"DON'T WORRY — I HAVEN'T A CLUE": ASPECTS OF DOCTOR/PATIENT COMMUNICATION

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INTRODUCTION: THE BACKGROUND

A very considerable amount has been written about medical communication, almost all of it unknown within the field of Language for Specific Purposes. The findings are summarised in two major overviews, one by Roter (1989), the other the so-called Toronto Consensus Statement (Simpson et al 1991). The latter in particular has received widespread currency — it was published on both sides of the Atlantic, and has proved to be very influential. An earlier literature review (Pendleton 1983) is instructive for what it tells the reader about preconceptions and predilections of medical approaches to communication, but has now obviously somewhat dated.

There are two main research traditions. The first of these is broadly quantifiable in nature, and is best exemplified by the series of papers written by Ley in the 1970s, summarised in Ley 1988. Ley and a variety of other scholars at that time attempted to show a relationship between «good» communication and a series of what they called «process outcomes», such as «patient satisfaction», «compliance», «memory and recall», and «understanding». The claim was made that there was a direct correlation between communication and these outcomes, but the results are, in fact, a little unsatisfactory in ways which are interesting. Firstly, attempts to define what could possibly be meant by the phrase «good communication» are either lacking or poorly thought through. Secondly, there is in many of these studies what one might call the correlational fallacy — that is to say, there is a belief that a particular behavioural quality (eye contact for example) is intrinsically a good thing and therefore, that the more there is of it the better the consultation will be. This latter fallacy was first identified by Stiles (1981) in a paper which has not received the attention it deserves. He made the very obvious point that as patients differed so the appropriate communication to use also differed – a young female patient will not necessarily want unlimited eye-contact with a middle-aged male doctor.

More generally, this tradition focuses essentially on defending a proposition which most linguists may feel does not need defending: that to put effort into talking nicely to people has a beneficial effect. The Toronto Statement is a document very much of this kind, a polemic which seeks to demonstrate that doing communication is time well spent.

From the point of view of the applied linguist this generally quantitative approach to research is extremely unsophisticated in nature. The other research tradition is qualitative, and often broadly ethnographic, but it too can be naive in the extreme. Within medicine, the best

known study of this kind is that undertaken by Byrne and Long in the 1970s which involved the transcription of 1800 medical interviews and the assignation of functional labels to stretches of text. These functional labels unfortunately were generated and deployed in a manner at once pre-theoretical and internally inconsistent. The point is well made in Mishler (1984), one of a number of ethnomethodological studies which are qualitative in nature, linguistically more aware, and therefore much more congenial to a humanistic audience (see also Fisher and Todd eds. 1983, West 1984, and Drew and Heritage eds. 1992). Perhaps for this same reason these studies do not have wide acceptability or influence within medicine.

Quite apart from the research tradition into communication, the last 20 years or so have seen radical changes in the climate of the opinion surrounding both the practice of medicine and of medical education. These changes are often linked both to general changes in educational theory and to the changing role of the doctor, at least in the developed world. Thus, the purpose of medical education until very recently was perceived as being the production at the end of the five year undergraduate course of a doctor who knew enough to practise independently. This led to medical courses which were full of rote learned information, and left very little time either for reflection or creativity. It is now recognised that education is something which will continue throughout a doctor's career, and that the doctor in the western world has many sources of information at his/her fingertips, and therefore does not need to carry everything in their head. What matters now, therefore, is that doctors be trained in how to learn, introspect and reflect on their learning. Coupled with this in turn is a recognition that the patient is more than the grateful beneficiary of the doctors' (rote learned) knowledge. Where there was once a tacit assumption that the patient was a machine that had broken down and the doctor was the mechanic who could fix it, there is now a growing recognition that patients have relevant psychological and sociological ideas, concerns and expectations which the doctor needs to take into account in treatment. The terms for this distinction are normally, despite their clumsiness, «biomedical» and «biopsychosocial».

THE GENERAL PRACTICE ENCOUNTER: THE BIRMINGHAM STUDY

It is against this background that the Department of General Practice at the University of Birmingham in collaboration with Cobuild Plc is undertaking concordancing based research into the language of general practice. It will be seen from the above that we have considerable doubts about quantitative research undertaken in the medical interview and that the ethnographic tradition has not had the influence it perhaps deserved. The central motivation for the present study is not merely, therefore, to extend the range of concordancing research as a methodology, but to offer medicine an approach which breaks with tradition -- even the Toronto Statement, which is more confident about the value of research to date than we are, calls for «new methodologies» to be employed. (There is a further point here, that much of this material dates from the early and mid-1980s, before the more recent sweeping changes in medical education had properly taken root. Preliminary findings suggest that doctors in UK do not behave in quite the way that the doctors reported on in these studies behave).

The main GP data base (other studies are also taking place, drawing on other data-bases) stands at the moment at one million words. This study however draws on the first 37 doctors, and 450000 words. The number of participating doctors evidently remains too small for sociological variables between doctors to be studied, but overall language patterns common to the group emerge clearly. Detailed study is now beginning, and what follows is a preliminary

report which may be of value in itself but, it is hoped, will also point the way forward for future study.

ONE CENTRAL ISSUE: UNCERTAINTY AND AFFECT

It is commonplace that there is a major division in language between what people say and the comments they make on what they say. Thus a doctor may say «you've got diabetes». This has the status of a proposition. Doctors may, however, go on to comment on this proposition in one of two ways, either by remarking upon the extent to which they believe it to be true or by remarking upon the feelings the proposition invokes in them or others. Thus the doctor might say (a comment on truth/certainty) «*I think you might* have diabetes» or (a comment on affect) «*I'm sorry to say that* you've got diabetes» (see Skelton, in press, for details). A focus on what is known and how it makes the participants in the interaction feel goes to the heart of the General Practice interview.

The latter kind of comment is of obvious importance in that it has value for an understanding of the psychological basis of the consultation. The former kind of comment is important given the nature of medicine in general, and general practice in particular.

General practitioners are faced with a wide variety of undifferentiated problems in their daily life. Many of these problems are accompanied by an initial presentation of broadly similar symptoms, for example, a low grade fever or a sense of tiredness. These problems may indicate nothing, or they may indicate a disease which is life-threatening. Thus, many children get low grade fevers of which a tiny fraction have meningitis. One of the most important aspects of the GP's training is to equip him/her with — to use the psychologist's term — sufficient tolerance of ambiguity to function successfully and with personal satisfaction in the face of uncertainty. Moreover, it is increasingly recognised that a great deal of contemporary medical practice, even under the best circumstances, is based on anecdote, guesswork, experience and instinct rather than on solid medical evidence. It is sometimes claimed (though the figure here depends on one's definition of the word «knowledge») that only around 10% or so of common medical practice is evidence-based in this way (for details of Evidence-based Medicine see the paper by the EBM Working Group, 1992) And finally, it is generally recognised that up to 50% of what a general practitioner sees is not «amenable to a biomedical solution» (Stewart and Roter 1989).

This means that the doctor faced with a patient often does not know for certain what the patient's problem is. It is clear from our data that GPs offer explicit labels for the problems they see only on a minority of occasions — the precise figure here depends on how one defines a first presentation of a problem (a patient with a chronic problem clearly does not expect the problem to be labelled on each visit), and on what counts as a label, but however these matters are defined, the proportion of consultations with clearly stated diagnoses is not large. (A clinician reading the transcripts will very likely have a clear sense of the most likely diagnosis, but that is a different matter). The archetypal GP interview perhaps concludes as this one does:

D ....sometimes people have a touch of what's called gastritis which has similar symptoms and it's usually quite tender there and you're not
P no
D So whatever it was I think you're right, you're better
P <laugh> sorry about that
D that's OK you can come back again if it gets worse

The difficulty is between the counter claims of truth on the one hand (one must not falsely reassure) and the need for reassurance on the other (one must not unduly frighten). Consider a word like *sure* for example, one which can convey both certainty and assurance. There are precisely 200 examples in the data base of doctors using *sure*, of which 46 are preceded by *I'm* and 25 by *I'm not*. (The other realisations of *sure* are *make sure* as an imperative to give advice or *to make* sure as an infinitive of purpose, and there is one example of the phrase *slow but sure*). Of the 46 instances of *I'm sure* only these 4 are concerned with some aspect of the diagnosis.

< we know you've got an infection/ I'm sure this is down to the infection/but
< given what you've described I'm sure it's an inflammatory reaction
<P>.
< it possibly caused this ?// <D>. I'm sure//Erm it can cause Otitis/ Externa
or
< and the Aspirin <D>. yes I'm sure it is yes and and yeh how do you

16 are concerned with peripheral areas (*I'm sure that's Chloroquine, I'm sure* says one doctor, trying to read the handwriting of another, for example), and the remaining 25 are concerned with reassurance, either about some aspect of the presenting problem, or — as in these examples — as a global evaluation:

< you in <P>. Sure ? <D>. Yeh. I am sure you'll feel a lot better. OK
then. >
all right in in future I'm sure/ I'm sure it will <P>. yeh <D>. Let's pop
nothing to worry about at all I'm sure. <P>. yes/hmm <D>. So it's one year
this will settle down on it's own I'm sure. Hmm, but I think she'll probably
to do with the pregnancy I'm pretty sure, well in a sense it's not involving

(The patient in the last of these instances is being reassured that she is not in danger of losing her baby: the preceding words are *it's nothing....*).

Equally, there is frequent recourse to what Lakoff (Lakoff 1972) called «vagueifiers», words whose function it is to make the proposition they accompany less precise — in this context, the diagnosis less certain. An interesting example is *some sort of*, of which there are 13 instances:

D wondering whether there is hu[zz] some sort of a a personality conflict >
D take the pill really erm and there some sort of problems with as I say being
D possibility you might be brewing some sort of little tummy bug but >
D Right I mean it looks to me to be some sort of tendonitis erm possibly the >
D your blood pressure would give you some sort of swelling and veins in your >
D huh I I guess there's been some sort of little cyst or something >
D sort of little cyst or something some sort of little/ fluid filled/ thing >
D might have thought they were having some sort of Thatcherite revival if he's >
D little spots and she may have had some sort of I mean, you get all sorts or
D viruses/ that can be part of it, some sort of diarrhoea sort of an >
D type reaction like I said a bit some sort of you know he's come up in >
D sort of you know he's come up in some sort of whether it is similar to the
D the second half of the cycle to get some sort of control for you <P>. Right >

There is an interesting overlap which may be emerging here between a desire to keep things vague and a desire to keep them small — between phrases like «some sort of...» and «little», or «a bit...». Imprecision and insignificance may go hand in hand.

There is evidently much more work which needs to be done here about the nature of the strength of claim which doctors make. To make the most obvious point, the strongest claim of all is one that is not explicitly stated — «I think you'll live» in the face of an obviously insignificant medical problem can only be a joke, and therefore will not normally be said. One level of certainty below this is the bare, unmodulated proposition such as «you've got flu». It is only at the next level of certainty down that an explicit comment becomes necessary (see Latour and Woolgar 1986). One aspect of this which we have explored so far, however, is the use of negative propositions which are stated without a comment to mitigate the force of the proposition. The possibility of seriousness, for example — the notion that the patient may be suffering from a problem that is not trivial — tends to be introduced only in order that the possibility may be discounted, as a look at the word *serious* suggests.

else entirely different <zz>. a more serious sort of chronic illness erm I >
help us exclude anything potentially serious but you know I'm pretty sure of >
< your tummy but/doesn't sound too serious I must say. <P>. right >
< nothing about it that indicates any serious erm cause and certainly I don't >
up. <D>. Right, well they're not the serious form of varicose vein that goes up
< they're not going to cause you any serious problem <P>. hmm <D>. ever. The >
distinguish is whether it's anything serious or whether it's just part of her >
< future, it's nothing that's that's serious it's just an irritating thing. The
< so I don't think there's anything serious but i[f] if you think there's a >
< It doesn't look anything too, too serious there, it's just a little bit of >
< t going to lead on to anything more serious and it will clear up over the next
< <silence>. now that's not serious, well it's not serious short term/
< that's not serious, well it's not serious short term/ but it will be enough >
< rash and then you may get a more serious allergic rash/ like you may you >
< were <P>. was I ? <D>. It was that serious. <P>. <silence3>. <D>. It was that
< <P>. <silence3>. <D>. It was that serious. <P>. Hmm. OK. <D>. I really >
< <D>. Erm or any s[erious], any serious problem <write5>. <inaudible>. >
< them getting worse. It's nothing serious, it is a bit unsightly/but >

Seriousness is spoken of as something hypothetical (*whether it's anything serious*) or something in the past (*it was that serious*), or — usually — as something which is denied. It follows from this that a large part of what a doctor does is to sustain an appropriate level of uncertainty while retaining the patient's trust and that this forms an important part of the GP's craft which must be learned.

Affective comments follow a very similar pattern. In particular, doctors seldom claim to be *worried* about their patients, whereas patients often express worry. (As with the previous finding, this is constrained by the fact that at the moment we are only dealing with very explicit references to certainty and affect — it is obvious enough that much of the psychological meaning of the consultation is not carried by explicit declarations of joy or sadness.) Of 186 examples in the database of *worr**, 46 were uttered by the patient or someone accompanying the patient, 140 by the doctor. 37 of the patient or companion's use of *worr** were an admission of worry,

and 3 were a denial. Of the doctor's uses, only 6 were an acknowledgement of present worry, one was an acknowledgement of previous worry (in the context that there was no further need for worry), 21 were a question to the patient about whether s/he was worried, one was a general statement (*it can be rather worrying*), and the remaining 112 were negative, almost all as straightforward as these examples:

general, but it isn't anything to be worried about # <ZP> Yes so It's nothing />>>
< until he's a bit bigger so I'm not worried about that OK and I'll give you >
< <ZD> yes I mean I'm not terribly worried about that and/ I don't think you'>
< side affects so erm don't don't be worried on/ that score <ZP> Right/mm/right/
< safe when your pregnant so don't worry <compS> <cough> <ZC> <inaudible> >
< Yeah III er I'll work on him don't worry as soon as I see him <ZC> Alright >
< booked up anywhere/<ZD> Don't worry about it /if you go away don't/ let
< <ZP> sorry <ZD> its alright don't worry.<ZP> erm I mean they might be >
< people every day with them so don't worry about it erm # <cough> <write11> >
< have really put this <ZD> don't worry it it you got the sort of the right

The general picture of the GP interview therefore is one of uncertain truth values being accompanied by a high degree of empathic affect and a specific willingness to reassure by belittling the presenting complaint: the corollary of this, one may presume, is that the use of words like *worry* or *serious* can be extremely powerful. In medicine, little words have big meanings: doctors often give the impression they feel they are walking on eggshells. The result is a generally very formal appearance. Doctors appear to employ in these areas a vocabulary which may strike the listener as remarkably anodyne, but it is anodyne for the same reason that diplomatic language often appears to be so. A breach of convention would have devastating consequences.

THE FUTURE

It will be seen from the preceding section that the detailed language study we have so far undertaken is not particularly sophisticated. We aim in this first phase of our study merely to understand some basic patterns of the kinds indicated. A further, badly needed area of study is an analysis of the overall structure of the medical interview (with or without concordancing techniques), and an analysis of the use of questions in the database. (The database is so constructed that a question mark, which is inserted at each functional question, is treated as a word and may be called up using the basic lookup program). Both these areas have been much studied in the past, but our preliminary findings seem to suggest that the typical accounts that are offered are mistaken.

We have also begun to consider a series of what we are calling «Access Studies». A great deal of information about what doctors actually do is a matter of self-reporting — the completion of questionnaires, participation in structured interview studies and the like. These suffer from the traditional difficulty of such methods, that they cannot tell you the truth, only — ignoring the possibility of the deliberate lie for the moment — what people think to be the truth and are prepared to admit. The database gives direct evidence of practice, however, and seems to reveal (though again, numbers are small) that GPs do less than they claim to do when it comes to matters of health prevention. Consideration of the word *smok** for example, appears to be revealing a much less interventionist stance than had been thought.

More broadly, we hope to compare and contrast the consulting styles of different types of doctor with different types of patient. This evidently requires a much larger and much broader database than we have at present, however, and this must remain a hope for the next few years. Among obvious questions which arise are: do male doctors consult differently from female doctors? (In this respect, it is worth noting that a great deal of the communication skills training which doctors undertake as part of their undergraduate or post graduate courses aims in effect to assist GPs to talk like women (see Coates 1993). Equally, it would be valuable to compare doctors at different ages, or with patients of different social classes, and so on. Finally, it is very likely that doctors consult differently across cultures: this is an area in which almost no work has ever been undertaken.

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