, respectively.

Scene B *[Tracey:Medical student, Billy:Child Patient at the age of around 7, Mother: Billy's mother, Dr Ross: Pediatrician]*

Tracy: Now, can you tell me what happened, Billy?

Billy: *[Looking down, keeping silent]* …

Mother: The school sent him home. They said he vomited blood.

Tracy: *[Ignoring what she said]* Can you tell me how it happened, Billy?

Billy:…

Mother: He's a very high-strung child. Always very tense, very nervous.

Tracy: Mrs. Robin, maybe you better wait outside while I examine your son. *[Sounds authoritative]*

Mother: Why?

Tracy: It's just procedure.

Mother: Well I think I should be here! I'm worried about Billy. He needs me.

Tracy: Please wait outside! *[Sounds like order]*

Mother: Oh, doctor. I don't know who you think you are, but this is my son and I want to be here. He's very high-strung!

Ross: Mrs. Robin. You're absolutely right. You love your son. And you want him treated as soon as possible. So it's best… if you have a seat outside here. And we'll be right with you. That's OK.

[to Billy] Hey, kiddo. All right. Did you vomit blood?

Billy: *[Nods]*

Ross: Do you have any pain?

Billy: *[Nods]*

Ross: Okay, can you point to the pain?

Billy: *[Points to the pit of his stomach]*

Ross: Right in here. Have you vomited blood before? Many times?

Billy: *[Nods]*

Ross:*[Giving him a hug]* Okay. *[ER I, Story 1]*

In this scene Tracy is first having a medical interview, in place of Dr Ross, who is observing Tracy's practice. From the beginning of the conversation, Tracy use wh-questions (*what* happened, how it happened) which the child cannot easily answer, so that he keeps mouth shut and is beginning to feel nervous. Furthermore Tracy speaks to his mother in such an authoritative manner (as shown in *You'd better* which implies sort of threatening and also a directive expression *Please wait outside!*) that the mother feels upset and even gets angry.

Therefore, we can imagine, their communication is not successful, because they fail to have common ground or become cooperators. In other words, Tracy's speech style is of strong

divergence and does not show any convergence. Though we do not consider the prosodic features in this paper, if we see the actual film, we would soon notice her voice tone also sounds harsh and authoritative. On the other hand, in the latter half of the Scene A, we can see Dr Ross agrees with his mother and even shows they are on the common ground, as shown in *You're absolutely right. ... we'll be right with you,* so that she feels secured about the treatment.

As for Billy, he can easily respond (by just nodding, though) to Ross's questions which only require *yes* or *no* as an answer, so that he is beginning to feel closer to the doctor. Finally, Ross gives Bill a hug, which makes Billy really feel relieved. In this case, Speaker (Ross) conforms to Hearer (Billy) in that Ross asks easy questions, which is one of the typical strategy of convergence and that works quite successfully.

3.3 Observations of Cases in ii)

Now let us see Scene C as the example in ii), where Susan (doctor) is having an medical interview with a patient who she doubts has a cancer.

[Scene C] *[Susan: ER Resident, Mr. Parker: Patient]*

Susan: We have your X-ray, Mr. Parker. *[Showing the X-ray]* You can see there's a density in the right middle lobe.

Parker: What does that mean?

Susan: It means something abnormal within the structure of your lung.

Parker: Is something in my lung?

Susan: Yes, that's right.

Parker: What is it?

Susan: It could be an infiltrate, a dense area of tissue from an old infection. Perhaps an inhaled foreign body. It could be a granuloma. It could be a lot of things.

Patient: What do you think it is?

Susan: There's no way to know. You'll need a bronchoscopy and possibly exploratory surgery.

Parker: I understand, but what do you think in the meantime?

Susan: <u>I think in the meantime you should consider it potentially serious</u>.

Parker: So I got a cancer.

Susan: I'm not saying that. I'm saying we don't know anything for sure.

Parker: Doctor, let me explain something to you. I'm 40 years old. I have a wife and 3 children and a house not paid for and a mother whose house isn't paid for. I have a lot of responsibilities. So I need to know. I need to know what you think.

Susan: <u>I think you should regard your condition as very serious but should wait for a final determination.</u>

Parker: I don't understand the problem. Are you afraid to tell me the truth?

Susan: Your history of coughing blood, weight loss and this X-ray is suggestive of cancer. But the diagnosis is not confirmed, and it may be something else. And we shouldn't jump to any conclusions until we know. That's what I think.

Parker: How long do I have?

<pause>

Susan: Six months to a year.

Parker: Do I have six months for sure?

Susan: No, not for sure.

Parker: OK. I was wondering because I always wanted to take my wife to Nassau. We talked about it, but we never did it, so I just figured, spring's coming, it's getting too late to go to Nassau. She always wanted a suntan in the winter to show off to the neighbor.

Susan: I understand.

Parker: Yeah. So I guess I'd better go. Summer will be here before you know it, so I better go soon, huh? Doctor, I want to thank you. I want to thank you for your help and for being straight with me. *[Sigh]* I guess I don't have to quit smoking. *[Starts crying]*

Susan: Mr. Parker, if there's one thing you learn in my job, it's that nothing is certain. Nothing that seems very bad and nothing that seems very good. Nothing is certain. Nothing… (They hug each other.)

Parker: I'm sorry. *[ERI, Story I]*

As you may notice, in the former half of the scene, Parker feels irritated and almost overwhelmed by the anxiety, because he suspects that Susan hides the truth and just gives him only technical explanations. Surely, this is where Susan does not take decisive attitude towards her patient, saying I think in the meantime you should consider it potentially serious. The ambiguous utterance like this makes the patient feel far more uneasy. On the other hand, in the latter half, Susan attentively listens to Parker's story (positive politeness & convergence in that she maintains patient's and also as for Parker, it is divergence in that he maintains his face) and also tells him exactly what she thinks now as a doctor (divergence in that she maintains her self-esteem as a doctor). After all, they can understand with each other quite well, which means their communication ends successfully. The last utterance of Susan's *nothing is certain* sounds encouraging not only Parker but also herself, suggesting they are on the common ground.

In Scene D below, on the other hand, Dr Benton fails to have a trustworthy relationship with his patient's wife . That is perhaps because he cannot prove himself as a cooperator and just only uses the speech style of divergence.

Scene D [*Benton :Surgical resident, Mrs. Powell :the patient's wife*

Benton: He was injured this morning in a snowmobile accident. He never regained consciousness. The medical examiner determined that your husband is brain dead. I'm sorry.

Mrs. Powell: I don't understand. Why is he hooked up to these machines if he's dead?

Benton: Well, because he can help others by donating his organs

Mrs. Powell: *[Touching her husband's face and hands]* His face. It's so warm. And his hands. I've heard of people waking up from comas. A man in our church was in a coma for 6 months. Everybody said it was hopeless. Then one day he woke up.

Benton: I'm sorry, Mrs. Powell. But there's no possibility of your husband recovering.

Mrs. Powell: I want a second opinion.

Benton: *[A little irritating]* I know he looks like he's alive. But the only reason he's on this ventilator is to keep his heart pumping.

Mrs. Powell:*[Defiantly]* I want a second opinion. *[ER I, Story 11]*

Even if Mr, Powell has no hope for recovering, Benton should have first considered how Mrs. Powell feel in front of her dying husband and should have tried to select some kind of the convergence speech style.

Through those observations, we can say, in the case where the patient is in critical condition, the medical expert should first of all give serious consideration and be trusted by the patient (as well as those close to the patient)., avoiding using stereotypical expressions or directions without emotions. In order to do that, by being a good cooperator, the medical expert should sincerely listen to what the patient wants, offering helpful advice so as not to make the patient feel uneasy, and promise best possible medical treatment.

3.4 Observations of Cases in iii)

Now let us observe the final cases where the patient has the brain damage, such as dementia or mental illness. Scene E shows the conversation between the psychiatrist and the patient with Alzheimer disease.

Scene E [*Carter :Medical student, Psychiatrist, Madam X : Patient*]

Carter: This is Madam X. I did a physical but had trouble with the psycho exam.

Psychiatrist: And the mental status questions?

Carter: Tried. Half the time she screamed, the other half she was in tears

Psychiatrist: Let's see what we can do.

…

Psychiatrist: My dad once saw Benny Goodman play at the old Monroe Theater.

Madam X: *[Apparently pleased]* On 33rd Street?

Psychiatrist: Yep.*[Giving an affirmative answer, even her answer is incorrect]*

Madam S: *[Being proud of herself]* I used to sing there during the war. All those boys in uniform.

Psychiatrist: He was one of them. Who knows, maybe you even danced with him.*[→the patient becomes relaxed and lively.]*

Carter: *[In a whispering voice]* I never thought to talk about music. I don't know music.

Psychiatrist: Are you ready to try of those questions?

Madam X: Like on Jeopardy!?

Psychiatrist: Yeah.

Madam X: OK.

Psychiatrist: Can you tell me where you are?

Madam X: What is a jail?

Psychiatrist: No, you're not in jail. *[Negative answer makes her uneasy.]*

Madam X: *[Beginning to feel uneasy]* The cops brought me in here.

Psychiatrist: *[Smiling]* Okay, I'll give you that one. *[→Learning the patient cannot answer, he stops asking the same question and goes on another one.]* What year is it?

Madam X: *[Being confident]* What is 1948?

Psychiatrist: *[Avoiding disagreement]* And who's the President?

Madam X:*[Being more confident]* Harry Truman. *[ER I, Story 3]*

As Carter says, in usual medical interview, Madam X can not give proper answers, and furthermore, as the above case shows, she seems very confused if she finds the question difficult to answer. However, given the questions which she is very interested in, she can start a lively talk. Accordingly, in order to get along with the mentally ill patient, the speaker should build the common ground between them by finding the same interests, for example. In addition, avoiding disagreement and listening attentively to what the patient wants to say are recommended strategies in this case, too.

4. Findings and Future Tasks

Observing so far, we have already got the following findings regarding to our research goals 1 and 2 mentioned in the earlier section: What conversational strategies are most suitable for the medical interview context and how are they effective for promoting the interpersonal relationship between the medical experts (referred to as Speaker, hereafter) and the patients and their family (referred to as Hearer, hereafter)? From our observations, we can give the following answers:: try to use convergence speech style at first by selecting positive politeness strategies, so that Speaker can build a secure interpersonal relationship with Hearer To be more concrete, firstly Speaker should not speak in a too authoritative manner; otherwise Hearer (signifying patients and their

family, here) feels very nervous and what is worse, both Speaker and Hearer cannot have the common ground. Secondly Speaker should avoid disagreement with Hearer as much as possible, and thirdly should try to choose the questions to which Hearer can easily respond; otherwise they cannot be good cooperators and Hearer often keeps silent, especially in the case where Hearer is mentally sick or has some sort of brain damage. Once Speaker succeed in getting a stable interpersonal relationship with Hearer, then Speaker incorporate the divergence speech style by, for instance, giving persuasive explanations and appropriate advice based on his/her profound medical knowledge as well as offering medical treatment to Hearer, so that Speaker can maintain his/her self-esteem as professional and also get strong trust from Hearer. After all, the balanced and appropriate use of the convergence and the divergence speech style is the most important for promoting the friendly and trustworthy interpersonal relationship between Speaker and Hearer and therefore for the successful communication between them.

Finally, regarding goal 3, to make the best use of the findings in English Education for the Japanese students, my students here, I have carried out the following practices in my English classes: students are encouraged to

i) observe how these strategies are linguistically realized in *ER* dramas,
ii) consider what to say if they were doctors or nurses in the context shown in ER dramas,
iii) perform doctor's or nurse's role in English, and
iv) discuss what they thought with the classmates.

I would like to shown one of the then carried out In actual classroom setting, by using Scene F.

Scene F *[Carol : Head Nurse Child : Patient's son]*

A child at the age of around 5 whose mother is mentally ill and so he is forcefully separated from his mother. Being so depressed, he runs away and hides himself so that the nurses cannot find him. Finally Carol finds him and tries to talk to him]

Carol: *[to Child who keeps his head down and never speaks to anyone]*

Hi! My name's Carol.

I like your sneakers.

Child: They're not the good kind. Y mom got them from the cheapo shop.

Carol: Uh huh.

Child: Where s she?

Carol: The doctors take her upstairs. She's very sick. They're goa try ad make her better.

Child: But that doctor said we can stay together.

Carol: Well, if looks like your mom may have to stay here for a while.

Child: Can I see her?

Carol: I don't know if she can have visitors, but I'll check.

You wanna hang out with me? *[←"I'm always with you."]*

Child: *[Looks up and stars at Carol's face for the first time]*

Carol: *[Smiles]* *[ER I, Story 4]*

At the first view, though I explained the situation, the students watched the scene , where the boxed parts above have no sounds, so they themselves think what sort of strategies to take and what to say to the child. For them, the first utterance was hard to come up with, but once reminded of the convergence speech style and giving the care for Hearer, they notice they should pay attention to the child's interests or belongings. In this scene, this child did not have anything with him, so naturally his clothes or shoes drew the students attentions. As the convergence speech style in English, I recommended to use *I* as a subject: saying not "Your sneakers are really nice", but "I like your sneakers" is appropriate. I also asked the students what to say in the final two boxed parts. I tried to encourage them to say as freely as possible so that they can develop their conversation with the child in the assumed situation.

This kind of use of visual teaching materials have worked quite well so far, since the students got used to conversational strategies as well as interested in talking in English, along with acquiring medical knowledge in case of *ER.* They can also improve their listening skills by watching films. In the future, I plan to make the best use of visual materials together with suitable conversational strategies so that the students can improve their communication skills more systematically and learn appropriate English usage more naturally.

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Data

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