A LINGUISTIC ANALYSIS OF TURKISH MEDICAL LANGUAGE AND DOCTOR PATIENT COMMUNICATION

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ÖZET

Bu çalışma, dilbilim ilkeleri doğrultusunda Türk tıp dilinin sistematik bir çözümlemesini yapmak amacıyla hazırlanmıştır. Temel amacı, Türk tıp dilinin ve doktorun hastayı muayenesi sırasında kullanılan dilin bir betimlemesini yapmaktır.

Çalışmanın birinci bölümünde, araştırma için temel oluşturabilecek kaynak taraması, konu ile ilgili problem, varsayımlar, amaç ve veri toplama ile inceleme tekniğinden söz edilmektedir.

Çalışmanın ikinci bölümünde, Türk tıp dili toplumdilbilim açısından incelenmekte ve bir meslek dili olarak özellikleri irdelenmektedir.

Çalışmanın üçüncü bölümü, Türk tıp dilinin dilbilimsel özelliklerinin incelenmesine ayrılmıştır. Bu bölümde, özellikle yazı dilinden alınan veriler üzerinde durulmuştur.

Çalışmanın dördüncü bölümü ise, doktor-hasta iletişimindeki önemli etkenler, kullanılan dil stratejileri vurgulanmak istenmiş ve doktor-hasta iletişiminde doktorun değişik eğitim düzeyine sahip olan hastaları ne kadar bilgilendirdiği ve bu meslek dilinin polikliniklerde ve hastanede yatan hastalara kullanılma sıklığı, söylem çözümlemesi yöntemi ile incelenmiştir.

Çalışmanın beşinci bölümünde, polikliniklerde muayene sırasında, doktor-hasta konuşmalarının, tümce çeşitleri, yapı ve metin özellikleri ele alınmıştır.

Altıncı ve son bölüm Türk tıp dilinin araştırma sonucu varılan dilbilimsel özellikleri ve de değişik eğitim düzeylerine sahip olan hastaların doktorları ile olan iletişimi incelenmiş, vizitlerde ise iletişimin sadece doktor-doktor arasında gerçekleştiği vurgulanmaya çalışılmıştır.

SUMMARY

This dissertation is designed to make a systematic and explicit description of Turkish medical language on the bases of the results of linguistic studies. The basic purpose of this dissertation is to make a comprehensive study about the type of language used by Turkish medical doctors in their professional activities, and also the language used in doctor-patient interviews.

Chapter I of the dissertation gives a background for the study which naturally brings forth the problem to be discussed, pursope of the dissertation, hypotheses and the technique of data collection and of discourse analysis.

Chapter II attempts to analyze the sociolinguistic aspects of Turkish medical language and the features of it as an occupational language.

Chapter III is the linguistic analysis of written Turkish medical language.

Chapter IV deals with the factors related to doctor-patient communication, including the information giving process of doctors and the language strategies concerning the communication. Furthermore, the informativeness of physicians to patients with different educational backgrounds, and the frequency of the usege of occupational code to patients in policlines and to those that are hospitalized are analyzed by means of the method favoured by Stiles (1978,1981).

Chapter V describes the sentence types, tense features and textual analyses of question-answer sequences during the medical interviews in policlinics.

Chapter VI is the conclusion part that summarizes the findings about Turkish medical language and doctor-patient interaction.

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ABBREVIATIONS

D	:	Doctor
D1	:	Assistant of the doctor
Lab.	:	Laboratory
P	:	Patient
Q	:	Question
R	:	Response
TML	:	Turkish Medical Language
VRM	:	Verbal Response Mode

CHAPTER I

INTRODUCTION

1.1. General View on Medical Language

Language we use in everyday living is remarkably varied. When we look closely at any language, we will discover that there is considerable internal variation, and that speakers make constant use of the many different possibilities offered to them. No one speaks the same way all the time, and people constantly exploit the nuances of the language they speak for a wide variety of purposes. "A recognition of variation implies that we must recognize that a language is not just some kind of abstract object of study" (Wardaugh 1986:5), but it is also something that people use. Therefore, according to Wardaugh (1986), there is considerable variation in the speech of any one individual, and there are also definite bounds to that variation, that is, no individual is free to do just exactly what he or she pleases so far as language is concerned. From this point of view, the variation has limits and these limits can be described with considerable accuracy which can be applied to a group of speakers not just to individuals. Hence, there is a group norms so far as variation is concerned; on the other hand, individuals have knowledge of the various norms, and that knowledge is both very precise and at the same time almost entirely unconscious (Wardaugh 1986). Therefore, it is important to specify the norms of linguistic behavior that exists in particular groups.

Sociolinguistic studies show that the varieties of language that speakers use reflect such matters as their regional social or ethnic origin. Moreover, they show that particular ways of speaking, choices of words, and even rules for conversing are determined by certain social requirements.

According to Wardaugh (1986:22), a variety can be something greater than a single language, as well as something less, less even than something traditionally referred to as a dialect. The term dialect can be used to describe differences in speech associated with various social groups or classes. There are social dialects as well as regional ones. A social group that is determined by social position; occupation, place of residence, education, cultural background, religion, and so on do appear to be related fairly directly to how people speak. Regional dialects, on the other hand, are geographically based (Wardaugh 1986).

Furthermore, language varies as its function varies; it differs in different situations. The name given to a variety of a language distinguished according to use is 'register'. Registers are sets of vocabulary items associated with discrete occupational or social groups, for example surgeons, airline pilots use different words for their professional activities. Therefore, a language for specific purposes, i.e., register, is the restricted use of language in certain domains of human activity, have been known for a very long time. From this view point, medicine is a profession with all its terminology which is alien to a layman, and the findings of which are put to use directly.

Speakers also can adopt different styles of speaking. One can speak very formally or very informally, the choice being governed by circumstances. Hence, the level of formality chosen may vary according to a variety of factors: the kind of occasion,various social, age and other differences that exist between the participants and the particular task that is involved, e.g., writing or speaking, the emotional involvement of one or more of the participants, and their social status and so on (Wardaugh 1986:48).

In sum, dialect, register and style differences are largely independent: one can talk casually about mountain climbing in a local variety of a language, or can write a formal technical study of wine making, or can be judged to speak 'better' or 'worse' than other speakers who have more or less the same background. Hence, many varieties of language exist and each language exists in a number of guises. It is quite possible to listen to an individual speaker and infer very specific impressions about

the speaker after having heard relatively little of his speech. The specific linguistic features, such as, being from a particular place, being a member of a certain social class, a representative of a specific profession, account for the recognition of individual's language use. Consequently, in specific domains of an human activity, words may be used which are unfamiliar to persons without a special education. Linguistic difficulties are inevitable when there is interaction between people from different social and occupational backgrounds. Therefore, a major aim of linguistic studies is to investigate the factors that promote and maintain the existence of varieties within a language and to provide descriptions of their use. Accordingly, these studies may clarify the reasons for the use of unfamiliar language and to provide a perspective that may help to resolve cases of linguistic conflict.

As a result, Turkish medical language used by medical professionals, is a linguistic variety. It is a register, which is used for specific purposes, i.e., in the daily activities of medical practitioners the occupational code is used and this code is technical, in the sense that its terminology is dependent largely on the characteristics of the concepts. Medical language is learned by the medical professionals through long periods of training, and it can be used either to hide and obscure or to open up knowledge. By means of this language, the medical practitioner may retain control over the patient. This means that there is inevitably a tacit distribution of knowledge attributed to physicians, who are presumed to be in a higher status and expertise than patients, and the language they use is not a simple language intelligible by patients.

1.2. Doctor-Patient Encounter

The essential unit of medical practice is the occasion when in the intimacy of the consulting room or the sick room, the individual who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts.

Obviously, the significance of information sharing in medical consultation cannot be denied. "The amount of information physicians give patients may be influenced by features of patients' communicative style and physicians'

communicative adaptations to patients with varying personal and social attributes or some combination of the two" (Street 1991:541). Thus, the frequency with which patients ask questions, offer opinions, and express concerns will be related to the patient's personal characteristics (such as level of education, age. social class) and to the frequency with which physicians utilize partnership-building utterances.

The physicians' information-giving process consists of statements by physicians that impart information to the patient. The information may be in the form of fact, opinion, laboratoary results, explanation and may serve functions such as informing, educating, persuading, instructing and counseling.

Utterances involved in a doctor-patient interaction are classified into three subcategories of information :

a) The diagnostic-health category contains comments related to the diagnosis, the patient's health status or health information in general.

b) The treatment category includes comments related to past, current, or proposed treatments and recommendations including drug thereapy, life style, laboratory work and so forth.

c) The procedural category includes utterances that describe examination procedures and administrative matters (Street 1991:543-544).

As a result, language is involved at all points in the medical consultation, and doctor-patient encounter is a communication situation in which a doctor attempts to understand the problems of a patient, and the patient attempts to understand the doctor's diagnosis.

Communication in doctor-patient encounter is seen as information exchange, and this includes asking leading questions, giving advice and logically ordering questions (Werner and Korsch 1979. c.in. Pettegrew and Logan 1989). In order to describe doctor-patient encounter, various models have been suggested. Among them Medical Model, Sick-role Model, and Sociological Model are worth mentioning.

a) **Medical Model** : The medical model of the diagnostic encounter presumes that a disordered state of the organism has some physical cause (Fielding and Evered 1980: 52). It is assumed that all patients are equivalent and doctor-patient contact should be neutral and socially unbiased. However, as Fielding and Evered (1980) state, this model is inadequate to the extent that the diagnostic decision not only identifies and gives meaning to the objective cause of the disease, but it also has a personal and social significance for the patient.

b) **Sick-role model** : Parsons (1950 c.in. Fielding and Evered) focused attention on the aspects of the patient's disorder, and the notion of the sick-role has provided information for many sociological studies of the medical process. According to Parsons (1950), the assumptions of the sick-role has four main consequences for the sick person:

1. He/she is exempt from certain normal social responsibilities.
2. He/she cannot be expected to cure themselves and therefore must be cared for.
3. He/she should want to be cured.
4. He/she should therefore seek medical help and cooperate with medical personnel.

However, as Mechanic (1963, c.in. Fielding and Evered 1980) suggested, a variety of factors can affect the actual performance of the sick-role, among them are the variations in the socially acceptable responses to a particular sort of symptom and its diagnosis and the importance of patient's social identity.

c) **Sociological model** : Balient (1964, c.in. Fielding and Evered 1980) emphasized the importance of establishing a negotiated meaning for the disorder, and he suggested that in the initial of doctor-patient encounter, it is the patient who offers an "unorganized phase" of the disorder. The doctor's response to this presentation in terms of its acceptability and organization in a professional (medical) description is expressed in the diagnosis made. According to Balient, the initial exchange is the most important stage in the negotiation.

The sociological model differs from the medical model in emphasizing the personal and social meaning of the diagnosis. It also differs from the sick-role model and emphasizes the variety of meanings involved, and the active role of both doctor and patient in negotiating a mutually acceptable outcome. However, the common aspect among them is the importance they give to the diagnostic decision (Fielding and Evered 1980).

1.3. Background to the Problem

1.3.1. Studies Abroad

The philosophers of language (Wittgenstein 1953; Austin 1961; Searle 1969, c.in. Fisher 1982:56) provide the foundation to examine talk in its contextual environment by treating talk as accomplishing action, instead of indexing underlying rules. Sociolinguists and discourse analysts suggest that language is a social product in which different linguistic arrangements are visible in different situations and they propose that there is a relationship between the words spoken, the actions performed and the structure of the talk.

The sociolinguistic concept of "communicative competence" and its methodological counterpart "ethnography of speaking" (Hymes 1962, 1972, 1974, c.in., Fisher 1982:56) have been foundational to many studies which examine the properties of natural language use (Bernstein 1971; Labov 1972; Shuy 1970; Halliday and Hasan 1976, c.in., Fisher 1982:56).

Discourse has also been analyzed in institutional contexts. Labov and Fanshel (1977, c.in., Fisher 1982:56) examine discourse in therapy situations and demonstrate Hymes' (1962, c.in., Fisher 1982:56) claim that discourse is a social or speech event organized around an exchange of information. Therapeutic discourse, as a speech event, is a routinized form of behavior with well defined boundaries. It is an interview structured by the individual who initiates the event and the one who is helped by it. Thus, the speech event in therapeutic discourse was found to be asymmetrical.

Similarly, as Shuy (1979, c.in. Fisher 1982: 57) puts, "the examination of discourse in institutional contexts involves some of the same properties as talk in more natural daily contexts, but utilizes them in ways that are context specific".

From the view point of doctor-patient communication, Cassell, Skopek and Fraser (1977), Skopek (1979) and Cicourel (1983, c.in., Fisher 1982), have examined the linguistic variations that emerge from cognitive and conceptual differences between the doctor and the patient. However, they did not identify the degree to which patients or doctors tend to change their linguistic patterns in response to each other. Cassell (1985, c.in., Pettegiew and Logan 1989:680) has also looked at patient narratives as a tool for diagnosis. Other sociolinguists have attempted to uncover structural rules embedded in doctor-patient communicatinon (Frankel 1980; Frankel and Bechman 1982; West 1983, c.in., Pettegiew and Logan 1989). For these researchers the key to understand doctor-patient talk relies on the structure of language, and rule-governed usage.

However, the first significant study of doctor-patient communication was carried out by Arntson, Droge and Fassl (1978, c.in., Pettegiew and Logan 1989:682). This was followed by Korsch's work on the interviews between pediatricians and the parents of their patients.

Pettegrew and Turkat (1986, c.in. Pettegrew and Logan 1989:683) argued for the examining of the patient's communicative contributions to the doctor-patient relationship. O'Hair, Behnke and O'Hair (1983, c.in., Pettegiew and Logan 1989) found that patients prefer their doctors to have affective styles rather than information-oriented styles. This was especially pronounced for patients who were high on communicative apprehension.

Thus, communication is an important factor contributing to the effectiveness of medical care. A major influence on compliance is the knowledge which patients bring to a medical consultation, and their understanding of what is said to them during the consultation. A very early study made by Redlich (1949) and later by Ley (1988) (Hadlow and Pitts 1991:193) found considerable variation among patients in their ability to define medical terms. Hawkes (1974, c.in., Hadlow and

Pitts 1991) reported clear differences between doctors and patients in their understanding and use of anatomical terms. Similarly Samora et.al. (1961) took 50 medical terms such as malignancy, cardiac and tendon, and embedded them into sentences. When the sentences were given to patients to explain what was meant, fewer than 30 were correctly explained by the majoirty of the patients (Hadlow and Pitts 1991:193). Thus, there are many "key" medical terms which are not adequately understood by many patients. However, as Lock (1982) and Rippere (1977 ; 1981, c.in., Hadlow and Pitts 1991) reported the differences in understanding may not be as dramatic as has sometimes been portrayed; it has been argued that doctors employ a language, which is between the biomedical language of the textbook and the common language used by the patient. Thus, in this case, it would be easy to be understood by the patients and this will be more affective for the consultation and diagnosis as a layman will see the doctor closer to himself. On the other hand, research made on complexities involved in the doctor-patient interaction has shown that, in general, dissatisfaction felt by patients regarding communication often leads to a failure to follow the advice given (Hadlow and Pitts 1991:193). As a result, studies on medical language in foreign literature concentrate mostly on doctor-patient communication, whereas in Turkey, the studies are based on language, especially on the terminology problem in Turkish medical language.

1.3.2. Studies in Turkey

In Turkey, studies on medical language started during the dynasty of Mahmut II.. Medical language in this period consisted of Greek, Latin and French terminology. Thus, Mahmut II ordered to write down the Arabic and Persian equivalants of these terms. In 1871, Sultan Aziz ordered that the education in Medical Schools should be in the Ottoman Turkish. In accordance with this order, the first dictionary was published by Cemiyet-i Tıbbiye-i Osmaniye in 1874. Between the years of 1864 and 1930 a new medical language mixed with Arabic and Persian was used by medical professionals. The following terms are the examples of this language (Ülker 1993:3):

hekim	:	tabip
hastalık	:	maraz
fizyoloji	:	ilm-i vezaif-ül aza
epithelium	:	beşere
necrosis	:	nahre
aorta	:	şiryan-i epher

During the period of Turkish Language Reform in 1930s, the use of Ottoman language was reduced. But, as Yörükoğlu (1986, c. in, Ülker 1993:12) stresses, studies on the nativization of medical terms were not satisfactory in this period because of the lack of colloboration and interest by medical professionals. In 1939, the first Turkish Medical Committee started the study on the medical terminology. Among the members were F.K. Gökay, Sadi Irmak, Zeki Zeren, etc. As a result of the studies of this committee, Zeren presented his article "Hekimlik Terimlerinde Yenilik-Reform" in the fourth Turkish Language Assembly in 1942, and the following views were accepted:

1. To find out the Turkish forms for foreign medical terms;
2. If the Turkish equivalents were not found, the current terms would be valid;
3. The terms that would be borrowed from foreign languages should have international character. (Zeren 1960:16).

In 1945, Dilemre published his work "Hekimlik Dili Terimleri" (Ülker 1993:14). In his book, Dilemre proposed some methods for translating the foreign terminology into Turkish. According to him, the only way of nativizing Turkish medical language was to find the Turkish equivalents of Latin or Greek affixes. Hence, he proposed for the foreign suffix [-İTİS] (meaning inflammation) the suffixes [-CA], [-CE], [-ÇA] and [-ÇE] in Turkish. Thus, for the inflammation of an organ these suffixes would be used, otherwise, without the suffix the term would mean "illness". However, when it was not suitable for a compound word to have a suffix (e.g: yemekborusu), then the synonym of the compound word was used with the suffix [-CA] as in the example : Yemekborusu = örtlek = örtlekçe. For the acceptability of the new terms Dilemre (1945) proposed that, in the morning session of medical courses the foreign terminoloy should be used (e.g.:uterus), whereas in the evening classes, the Turkish version (e.g. döllük) should be used.

These studies lasted till 1948. After this period, for almost fifteen years Turkish medical language was left to fluctuation. In 1970 a group of scholars from Hacettepe University, including A.Yörükoğlu, Y.Örs, C.A.Kansu and Onaran proposed new nativized terminology for medical language and "Hekimlik Terimleri Kılavuzu 1" was published in 1978. By 1980 the number of terms reached almost to 3000. Örs (1974:1003-1006) summarizes the studies in his article "Türk Dilini Türkçeleştirme Çalışmaları" and indicates that the main aim of the committee was to develop or improve the prefixes and suffixes found in Turkish medical language which would be the equivalents of those found in foreign languages.

In 1981, Ekrem Kadri Unat organized a meeting on Turkish medical terminology in Cerrahpaşa Medical Faculty, for the 100th Anniversary of Atatürk's birth. During this meeting, it was decided that the terminology studies should be completed with the colloboration of linguists.

On the other hand, Neyzi and Yazıcı (1992, c.in., Ülker 1993:5) emphasized that the medical terminology of Latin, Greek, Anglo-Saxon and French origin is used world wide, so it is a matter of question how much of it will be accepted, i.e., the nativized terminology would be understood only by Turkish physicians.

Hence, there are still studies for the purification of Turkish Medical language, but the problem of acceptability still exists.

The following paragraphs will illustrate the differences in Turkish medical language; the first example is the language used mostly by the professionals of today and the latter example, which is proposed by Ülker (1993:21) has the nativized terminology.

a) Appendix vermiformisin akut iltihabina akut appandisit denir. Genellikle appendix vermiformisin tıkanmasıyla oluşur. Daha çok adölesanlarla, genç adültlerde görülür. Erken dönemde kendisini mültinükleer iltihap hücresi infiltrasyonuyla gösterir. Daha sonra bu infiltrat, yer yer yoğunlaşarak apseler oluşturur.

b) Solucansı uzantının eveğen yangısına eveğen takıca denir. Genellikle solucansı uzantının tıkanmasıyla oluşur. Daha çok ergenlerle genç erişkinlerde görülür. Erken dönemde kendisini çok çekirdekli yangı gözesi sızımıyla gösterir. Daha sonra bu sızıntı yer yer yoğunlaşarak çıbanlar oluşturur.

1.4. Problem

The field of medicine reveals a confrontation between technical and everyday language.The language doctors use is often unclear both as regards the use of technical register and in relation to a lack of the expected shared meanings of relatively common terms (Fader 1981; Mackillop 1988; c.in, Simpson et. al. 1991: 1385).

This language is unintelligible and frightening to patients; while, this specialized language is the professional code for the doctors. They have the knowledge and skills which are basically mysterious to patients. Thus, physicians speak in a language which is unintelligible to a layman, and as Kimball (1971; c. in, Shuy 1984 : 244) puts it, doctors call everyday common objects by absurd and antiquated terms and this creates a communication gap between physicians and patients. According to Crystal (1987 : 383) doctors identify medical language, that is the terminology, with the traditional use of Latin or its vernacular equivalent. Moreover, in hospitals and clinics the kinds of conversation induce a wide range of additional terminology.

Besides, as Cicourel (1985:193) emphasizes, communication between a physician and a patient is a relentless form of discourse. Thus, the language used by the physicians reveals status differences in the social stratification system of the society in question.

To Shapiro (1989; c.in, Simpson et al. 1991 : 1385), most complaints by the public about physicians deal not with clinical competency problems, but with communication problems and the majority of malpractice allegations arise from communication errors. High proportions of patients do not understand or remember what their physicians tell them about diagnosis and treatment (Ley 1988; c.in,

Simpson et. 1991: 1385). Patients' anxiety and dissatisfaction is also related to uncertainlty and lack of information, explanation and feedback from the doctor, as they are startled when they enter into unfamiliar surroundings in which all of the other participants seem to share a common language. Moreover, the increased specialization refines this particular language, and the physician becomes much like a computer, tolerating only the imprint of words that fits into the programmed language (Kimball 1971: c.in, Shuy 19846: 244).

Therefore, the problem stems from the great demand for a systematic and explicit description of the language used by Turkish physicians on the basis of linguistic and sociolinguistic concepts. Besides, the current investigation is concerned with the question of how communication is carried out between medical professionals and medically illiterate people, that is, patients.

1.5. Hypotheses

The participants of communication vary in social position, age, sex, in education, or when they meet in different situations or have different motives for communication. Hence, the system of language is determined by the parameters of the communication situation. From this point of view, Turkish medical language is a language used according to the situation by professionals. It is a register that a doctor uses in the medical space and cannot be understood by a layman. Therefore, T.M.L. is a language which is in itself closed, and is to be chosen according to the respective situations of communication. From this pont of view, doctors select the suitable register, that is medical language, in their daily professional activities. As a result, in medical practice which is focused predominantly on technical knowledge, the phsician is engrossed in technical concerns and terminolgy which mistify the patient (Korsch and Negrete 1972: 66).

During the doctor-patient encounter, patients seem to be diffedent about asking for information. This reluctance to ask questions appears to stem from the hierarchical relationship between doctors and patients, and overdeferential attitudes toward doctors. About the hierarchical barriers, one sociological view is that doctors have in the past controlled information and created an aura of superior

expertise to maintain professional power and authority, and to enhance their economic and social positions (Freidson 1970; c.in, Buchanan 1991:63).

On the other hand, Bruton (1976; c.in, Andersen 1988:156) observed that the general pattern in doctor-patient communication was fairly obvious, that is, moving from greeting, and then some questions were put forward in order to establish the broad outline of the complaint, then came more detailed questions and examination; after reaching and communicating a diagnosis, the doctor gives or prescribes some treatment plus some information about the future, and finally leave taking takes place. According to Bruton (1976), particular sequences were common, such as the initial greeting being followed immediately by reassurance. Bruton also found that different types and levels of vocabulary were used depending on who the doctor was talking to, and different doctors struck different balances between the technical and emotional aspects of what they were saying to patients.

Various studies suggest that the presentation of symptoms by patients varies as a function of their social class and that doctors' responses to these presentations are influenced by patients' perceived social class. It is assumed that doctors are more informative with some patients than with others. For example, patients who are upper middle-class, more educated, generally receive more information from doctors than lower-class and less-educated patients (Waitzkin 1985; Pendleton and Bochner 1980, c.in., Street 1991). Stewart (1983, c.in, Street 1991:541), discovered that physicians were more likely to justify their choices of treatment to patients with university education than they were to the less educated, and the systematic differences in physician's information - giving are related to the patients' communicative style. Patients who are more assertive, express more concerns, and ask more questions and conceivably acquire more information from doctors then do less verbally active patients. Hence, more educated, higher income patients may receive more information, because they have communicative styles that elicit this information from doctors.

In general, the doctor is the controller of the situation; if the patient challenges this, the doctor almost invariably regains control. Thus, it can be claimed that patients have little control over the communication content and structure of the medical consultation. In most instances, the physician is the more dominant interactant who initiates most of the topics of the consultation (Todd 1989; Street 1991), talks for longer durations and interrupts the patient more than the reverse (West 1984; c.in., Street 1991). On the other hand, conversation even that within the medical consultation, is an enterprise that is mutually constructed by the interactants. How a physician interacts with a patient is in part a function of how the doctor chooses to communicate and in part a function of what the patient allows the doctor to do. However, as conversational exchanges require co-ordination for topic development and turn-taking, patients potentially have the verbal resources to exert considerable control over the physician's behavior. Thus, in particular, three features of the patient's communicative style appear capable of influencing the doctor's informativeness: asking questions, expressing concerns and worries and offering opinions.

According to the views presented above, this study aims at investigating the hypothetical questions presented below:

1. What are the linguistic characteristics of Turkish medical language as a register?
2. What type of language is used by the medical professionals in different social environments?
3. How much information is given to the patients with different social backgrounds, and to what extent medical language is involved during the information-giving process?

1.6. Purpose

The typical linguistic features of medical language coincide with what we call language for specific features. It is nothing more than the restricted use of language in certain domains of human activity. Hence, a sociolinguistic view in research on languages for specific purposes takes into account at least four complexes of distinctive features in order to arrive at an unambiguous classification of text type (Cheshire 1987: 659): a) Social variables of author and recipient e.g., expert vs. non-expert, social status, generation; b) intention and strategy e.g., information, argumentation; c) situation e.g., research, instruction; d) topic e.g., medicine, chemistry etc., with all their branches. Most of these influence the selection and arrangement of linguistic means directly or indirectly, so that only sociolinguistic view can give as the full truth on the nature and peculiarities of specialized communication.

The subject matter of medical science is the human body, in other words humans' health is directly related to this science. In spite of sophisticated technologies for medical diagnosis and treatment, talk remains the primary means by which the physician and the patient exchange health information.

The main aim of the present research is to make a comprehensive study about the type of language used in Turkish medical code covering different related aspects within the boundaries of linguistics and also the discourse analysis of doctor-patient communication from the sociolinguistic point of view. Moreover, the study aims at describing social environment in which the medical professionals use the occupational code and the contexts in which social environment this code is switched by them to the common language.

Because of the critical role that information plays in health care delivery, the purpose of this investigation is to examine factors potentially affecting the physician's informativeness and to account for differences in the amount of information given to various groups of patients.

1.7. Data Collection

The collection of written and spoken medical texts, and also of medical interviews in policlinics have comprised the data of the study.

Written texts are obtained from various medical journals.

Most of the medical interviews have been taped in Eskişehir Osmangazi University Hospital. Proper authorization is obtained from each doctor before recording either doctor-doctor or doctor-patient conversations. At the sight of the tape-recorder, the doctors felt excitement, but when they began to be interested in the patient's problem, a natural environment was obtained. However, the patients were unable to understand the purpose of the recording, although they saw the tape-recorder. The investigator was thought to be a doctor as she was wearing a doctor's uniform. Few of the interviews are recorded from the "Medical Scanning" of a village. The medical interviews were conducted by the doctor members of a social club.

All medical interviews used as examples have been recorded in the past two years.

1.8. Method

With respect to the doctor-patient relationship there are two competing theories, the consensus-model of Parsons (1951, c.in., Meeuwesen et. al. 1991), and the discrepancy-model of Freidson (1961, 1970, c.in., Meeuwesen et. al. 1991). To Meeuwesen et. al (1991:1143) the first model assumes a harmonious relationship where the physician is leading and the patient is following; the physician's role is characterized by high status and control vis-a-vis the patient. There is a normative pattern of trust, that is, the physician will be attentive to the needs of the patient and will act in the patient's interests. The patient has to cooperate and to do everything the doctor advises to become healthy as quickly as possible. On the other hand, the discrepancy model argues that there is an inherent

discepancy between the expectations of the patient and what the doctor can really offer. (Meeuwesen, et. al, 1991: 1143). Thus, only a part of the physician's control is used to advance the patient's interests, and the physician also uses control to maintain his institutionalized authority. It is assumed that illness is less objective than has been thought, and the reactions of the environment, including the physician, are very important in the process of health and illness. Consequently, the discrepancy model emphasizes the interactional and dynamic aspects of doctor-patient interaction. However, both theories postulate an asymmetrical relation between doctor and patient, where the doctor is the leading party, who structures the medical conversation, and gives advice, while the patient gives biographical information regarding the complaints (Meeuwesen et. al. 1991:1143).

In this study, as a method of coding the relational aspects of doctor-patient conversation, the Verbal Response Mode (VRM) system of Stiles is used. According to Stiles (1978:693), verbal response mode use has been shown to reflect many important aspects of interpersonal relationships.

By the application of VRM method relative position of dyad members in a business hierarchy, seeking or avoiding approval from peers, the physician's and patient's role in the communication process can be analyzed.

The principles of classification are based on a theory of the verbal communication of experience, and exclude speaker's intent (by intent, speaker's tone of voice and non-verbal cues are meant). Hence, VRM restricts the interpretive work by confining intent judgements to three forced choices: "Whose experience is the topic?" "Whose frame of reference is used?" and "On whom is the utterance forced? (that is, does the speaker presume knowledge of the other?). Coders are encouraged to use all available information in answering these questions. Thus, Verbal Response Mode categories (Stiles 1978;1981) are given below, for the analysis of doctor-patient interviews :

1) Acknowledgement conveys reception of receptiveness to communication from addressee such as simple accceptance or salutations e.g.: Yes; him-him; hello.

2) Edification states objective information, e.g.: "The blood pressure is 120 over 70".

3) Question requests information or guidance, e.g.: "How long did it start bothering you?

4) Reflection puts addressee's experience into words which can be repetitions, restatements and clarificatons e.g.: "You are feeling miserable".

5) Disclosure reveals thoughts, feelings, perceptions, intentions and all subjective information, e.g.: "I guess it is muscular pain".

6) Confirmation compares speaker's experience with addressee's. Agreement, disagreement, shared experience or intention is involved in Confirmation, e.g.: "I don't agree", "You are right".

7) Interpretation explains the addressee's judgements, evaluation, behavior or experience, e.g.: "You are too nervous."

8) Advisement attempts to guide addressee's behavior which can be commands, suggestions, permission and prohibition. e.g.: "You are not allowed to work next week".

Hence, by means of VRM analysis the relational aspects of communication between doctor and patient can be measured.

CHAPTER II

SOCIOLINGUISTIC ASPECTS OF TML

2.1. Language and Social Context

Examining the way people use language in different social contexts provides a wealth of information about the way language works, as well as about the social realationships in a community. The way people talk is influenced by the social context. It matters who can hear us and where we talk and how we feel. Therefore, the same message may be expressed very differently to different people, in different social contexts.

Sociolinguists use the term variety or code to refer to any set of linguistic forms which patterns according to social factors (Holmes 1992:9). Therefore, variety is a sociolinguistic term referring to language in context. A variety is a set of linguistic forms used under specific social circumstances, i.e., with a distinctive social distribution (Holmes 1992:9).

In any community the distinguishable varieties or codes which are available for different social contexts form a kind of repertoire or available options. The members of each community have their distinctive "linguistic repertoires". In other words, in every community there is a range of varieties from which people select, according to the context in which they are communicating (Holmes 1992:10).

2.1.1. TML as a Linguistic Variety

Bearing in mind that medical language is only used by the professionals of the medical world, it can be said that it is a linguistic variety. In Holmes' (1992) terms ML is a set of linguistic forms used under specific social circumstances.TML has a different linguistic repertoire than the Turkish language, by means of which physicians understand each other and exchange information.

Holmes (1992:16) suggests the following steps in order to describe and explain a variety:

1. To identify clearly the linguistic variation involved (e.g. vocabulary, sounds, grammatical constructions, languages)
2. To identify clearly the different social or non-social factors which lead speakers to use one form, rather than another (e.g. features relating to participants, setting or function of the interaction).

Thus, in hospitals, among physicians when they discuss a medical state or diagnose a health problem of patients, the use of medical language is obvious.

As a result, certain social factors - who you are talking to, the social context of the intereraction, the function and topic of the discussion - turn out to be important in accounting for language choice in many different kinds of speech community. Thus, Fishman (c.in. Holmes 1992: 24) termed these factors as "domains of language use". In the case of the TML usage, one can say that the domain is health, the addressee is the doctor, the setting is hospital, the topic is the discussion on the health problem of a patient and the variety/code used is the medical language. Hence, domain is a very general concept which draws on three important social factors in code choice-participants, setting and topic. As Holmes (1992:26) states, "domain" is useful for capturing broad generalizations about any speech community, by using information about the domains of use in a community.

2.1.2. Components Which Influence The Choice of Linguistic Variety

In addition to the factors stated above, Holmes (1992:12) suggests other four different dimensions which have influence on linguistic choices. These dimensions have close connections with the choice of medical language:

1. The solidarity - social distance scale: It is concerned with participant relationships. How well one knows someone is a relevant factor in linguistic choice. For example the choice of Ahmet, Doktor Bey in a doctor-patient interaction, reflects consideration of this dimension.
2. The status scale concerned with participant relationships : It points to the relevance of the relative status in some linguistic choices. For example, the choice of Doktor Bey, instead of Ahmet, signals that the doctor is of higher status. This means that in the relevant linguistic situation, that is in a hospital or surgery, the doctor has occupationally higher status than the patient.
3. The formality scale is related to the setting or type of interaction. It is useful in assessing the influence of the social setting or type of interaction on language choice. In a formal transaction in a hospital, the language used with the doctor will be influenced by the formality of the setting.
4. The referential and affective function scales are related to the purposes or the topic of interaction. Though, language serves many functions, the two identified in these scales are particulary pervasive and basic. Language can convey objective information of a referential kind; and it can also express how someone feels. In general, according to Holmes (1992), the more referentially oriented an interaction is, (for example an interaction on patient's health or problem among colleagues), the less it tends to express the feelings of the speaker. Thus, as it has been stated, linguistic choices are influenced by the participant relationships, and their statuses. Moreover, the social setting in which the interaction takes place, the purpose or the topic of interaction all play a considerably important role on linguistic choices.

2.2. Register

It is clear that language varies according to the functions it is being made to serve, i.e, what people are actually doing, in the course of which there is talking or writing involved, who the people are that are taking part (in what statuses and roles they are appearing) and what exactly the language is achieving in the process (Halliday and Hasan 1989:44). Therefore, these three variables according to Halliday an Hasan (1989) determine the register. Registers are determined by the parameters of the communication situation. They refer to both written and spoken language.

Registers differ semantically; they differ also in grammar and in vocabulary, as grammar and vocabulary express the meanings. (Halliday and Hasan 1989)

According to Halliday and Hasan (1989) medical language is a technical and an institutional register. All the medical students have to learn the technical terminology, and all the doctors have to communicate with each other in the hospital, in the operation room or in the lab. This language is institutionalized; the colleagues exchange either spoken or written information by means of this language no matter where they live in the country.

2.2.1. TML as an Occupational Language

Every occcupation has its own code, the form of speech used during the working period among colleagues which may be considered as a variety of the common language. These languages of occupations may be thought of as reinforcing the power of holding its members together. Each language or code of a profession is unique in the way its form serves its function and must be learned when first encountered just like another language. Occupational languages have their own terminology without which their members cannot think or express themselves. To deprive them of such lexical items would be to condemn them to inactivity.

For the recognition of such a profession which has its own terminology, Hudson (1978:11) puts forward the following requirements:

1. Entry to it must be permitted to those who have satisfied an examining and supervisory body that they have reached to a satisfactory standard of training. There will be a document issued to successful candidates, which makes this clear and a register of the members of the profession will be maintained by the governing body.
2. Continued membership of the profession must be conditional on observing certain clearly understood conditions of behavior and competence.
3. Removal from the register of anyone who is judged unfit to practice must be under the direct control of the professional body itself not of the courts.

According to the views presented above, the legal protection given to doctors is perfectly clear. In order to be a doctor, one has to reach a satisfactory standard of training, i.e. he has to graduate from a Medicine Faculty. Medical education consists of both theoretical and practical training. Thus, one has to obtain certain conditions of behavior and competence within this period. After graduation, a physician must be registered to the Chamber of Physicians, if he does not practice in a hospital. However, in case of dismissal from profession, the court gives the final decision. The cause of the dismissal may be due to the neglect or breach of duty.

2.2.2. Jargon or Technical Language

Jargon is the specialized language of different occupations and interests which is fundamentally impersonal and serious (Hudson 1978:12). By the usage of jargon the public is kept at a respectful distance, therefore it is a defence against those who belong to other groups. In addition, for the group members it is a way of improving coordination and solidarity.

Jargon is said to be more condensed and therefore time-saving and supportive in that it allows one professional to recognize another without waste of time (Hudson 1978:6). It is a special phenomenon and, most people in learning the profession, also learn the behavior appropriate to it, as a part of their professional identity.

The key test for jargon is the question: "Could this have been expressed more simply without communication suffering in the process?". If the answer is " yes ", then probability is that one is faced with a piece of jargon (Hudson 1978:4).

On the other hand, technical language is a professional code which is perfectly intelligible to anyone who has learnt its elements and who knows how to interpret them. Accordingly, technicality is illustrated by the people who change their language along with their clothes. "...It is a language with a proper social setting; its use outside the setting is condemned as 'talking shop'." (Turner1973:169). When technical language becomes widely known, that is, it is accessible to everyone, it ceases to be technical and becomes part of the general language. The following examples illustrate this fact. By means of media these terms are used widely and they have become a part of the common language: anjiyo, antibiyotik, AIDS, astım, check-up, depresyon, diabet, enfarktüs, hipertansiyon, hepatit, hemoroid, kolesterol, lipid, kist, gastrit, miyom, menapoz, megalomani, tomografi, tümör, tüberküloz.

It is important to distinguish different levels of technicality. Hudson (1978:5) subdivides technical language into three : a) high-technicality language, b) medium technicality language, and c) low-technicality language. TML is a high-technicality language (Hudson 1978:5), by which doctors communicate and exchange ideas and information with each other. It is not a jargon, because it cannot be expressed simply with all its terminology proper for the situation. As a result, a layman who does not have any medical education, is unable to understand it, and cannot interact in medical language. Hence, high-technicality language corresponds to the language used among physicians. The other two levels, medium-technicality and low-technicality languages are realized according to the setting of the written or spoken communication. The following samples illustrate these three levels:

a) "Endokrin enterokromaffin hücreler gastrointestinal mukoza epiteli içinde tek tek dağılmış, küçük granüllü hücrelerdir." (Akbay and Açıkalın 1979:221).

b) "Vitreus ile lens gençlerde yapışıktır, yaşlılarda ise biraz daha açıktır." "Arka kapsüle dokunduğumuz zaman daha fazla kanamaya yol açar, Vitreusla lens arasında bir ligament var; o ligament sağlamlığı koruyor" (cited from tape-recording of a lecture).

c) "Alkolün beyinde ve karaciğerdeki zararlı etkilerinde, damar sertliğinden, yaşlanmadan, şeker hastalığından kaynaklanan gözdamarı bozukluklarında, vücutta oluşan ve lipitperoksitlere dönen, zararlı ürünlerin rol oynadığını saptadım." (Uysal 1991).

In the examples above the amount and the use of technical terms decrease respectively. In the high-technicality language, scientific terms are not new, but they have associations with other scientific terms containing the same roots of Greek or Latin. Thus, it is obvious that doctors communicate with each other easily by using this language. The second example which is considered to be a medium-technicality language, is recorded by a tape-recorder during a lecture. The students have not reached the linguistic level of their teachers yet. As a result, the teacher has to use a language which will be more explanatory so that the students can follow him easily. The third example corresponds to the low-technicality language. It is taken from a newspaper article, and it is about the damage caused by alcohol on the human body. It is comprehensible for a layman as the only technical term is "lipitperoksit". Obviously, it aims at giving information to the public about the harms of alcohol.

2.2.3. Linguistic Repertoire of TML and The Place of Borrowing

The linguistic repertoire of TML is related to the vocabulary used in the prevention, the investigation, the diagnosis and the treatment of a disease, all alleviation of suffering and with the furtherance of medical knowledge and medical education.

Medical terminology is mostly derived from Greek and Latin. This has resulted from the physicians of ancient Greece among whom was Hippocrats, who was the first to introduce scientific methods into medicine. Later after the decline of Greek civilization Latin language obtained this dominant position.

At present, TML still has Greek and Latin affixes and roots, as well. But Persian and Arabic lexemes are also used (e.g. :tabib, dahiliye). However, French (as French language has its roots in Latin) and especially English lexemes (as English language is considered to be the international language of medicine (Maher 1986)) are also in use.

The integration of borrowed elements is a very gradual process (Appel & Muysken 1987 :172), which takes generations. The frequency of use, grammatical integration and acceptability by the user are parameters for the integration of borrowed items into a language (Poplack and Sankoff 1984, c.in. Appel & Muysken 1987).

But in the case the of TML, borrowing is slightly different. As the medical language can be considered. as a scientific language, new findings, inventions or medical methods are borrowed easily in order to fill the lexical gaps in TML. Thus, the borrowed items are incorporated into the grammatical system of Turkish medical language and take the morphological characteristics of Turkish and enter into its syntactic structure:

> "Elusyon, bebek eritrositlerine bağlanmış immun globulinleri hücreden ayırma işlemine denir." (Kılıç et al. 1989:119).

or:

> "Experimental çalışmalarda, böbrek kitleleri hayli azaltılanlarda fonksiyone nefronlara düşen filtrasyon miktarın 20 misli arttığı gözlenmiştir." (Eren et al 1990: 50).

Similarly, as Bokamba (1988:26), states, the main object of borrowing is to fill lexical gaps, and the lexical items which are borrowed must be found also in the dictionary of the host language. This is the case in TML the borrowed terminology is also found in the Turkish medical dictionaries.

2.3. Code-Switching in Turkish Medical Language

The particular language that a person chooses to use on any occasion is a code. It is a system used for communication between two or more parties. Most speakers command several varieties of any language they speak. People are usually required to select a particular code whenever they choose to speak, and they may also decide to switch from one code to another or to mix codes.

As Gal (1988, c. in; Wardaugh 1986:103) states "Code switching is a conversational strategy used to establish cross or destroy group boundaries, to create, evoke or change inter-personal relations with their rights and obligations". To the question: "what might cause a speaker to switch from one variety to another, or from one language to another language?" a number of answers have been suggested, including solidarity with listeners, choice of topic, and perceived social and cultural distance (Wardaugh 1986).

2.3.1. Situational Code-Switching in T.M.L.

Turkish medical language is a code used according to the social environment, that is, doctors use their professional code in their medical activities among their colleagues. As Wardaugh (1986:106) states, situational code-switching occurs when the language used changes according to the situations in which the conversants find themselves: they speak one language in one situation and another in a different one. During medical interviews the language used by doctors is the standard language. They are in the situation where they have to communicate with patients in order to get information on the problem and they have to reach a diagnosis. On the other hand, when doctors are with their colleagues, discussing a particular medical problem, they change their code according to the situation and use their medical code. The following examples illustrate the situation:

Ex.1.

D1 : İdrardaki proteini kaç?

D2 : Bir pozitif geldi. Asosu 250 tod, ünitesi negatif. C3-C4 çalıştık normal çıktı.

D1 : Tansiyon kaç?

D2 : 150. Biz plomoni düşünmedik .....

D1 : Adın neydi?

P : Ali

D1 : Sen her halde ortaokula gidiyorsun, yanılmıyorsam. Bi de sen anlatır mısın, yani nasıl oldu?

P : Doktorun anlattığı gibi...

D1 : Bi de bacaklarında şişmeler oldu

P : Hayır.

Ex 2

D1 : Raşit Bey günaydın!

P : Günaydın, ...

D1 : (toD2) - sondası açık geliyor, hemoglobini normal. İdrar kültüründe birşey çıktı mı?

D2 : Çıkmadı.

D1 : Nasıl hissediyorsunuz kendinizi? Çocuklar geliyor değil mi ?

P : Geliyor.

D1 : Geçmiş olsun!

In both cases, while talking to the patient the common language is used, but the medical results are discussed in the medical code, because the interectants are medical professionals.

D1 stands for doctor 1, D2 stands for doctor 2, and P stands for patient.

2.3.2. Functions of Code-Switching in TML.

A fundamental difficulty in understanding the phenomena of code-switching is accounting for a particular choice or switch on a particular occasion. Appel and Muysken (1987:118) suggest certain functions in order to fulfil the discussion on code-switching:

1. Switching can serve the referential function, because it often involves lack of knowledge of one language or lack of facility in that language on a certain subject. Certain subjects may be more appropriately discussed in one language, and the introduction of such a subject can lead to a switch. In the case of Turkish medical language, most of the terminology is still not in Turkish. Medical professionals among themselves switch from the common language to the medical code, as the knowledge conveyed or the facility of communication in the common language seems to be insufficient.
2. Switching often serves a directive function in that it involves the hearer directly. When certain persons present are wanted to be excluded from a portion of the conversation the directive function of language use is used. Hence, doctors speak in medical language when they do not want their patients to understand what is being said, especially when there is a critical situation concerning the patient.
3. Poplack (1980, c.in., Appel and Muysken 1987) in particular has stressed the expressive function of code-switching. Speakers emphasize a mixed identity through the use of two languages in the same discourse, An example is a medical doctor in a family setting. when his opinion on a certain medical topic is asked, his discourse is full of code-switching. Thus, this speech by itself, with the individual switching the code has no longer communicative function as the hearers are unable to follow it.

2.4. Styles

It is assumed that the system of language is not of a uniform, homogeneous structure. In standard language, utterances may convery the same information and have the same semantic value, but may differ either in aesthetic information or in same information which qualifies the speaker as to his membership in some social group. Hence, style is a subsystem of language or a bundle of possibilities of realization in specified ranges of use.

A number of attempts have been made to classify styles. One of the most famous of such classification is that of Joos (1962)with reference to spoken language. Joos (1962, c.in., Penalosa 1981:95) identified five styles corresponding to different stages of individual's socialization:

1. **The intimate or informal style :** It is used with close friends or family and with casual acquaintances. Kocaman (1992:185) emphasizes that one of the designing features of informal style is the use of elliptical constructions. When participants have a common ground, they share the information about the event, the grammatical and world knowledge. In Turkish, another feature of informal style is the use of the second person singular pronoun used as an address form. (Kocaman 1992:185). The informal style is used by the doctors when they have less-educated patients. They address them in the second person singular pronoun.
2. **The consultative style:** It is used in semi-formal situations such as between strangers, between teacher and student or doctor and patient. It produces cooperation without the necessity of integration of the individual personalities. This type is termed as normal or ordinary style by Kocaman (1992:184).
3. **The formal style:** The purpose of it is to inform the addressee on an individual basis. In Turkish, certain tense markers, passive constructions, plural pronouns and certain modality markers are used in formal style (Kocaman 1992). Hence, a lecture on medicine or a seminar can be presented by using this style.

4. **The frozen style:** It is used in print and declaration in situations where the addressee is not allowed to cross-question the author. An example is a newspaper article on a medical topic.

In addition to this classification, scientific style can be added. The general description of scientific style emphasizes qualities like exactitude; simplicity and clarity; objectivity; abstractness, generalization; density of information; brevity; emotional neutrality; unambiguousness; impersonality; logical consistency; use of defined technical terms, symbols and figures. The following is an example of scientific style in written medical laguage:

"76 alopecia areatalı hastadan 17 sinde vellus ve terminal kıllar gelişirken, 33 hastada vellus kılları ve birkaç adet terminal kıl gelişti, geri kalan 26 hastada ise cevap alınamadı" (Sabuncu 1989:84)

Accordingly, the written or spoken scientific style has to be exact, clear, objective and abstract as the trem "scientific" implies. The scientific idea which is put forward must be generalized, so that it can be applied to other situations related to it. The information given must not be ambiguous, emotional or personal, furthermore, it must be in accordance with the concepts related to it.

As a result, the cited paragraph above illustrates the findings of a research study made on 17 patients. The findings are generalized, as it is not the finding related to only one patient. The style is clear. It is neither personal nor emotional as it will be understood from the use of the passive construction "alınamadı". Thus, the use of the passive constructions is another feature of scientific style which makes it impersonal.

However, during the doctor-patient interaction a female pediatrician may switch among three distinct styles, each with its own intonation, voice quality, lexical and syntactic structures and content. In talking to or examing the child she uses the classic features of "motheres" (Newpont, Gleitman and Gleitman 1977, c.in., Tannen and Wallat 1982). Such features include high pitch, elongated vowel

sound, sing-song intonation and teasing, and resembles child's language. While talking to the mother, she looks at her and uses another code, which is similar to the everyday conversation. On the other hand, when she talks to her colleagues during the examinatian of a patient, flat information, rapid rate of speech, relatively low pitch, absence of marked facial expessions and gestures are remarkable while using the technical code. All these cues give this style an unmistakable character that may be called "reporting" (Tannen and Wallat 1982:45). As a result, each of these styles represents a different "frame" or interactional activity in Goffman's (1979, c.in., Tannen and Wallat 1982) terms.

CHAPTER III

THE LINGUISTIC ANALYSIS OF WRİTTEN TURKISH MEDICAL LANGUAGE

3.1. Turkish Transcription of Greek or Latin Terms.

3.1.1. Rules for the Turkish Transcription

The study conducted by Erimoğlu and Başkaya (1988) concerning the Turkish transcription of Latin and Greek terminology enables the reader or medical students to study and understand them correctly in Turkish. The following table is taken from this study (1988:1-3).

3.1.1.1. Rules for Consonants

orthography		phonetic transcriptions (İPA)	Explanation	Example
c	is transcribed	[k]	before 'a', 'o' and 'u'	corpus ⇒ korpus caput ⇒ kaput
c	is transcribed	[s]	before 'i','ae','oe' and 'y'	cisterna ⇒ sisterna caecum ⇒ sekum
g	is transcribed	[ʒ]	before 'e' and 'i'	gelatina ⇒ jelatina
j	is transcribed	j	before vowels	junctura ⇒ yunktura
q	is transcribed	[kw]	before 'u'	aqua ⇒ akuva
t	is transcribed	[s]	before 'ia', 'ie' and 'io'	portio ⇒ porsiyo substantia ⇒ substansia
v	is transcribed	[v]		vita ⇒ vita vena ⇒ vena
x	is transcribed	[ks]		flexura ⇒ fileksura coxa ⇒ koksa
th	is transcribed	[t]		therapia ⇒ terapia thorax ⇒ toraks
rh	is transcribed	[ɹ]		rhomboideus ⇒ romboideus
ph	is transcribed	[f]		pharynx ⇒ farinks
ch	is transcribed	[k]		chorda ⇒ korda
ps	is transcribed	[ps]		psychologia ⇒ psikologia
sch	is transcribed	[ʃ]		schizophrenia ⇒ şizofrenia

3.1.1.2. Rules for Vowels

a,e,o	are transcribed	[a] [ ] [o]		aden → aden endocrin → endokrin obturator → obturator
i	is transcribed	[j]	before vowels	iudex → yudeks
i	is transcribed	[i]	before consonants	iris → iris
y	is transcribed	[i]		systema → sistema syndesmologia → sindesmologiya
u	is transcribed	[v]	before 'ng' and 'q'	equinus → ekvinus

3.1.1.3. Rules for Diphtongs

ae	is transcribed	[ɛ]		caecum → sekum
au	is transcribed	[av]		auricula → avrikula
ei	is transcribed	[ɛ]		eiectio → eyeksiyo
eu	is transcribed	[oe]		neurologia → nörologiya
oe	is transcribed	[oe]		oedema → ödema coeliacus → söyliyakus

3.1.1.4. Place of Accent in Medical Terminology

Accent also plays an important role in the pronounciation of medical terminology. Erimoğlu and Başkaya (1988 : 3) gives rules adapted from Latin.

two	syllabed words have the accent on the	2 nd syllable
three	syllabed words have the accent on the	middle syllable
multi	syllabed words have the accent on the	syllable before the last one

3.2. Morphological Description of TML

3.2.1. Introduction

Morphology deals with the internal grammatical structure of word-forms. (Word-form is used in the sense of word) (Lyons 1981:118). Thus, word-forms can be represented as strings of one or more morphemes. The field of morphology, in general, is divided into two major subfields: one concerned with the process of inflection and the other with what is usually referred to as the process of word-formation, which is named as "Lexical Morphology" (Matthews 1974:38). Lexical morphology is then divided into two subfields, of which one is concerned with the

process of derivation, and the other with the process of compounding. Derivational morphology is the concern of this study.

3.2.2. Morpheme

"A morpheme is the minimal linguistic sign, a grammatical unit in which there is an arbiitrary union of sounds and a meaning, and which cannot be further analyzed" (Fromkin and Rodman 1978:142).

Morphemes are either bound or free. Bound morphemes are constituents of words and are called affixes. Affixes are named according to their position: prefixes precede the base-form to which they are attached or affixed, and suffixes follow the base-form. In Lyons' term 'base-form' is the form from which all the other forms of the lexeme can be derived by the morphological rules of language (Lyons 1981:101).

3.2.3. Lexeme

Morphemes constitute lexemes which are the fundamental units of the lexicon of a language. A lexeme belongs to the grammatical or primary articulation of language and its properties are usually characteristics of syntactic classification or of meaning (Matthews 1974:38). In the medical terminology, a lexeme is either a simple stem (eg: radyo, hepat) or a complex stem which is morphologically derived from a base by means of derivational elements (e.g.:radyoloji, hepatom).

The terminology used in TML is mostly borrowed from several languages such as Greek, Latin, French, English, Arabic and Persian; however the place the classical languages hold is fundamental. The word-forms of TML is mostly formed by the process of derivation, which are derived from classical languages. Therefore, this study will focus on the lexemes derived from such languages that shape most of the terminology.

The reference guides used in this study are "Dorland's Illustrated Medical Dictionary", (1974) "Mesleki Latince", (1978) and "Anatomi'de Terminoloji" (1988).

3.2.4. Derivational Processes in TML

1. In lexical morphology, the morphemes that change the category, or of class of words are called derivational morphemes. This means that where they are conjoined to other morphemes or lexemes, a new word is derived or formed. Thus, the derived word may be in a different grammatical class than the base form.

   i. In TML, the derivational elements such as:

   [-ik], [-ize], [-slyon], [-ite], [-tomi] and [-oid], change the grammatical category, and form new words.

   a) **[-ik]**, is a bound morpheme and is used to change nouns into adjectives:

mikrobiyoloji	mikrobiyolojik
gastro	gastrik
radyoloji	radyolojik

   b) The derivational element **[-ize]**, is used with the auxiliary verbs "etmek" and "olmak" and forms compound verbs (Banguoğlu 1990) from nouns:

immun	immunize **etmek**
monitör	monitorize **etmek**
insulin	insulize **etmek**
ospital	ospitalize **etmek**

c) The derivational element [-slyon], which is a bound morpheme used as a suffix, is used to form nouns from compound verbs:

aspire etmek	aspira**syon**
kontamine olmak	kontamina**syon**
irrite olmak	irrita**syon**

d) The bound morpleme **[-ite]**, is a derivational element and it is used to *form nouns from adjectives:*

malin	malin**ite** 'malignant, state of being worse
mortal	mortal**ite**
benin	benin**ite**

e) The derivational element **[-oid]** is a suffix, a bound morpheme; and is used to form adjectives from nouns, meaning "like, as".

oste(o)	oste**oid** "bonelike"
lenf	lenf**oid**
şiz	şiz**oid**
aden	aden**oid**

i i . There are other derivational morphemes which do not cause a change in the grammatical class of a word, In TML, many prefixes or suffixes such as [-om], [-alji], [-itis], [-ist], [-tomi], fall into this category:

a) The suffix and bound morpheme **[-om(a)]** means "tumor of an organ":

hepat**om** "a tumor of the liver"
miks**oma**
sark**oma**
osteofibr**oma**
lenf**oma**

b) Another bound morpheme used as a suffix is the derivational element **[-alji]** which indicates a painful condition of the organ it is joined to:

nevr	+ alji = nev**ralji** "pain of the nerves"
gastr	+ alji = gast**ralji**
braki	+ alji = braki**alji**
miy	+ alji = miy**alji**

c) The derivational morpheme **[-itis]** denotes inflammation, it is a suffix:

farangi**tis** "inflammation of the pharynx"
retini**tis**
hepati**tis**
tonsilli**tis**

d) The derivational mopheme **[-ist]** is a suffix, denoting the person who practices:

anastezi	anestezi**st**
ortopedi	ortopedi**st**
anatomi	anotomi**st**
fizyoterapi	fizyoterapi**st**

e) **[-tomi]** is a bound morpheme, a derivational element, denotes the operation of cutting into or through:

osteo**tomi** "operation by culting through bone"
miyo**tomi**
trakeo**tomi**
arterio**tomi**

iii. In TML, there are also adjectives used as prefixes, such as:

[ö-(eu)-], [mal-], [mon-], [olig-], [orto-]

a) **[ö-(eu)]** is a bound morpheme meaning normal or good

ökromatin "normal state of chromatin".
öfori
öknes

b) **[mal-]** is a bound morpheme which means abnormal

malformasyon "defective or abnormal formation"
malnütrisyon
malabsorbsiyon

c) **[mon-]** is a bound morpheme, meaning only:

monopleji "paralysis of a limb"
monortiküler
monoblast

d) **[olig-]** is a bound morpheme and means few, small:

oligüri "secretion of a diminished amount of urine in relation to the fluid intake"
oligofreni
oligoblast

e) **[orto-]** a bound morpheme, meaning straight

ortopedi "the branch of surgery, which is concerned with the preservation and restoration of the function of the skeletal system"

ortopne
ortodonti

iv. In TML, most of the derivational elements used as prefixes are prepositions in the source languages, such as :

[supra-], [infra-], [retro-], [pre-], [post-], [pro-], [sub-],

a) [supra-] is a bound morpheme meaning "above"

supravajinal	"situated above the vagina"
suprarenalis	
supranasal	

b) [infra-] is a bound morpheme, means "below":

infraklavikular	"beneath a clavicle"
infratrakeal	
infranüklear	

c) [retro-] is a bound morpheme, meaning "behind":

retrokardiac	"behind the heart"
retroservikal	
retrobulbar	

d) [pre-] is a bound morpheme, meaning "before":

prekanser	"the condition before cancer"
premedikasyon	
prediabet	

e) [post-] is a bound morpheme, meaning "after":

postembriyonik "occuring after the embriyonic stage"
postmortal
postnasal

f) [pro-] is a bound morpheme means "before" or "in front of" :

prosefalik "pertaining to the anterior part of the head"
proamniyon
proaktivitor

g) [sub-] is a bound morpheme meaning "under", "near", "almost":

subabdominal "situated below the abdomen"
subcortex
subcostal

3.3. Acronyms in Turkish Medical Language

Medical language contains many compound expressions, some of which can be extremely long and very difficult to pronounce. As a result, abbreviation for practical usage is required. Compound expressions are mainly nominal compounds, i.e., they are made up of nouns, for this reason the first letters of a group of words are taken, they are often written in capital letters and pronounced as words made up of initials. As Andersen (1988:144) points out the problem with acronyms is that they are easy to invent but less easy to decode, especially for outsiders.

The following are examples of some of the acronyms used in the Turkish Medical Language :

EKG	(elektro-kardiografi)
EEG	(elektro-ensefalografi)
Hb	(hemaglobin)
KC	(karaciğer)
VSR	(vena sentralis retina)
AMI	(akut miyokard infarktüs)
KIBAS	(kafa içi basınç artış sendromu)
KBB	(Kulak, Boğaz, Burun)
ESH	(eritrosit sedimentasyon hızı)
ANA	(antinükleer antikor)
PTKA	(perkütan transluminal koroner anjioplasti)
KBY	(kronik böbrek yetmezliği)
BDK	(basit diffüz guatr)
NG	(nodüller guatr)
RNA	(ribonükleik asit)
NBF	(normal boğaz florası)
SM	(streptomisin)
AFP	(alfa-fetoprotein)

Acronyms are also used in prescriptions. As Brunner and Tanker (1978:69) state, prescriptions are vehicles of communication between doctors and pharmacists. The following abbreviations are taken from "Ankara Eczacı Odası, 1992 Ajanda" (1992:161). It was distributed to all its members i.e., the pharmicists, in order to facilitate the understanding of prescriptions written by doctors. Doctors prescribe medicines by means of these acronyms, and pharmacists explain the instructions written on the prescriptions to patients. Hence, acronyms are used among doctors and patients as a communication vehicle.

a.a.	:	each of them (her ikisinden de)
a.c.	:	before the meals (yemekten önce)
a.d.	:	until (kullanım süresi)
add	:	add it (ilave edin)
a.h.	:	every two hours (iki saatte bir)
a.j.	:	before breakfast (kahvaltıdan önce)
a.m.	:	during the morning period (sabah saatlerinde)

agit	:	agitate (çalkalayın)
ante	:	before (önce)
a.q.	:	water (su)
aq.bull.	:	boiled water (kaynatılmış su)
cib.	:	meal (öğün)
coch.	:	ful spoon (kaşık dolusu)
d.	:	day (günde)
d	:	doze (doz)
gtt.	:	drops (damla)
h	:	hour (saat)
h.d.	:	before going to bed (yatmadan önce)
i.c.	:	before the meals (yemek arası)
inj or inject.	:	injection (iğne)
o.h.	:	every hour (her saat)
ol	:	oil (yağ)
o.d.	:	right eye (sağ göz)
o.s.	:	left eye (sol göz)
R,.Rp,rp	:	addressing to pharmacist (Sayın eczacı)
R.c.	:	after meal (yemek sonrası)
pro.uso.ex.	:	extęrnally (dıştan)
a.d.	:	four times a day (günde dört defa).
t.d.d.	:	three times a day (günde üç defa)

At present, the use of acronyms in prescriptions is much more limited. The following examples illustrate the most frequently used acronyms:

1. Rp.
   Novalgin tab. D. 1.B.
   S. 4 x 1

The doctor asks the pharmacist (Rp.), to give "Novalgin" to the patient. "Tab." is the abbreviation for tablet. "D" indicates the amount of boxes. In this case, one is enough says the doctor, and "B" is the abbreviation of "boat" which means box. "S" stands for the usage instruction, and 4x1 means four times a day, that is, every six hours.

2. Rp.

1) Duacid 375 mg. caps. D.1B.

S. 2 x 1

2) Termaljin tab. D.1B.

S. tarif üzere

3) Claritin tab. D.1B.

S. sabah 1

The doctor asks the pharmacist (Rp.) to give Duacid, capsule, 375 mg.. The quantity (D) is 1 Box (1B). The instruction for the usage (S) is two times a day (2x1).

Sometimes doctors do not indicate the usage instruction (tarif üzere) in this case, the pharmacist has to write the normal instruction written in the box of the medicine. In some cases, the usage instruction given by doctors is more specific, e.g. S. sabah 1, meaning one tablet should be taken only in the morning.

3. Rp.

1) Augmentin forte susp. D.1B.

S. 3 x 1 ölç.

2) Buğuseptil sol. D.1B.

S. odaya

The doctor asks the pharmacist to give "Augmentin" syrup (susp.) fortified (forte). The quantity of the box (D) is 1 box (1B), and the instruction of the usage (S) is three times a day (S. 3x1), only one spoon i.e., every 8 hours.

The usage instruction (S. odaya) of the second medicine indicates that the room should be vaporized by means of this medicine.

3.4. Formal and Informal Language use in Medical Activities

3.4.1. Informal Language Use

Medical professionals communicate in academic settings in order to inform novice professionals and their colleagues on empirical bases. Gilbert and Mulkay (1984, c.in., Andersen 1988) focused on the differences between the formal and the informal language of scientists, much of the formal discourse being written and the informal spoken (Andersen 1988:150).

In informal language of scientists, the talk is about all the non-empirical factors, such as hunches, feel, getting on with the research works etc., hence, Andersen (1988) calls this repertoire "contingent repertoire". As an example, the following is recordred during the gynocology seminar. The participants are the research assistants and the specialists:

"Interferon dediğimiz zaman, genellikle son BRM (Bioloji Response Modifier) olarak kısalttığımız bir takım maddelerin, yani biolojik modülasyon sağlayarak hem bir enfeksiyonu, hem de malignesleri tedavi ettiği grup altında topluyor. Yeni terminoloji bu. Bunlar içinde de en büyük yerleri tutanlardan biri de interferonlar.

Interferonlarla ilgili tartışmayı çok iyi yaptı, teşekkür ederim. Fakat, bir şey de ortaya çıkıyor ki, bizim bu seminer programı belirli kadın-doğum şeyleri içinde dönüp durmamızın artık dışına çıkmamız gerektiğini bir kez daha ortaya çıkıyor".

The first paragraph is the general summary of the article presented; however, the second paragraph reflects the speaker's hunches about the seminar program. According to him, the seminars should also include the new methods and findings. This paragraph also reflects the speaker's feeling on the presented seminar, which was done perfectly. He also expresses his gratitude to the assistant. Hence, this example is in line with Andersen's view on the informal language of scientists.

3.4.2. Formal Language Use

In formal scientific writing there is an attempt to exclude the contributions of the author. Andersen (1988:150) calls this repertoire the "empiricist repertoire" because it potrays scientists' actions and beliefs as following unproblematically and inescapably from the empirical characteritics of an impersonal natural world. Andersen (1988) also states that in formal scientific writing, there is an implicit model of external objects and relations between them that reduces the role of the observation of people with objects.

In written scientific medical articles, there is a pattern of textual dynamics which typify them (Gosden 1993:57). The formally distinct components are designed as: Introduction, Method, Results / Discussion.

3.5. Sentence Types and Tense Features of the Written TML

3.5.1 Sentence Types in the Written TML.

In Introduction, Method, Results and Discussion parts, the sentence types used are simple, complex and compound sentences. Accordingly the followings illustrate these types:

1. "Anadolu Üniversitesi Kimya Fakültesinde taşların biokimyasal analizleri Hithachi 18070 atomik absorbsiyon spektrofotometresi ve analitik kimyasal metodlarla incelenmiştir." (Anadolu Tıp Dergisi 1989:165).
2. "Vakalara milier tüberküloz tanısı konulmadan önce, 7 tanesi bronşit, üç tanesi gripal enfeksiyon, ikisi tifo, bir tanesi de mylesklerоz tanısı ile tedavi edilmişlerdi." (İstanbul Tıp Mecmuası 1987:236).
3. "Bu çalışma ile ABO hemolitik hastalığının tanısında ABO-Coombs serumunun daha güvenilir olduğu gösterilmiş, doğumda kord kanında rutin olarak bakılması risk grubunu belirlemesi ve gecikme süresini önlemesi açısından önemli olduğu vurgulanmıştır." (Anadolu Tıp Dergisi 1989:124).

The first example is the sample of a simple sentence. As in Turkish language, also in Medical language, simple sentences carry only one proposition and have one verb (i.e., the subject and the predicate). In the example, the subject is "taşların biyokimyasal analizleri" and the predicate is "incelenmiştir."

In the second example, which is a sample of complex sentence, the subordinate clause "vakalara milier tüberküloz tanısı konulmadan önce" is connected to the main clause by means of adverbial construction of manner { -mEdEn} which functions as a connective.

The third example is a compound sentence. The co-ordinating sentences are joined together by means of the linking word 've', and the items that make up the complex sentence are linked together by means of participles, such as bakılması, belirlemesi and önlemesi : {-mEsI}

What is common in all of the examples is the use of the passive forms of the verbs as 'incelenmiştir', 'edilmişlerdi' and 'vurgulanmıştır'. The passive constructions {-(I)n} and {-iL} are added to the verb stems incel-, et (ed) - and vurgula - .

As, Andersen (1988) states in scientific papers the passive form accounted for over a quarter of the verbs, especially is in the form where the agent of the action or even the instrument is omitted. To Lewis (1967), the most remarkable feature of the Turkish passive is its impersonal use. As a result, in written Turkish medical language, the use of passive verbs, the agents of which are not given, and the use of impersonal sentences where the agents are left indefinite, are frequently used.

3.5.2. Tense in Written TML.

In written Turkish medical language, the most frequently used tense is either the present tense (the aorist tense) used together with the {-DIr} suffix, or the (definite) past tense used with {-DI}. In both of the cases, the use of {-DIr} and {-DI} suffixes indicate the truth of the statements being made. Hence, by using the

present tense with the suffix {-Dlr} the statements that are considered to be true have no restrictions of time, whereas the past tense usage with {-Dı} suffix emphasizes the truth of the statement in the past.

As a result, as Andersen (1988:147) indicates, in scientific style, in describing actual experiments the past tense is used, but in general discussion the present is the common tense. This use of the present indicates the timeless or universal present where objects exist without changing and science exists without humans creating and recreating it, as it is apparent in the following example: "Milier tüberküloz belirli bir odaktan massif, hematojen yayılmayla oluşan ve vücudun bir çok organında yaklaşık aynı yaş ve büyüklükte lezyonlar oluşturan bir tüberküloz şeklidir." (Istanbul Tıp Fakültesi Mecmuası, 1987:235).

CHAPTER IV

COMMUNICATION PROCESS DURING MEDICAL INTERVIEWS

4.1. Introduction

Medical interviews are structured, predictable and organized around topics. The fluency of the interaction between the doctor and the patient depends on the patient's participation and understanding of the doctor's questions. The patient is the only source that contributes to the formulation of diagnoses and prescription of treatment by giving necessary information on his problem. As it has been argued, the ways in which information is exchanged is situationally produced (Mehan 1979; Shuy and Griffin 1979 c.in., Fisher 1982:57) and this has a strong effect on the ways it is understood (Cicourel 1974, Chafe 1976, Keenan and Schieffelin 1976, Kuno 1976, c.in. Fisher 1982:57).

Participants i.e. doctors and patients, come to the medical interviews with different resources. Therefore, as Labov and Fanshel (1977, c.in. Fisher 1982:56) claim the speech event (medical interview) is found to be asymmetrical. This means that the participant who initiates the event and is helped by it (patient) is in a subordinate position. On the other hand, the doctor is in a position to determine the form of the interaction (Fielding & Evered 1980:52).

Thus, Candlin, Leather and Bruton (1974, c.in., Fielding & Evered 1980:64) analyzed the functions performed in typical doctor-patient communication sequences and noted that a major activity of the doctor was to translate the information from the patient's lay code to the technical code of the medical profession.

Empirical and theoretical studies of the communication process suggest that the accuracy and efficiency of this recoding process will be dependent on the existence of a shared code, thus the absence of such a shared code will lead to a failure to recognize significant cues and to the erroneous recoding of the cues (Fielding and Evered 1980:64) and this will lead to misdiagnosis.

On the other hand, vagueness and euphemism on the part of the patient will lead to a communication gap between the doctor and the patient. Hence, the doctor, in certain cases will not be able to diagnose. By vagueness, the vague response of the patient to the doctor's questions are meant. Vagueness appears in medical interviews when the patient avoids answering the doctor's questions or when it is difficult to describe things such as pain or illness. Accordingly, euphemism may be used when patients do not want to discuss their problems when they feel uneasy.

Shuy (1982, c.in., Fisher 1982:57) suggests the following aims in the examination of the structure of the doctor-patient talk and context:

1. To examine the organization of doctor-patient communication as a process occurring in the more specialized institutional context.
2. To demonstrate the physican-patient communication as a speech event oriented toward the specific end of treatment decisions.
3. To display how language is used strategically by physicians and patients to negotiate treatment decisions; then how the negotiation is produced and constrained by the specific organizational context in which it occurs and to show the practical concerns of the participants and the asymmety inherent in their relationship.

4.2. Status and Power Differences in Doctor-Patient Communication

During the medical training, students encounter the specialized language of medicine; future doctors by using this language relate most of the material they learn to a specific scope, that is to be a doctor. However, there is no special training concerning the communication with patients. Thus, medical language, which is learnt through long periods of training can be considered as an attempt by doctors to retain control.

During the doctor-patient interaction the doctor occupies a much more powerful position than the patient. By virtue of that role and the expertise and experience that enables him to enact it successfully, the doctor is in a position to determine the form of the interaction and its outcome (Fielding and Evered 1980:52).

During the encounters, the physician guides the patient through the precarious scene in a contained manner, this is, taking the initiative, controlling the encounter, defining the situation by his reaction and giving cues that "this is done" and "other people go through this all the time" (Emerson Swam 1980:127).

By using soothing voice, probably calling the patient by his name, the doctor heightens his interpersonal relation with the patient. Hence, the physician's demeanour is highly stylized. Moreover, most of the phrases with which he encourages the patient to relax are routine, even though his delivery may suggest a unique relationship (Emerson & Swan 1980).

On the other hand, the patient is in a setting which is completely alien to him. Features of the setting such as divisions of space, decor and equipment are constant reminders that he is in the 'medical world'. Furthermore, he is embarrassed by the explicit terminology that is used around him. These factors contribute to the increase of emotion on the part of the patient, whereas the doctor is in his own setting. The specialized language is his professional lexicon and he has knowledge and skills which are basically mysterious to patients.

4.3. Asymmetrical Relationship in Therapeutic Discourse

Therapeutic discourse, which is a speech event, is a routinized form of behavior with well defined boundaries. The doctor by using the questioning strategies tries to get the necessary information from the patient. The patient is in a subordinate position, as the doctor is the one who guides him/her. Therefore, the major influence on compliance is the knowledge which patients bring to a medical interview and their understanding of what is said to them during the interviews. This is the important factor which contributes to the effectiveness of medical care.

However, for the hospitalized patients, the situation is much more different. The communication event takes place around his bed. For the patient a group of people in white, stand over his head and translate someone else sets of symptoms, results of tests etc. The language used is technical and obscure for him, and he is not involved in this speech event as a result, a feeling of inequality and lack of control will usually be present.

4.4. The Influence of Patients' Personal Characteristics in Information-Giving Strategy

Physicians modify their responses and attitudes according to the patients' personal characteristics. (Street 1991:542). Pendleton and Bochner (1980, c.in. Street 1991:542) observed that physicians gave more explanations to more educated patients, even when the explanation was not explicitily requested by the patient. Finally, Waitzkin (1985, c.in., Street 1991) claimed that doctors may be less informative with less educated and lower income patients, because they inaccurately assume that these patients are not particularly interested in learning about health. Consequently, the physician's informativeness may be strongly influenced by the features of the patient's communicative style such as question-asking, opinion-giving and affective expressiveness.

4.4.1. Patients' Non-verbal Behavior in Medical İnterviews and its Effecct on Compliance

Martin (1985 c.in. Andersen 1988:158) in his own research pointed out some problems on the level of non-verbal communication: he noted that while a patient was speaking, doctors regularly wrote notes, often with the head turned away. This leads patients to stop talking and to feel that the doctor is not listening. The way doctors position themselves, look at and touch patients have effects on compliance.

Therefore, voice tone, eye contact, facial expression, posture, hand movements and body lean all have effects on patient perception. Freidman (1979, c.in. Pettegrew and Logan 1989 :680) examined both verbal and non-verbal

channels and found that patients expressed greater negative effect when the two channels were contradictory. Di Matteo and Di Nicola (1982. c.in. Pettegrew and Logan 1989:680) summarize that patient compliance could be improved if physicians were more adept at establishing communication effect through verbal and non-verbal means. Thus, the amount of information a patient has about his or her illness and medical regimen is related to compliance (Blackwell 1973, Roter 1977 c.in. Pettegrew and Logan 1989). Di Matteo and Di Nicola (1982) reviewed the literature on compliance and concluded that the amount of information does influence patient compliance.

4.5. Strategic Use of Language : Information-Giving Process

> "We need a medicine which seeks explanations of what happens to people's bodies, not only at the level of germs and pathology, but also in terms of people's social world.... A medicine would develop a language for talking about the impact of feelings on bodies, for describing the realm of experience that is neither entirely psychological nor physical... Listening to what people say, would be as important as examining their bodies..." (Mitchell 1984 c.in. Andersen 1988:159)

In spite of sophisticated technologies for medical diagnosis and treatment, talk remains the primary means by which physicians and patients exchange health information. For the doctor, information is crucial for formulating diagnoses and prescribing treatment; for the patient, information fosters an understanding of one's health status which in turn may reduce uncertainty, alleviate concerns and improve health (Roter 1987, Waitzkin 1985; c.in. Street 1991:541). Unfortunately the exchange of information between the patient and physician is often fraught with problems. Although expecting doctors to be informative, patients often perceive them as insufficiently so (Stiles et al 1982; Strull et.al. 1984, c.in., Street 1991), which in turn contributes to the patient's dissatisfaction, non-compliance, and misunderstanding of medical information.

Additionally, physicians tend to overestimate the amount of information they give patients, underestimate the patient's desire for information and give varying

amounts of information in response to the patient's education, income, sex and age (Waitzkin 1985, c.in., Street 1991).

Another important fact concerning the success of information-giving process is related to the patient's communicative style. Patients who are more assertive, express more concerns and ask more questions, acquire more information from doctors than do less verbally active patients. Hence, more educated, higher income, older and female (or male) patients may receive more information, because they have communicative styles that elicit this information from doctors (Street 1991:541).

However, another perspective suggets that doctors may vary, according to the amount of information they give to the patients because of their impression of a particular patient (e.g. likeable, intelligent) or because of their subjective judgements about the patient's informational needs and requirements (Stiles 1989, c.in. Street 1991:542).

4.5.1. The Influence of Patients' Communicative Style on The Information-Giving Process

In most instances the physican is more dominant in the medical interaction, as he is the first who initiates most of the topics of the consultation. On the other hand, conversation in the medical consultation, is an enterprise that is mutually constructed by the interactants. How a physician interacts with a patient is in part, a function of how the doctor chooses to communicate and in part a function of what the patient allows the doctor to do (Street 1991:542).

Hence, because conversational exchanges require coordination for topic - development and turn-taking, patients potentially have the verbal resources to exert considerable control over the physician's behavior. In particular, according to Street (1991:542.), three features of the patient's communicative style appear capable of influencing the doctor's informativeness:

a) asking questions,

b) expressing concerns and worries,

c) offering opinions.

4.5.1.1. Asking-Questions

There are two reasons why a patient's question will elicit an informative response from the doctor (Street 1991:542). First, both doctors and patients share the goal of helping each other for the diagnosis. Secondly, one rule of conversation is that a partner's utterance should be topically connected and fulfill obligations raised in the prior speaker's utterance. For example, answers are expected to follow questions, an acceptance is expected to follow an offer, requests should be accepted or rejected etc.. Thus, although, they may experience frustrations with patients who ask numerous questions and may be uncomfortable or unwilling to answer some questions (West 1984, c.in., Street 1991), physicians may feel obligated to provide at least some information in response to the patient's query. Several studies have revealed that physicians provide more information to patients who ask more as opposed to fewer questions (Street 1991:542).

4.5.1.2. Affective Expressiveness And Opinion-Giving by Patients

Affective expressions refer to utterances that express concerns, worries or emotions (Street 1991:542); opinion-giving, on the other hand, represents the patient's efforts to assert his/her perspective into the consultation, by offering opinions about diagnosis and treatment, disagreeing with the doctor, making recommendations and so forth (Street 1991).

According to Street (1991) a patient's expressiveness and assertiveness may influence the doctor's informativeness in two aspects: first, once again assuming that the goal of both parties is to help the patient, the doctor may be inclined to respond informatively to the patient's concerns or opinions in order to reassure the patient, to alleviate the patient's uncertainty, or to offer an opinion or evidence that supports, rejects, or clarifies the patient's perspective on an issue; secondly, by

expressing emotions, concerns, and opinions, the patient is providing a topical context for the doctor's subsequent utterance. An extension of the patient's utterance may present information in the form of opinion, data, explanation, and description.

As Street (1991) observed, doctors were more interpersonally engaged with and provided more opinions to patients who were more rather than less affectively expressive and he also observed that, patients who attempt to exert some control over the physican's behavior (through questions and opinions) elicited more information from physicians that did less verbally assertive patients.

4.6. Strategic Use of Language By Physicians in The decision-Making Process

Medical interviews are social events oriented toward the specific end of a treatment decision. Language is used strategically in this event, to accomplish treatment decisions (Fisher 1982:58).

Doctors, because of their specialized knowledge and technical skill, act as gatekeepers in the decision-making process (Fisher 1982). In analyzing how language is used strategically to accomplish treatment decisions, Fisher (1982) intends to demonstrate that doctors and patients have different practical concerns, which organize the ways they exchange information, and this organization has consequences in terms of the decision reached.

Similarly, questioning strategies are used by both partners, whereas presentational and persuasional strategies in decision-making process are only used by doctors.

4.6.1. Questioning Strategies

Doctors use them in reproduction of talk, in order to gain access to information which only patients can supply. Patients, on the other hand, use them during option talk to get information about the necessity of the treatment being recommended. (Fisher 1982:60). Thus, the communicational work of participants is oriented toward the specific end of a treatment decision.

4.6.2. Presentational and Persuasional Strategies

Information is provided in ways that function as Presentational and Persuasional strategies. According to Fisher (1982:60) both of these strategies are selling mechanisms. Presentational strategies provide information about a treatment opinion while suggesting that it is the "usual" or "normal" way to treat the patient's condition. Persuasional strategies, on the other hand, provide information in specifying how it should be understood. For example the presentation- "What you should do if you don't want any more children" is to have hysterectomy that means no more uterus and cancer, no more babies-provides the patient with information about what treatment option she should have while specifying why she should have it (Fisher 1982:60).

In this case, according to Fisher (1982), only physicians use Presentational and Persuasional strategies in order to provide information about the treatment decision the patient should make. Therefore, through these strategies the information necessary to negotiate treatment decisions is exchanged.

4.7. Analyses of Doctor-Patient Interviews by VRM System

4.7.1. Introduction

According to Stiles (1978:694), "..... dyadic communication rests on three dichotomous principles of classification : source of experience, frame of reference, and focus". This means that an utterance can have either speaker or addressee as its source of experience, it can use the speaker's or the addressee's frame of reference and it can have either speaker or addressee as its focus.

Thus the taxanomic principles of Verbal Response Mode derive from a theoretical conception of dyadic verbal interaction as communication between two centers of experience. 'Experience' is anything of which a person can be aware - facts, feeelings, actions, conditions, opinions, fantesies, memories, perceptions, intention and so forth. According to Stiles (1978), each utterance concerns one experience and while its specific content may be anything imagineble; its 'source'

must be the speaker or the addressee. Even when both dyad members are aware of the same information, each utterance draws its main idea from one center of experience.

Theoretically, a single experience is meaningless in isolation; its meaning consists of other experiences that are associated with it. The associated ideas, feelings and memories form its "frame of reference" (Stiles 1978:695) and give it the meaning it has at a particular time. The words used to express an experience are not the experience itself, but they are associated with the experience. Thus, putting an experience into words automatically places it in a particular frame of reference. In a dyad, the frame of reference can be classified as either the speaker's or the addressee's, that is, each experience is expressed from the speaker's viewpoint or from a viewpoint shared with the other (Stiles 1978).

However, an utterance may or may not carry a presumption of knowledge of the addressee's experience or frame of reference, in that case, such a presumption is said to be focused on the addressee. For example, the interpretation "You have done well" presumes knowledge of the addressee's actions and the question "How well did you do?" does not (Stiles 1978).

The reflection "You feel disappointed" presumes knowledge of the addressee's experience, whereas the acknowledgement "MM-hm" does not. The advisement "Get out of here" presumes knowledge of what the addressee should or will experience, whereas the disclosure "I'm leaving" does not. In each case, the intended meaning of utterances focused on the other depends on such a presumption. Thus, the name of this principle "focus" refers to the tendency for utterances that presume knowledge of the addressee to focus the addressee's attention on himself or herself and the for utterances that do not presume such knowledge to focus the addressee's attention to the speaker (Stiles 1978:695).

Under the light of the principles presented above (i.e. source of experience, frame of reference and focus) Stiles proposed "Verbal Response Mode" which is a category of language behavior that implies a particular interpersonal intent or

microrelationship between communicator and recipient. Verbal response modes describe and quantify the clear differences between the dyad members' relationships in these two interactions (Stiles 1978:693).

According to Stiles (1978), mode categories should be distinguished from content categories, which code the semantic meaning of an utterance and extralinguistic categories such as pauses, rate, pitch, speech disturbances and laughter (Stiles 1978:693).

Hence, Stiles presents a general-purpose taxonomy of verbal response modes, and explains how three dimensions of interpersonal roles -attentiveness, acquiescence and presumptuousness- can be derived from it. The taxonomy is analytic rather than empirical; that is, the modes are defined by principles of classification rather than by verbal descriptions or standard examples (Stiles 1978:694).

4.7.2. Categories of Verbal Response Modes

1. Disclosure concerns the speaker's experience in the speaker's frame of reference, focused on the speaker, that is, the speaker reveals something about his/her own internal experience, or point of view without necessarily presuming knowledge of the addressee. Disclosure form is first-person singular (I) or first-person plural (we).
2. Question concerns the addressee's experience in the speaker's frame of reference, focused on the speaker. The speaker attempts to fill a gap in his/her own frame of reference with information supplied by the addressee. The focus is on the speaker, in that the speaker does not need to presume knowledge of the addressee's experience in order to ask a question.
3. Edification concerns the speaker's experience in the addressee's frame of reference, focused on the speaker. The experience conveyed is information held by the speaker. The focus is on the speaker in that no presumption regarding the addressee's experience or view point is necessary for the utterance to have the meaning it has, and no specific knowledge of the addressee's viewpoint is presumed. In other words, edifications express objective information; their truth or accuracy could be ascertained by anyone

in the right place at the right time. Of course, the statement needs not be true or affectively neutral to be on edification. Edification form is declarative and 3rd person.

4. Acknowledgement concerns the addressee's experience in the addressee's frame of reference, but focused on the speaker. Acknowledgement is a contentless mode in the sense that the speaker does not convey his/her own viewpoint or information in the utterance, nor does the speaker presume knowledge of the addressee's frame of reference or experience. In general, acknowledgements convey reception of or receptiveness to communication from the addressee. Acknowledgement form includes nonlexical utterances, content-free lexical utterances, and terms of address and salutation (mm, hm, Yes sir, hello).

5. Advisement concerns the speaker's experience in the speaker's frame of reference, focused on the other. The speaker presumes to expess what he/she wants done (experience), gives his/her view of the situation (frame of reference). Thus, in advisement the speaker attempts to impose his/her experience on the addressee by guiding the addressee's behavior. Advice, command, suggestion, instruction, permission and prohibition are scored as advisement. Advisement form is imperative, with the subject omitted, but understood, or 2 nd person (you) with a verb of permission, prohibition or obligation.

6. Interpretation concerns the addressee's experience in the speaker's frame of reference, focused on the addressee. The speaker offers an explanation or a particular way for the addressee to understand his/her own experience or behavior. The frame of reference into which the speaker presumes to place the addressee's experience may be the speaker's personal opinion or some general standard or even a formal theory, such as psychoanalytic theory. Judgements or evaluations of the addressee's experience or behavior are scored as interpretation; however, judgements about other matters are not scored as interpretation in this taxonomy. Interpretation form is second person (you) with a verb that describes an attribute, condition, or ability of the addressee.

7. Confirmation concerns the speaker's experience in the addressee's frame of reference, focused on the other. The speaker presumes a common frame of reference in order to compare his/her own experience with that of the addressee. Expressions of joint thought or action, agreement and similarity of opinion or experience are scored as confirmation. This mode also includes disagreement and expressions of dissimilarity; the speaker must presume knowledge of the addressee's experience or frame of reference in order to make a comparison. Confirmation form is 1st person plural (we) when both the speaker and the addressee are referents or there is a compound subject that includes both the speaker and the addressee (eg. you and I).
8. Reflection expresses the addressee's experience in his/her frame of reference, focused on him/her. The speaker attempts to express the addressee's experience in a way that is compatible with the addressee's view of it. Obviously, in order to do this, the speaker must presume knowledge of the addressee's experience and frame of reference, so the focus is on the addressee. An utterance need not use the addressee's words, nor must it be accurate, to be scored as reflection, so long as the implied standard of accuracy is the addressee's internal frame of reference. Reflection form is second person (you) with a verb that describes an internal experience or an action of the addressee (i.e. things of which the addressee is presumed to be aware) (Stiles 1978:697).

4.7.3. Comparison of VRM Approach With Traditional Speech Act Theory

As Austin (1975, c.in., Stiles 1981) showed, illocutionary force is a general characteristic of utterances, by no means restricted to explicit performatives. Hence, explicit performative verbs have the curious property of naming the illocutionary act performed in uttering them in the first person singular, present indicative active sentences. For example, if "one says" , "I promise x", I have promised X. Saying makes it so. Thus, nonverbal or physical actions by speaker or addressee and actions by nonhuman agencies are excluded (Stiles 1981:239).

However, from the perspective of VRM system, whose roots are in study of psychotherapeutic techniques (Goodman & Dooley 1976; Stiles 1979, c.in., Stiles 1981:239), the association with performatives appears to have been severely limiting : All explicit performative utterances are first person singular and so would be classified as Disclosure in form. Altough form does not necessarily constrain intent, usage and vocabulary emphasize pure modes over mixed modes: so performative verbs are most likely to describe Disclosure intents.

Searle's (1976, c.in., Stiles 1981) five-category scheme is illustrative. Commissives, which commit the speaker to some future course of action, and expressives, which express the speaker's psychological state are obviously subclasses of Disclosure intent (Stiles 1981:240). Representatives, which commit the speaker (in varying degrees) to the truth of some proposition, are primarily Edification in intent, although this category might include some other modes as well. Directives, which are attempts by the speaker to get the other to do something, correspond to Advisement intent, although Searle also included Question in this category. Declerations, which are utterances whose "successful performance guarantees that the propositional content corresponds to the world", such as declerations of war or marriage are Searle's examples of Edification.

Hence, Searle deals most explicitly, with Disclosure intent and with illocutionary forces that differ from Disclosure in only one of the three principles of classification, i.e. with Edification, Advisement, and Question. He ignores the four remaining modes, Confirmation, Acknowledgement, Interpretation, and Reflection, which differ from Disclosure in two or three of the principles (Stiles 1981:240).

However, Hancher's (1979, i.in., Stiles 1981:240) modification of Searle's taxonomy shares the view that the interpersonal context should be incorporated in a taxonamy of illocutionary acts. Thus, Hancher's solution- to admit categories that require collabaration of two or more individuals, such as cooperative commissives (e.g. contracts, marriages) and reciprocal cooperative declarations (e.g. gifts, sales)- diverge sharply from VRM solution, because as Stiles (1981:241) states Hancher seems to have focused on the performative aspect of speech acts, with which Stiles disagrees.

Therefore, according to Stiles, the VRM taxonomy rests on the essential separateness of communication centers of experience. "Shared" experiences or frames of reference are shared only in the speaker's assumption, and the VRM code is unchanged if the speaker's assumption is mistaken or if the utterance is infelicitous or misunderstood (Stiles 1981:241).

4.7.4. Relationship Between Verbal Response Modes and Illocutionary Acts.

J.L. Austin (1975, c.in., Stiles 1981:227) defined an illocutionary act as the act performed in producing an utterance, as distinct from simply uttering the words (a locutionary act), from producing some external effect on the actions or attitudes of others (a perlocutionary act) and from the propositional content (if any) of the utterance.

As implied by Austin, and subsequently elaborated by Searle (1969), Vendler (1972, c.in., Stiles 1981), and others, the illocutionary force of an utterance depends on the speaker's communicative intent which must be inferred in context.

Searle's and Vendler's analyses show that illocutionary acts presuppose a speaker- a center of experience whose intent defines the act. To this, Stiles (1981:228) adds that illocutionary acts also presuppose an intended recipient; that is, illocutionary force must be on some other person. For example: "Shut the door" has directive force only on the person addressed, not on anyone who overhears it. If there is no intended recipient, then there is no illocutionary act.

Stiles' (1981:228) view, thus, is that, every illocutionary act includes an "intersubjective" aspect; it connects two centers of experience in a particular way (Russell and Stiles 1979, c.in. Stiles 1981:228). Hence, the intersubjective illocutionary force of an utterance describes the particular quality of the impact of one center of experience on another. In other words, the intersubjective aspect of an illocutionary act is that, which defines the relationship of speaker to addressee for that utterance.

Like Austin (1975), Searle (1969), Vendler (1972), Ohmann (1972), Fraser (1975), Wunderlich (1976), Green (1977, c.in., Stiles 1981) and others, Stiles also recognizes family resemblances among illocutionary acts (Stiles 1981:228). For example, commands, orders, suggestions, advice, permission and prohibition are all attempts by the speaker to guide the addressee's behavior. Therefore, according to Stiles (1981:228), an utterance can have either the speaker or the addressee as its source of experience; it can use the speaker's or the addressee's frame of reference; and it can have either the speaker or the addressee as its focus. Thus, to Stiles (1981), the eight possible combinations of 'speaker' and 'addressee' values (verbal response mode categories) of these three principles define mutually exclusive families of intersubjective illocutionary acts.

4.7.5. Procedure

The medical interviews recorded in the University Hospital are divided into three groups. The first group (Group 1) includes the patients who are either university graduates or attended the university for some time; the second group (Group 2) consists of the less-educated and lower-income patients; and the third group (Group 3) is registered in the village. The medical interviews of this group are recorded while the doctor members of Eskişehir Lions Club scanned the village. The last group (Group 4) includes the hospitalized patients. In each group, the medical interviews are divided into three segments as the medical history, the physical examination and the conclusion segment (diagnosis and prescription). Then, the transcripts of the medical interviews are segmented according to the Verbal Response Mode system. The unit of analysis is an utterance.

4.7.6. Analyses of Group 1 : Educated Patients

4.7.6.1. Case 1

a) History taking

D : Ne şikayetiniz var?
P : Başağrısı, şakaklarım filan ... başımı öne eğince ağrı oluyor.
D : Ne zaman başladı?
P : Epeydir. Muayene olmuştum; Bekir Bey sinuzit demişti.
D : Sinuzit mi demişti?
P : Evet.
D : İlaç kullandınız mı?
P : Evet, antibiyotik filan ...
D : Tansiyonunuz normal mi?
P : Günaşırı Synopril alıyorum. Bazen yükseliyor, bazen düşüyor.
D : Genellikle kaç çıkıyor en fazla tansiyononuz?
P : 14
D : Burun tıkanıklığı var mı?
P : Hayır, sıkça aksırık nöbetleri oluyor; bir de geriye doğru akıntım var, bir de başağrısı.
D : Başağrısı geldiğinde ne kadar sürüyor?
P : Sabahtan öğleye kadar. Sabahları öyle kalkıyorum.
D : Uykudan uyandırıyor yani ...
P : Evet.
D : Bu son 1 haftada mı rahatsız etti sizi?
P : Hayır, epeydir var.
D : Sırtınıza doğru iniyor mu bu ağrı?
P : Hayır.
D : Öne eğildiğinizde filan?
P : Evet, biraz artıyor.

b) Physical Examination

D : Dönderin gövdenizi öyle durun... Bu kulağınız akmış çocukken sizin; sonra tamir etmiş kendini.

P : Öbürü?

D : O iyi. O pırıl pırıl.

P : İyi ne demek? Kireçlenmiş mi?

D : İki türlü kiriçlenme var. Birincisi, özengi kemiğinde var olan kireçlenme. Bir de normal zar delinir. Yani, yeni böyle bir kemik teşekkülü oluyor. Sizdeki birincisi, akmış, akarken kireçle tamir olmuş. Ameliyatlık bir durum yok sizde... Serbest durun, rahat olun, sıkmayın kendinizi, ağzınızı açın.

P : Dişlerimi çıkarayım mı?

D : Evet, rahat göreyim : Rahat olun.

P : Kuruma oluyor bu ara...

D : Burunda biraz şişlik var, içerde. Birazda üst tarafta şişlik var, ama açık. Sıkmayın! Diliniz içerde kalsın ... Çok güzel ! Böyle durursanız hiç bir şey yok. Evet; gördüm sıkmayın kendinizi. Nefes alıp, verin. E. e. e. deyin. Serbest durun. Bademcik azıcık müzmin, iltihaplı gibi ama birşey yapmıyor... Gerek yok...

c) Conclusion Segment

D : Boyun filmi, iki yönlü kafa, bir de sinus filmi çektirelim. Sıvıyı azıcık bol alın. Buhar yapın. Filmleri bi çektirin, sonra bunları görelim...

4.7.6.1.1. Analysis of Case 1

In Case 1, the doctor questions the patient as:

- Ne şikayetiniz var?

The answer is in Edification mode, that is, it is in 3rd person and it is her experience in the doctor's frame of reference, but is focused on the patient:

- Başağrısı, şakaklarım filan... başımı öne eğince ağrı oluyor.

To the question:

- Ne zaman başladı?

the patient's answer is again in Edification mode:

- Epeydir.

Then, the patient states that another doctor "Bekir Bey" has said that it was "sinusitis".

The doctor's further questions are as follows:

- İlaç kullandınız mı?
- Tansiyonunuz normal mi?
- Genellikle kaç çıkıyor, en fazla tansiyonunuz?
- Burun tıkanıklığı var mı?
- Başağrısı geldiğinde ne kadar sürüyor?
- Uykudan uyandırıyor yani?
- Bu, son bir haftada mı rahatsız etti sizi?
- Sırtınıza doğru iniyor mu?
- Öne eğildiğinizde filan?

These questions aim at investigating the patient's experience in the doctor's frame of reference. Hence, the doctor tries to fill the gap with the information supplied by the patient.

The patient's answers are either in Disclosure or Edificatiion mode:

- Evet, antibiyotik filan...
- Günaşırı Synopril alıyorum.

are stated in Disclosure mode, that is, she tells her experience in her frame of reference, which are focused on her. Then, she continues in Edification mode, where the experience conveyed is in the doctor's frame of reference, but is focused on the patient :

- ... Bazen yükseliyor, bazen düşüyor.
- 14
- Hayır, sıkca aksırık nöbetleri oluyor; bir de geriye doğru akıntı var, bir de başağrısı.
- Sabahtan öğleye kadar: Sabahtah öyle kalkıyorum (the last utterance expresses her internal experience in Disclosure mode)
- Evet.
- Hayır, epeydir var.
- Hayır.
- Evet biraz artıyor.

During the physical examination, the doctor interprets what he sees in Edification mode:

- ... Bu kulağınız akmış, çocukken sizin. Sonra tamir etmiş kendini.

To the patient's question :

- Öbürü?

the doctor's answer is again in Edification:

- O, iyi, pırıl pırıl.

Thus, the experience conveyed is the information held by the doctor. The focus is on the doctor, in that no presumption regarding the patient's experience is necessary.

However, the patient is eager to get more information about her ear:

- İyi ne demek ? Kireçlenmiş mi?

The doctor explains her situation in Edification mode, as:

- İki türlü kiriçlenme var. Birincisi, özengi kemiğinde var olan kireçlenme. Bir de normal zar delinir. Yani, yeni böyle bir kemik teşekkülü oluyor. Sizde ki birincisi, akmış, akarken kireçle tamir olmuş.

To the patient's question :

- Dişlerimi çıkarayım mi?

the doctor's response is in Disclosure mode, that is, he uses first person singular in order to reveal his view :

- Evet, rahat göreyim.

The patient comments her situation in Edification mode :

- Kuruma oluyor bu ara...

The doctor interprets what he observed in Edification :

- Burunda biraz şişlik var, içerde. Birazda üst tarafta şişlik var, ama açık.
  (he continues the physical examination, then adds)
  Bademcik azıcık müzmin, iltihaplı gibi ama birşey yapmıyor.

In the conclusion segment, the doctor presumes to express what he wants to be done in Advisement mode :

- Boyun filmi, iki yönlü kafa, bir de sinus filmi çektirelim.

The doctor uses 1st person plural form in order to be more suggestive (çektirelim), though they are not going to have the film taken together. Then, in 2nd person form he advises as:

- Sıvıyı azıcık bol alın. Buhar yapın. Filmleri bir çektirin,.

Hence, the doctor's instructions are expressed in his frame of reference and they are focused on the patient. He attempts to impose his suggestions on the patient by guiding her.

4.7.6.1.2. Results of Case 1

Case 1 takes place in the Ear-Nose-Throat policlinic. The patient is over her seventies. She had attended the university. Her answers to the doctor's questions are mostly in Edification mode, that is, she gives objective information rather than

subjective information. She also asked questions to the doctor, as she has a communicative style that elicit information from the doctor, and as a result, the doctor answered her questions in detail:

- İki türlü kireçlenme var. Birincisi özengi kemiğinde var olan kireçlenme. Bir de normal zar delinir, yani yeni, böyle bir kemik teşekkülü oluyor. Sizdeki birincisi, akmış, akarken kireçle tamir olmuş.

The patient also expresses her worries such as :

- ... sıkca aksırık nöbetleri oluyor, bir de geriye doğru akıntım var, bir de başağrısı.
- ...Kuruma oluyor bu ara...

These statements expressed her concerns and worries and by means of them she was able to change the topic. On the other hand, the doctor uses Presentational strategy that provides information about a treatment opinion. He suggests that it is a usual or normal condition :

- Burunda biraz şişlik var, içerde ... Bademcik azıcık müzmin, iltihaplı gibi, ama bir şey yapmıyor.

As a result of VRM analysis, the doctor asked questions in order to get information. Also the patient asked questions for the same purpose. Edification mode is used more than Disclosure mode, and the doctor also used Edification mode in order to give objective information.

4.7.6.2. Case 2

a) History Taking :

D : Şikayet olarak?
P : Yutkunma zorluğu
D : Yutkunma zorluğu olarak neyi kastediyorsunuz?
P : Yani, şöyle .. Sanki boğazımda bir şey var. Yemek yerken sanki birşey takılıyor boğazıma .. Şu kısımda sanki...
D : Takılıyor dediğinizde, geçmiyor mu aşağıya ?

P : Sürekli duruyor.

D : Sizinki yutma güçlüğü mü, yutkunma güçlüğü mü ?

P : Şimdi normalde yutuyorum, sanki şurda birşey takılıyor.

D : Yani aşağıya gitmiyor mu?

P : Gidiyor, gidiyor. Sürekli takılıyor, su içerken dahi; ben sürekli hissediyorum bunu.

D : Ne zamandan beri?

P : 15 gündür. Önceden bademcik dedim. Alfasit kullandım, ama bu daha aşağıda

D : Boğaz ağrısı oluyor mu?

P : Tabii... sabahları kalktığımda

D : Sinirli, stresli olduğunuzda artıyor mu?

P : Evet.

D : Bir olay var mı sinirlerinizi bozacak?

P : Genelde oluyor bu türlü şeyler...

D : Nerde çalışıyorsunuz?

P : PTT'de.

D : Daha önce herhangi bir kaza, ameliyat?

P : Ameliyat geçirdim, apandisit, laporoskopi ...

D : Ne zaman?

P : Apandisit hemen hemen 14-15 sene oluyor. Loporoskopi 2-3 sene oldu.

D : İlaçlara göre alerji?

P : Yok.

b) Physical Examination

D : Açın ağzınızı, e, e, e deyin. Rahat olun. Sıkmayın kendinizi... Ağzınızı iyice açın.

c) Conclusion Segment

D : Aç karnına geleceksiniz, tahlil yaptıracaksınız. Film yazacağım, onu çektireceksiniz. Diğer tahlil sonuçlarını getireceksiniz, ondan sonra bakacağız. Olmazsa ileri bir araştırma olarak bir ilaçlı film çekilebilir.

Onlardan da birşey bulamazsak, dediğim büyük olasılıkla sizin rahatsızlığınıza uyuyor. Bazı insanlarda çok stresle, bazı insanların mesela stresle başı ağrır.

P : O zamanla mı geçer?

D : O zamanla geçer. Ya da biz bir ilaç veririz. Ya da arzu ederseniz, psikiatri polikliniğine de gidersiniz. Onlar da bakarlar. Onun gibi birşey yapalım.

4.7.6.2.1. Analysis of Case 2

In Case 2, the doctor asks her problem, the patient's answer is in Edificaition:

- Yutkunma zorluğu.

By using this mode, no presumption regarding the doctor's experience is necessary for the utterance to have the meaning it has.

The doctor tries to get more information by asking :

- Yutkunma zorluğu olarak neyi kastediyorsunuz?

The patient, again in Edification mode states her experience as :

- Sanki boğazıma birşey takılıyor.

Hence, the doctor questions the patient in various ways, in order to grasp the problem :

- Takılıyor dediğinizde geçmiyor mu aşağıya?
- Sizinki yutma güçlüğü mü, yutkunma güçlüğü mü?
- Yani aşağıya gitmiyor mu?
- Ne zamandan beri?
- Sinirli, stresli olduğunuzda artıyor mu?
- Bir olay var mı sinirlerinizi bozacak?
- Nerde çalışıyorsunuz?
- Daha önce herhangi bir kaza, ameliyat?
- Ne zaman?
- İlaçlara göre alerji?

The patient's answers express her experience in the doctor's frame of reference (Edification), except one answer that is expressed in her frame of reference (Disclosure) :

- Sürekli oluyor.
- Şimdi normalde yutuyorum, sanki şurda birşey takılıyor.
- Gidiyor, gidiyor. Sürekli takılıyor, su içerken dahi;
- 15 gündür.
- Tabii... sabahları kalktığımda.
- Evet.
- Genelde oluyor.
- PTT'de
- Ameliyat geçirdim,(Disclosure)
- Hemen hemen 14-15 sene oluyor.
- Yok.

In the physical examination, no dialogue between the doctor and the patient is observed. The doctor gave the instructions, so that he could examine well, and the patient obeyed them.

In the conclusion segment, the doctor tells what the patient has to do in Advisement mode :

- Aç karnına geleceksiniz, tahlil yaptıracaksınız. Film yazacağım, onu çektireceksiniz. Diğer tahlil sonuçlarını getireceksiniz, ondan sonra bakacağız.

Hence, the doctor uses the imperative forms of the verbs "gelmek", "yaptırmak", "çektirmek", "getirmek", in order to express his instructions. By this mode, the doctor imposes the instructions on the patient, by guiding her behavior or action. Thus, his commands are in his frame of reference, which are focused on the patient.

4.7.6.2.2. The Results of Case 2

In Case 2, the patient is 35 years old. She works in the post office as a director. She is in the Ear-Nose-Throat policlinic. Her answers to the doctor's questions are all in Edification mode, that is, she gives objective information concerning her problem she asked only one question in order to get information and she expressed all her worries and concerns about the problem such as :

- ..... sanki şurda birşey takılıyor.
- ..... sürekli takılıyor, su içerken dahi ...
- ..... Alfasit kullandım, ama bu daha aşağıda.

However, the doctor tries to change the topic as :

- Boğaz ağrısı oluyor mu?

and he uses Presetantional strategies in order to provide information about the treatment :

- ..... bazı insanlarda çok stresle, bazı insanların mesela stresle başı ağrır.
- ..... ya da arzu ederseniz, psikiatri polikliniğine de gidersiniz. Onlar da bakarlar.

4.7.6.3. Case 3

a) History taking :

D : Ne tür şikayetler var?
P : Kanama gibi birşey oldu. Yani, değişik bir gerilim oldu. Boğazımda çatlamalar oldu sanki...
D : Son bir ayda mı bunlar?
P : Evet, ama son bir ayda hassaslaştı belki. Radioaktiv hastalar çoğaldı. Daha fazla günler çalışma oldu. Daha önce hasta almıyorduk; belki ondan olabilir.
D : Evet ... Yani ondan sonra oldu diyorsunuz?
P : Ondan sonra, daha belirgin oldu.
D : Daha önce hissetmiyordunuz?

P : Daha önceden hissetmiyordum; kokusunu hissettim İyot kokusunu hissettim yani. Yani boğazımda iyot kokusunu hissettim.

D : Peki, şikayet olarak ne yapıyor? Boğazda ağrı yapıyor mu?

P : İki yanda sürekli acıma (she shows); dilimde sürekli acıma var.

D : Dilde acıma, boğazda acıma.

P : Bu hafta sonunda biraz düzeldi o şikayetlerim, ama yine acıma oluyor.

D : Peki, boğazda yanma, kuruma şikayetleri oluyor mu?

P : Kuruma hissediyorum; Ihh yapma ihtiyacı duyuyorum.

D : Evet. Boğazda birşey takılma hissi yaratıyor mu?

P : Evet, bir dolgunluk hissediyorum.

D : Peki. Daha önceden bu tür şikayetleriniz var mıydı?

P : Şeyim var ... Faranjitim.

D : Öksürük, gıcık tarzında, veya balgamlı öksürük?

P : Balgamlı yok.

D : Arka arkaya öksürüyor musunuz ?

P : Öksürük yok, ama hep böyle boğazımdaki o şeyi hissediyorum.

D : Evet ... Peki ... Şikayetler sabah yataktan kalkıyorsunuz ... sabah daha çok mu oluyor, yoksa gün içerisinde mi?

P : Hocam, sürekli, sürekli hissediyorum. Şu anda da acıma var

D : Evet ... Peki ... Yiyeceklerden etkileniyor musunuz? Asitli yiyeceklerden limon gibi veya asitli içeceklerden?

P : Acıdan çok.

D : Acı çok yakıyor.

b) Physical examination :

D : Ağızdan nefes alın, verin, arada bir e-e-e deyin, derin nefes alın. Derin nefes alın! Elinizle burnunuzu tıkayın! Yutkun deyince yutkunacaksınız ... Boğazınızda kızarıklık var; hafif faranjit durumu var... bu eski de olabilir... veyahut eski faranjitinizin üzerine o tahriş edici duman ile de şikayetleriniz artmış olabilir...

P : Mesela sigara dumanı... Şimdi çok etkiliyor.

D : Etkiler... Yani sıcak, soğuk yiyecekler, dumanlı hava etkiler. Şimdi şu anda bir şey yok, yani kötü bir şey yok ya merak etmeyin de... Tabii, alınan dozla ilişkili olan bir şey ...

c) Conclusion Segment

D : Bazı tetkikler yapacağız, yani, daha doğrusu sinus filmi çektirmeniz lazım; o film gelsin ayrıca sinus ile ilgili şikayetler varsa, ayrıca onları da tedavi etmek lazım, çünkü o genze doğru akıntı, şikayetlerinizi arttırır. Arkadaşlar filmleri incelesin, ona göre bir ilaç tedavisi verelim. Kültür ne zaman alınmıştı boğazınızdan en son?

P : Bir hafta önce

D : Peki, normal yani ... Bir de ben boğazınıza bir ilaç süreceğim, yumuşatmak amacıyla... Yani, şimdi, tabii faranjit var ve bu müzmin faranjit; dolayısıyla bu biraz arkadaş olacak sizle... Şimdi, bu hastalık bazı şeylere dikkat edilince daha az şikayet yapar. İşte, söylediğim şeyler... sıcak, soğuk yiyecekler.

P : Daha öncesine kadar faranjitim vardı ama, bu derece birşey olmadı, hocam

D : Tamam tetkikleriniz yapılacak.

4.7.6.3.1. Analysis of Case 3

In Case 3, the doctor tries to get information on the patient's problem, which is the patient's experience focused on her; thus, the doctor puts forward the question:

- Ne tür şikayetler var?

The patient reveals her thought, concerning her problem: this is the information conveyed in Edification mode:

- Kanama gibi birşey oldu.... boğazımda çatlamalar oldu sanki...

The doctor puts the patient's experience into words hence, he restates the beginning date of the problem by using Reflection mode:

D : Son bir ayda mı bunlar?

P : Evet, ama son bir ayda hassaslaştı belki. Radioktif hastalar çoğaldı.

D : Evet ... Yani ondan sonra oldu diyorsunuz?

Hence, the doctor expresses the patient's experience in her frame of reference, he does not use the patient's words, he uses second person plural, suffix with the verb "demek" which is the characteristic of Reflection mode.

Then, the patient gives the objective information in declarative and 3rd person singular form :

- Ondan sonra, daha belirgin oldu.

The patient's statement is in Edification mode, it concerns the patient's experience in the doctor's frame of reference and it is focused on her.

To the doctor's question :

- Daha önce hissetmiyordunuz?

the patient's answer is in Reflection and Disclosure modes :

- Daha önce hissetmiyordum; kokusunu hissettim; İyot kokusunu hissettim yani. Yani boğazımda iyot kokusunu hissettim.

The repetitions are identified in Disclosure mode, as they are the patient's experince, in her frame of reference, they do not necessarily presume knowledge of the doctor, and they are all first person singular in "hissettim".

The doctor's questions :

- Peki, şikayet olarak ne yapıyor? Boğazda ağrı yapıyor mu?
- Dilde acıma, boğazda acıma...?
- Peki boğazda yanma, kuruma şikayetleri oluyor mu?
- Boğazda bir şey takılma hissi yaratıyor mu?
- Daha önceden bu tür şikayetleriniz var mıydı?

- Öksürük gıcık tarzında, veya balgamlı öksürük?
- Arka arkaya öksürüyor musunuz ?
- Şikayetler, sabah yataktan kalkıyorsunuz, ... sabah daha çok mu oluyor, yoksa gün içerisinde mi?
- Yiyeceklerden etkileniyor musunuz? Asitli yiyeceklerden limon gibi?

aim at gathering information from the patient. Thus, the doctor attempts to fill gap in the patient's frame of reference with the information supplied by the patient.

The patient's answers to these questions are either in Edification mode, which concerns the patient's experience, focused on the doctor, such as:

- İki yanda sürekli acıma ; dilimde sürekli acıma var.
- Bu hafta sonunda biraz düzeldi o şikayetlerim ama yine acıma oluyor.
- .....şu anda da acıma var.
- Acıdan çok (etkiyeniyor).

or in Disclosure mode which reveal her own internal experiences :

- Kuruma hissediyorum; Ihh yapma ihtiyacı duyuyorum.
- Evet, bir dolgunluk hissediyorum.
- Şeyim var ... Faranjitim.
- .... hep böyle boğazımda ki o şeyi hissediyorum.
- Sürekli, sürekli hissediyorum.

During the physical examination, the doctor by using imperatives, indicates the patient what she is suppossed to do. Then, he tries to examine the different states of her throat, he uses Edification mode and states the objective information :

- Boğazınızda kızarıklık var; hafif faranjit durumu var...

Then, he interprets the situation as :

- ...Bu eski de olabilir... veyahut eski faranjitinizin üzerine o tahriş edici duman ile de şikayetleriniz artmış olabilir...

Hence, the judgements of the patient's experience can be scored as interpretation. The interpretation form is second person (şikayetleriniz) used with

the verb "artmak" that describes a condition.

The patient reveals her feeling by using Edification mode :

- Mesela sigara dumanı... Şimdi çok etkiliyor.

The doctor agrees with her, that is, the patient's experience in the doctor's frame of reference is focused on the patient, by which the doctor expresses the objective information, in declarative form in Edification mode :

- Etkiler... Yani sıcak, soğuk yiyecekler, dumanlı hava etkiler,

In the conclusion segment, the doctor presumes to express what the patient has to do by giving his view on the situation (frame of reference); thus, the doctor in Advisement mode, attempts to impose his patient's experience by guiding her behavior; he advises the patient as :

- Sinus filmi çektirmeniz lazım;

and, in Edification form he states the objective information as:

- O film gelsin, ayrıca sinus ile ilgili şikayetler varsa, ayrıca onları da tedavi etmek lazım, çünkü o genze doğru akıntı, şikayetlerinizi arttırır.

In the last segment, he again continues in Edification form as :

- ..... bu müzmin faranjit; dolayısıyla bu biraz arkadaş olacak sizinle... Şimdi, bu hastalık bazı şeylere dikkat edilince daha az şikayet yapar.

However, the patient in Confirmation mode utters that she had faranjitis before, but she expresses the dissimilarity as :

- Daha öncesine kadar faranjitim vardı ama, bu derece birşey olmadı, hocam.

That is, she compares the present situation with that of the one before. Thus, the expressions of joint thought, agreement or disagreement are the characteristic usuage of Confirmation mode: the patient presumes knowledge of the doctor's frame of reference in order to make a comparison.

4.7.6.3.2. The Results of Case 3

In Case 3, the patient graduated from a Technical College, she works in the University Hospital. She is 30 years old.

The physician's questions are aimed at gathering more information about her problem. Her answers either gave the objective information on her problem or included the subjective information, concerning her feelings. Both of the parties used Reflection mode in order to express the addressee's experience which is compatible with the addressee's view. The patient expressed her concerns and worries in detail, and in return, she was able to get information from the doctor. The doctor stated his judgements in Interpretation mode. Also the patient with her communicative style used her verbal resources in order to exert control over the physician's behavior, and also to be in the same line with the physician, she used Confirmation mode. This mode is used by the patient in order to presume a common frame of reference in order to compare her own experience with that of the doctor.

4.7.6.4. Evaluation of Results of Group 1 : Educated Patients

Group 1 consists of educated patients. It has been observed that educated patients express more concerns and worries which, in return, influence the doctors' informativeness. Doctors are more interpersonally engaged with and provided more opinions to patients who are more affectively expressive as a result of their education; this is due to the patient's communicative style which includes the factors such as asking questions, opinion-giving and affective expressiveness. Hence, as Street (1991) emphasizes patient's expressiveness and assertiveness may influence doctor's informativeness in two aspects: first, the goal of patients and doctors is to help the patient, therefore the doctor is inclined to respond informatively to the patient's concern in order to reassure the patient, to alleviate the patient's uncertainty or to offer an opinion or evidence that supports, rejects or clarifies the patient's perspective; secondly, by expressing emotions, concerns and opinions the patient is providing a topical content for the doctor's subsequent utterance, which results in informativess of the doctor.

Furthermore, in this group, Presentational strategies used by the doctors in decision-making process has been observed. This is in line with Fisher's (1982:60) approach which states that presentational strategies provide information about a treatment opinion. As a result, physician's informativeness is influenced by patients' communicative style which elicits the information from the doctor.

4.7.7. Analyses of Group 2 : Less Educated Patients

4.7.7.1. Case 1

a) History taking

P : Ayağım mosmor oldu, şişti.
D : Daha önce çarpma, burkma oldu mu?
P : Ayağımı çarpmıştım.
D : Hım...
P : Ayağım şişti, böyle felaket bir şekilde. Ayağımı hareket ettirememiştim. Devlet Hastanesine müracaat ettim, ortopedisine... Orada bana yanlış tedavi uyguladılar.
D : Yanlış tedavi? Ne yaptılar sana?
P : Kemiğinde iltihap var dediler. İğne verdiler.
D : Hım...
P : İğne verdiler, iğneyi vurdururken, bana iğne yapan ayağıma baktı, bana ayağımın birşey hissetmediğini söyledi ve doktoru çağırdı. O da buraya gönderdi hemen.
D : Hım...
P : Doctor da kalp damar şeyine gönderdi.
D : Hım... Bacağın şişip duruyor mu?
P : Evet.
D : Öbür bacağında bir şey var mı?
P : Hayır; ötekinde bir şey yok, sadece sağ ayağımda.
D : Hım ... Sağ ayağında ... Ne kadar oldu? Bir sene mi oldu?
P : 1 yıl

b) Physical examination

D : Bir yat, ayaklarını aç bakalım, ikisini de. (to another doctor) Bir masküler yetersizlik, travma sonrası çok görülür... Hasta daha önce bize muayene olmadığı için kemik yapıda bir şey var mı yok mu...? Bir onu görüp, ondan sonra damarda tıkanıklık var mı, ilaçlar doğrultusunda... Bir yıllık olay olduğu için artık ...

c) Conclusion Segment

D : Kalk bakalım, sana yazdıklarımı gidip yaptıracaksın, tamam mı? Sonra getirirsin, biz bakarız.

4.7.7.1.1. Analysis of Case 1

Case 1 takes place in the orthopedi policlinic. The patient is a young girl; she had her education till the secondary school, and she doesn't come from a wealthy family.

During the history taking period, the patient utters her experience as :

- Ayağım mosmor oldu, şişti.

in Edification mode, this is her experience, in the doctor's frame of reference and focused on the patient. She gives the information to the doctor. The doctor tries to get the background information of the problem by asking :

- Daha önce çarpma, burkma oldu mu?

Then, in Disclosure form, the patient reveals her experience in her frame of reference, which is focused on the doctor :

- Ayağımı çarpmıştım.

The doctor acknowledges the information as "Hımm" that is, he does not convey his own viewpoint. The patient continues giving information in Edification and Disclosure modes :

- Ayağım şişti, böyle felaket bir şekilde.

This is her objective information, then in Disclosue mode she says :

- Ayağımı hareket ettirememiştim. Devlet hastahanesine müracaat ettim. Orada bana yanlış tedavi uyguladılar.

The doctor repearts the last phrase :

- Yanlış tedavi?

and then asks what happened to her.

The patient utters the other doctor's diagnosis in Edification mode :

- Kemiğinde iltihap var dediler. İğne verdiler.

Of course this statement need not be true from the diagnostic point of view, but the people near her can ascertain what the doctor had told. Hence, she continues on giving background information, in Edification mode by using 3rd person form :

- İğne verdiler, iğneyi vurdururken, bana iğne yapan ayağıma baktı, bana ayağımın birşey hissetmediğini söyledi ve doktoru çağırdı. O da buraya gönderdi hemen.

The doctor acknowledges the situation by uttering :

- Hım...

The patient continues in Edification mode :

- Doctor da kalp damar şeyine gönderdi.

The doctor still acknowledges the situation as "Hım..."

Then, he questions as :

- Bacağın şişip duruyor mu?
- Öbür bacağında bir şey var mı?

The patient's answer is in Edification form :

- Hayır; ötekinde bir şey yok, sadece sağ ayağımda.

The doctor again acknowledges the situation with : "Hım ..." and repeats the statement :

- Sağ ayağında ...

and questions her as :

- Ne kadar oldu? Bir sene mi oldu?

During the physical examination, the doctor gives commands in imperative form :

- Bir yat, ayaklarını aç.

Then, he turns to his research assistant and explains the symptoms; this explanation does not concern the patient, and he speaks in a way that the patient will be unable to follow.

The conclusion segment is short. The doctor tells her to get up :

- Kalk bakalım, ...

then, tells her what he wants to be done :

- Sana yazdıklarımı, gidip yaptıracaksın.

The advisement segment is directed to the doctor's experience in his frame of reference, but it is focused on the patient. In order to diagnose her problem the instructions are to be completed by the patient.

4.7.7.1.2. The Results of Case 1

In Case 1, the patient, in the orthopedi policlinic, is 20 years old, she had her education till the secondary school. She tells her story in Edification and Disclosure modes. Few questions are asked by the doctor. While she was stating her story the doctor acknowledged her with "hımms".

She didn't ask questions, didn't express concerns or worries, or offer opinions. The only thing she said is the problem and the history of it. In return, the doctor does not offer her any explanation or interpretation, he talks with his colleague, and explains what he thinks about her problem. Thus, neither Presentational nor Persuasional Strategy is used by the doctor. The doctor was not informative.

4.7.7.2. Case 2

a) Medical History

D : Ne şikayetin var?
P : Buramda şişlik var. Ağrı var.
D : Ne zaman ameliyat oldun?
P : 92'de oldum, 6 ay ilaç kullandım.
D : O zamanda bu şişlik için mi oldun, yoksa ağrı filan mı vardı?
P : Ağrı falan vardı.
D : Ameliyattan sonra ağrılar azaldı mı, kesildi mi?
P : Kesilmedi.
D : Kesilmedi... Ağrı aynen devam ediyor. Ameliyatda bir değişiklik olmadı di mi?
P : Evet.
D : Fonksiyonda ne çıktı? Fonksiyon yapıldığı zaman cerahatli bir sıvı geldi mi? Beyaz bir su gibi sıvı? Hatırlıyor musun ?
P : Hayır.
D : Koku oluyor mu?
P : Hayır.
D : Her zaman mı oluyor bu, yoksa soğuk havalarda mı?
P : Her zaman.
D : Her zaman... Yazın, ilkbahar aylarında filan bir artış gösteriyor mu?
P : Hayır.
D : Veyahut arka arkaya bir aksırık filan?
P : Hayır.

D : Gözlerinde yaşarma filan?

P : Gözlerimde ağrı oluyor bazen; şu kaşımın kısımlarında.

b) Physical examination

During the physical examination, the doctor explains the things he sees to his research assistant:

- Arkada röleve olmuş. Aspiratöre de geliyor... Operasyondan ötürü de olabilir. Aspiratörle tekrar aspire edelim. Et kalmış. Şöyle...

D : Hiç kanama olmuyor değil mi?

P : Yok.

D : Tam aspiratöre geliyor.

D1 : Konka?

D : Hayır. Konka biraz üstte var. Aspiratöre geliyor. Konka şurası... Konkanın arka ucunda ve alt kenarında arka ucuna yakın yerden çıkan bir problemli kitle var. Aspiratöre geliyor; görüyor musun?

D1 : Evet görüyorum.

D : Şeyini takta... Daha sonra bak.

D : Akıntı oluyor mu?

P : Mideme doğru.

D : Bu, öksürük yapıyor mu? Onu nasıl hissediyorsun... akıntı olduğunu? Böyle çekmek zorunda mı kalıyorsun?

P : Evet, bazen.

D : Tıkanıklık oluyor mu çok?

P : Evet, bazen.

D : Pekii... bu tıkanıklık bir sağa, bir sola geçme durumu oluyor mu? Yoksa hep aynı tarafta mı?

P : Oluyor. Bir sağa, bir sola... Yatakta mesela sağ tarafa yatarsam, sağda oluyor.

D : Post farenkste yer kaplıyan bir kitle yok, puanalar açık görünüyor, ama bol miktarda pürünel akıntı... Bayaa ödemli bir mukaza var. Sol tarafta ise, burun gerisinde oldukça bol pürünel akıntı var.

D1 : Bunu neyle alalım?

D : (to the patient) - Nefes al, tut!

D1 : Bu ayrı birşey değil mi?

D : Nasıl? Alt konka ile bağlantılı görünüyor. Ordaki mükoza bir brülez yapı kazanmış olabilir.

D1 : Evet

D : Yani aspiratörle de konkaya bağlı gibi gözüküyor. Sağla sol arasında fark var mı?

D1 : Civarı görünüyor. Ordakiler yeter mi?

D : Yeter.

D : (to the patient)- Şimdi ben yap deyince, burnunu tıkayacaksın, yutkunacaksın.

P : .....

D : Yap! Bi daha ... Bir basınç geliyor mu bu şekilde yutkunduğunda filan?

P : Hayır.

c) Conclusion Segment

D : Peki, kalk bakalım!

D-D1: Bir fibröz diskleri filan olabilir. Ama o en son düşünülebilir; biopsi yapalım.

4.7.7.2.1. Analysis of Case 2

Case 2 is in the policlinic of Ear- Throat and Nose Department; the patient is a technician, a young man. The doctor responsible, is with his assistant, as it is obvious from the dialogues, in various states of the interview, the doctor addresses to his assitant either to show the patient's state, or to give information on the peculiar situation of the patient. In order to get the detailed information, during the medical history taking, the doctor asks the patient various questions. These questions concern the patient's problem, in the doctor's frame of reference and they are focused on the doctor, because it is the doctor who directs the questions :

- Ne şikayetin var?
- Ne zaman ameliyat oldun?
- O zamanda bu şişlik için mi oldun, yoksa ağrı filan mı vardı?
- Ameliyattan sonra ağrılar azaldı mı kesildi mi?
- Ameliyatda bir değişiklik olmadı di mi?
- Fonksiyon da ne çıktı? Fonksiyon yapıldığı zaman cerrahatli bir sıvı geldi mi? Beyaz bir su gibi sıvı? Hatırlıyor musun ?
- Koku oluyor mu?
- Her zaman mı oluyor bu, yoksa soğuk havalarda mı?
- ... Yazın, ilkbahar aylarında filan bir artış gösteriyor mu?
- Veyahut arka arkaya bir aksırık filan?
- Gözlerinde yaşarma filan?

The patient's answers to these questions are in Edification mode. These answers are in the patient's frame of reference, and they are focused on the doctor :

- Buramda şişlik var. Ağrı var.
- 92'de oldum.
- Ağrı falan vardı.
- Kesilmedi.
- Evet.
- Hayır.
- Hayır.
- Her zaman.
- Hayır.
- Hayır.
- Gözlerimde ağrı oluyor bazen; şu kaşımın kısımlarında.

However, during the medical history taking period the usage of Reflection mode by the doctor is observed :

D : Ameliyattan sonra ağrılar azaldı mı kesildi mi?

P : Kesilmedi.

D : Kesilmedi... ağrı aynen devam ediyor.

or :

D : Her zaman mı oluyor bu, yoksa soğuk havalarda mı?
P : Her zaman
D : Her zaman... Yazın, ilkbahar.....

The use of Reflection mode expresses the patient's experience in his frame of reference, and focused on the patient. Thus, the doctor presumes knowledge of the patient's experience and frame of reference and uses the patient's words; that is, it is the patient's internal experience which the patient is presumed to be aware of.

During the physical examination, most of the dialogues belong to two doctors. Very few questions are asked to the patient. Hence, the doctor attemps to get more information while he is examining him.

D : Hiç kanama olmuyor değil mi?
P : Yok.
D : Akıntı oluyor mu?
P : Mideme doğru.
D : Bu, öksürük yapıyor mu? Onu nasıl hissediyorsun... akıntı olduğunu? Böyle çekmek zorunda mı kalıyorsun?
P : Evet, bazen.
D : Tıkanıklık oluyor mu çok?
P : Evet, bazen.
D : ... bu tıkanıklık bir sağa, bir sola geçme durumu oluyor mu? Yoksa hep aynı tarafta mı?
P : Oluyor. Bir sağa, bir sola... yatakta mesela sağ tarafa yatarsam, sağda oluyor.
D : ... bir basınç geliyor mu, bu şekilde yutkunduğunda filan?
P : Hayır.

Hence, the patient's answers are all in Edification mode. The answers convey the information that the doctor seeks. Thus, the patient tells his experiences in the doctor's frame of reference, which is focused on him.

In the conclusion segment of the medical interview, no results are told to the patient, as was seen in other medical interviews. The results are discussed between the two doctors, and the patient was told to get up.

4.7.7.2.2. The Results of Case 2

In case 2 the patient is 19 years old. He didn't complete the high school. Various questions are asked by the doctor, by using questioning strategies in order to reproduce talk and to gain information. The patient answered them mostly in Yes / No forms, in Edification mode.

The doctor, on the other hand, did not use any Presentational strategy, as it was not demanded by the patient. However, the doctor with his assistant used their specialized language that is technical register while examining the patient.

As a result, no concerns, no worries are presented by the patient that would bring to light his communicative style, and that would influence the doctor's informativeness.

4.7.7.3. Case 3

a) Medical history

D : Ne şikayetiniz var?

P : İki gündür sırtım... bi de kolumun şurasına kadar sızlıyor, inliyorum. Yani, iki gündür ben, rahat nefes bile alamıyorum.

D : Sağ kol ve sırtınızda ağrı var, öyle mi?

P : Sırtım şuraya kadar, ağrım var.

D : Ezilme, soğuk alma, çarpılma gibi birşey oldu mu?

P : Evvelki gün bahçede, gül ağacının dibini açayım dedim, bi terledim... Ondan olabilir. Bi de sigara kullanıyorum, damar tıkanıklığı filan olmasın diye ondan korkuyorum...

D : Kolunuzdan bir şikayetiniz var mı daha önce?

P : Hayır, yoktu.

D : Yoktu.

P : Hasta da olmam doktor bey öyle, maşallah! Bu bayaa bana ağır geldi...

D : Böyle bir kasılma filan oldu mu hiç?

P : Hayır.

D : Böyle bir çekilme, kasılma?

P : Oluyor ama, şimdi de oluyor.

D : Şimdi ilk defa oluyor. Biz bir bakalım. Filmlerinizi isteriz de, bu arada beyin cerrahlarının görmesini isteriz. Film çektirdikten sonra, bi de beyin cerrahlarına gösterin. Ondan sonra tekrar bize gelin. Kaç gündür ağrı?

P : İki gündür.

D : Düşme, çarpma v.s. yok?

P : Hayır, hayır. Doktor bey, beyinle şeyin, kusuruma bakmayın...?

D : Boyun ağrıları, genelde bizden ziyade beyin cerahlarının ilgilendiği bir yer. Yani, biz boyundan aşağı fermorlarla ilgileniyoruz.

P : Şöyle yaptığım zaman, kusura bakmayın, bir rahatlama gibi oluyor. Kolumu şöyle yapıp, gerdiğim zaman rahatlama oluyor.

D : Tahmin ettiğimiz gibi, kaslarda bir spazmınız var da... Yine de bir şey atlamayalım diye... Boyun filmlerinizi gösterirsiniz onlara...

b) Physical Examination

D : Üstünüzü çıkarın... Açın omuzlarınızı.

P : Şurda , şuralarımda, şu bölge...

D : Şöyle bi ellerinizi sıkın, kuvvetli. Güzel! Şöyle... Ben aşağıya doğru bastıracam, siz bastırmayın. Yukarı kaldırın. Resmiyetiniz var mı?

P : Eşim.

D : Kendinize doğru çekin. Uyuşma, karıncalanma filan oluyor mu?

P : Hayır.

D : Boyunda şiddetli bir ağrı var mı?

P : Sızlıyor. Bilmiyorum. Bu güne kadar görmedim hastalık; sızlıyor...

c) Conclusion segment

D : Film çektireceksiniz, oldu mu?

P : Tamam doktor bey!

4.7.7.3.1. Analysis of Case 3

In Case 3, the patient is a housewife, and the case takes place in the orthopedi policlinic.

The doctor is concerned with the patient's problem, and he wants to know what kind of suffering she has:

- Ne şikayetiniz var?

The patient, in Disclosure mode states her problem from her own point of view:

- İki gündür sırtım... bi de kolumun şurasına kadar sızlıyor, inliyorum. ..... rahat nefes bile alamıyorum.

The doctor tries to fill the gap, with the information supplied by the patient :

- Sağ kol ve sırtınızda ağrı var, öyle mi?

The patient shows the problematic part by using Disclosure mode :

- Sırtım şuraya kadar. Ağrım var.

Then, the doctor questions her in order to obtain detailed answers :

- Ezilme, soğuk alma, çarpılma gibi birşey oldu mu?
- Kolunuzdan bir şikayetiniz var mı daha önce?
- Böyle bir kasılma filan oldu mu hiç?
- Böyle bir çekilme, kasılma?

The patient's answer to the first question is in Disclosure mode, that is, she tells her personal experience, which she thought would be the cause of the problem.

- Evvelki gün bahçede, ... açayım dedim, bi terledim..... Bi de sigara kullanıyorum....

To the second question, she answers very briefly. Before the other question was put forward the patient in Disçlosure mode, talks about her internal experience:

- Hasta da olmam doktor bey öyle, ...

The answers for the other 2 questions are brief which state the objective information in Edification mode :

- Hayır
- Oluyor ama, şimdi de oluyor.

Then, the doctor repeats the patient's words in his frame of reference, focused on him again, thus Reflection mode is used :

- Şimdi ilk defa oluyor.

His other utterances are in Disclosure mode, as he explains some future procedures that she is going to achieve; in his frame of reference, which is focused on the patient:

- Filmlerinizi isteriz de, bu arada beyin cerrahlarının görmesini isteriz.

The questions of the doctor continues, the patient answers them briefly, but the patient is in need of explaining the problem according to Disclosue mode, that is, she tries to reveal her own internal expriences :

- Şöyle yaptığım zaman, kusura bakmayın, bir rahatlama gibi oluyor.....

During the physical examination, the doctor tries to diagnose her state by asking her various questions :

- .....Uyuşma, karıncalanma filan oluyor mu?
- Boyunda şiddetli bir ağrı var mı?

On the other hand, the patient tries to give objective information, as such :

- Hayır.

or :

- Sızlıyor.

but she adds to her utterance her own experience about her life, in Disclosure mode :

- ..... Bu güne kadar görmedim hastalık; sızlıyor...

The conclusion segment of the interview, finishes in Advisement mode, it is in imperative form:

- Film çektireceksiniz.

Then, in order to convey reception to communication from the patient he says :

- .....oldu mu?

Thus, the Acknowledgement mode concerns the patient's experience, in her frame of reference, but it is focused on the doctor.

4.7.7.3.2. The Results of Case 3

In Case 3; the patient is housewife; she had her education till the seconday school; she is 35 years old.

The doctor questioned her, in order to gain information which only the patient could supply. The answers are either in Disclosure or Edification mode. However, the patient is quite talkative. She expressed her worries and concerns, although they were not asked. In return, the doctor is not much concerned with her worries. What is important for him, is to get the right answers, by eliminating her thoughts. He only used the Presentatitional strategy about the Brain Surgery and explained the purpose of sending her to this department, after it is being asked by her. As a result, the patient, did not ask questions, the doctor kept his place as a dominant interactant, and sometimes interrupted the patient.

4.7.7.4. Evaluation of The Results of Group 2 : Less-Educated Patients

It has been observed that, during the interviews of less-educated patients, doctor is in a position to determine the form of the interaction. This means that, during the encounters, the physician guides the patient, i.e., he initiates the talk and controls the encounter, and the patient is in a subordinate position as the doctor is the one who changes topics (Fielding & Evered 1980:52).

Furthermore, as Waitzkin (1985, c.in., Street 1991) observed physicians tend to overestimate the amount of information they give patients and underestimate the patient's desire for information and give varying amounts of information in response to the patient's education. Thus, the doctor is in a dominant place, in that it is his choice either to give information to the patient or not. This means that, a physician's interaction with a patient is in part a function of how the doctor chooses to communicate, and in part a function of what the patient allows the doctor to do (Street 1991:542). Hence, as patients who are not engageed in topic development or contribute to turn-taking do not exert control over the physician's behavior and do not receive much information. This fact is due to the patient's education. Communicative style of less-educated patients is not high, therefore status differences are seen, which limit the patient's question-asking, expressing worries and concerns to the doctor.

4.7.8. Analyses of Group 3 : Uneducated Patients

4.7.8.1. Case 1

a) Medical History

D : Neyin var?
P : Ağrılarım var.
D : Sabahları tutukluk oluyor mu?
P : Oluyor.

b) Physical Examination

D : Tansiyonun iyi, peklik var mı? Hep kabızlık var mı?

P : Hep var.

D : Var! Sen safra kesesi ameliyatı mı oldun?

P : Yok. Karaciğerde kist ameliyatı.

D : Karaciğer kist ameliyatı oldun. Nerde oldun?

P : Devlet Hastahanesinde.

D : Otur bakalım, karnını aç. Dur bakalım... Peklik, kabızlık var da, idrarda bir sorun var mı? Ufak idrarda?

P : Yapamıyorum.

D : Ufak idrara çıkamıyorsun. Büyük idrara mı, küçük idrara mı?

P : Çıkamıyorum.

D : İkisi de? Öksür!

P : Öhö, öhö.

D : Ağrın var mı?

P : Hayır.

c) Conclusion Segment

D : Pekii. Bu peklik için bol sıvı ve sebze yemeği yiyeceksin. Hap vereceğim, onu kullanacaksın. Dinlemekle öyle akciğerinde filan fazla bir şey yok. Öksürük var mı?

P : Azıcık var.

D : Kalp grafisi olmadan bir şey diyemem, ama yalnız kalbinde fazla bir şey yok. Hap yazıyorum, günde iki defa yut. Öksürük şurubu yazıyorum. Kilo ver biraz. Kilo... Ekmeği çok yeme, tuzlu yeme, olmaz mı?

4.7.8.1.1. Analysis of Case 1

Case 1, is recorded in the village; the patient is a villager.

During the medical history, the doctor asks the patient what problem she has.

- Neyin var?

The patient's answer is in Disclosure mode :

- Ağrılarım var.

It is her own information, by which she states her problem.

Hence, the doctor in order to get more detail, asks :

- Sabahları tutukluk oluyor mu?

The patient's answer is in Edification, that is, the experience conveyed is the information held by the patient and no presumption regarding the doctor's viewpoint is necessary, hence the focus is on the patient.

- Oluyor.

In the physical examination segment, the doctor examines the patient, and at the same time he questions her, after he has stated her blood pressure in Edification mode:

- Tansiyonun iyi. Peklik var mı? Hep kabızlık var mı?

He continues his questions while he is examining her in a way to fill the gap in his own frame of reference, with the information supplied by the patient :

- ..... Sen safra kesesi ameliyatı mı oldun?
- Karaciğer kist ameliyati oldun. Nerde oldun?
- Peklik, kabızlık var da, idrarda bir sorun var mı? Ufak idrarda?
- Büyük idrara mı, küçük idrara mı?
- Ağrın var mı?

While he is gathering the answers, he also uses Reflection mode, as :

- Ufak idrara çıkamıyorsun.

or :

- Karaciğer kist ameliyatı oldun.

By this mode, the doctor expresses the patient's experience, in order to presume knowledge of the patient's experience and frame of reference.

On the other hand, the patient either answers in the Edification or Disclosure mode :

- Yok. Karaciğerde kist ameliyatı. (Edification)
- Devlet Hastahanesinde (Edification)
- Yapamıyorum. (Disclosure)
- Çıkamıyorum. (Disclosure)
- Hayır. (Edification)

In the conclusion segment the doctor acknowledges the situation as :

- Pekii.....

then, continues in Advisement mode :

- ..... Bu peklik için bol sıvı ve sebze yemeği yiyeceksin. Hap vereceğim, onu kullanacaksın.
- ..... Hap yazıyorum, günde iki defa yut. Kilo ver biraz. Ekmeği çok yeme, tuzlu yeme olmaz mı?

Thus, the doctor's experience, in his frame of reference is focused on the patient. He advises and prohibits certain things which are scored as advisement. He uses the imperative form of the verbs. Moreover, in order to be sure of his advice to be understood, he uses the rhetorical question form as Acknowledgement mode and gets no answer.

4.7.8.1.2. The Results of Case 1

In Case 1, the patient is 65 years old. She is a villager. The doctor is a specialist of Internal Diseases. To the doctor's questions, the patient's answers are in Edification and Diclosure modes. Although, she doesn't have a particular communicative style that will elicit information from the doctor, in Advisement mode, the doctor gives information on her present situation, at least on the findings of the physical examination.

The doctor thinks that she is uneducated, and because of her age she may have worries, hence he explains what she is going to do for the treatment.

4.7.8.2. Case 2

a) Medical History

D : Ne şikayetin var?
P : Hastayım doktor bey. Hiç uyuyamıyorum.
D : Bunaltı yapıyor mu?
P : Yapıyor. Hiç uyuyamıyorum, ağrılarım çok doktor bey, yürüyemiyorum.

b) Physical Examination

D : Tansiyonun yüksek. Tuzsuz ye; 20 tansiyonun. Hiç ölçtürdün mü önce?
P : Hayır.
D : Dur bakiim: fıtığın mı var senin burda?
P : Doktor bey, daha önce 4-5 kere ameliyat oldum.
D : Ne ameliyatı oldun? Hiç olmasaydın keşke, bi sürü iş açıyorsun başına... Tamam! Peki! Ağrı yapıyor mu? Bu karındaki şişlikler çok ağrı yapıyor mu? Bu sertlikler?
P : Az yapıyor.

c) Conclusion Segment

D : O zaman hiç kurcalatma sen bunu, Yaşın ileri, tansiyonun da yüksek. Tekrar ameliyat derler, olma. Böyle idare edeceksin. Tuzu kıt ye biraz. Ben ilaç yazayım, tamam mı? Peki ... hadi....

4.7.8.2.1. Analysis of Case 2

In Case 2, the patient is an old woman; the doctor questions her problem, during the medical history taking period :

- Ne şikayetin var?

The patient uses Disclosures, in order to reval her own internal experience :

- Hastayım doktor bey. Hiç uyuyamıyorum.

To the doctor's question :

- Bunaltı yapıyor mu?

the patient's answer is first in Edification mode

- Yapıyor.

then, she continues by using Disclosure :

- .....Hiç uyuyamıyorum,..... yürüyemiyorum.

During the physical examination, the doctor states the objective information on his finding :

- *Tansiyonun yüksek. ..... 20 tansiyonun.*

While examining her body, he suddenly touches something and asks as :

- Dur bakiim: fıtığın mı var senin burda?

She, in the Edification mode, gives the information which is her experience, focused on her :

- ..... 4-5 kere ameliyat oldum.

To this answer, the doctor wants to know what kind of operation she had and by using Interpretation mode he says :

- ..... Hiç olmasaydın keşke, bi sürü iş açıyorsun başına...

The frame of reference into which the doctor presumes to place the patient's experience is the doctor's personal opinion.

Then, he acknowledges her state as :

- ..... Tamam! peki!

Thus, these lexical utterances are content-free, which are used in Acknowledgement mode. He asks other questions about the fact, and the patient gives the objective information in Edification :

- Az yapıyor.

In the conclusion segment by using Advisement mode the doctor gives instructions :

- ..... hiç kurcalatma sen bunu. Yaşın ileri, tansiyonun da yüksek, tekrar ameliyat derler, olma. Böyle idare edeceksin. Tuzu kıt ye biraz. Ben ilaç yazayım, tamam mı? Peki ... Hadi....

By uttering "tamam mı?", "Peki...", "Hadi," the doctor acknowledges her, which concerns the patient's experience in her frame of reference, but the focus is on the doctor.

4.7.8.2.2. The Results of Case 2

In Case 2, the patient is 75 years old, she is a villager. The doctor who is a specialist of Internal Diseases, asks her various questions, in order to get information. Her answers are either in Disclosure mode, which state her feelings or in Edification mode which include objective information about her problem. The doctor acknowledges her state, and interprets the situation in simple words, so that

she can understand him, such as : "..... kurcalatma sen bunu" or "Tuzu kıt ye biraz." Thus, although information is not demanded by the patient, the doctor tries to explain his findings to her.

4.7.8.3. Case 3

a) Medical History

D : Ne derdin var?
P : Kulağım pek ağrır.
D : Ne zamandan beri?
P : Birbuçuk ay filan oldu.

b) Physical Examination

D : Çıkar başındakini. Dur bakiim!
P : Gözlerim görmüyo. Ameliyat oldum gençliğimde.
D : Bu akıyor.
P : Akıyor.
D : Ne zamandan beri akar?
P : Çoktan akar.
D : Ne zaman 'çoktan' dediğin? Kaç sene oldu?
P : 4-5 sene oldu.
D : Pekii... 4-5 sene oldu. Peki... su kaçırıyor musun?
P : Hayır.

c) Conclusion segment

D : Hiç su kaçırmayacaksın, olur mu? Banyoya girerken "Vaselin" merhemi diye bir merhem var. Ondan süreceksin. Dikkatli sür ki su kaçmasın, Banyodan sonra çıkar. Burnuna da tuzlu su çekeceksin. İlaç verecem sana, onu da kullan olur mu?

4.7.8.3.1. Analysis of Case 3

In the medical history taking, the doctor's questions aim at gathering information from the patient :

- Ne derdin var?
- Ne zamandan beri?

The patient's answers state the objective information, in Edification mode:

- Kulağım pek ağrır.
- Birbuçuk ay filan oldu.

After the physical examination, the patient states the problem on her eyes, in Edification mode; this is the objective information; the truth of which can be ascertained :

- Gözlerim görmüyor.

and in Disclosure mode, he gives her past experience :

- ..... Ameliyat oldum gençliğimde.

The doctor states what he found during the physical examination, as an objective information in Edification :

- Bu akıyor.

Then, he asks questions in order to take detailed information :

- ..... Ne zamandan beri akar?
- Ne zaman 'çoktan' dediğin? Kaç sene oldu?

The patient gives objective information as answers, which concerns her experience, in the doctor's frame of reference, and is focused on her :

- Akıyor.
- Çoktan akar.
- 4-5 sene oldu.

Then, the doctor acknowledges the situation as :

- Pekii...

and repeats the patient's answer in Reflection mode which expresses the patient's experience :

- .....4-5 sene oldu.

Then, asks her as :

- ..... su kaçırıyor musun?

In the conclusion segment, the doctor advises her in Advisement mode :

- Hiç su kaçırmayacaksın, oldu mu?

Thus, the doctor's advice concerns his experience, i.e. in his frame of reference, but it is focused on the patient. Then, he offers explanation to the patient in Interpretation mode :

- .....Banyoya girerken "Vaselin" merhemi diye bir merhem var, ondan süreceksin. Dikkatli sür ki su kaçmasın.

His last utterances correspond to Advisement mode :

- Banyodan sonra çıkar. Burnuna da tuzlu su çekeceksin. İlaç verecem sana, onu da kullan, olur mu?

4.7.8.3.2. The Results of Case 3

In Case 3, the patient is 80 years old. She is a villager. The doctor is the speacialist of Ear-Nose-Throat. She answers the doctor's questions mostly in Edification mode.

After the physical examination, the doctor tells her how to use the prescribed medicine by giving instructions in detail. On the part of the patient, no information is demanded. But, the doctor is obliged to explain certain things to her othewise, as she is old and uneducated, she may misperceive how to use it.

4.7.8.4. Evaluation of The Results of Group 3 : Uneducated Patients

The doctors of Group 3, are members of Lions Club. The aim of the Medical Scanning activity is to serve the villagers who are in need of health care. Therefore, the doctors, who do not demand any money from this activity, are conscious of the patients' illiteracy. From this point of view, in order to be helpful, they try to explain briefly either the steps of the treatment or their health problem.

On the other hand, patients listen in silence, as Waitzkin (1985; c.in. Street et.al. 1991:542) states, uneducated patients are not particularly interested in learning about health; what is important for them is the miraculous medicine that will put an end to their pain or suffering. As a result, no coordination for topic development is observed because, patients do not have the verbal resources to exert considerable control over the physician's behavior. In all the cases, doctors had control on communication content which is in line with Todd's view (1989: c.in. Street et.al. 1991:542) which states that in most instances, physicians are clearly the more dominant interactant who initiate most of the topics of the consultation, if patients do not have verbal styles.

4.7.9. Analyses of Group 4 : Hospitalized Patients

4.7.9.1. Case 1

D : Günaydın! Nasılsınız?
P : Sağol!
D1 : Bugün 4. gün; 3-4 siporis akıntısı var.
D : Dolaşıyor musunuz? Geziyor musunuz?
P : .....
D : Sondası açık mı?
D1 : Açık, geliyor.
D : Dolaşıyor mu? Rahat değil mi?
D1 : Dolaşıyor, rahat.
D : Yarın gönderelim sizi .....
P : .....

4.7.9.1.1. Analysis of Case 1

Case 1 takes place in the Urology ward. The doctors are in their daily raunds. The patient has been hospitalized for some time.

The doctor, in Acknowledgement mode salutes the patient; this mode conveys reception to communication :

- Günaydın! nasılsınız?

The patient is not in the mood of receptiveness thus, he only utters :

- Sağol!

This utterance of the patient is in a contentless mode, in the sense that he does not convey his own viewpoint hence, it corresponds to Acknowledgement mode. The rest of the dialogue is between D and D1, thus the patient is excluded.

4.7.9.1.2. The Results of Case 1

In case 1 the patient is 55 years old, he was operated on four days ago. The doctor (D), who is a professor, is visiting the patient with his assistant (D1). He salutes him and asks how he feels, in order to be informed about his state. The patient does not bother to answer him. Then, his condition is discussed between the two doctors. However, also the professor is not in need of gathering information from the patient, as his assistant and the patient's chart explain everything. Hence, a complete communication gap between the doctors and the patient is observable.

4.7.9.2. Case 2

D : Raşit Bey, Günaydın!
P : Günaydın, Allah razı olsun, sağol!
D : Sondası açık geliyor, hemoglobini normal. İdrar kültüründe bir şey çıktı mı?
D1 : Çıkmadı.
D : Nasıl hissediyorsunuz kendinizi? Çocuklar geliyor, değil mi?

P : Geliyor.

D1 : Geçmiş olsun!

4.7.9.2.1. Analysis of Case 2

In Case 2, the doctor greets him, when he is in front of the patient's bed. The doctor uses the Acknowledgement mode, also by addressing the patient by his name:

- Raşit Bey, Günaydın!

Thus, the use of his name and the salutation convey receptiveness to the patient's communication which can be classified as Acknowledgement.

Hence, the patient's answer is also in the Acknowledgement mode, as he receives the doctor's salutation.

- Günaydın, Allah razı olsun, sağol!

and he adds also other Acknowledgements which are content-free lexical utterances, such as :

- Günaydın, Allah razı olsun, sağol!

D, after taking the medical information from D1 about hes state asks him how he feels and whether his children are coming :

- Nasıl hissediyorsunuz kendinizi? Çocuklar geliyor, değil mi?

This question about the children is asked in order to make the patient feel better and to make the patient feel that the doctor considers him, even his family problems. The patient simply answers as :

- Geliyor.

By this answer he gives, the focus is on the speaker i.e., he answered in Edification mode, what the doctor asked.

Then, the doctor, during his leave-taking, uses again Acknowledgement mode:

- Geçmiş olsun!

Thus, this utterance, in the form of greeting is uttered by the doctor in the sense that he does not convey information or does not presume knowledge of the patient's frame of reference or experience.

4.7.9.2.2. The Results of Case 2

In Case 2, the patient is in urology ward, he is 60 years old. The doctor greets him by using his name and asks how he feels. The patient does not ask any question, that is, he does not demand any information, and the doctor's questions were formal. The doctor's assistant informed him on the present state of the patient, by using their register, that is, the technical language.

Thus, from the view point of information-giving process, no information has been exchanged concerning the patient.

4.7.9.3. Case 3

D1 : Cumartesi günü gözlerinde, dudaklarında ve kulaklarında şişmesi var hastanın. Önce bir diş ağrısı başlıyor. Diş ağrısı aspirinle geçmedikten sonra gargara yapmış.

D : Diş ağrısından başka bir şikayeti yok mu?

D1 : Yok.

D : Eklemlerde filan?

D1 : Yok, hiçbir şikayeti yok. Gargara yaptıktan sonra gözlerde şişme başlıyor. Şişmeler geçmeyince Afyon'a Devlet Hastenesine gidiyor; orada tansiyon yüksek bulunuyor. Bir de ... idrar mikroskopisine dikkat çekiliyor. Buraya geldiğinde tansiyon normaldi.

D : Özgeçmişinde, soygeçmişinde bir şey var mı?

D1 : Özgeçmişinde herhangi bir özellik yok, yanlız bala ve balığa karşı alerjisi varmış.

D : Ne oluyormuş yiyince?

D1 : Kolları şişiyormuş, kaşınıyormuş.

D : Peki, bizim fizik muayenede ne var?

D1 : Bizim muayenede olumlu bulgular sadece sol lobu üzerinde 1X15 cm. lokal bir ödemi vardı geldiğinde; o hariç bi de petibel, minimal bir ödemi vardı; şu anda da yok.

D : Laboratuar?

D1 : Laboratuar bulguları, CVS'i normal, 5-6 lokosit, 5-6 epiteli vardı. İdrar kültürü aldık, normal çıktı.

D : İdrardaki proteyini kaç?

D1 : Bir positif geldi. Aso'su 250 tod, unitesi negatif. C3-C4 çalıştık, normal çıktı.

D : Tansiyon kaç?

D1 : 150. Biz pnömoni düşünmedik.

D : Ağrı var mı, yani taş yönünden?

D1 : Yok, hocam. Dışarda bir urtiker şeklinde şişmesi olunca, ürtikere bağlı... Aspirin, en son olayı maskeler, onun için aspirin kullanmaması uygun. Tansiyon sınırda, agene olarak yorumladık. Böbreklerde taşı da yok. Yalnız, mesanesi ödemli gözüküyor.

D : Adın neydi?

P : Ali.

D : Sen herhalde ortaokula gidiyorsun, yanılmıyorsam. Bi de sen anlatır mısın, yani nasıl oldu?

P : Doktorun anlattığı gibi. Cumartesi akşam dişim feci, epey ağrıyordu. Yarım aspirin koydum.

D : Bi de bacaklarında şişmeler oldu...

P : Hayır.

D1 : O, ürtiker sırasında.

D2 : Ürtiker sırasında, el bileğinde, dizinde şişmeler olmuyor?

P : Yok.

D2 : Peki, geçmiş olsun! Çok önemli bir şey olarak düşünmüyoruz. Belki çıkartırız seni.

4.7.9.3.1. Analysis of Case 3

In Case 3, most of the dyads is consisted of the medical information between D and D1. D1, after taking the necessary information on physical examination and on laboratory results asks the patient his name.

- Adın neydi?

However, in wards, the names of the patients are written in their charts. The doctor, by asking his name, tries to show sympathy for him. The patient in Edification mode, states his name:

- Ali.

The doctor continues to show personal sympathy to the patient :

- Sen herhalde ortaokula gidiyorsun, yanılmıyorsam....

Thus, she reveals her own thought; i.e., she reports her subjective perception in Disclosure mode; however, her intention is to hear his history; thus, she requests from the patient how it happened, in his own words :

- .....Bi de sen anlatır mısın, yani nasıl oldu?

The patient is not in the mood of repeating it. Hence, he affirms what D1 told her, as the information given by D1, was true :

- Doktorun anlattığı gibi.

Then, he continues to use Edification mode as :

- .....Cumartesi akşam dişim feci, epey ağrıyordu.

This utterance concerns the doctor's frame of reference but it is focused on the patient. Thus, this statement concerning his toothache is an Edification.

Then, in Disclosure mode, he states what he has done for it :

- .....Yarım aspirin koydum.

Thus, Disclosures report the speaker's subjective experiences.

D1 in Edification mode, adds to the statement of the patient :

- Bi de bacaklarında şişmeler oldu...

Hence, the fact conveyed about his legs is the information held by the doctor in Edification. However, the patient does not agree with her by stating:

- Hayır.

This is the objective information that the patient is sure of. D asks another question:

- Urtiker sırasında, el bileğinde, dizinde şişmeler olmuyor?

Again the patient answers in Edification mode as :

- Yok.

Then the doctor (D) reports their (doctors') perceptions on the subject (Disclosure mode). She uses first-person plural form, to indicate that she and her assistants are in collaboration; hence, the doctor presumes a common frame of reference; thus expressions of joint thought are scored as confirmation:

- ..... Çok önemli bir şey olarak düşünmüyoruz. Belki çıkartırız seni.

Her Ancknowledgements :

- Peki, geçmiş olsun!

require no specific presumption about the patient's experience or frame of reference.

4.7.9.3.2. The Results of Case 3

Case 3 takes place in the pediatry ward. The patient is 14 years old. While the professor was visiting him, the dialogues in front of his bed, are between the professor and his assistant. The language used between them is the technical register, and the patient is unable to follow it. To the questions of the professor the patient's breve answers are in Disclosure and Edification modes.

The patient does not tell his worries or concerns, hence he does not have a communicative style for topic development that would elicit information from the doctor.

4.7.9.4. Evaluation of Results of Group 4 : Hospitalized Patients

The results of Group 4 indicate that the communication event is fairly difficult for the hospitalized patients. Doctors in white uniform, stand in front of their beds, look at the charts and discuss the symptoms or the treatment that was applied to the patient. Hence, the language they use is a technical register which is obscure to the patient and, as a result, makes the patient feel alien to the whole evironment. The use of technical register, between doctors, at the bedside of the patient indicates that doctors are not concerned in giving information to the patient and, moreover, they do not need any more to take information from the patient, as they already know the patient's medical history. Thus, they are concerned with the technical results of the treatment, which puts the patient in a passive position. Therefore, the discussion between the doctors which takes place in the technical language aims at not exchanging information between the doctor and the patient.

On the other hand, one has to take into consideration that the hospitalized people, because of their sufferings, do not even have desire to talk or to ask questions. As a result, in this group, concerning the communication between the doctor and the patient only phatic communication is observed.

4.7.9.5. Evaluation of The Results of Four Groups : Educated Patients, Less-Educated Patients, Uneducated Patients and Hospitalized Patients

This study is an attempt to account for systematic differences in physicians' informativeness that often are related to the patients' level of education. The physicians' informativeness may be strongly influenced by features of the patients' communicative style, which is related to their educational level. Communicative style of patients corresponds to the patient's expressiveness. Hence, the topical

content of medical consultations is mutually created by the physician and the patient as each negotiates their goals and situational expectations around the constraints imposed by the communicative choices of the other.

However, in the case of hospitalized patients, complete communication gap has been observed, regardless of the communicative style of the patients. It can be claimed that the communication process, in front of the hospitalized patients does not include patients, hence it is a communication event between doctors, where the specialized, technical and institutional language is employed.

For the other 3 groups (educated, less-educated and uneducated patients) the effect of education on communicative style is apparent. Educated patients received more information than less educated patients and uneducated patients are not concerned with the doctor's informativeness.

Therefore, the present study confirms the hypothesis of the asymmetrical relationship between the patient and the physician. In the medical history part, the patient is more directive, and more talkative; however, as the conversation progresses the physician becomes verbally dominant.

As for as the VRM categories are concerned, patients presented subjective and objective information (Disclosures and Edifications) at the start of the interview, whereas, the physicians engaged in active listening (giving many acknowledgements) and probing for specific data (asking questions). At the end of the interview, the physicians gave medical information (Edifications and prescribed a therepeutic regime Advisements). Hence, the role-dimensions of the patient and the physician in the three major segments (medical history, physical examination and conlusion segment) of the medical interview varied systematically according to their function.

CHAPTER V

LINGUISTIC ANALYSIS OF DOCTOR-PATIENT INTERACTION

5.1. Sentence Types Used During The Doctor-Patient Interaction

5.1.1. Interrogotives

During the history-taking period mostly interrogatives are used, when the doctor and the patient are face to face to each other. Interrogatives require active responses from the addressee. These responses are very important from the doctor's point of view, as the complaints of the patient and the doctor's diagnosis are very closely related to each other. If the patient understands the questions and answers them verbally then it will be easieron the doctor's part to reach a diagnosis.

Generally, two kinds of interrogative clauses are used during the medical interviews :

a) those which can be answered by Yes/No (Evet/Hayır) questions :

1. - Topuklarda ağrı oldu mu?
   - Evet
2. - Daha önce taş düşürmüş müydün?
   - Hayır.

b) those having a question word like : how (nasıl), when (ne zaman), how much (ne kadar, kaç) :

1. - Ne zaman ağrı başladı?
2. - Kaç yaşındasın?
3. - Ne tür şikayetler var?

However, mostly the interrogatives are expressed by means of intonation, otherwise they would be simple statements:

1. - Daha önce hissetmiyordunuz?
2. - Dilde acıma, boğazda acıma?
3. - Düşme, çarpma yok?

The frequent use of intonation in interrogatives may be related to the lack of time doctors have as they are obliged to treat 50-60 patients a day.

5.1.2. Imperatives

During the physical examination of the patient, the doctor examines the patient and tells him to do something. Linguistically these utterances are considered as commands, and the patient is in a position to follow the instructions that the doctor dictates. Thus, the doctor is in a higher status than the patient.

1. - Şimdi ben yap dedince, burnunu tukayacaksın
2. - Ağzınızdan nefes alın, verin, e-e deyin
3. - Üstünüzü çıkarın, omuzlarınızı açın.

From the structural point of view, these sentences are co-ordinates. The items are combined by parataxis, i.e., without a linking word, but by commas.

In the conclusion segment, the doctor prescribes the medicine or the instructions that the patient is going to follow. Hence, the use of imperatives is very common :

1. - Sen bunu kullan, rahatlarsın herhalde; sabah, akşam tok karnına bir tane al.
2. - Aç karnına geleceksin, tahlil yaptıracaksın.

Another feature used in the conclusion segment is the use of conditional sentences. Among doctors it is said that there are no illnesses but there are patients. The indication of an illness shows differences according to the personality and body features of the patient. Also the same diagnosis of the two patients, supported by laboratory anaysis may have different responses to the medicine they take. From this point of view, the use of conditional sentences by the doctors is inevitable :

1. - Hiç bir rahatlama olmazsa perşembe, cuma gel.
2. - Tahlil sonuçlarını getireceksin, olmazsa ileri bir araştırma olarak ilaçlı film çekilebilir.

5.2. Tense in Policlinics

During the history taking period, the interrogatives are usually in the present tense, as the doctor is concerned with the present state of the patient :

1. - Ne şikayetiniz var?
2. - Ağrı sırtınıza doğru iniyor mu?

However, the past description of the patent's problem gives important clues for the diagnosis. Therefore, the past tense interrogatives are also very common :

1. - Ne zaman ağrı başladı?
2. - Kaç doğum yaptın?
3. - Tansiyonunu hiç ölçtürdün mü?

Another usage of the past tense is in the evidential [-Miş] used together with the definite past tense. This type of usage indicates that the speaker has no firsthand knowledge of the events described :

1. - Kültür ne zaman alınmıştı?
2. - Röntgen çekilmiş miydi?

In the conclusion segment, the use of the future tense is marked. Hence, the use of this tense indicates the future analysis and the further results in future, which means that the diagnosis is not completed yet :

1. - Zarı görmek için temizleyeceğiz, bir aletimiz var, o çekecek.
2. - Şimdi, sizden film istiyeceğiz.

5.3. Textual Analysis of Doctor-Patient Interaction in Policlinics

5.3.1. Introduction

The word text is used in linguistics to refer to any passage of whatever length and to a unified whole. A text may then be spoken or written, dialogue or monologue.

Halliday and Hasan (1976) take the view that the primary determinant of whatever a set of sentences do or do not constitute a text depends on cohesive relationships within and between the sentences which create texture. Similarly, a text is not a grammatical unit, like a clause or a sentence, and it is not defined by its size; it is best regarded as a semantic unit, i.e. a unit not of form but of meaning.

Texture

A text has texture and this is what distinguishes it from something that is not a text. The concept of texture expresses the property of "being a text" (Halliday & Hasan 1976). Thus, the texture is provided by the cohesive relation, that means that the items refer to the same thing, they are identical in reference or co-referential.

5.3.1.1. Cohesion in Texts

"Cohesion occurs when the interpretation of some element in the discourse is dependent on that of another. The one presupposes the other, in this sense, a relation of cohesion is set up, and the two elements, the presupposing and the presupposed are thereby at least potentially integrated into a text" (Halliday and Hasan 1976:4).

Cohesion is expressed partly through the grammar and partly through vocabulary, that can be referred to as grammatical cohesion and lexical cohesion. However, in this study only grammatical cohesion will be studied.

5.3.1.2. Context of Situation : Register and Text

The linguistic features which are typically associated with a configuration of situational features constitude a register (Halliday and Hasan 1976:22). That is the more specifically we can characterize the concept of situation, the more specifically we can predict the properties of a text in that situation.

According to Haliday and Hasan (1976:26) texture results from the combination of semantic configurations of 2 kinds: those of register and those of cohesion. The register is the set of semantic configurations that is typically associated with a particular class of context of situation and it defines the substance of the text.

On the other hand, cohesion is the set of meaning relations that is general to all classes of text that distinguishes text from "non-text", and interrelates the substantive meaning of the text with each other. Cohesion, therefore, does not concern what a text means, it concerns how the text is constructed as a semantic edifice (Halliday and Hasan 1976:26).

Halliday and Hasan outline a taxonomy of types of cohesive relationships which can be formally established within a text, providing cohesive "ties" which bind a text together. The cohesive relationships which are particularly discussed are

grouped under the headings of reference, substitution, ellipses and conjunctions from the point view of grammatical cohesion.

In the rest of this section, reference, ellipsis and conjunctions will be outlined as cohesive relationships of doctor-patient interaction in policlinics.

5.3.2. Reference

There are certain items in every language which have the property of reference, that is to say, instead of being interpreted semantically in their own right, they make reference to something else for their interpretation (Halliday and Hasan 1976:31). What characterizes this particular type of cohesion is that there is a presupposition that must be satisfied; the thing referred to has to be identifiable somehow and the cohesion lies in the continuity of reference, whereby the same thing enters into the discourse a second time.

Halliday and Hasan (1976) divide the reference forms into 2 parts, where their interpretation lies outside the text in the context of situation, the relationship is said to be an "exophoric" relationship, which plays no part in textual cohesion. When their interpretation lies within a text, they are called "endophoric" and they form cohesive ties within the text.

Endophoric relations are of two kinds: those which look back in the text for their interpretation, which are called "anaphoric" relations and those which look forward in the text for their interpretation which are called "cataphoric" relations (Halliday and Hasan 1976:33).

Moreover, Halliday and Hasan (1976) distinguish three types of reference : Personal, Demonstrative and Comparative reference. However, in doctor-patient interviews, only demonstrative reference is observed.

Demonstrative reference belongs to the class of determiners and has the experimental function of Deictic, and it is a reference by means of location on a scale of proximity.

e.g.: D - Bir olay var mı sinirlerinizi bozacak?

P - Genelde oluyor bu türlü şeyler.

"Bu türlü şeyler" (these kind of things) refers to "sinirlerinizi bozacak bir olay" anaphoricly, and forms the endophoric reference tie. Whereas, in the following example, typical exophoric reference is seen, because the interpretation of it lies outside the text, in the context of situation :

D - Çok iyi maşallah! Biz bunları ince ince inceleyelim.

What is meant by bunları (these) is obscure. But, according to the context of situation "bunları" refers to the films that the doctor is going to analyze, so no cohesion is realized.

5.3.3. Ellipses

Ellipses is also a cohesive device contributing to the compactness and efficiency of a text. (Halliday and Hasan 1976:88). With ellipses certain words can be omitted from the surface structure of the sentence but they can be recoverable from the rest of the sentence.

During the interaction between the doctor and the patient question-answer and other rejoinder sequences of clausal ellipsis play the most important role in the elliptical constructions.

Not all questions have an answer. The question and answer have special type of cohesive relation that subsists between an answer and its question, has its own characteristic grammatical properties (Halliday and Hasan 1976:206). At the same time, there are other sequences involving rejoinder of one kind or another. Thus, a rejoinder is any utterance which immediately follows an utterance by a different speaker and is cohesively related to it, Therefore, a rejoinder that follows a question is called a "response". As Halliday and Hasan (1976) emphasize, within the category of responses there is a further distinction between Direct responses and Indirect responses. A direct response is one which answers the question; it is either

a form of "Yes" or "No", if the question is of Yes-No, or a specification of the information asked for by the WH-element if the question is of WH-type.

Accordingly, an indirect response is either one which comments on the question (commentary), or one which denies its relevance (disclaimer), or one which gives supplementary information implying, but not actually expressing an answer (supplementary response) (Halliday and Hasan 1976:206).

Doctor-patient interaction is idiosyncratic in terms of direct responses to Yes/No and WH-questions. It is also idiosyncratic in terms of indirect supplemantary responses.

5.3.3.1. Direct Responses to Yes/No Questions

Q - Buralarında filan hiç ağrı oluyor mu?
R - Hayır.

Q - Herhangi bir ilaç verdiler mi size?
R - Evet.

The words "evet" and "hayır" express polarity, i.e. evet and hayır mean the answer is positive and negative, respectively. However, the choices such as tabi (certainly/of course), elbette (certainly), yoo (no), belki (perhaps), tamam (O.K/oldu) should also be considered as cohesives (İnce 1993:147). The most common of these choices used in doctor-patient interaction are : 'tamam' and 'oldu' (O.K.)

Q - Film isteyeceğiz sizden tamam mı?
R - Oldu yavrum!

Q - Sende kontrollere geleceksin oldu mu?
R - Oldu!

Thus, as Halliday and Hasan stress (1976:209) Yes/No questions are "realizations of a single clause feature: polarity which is being expressed on its own instead of an associatioin with the verbal group". The fact that it is expressed on its own means that the whole of the remainder of the clause is presupposed.

5.3.3.2. Direct Responses to Interrogatives

Interrogatives such as kaç (how much), hangi (which), ne zaman (when), ne (what), kim (who) nereli (where from) are distinguished as non-polarity questions (Halliday and Hasan 1976:210). They require the specification of a particular item which is, as it were, missing from the clause. The respondent knows the function of these items in the clause structure, as it has been supplied by the questioner. Therefore, the respondent merely has to fill in the blank :

Q - Nereli?
R - Alpulu.

Q - Ne şikayetiniz var?
R - İki gündür sırtım...

Q - Kaç gündür ağrı?
R - İki gündür.

Q - Nerde çalışıyorsunuz?
R - PTT'de.

As in Yes/No questions, also in WH-(ne, nezaman, hangi, nereli) questions elliptical forms of answers are used.

5.3.3.3. Indirect Response : Supplementary Response.

Supplementary response gives information other than that which is asked for, but answers the question by implication (Halliday and Hasan 1976:213).

Q - Ne raporu?

R - Geçen kağıt geldi; işte buraya gel git şey yaptı, dersten filan çıktı, izin aldı, eğer mümkünse...

Q - Ezilme, soğuk alma, çarpma gibi bir şey oldu mu?

R - Evvelki gün bahçede gül ağacının dibini açayım dedim, bi terledim.... ondan olabilir.

As Halliday and Hasan (1976) stress, these supplementary responses presuppose the entire question. Instead, the full form of these questions would be directly answered. But, the respondent in the first example, instead of answering the question "Ne raporu" directly, describes the events i.e., the patient who is a student has to give an official paper to his school taken from the hospital in order to cancel his absences, in the class while he was away from the school, in the hospital.

5.3.4. Conjunction

Another cohesive relation from the grammatical point of view is conjunctions. Conjunctive elements are cohesive by virtue of their specific meaning., i.e., they are not primarily devices for reaching out into the preceding or following text, but they express certain meanings which presuppose the presence of other components in the discourse (Halliday and Hasan 1976:226).

Conjunctions which serve as cohesive markers are seen according to the function they ful fill. They can be categorized under four headings : additive, adversative, causal and temporal. However, adversative conjunctions will not be studied, as they are not frequently seen.

a) Additive conjunctions are used to indicate an addition to what has been said before. Therefore, they are mostly signalled by ve (and), üstelik (in addition),

bundan başka (futhermore), yani (that is), örneğin/mesela (for example), aynı şekilde (similarly), böylece (thus).

e.g. : - Şu anda birşey yok. Yani kötü birşey yok ya merak etmeyin.
- Bazı tetkikler yapacağız, yani daha doğrusu sinus filmi çektirmeniz lazım.

Also in doctor-patient interaction, additive conjunctions such as "yani" is used to indicate an addition to what has been said before. The other additive conjunction "şu anda" (now) expresses certain meaning which presupposes the presence of the components in the discourse.

b) Causal conjunctions are expressed by çünkü (because), böylece (so), bu amaçla (for this purpose) yoksa (otherwise), etc. With the cohesive relation between sentences, in which the text unfolds one sentence after another, the logical precedence of cause over effect is reflected in the typical sequence in which sentences related tend to occur.

e.g. : Sinus ile ilgili şikayetler varsa, ayrıca onları da tedavi etmek lazım, çünkü o genze doğru akıntı şikayetlerinizi arttırır.

However, there is another conjunctive relation which is considered under the general heading of causal, this is the "conditional" type (Halliday and Hasan 1976 : 258). The simple form of expression of the conditional relation in the above example means "in that case" In our case "sinus ile ilgili şikayetler varsa" (a) entails "onları da tedavi etmek lazım" (b) without being its cause, i.e., the conditional means "possibly (a) if so, then (b).

c) Temporal conjunction is the last type of conjunction relationship. Roughly speaking, temporal conjunctive items indicate that what is being said is related in time, with what has been said previously (Halliday and Hasan 1976:261). One sentence is subsequent to the other by the help of temporal expressions.

Among such expressions we can list sonra (afterwards/then), önce (first/before), aynı zamanda (simultaneously), o sırada (meanwhile), sonunda (finally/in the end), nihayet (finally/in the end), bundan sonra (then/afterwards) etc. .

In doctor-patient interaction, the time dimension is very important. The analysis, the medicine that the patient is going to have, or laboratory research are all limited with time. Therefore, temporal conjunctions, i.e. the cohesive relations, are the most used among the other conjunctions; the medical event is situated one after another :

- Tabanlık bir-iki hafta rahatsızlık verir, kızım, daha sonra alışırsın, rahatlarsın oldu mu?
- Diğer tahlil sonuçlarını getireceksiniz, ondan sonra bakacağız.

CHAPTER VI

CONCLUSION

The study is initiated with the idea that Turkish medical language is the clothing over assumed naked truth, and it is incomprehensible to those without any medical education. Therefore, it is a linguistic variety used under specific social circumstances, i.e., in medical settings. Its linguistic repertoire is different than the standard language, since medicine, as a science, includes a commitment to specific methods and instruments, or a range of common laboratory experience. It also includes theoretical perspectives, models for looking at certain phenomena. Therefore, its linguistic repertoire is related to the technical terms used in prevention, investigation, diagnosis and treatment of diseases where the human body is its subject matter. Taking into consideration that, it is directly related to the humans' health matters, where patients are considered to be medically illiterate, we have tried to analyze Turkish medical language and describe the principles of its structure and use.

Moreover, the study attempted to put forward a description of doctor-patient interaction and to what extent this occupational code is used during the medical interviews. For our purposes, we can say that Turkish medical language includes the following sociolinguistic characteristics :

Turkish medical language is a linguistic variety, used under specific social circumstances. It is an occupational code used only by medical professionals during their medical activity. Thus, its usage is affected by social factors such as the participants, the topic, and the setting. Moreover, it has also been observed that, participant relationships, status differences and the formality of the social setting, the purpose or topic interaction have all impact on the choice or usage of medical

language. Futhermore, Turkish medical language is a register, which is determined by the parameters of communication situation, such that, it is realized either spoken or written according to the function. In other words, in the course of medical activity, professionals use Turkish medical language in order to exchange medical information or to discuss health matters.

Another important conclusion of the present study is that, Turkish medical language is a technical and institutionalized register, such that the language used by every medical professional either in lab.or in the operation room is technical, and is learned through the medical education. Hence, the language used in hospitals and among medical professionals is a technical professional code, which is intelligible only to those who have the medical training, and in Hudson's (1986)term it is a "high-technicality" language as its terminology cannot be expressed simply in the standard language. This results in the economy of the usage, such that the linguistic repertoire of Turkish medical language has still Greek, Latin, French and English affixes and roots, and sometimes it also includes Arabic and Persian lexemes. As a result of this fact, medical professionals who learned this language through their education have difficulties in expressing themselves in the standard language, as a high portion of technical terms are not Turkish.

At the linguistic level, the following characteristics are observed in written Turkish medical language.

1. Most of the medical terminology is borrowed from Greek and Latin, and accepted. Therefore, the Greek and Latin affixes and roots are commonly used. From this respect, Turkish transcriptions of vowels, consononts and diphtongs are listed, and the place of accent in the lexeme is given in order to facilitate the reading.
2. At the morphological level, most of the medical terminology is constucted by means of derivational process. In other words, by means of derivational elements new terms are formed. As a result of this process, the facility, flexibility and fluency of the communication has been achieved.

3. Another pecularity is the use of acronyms. Medical language contains extremely long expressions which are quite difficult to pronounce. By means of acronyms, that is to say, by using the first letters of a group of words the practical usage is achieved. (e.g., KC for "karaciğer", or PTKA for "perkuton translümünal koroner anjioplasti"). Acronyms are also used as a communicational vehicle among doctors and pharmacists in order to facilitate the explanation of prescriptions written by doctors. Hence, it is the duty of pharmacists to explain the usage instruction to patients, as the information written in the prescription of medicines, is addressed generally either to doctors or pharmacists, not to patients.
4. At the syntactic level of the written TML, simple, complex and compound sentences are observed, and the medical articles designed as introduction, method and results/discussion contained the above mentioned structures. Mostly, impersonal sentences and passive forms of the verbs are used, where the agents are not given or left indefinite. As for the tense, in describing actual experiments, the past tense is used, but in general discussion the present tense is used. Hence, the use of the present tense indicates the universal presence of science, and the past tense usage indicates the experiments that were done before.

From the functional point of view, the following characteristics are observed in the Turkish medical language :

1. Turkish medical professionals use situational code-switching; that is, they speak the common language when the topic is not medicine, whereas they use their professional code in discussing medicine with their colleagues. Among colleagues, the use of the professional code is inevitable, by means of which solidarity is achieved. By switching from the standard language to the medical code, communication facility is achieved, because certain subjects are more appropriately discussed in the medical code.
2. Another function of the medical code is that, doctors do not want their patients to understand their language when the patient's state is critical. Moreover, by using the medical language, professionals try to retain control over the

patient. The use of specialized language of medicine, in medical activity, has a specific scope which is to diagnose the patient's health problem. Therefore, it is the doctor who will diagnose it, and his knowledge is interrelated with his professional code in the treatment.

3. The use of the medical language outside the medical setting may be related to the mixed identity which the professionals possess. It can be claimed that the physician's medical identity is always apparent when his opinion is asked on a medical topic, outside the medical setting.

The study also attempted to put forward a description of doctor-patient interviews from the informational view point, by relating the information-giving process of the doctors to the educational background of patients. This study focused upon the relational aspects of communication, using Stiles' VRM coding system, and to a limited extent, upon the content of patient's complaints and the hypothesis of an asymmetrical relation between physician and patient was confirmed.

At the beginning of the interview, the physicians were engaged in active listening (giving acknowledgements) and probing for specific data (asking questions). At the end of the interview, they gave medical information (Edifications) and prescribed a therapeutic regime (Advisement). At the beginning of the interview the patients appeared to have the opportunity to present their complaints and elaborate on them. As the interview progressed, the physician become the dominant partner by giving advice and Edification.

The behavior of the patient and the physician corresponds, with the functions of the three segments of medical conversation. The results are in line with Stiles' data; the same can be said about the results of the role-dimensions: in almost every phase the patients and the physicians differed with regard to the role-dimension. In the medical history, the patient is more directive and more talkative, however, as the conversation progresses, the physician becomes verbally dominant. Therefore, the role-dimensions of the patient and the physician in the three major segments of the medical interview varied systematically according to their function. The findings of the study can be considered as a validation of VRM taxonomy for studying medical conversation.

However, in Group 4: Case 1, Case 2, Case 3, in hospitalized patients neither role-dimension nor the behavior of the patient and the physician changed. Doctors kept their dominant place, throughout the interaction.

As for the usage of medical language, doctors used their technical register neither in Group 1: Case 1, Case 2, Case 3, (educated patients), Group 2: Case 1, Case 2, Case 3, (less-educated patients), and nor in Group 3 : Case 1, Case 2, Case 3, (uneducated patients). The striking point was that in their visits to the hospitalized patients, they discussed the patients' medical state with their colleagues, and the patient is left outside the discussion.

It is obvious that informing the patient is the physician's most important communicative responsibility. In this study, it is argued that the amount of information physicians provide to patients during medical interviews, may be influenced by 2 sets of factors: 1) patients' level of education and 2) patients' communicative style. Communicative style of patients corresponds to asking-questions, opinion-giving and expression of their corcern.. The analysis of tape-recording of physician-patient interviews revealed several notable findings, such that information regarding diagnosis and health matters were primarily related to the patient's level of education and asking questions; patients' assertiveness and expressiveness were strongly influenced by the pysicians' use of "partnership-building" utterances that solicited the patients' questions, concerns and opinions. It has been observed that physicians volunteered more explanations to more educated patients and they were less informative with less educated patients, because they inaccurately assumed that these patients were not particularly interested in learning about health (Waitzkin 1985, c.in., Street 1991). For uneducated patients in Group 3 : Case 1, Case 2, Case 3, (villagers), physicians informed patients, although it was not demanded. This is due to the activity carried out by the member doctors of a social club. The aim of the medical scanning activity was to help uneducated and poor patients. Thus, at the end of the interviews also the medicine was supplied by the social club. For the hospitalized patients in Group 4 : Case 1, Case 2, Case 3, the information-giving process was completely different, and a communication gap has been observed, as in this group no information is wanted from the patient and no information is given to the patient, because all the

information necessary had been obtained before, during the medical history taking period. In this group, status differences between the doctor and the patient are observed. The patient lies in his bed and the physicians in white uniform, around his bed, discuss his health matter in the medical code. Although, it is his problem, no information is given to the patient. Phatic communication is the pecularity of doctor-patient interaction in this group.

Consequently, the hypothesis examined the extent to which differences in the patient's communicative behavior were related to the patients' education and to the physicians' use of partnership-building utterances that directly solicited the patient's questions, corcerns and opinions or that expressed agreement with the patient. Patients' affective expressiveness was strongly related to physicians' use of partnership-building utterances. In particular, the frequency with which patients asked questions were strongly related to the degree to which doctors provided medical information in general. To the extent that questions are asked infrequently and concerns are rarely expressed, patients appear to underutilize verbal resources that can effectively elicit more informative responses from physicians.

Interestingly, the doctors' informativeness varied most in relation to the patients' anxiety, as more worried patients received more information in general than less anxious patients did. Physicians may have given more information to anxious patients, because these individuals had more complicated conditions that required more discussion, or because physicians recognized that these patients were worried and were in need of reassurance or information to reduce their uncertainty and apprehension. Hence, educated patients in Group 1 : Case 1, Case 2, Case 3, were able to elicit information from the doctors due to their affective expressiveness and anxiety.

Given the possibility that the patient's behavior influences the physician's informativeness, another objective of this research was to identify factors related to differences in patients' communicative styles. In this study, patients indeed varied considerably in their communication during the interview. More educated patients were more opinionated and more affectively expressive than were less educated patients.

More educated patients were more communicatively active, because they were less "culturally distant" from the doctor and thus, experienced fewer difficulties when interacting with physicians. Thus, less educated patients may not only be culturally disinclined to freely express opinions and feelings but, also may perceive constraints and barriers to doing so and accept the communicative dominance of the doctor, and they are passive during the consultation, and wait for specific cues to express themselves.

In sum, the results of this study suggest that the amount of information physicians give patients is strongly influenced by patients' communicative styles and by patients' level of education. The most striking result was that physicians during the medical interviews did not use their professional code while interacting with patients. Face to face interaction involved the standard language which can be understood by both of the parties (doctors and patients). On the other hand, in Group 4: Case 1, Case 2, Case 3, in front of the bed of the hospitalized patients, during the daily rounds, doctors interacted in their technical register, where the presence of the patient is ignored.

At the linguistic level of the doctor-patient interviews, the following characteristics are observed :

1. At the syntactic level, during the history taking period, the frequency of interrogative clauses are observed. Interrogatives are also expressed by means of intonation on the part of the doctor. However, both of the parties, patients and physicians, used the questioning strategies.

In the physical examination period, imperatives used by doctors were common, and the conclusion segment consisted of conditional sentences in order to verify the outcome of the treatment or to change the medicine.

As for the tense, the present tense is used when the doctor is concerned with the present state of the patient. The past tense interrogatives were common for the past decription of the problem, however, in the conclusion segment of the interviews the use of the future tense is marked, in order to indicate the future

results of the problem or the treatment.

2. At the textual level of the doctor-patient interviews the cohesive ties, such as reference, ellipses and conjunctions are observed, which contribute to the efficiency of texts. Especially, while analyzing question-response sequences of doctors and patients, elliptical constructions were common, in the responses to Yes/No and WH-questions. Similarly, additive, casual, temporal conjunctions are commonly used.

The use of cohesive markers in the doctor-patient interviews indicate a more intelligible communication avoiding any potential breakdowns.

Before starting this study, it was hypothesized that the medical language is also used in medical interviews. The results provide a considerable difference of the usage such that, the choice of the medical code is limited in professional relationships. The strategic use of language by doctors in policlinics, during the doctor-patient interaction is achieved by means of the common language. Furthermore, the amount of information given to medically illiterate people according to their level of education is coded in the common language. On the other hand, the professional code is used among those having the same education. Thus, the use of this language may reflect the power of its users towards patients, and also the solidarity aspect, which is unintelligible to those without medical education.

In conclusion, we can say that this dissertation has only been a preliminary attempt to describe Turkish medical language and doctor-patient interaction. We hope that, this study will prepare the way to further studies on the language of medicine and the process of information-giving in various phases of doctor-patient interviews, in specific diseases and also initiate the studies on other specialized languages.

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APPENDIX

TEXT 1 :

D1 : Efuzyonu var, biopsi yapmıştık. 1 cc. mayi boşalttık; nefesinin rahatlaması için.

D : Tomografinizi çektiniz ?

D1 : Evet

D : Nereli ?

D1 : Alpulu

D : Alpu'da var.

D1 : Aspest pozitif.

D : Alpu'da var.

D1 : Tomografisi de burda, hocam.

D : Aspest plakaları nasıl görünüyor ? Çok tipik plakalar var ..... burda .....

D1 : Biopsi yapmıştık, hocam.

D : Evet. Yarın sonuç gelecek. Aspest altda, alt sınırlarda, karaciğer üstü, mümkün olduğu kadar alta girmekte yarar var. Bi de faranjitine bakalım mı ? Bi daha ?

D1 : Daha sitolojiler gelmedi, hocam.

D : Evet, sitolojiler gelmedi.

TEXT 2 :

D : Düştün mü ? Durup dururken mi başladı ?

Patient's mother : Hayır, hiç biri ... Kendisi çok hareketli. Önümüzde park var. Hiç durmaz orada. Parkta oynuyor.

D : Bi bakalım ... Tabanda çöküklük var. Buralarında filan hiç ağrı oluyor mu ? Şuralarında ?

P : Hayır.

D : Böyle yürürken kramp filan giriyor mu ?

Patient's mother : Hayır.

P : Bazen giriyor.

D : Bazen giriyor. Düz tabanlığın var şurda. Dizlerinde bir şey yok.

Patient's mother : Doktor bey de öyle demişti... Ortopedi ... Ortopedi, ayakkabıyı tavsiye etti, geçen. Daha önce de, Doktor bey, rapor rica edeceğim.

D : Ne raporu ?

Patient's mother : Geçen kağıt geldi. İşle buraya gel, git şey yaptı, dersten filan çıktı, izin aldı. Eğer mümkünse ?

D : Sevk kağıdınız var mı ?

Patient's mother : Var. Tabanlık mı vereceksiniz ?

D : Tabanlık. Bu yaştaki insana, ayakkabı şeyi rahat olmaz, tabanlığı her türlü ayakkabıya koyar : sporuna da, kışlığına da... Tabanlık kullanışlı olur. Rapor yazacağım size. Yukarıda merkez sekreterliğe gideceksiniz.

Patient's mother : Evet.

D : Tabanlık 1-2 hafta önce rahatsızlık verir, kızım. Daha sonra alışırsın, rahatlarsın, oldu mu ? Yani biraz sabret kullanımda. Bunu tasdik ettiriyorsunuz. Sağ tarafta sekreterlik var, onlar size rapor yazacaklar. Dediğim gibi, bu diz ağrıları biraz da tabanlıktan kaynaklanıyor olabilir. Biraz da yaşın şeyi ... Büyüme çağındasın şu anda. Tabanlık biraz sabırlı kullansın, 2-3 hafta. Rahatsızlık verir, alışamazsın, sonra rahatlarsın, tamam mı ?

TEXT 3 :

D : Nasılsınız ?

P : İyiyim yavrum.

D : Rahatladın mı biraz ?

P : Rahatladım. Allah var iyiyim. İlkin biraz daha burada şeydi, ama ... Çok rahatladım yavrum.

D : Şimdi rahatladınız peki.

P : Sağolun, yavrum. Allah size de ömürler versin.

TEXT 4 :

D : Yemek programı devam ediyor ?

D1 : Evet, devam ediyor. Hiç bir sıkıntısı, yani şikayeti yok.

D : Çok iyi maşallah ! (She looks at the films) Biz bunları inceleyelim.

D1 : Kemoterapi devam edecek mi ?

D : Tamam. Biz onu iyice değerlendirelim. İsterseniz siz gidin.

P : Evet; raporum bitti.

D : Rapor ... verelim sana. Şimdi biz şöyle yapalım : biz buna bakalım. Muzaffer bey de gelsin. Ondan sonra belirli kararlar alacağız. Oldu mu, Ömer Bey ? İsterseniz bekleyin işiniz yoksa, yemek yiyin hastaneden. İsterseniz sonra da gelin. Siz nasıl isterseniz.