

INTERRUPTIONS AND OVERLAPS IN DOCTOR–PATIENT COMMUNICATION REVISITED^[*]

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Abstract. The paper offers partial results of a long-term project aimed at the inquiry into the field of medical interviewing. The main goal of the project is to search for communicative strategies of doctors and patients that are capable of conveying empathy and trust. Via an interdisciplinary analysis, based on the data excerpted from the most recent edition of the *British National Corpus* (2007), the author attempts to bring quantitative and qualitative evidence that doctor–patient communication has undergone significant modifications, resulting in social redefinition of the asymmetrical roles of the main protagonists. The paper draws attention to those communicative practices of doctors and patients that usually result in overlapping speech.

1. Introduction

Wynn (1995: 81) claims that doctor–patient communication research should focus on three main aspects of medical interviewing: (i) *questions*, (ii) *turn time and verbosity*, and (iii) *interruptions and overlaps*. Since I already discussed the first two aspects in some of my previous papers (Černý 2007, 2010), let me now draw attention to the role of the last one. With respect to the main goal of my long-term research, that being a search for discourse strategies of doctors and patients that are capable of conveying empathy¹ and trust, I will focus only on a selected number of functions carried by the employment of interruptions, resulting in overlapping speech. At the same time, I plan to revisit the frequently quoted standpoint (see Furst 1998) that recent social changes have modified the traditional model of the doctor–patient relationship and prepared ground for reduction of hierarchies and redefinition of roles in favour of the patient. Let me note that social position may affect the selection of words as evidenced by Körtvélyessy (2009).

For the purposes of the analysis I have taken the advantage of the spoken component of the *British National Corpus* (2007) and its collection of transcribed and annotated medical interviews. I have selected 50 medical interactions, with the total extent of text amounting to 34,376 words. In order to be successful in meeting my research aims, I have combined

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¹ In general, I understand empathy as an “emotional experience between an observer and a subject in which the observer, based on visual and auditory cues, identifies and transiently experiences the subject's emotional state. In order to be perceived as empathic, the observer must convey this understanding back to the subject” (Hirsch 2009).

the quantitative² perspective of the medical science with the qualitative viewpoints of conversation and discourse analysis (cf. Wynn 1995). My findings will be compared and contrasted with findings resulting from previous studies on the role of interruptions in doctor–patient communication, conducted in 1970s, 1980s, and early 1990s.

2. In search of definitions

Interruptions and overlaps belong among the conversation analytical variables which are problematic as far as their unambiguous definitions are concerned (cf. questions, topics, etc.). As Wynn summarizes: “Most researchers think that an interruption involves some sort of simultaneous [overlapping] speech. The additional criteria seem to vary, however” (1995: 75). Nevertheless, not even all overlaps within verbal interaction are interruptions. So called backchannels, for example, cannot be regarded as interruptions because they do not disrupt the topic or claim the floor (James – Clarke 1993).

The delimiting criteria include either whether the particular speaker is successful in interrupting the other interactant (Bennet 1981), or they take into consideration the intent of the speaker (cf. Tannen 1986). There is one more group of scholars: these classify interruptions as specific instances of simultaneous speech, emphasizing neither the success, nor the intent of speakers (Zimmerman – West 1975). The methodological problem of the first criterion is that it argues that those cases of simultaneous interaction which are not successful in interrupting the speaker cannot be classified as interruptions. The question then is how to assort such utterances which *do* intend to interrupt, but fail. The problem of the second criterion rests in the fact that it is frequently difficult to recognize the real intention of the speaker. The last method is, in my opinion, ignorant of the interactional context in which the interruption is realized, and thus so much can be ‘lost in translation’ for the researcher.

Opinions also differ as regards the function of the interruption (and overlap). According to Waitzkin (1984: 2445): “Interruptions are dominance gestures.” The largest part of scholars really view interruptions as ‘control devices’, ‘displays of dominance’, as ways of claiming power in face-to-face communication (West – Zimmerman 1983, Cameron 1985, Fairclough 1989, Ainsworth-Vaughn 1992). However, it has been proved that interruption can function as manifestation of support, cooperation and understanding (cf. Edelsky 1981; Tannen 1984, 1986; Goldberg 1990).

Within the scope of this study, interruption is defined as “an initiation of simultaneous speech which intrudes deeply³ into the internal structure of a current speaker’s utterance”

² Besides calculating absolute and relative numbers, I also use more sophisticated statistical approaches, namely correlation and the F-test. Correlation is a measure of the relation between two or more variables. Correlation coefficients (I employ Pearson) can range from –1.00 to +1.00. The value of the former one represents a perfect negative correlation, the value of the latter represents a perfect positive correlation. The F-test gives statistical evidence whether two samples have the same standard deviation with specified confidence level. Samples may be of different sizes. In lay terms, it proves whether two samples differ to such an extent that this differentiation is worth studying.

³ In Zimmerman – West (1975), the word ‘deeply’ appearing in the definition of an interruption is meant as “found more than a syllable away from a possibly complete unit-type’s boundaries”. Since it is often quite difficult to guess when the speaker’s completion point appears, I classify a ‘deep intrusion’ from the semantic

(Zimmerman – West 1975: 113), with the intent of disrupting the topic, claiming the floor of the interaction or manifesting cooperation and support; does not matter if it results in successful interrupting the speech-flow or failure. While overlap is to mean “simultaneous speech in general, a phenomenon which can be mechanically or objectively defined” (Wynn 1995: 93), the identification of an interruption is based on such factors as context, topic, interactional response, etc. (Bennet 1981, Tannen 1986). This situational dependence then decides whether a particular interruption is to be interpreted as a display of dominance (Example 1) or cooperation (Example 2).

- (1) D: *Well I don't why it's been changed because*
 P: *Well, I, that's really the only reason I came up was because I wondered if they wanted to take me off it, you know if you wanted to change it, because I, it isn't working. Cos if I miss one of my toes are absolutely giving me gyp.*
 (BNC/H4M/34–35)
- (2) D: *Now what about Alice, is she needing?*
 P: *Aye er (.) (unclear) er Lus Lustril*
 D: *Need some of the Lusterol*
 P: *(21.0) Lusterol Bolterol er*
 D: *And Bolterol*
 P: *(12.0) Er Ni Nikram, Ni Nikram tablets*
 D: *Nikram*
 P: *Nikram (unclear) tablets*
 D: *What's she taking that for Tom?*
 (BNC/H5P/35–43)

Drawing on Goldberg (1990), I distinguish between (i) *neutral interruptions*, (ii) interruptions expressing *relational rapport*, (iii) *competitive interruptions*, and (iv) those which display *relational power*. The neutral interruptions are relationally relevant, usually they do not initiate any significant shifts in the flow of the communication, and are not perceived as face-threatening. By contrast, the power type interruptions “are designed to wrest the discourse from the speaker by gaining control of conversational process and/or content [...], involve topic change attempts accomplished by questions and requests or by assertions or statements whose propositional content is unrelated to the specific topic at hand” (Goldberg 1990: 892). The remaining two categories of interruptions stay on the topic, but unlike the rapport interruptions which often function as emphatic markers of interest, the competitive interruptions act as functional devices in the process “where each party strives to get the other to acknowledge her own particular beliefs, accomplishments or experiences as being in some sense ‘superior’ to those of the other” (Goldberg 1990: 896). Examples are offered in section 3.

As is evident, Goldberg’s classification forms a symmetry–asymmetry continuum, with neutral and power type interruptions representing its respective extremes, and rapport and competitive interruptions standing for the in-between types. It will be interesting to spot to

point of view. In other words, if the simultaneous speech involves only synsemantic words (e.g. conjunctions), it cannot be considered an interruption.

what extent are these types doctor- or patient-initiated, and how they relate to the particular sections of the medical encounter: the information-gathering, the diagnosis or the treatment section. Before approaching the actual analysis, both quantitative and qualitative, let me offer a selective summary of results from previous studies referring to various functions of interruptions in medical consultations (Chart 1).

Chart 1: Findings resulting from previous studies on the function of interruptions in doctor–patient interaction

Study	Research results
Byrne – Long (1976)	Patients are often interrupted while presenting their problems.
Shuy (1983)	There are very few instances of doctors interrupting patients, but often interruptions of the doctor by the patient.
West (1984)	Doctors interrupt patients far more often than the reverse.
Mishler (1984)	Interruptions belong among the means by which the voice of medicine is established.
Waitzkin (1984)	Interruptions tend to be initiated by the interactant who holds the dominant position in the interaction (i.e. doctor).
Aronsson – Larsson (1987)	Interruptions may function as expressions of eagerness, support, and cooperation.
Henzl (1989)	Interruptions correlate with the asymmetry in the amount and distribution of speech during the medical interview.
Fairclough (1989)	Interruptions are used by doctors with the purpose of controlling the medical consultation.
Måseide (1990)	In order to be able to carry out systematic investigations, doctors have to limit patients' contributions.
Roter – Hall (1992)	Doctors interrupt patients right from the beginning of the consultation.

(cf. Wynn 1999: 64–68)

3. Statistical distributions

The statistical analysis of the variable 'interruption' has produced the following numerical data (Table 1 & 2). Out of 50 medical encounters, comprising 5525 turns (34,376 words), it was possible to excerpt 290 interruptions. 168 (58%) instances could be classified as

doctor-initiated, 122 (42%) as patient-initiated. 124 (43%) interruptions take place in the info-gathering phase, 38 (13%) during the period when the diagnosis is revealed, and 128 (44%) interruptions occur in the treatment section. 34 (12%) cases belong to the category of neutral interruptions, 199 (68%) interruptions display relational rapport, 43 (15%) are competitive interruptions, and 14 (5%) interruptions display relational power.

Table 1: Absolute frequency of interruptions in doctor-patient interaction

<i>Abs.</i>	Participant		Phase			Total
	<i>Doctor</i>	<i>Patient</i>	<i>Information</i>	<i>Diagnosis</i>	<i>Treatment</i>	
<i>Neutral</i>	20	14	14	6	14	34
<i>Rapport</i>	114	84	85	24	90	199
<i>Competitive</i>	22	22	18	6	19	43
<i>Power</i>	12	2	7	2	5	14
Total	168	122	124	38	128	290

Table 2: Relative frequency of interruptions in doctor-patient interaction

%	Participant		Phase			Total
	<i>Doctor</i>	<i>Patient</i>	<i>Information</i>	<i>Diagnosis</i>	<i>Treatment</i>	
<i>Neutral</i>	12	11	11	16	11	12
<i>Rapport</i>	68	69	68	63	70	68
<i>Competitive</i>	13	18	15	16	15	15
<i>Power</i>	7	2	6	5	4	5
Total	58	42	43	13	44	100

In relation to Chart 1, the above distributional spread seems to refute both the research findings by Shuy (1983), who claims that patients interrupt doctors far more often than the reverse and, at the same time, the findings by West (1984), who claims the opposite. To be more specific, in my samples, patients are as active ‘intruders’ into the talk of the other dialogue participant as doctors are. Generally, it can be said that doctors as well as patients interrupt straight away from the beginning of the medical consultation (cf. Roter – Hall 1992) and do not stop until the interview is over. It is also evident that neither doctors nor patients limit themselves in the use of any type of interruption (Examples 3, 4, 5, 6) and that overlapping speech is a common interaction pattern.

- (3) P: *I thought I was taking a heart attack, but er Doctor (anonym) gave me a rub of that Di Difa Dif D:*
 D: *Diflam.*
 P: *Diflam?*
 D: *Diflam. Yes.* (neutral)
 (BNC/G4D/51–54)
- (4) P: *Or er (unclear) you know [into my finger.*
 D: *Into your fingers.]*
 P: *You know when I, when I go to lift something, or if I use*
 D: *Mhm.*

- P: *pressing on this finger,*
 D: *Aye, it feels [numb.*
 P: *(unclear)] right up*
 D: *Right up the arm. Right.*
 P: *this arm. (7.0)* (relational rapport)
 (BNC/G47/24–32)
- (5) D: *Still on the Froben. What about the Tylex?*
 P: *I tried the they keep me, now and again with them Doctor, [they make*
 D: *They're not]*
 P: *me awfully sick.* (competitive)
 (BNC/H60/9–12)
- (6) D: *Yeah.]*
 P: *er what will you do, let me know? Or*
 D: *No, what we'll do is go and actually get you booked in.*
 P: *Oh.* (relational power)
 (BNC/GY5/20–26)

A more sophisticated quantitative analysis via the calculation of the F-test (Appendix) confirms that there really is balanced dispersion of the interruption-types with respect to participants and dialogue phases. In other words, from the statistical point of view, the acquired data indicate that it is not worthy to focus on the interrelations between the variables ‘interruption type’ – ‘participant’ and/or ‘interruption type’ – ‘phase’. What is, by contrast, worthy of examining here is the significant correspondence ($r = 0.3438$) that exists between the variables ‘participant’ and ‘phase’ with regard to the category of interruptions as such. To put it differently, the investigation of a researcher should concentrate on to what extent a particular phase influences either the doctor or the patient to initiate interruptions.

Despite what the quantitative analysis suggests, I still find it rewarding to trace how particular types of interruptions relate both to the interactants and the interview phases. My focus, however, will not take into consideration the numerical perspective, but the functional one. The point is that doctors may, for example, employ the same amount of the same interruption-types as patients do, though with different communicative intentions. Similarly, the same interruption-types may occur in all the interview sections, nevertheless with different functional use. It is for this reason that the distributional/statistical analysis calls, in my opinion, for more sensitive qualitative complementation.

4. Doctors interrupting their patients

Though any definition of interruption is, to a certain extent, problematic (cf. Davis 1996), and it is not possible to attain any ultimate definition of this discourse category, the distributional analysis of doctor-initiated interruptions, following the criteria introduced in above, insinuates (Figure 1 & 2) that the largest number of instances should be classified as rapport (68%), 13% as competitive, 12% as neutral, and 7% as power interruptions. Re-

garding the distribution of doctor-initiated interruptions with respect to the interview phase, it can be stated that the largest number of instances occur during the information-gathering phase (60%), 33% of interruptions occur during the treatment section, and only 7% during the phase of diagnosis.

Fig. 1: Relative distribution of doctors' interruptions with respect to their classification

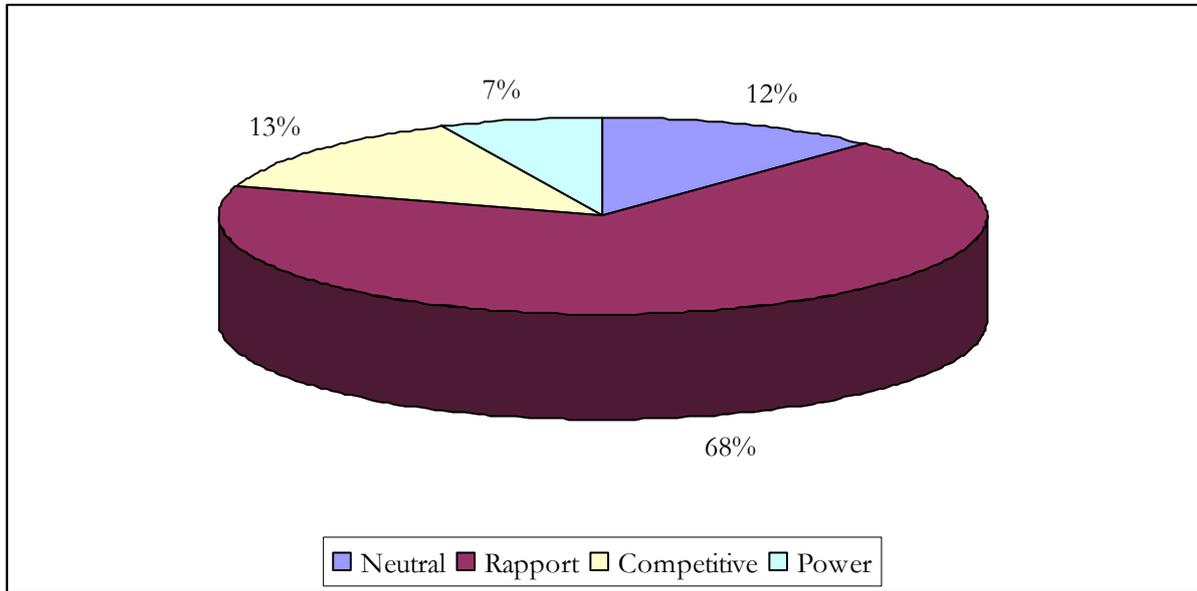
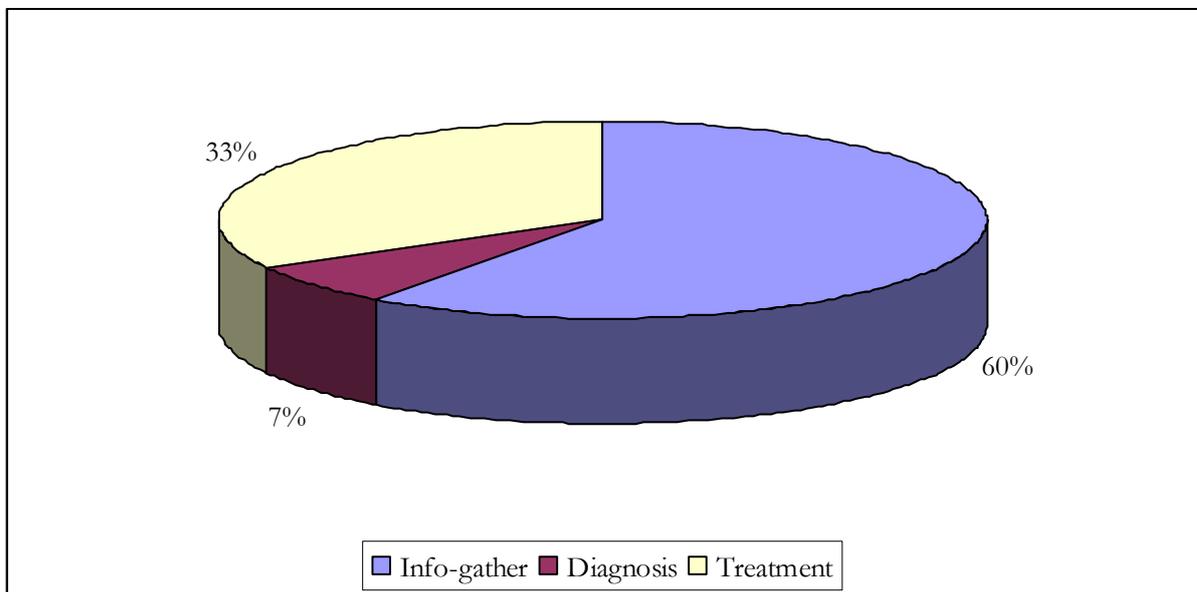


Fig. 2: Relative distribution of doctors' interruptions with respect to the interview phases



Taking into consideration the classification of interruptions along the symmetry–asymmetry continuum, the data demonstrates that the symmetry-oriented interruptions (i.e. neutral interruptions and those expressing relational rapport) prevail over the asymmetry-oriented interruptions (i.e. competitive and power interruptions) 80% to 20%. This finding seems to rebut Fairclough’s (1989), Mishler’s (1984), and Waitzkin’s (1984) arguments that interruptions belong among the means by which the *voice of medicine* is established,

and that interruptions are used by doctors with the purpose of controlling the medical consultation. Much more frequently, they function as discourse devices expressing either support and cooperation (neutral interruptions) or, first and foremost, eagerness and/or signs of interest and empathy (relational rapport).⁴ For the illustration see Example 7.

- (7) P: *(cough) (18.0)*
 D: *Stupid machine. Can't be doing with that way down there. (11.0) That should it's found you (.) at last.*
 P: *[It's found me. Oh so I am*
 D: *(unclear) at last.]*
 P: *here. After all [these years I'm definitely*
 D: *Still alive.]*
 P: *here.*
 D: *Still alive. (.)*
 P: *That's given me all sorts of things, has it? (ha-ha)*
 (BNC/H4M/24–32)

If the controlling interruption does take place, it is usually with the intent to take the floor and change the topic of the interaction. In the following illustration (Example 8), it can be seen how the doctor intrudes into the patient's speech by shifting their interaction from the currently discussed topic about the increasing number of patients during the school holidays to the real reason of the patient's visit, which is the back pain. Since it is the doctor who has initiated the social topic (*don't come in the school holidays*) and the patient simply wants to be polite and follows what has been opened, his interruption might be viewed as rather rude and face-threatening because it disrupts the patient's desire to be listened to and also her feeling that what she says is interesting and worth attention. To put it differently, the doctor violates both the patient's positive and negative face.

- (8) D: *Oh, it's getting, don't come in the school holidays.*
 P: *Aha. [How is it?*
 D: *Cos it's pandemonium.]*
 P: *Aha.*
 D: *It's er (.) full of, full of youngsters.*
 P: *Not obeying you. [Now just because of*
 D: *What've you been doing?]*
 P: *Doctor (anonym) gave me er I can't, I can hardly walk I've got a terrible sore back.*
 D: *Your back been giving you trouble again?*
 (BNC/H56/11–19)

⁴ “Although there are some methodological problems related to classifying interruptions as controlling or cooperative, it is difficult to avoid such classification entirely. Much of what is interesting about interruptions relates to how particular instances of interruptions function in specific circumstances, for example, if an interruption results in a shift of speaker or topic” (Wynn 1999: 2000).

Moreover, controlling interruptions occur when the doctor’s plan is to change the section of the interview. As is illustrated below (see Example 9), the patient outlines her physical condition (from the context of the complete interview it is clear that the patient’s turn is realized in the phase of diagnosis) when the doctor suddenly interrupts her and leads the interview towards the treatment phase (cf. Byrne – Long 1976).

- (9) P: *I do actually feel better. I I eat I don’t usually take my first lot of tablets till sort of around dinner time. And I find sort of about an hour or so afterwards [I do*
 D: *(unclear)]*
 P: *actually start to feel*
 D: *Anyhow we’re g we’re gonna [summarize*
 P: *(unclear)]*
 D: *your Lithium in October of course, that’s [(unclear)*
 P: *Mhm.]*
 D: *And that’s fine. [What I*
 P: *(unclear)]*
 D: *would apart as far as the levels are concerned I’d check them again in September no hang on we’ve just checked them.*
 (BNC/G5X/72–81)

Even more interesting seems to me the case which occurs in the information-gathering phase and in which the doctor interrupts the patient in order to shift the encounter from verbal examination to physical examination (Example 10). Here again, the doctor’s verbal behaviour can be perceived as impolite, and presents a traditional example of the struggle between the *voice of medicine* and *voice of the lifeworld* or, in other words, between the medical agenda, on the one hand, and patient agenda, on the other.

- (10) D: *That’s okay. Not to worry about that. What’ve you been doing to yourself?*
 P: *I’ve been no I’ve been taking kind of palpitations, I don’t know, and I’m as tired as*
 D: *Come on let’s have a listen to you and see what you’re doing to your poor old self.*
 (BNC/G4E/5–7)

Sometimes it is not easy to interrupt the patient, especially when she is or feels to be competent enough to question the doctor’s authority. In such cases, the doctor has to compete with her to prove that his professional opinion is the correct one. The verbal competition, of course, results in a series of interruptions on both sides. In the following extract (see Example 11), the patient tries to offer her personal perspective on the medical problem; in her view it is a frozen shoulder. The doctor rejects this diagnosis and later in the interview he suggests his own (neuralgia). Before the patient accepts that she is wrong, it takes some time filled with frequent interrupting. The patient, however, is not such a powerful contestant to oppose for too long, which could be, among others, sensed from the very polite manner of proposing the diagnosis (*I wondered if it was a frozen shoulder, I thought that if ...*).

- (11) P: *Yeah, (unclear), (anonym). Er, oh, it's, see actually I wondered if it was a frozen shoulder? **I thought that if, you know how [sometimes***
 D: **No, no.]**
 P: *you, see when I, I can nae turn,*
 D: *[That's (unclear)*
 P: *see when I go] I, I can nae*
 D: *You wouldn't be able to do that if you had a frozen shoulder.*
 P: *Wouldn't?*
 D: *No.*
 P: *I can, **I can actually get it to there, but [see when I***
 D: *Aye well, **if] you had a frozen shoulder you wouldn't get it past there.***
 P: *Well, I can get it past but I couldn't lift it up.*
 D: *That's right.*
 (BNC/G45/49–60)

Despite the above presented illustrations, it needs to be stressed once again that whereas the controlling interruptions form the minority, the category of cooperative and empathic interruptions is very productive (cf. Aronsson – Larsson 1987). Among the most frequent communicative aims accomplished by cooperative (i.e. neutral) interruptions belong those intending to elicit either repairs of patients' preceding utterances (Example 12) or repeats for confirmation of what the patient has suggested (Example 13 & 14).

- (12) D: *Right. Well Nikram was fine thirty years ago, but it, it's too dangerous now.*
 P: *Ah, ah, ah.*
 D: *[Cos er it was alright*
 P: *Ah.]*
 D: *way back in the old days but (10.0) now then,*
 P: ***Er some Stella Stelladine***
 D: ***Some Stellazine***
 P: ***Stellazine aye. (11.0)***
 D: *And*
 P: ***Norvex? Nordex***
 D: ***Sorry, Norvex***
 P: ***Norvex aye. (.)***
 (BNC/H5P/57–68)
- (13) D: *Oh well I'll keep the insurance company er I er we will send them a little note in that case, saying look, you know, this is the case, it appears to be an innocent lesion she's just been finely checked over on the eighth of October, do you feel you can now proceed?*
 P: ***I mean they they've given (unclear) me insurance but it's***
 D: ***Oh right, so you are covered?***
 P: ***Sort of, they're going to review it.***
 D: *Oh right.*
 (BNC/G5Y/13–17)

- (14) P: *Doctor (anonym) see about this hair of mine, it's just not coming back in.*
 D: *It's not coming back in?*
 P: ***No. And I feel it's getting really really [I mean I thought maybe***
 D: ***Is that right?]***
 P: *I have took alopecia before I mean I thought [maybe*
 D: *Mhm.]*
 P: *it was because it was the wee one, but that's her*
 D: *Aha.*
 P: *fourteen months, so I mean it should be*
 D: *Oh aye.*
 P: *showing as wee bit er of improvement.*
 (BNC/H5W/15–25)

The communicative intention hidden behind the employment of empathic (i.e. relational rapport) interruptions is to signal high involvement and understanding. Via the utilization of this type on interrupting the doctor demonstrates to the patient that he empathizes with her feelings and experiences. Though the patient's desire to be listened (the negative face) is due to the doctor's verbal intrusion violated, her desire for social closeness (the positive face) is addressed (see Example 15 & 16). What is important, identically to cooperative interruptions, also empathic interruptions stay on the topic.

- (15) P: *Enough.*
 D: *Tt! That was it. No chance.*
 P: ***I've been off for three of four time before (unclear) [for long a few years***
and
 D: ***Aye. Och aye.] I know but [(unclear)***
 P: ***back to it.]***
 D: *They go back to it, this is the thing.*
 (BNC/H53/36–41)
- (16) P: *Yeah that's it, yeah. If I, and salad cream I can't er I can't even put salad*
cream on a salad
 D: *Oh dear.*
 P: *because that upsets me and all.*
 (BNC/GY6/186–188)

A specific instance of empathic interrupting that also occurs in the material under investigation can be labelled as agreement discourse markers (cf. Cordella 2004: 131–136). This discourse strategy, belonging to the *fellow human voice*,⁵ enables the doctor to respond positively to the patient's contributions, and thus indicate that he agrees with what is being said by the patient. The positive feedback does not merely confirm that the doctor supports

⁵ According to Cordella (2004: 121–148), there are five functions of the fellow human voice: (i) facilitating the telling of patients' stories, (ii) assisting in the telling of patients' stories, (iii) creating empathy with the patient, (iv) showing special attentiveness to patients' stories, (v) asking questions unrelated to the patient's health.

the patient, and assists in her developing of the consultation, it can be, in addition, interpreted as an expression of empathy and understanding (Example 17).

- (17) P: *And I came er I came up before, can't [remember*
 D: *Yeah.]*
 P: *I come [up and*
 D: *That's right.]*
 P: *ere r that's the only time. I don't [have*
 D: *Right]*
 P: *any bleeding [in between*
 D: *good,]*
 P: *nothing*
 D: *good,*
 P: *you know.*
 D: *good.*
 P: *But the first time I did use it I thought me inside were on fire.*
 D: *Oh yes, it often irritates in the same way when you first start to drink spirits.*
 P: *Oh dear,*
 D: *Yeah.*
 P: *I whatever am I [going*
 D: *Yeah.]*
 P: *to do and I rung my daughter next [morning,*
 D: *But it] goes as you notice it goes off*
 P: *It went and it sent to sooth*
 D: *That's right. Yeah.*
 (BNC/G5R/129–150)

5. Patients interrupting their doctors

The distributional analysis of patient-initiated interruptions was no less difficult than the analysis of doctor-initiated interruptions; it was inevitable to struggle with many blurred cases that struggled against univocal categorization (Example 18). Finally, it has resulted in the following findings (Figure 3 & 4). The largest number of instances can be classified as rapport interruptions (69%), 18% as competitive, 11% as neutral, and 2% as power interruptions. Regarding the distribution of doctor-initiated interruptions with respect to the interview phases, it can be stated that the largest number takes place during the treatment (58%), 22% take place during the diagnosis, and 20% during the info-gathering.

Fig. 3: Relative distribution of patients' interruptions with respect to their classification

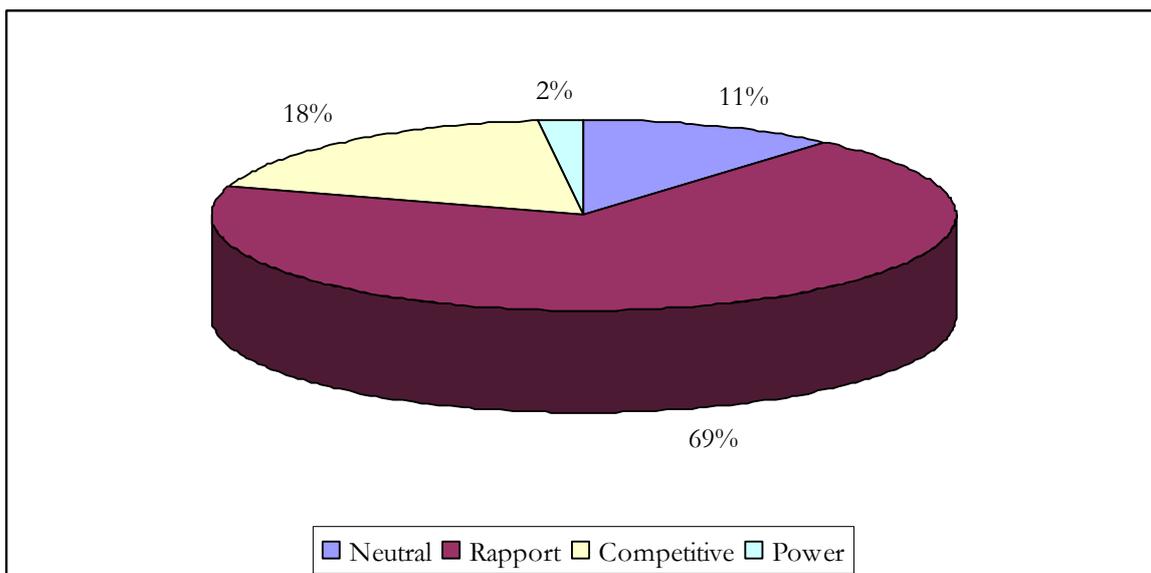
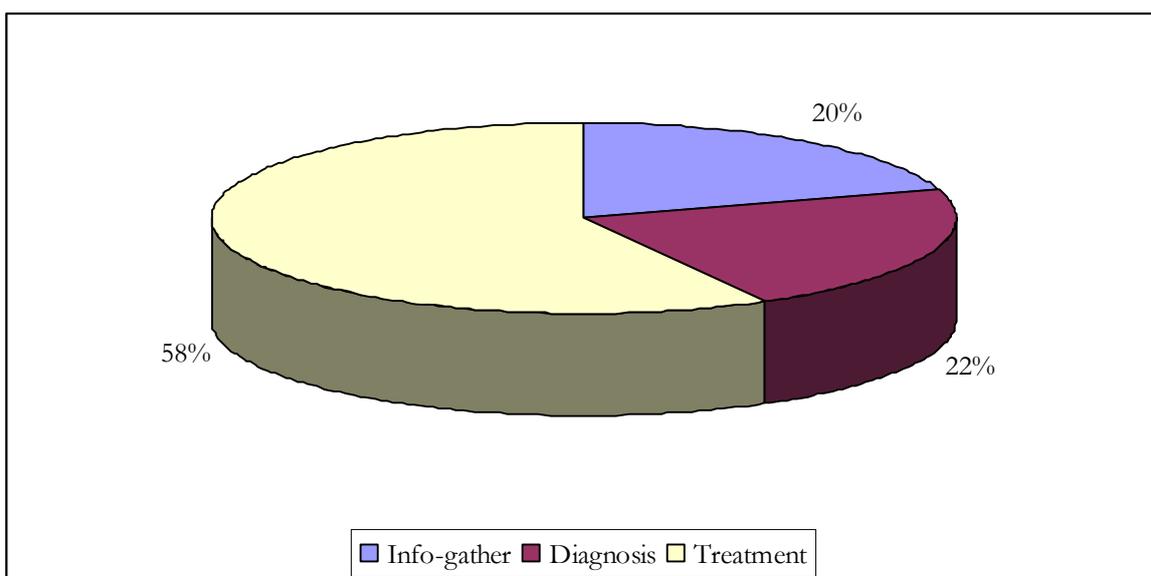


Fig. 4: Relative distribution of patients' interruptions with respect to the interview phases



- (18) P: *And I'm permanently crying. (.) Help. (.)*
 D: **What's happened, has your appetite**
 P: **No.**
 D: **changed? No?**
 P: *No. And when I started putting on weight I and I'm still putting on weight.*
 D: *Right. (.) [Are you*
 P: **I'm actually](.) about just over ten and a half stone now.**
 D: *Mhm. (.) Your hair falling out?*
 P: **No.**
 D: *No problems with you hair? It's not getting brittle?*
 P: **No.**
 D: **No.**
 (BNC/G4B/9–20)

Example 18 represents a fuzzy case. We are in the info-gathering phase, and we know that the patient’s reason for visiting the doctor’s surgery is her growing weight. The doctor asks a series of questions some of which are interrupted by the patient’s answers before the doctor’s elicitation is completed. At first sight, a researcher may classify the patient’s style of interrupting as competitive and/or even face-threatening. However, in my opinion, the larger context of the interview shows that the patient is simply too worried about her medical problem, which influences the way she interacts. This is the reason she is, at first, too hasty when giving her responses. Gradually, she slows down and together with the doctor they successfully arrive at the correct diagnosis. As from the very beginning her intention has been to cooperate and not to compete, I classify her style of interrupting as cooperative (i.e. neutral).

Interestingly and unexpectedly, the above data give statistical evidence that if the classification of interruptions along the symmetry–asymmetry continuum is taken into consideration, there is exactly the same distribution between the symmetry-oriented interruptions and asymmetry-oriented interruptions initiated by patients as between those initiated by doctors; in both cases the estimation is 80% to 20%. In addition to that, the numerical order of patient-initiated interruptions from the most numerous category to the least numerous category follows the numerical order calculated for doctor-initiated interruptions: rapport interruptions – competitive interruptions – neutral interruptions – power interruptions. All this suggests that Henzl’s (1989) assertion about interruptions correlating with the asymmetry in the amount of distribution of speech during the medical interview (see Chart 1) cannot be taken for granted. As is obvious, interrupting does not necessarily relate to asymmetry, and can be, by contrast, viewed as a symmetrical feature of doctor–patient relationship.

The following two examples (Example 19 & 20) demonstrate an ‘attractive’ illustration of symmetrical patient-initiated interrupting. In both cases, the patient intrudes into the doctor’s talk while saying the same piece of thing as the doctor at same time as the doctor. In the first instance, the interactants share the opinion regarding the diagnosis. In the second instance, they have agreed on the time perspective.

- (19) D: *Well it looks as though it could well have been*
P: *[originally chicken pox?*
D: *like chicken pox.] Yeah. But that’s, it takes, it’s just the skin to get broken, and underneath the skin and it just spreads and it’s (unclear)*
P: *And you haven’t seen my arms.*
D: *Same. Alright. Okay.*
(BNC/H5A/25–29)
- (20) D: *Mm. (phone call starts and ends) Now you went off, when when was it you?*
[(unclear)
P: *Oh, it was] a week past this Sunday. (unclear)*
D: *A week past Sunday.*
P: *But you know how you’ve got a week*
D: *[Aye.*
P: *you can] [self-certificate.*

- D: *So that covers] you up till the [Monday*
 P: **Monday.]**
 D: *does it?*
 P: *Aye.*
 D: *Up till the Monday. Right.*
 P: *Up to the Monday.*
 (BNC/H50/17–28)

Another interesting case of patient-initiated interruption can be documented by Example 21. Here, as one part of physical examination, the doctors want the patient to breathe into a special tube to measure her maximum breathing capacity. At first, the patient is not successful, and interrupts the doctors with an excuse (*Sorry.*). The doctor is patient and leads the patient towards satisfactory output. In my opinion, the extract shows the effort to cooperate on the part of the patient and to convey patient-centredness on the part of the doctor.

- (21) D: *What you do with this is take a big breath,*
 P: *Yeah.*
 D: *put it your mouth and blow out as hard and as fast as you can. It'll make you cough probably, and **keep your fingers off the s off [the***
 P: **Sorry.]**
 D: **scale.** *It's okay. Right big blast.*
 P: *(breath)*
 D: *You actually put it in your mouth.*
 P: *Sorry.*
 D: *It's alright.*
 P: *(breath) (cough)*
 D: *Oh dear, is that as hard and as fast as you can manage?*
 P: *Well I can have another try if you want.*
 D: *As if you're blowing out your birthday cake candle.*
 P: *Yeah.*
 D: *You remember the story bit about the big black wolf [who*
 P: *Yeah.]*
 D: *blow the little piggies house down. Well that's what you're blasting at. That's how you blast through one of these.*
 P: *(breath) (cough)*
 D: *Yeah, yeah.*
 (BNC/G5W/41–59)

In harmony with doctors, also patients use the type of interruptions that can be labelled as empathic, express relational rapport, are markers of interest, affection, social closeness, and active listening. The following two examples illustrate the initiation of an agreement discourse marker and positively polite behaviour, respectively.

- (22) P: *So would I, would I still use that or what do you think, painkillers or what doctor?*
 D: *No there is a, there's a special stuff I'm going to give you [(unclear)]*
 P: *Is there?]*
 D: ***to get rid of this for you. (.) Now the other thing that very often goes with this is a crunching noise***
 P: *[That's right.*
 D: *when you,] when you move your neck.*
 (BNC/G4D/57–62)
- (23) P: *What about your own family? You still got them?*
 D: *Yeah. Oh well. Yeah, they're still*
 P: *Still keeping you*
 D: *still keeping me out of mischief.*
 P: *[Still keeping*
 D: *Still keeping me out of mischief.] [(ha-ha)*
 P: *Are they keeping you] out of mischief? ((ha-ha)) Ah well. [((ha-ha))*
 D: *Oh aye.] Oh aye. Okay Agnes.*
 (BNC/H5V/132–139)

Finally, let me offer one illustration of patient-initiated intrusion into the doctor's speech classified according to its discourse function as power or controlling interruption (see Example 24). The following extract shows how the doctor poses a 'scale' question (*how you feel on a scale of one to ten?*). Since the question is answered by the patient (*I'm two on, two or lower*), the doctor acknowledges the response (*Yeah*), and proceeds to another question and another topic. However, the patient shifts the topic back to the issue of her feelings (*feel really low and out of breath easily*), thus specifying what she finds to be important as far as her medical problem is concerned. The doctor acknowledges the given information once again, and only then he continues with what has been interrupted by the patient.

- (24) D: *How would you feel if er if I said sort of describe how you feel on a scale of one to ten?*
 P: *Er right now I'm two one, two or lower.*
 D: ***Yeah, do you get***
 P: ***Feel really low and out of breath easily.***
 D: *Yeah. Are you getting hot sweats?*
 P: *Yeah, do now and then, yeah.*
 D: *Have you been anywhere exotic on holiday in the past three months?*
 P: *No.*
 D: *Past year?*
 P: *No.*
 D: *And conditions down the pits (unclear)?*
 P: *Hot.*
 (BNC/GYC/26–37)

As the functional aspect of interrupting in the medical consultation has been outlined, what remains to be said is a comment on the formal side of both doctor-initiated and patient-initiated interruptions. According to Wynn (1999: 201–209), doctors and patients often interrupt with a question, with an excuse, with a response, and with an explanation. As some of the above examples demonstrate, my findings, based on English data, confirm what Wynn has found in the language material recorded in Norway.

6. Concluding remarks

In my opinion, the information just presented demonstrates sufficiently how complex the phenomenon of interrupting is, and how varied and interrelated with other aspects of verbal behaviour the discourse strategies resulting in the interruption of the speaker are. This complexity may, of course, raise certain amount of criticism aiming at the present research of mine. What can be questioned is the selected classification of interruptions, or the definition of an interruption as such. I am aware that there are other classifications worth considering: for example by James – Clark (1993), dividing interruptions into *neutral*, *powerless*, and *powerful*; or by Neustein (1989), introducing so called *simple*, *expansive*, and *closure-implicative* interruptions. Nevertheless, Goldberg’s (1990) classification seems to me as the most delicate. Regarding the definition, I tried to organize an ‘operational’ definition that would comprise both the functional and the formal aspect of interrupting, with a more significant stress on the former.

As far as the research results are concerned, my findings reflect the tendency towards a more balanced character of doctor–patient interviewing. Both interactants are very active interrupters, with slight numerical dominance on the part of the doctor. Both the doctor and the patient interrupt throughout the medical encounter, and take the advantage of all the functional types of interruptions. In both cases, there is quantitative prevalence of the employment of symmetry-oriented interruptions over the asymmetry-oriented. Moreover, the doctor and the patient share the same numerical order of the interruption types initiated: rapport interruptions (being the most numerous) – competitive interruptions – neutral interruptions – power interruptions (being the least numerous). When the division of interruptions into controlling, on the one hand, and cooperative and empathic, on the other hand, is considered, we can see evident inclination towards the latter category. From the formal point of view, both speakers interrupt with the same set of utterances: most frequently with a question, an excuse, a response, and with an explanation. An interesting case is that of an agreement discourse marker.

The qualitative part of the investigation further documents that the controlling interruptions take place when there is an attempt to take the floor and/or change the topic of the interaction. Doctors, moreover, use these interruptions with the intention to change the phase of the consultation. As for the cooperative interruptions, they are employed by doctors in order to elicit either repairs of patients’ preceding utterance or repeats for confirmation of what the patient has suggested. As for the empathic interruptions, they are used by doctors to signal involvement and understanding, and also to express positive feedback. As for the other speaker, the patient-initiated interruptions take place when the very same

thing is said by the patient at the same time as by the doctor. Some interruptions are also related to positive politeness.

To conclude, I view interruptions as effective language devices via which the process of the medical interview can be, under suitable conditions, enhanced. I agree with Måseide (1990) that in order to be able to carry out systemic [and empathic!] investigation, doctors sometimes have to limit patients' contributions. At the same time, I would like to add that patients too have to restrict doctors' contributions in order to be able to claim their needs and/or to express their alignment with the opposite party.

Appendix

Below are results of the F-test, containing calculations relevant for the quantitative section of the analytical part of the study.

F / Participant	<i>Rapport</i>	<i>Competitive</i>	<i>Power</i>
<i>Neutral</i>	0.8965	0.9509	0.2202
<i>Rapport</i>		0.8185	0.202
<i>Competitive</i>			0.1957

F / Phase	<i>Rapport</i>	<i>Competitive</i>	<i>Power</i>
<i>Neutral</i>	0.9313	0.9218	0.8442
<i>Rapport</i>		0.9689	0.8664
<i>Competitive</i>			0.896

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