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## On the Function of Speech Acts in Doctor-Patient Communication<sup>†[\*]</sup>

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Perhaps the most vivid point of convergence between language and social organization arises at the level of speech acts. ... because activities or speech events are built out of particular component actions, speech acts are arguably central to the analysis of all forms of interaction.

Drew & Heritage

### 1 Introduction

The aim of this article is to analyse the function and the character of speech acts in doctor-patient interaction. The paper consists of two main parts. The first section describes the role of questions and methods of asking. The second section is devoted to a more thorough examination of other speech acts and their sequential properties. Although more studies dealing with the topic have been published in recent years (Gwyn 2002, Humphreys 2002), my findings are based on a comparative analysis of various medical disciplines.<sup>1</sup>

My approach is grounded in the speech act theory as proposed by Austin (1962) and elaborated on by Searle (1969). With respect to the classification of speech acts, I have drawn upon several sources, namely Todd (1983) and D'Andrade (n.d.). Concerning the sequential organisation, the findings of the Birmingham discourse analysts (e.g. Coulthard 1977) and the turn-taking analysis of Sacks, Schegloff and Jefferson (1974) have been consulted. For the background description of the interaction in institutional settings I refer to Drew and Heritage (1992).

The language material for the present inquiry is taken from the corpus of conversational texts recorded in consulting rooms throughout Great Britain and the United States during 1990s, available in the book *English for Doctors* ed-

ited by Mária Györffy in 2001 (see the Works cited).<sup>2</sup> For the purposes of the analysis I have investigated doctor-patient interviews from five medical specialties, namely, Internal Medicine, Gynaecology, Paediatrics, Oto-rhinolaryngology, and Orthopaedics. The total extent of the material under scrutiny is 725 turns, and the total word stock amounts to 12 000 items.

### 2 Speech acts revisited

In accordance with the research which has already been completed, I understand **speech acts** as acts of communication “performed by the use of language, either in speech or writing, involving **reference, force, and effect**” (Widdowson 1996: 131). These acts are usually classified into five categories: namely **declarations, representatives, expressives, directives, and commissives** (e.g. Searle 1976). A distinction is also made between **direct speech acts** and **indirect speech acts**.

Despite what the motto at the beginning of the paper suggests, the speech act theory has been heavily criticised.<sup>3</sup> Conversation analysts have specifically argued that speech act theorists “do not address a cultural, or contextual, sociological analysis”, and that “the basic unit of analysis used is the self-contained action rather than the interaction unit, where context and the role of all the participants are important” (Todd 1983: 161). Nevertheless, I still find this approach useful as it contributes to a broader view of how power and asymmetry are distributed in the medical encounter.

In order to satisfy the specific needs of doctor-patient communication, Todd's classification of speech acts has been adopted.<sup>4</sup> As a result, five categories: **statements** (Example 1), **questions** (Example 2), **answers** (Example 3), **directives** (Example 4), and **reactives** (Example 5), have been distinguished. The distinction between answers and reactives consists in the fact that the reactives usually follow the answers and are provided by doctors, who use them to acknowledge the answers provided by patients.

#### Example 1

D: *Some of the slides that I'll take from you today will be looked at in clinic, and from these I'll decide whether you require treatment or not.*

#### Example 2

D: *Could you describe what the vomiting is like Mrs Smith, for example, does it clear your lap and land on the floor?*

<sup>†</sup> Previously unpublished. Reviewed before publication. [Editor's note]

### Example 3

D: *Was it managerial – did you have a lot of responsibility?*

P: **Yes, I was in charge of a large department.**

### Example 4

D: *Now let me have a look at you. **Sit down, open your mouth, head slightly forward.** Let me put this tongue depressor on your tongue.*

### Example 5

D: *Have you been abroad to any tropical or developing countries recently?*

P: *Yes, I just came back from Thailand a few months ago.*

D: **I see.**

Compared to Searle's classification, there are a few differences in my approach. Noticeably, besides others, two speech acts, namely **expressives** and **commissives**, have been excluded from the analysis. Although speech acts of these types do emerge in doctor-patient talk, their occurrence is not conspicuous and is rather infrequent (Examples 6 and 7). As Todd (1983: 161) maintains: "Strong emotion is not considered appropriate ... and actions such as vowing and exasperation tend to be played down and absorbed into other acts."

### Example 6

D: *Do you have a job at the moment?*

P: *No, I've just been made redundant.*

D: **Oh, I am sorry.** *What was your job?*

P: *I was desk-bound, I'm afraid.* (expressive)

### Example 7

P: *Oh, Thank God! No sign of cancer! No sign at all?*

D: *Yes, that's right. But listen for a moment. ... In the future you really must try to stop smoking, as long as you keep smoking you can get more trouble with your voice, and one day it could turn nasty.*

P: **Oh, yes, Doctor. I am trying** – *I've cut down a lot, but you know, it's not easy.* (commissive)

## 3 Role of Questions in D-P Communication

As has been stated above, this section of the article concentrates on the role of questions and methods of asking, especially how they contribute to asymmetry, the characteristic feature of the relationship between doctors and their patients (Mishler 1984, Fisher and Todd 1983, Müllerová 2002). Moreover, it discusses some differences and obscurities in previous research (e.g. Korsch, Gozzi, Francis 1968, West 1983, Ainsworth-Vaughn 1998), and offers a possible explanation.

"Asking questions is a very important part of your visit to the doctor. By asking questions your doctor can help clear up doubts, concerns, or worries. It is an important way in which you can get things straight." (Roter and Hall 1992: 104). As is obvious, questions are the focal point of any medical encounter. Their centrality is rooted in the fact that they constitute key mechanisms "by which power can be exercised and resisted" (Humphreys 2002: 2). For these reasons questions have often been discussed separately from other speech acts (e.g. Frankel 1990). The structure of the presented article follows this trend.

### 3.1 Analysis

From 725 turns, 374 questions have been excerpted. In accordance with the research which has been done before (West 1983, Humphreys 2002), I understand the *question* (Examples 8, 9) as "...any utterance requiring a response within the context of the interaction, regardless of form (interrogative, declarative, etc.); any formal question; and any utterance that receives a response as though it were a question" (Humphreys, 2002: 20). The excerpted questions have been categorised into three groups, namely **yes/no questions** (Y/N), **either/or questions** (E/O), and **open questions**.<sup>5</sup> Furthermore, doctor-initiated and patient-initiated questions have been distinguished and classified according to their place (phase) within the dialogue.

### Example 8

D: **How long have you been smoking?**

P: *Since I was about fourteen.*

### Example 9

D: **So, you say that you are having problems with bleeding or bruising.**

P: *Yes, I am.*

My classification of questions draws on Quirk *et al.* (1985: 804), who distinguish three major classes of questions according to the different answers expected: **YES/NO questions**, i.e. those that expect affirmation or negation (Example 10); **ALTERNATIVE questions**, i.e. those that expect as the reply one of two or more options presented in the question (Example 11); **WH-questions**, i.e. those that typically expect a reply from an open range of replies (Example 12).

**Example 10**

**D:** *Have your waters broken yet?*

P: *Yes, about a half an hour ago.*

**Example 11**

**D:** *Are they very painful or do you just feel tightening across the tummy?*

P: *They're really becoming quite sore now.*

**Example 12**

**D:** *How often are your contractions coming?*

P: *About every ten minutes at the moment.*

The reason that different terminology for particular question categories is used in my analyses (ALTERNATIVE questions – E/O questions, WH-questions – OPEN questions) rests in the fact that researchers studying doctor-patient communication (e.g. Humphreys 2002, Roter and Hall 1992) frequently apply the same classification as is adopted in this article. Nevertheless, the definitions of E/O questions and OPEN questions correspond to those proposed by Quirk *et al.* (1985) for ALTERNATIVE and WH-questions.

Stenström (1984) applies a different classification of questions. Unlike Quirk *et al.* (1985), who base their categories on semantic and formal criteria, Stenström (1984) classifies questions with regard to their form and function.

Function refers to what type of R (response) is required: <Q: identify> asks for identification (of the referent of the WH-word); <Q: polar> requires a polarity decision; <Q: confirm> asks for confirmation of what is proposed in Q; <Q: acknowledge> asks for acknowledgement of the information prof-fered. (Stenström 1984: 152)

As regards lexico-grammatical forms, Stenström (1984: 152) distinguishes the following categories of questions: **wh questions**, **alternative questions**, **yes/no questions**, **tag questions** (Example 13), **declarative questions** (Example 14), **declarative + tag** (Example 15) and **declarative + prompter** (Example 16). Examples of these categories excerpted from the material that has been researched in the presented article are supplemented below.

**Example 13**

**D:** *It's the right side that bleeds more, isn't it?*

P: *Yes*

**Example 14**

**D:** *So you say that you are having problems with bleeding or bruising.*

P: *Yes, I am.*

**Example 15**

**D:** *Your wife is at home, is she?*

P: *Yes, with my two youngest children.*

**Example 16**

**M:** *I've heard different views on this, you know.*

D: *That's quite true, Mrs Smith.*

Stenström's typology of questions is more subtle than Quirk *et al.*'s. However, her approach has not been adopted in the paper as it would be difficult to organise its quantification. A functional description of questions by Tsui (1992) has not been applied for the same reason.<sup>6</sup>

The results of the quantitative analysis are offered in the form of five tables below. Tables 1 and 2 present absolute and relative frequencies of the distribution of questions between doctors and patients. They also give information about the number (percentage) of questions in particular medical specialities with regard to the question types and phases of the D-P interview. Tables 3, 4 and 5 offer results of the F-test.<sup>7</sup>

I have also calculated correlation between particular variables (participants, medical specialities, question types, and phases). However, the only significant correlation ( $r=0.33$ ) is between the participants and phases of the encounter. For example, patients usually raise their questions during the phase of examination and treatment. There are no patient-initiated questions asked during the history-taking phase. Other correlation is not as important.

### 3.2 Findings

The importance of questions and answers in D-P dialogues is justified because they “introduce, develop and dissolve topics” (Paget 1983: 71), and help to reach the correct diagnoses and treatment. Statistics I have tried to elaborate on show that as many as 649 turns (90%) out of 725 are formed solely by questions or answers. Out of 374 questions, 354 (95%) are initiated by doctors, only 20 (5%) are initiated by patients (see Tables 1, 2). 199 (53%) belong to Y/N questions, 52 (14%) to E/O questions, and 123 (33%) to open questions (see Tables 1, 2). 38 questions (10%) appear during the history-taking phase, 327 (87%) during the examination phase, and 9 (3%) during the treatment phase (see Tables 1, 2).

**Table 1: Absolute Frequency of Questions in D-P Interviews**

Abs.	Particip		Phase			Question Type			Total
	D	P	Hist	Exam	Treat	Y/N	E/O	Open	
Internal	99	1	24	76	0	43	28	29	<b>100</b>
Gynaec.	65	1	0	64	2	36	8	22	<b>66</b>
Paed.	88	4	13	79	0	45	8	39	<b>92</b>
ORL	55	8	1	61	1	50	7	6	<b>63</b>
Orthop.	47	6	0	47	6	25	1	27	<b>53</b>
<b>Total</b>	<b>354</b>	<b>20</b>	<b>38</b>	<b>327</b>	<b>9</b>	<b>199</b>	<b>52</b>	<b>123</b>	<b>374</b>

**Table 2: Relative Frequency of Questions in D-P Interviews**

%	Particip		Phase			Question Type			Total
	D	P	Hist	Exam	Treat	Y/N	E/O	Open	
Internal	99	1	24	76	0	43	28	29	<b>27</b>
Gynaec.	98	2	0	97	3	55	12	33	<b>17</b>
Paed.	96	4	14	86	0	49	9	42	<b>25</b>
ORL	87	13	2	96	2	79	11	10	<b>17</b>
Orthop.	89	11	0	89	11	47	2	51	<b>14</b>
<b>Total</b>	<b>95</b>	<b>5</b>	<b>10</b>	<b>87</b>	<b>3</b>	<b>53</b>	<b>14</b>	<b>33</b>	<b>100</b>

**Tables 3, 4, 5: Results of the F-test\*<sup>8</sup>**

F	Participant			
	Gynaec.	Paed.	ORL	Orthop.
Internal	2.00E-08*	1.00E-11*	4.00E-25*	2.00E-22*
Gynaec.		2.00E-05*	8.00E-14*	3.00E-12*
Paed.			2.00E-05*	0.0002*
ORL				0.73

F	Question Type			
	Gynaec.	Paed.	ORL	Orthop.
Internal	0.22	0.2	0.02*	0.14
Gynaec.		0.73	0.004*	0.52
Paed.			0.001*	0.72
ORL				0.001*

F	Phase			
	Gynaec.	Paed.	ORL	Orthop.
Internal	7.00E-13*	0.05*	1.00E-11*	0.02*
Gynaec.		1.00E-08*	0.76	4.00E-06*
Paed.			1.00E-07*	0.48
ORL				2.00E-06*

Considering the findings of previous researchers (Ainsworth-Vaughn 1998, West 1983), these results are surprising. The greatest difference is in the distribution of questions and answers between doctors and patients. As West points out, only 9% of all questions in her material are patient-initiated. The relative frequency of patient-initiated questions in the corpus studied by Ainsworth-Vaughn is much higher (40%). Thus, the very first problem which needs to be solved is to find an explanation for this divergence.

One might suspect that the distinction could be closely connected with the context of the particular medical branch under examination. Patients, as non-professionals, are not acquainted with any of these disciplines, they lack the knowledge of medical terminology, and hardly understand the process of examination and following treatment. However, for some reasons, one may still

believe that certain medical branches (e.g. Paediatrics or ORL) are easier to become familiar with than to understand, for instance, Internal Medicine or Orthopaedics.<sup>9</sup> As a result, patients are more confident and would rather ask more questions when visiting a paediatrician or an oto-rhino-laryngologist than when seeing an internist.

Such hypothesis would be acceptable if there was no evidence against it. Unfortunately, both West and Ainsworth-Vaughn worked with collections of dialogues between patients and their *family practitioners*, i.e. within the same medical branch. Still, their findings were considerably different. Furthermore, the correlation ( $r=0.2$ ) that has been calculated for my material proves there is no direct correspondence between the medical branch and participants, and even some results of the F-test (e.g. the comparison of ORL and Orthopaedics with regard to participants,  $F=0.73$ ) show that we cannot take the proposed assumption for granted.

Also worth possible investigation is whether the asymmetrical features in the distribution could not be sought in the differences in sex, race, and age of doctors and patients who are studied. However, according to West (1983: 88): “Neither sex nor race (of physician or patient) seemed to influence the distribution of questions between parties.” She also claims that the very same conclusion works for the category of age. Consequently, the explanation must be looked for somewhere else.

The interpretation of D-P questions and answers in the corpus that has been worked with proves that most questions patients ask take place when they really feel deeply concerned about a medical issue. Usually they must undergo an operation (Examples 17 and 18), and they want doctors to explain the operation in detail. They want information about what it involves, whether it is dangerous or not, what possible complications they may expect. Simply, patients wish to hear that the surgical intervention will help them and there is nothing to fear. It does not matter whether such dialogues take place in consulting rooms of ORL practitioners or orthopaedic specialists. It does not matter of which age, sex, or race doctors and their patients are.<sup>10</sup> The most important element that should be taken into consideration when solving the problem of the distribution of D-P questions is the level of patient’s anxiety concerning his/her health problems and their treatment.

**Example 17**

D: *You’ve got a deviated nasal septum. This part of your nose is cartilage, and instead of being straight it’s twisted and the twist is blocking you on the left side. I’m pleased to say we can fix it for you. We can put it right with an operation to straighten up*

*your nose, as there are nomodices or tablets really that will help.*

**P: *Is it a big operation?***

D: *No, not too big. It’s quite common. If you agree, we’ll bring you into hospital the day before the operation. You can usually go home the day after your operation, or possibly the second day after that. We do it under a general anaesthetic. It’s done through your nostrils, there’s no cuts on your face.*

**P: *No black eyes?***

D: *Not for this operation. When you wake up from anaesthetic, you’ll probably have a bandage up both nostrils overnight so, you see, you’ll have to breathe through your mouth that night. Would you like the operation?*

**P: *Will it work?***

D: *Yes, we can say that we can make things a lot better than they are now.*

(Oto-rhino-laryngology)

**Example 18**

D: *Mrs. Wallis, I have the results of your X-rays. These show you have severe osteoarthritis of your left hip. This is due to a congenital dislocation of the hip which you’ve had since birth. I think the best treatment for you would be an operation to replace your left hip.*

**P: *Tell me, Doctor, is that a major operation?***

D: *Yes, it is undoubtedly. But you are having so much trouble I do not think there is any other alternative.*

**P: *I’m very worried about this, Doctor. What does the operation involve?***

D: *It is a major operation which would require you to be in hospital for about two weeks. You’ll come to hospital a day or two before surgery so that we can examine you and check that you are fit for an anaesthetic. The operation itself involves quite a long cut on the outside of your thigh and then the worn part of your hip will be cut away and replaced with a metal and plastic joint. This should make you more comfortable, and your hip less stiff. But of course, as with any operation, there’s a small risk of complications.*

**P: *What are those complications, Doctor?*** (Orthopaedics)

**3.2.1 Doctor-Initiated Questions** As has been mentioned above, doctor-initiated questions are more numerous than those initiated by patients. Out of 354 doctor-initiated questions, 188 (53%) can be classified as Y/N questions, 52 (15%) as E/O questions, and 114 (32%) as open questions (see Tables 6, 7). 38 (11%) questions take place during the history-taking phase, 315 (89%) during the examination phase, and only 1 (0%) during the treatment phase (see Tables 6, 7).

**Table 6: Absolute Frequency of Doctor-Initiated Questions**

Abs.	Phase			Question Type			Total
	Hist	Exam	Treat	Y/N	E/O	Open	
Internal	24	75	0	43	28	28	<b>99</b>
Gynaec.	0	64	1	36	8	21	<b>65</b>
Paed.	13	75	0	45	8	35	<b>88</b>
ORL	1	54	0	42	7	6	<b>55</b>
Orthop.	0	47	0	22	1	24	<b>47</b>
<b>Total</b>	<b>38</b>	<b>315</b>	<b>1</b>	<b>188</b>	<b>52</b>	<b>114</b>	<b>354</b>

**Table 7: Relative Frequency of Doctor-Initiated Questions**

%	Phase			Question Type			Total
	Hist	Exam	Treat	Y/N	E/O	Open	
Internal	7	21	0	12	8	8	<b>28</b>
Gynaec.	0	18	0	10	2	6	<b>18</b>
Paed.	4	21	0	13	2	10	<b>25</b>
ORL	0	16	0	12	2	2	<b>16</b>
Orthop.	0	13	0	6	0	7	<b>13</b>
<b>Total</b>	<b>11</b>	<b>89</b>	<b>0</b>	<b>53</b>	<b>14</b>	<b>33</b>	<b>100</b>

Unlike patients, doctors freely take advantage of using all question types. Because the correlation between the question type and the participant is quite low (0.03), there is no significant correspondence between these two attributes of the consultation. What is significant, however, is the fact that 100% of doctor-initiated questions are asked during the history-taking and examination section. Since doctors have on the average only eight minutes to “establish rapport,

discover the reason for a patient’s visit, verbally and physically examine the patient, discuss the patient’s condition, establish a treatment plan, and terminate the exchange” (Paget 1983: 59), these two parts are reserved solely for the gathering of information and to concentrate and diagnose responsibly.

We may see that there is only one doctor-initiated question asked during the treatment phase in my corpus (Example 19). This question appears after a long speech by the doctor concerning the possible treatment, and invites a female patient to raise any questions concerning her problems. As the correlation proves ( $r=0.33$ ), there is a relation between participants and phases in their dialogue. The treatment section is used by doctors to explain the process of treatment or therapy, and for patients to ask additional questions about their diagnosis and following cure (Example 20).

**Example 19**

**D:** *Would you like to ask me any questions...?*

**P:** *Doctor, I wonder how I got these warts.*

**Example 20**

**P:** *Is it a big operation?*

**D:** *No, not too big. It’s quite common.*

In addition to what has been mentioned about the role of doctor-initiated questions during the treatment section, some recent studies refer to a specific sequence of doctor’s talk, which repeatedly appears throughout each medical consultation, especially during the treatment phase (e.g. Humphreys 2002). The sequence consists of a rhetorical question, an answer, and final **interpretation**. As Humphreys (2002: 34) points out:

This Question-Answer-Interpretation sequence places the patient in a position where they could, if they wished, question not only the treatment offered, but the thinking behind it. Therefore, this strategy is significant in balancing the asymmetry between doctors and patients.

On the other hand, Wallen, Waitzkin, and Stoeckle (1979) point out that “less than 1% of total time in information exchange between patient and physician is spent on physicians explanations to patients”,<sup>11</sup> and that the D-P interviews are strictly asymmetrical. Nevertheless, since the interpretation phase is also strongly rooted in the corpus that has been worked with within all the medical

branches (Examples 21, 22, and 23), I must confirm the findings reported by Joanne Humphreys.

**Example 21**

D: *You have been exposed to the genital wart virus through sexual contact with somebody who has genital warts or has the virus in his skin and the genital area. Unfortunately, I cannot tell you how long you have had the virus in your skin or who you could have caught it from, as it does not have to be your present partner but could have been from a partner several years ago... The warts will disappear with treatment, but unfortunately, I can't give you any guarantee that they will not return.*  
(Gynaecology)

**Example 22**

D: *The cardiologist will inform you about the procedure. After you have received the isotope injection, you should eat or drink something containing fat, such as cheese, milk or a sandwich. This is necessary in order to stimulate the substance being passed through the live, so that we can make an accurate image of the blood supply to your heart muscles.*  
(Internal medicine).

**Example 23**

D: *We need to change your tracheotomy tube. We've got the new ready here with an introducer. Let's untie these tapes around your neck and bring them round. That's good. We have the suction running in case we need it. We have to suck out your tracheotomy before we take the old tube as we put it in. It'll only suck as we pull it out. Now take a deep breath for me and we'll pull this tube out. Right, we are putting a new tube in.*  
(Oto-rhino-laryngology)

**3.2.2 Patient-Initiated Questions** The distribution of patient-initiated questions in my corpus is as follows: 11 of them (55%) belong to Y/N questions, no question (0%) could be classified as E/O question, and 9 (45%) belong to open questions (see Tables 8, 9). There are no patient-initiated questions (0%) taking place during the history-taking phase, 12 questions (60%) take place during the phase of examination, and 8 questions (40%) take place during the phase of treatment (see Tables 8, 9).

**Table 8: Absolute Frequency of Patient-Initiated Questions**

Abs.	Phase			Question Type			Total
	Hist	Exam	Treat	Y/N	E/O	Open	
Internal	0	1	0	0	0	1	1
Gynaec.	0	0	1	0	0	1	1
Paed.	0	4	0	0	0	4	4
ORL	0	7	1	8	0	0	8
Orthop.	0	0	6	3	0	3	6
<b>Total</b>	<b>0</b>	<b>12</b>	<b>8</b>	<b>11</b>	<b>0</b>	<b>9</b>	<b>20</b>

**Table 9: Relative Frequency of Patient-Initiated Questions**

%	Phase			Question Type			Total
	Hist	Exam	Treat	Y/N	E/O	Open	
Internal	0	5	0	0	0	5	5
Gynaec.	0	0	5	0	0	5	5
Paed.	0	20	0	0	0	20	20
ORL	0	35	5	40	0	0	40
Orthop.	0	0	30	15	0	15	30
<b>Total</b>	<b>0</b>	<b>60</b>	<b>40</b>	<b>11</b>	<b>0</b>	<b>9</b>	<b>100</b>

There are four important points which we should take into consideration when interpreting the patient-initiated questions in my corpus. The first being that there are very few questions (only 20) posed by patients. It is not easy to find a reliable explanation, and I align myself with Tuckett and colleagues (1985), who report that many patients do not want to ask questions. “The lack of question asking may reflect lack of confidence and skill for many patients – but for some patients it may reflect true avoidance of or resistance to information” (Roter and Hall, 1992: 104).

Interestingly, no questions are asked during the history-taking phase (Example 24). At the beginning of the consultation, the interview is usually in doctor's hands. Doctors aim to acquire as much information as possible, and there is no place for patients to raise their questions, even if they want to. To keep this form, doctors make only short pauses so as not to give patients too much time to ask. They also avoid giving them any explicit invitation to do so.

According to Humphreys (2002: 37): “This may indicate a higher degree of consensus to the conventional roles of doctor and patient.”

**Example 24**

P: *Doctor, I can never breathe out of my left nostril.*

D: ***Have you ever broken your nose?***

P: *Yes, last year.*

D: ***Have you had any bad colds or high temperatures lately?***

P: *No.*

D: ***Are you otherwise well?***

P: *Yes.*

Another interesting point to be noted is that there are no E/O questions on the side of patients. As the sample of patient-initiated questions is very low, it cannot be explained without difficulty. In my opinion, the most probable explanation could be deduced from the type of information patients look for. Patients usually raise their questions when they do not understand what doctors would like to know, what they are actually asking about (Example 25), when they need advice (Example 26), or when they desire direct replies as to relate to their worries and anxieties (Example 27). In all these situations Y/N questions (Example 27) or open questions (Examples 25 and 26) are preferred. Most patients, as lay people, do not have sufficient medical knowledge to offer their doctors more than one alternative, and therefore it is easier and more natural for them to use the other two question types. In addition, some behavioural scientists argue that questions in the form of either/or *force* a choice,<sup>12</sup> and thus patient-initiated questions of this type could be regarded impolite.

**Example 25**

D: *What is it /the phlegm/ like?*

P: ***What do you mean?***

**Example 26**

P: ***Well, what should I do in the meantime, Doctor?***

D: *Well, the important thing is to make sure that he has sufficient fluids...*

**Example 27**

P: ***Will my hearing get better, Doctor?***

D: *Yes, it will.*

The last point to be mentioned here is in a sharp contrast with the findings of Korsch, Gozzi, Francis (1968) and West and Paget (both in Todd and Fischer 1983), whose results show that there is a tendency to ignore patient-initiated questions. For example, according to West, only 87% of questions raised by patients in her corpus were answered. My findings differ rapidly because all questions asked by patients in this material, i.e. in all the medical branches under consideration, are answered. Here I am inclined to agree with Joanne Humphreys (2002: 4) and her explanation that: “Recent social changes have altered the balance of power between doctors and patients through increased openness on the part of the medical profession and greater access to information for patients.” My research, yielding similar results as hers, lays a possible foundation for such an argument. However, it is necessary to add that the shape of doctor-patient interaction from the standpoint of using questions has not been changed in all its aspects, and that the asymmetrical relationship has been preserved.

**4 Other Speech Acts in D-P Communication**

The purpose of the present section is to develop the discussion started in the first part of the present paper, by examining the function and sequential properties of other speech acts that occur throughout the medical encounter. In the previous section I have attempted to reveal the role of questions in doctor-patient communication. In this section my analysis is aimed at **answers, statements, directives, and reactives**. My investigation is based on the assumption that results of such research may reveal the process whereby power and asymmetry are manifested in the interaction.

**4.1 Analysis**

To follow the form of the previous section, doctor-initiated speech acts and patient-initiated speech acts have been distinguished and classified according to the phase within the medical interview. The results of the quantitative analysis are presented in the form of tables in order to give a more lucid account of the distribution of speech acts between particular medical branches. Where the results of the F-test or the computation of correlation allow a comparison of the medical disciplines under discussion, then such comparison is elaborated.

**4.2 Findings**

“Speech act theory offers a means to break the flow of talk into discrete parts” (Todd 1983: 160). In the sample, 622 following speech acts (besides questions)

have been excerpted: 216 (35%) statements, 323 (52%) answers, 20 (3%) reactives, and 63 (10%) directives (see Tables 10, 11). 282 (45%) of these speech acts are initiated by doctors, 340 (55%) are initiated by patients. 65 (10%) are used during the history-taking phase, 390 (63%) during the phase of examination, and 167 (27%) during the treatment section (Tables 10, 11).

**Table 10: Absolute Frequency of Speech Acts in D-P Interviews**

Abs.	Particip		Phase			Speech Act				Total
	D	P	Hist	Exam	Treat	Sta	Ans	Rea	Dir	
Internal	10	91	22	79	0	7	87	5	2	101
Gynaec.	56	63	0	76	43	48	60	3	8	119
Paed.	38	66	20	67	17	23	67	2	12	104
ORL	119	61	12	92	76	90	58	6	26	180
Orthop.	60	58	11	76	31	48	51	4	15	118
<b>Total</b>	<b>283</b>	<b>339</b>	<b>65</b>	<b>390</b>	<b>167</b>	<b>216</b>	<b>323</b>	<b>20</b>	<b>63</b>	<b>622</b>

**Table 11: Relative Frequency of Speech Acts in D-P Interviews**

%	Particip		Phase			Speech Act				Total
	D	P	Hist	Exam	Treat	Sta	Ans	Rea	Dir	
Internal	10	90	22	79	0	7	87	5	2	16
Gynaec.	47	53	0	64	36	40	50	3	7	19
Paed.	37	63	19	65	16	22	64	2	12	17
ORL	66	34	7	51	42	50	32	3	15	29
Orthop.	51	49	9	65	26	41	43	3	13	19
<b>Total</b>	<b>45</b>	<b>55</b>	<b>10</b>	<b>63</b>	<b>27</b>	<b>35</b>	<b>52</b>	<b>3</b>	<b>10</b>	<b>100</b>

**Tables 12, 13, 14: Results of the F-test**

F	Participant			
	Gynaec.	Paed.	ORL	Orthop.
Internal	2.75E-07*	2.60E-06*	1.05E-06*	2.62E-07*
Gynaec.		0.72	0.51	0.99
Paed.			0.81	0.7
ORL				0.5

F	Speech Act			
	Gynaec.	Paed.	ORL	Orthop.
Internal	5.70E-09*	3.50E-10*	1.70E-17*	4.40E-14*
Gynaec.		0.52	2.30E-03*	0.04*
Paed.			2.50E-02*	0.18
ORL				0.4

F	Phase			
	Gynaec.	Paed.	ORL	Orthop.
Internal	0.12	2.70E-04*	4.80E-05*	9.20E-04*
Gynaec.		2.30E-02*	8.50E-03*	0.06*
Paed.			0.92	0.66
ORL				0.55

The analysis, both quantitative and qualitative, has revealed a number of interesting points I would like to comment on. Firstly, the most numerous speech acts (besides questions) are answers. As has already been discussed, 649 (90%) turns out of 725 are manifested solely by questions or answers in the first sample. Moreover, all doctor-initiated questions are answered by the patient, and all patient-initiated questions are answered by the doctor. How such fact influences the phenomenon of asymmetry and its changes has been stressed as well.

More importantly, the qualitative investigation has also revealed the sequential organisation of the speech acts under consideration. As Sacks, Schegloff, and Jefferson (1974) assume, there is a **two-part structure** in conversation between equal participants in **non-institutional settings** (e.g. question-answer, greeting-reply). The interaction in institutional settings, however, is organised in a different manner. According to the Birmingham discourse analysis group, it is a **three-part exchange** (initiation-response-feedback) that is characteristic of the **institutional talk**. “The difference seems to be a consequence of the asymmetry between participants, which produces a third part to the conversation” (Todd 1983: 164).

Originally, the three-part exchange was proposed for the educational setting (Coulthard 1977), only later for the medical setting (Coulthard & Brazil 1992). During the classroom interaction, the third part is initiated by a teacher as an evaluation of a students’ work. In the medical encounter, it is a reactive, which is initiated by the doctor in order to maintain control of the medical encoun-

ter.<sup>13</sup> What is important, is the three-part structure of interaction, with the reactive at the end, and the way in which it enters doctor-patient talk in all the medical branches (Examples 28, 29, and 30).

**Example 28**

D: *So you haven't experienced this symptom before?*

P: *No, not that I can remember, Doctor.*

D: ***I see.*** (Internal medicine)

**Example 29**

D: *How did you feed your children? Breast or bottle?*

P: *I breast-fed all of them but only managed for about the first three months and after that we began to top them up with bottle milk.*

D: ***OK.*** (Obstetrics and Gynaecology)

**Example 30**

D: *Does it hurt?*

P: *No.*

D: *Does it run?*

P: *No, I just can't hear.*

D: ***Right.*** (Oto-rhino-laryngology)

According to Todd, there are two reasons the doctor uses the reactive. "First, to end the interactional segment and the topic, and second, to bring control of the interaction back to the doctor, allowing the doctor to end that frame and to initiate a new one" (1983: 165). As is obvious from Example 31, by using the reactive *That seems OK*, the doctor acknowledges the patient's reply, ends the topic and the particular part of the interview, and continues with another question. The question introduces a new topic, is answered by the patient, and finally acknowledged by the doctor's reactive *Good*, which fulfils the same function as the previous one.

**Example 31**

D: *What does the stool look like? Is it yellow or green? Does it smell strong?*

M: *Well, it's very pale but it doesn't smell much.*

D: ***That seems OK.*** *Can you tell me about James's immunisation?*

M: *Yes, he's had his triple, Doctor.*

D: ***Good.*** *How are things generally? Any anxiety about James?*  
(Paediatrics)

As is evident from Tables 10 and 11, most speech acts occur during the phase of examination (390; 63%). By comparing the length, the amount of talk, and the structure of turns between the phases of the medical encounter<sup>14</sup>, it appears to me that the explanation could be summarised as follows: The examination is the longest part of the interview (<sup>2</sup>/<sub>3</sub> of total time). The doctor does not only question the patient and receive his/her responses in return, as it is common during the history-taking phase, but he also conducts physical examination and considers the patient's condition (Example 32).

**Example 32**

P: *Everyday when I wake up, my mouth's dry and I can't talk. I have to have a few drinks or something to get my mouth working. As the day goes on, my voice tires as well and I get hoarse.*

D: ***I'd like to look down your voice box with this mirror. Open your mouth wide. That's lovely. Put your tongue out. Let me hold it with this swab. I've warmed this mirror slightly on the Bunsen burner. It's not hot, you can see that. Breathe through your mouth. Sit up straight. Lean very slightly forward ... lovely. Let me put this to the back of your mouth. Keep your tongue down, that's super, and say "hay" ... You've got laryngitis. Your vocal cords, your voice box, they're all sore. Do you smoke?***

P: *Yes.*

Furthermore, the doctor provides **multiple speech acts** per turn during the phase of examination (Example 33). This feature is not characteristic of the history-taking phase, where both the doctor and the patient utter only one, two, or three speech acts per turn (Example 34). The treatment phase, on the contrary, also consists of multiple speech acts provided by doctors. However, this phase of the medical interview is much shorter than the examination, and there are almost no questions and answers, i.e. the most numerous speech acts, initiated (Example 35).

**Example 33**

D: *Well, what I'm going to do is I'm going to listen to your breathing. So, could you take a deep breath for me? Right. That's fine. You can just breathe normally now. Now I'm going*

*to listen to your heart. Just lie down. I'll just have a look at your tummy. Now what we also need to do is have a little look at your pee so could you put a little bit in this pot here.* (Examination)

**Example 34**

**D:** *As far as you know, are there any illnesses that run in your family?*

**P:** *None that I know of, Doctor.*

**D:** *Nothing like diabetes, high blood pressure, or heart disease, stroke, cancer, mental illness or anything like that?*

**P:** *Oh, I see! My father had a heart condition, and I have two aunts who have diabetes.* (History-taking)

**Example 35**

**D:** *I'll also get you to speak to one of the contact tracers who will give you some information about sexually transmitted infections and how you can prevent them. Before you leave the clinic, could you also please give me a specimen of urine...* (Treatment)

**4.2.1 Doctor-Initiated Speech Acts** As Tables 15 and 16 show, doctors initiate 283 speech acts (besides questions) in my sample. 183 (64%) of them belong to the category of statements, 19 (7%) to the category of answers, 19 (7%) to the category of reactives, and 62 (22%) to the category of directives (see Tables 15, 16). 27 (10%) of the speech acts occur during the history-taking phase, 97 (34%) speech acts during the phase of examination, and 159 (56%) speech acts during the treatment section (see Tables 15, 16).

**Table 15: Absolute Frequency of Doctor-Initiated Speech Acts**

Abs.	Phase			Speech Act				Total
	Hist	Exam	Treat	Sta	Ans	Rea	Dir	
Internal	3	7	0	3	0	5	2	10
Gynaec.	0	15	41	45	0	3	8	56
Paed.	8	13	17	22	2	2	12	38
ORL	8	36	75	79	8	6	26	119
Orthop.	8	26	26	34	9	3	14	60
<b>Total</b>	<b>27</b>	<b>97</b>	<b>159</b>	<b>183</b>	<b>19</b>	<b>19</b>	<b>62</b>	<b>283</b>

**Table 16: Relative Frequency of Doctor-Initiated Speech Acts**

%	Phase			Speech Act				Total
	Hist	Exam	Treat	Sta	Ans	Rea	Dir	
Internal	30	70	0	30	0	50	20	4
Gynaec.	0	27	73	80	0	6	14	20
Paed.	21	34	45	58	5	5	32	13
ORL	7	30	63	66	7	5	22	42
Orthop.	14	43	43	57	15	5	23	21
<b>Total</b>	<b>10</b>	<b>34</b>	<b>56</b>	<b>64</b>	<b>7</b>	<b>7</b>	<b>22</b>	<b>100</b>

In general, doctors initiate the speech acts from all categories selected and in every part of the medical encounter. More interestingly, most speech acts are provided during the treatment section and from the category of statements. As the correlation between the phase and the participant of the interview proves ( $r = -0.46$ ), there is a connection between these two variables. Moreover, the result of the F-test for the comparison of the participant and the phase with regard to the category of speech acts is  $1.10E-25$ , which also indicates that it is worth considering the significance of the category of speech acts, for their distribution.

As has already been shown, the treatment section is reserved for doctors to explain the process of treatment and therapy to their patients. Naturally, this task can be successfully manifested particularly by initiating statements (Example 36).

**Example 36**

**D:** *Here you can see a fracture through the third bone which is called the metacarpal. You can see that the bone is bent and in order for you to be able to use your hand normally, I think we ought to give you an anaesthetic to put you to sleep in order to straighten the bone. We should be able to hold it in the straight position with a plaster, but it is possible we might need to put wires in the bone to hold it in place.*

Aside from statements, another numerous category initiated by doctors are directives. Out of sixty-three directives there were sixty-two provided by doctors. As Todd (1983: 169) suggests, directives provide the doctor with control of the floor as much as the reactives do. In my corpus, directives usually take

place during the examination and treatment sections. More interestingly, they are provided in the form of direct speech acts during the phase of examination (Example 37), and in the form of indirect speech acts during the treatment section (Example 38).

**Example 37**

D: *I'm going to examine your mouth. **Open your mouth wide for me. Let me put these tongue blades under your lips to look from side to side. Stick your tongue out. Lift it up to the roof of your mouth ... down again ... to your right ... to your left.***

**Example 38**

D: *Before you leave the clinic, **could you please give me a specimen of urine so that I can test it for any signs of infection? I will also need to take a blood sample from you which will be tested for syphilis which is a routine blood test we do on everybody that attends the clinic. Thank you.***

In addition to what has been said, out of 283 doctor-initiated speech acts 119 (42%) are provided by oto-rhino-laryngologists. As Tables 15 and 16 show and as the results of the F-test for the comparison of ORL and other medical branches with regard to the category of speech acts proves (1.70E-17; 2.30E-03; 2.50E-02), there is a significant distinction between ORL and other medical branches under discussion. The factors underlying this point of divergence are the large number of directives provided by the oto-rhino-laryngologists and the context of their medical branch which forces them to use many directives so frequently.

Significantly, oto-rhino-laryngologists use tools and medical instruments for examining the patient, more than in any other discipline. They must conduct a **physical examination** of subtle parts of a body, and the examination, of course, is not always pleasant for the patient. Generally speaking, the shorter the process of the examination, the better it is for the patient. Therefore, short directives (Example 39, Example 40) are preferred to longer questions, which are characteristic of **verbal examination**. The patient, whose throat is very often checked, would not be able to answer anyway.

**Example 39**

D: ***Sit up straight. Lean very slightly forward. I'd like to look deep into your throat with this mirror. I've warmed it with a burner. You can see it's not hot. I can touch it and it doesn't***

***hurt. Open your mouth wide. Stick your tongue out. I'm going to put a swab round it and hold it. Breathe steadily through your mouth. I'm passing this mirror to the back of your mouth and now say "ee".***

**Example 40**

D: *Right. Nurse, would you come here? ... **Sit on mummy's lap, lie back, let's put this sheet round you, well done. The nurse is going to hold your nose, that's lovely. Now I've got this little magic light. I'm going to look in your nose. Well done! I haven't looked up your nose before. Now wait, I'm putting this little hook down it. Ohh, now it's out. Here we are.***

**4.2.2 Patient-Initiated Speech Acts** As the quantitative analysis shows, out of 339 patient-initiated speech acts (besides questions), 33 (10%) belong to the category of statements, 304 (90%) to the category of answers, 1 (0%) to the category of reactives, and 1 (0%) to the category of directives (see Tables 17, 18). 38 (11%) appear during the history-taking, 293 (87%) during the examination, and only 8 (2%) during the treatment (see Tables 17, 18).

**Table 17: Absolute Frequency of Patient-Initiated Speech Acts**

Abs.	Phase			Speech Act				Total
	Hist	Exam	Treat	Sta	Ans	Rea	Dir	
Internal	19	72	0	4	87	0	0	<b>91</b>
Gynaec.	0	61	2	3	60	0	0	<b>63</b>
Paed.	12	54	0	1	65	0	0	<b>66</b>
ORL	4	56	1	11	50	0	0	<b>61</b>
Orthop.	3	50	5	14	42	1	1	<b>58</b>
<b>Total</b>	<b>38</b>	<b>293</b>	<b>8</b>	<b>33</b>	<b>304</b>	<b>1</b>	<b>1</b>	<b>339</b>

**Table 18: Relative Frequency of Patient-Initiated Speech Acts**

%	Phase			Speech Act				Total
	<i>Hist</i>	<i>Exam</i>	<i>Treat</i>	<i>Sta</i>	<i>Ans</i>	<i>Rea</i>	<i>Dir</i>	
<i>Internal</i>	21	79	0	4	96	0	0	<b>27</b>
<i>Gynaec.</i>	0	97	3	5	95	0	0	<b>19</b>
<i>Paed.</i>	18	82	0	2	98	0	0	<b>19</b>
<i>ORL</i>	6	92	2	18	82	0	0	<b>18</b>
<i>Orthop.</i>	5	86	9	24	76	0	0	<b>17</b>
<b>Total</b>	<b>11</b>	<b>87</b>	<b>2</b>	<b>10</b>	<b>90</b>	<b>0</b>	<b>0</b>	<b>100</b>

In general, aside from questions, patients initiate only two types of speech acts: statements and answers, particularly during the first two parts of the medical encounter. Since the explanation for this fact is easily deduced from what has been said about the speech acts provided by doctors, it not necessary to comment on the issue. What is of greater interest, however, are the figures obtained for patient-initiated reactives and directives.

As displayed by Table 17, only one reactive and one directive are provided by one patient in the sample. They take place during the history-taking phase (R) and at the beginning of the phase of examination (D), and are provided in the surgery of an orthopaedist. Since such a low number limits any reliable interpretation, let me introduce the following situation (Example 41) and consider the process of the interview.

**Example 41**

D: *How's Mary's health?*

M: *She's usually a very fit girl. She has suffered from asthma in the past, but doesn't take any medicine regularly.*

D: *Is there anyone else in your family who suffered from curvature of the spine?*

M: *Yes, my brother, that's Mary's uncle, was quite severely disabled by curvature of the spine when he was in his teens.*

D: *I see, so you're obviously concerned that the same thing may happen to your daughter.*

M: *Yes, Doctor, that's right.*

D: *What I'd like to do now is to examine Mary if that's all right with you.*

M: *Yes, please go ahead.*

In Example 41, an orthopaedist is visited by Mrs Black and her daughter Mary. It is the first meeting between the doctor and the family. The mother is worried about her daughter's health as she thinks that Mary suffers from curvature of the spine. The doctor initiates the talk by asking Mrs Black questions about Mary's past medical history, and whether or not anyone in the family is disabled. When he finds out that Mary's uncle had a similar problem as a teenager, he utters a reactive *I see*, and continues with a structure, which is rather more of a commentary on the situation than a real question (*so you're obviously concerned that the same thing may happen to your daughter*).

Nevertheless, Mrs Black provides an answer and even proceeds with a reactive. Then, the doctor approaches Mary's examination, which is followed by the permission-seeking *if that's all right with you*. This use of modality can indicate the doctor's sensitivity to 'the delicacy of consulting with a small child'.<sup>15</sup> The permission is, of course, given by Mrs Black; surprisingly, it is provided in the form of a directive *go ahead*.

As Todd (1983: 165) maintains:

The patient's conversation also displays reactives; the patient's reactives, however, differ from those of the doctor in that they occur in single speech act turns. The patient does not usually, in her turn, utter a reactive and continue. Rather, she utters the reactive as both the initiation and the end of her turn and in response to the doctor's utterance.

Patient-initiated directives, on the other hand, are very unusual for doctor-patient communication. From what has been observed I would suggest that it is the personality of Mrs Black that influences the flow of interaction.<sup>16</sup> A highly verbal, assertive, and educated woman, a caring mother. It has been proven (e.g. Roter and Hall 1992) that better-educated patients have more to say and are more assertive. However, as has been stressed, in this particular case we cannot generalise.

**5 Concluding remarks**

What has been said about the roles and functions of speech acts might suggest that the asymmetrical relationship between doctors and patients has been preserved. However, there is a tendency to "reduce hierarchies and renegotiate roles" (Gwyn 2002: 69). As has been stressed elsewhere (e.g. Todd 1983), more empirical research is needed. Only then we will be able to 'enlighten

theory' and to suggest new strategies for improved doctor-patient communication.

## 6 Notes

[\*] The present paper is based on Chapter 6 of my treatise *Sociolinguistic and Pragmatic Aspects of Doctor-Patient Communication* (see Černý 2007).

<sup>1</sup> This approach is proposed by Müllerová, Hoffmannová, and Schneiderová (1992).

<sup>2</sup> For anybody who is to continue with the research within doctor-patient interaction it will be, of course, inevitable to investigate much larger and more suitable language material. The corpus under scrutiny suffers several disadvantages: e.g. the incompleteness of dialogues and lack of tagging (for details see Černý 2007). However, when preparing this analysis no better source of conversational texts was available.

<sup>3</sup> See, for example, Drew and Heritage (1992).

<sup>4</sup> Todd's classification of speech acts is based on D'Andrade's Preliminary Speech Act Category System: A. *Statements* (expositives, representatives, assertions) reports / quotes / instantiations / claims / stimulations / inferences; B. *Directives* (requests, orders, exercitives) suggest / request / order / request object / agree as to truth / expression of approval / sympathy / support / commitment / direct action / direct / indirect; C. *Questions* / wh-form / yes/no form / tag form / intonation-only form / information-only versus other uses / D. *Reactives* (various kinds of agreement or disagreement with what has previously been stated) agree as to truth versus disagree as to truth / give attention / accede (agree to commit, or actually do) versus refuse; E. *Expressives* / give approval versus disapproval (sympathy, regret, exasperation, etc.) direct versus indirect (accusation, disagreement, etc.); F. *Commissives* / promise, offer, vow, etc.

<sup>5</sup> For details about the function of different types of questions in general, see Roter and Hall (1992: 83).

<sup>6</sup> Tsui (1992: 102-109) claims that elicitations are targeted towards the following functions: information, confirmation, agreement, commitment, repetition, clarification.

<sup>7</sup> I interpret the results of the F-test in order to make the quantitative analysis more reliable. On the other hand, the F-test is understood as a supplementary device, which has no priority over the qualitative analysis, and is taken into consideration only when the sample discussed is large enough, or when the results of the F-test are so significant that they could provide new insights into the subject under scrutiny.

<sup>8</sup> I use the asterisk to indicate when the results are of certain significance.

<sup>9</sup> Here I would see the influence of various TV series and soap operas (e.g. *Chicago Hope, Emergency*), which sometimes present surgeons as some supernatural creatures.

<sup>10</sup> Cf. Roter and Hall (1992).

<sup>11</sup> This information is acquired in West (1983: 76).

<sup>12</sup> See, for example, West (1983: 67).

<sup>13</sup> Cf. Mishler (1984: 61) and his structural unit of doctor-patient discourse: a. Physician Question / b. Patient Response / c. Physician Assessment / d. (pause) / e. Next Question.

<sup>14</sup> Cf. the division of the medical consultation proposed by Byrne and Long (1976).

<sup>15</sup> Cf. Gwyn (2002: 82).

<sup>16</sup> Cf. Roter and Hall (1992); especially the chapter "The Influence of Patient Characteristics on Communication between the Doctor and the Patient".

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