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LANGUAGE AND MEDICINE

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INTRODUCTION

Research on the forms and functions of language in medical practice and training has expanded rapidly during the past two decades, a development marked by diversity in theoretical perspectives and methods brought to bear on a variety of problems. Although we label the area as "language and medicine," it includes other health professionals and nonclinical settings. Our discussion is organized under four headings that we believe represent primary topics and domains of interest among investigators as well as the variability within the field: speaking to patients, speaking with patients, speaking about patients, and speaking by patients. A few exemplar studies will be cited in each section and the contributions and limitations of approaches in each topic area will be noted.

SPEAKING TO PATIENTS

An early direction for research in this field, dating back to the mid-1960s and continuing to the present, focuses on ways physicians may improve their communicative skills so as to more effectively perform their clinical tasks: history taking, diagnosis, and treatment. We refer to the central theme of these studies as speaking "to" patients since two primary emphases are stressed: 1) how physicians establish relations with patients through their modes of asking for and giving information and 2) how different styles of communication may enhance or diminish patient satisfaction and compliance. Analyses of talk in medical interviews, based typically on observations, audio-, or video-recordings, provide indices of the patient-physician relationship, and a good relationship is viewed as the basis for effective clinical care. As two proponents of this line of inquiry observe, "Talk is the main ingredient in medical care and it is the fundamental instrument by which the doctor-patient relationship is crafted and by which therapeutic goals are achieved" (Roter and Hall 1992). A similar perspective, expressed in a recent

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review (Ong, *et al.* 1995), is that the medical interview has three aims: to create a positive interpersonal relationship between physician and patient, that is, a working alliance; to offer opportunities for both physician and patient to give and seek information; and to provide the basis for the physician to make medical decisions.

Reflecting this general orientation, studies tend to address how well physicians achieve their clinical tasks, defined within the medical perspective, and findings often lead to recommendations for modifying physicians' practices through better communicative skills (Ptacek and Eberhardt 1996). There is little interest, and few studies, concerned with how patients can enhance their communicative skills in their interaction with physicians (Roter and Hall 1989).

The uncritical reliance of these studies on medical assumptions of good clinical care and on the practical interests and aims of physicians is accompanied by neglect of broader theoretical issues, for example, cultural and social contexts of illness and patterns of care. These concerns rarely enter the design of studies or the analysis and interpretation of findings. Further, there is no consistent theoretical direction that relates various studies to each other. Instead, the unifying factor is methodological: The method of choice is some form of interaction coding based on the model developed in the 1950s (Bales 1950) and modified for application to medical settings (Ong, *et al.* 1995: For an early detailed study applying a modified Bales system, see Byrne and Long 1976; and see Mishler 1984 for a critique of the approach). Discussions of method center primarily on which type of code-category system might better suit these encounters—global or exchange-based coding systems (Stiles and Putnam 1992), and whether and how standardized codes that permit quantitative analysis might be combined with qualitative approaches, for example, in Conversation Analysis (Charon, *et al.* 1994, Roter and Frankel 1992). Types of communicative behavior coded in typical studies include the following: information giving and information-seeking, social or non-medically relevant talk, positive and negative comments, partnership-building statements (Roter and Hall 1989, Roter, Hall and Katz 1988), high or low controlling statements, relative use of medical or everyday language, and rates of verbal vs. nonverbal behavior (Beisecker 1990, Ong, *et al.* 1995).

Underlying much of this research is a three-part model of the communication process, an adaptation of the standard distinctions in the social and behavioral sciences among independent, intervening, and dependent variables. The first (independent variables) refers to 1) differences between physicians and patients in their respective social and cultural backgrounds, including demographic factors such as age, social class, education, and gender; 2) stylistic patterns of verbal and nonverbal communication; and 3) variation in types of illness as acute or chronic, lifethreatening or not. The influence of these independent variables on outcomes is mediated by intervening communicative behaviors of physicians and patients in the clinical encounter. This process is assessed, as we noted earlier, by applying coding systems with predefined categories and the use of aggregate measures, for example, the total number of questions asked by the physician or

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patient. Finally, dependent outcome variables are specified, for example, as levels of patient satisfaction with an interview and compliance with physicians' recommendations.

In the last two decades, there has been a shift away from studies of the direct influence of social background factors on outcomes and toward the three-part model that focuses on how those variables may affect the communicative process, which in turn is related to outcomes. Findings suggest how variation in physician and patient social and cultural backgrounds may affect the course of medical interviews. For example, female physicians tend to spend more time with patients than their male peers, and patients with higher incomes tend to ask more questions and expect more detailed answers from physicians (Beisecker 1990). A review of various studies suggests that outcomes may be affected by several features of the interaction process. For example, more information giving and "quality" time spent with patients is associated with higher patient satisfaction and with more positive and less negative talk; fewer questions from the physician is associated with an increase in patient compliance. These same factors, plus more partnership-building statements, correlate with better patient recall and understanding of the information given by the physician (Ong, *et al.* 1995).

The stability and generalizability of these findings is problematic since they are constrained by limitations of the approach noted earlier—reliance on medical conceptions of care and treatment, isolation of medical interviews from social and institutional contexts, and a focus on fragments of speech removed from the structure and flow of discourse. These features reflect the origins of this work (within the research tradition in social psychology and sociology) that relies on standardized coding systems as primary methods and does not analyze the communicative process as an ongoing discourse between speakers. Other approaches, discussed below, draw on different research perspectives.

SPEAKING WITH PATIENTS

An alternative research paradigm for studying medical interviews emerged in the early 1980s (Fisher and Todd 1983, Freeman 1987, Mishler 1984, Silverman 1987). Applying various sociolinguistic approaches (for example, discourse and narrative analysis, and conversation analysis), this view respecifies interaction in clinical encounters as speech events (Gumperz and Hymes 1972), and it directs attention to ways physicians and patients engage in a dialogue through which the particular structure and organization of medical interviews is jointly constructed. Thus, how they talk "with" each other is the central topic.

Rather than isolating predefined categories of speech units from the stream of talk and aggregating them into global measures, these studies focus on the sequential patterning of exchanges between physicians and patients. The theoretical and research tasks are to locate different types of structures and

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interpret their functions. Carefully prepared transcripts of audio- or video recordings serve typically as primary data for analyses.

Another notable departure of this work from the "talking to patients" approach is that it does not rely on the medical conception of clinical tasks and goals. Rather, it displaces the medical framework, often within a general critique of current medical practice. This displacement cum critique is evident in the central question examined in many of these studies, namely, the asymmetry of power between physicians and patients. The dominance of physicians is exercised through their control of both the structure of the interview (for example, who asks and who answers questions, who gives and who receives information) and the content of the interview (that is, what problems are included or excluded as relevant, and what courses of action are assessed as worth pursuing or not).

From this perspective, medical interviews are viewed as structured by physicians engaged in their medically defined tasks of diagnosis and treatment planning (ten Have 1991). Their typical form of organization, found repeatedly in many studies, consists of a relatively standard series of physicians' questions aimed at systematically eliciting and specifying symptoms and complaints. Instead of summing the number of questions across the interview, these studies often focus on a three-part sequence as the basic discourse unit, a conversational or dialogic exchange that is both bounded by and linked to prior and following units by physicians' successive questions: 1) an opening question, 2) the patient's response, and 3) the physician's evaluation of the response—often implicit without a direct acknowledgment—either in the form of a question or joined to a question (Frankel 1990, Mishler 1984).

The sequence of physicians' questions appears to represent an underlying biomedical model of illness that patients are often not aware of, and questions are usually asked without an explanation of their purposes or of their relation to each other. This backgrounding of reasons combined with lack of acknowledgment to their responses, often results in patients experiencing the questions as disconnected from each other and from their answers: It may seem as if anything can be asked at any point (Mishler 1984). Despite problems in understanding where the conversation may be going, patients are generally attentive to each new question and try to provide adequate answers. They may add further information beyond what is specifically asked for, or they ask questions of their own. Their attempts to move beyond the boundaries of the physician's questioning format tend to be disregarded; for example, patient-initiated questions are "dispreferred" (Frankel 1990). In sum, these studies find that physicians dominate and control the course of medical interviews through their questioning strategies: asking nearly all the questions, controlling topics and topic development, and interrupting and disregarding patients' efforts to contribute something new to the conversation.

Three alternative theoretical perspectives have been proposed to explain the sources and consequences of the pervasive asymmetry of power in medical

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interviews: 1) structural, macro-social factors; 2) conflicts between patients' lived experiences of their problems and medical conceptions of illness; and 3) cultural expectations, shared by both physicians and patients, about their respective roles in this institutionalized context. Each of these orientations highlights factors that tend to be neglected in the others.

The first approach, for example, may locate the power differential between physicians and patients within the social-class structure of society. From this standpoint, the general pattern of social inequality is expressed in medical interviews, as elsewhere. For example, medical institutions and the health professions, especially physicians, rank high in the hierarchy of social values and statuses; physicians are typically of higher social status than their patients, with higher levels of income and education. These larger structural factors, some researchers argue, are reflected directly in medical encounters (Fisher and Groce 1990, Waitzkin 1991). This emphasis on macrosocial factors provides an important context for understanding typical features of medical interviews. One limitation that must be borne in mind in this line of research is the tendency to treat the impact of structural factors as self-evident—as external, causal factors—without further analysis of the interactional process through which they may be resisted as well as reproduced.

The second interpretative approach emphasizes conflicting views and positions of patients and physicians about their clinical encounters: The former try to gain some control over the communicative space of the medical interview to enhance possibilities to present their experiences, understandings, and aims; the latter try to control topics and direct the interview course so as to accomplish their clinical tasks as systematically and efficiently as they can. Mishler (1984) conceptualizes this conflict as a struggle between the "voice of the lifeworld" and the "voice of medicine." The former tends to be suppressed in medical interviews—this is an index of the physician's dominance—and there are severe limitations on the degree to which patients can present their own understandings of their problems (Clark and Mishler 1992, Mishler, *et al.* 1989).

Clark and Mishler (1992) further argue that different ways through which physicians may conduct medical interviews either hinder or facilitate patients' efforts to account for and explain their problems in narrative form, that is, to tell their stories. In typical interviews, physicians either ignore or interrupt patients' storied accounts. The traditional medical "story" of illness is in the form of a chronicle in which signs and symptoms are ordered sequentially but removed from the larger context of patients' lives. In their stories, patients try to restore this context, locating the trajectory of symptoms within their daily experiences, specifying their impact on how they can function personally and socially, reporting their own remedial and reparative efforts. Opportunities for patients to present these contextualized accounts require a realignment of the relationship typically enacted in medical interviews. Physicians would have to relinquish, or at least modulate, their dominance and move toward becoming more attentive and

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responsive listeners, encouraging patients to tell their stories instead of imposing the medical plot of illness (Clark and Mishler 1992, Mishler 1997, Mishler, *et al.* 1989).

The third approach to the asymmetry of power problem counters the conflict model and posits culturally shared expectations of physicians and patients about their respective, appropriate roles as experts and laypersons in service encounters. In general, laypersons are expected to have legitimate problems, can in turn expect them to be recognized and responded to, and may not consider it appropriate to interfere with how experts go about their business. This collection of expectations is well understood by both physicians and patients, with the consequence that the asymmetry found in medical interviews is not simply the result of physicians' one-sided actions but is jointly produced by them and their patients (ten Have 1991, Maynard 1992).

Maynard (1991b) makes the further point that there are similarities between the asymmetry of physician-patient encounters and informal conversations. Ways used by speakers in informal conversations to align each other to common topics and perspectives are also found in the former. He argues that the asymmetry of discourse roles in medical settings may not only have an "institutional mooring" but also an "interactional bedrock."

Some studies have also documented how physicians may offer openings for patients to make extended responses, ask questions, or comment about diagnoses, but that patients do not take advantage of these opportunities (ten Have 1991, Maynard 1991a). These researchers propose that patients and physicians act in concert, striving together to establish a relationship between the one as a layperson seeking medical assistance and advice, and the other as an expert responding to the request. It is, therefore, important for patients to preserve their layperson status and the complementary status of physicians as experts. To this end, they present their problems in ways that will be acceptable to physicians and respond to recommendations in ways that do not contest or undermine the legitimate authority of the physician as expert. As a consequence, patients do not introduce new topics or ask questions even when physicians seem to give them permission to do so (Heath 1992). This perspective is different from the problem of asymmetry emphasized in studies from macrosocial and conflict perspectives, and it suggests an alternative interpretation of high levels of interruption by physicians of patients' accounts and their frequent disregard of topics patients do introduce and questions they do ask (Mishler 1984; 1997).

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SPEAKING ABOUT PATIENTS

Studies of speaking "to" and "with" patients are based on observations of interaction in medical interviews, still the most prominent focus of research on language and medicine. Recognizing the limitations of this work that tends to isolate and abstract the physician-patient relationship from institutional and social contexts, researchers have turned their attention to the discourse "about" patients among physicians and between them and other health professionals. This shift represents a move beyond the confines of physicians' offices to other practice settings, such as clinical rounds, staff conferences, training, and medical education. Further, this approach highlights the tasks faced by physicians in assembling and integrating information from various sources in addition to patients' accounts: laboratory findings, other canonical cases, and the research literature. Ethnographic methods and observations of practice settings are typically used for such research.

Atkinson (1995), for example, argues that the dominant emphasis on physician-patient interaction in medical interviews, as symbolic of the work of medicine, neglects the significance of what goes on in the talk among physicians and other health care professionals. He observes that in modern medicine, the body has ceased to be coterminous with the presence of the patient, since traces and signs of the body's structures and functions may be read elsewhere, for example, from laboratory tests and instruments that monitor vital signs. Physicians draw together information from multiple sources to develop a plausible and persuasive account of a case, often in a chronological account of the progress of a patient's disease.

Looking closely at what transpires beyond the boundaries of medical interviews, Atkinson finds that the "voice of medicine" is not singular but that there is a plurality of voices. He identifies three such voices: 1) the voice of personal experience representing each physician's unique biography of practice; 2) the voice of accumulated, collective experience that includes medical stories about doctoring and difficult cases, and that provides a more general warrant for knowledge and judgment; and 3) the professional voice of "journal" science, warranted by reference to published literature. Each voice provides a distinctive ground for authority claims by physicians differing in experience and expertise, and they may conflict with each other as physicians review and discuss cases. This approach, exemplified in Atkinson's work, tends to treat patients' accounts in medical interviews and other settings as only one of the many sources of information for clinical practice.

The objectification of patients in modern, scientific, high-tech medicine detailed in Atkinson's studies—the reduction of the patient as a person to an assemblage of discrete physical signs and symptoms—has a long history (Jewson 1976) and has been the target of many critiques.

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Young's (1997) phenomenological analysis of the separation of self from body in clinical practice, that is, the displacement of an "embodied self" by a depersonalized "body," also goes beyond the medical interview, adopting a critical perspective on the process of objectification. She observes that the organization of medical care—from spatial arrangements and boundaries between reception areas, examining rooms, and physicians' offices through norms for appropriate behavior in physical examinations—is directed to isolating the body from the selves of both patients and physicians. The self, nonetheless, continues to intrude, creating problematic situations (see also Young 1989). Her perspective raises serious questions about the impact of these strategies of objectification for possibilities of clinical care where patients can become collaborators and active agents in the process rather than passive, un-selved bodies.

A pervasive theme in much of this research is the central role of narratives in how physicians formulate and convey clinical and medical knowledge. Hunter (1991) documents how physicians use narrative forms to present cases in patient rounds, case conferences, and medical charts as a mode of communicating medical knowledge to both colleagues and students. Their narratives tend to focus on unusual or deviant instances of disease signs and processes, emphasizing the features of particular cases within the general framework of what is known about different types of disease and their typical forms of appearance. This narrative strategy expresses and supports a pragmatic and instrumental orientation to the treatment of patients.

Patients' "illness narratives," presented in medical interviews as well as other settings, are also viewed as a significant source of information in the overall process of arriving at a more complete picture of the clinical problem and are helpful in sorting through and resolving problems of diagnosis and treatment. Kleinman (1988) and Brody (1987) emphasize their importance as the primary means for physicians to acquire a more detailed clinical picture of patients. They argue that clinical practitioners must become versed in patients' narrative accounts of their problems, not only for correct diagnoses, but also to develop treatment plans that are acceptable to patients and more likely to result in compliance. Charon (1993; 1998) elaborates this approach, suggesting that clinical practice is akin to the work of literary critics; that is, listening to patients' narratives is an analogue to "reading" a text. She argues that this process of close, attentive listening/reading is conducive to the development of positive and effective therapeutic relationships. Other researchers note the influence of differences between patients' and physicians' narratives of illness on how information is communicated to and received by patients (Boyd 1996, Clark and Mishler 1992, Good, *et al.* 1994, Lind, *et al.* 1989, Sharf 1990).

Narrativization may also serve as an active component in therapeutic work. Mattingly (1991; 1994) describes how occupational therapists as well as physicians try to shape a progressive course of treatments and the process of recovery into a coherent plot, which she refers to as "therapeutic emplotment."

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For example, repetitive and tedious procedures aimed at repairing memory deficits or movement disabilities may be framed—for themselves and patients—as a sequence of events in a progressive narrative that moves toward restoring earlier levels of competence: This falls within the genre of the happy ending story. Placed in this narrative context, the daily tedium of routine and repetition takes on new meaning and becomes endurable. This form of therapeutic emplotment may have further consequences: It changes the patient's time horizon for the course of the illness; it establishes a link between successive medical interventions and the trajectory of recovery; and it engenders hope of eventual cure (Good, *et al.* 1994).

SPEAKING BY PATIENTS

Although patients' stories are clearly a significant source of data, particularly in studies focused on talking "with" patients, they are usually treated from the standpoint of the biomedical model of illness and treatment (Mishler 1981), with an emphasis on their utility for physicians to achieve their clinical tasks more effectively. An alternative approach displaces this instrumental orientation and addresses the question of how patients' ways of "storying" their illnesses function for them, helping them understand and adapt to their problems within the sociocultural contexts of their lives. These studies, of speaking "by" patients, tend to be based on accounts found or elicited in nonclinical settings: autobiographical reports of illness experiences, ethnographies, and research interviews.

The specific form and content of illness narratives receive serious attention in this work, guided by a view of narrativization as a way of meaning-making, where illness events and symptoms are framed within lifeworld contexts. By weaving the threads of their illnesses—their presumed origins, trajectories of problems, and personal and social consequences—into the fabric of their lives through their stories, patients strive for and sometimes attain answers to such questions as "why" this happened to them and what they can look forward to in the future. Their stories are also made public as they communicate to others in their social worlds who may, in turn, offer suggestions and new interpretations that can complicate or transform the original story. Thus, patients' narratives enter a social discourse where personal and cultural meanings of their illnesses are discussed and negotiated, providing ways of dealing with their problems that do not rely solely on the medical framework and, as well, may restore a sense of personal agency lost through the objectifying procedures of clinical care and treatment (Hydén 1997).

Kleinman (1988), a psychiatrist and medical anthropologist, and Cassell (1991), a physician, called attention to the suffering of patients as a central feature of illness experiences. And Frank, (1992; 1993; 1994; 1995), a medical sociologist, has developed this concern in his studies of living with chronic illnesses. He suggests that patients' illness narratives not only express suffering but also serve as ways for them to articulate their experiences from a different

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perspective than how their illnesses are represented within a medical framework. Based on analyses of written, autobiographical accounts, he proposes a typology of illness narratives, each with a different storyline specifying relations between patients' selves, bodies, and illnesses, and their expectations for the future: These storylines may be seen as restitution, chaos, and quest narratives. In the first, individuals view their illness as temporary, a bounded time of bodily impairment or affliction. They remain the same persons they were before the illness, and when it passes or they are in remission, they expect to be restored to their former levels of functioning. Essentially, being ill does not change "who" they are. In the second type, life is radically disrupted: The self is submerged in the illness, chaos reigns, the severity of symptoms is unpredictable, and the future is uncertain. Finally, quest narratives express a sense of self that has been changed by the illness. Being ill initiates a journey toward a new identity. As witnesses to their own transformation, these individuals believe they have learned something valuable that they can bring back and contribute to others—particularly other sufferers from pain and illness.

Hawkins (1990), applying an approach based on studies of comparative literature to written illness narratives, argues that they have a common pattern (see also Charmaz 1991 and Robinson 1990). She views them as a distinct narrative genre and refers to patients' narratives of illness and their struggles to overcome them as "pathographies." There is a close parallel between Frank's quest narrative and the concept of "regeneration" she sees as central in the plots of pathographies: The patient has suffered a severe life crisis and come through it, emerging regenerated as a new human being. Typically, she finds a three-part narrative: 1) the time before the onset of illness, often viewed retrospectively as marked by an unhealthy life style that is now rejected; 2) the crisis accompanying the onset of illness, which has become a matter of life or death; and 3) regeneration, the resolution of the crisis and entry into a new life with a different appreciation of the world. Hawkins suggests that this narrative genre draws upon and replaces traditional religious conversion stories, for example, the sinner having met God face to face, realizes and regrets her life of sinfulness, undergoes conversion, and begins a new God-fearing life. Her analysis points to how narrators may make use of established genre and narrative strategies to reconfigure their lives and illness experiences in culturally recognizable and acceptable forms.

The exclusive reliance on written texts by both Frank and Hawkins limits the generalizability of their analyses. Oral narratives, the primary data in most other studies, are composed in different ways and produced in interactional contexts. The study of written narratives cannot give us access to important features in the production and structuring of illness narratives that reflect the social contexts of storytelling—identifying the setting as medical or nonmedical, establishing relations of other participants to the patient, and understanding the contributions of these other participants to the story.

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The significance of these factors is documented in an ethnographic study of a Turkish family's joint production of an illness narrative about one of its member's epilepsy (Good 1994, Good and Good 1994). Adopting the view that narratives are presented in the subjunctive mode (Bruner 1986) and display a tension among multiple meanings, the Goods report that different family members had different perspectives on the illness, with alternative plots and possible endings. A mystical orientation was often represented, for example, in the form of the "evil eye" as the cause of the disease. This orientation was combined with various time horizons so that the consequences and termination of the illness was not predetermined but open to a range of possibilities.

Another important consideration in understanding the structure and function of patients' illness narratives is that they are not fixed or static but change over time, reflecting the course of illness, efficacy of treatments, and the individual's personal and social situation. Bell (1988), a medical sociologist, interviewed women who were exposed in utero to a synthetic hormone given to their mothers during their pregnancy (DES-daughters) and who are at high risk for infertility problems and vaginal cancer. Analyzing three stories told by a respondent in one interview, she found that their sequential ordering represented a process of personal change over time, beginning with her initial diagnosis: The stories moved from denial, through acceptance of her DES identity, and finally to recognition that she was not alone but part of a community of similarly-afflicted women and that her problem was not only personal but social and political as well.

Langolier (in press), a communications researcher using performance theory as an interpretative framework, provides another example of how an illness narrative may function in the construction of an identity that contests the biomedical definition of patienthood. She analyzes a series of five stories told in two interviews by a breast cancer patient: the first interview, shortly after her lumpectomy, recounts how "they tattoo you" preparatory to radiation and notes her desire to have her scar tattooed; the second interview, a year and a half later, occurs after she had fulfilled her desire. Her series of stories follows a temporal order, beginning with her experience during radiation therapy in which she is a passive object and the tattoo is compulsory; through her problematic encounter at a local frame shop when she asks them to frame a widely circulated poster of a nude woman with a tattoo over her mastectomy scar; then her experience of being tattooed; the subsequent discomfort of her gynecologist; and the positive response of a physician when she goes for a postoperative biopsy. In all these stories, she is actively engaged in performing her changing identity within interactional contexts. Moving through issues of stigmatization, nudity, the public display of the body, to a sense of agency and a reclaiming of her body, she is keenly aware of the multiple audiences she addresses. Langolier argues that the full meaning of narrative is performative and that its potential recuperative functions cannot be understood from texts alone.

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The studies reviewed in this section do not simply fill a gap in the research literature on language and medicine. They extend the boundaries of the field and reconfigure it as an area of inquiry. We specified the disciplines of investigators to indicate the variety of perspectives that inform this direction of research and that may account for this pattern of development. By shifting attention to patients' socially-situated ways of storying their lived experiences of illness, these studies break free of the medical conception of illness and the research focus on physicians' clinical tasks that is prominent in studies reported in earlier sections.

CONCLUSION

We have emphasized the diversity of theoretical and research perspectives in current work on language and medicine, adopting a typology that specified four different foci of interest: speaking "to," "with," "about," and "by" patients. We believe that collectively they represent the major themes and issues of the field as it has developed and is now defined. However, that goal has also limited the scope of our review. In a sense, we were constrained by what might be found in a computer database search of the key words "language and medicine" with their associated terms. Further, research areas "on the borders" of medicine, like psychiatry (Hydén 1995, Ribeiro 1994), psychotherapy (Ferrara 1994), and counseling (Peräkylä 1995, Silverman 1997) have been excluded. The field as it exists, particularly one as new and expanding as this one, may not be an adequate basis for forecasting future trends. In these concluding remarks, we wish to point to an area that deserves and, we hope, will receive more attention as a further potential extension of the boundaries of this field of study.

Briefly stated, during the past few decades, the health field has become a contested space where alternative conceptions of illness and treatment compete with the dominant tradition of Western scientific medicine. New lexicons of illness have grown in prominence, some based on non-Western approaches, such as Aryuvedic medicine or various indigenous cultures' models of healing. There is an increase in the use of homeopathic practitioners, for example, osteopaths and chiropractors, as well as acupuncturists. Etiological factors, within the standard medical model, have come to include "lifestyle" factors, for example, in the relation between smoking and lung cancer, or sexual activity and AIDS. Patients have access to sources of information that were previously unavailable—one can find a "chat" group for every known illness on the Internet—and now approach their physicians with more knowledge and different demands. Feminist health perspectives and the disability movement have transformed medical discourses (for example, by altering views of menopause), defining people with physical problems as "challenged" rather than impaired.

This ad hoc list suggests that the dominant discourse of medicine is undergoing radical change, invaded by new definitions and theories of health and illness, and alternative forms of practice. These developments are not

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encompassed under the current rubric of "language and medicine," but they will have to be taken into account in future reviews.

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The author argues that it is necessary for social scientific research on medicine to move beyond the medical interview and focus on what goes on in the talk among physicians and other health care professionals. The study focuses on the work of hematologists and their work in relation to other types of clinical practice.

Beisecker, A. E. 1990. Patient power in doctor-patient communication: What do we know? *Health Communication.* 2.105–122.

The author reviews research on how various social variables affect the power balance between doctor and patient. She focuses on how sociodemographic factors and aspects of the actual communications process affect the patient's attempts to obtain information and participate in medical decisions.

Charon, R. 1993. Medical interpretation: Implications of literary theory of narrative for clinical work. *Journal of Narrative and Life History.* 3.79–97.

The author suggests that clinical work is similar to the work of literary critics in the sense that listening to the patient is like reading a text. The doctor has to be attentive in listening in the same ways as a reader of a text has to be. It is through close listening that an effective therapeutic relationship develops.

Clark, J. A. and E. G. Mishler. 1992. Attending patient's stories: Reframing the clinical task. *Sociology of Health and Illness.* 14.344–371.

This article provides a study of how physicians conduct medical interviews in ways that either hinder or facilitate patients' efforts to account for and explain their problems in narrative form. In order for patients to be able to present their contextualized account, the doctors have to modulate their dominance.

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Fisher, S. and S. B. Groce. 1990. Accounting practices in medical interviews. *Language in Society.* 19.225–250.

In this study, the relation between social structure and interaction between doctor and patient is in focus. The authors argue that accounts presented by doctors and patients can be seen as attempts to use social norms to structure the interaction.

Frank, A. W. 1995. *The wounded storyteller. Body, illness, and ethics*. Chicago: University of Chicago Press.

In this book, Frank argues that seriously ill persons not only are wounded in their bodies but also in their voices. They have to become storytellers in order to recover their voices. Patients have to gain a public voice in order to relate a private experience, to sustain the primacy of their own voice in relation to the voice of medicine, and to balance the illness experience against the scheme of their own lives.

Frankel, R. M. 1990. Talking in interviews: A dispreference for patient-initiated questions in physician-patient encounters. In G. Sathas (ed.) *Interaction competence*. Washington, DC: International Institute for Ethnomethodology and Conversation Analysis and University Press of America. 231–262.

In this study, Frankel shows how the turn-taking system in medical interviews is restricted in comparison to casual conversations concerning turn types and speaker identity. Doctors tend to be the ones asking questions and patients answering them. Further patient-initiated utterances and questions are disprefered.

Good, B. J. and M. J. V. Good. 1994. In the subjunctive mode: Epilepsy narratives in Turkey. *Social Science and Medicine.* 38.835-842.

This anthropological study focuses on how sufferers and their families, in their narrative representation of illness, maintain multiple perspectives and potential for multiple readings. This multiple perspective-taking is a way to justify continued care-seeking and to maintain hope for positive outcomes.

ten Have, P. 1991. Talk and institution: A reconsideration of the "asymmetry" of doctor-patient interaction. In D. Boden and D. H. Zimmerman (eds.) *Talk and social structure. Studies in ethnomethodology and conversation analysis*. Cambridge: Polity Press. 138–163.

In this chapter, the author analyzes medical interviews in order to show how interactional asymmetries are produced in and through the concerted

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activities of doctors and patients. He stresses that asymmetry is an achieved and varying aspect of the interaction.

Hunter, M. K. 1991. *Doctor's stories. The narrative structure of medical knowledge*. Princeton: Princeton University Press.

The author argues that medicine is an interpretative activity. The medical doctors have to adjust general scientific abstractions to individual cases. In doing this, doctors use narratives to connect individual patients with medical knowledge and experience.

Hydén, L. C. 1997. Illness and narrative. *Sociology of Health and Illness*. 19.48–69.

This article provides a review of narrative studies in the medical field. Three types of narratives are discerned: illness *as* narrative, narrative *about* illness, and narrative *as* illness. It is argued that social scientists can use illness narratives as a means to study not only the world of biomedical reality, but also the illness experience and its social and cultural underpinnings.

Kleinman, A. 1988. *The illness narratives. Suffering, healing, and the human condition*. New York: Basic Books.

In this book, focus is on the story that the patient tells in order to give coherence to the distinctive events and long-term course of suffering. The illness narrative makes it possible to integrate the symptoms and the consequences of the illness into a new whole. For the doctor, it is important to attend to the patient's illness narratives.

Mattingly, C. 1994. The concept of therapeutic "emplotment." *Social Science and Medicine*. 38.811–822.

Starting from a study of occupational therapists, the author discusses ways that health care professionals actively use narrativization in order to create a plot that connects seemingly unconnected experiential, clinical, and therapeutical aspects into a new whole.

Maynard, D. W. 1991b. Interaction and asymmetry in clinical discourse. *American Journal of Sociology*. 97.448–495.

The asymmetry between doctor and patient is the focus of this article. Through analysis of "perspective display series," the author shows how asymmetry is interactively established and achieved, rather than being imposed.

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Mishler, E. G. 1984. *The discourse of medicine. Dialectics of medical interviews.* Norwood, NJ: Ablex.

The author investigates the conflicting views and positions of physicians and patients in medical interviews. Patients try to present their experiences while doctors control conversational topics and perspectives. This conflict is conceptualized as a struggle between the "voice of the lifeworld" and the "voice of medicine."

Ong, L. M. L., J. C. J. M. de Haes, A. M. Hoos and F. B. Lammes. 1995. Doctor-patient communication: A review of the literature. *Social Science and Medicine.* 40.903–918.

This article reviews quantitatively-oriented research on communication between doctor and patient. The focus is on how communicative behavior and style affect the outcomes of encounters in terms of satisfaction, compliance, and health.

Robinson, I. 1990. Personal narratives, social careers and medical courses: Analysing life trajectories in autobiographies of people with Multiple Sclerosis. *Social Science and Medicine.* 30.1173-1186.

In this article, the storylines in narratives of patients with multiple sclerosis are analyzed. He identifies three different life trajectories in these illness narratives: "stable," "progressive," and "regressive."

Roter, D. and R. Frankel. 1992. Quantitative and qualitative approaches to the evaluation of the medical dialogue. *Social Science and Medicine.* 34.1097–1103.

In this methodological paper, qualitative and quantitative methods for investigating the medical dialogue are compared and discussed. Cross-method research is suggested to have rich potential for understanding and describing, for instance, information gathering and information giving.

Silverman, D. 1987. *Communication and medical practice. Social relations in the clinic.* London: Sage.

In this book, research from pediatric and cancer clinics is used to discuss the interactive and discursive construction of patients and parents. It further entails an analysis of how patient-centered medicine can work in different directions, some quite coercive.

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Waitzkin, H. 1991. *The politics of medical encounters. How patients and doctors deal with social problems*. New Haven: Yale University Press.

In an analysis of medical encounters, the author discusses the ways in which doctors maintain dominance in dealing with patients and especially how social problems are marginalized and social norms reinforced.

Young, K. 1997. *Presence in the flesh: The body in medicine*. Cambridge, MA: Harvard University Press.

This book provides a phenomenological analysis of the ways in which the spatial arrangements and norms of behavior in examinations contribute to the separation of patient's selves from their bodies in clinical practice. She also points to how the self nonetheless continues to intrude in the clinical encounter.

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