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From a medical consultation to a written text

2. *Pragmatics and textlinguistics applied to medicine*

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***Objective* – To present linguistic and pragmatic theory applied to a consultation in general practice.**
***Design* – Reflect upon what happens during a referred consultation, illustrating key pragmatic concepts. Apply these concepts to the medical outcome of GP consultations.**
***Implications* – The spoken language is the most important tool in general practice. Speech-act theory, pragmatics, and textlinguistics may help us to grasp the process of doctor-patient interaction, and hence some essential aspects of the dynamics of clinical work.**

***Key words:* speech-act philosophy, illocutionary force, direct and indirect speech acts, semantics, pragmatics, textlinguistics.**

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In the first article, I described the process of transcribing a consultation to a coherent written text and analysed the interactional outcome of the consultation. In this article, the main focus is on linguistic and pragmatic theory, using this theory to highlight the patient-doctor interaction and the text producing process. The theory will be applied to the consultation transcript presented in the first article.

Doing by speaking

First, I want to pay attention to the fact that medical work has been done in the actual consultation. The medical work is in essence neither surgery nor pharmacology. The main outcome is what could be described as interactional work. Doctor and patient have acted together towards a common goal to help the patient to cope with her problems. This work is not done on a technical or mechanical level, but on a symbolic one. Patient and doctor have interacted in a symbolic way, mainly through talk. Talk and action are not different things. On the symbolic level, people are doing by speaking (1).

According to speech-act philosophy, people can do many different things with words. All utterances in causal talk are not only statements or questions about some piece of informations, but are actions. People are doing by speaking on three levels. According to Austin (1), the first level is *locutionary*, which means the physiological act of saying something: produce a series of sounds which means something. This is mainly of interest for neurologists and phonetics. The next level is the genuine speech-act level, called *illocutionary*, which means "doing by doing", e.g. promising by saying "I will do it for you". The third level is called *perlocutionary*, which means what the speaker makes happen by speaking, e.g. the doctor gets the patient to comply by explain-

ing the importance of some treatment. Speech acts are not a matter for philosophers only; they belong to ordinary life activities, which means speech in a social context of ordinary life interaction, as in the medical consultation.

Illocutionary force, direct and indirect speech acts

Speech act philosophy delivers a theoretical frame of reference for a multi-level analysis of the verbal interaction between speakers. For our purpose, studying medical work as doctor-patient interaction, it is the illocutionary level which is of main interest. Another term, illocutionary force, can further be introduced. Words have effect in shaping the world, and this effect depends on the illocutionary force of a given utterance in a given situation.

The relation between words and actions is, however, complex. In my first article, I stressed that the patient, by her utterance about marriage and neck, implicitly asks for medicine. She does it, however, indirectly, not mentioning medicines at all, but in a way significant to the doctor, who tries to argue for "better solutions". The patient is, on the other hand, arguing for herself, and the doctor at last accepts her needs. The interactive stages have been closed by a somewhat ambiguous statement from the patient:

D says "okay, you have to try medicine"
P says "maybe it will not help. But..."

This sequence illustrates the concept of indirect speech acts. Speech acts may be direct or indirect. The indirect speech act of asking for medicine by commenting on marriage and neck has the illocutionary force – and the perlocutionary effect of getting the doctor to prescribe medicine.

Another example of an indirect speech act performed by the patient is found in the third episode:

P tells that for some time she has wanted to stay at a rest house
D asks if she is now commenting on her husband's drinking problem. She answers that he is right

The indirect speech act is the act of expressing a need for a rest house meaning something about her husband's drinking problem.

I find that indirect speech acts are very common in medical conversations. The term "indirect speech act" may represent a key concept in the understanding of clinical interactional activities. Symptom language, especially about pain and discomfort, may rather be understood as expressing a meaning hidden behind the words. This meaning may be quite different from what we would expect, given an ordinary bio-medical explanation model (2). But how to grasp this "meaning behind the words"? What is the meaning of something said, and what does somebody mean by saying something? We have to sharpen our minds, and separate analytically the meaning of something from the meaning of somebody. To understand this point, we have to know the difference between two linguistic fields, semantics and pragmatics.

Semantics and pragmatics

Both semantics (the meaning of an expression) and pragmatics (the meaning expressed or understood by somebody) are related to the question of meaning. However, an essential difference is reflected in the different uses of the verb "to mean":

1) What does X mean?
2) What do you mean by X?

Semantics traditionally deals with meaning as a dyadic relation, as in 1), while pragmatics deals with meaning as a triadic relation, as in 2). Thus meaning in pragmatics is defined relative to a speaker or user of the language, whereas meaning in semantics is defined purely as a property of expressions in a given language, in abstraction from particular situations, speakers or hearers (3).

In analysing the actual presented medical dialogue, I have been interested in what the doctor and the patient, respectively, are trying to do, and how they understand each other. These matters are purely pragmatic problems. But when listening to a spoken text and trying to convert it to a written one, the editor reaches the pragmatic level mainly through the semantics of the words. First: what does this expression mean? Next: what does the speaker mean by this? The first question is a lexico-grammatical one, while the answer to the last question is highly dependent on the context. What shapes the meaning of an utterance in doctor-patient interaction is the context of that par-

ticular medical consultation. A "resting house" has semantically the same meaning – a place where we can rest – independent of who is using the words. But when uttered in a medical consultation, it has some relevance to a medical problem. Pragmatically, the patient, by talking about a resting house to the doctor, means in this case that she has a husband with a drinking problem.

The term "pragmatics" was introduced by Charles Morris (4), and is understood as the relationship between the use of language, the language user, and the context (5).

Pragmatics, text and context

Before going any further, a brief summary is necessary to understand the rather complex link between the medical consultation and general pragmatics: medical interaction is symbolic inter-action, realized through speech acts. Speech acts are often indirect, people expressing what they mean not openly, but in an indirect way, only conceivable regarding the specific situation, the context in which the utterance is used. Hence, we have to differ between the meaning of a word, which is dyadic, semantic, and lexical, and the meaning of an utterance, which is triadic, pragmatic, and specific to the situation.

The next question is why and how the participants of a dialogue understand each other in a consistent way. My answer is connected to the notion of "text". As stated by Halliday (6), language does not consist primarily of sentences. It consists of text, or discourse – the exchange of meaning in interpersonal contexts of one kind or another. A distinctive feature of a text is that it has an underlying cohesion or coherance, a "story" behind the words, which ties the utterances together. We can illustrate this coherance by a common experience: if we put on the radio and listen to a program by chance, we soon experience what is the main story even though we have only heard parts of the programme, without any introduction. Hence, we have to understand the coherance of the story behind the text as a pragmatic entity realized through the combination of the text, the language users, and the context. It follows from this that one and the same story can be represented and realized through many different texts, such as tellings, retellings, summaries, spoken and written texts. A dialogue is linguistically always regarded as a text. Both to pay attention to the patient's stories and to regard the patient as text is common in theoretical medical literature (7,8).

Spoken and written texts

Talk is mainly a social activity, and texts have their function in a communicative setting. The written text presented in my first paper is quite different from the original spoken dialogue. Three differences are significant:

1) The written text is far shorter than the spoken dialogue. Many words, sentences, hesitations, and repetitions are present on the audiotape recording, but are omitted in the written text.
2) The originally spoken text results from a cooperation between two actors, both of them of equal responsibility for the end product. The written text is the product of the editor, presenting his explicit and implicit interpretations of what is happening in the consultation. The doctor and the patient have given access to the consulting room. But neither of them is responsible for interpretations and conclusions about what the editor is hearing.
3) A third difference between spoken and written texts is that the addressee, namely the receiver of the verbal message, is different. A dialogue is a momentary activity, limited in time and space, and in an immediate communication with the listener. A written text is a permanent representation of what has been going on, accessible to all readers who want to read and interpret the text today or in the future.

It follows from the notion of coherance of a text that one can convert a spoken dialogue into a written text without losing the "story". Hence my written transformation of a doctor-patient dialogue may represent in principle a valid and responsible interpretation of what was going on. However, the written text cannot replace the consultation. The consultation as a dynamic, transient, contextbound, individual and confident happening is converted by me into a permanent and "dead" product, giving only a skeleton-like impression of living and embodied verbal interaction. The transcript can only serve as a pale interpretive representation. Nevertheless, this repre-

sentation may still deliver valid knowledge about certain aspects of what is going on.

Medical implications

Western medicine is a sort of service encounter. People consult the doctor for their problems which they assume to be health problems, doctors are collecting clinical information before giving treatment and advice. The collecting of clinical information can be portrayed as taking place in three kinds of situation (9). The "talk situation" consists of a dialogue between doctor and patient, the "body situation" consists of the clinical examination, and the "machine situation" concerns laboratory examinations and technological procedures of different kinds. The talk situation is primary because the doctor and the patient through the dialogue decide what to do next. The patient is not sure what is the case, e.g. if he or she is ill or not, or the patient wants to change what is the case. Through the dialogue, the doctor has to make a sort of conclusion about what is the most likely diagnosis and adequate management. My text shows that the doctor is doing interpersonal work as a psychotherapist, listening to the patient's story, giving personal support, and suggesting new ways of thinking about her problems. Formally and logically speaking, the doctor and patient, in cooperation, choose between many possible worlds and decide how the world actually is and how they would like it to be (10). They are creating a medical reality. This is a linguistic reality, with symbols and distinctions from the language, constructed through interaction.

Pragmatics can help us to identify medical interaction (11). The concepts of illocutionary acts and illocutionary force, direct and indirect speech acts, meaning and context make us aware of what happens and what are the effects of the talk. Medicine is, however, a practical and empirical activity, and the problem exists of how to handle conversational data. The textual method for transcription and interpretation of the consultation story presented here is an example of textlinguistics applied to medicine and one of many possible approaches to the medical dialogue.

Conclusion

The spoken language is the most important tool in medicine (12,13). Through audio- and videotape recordings we can easily identify medical interaction. However, to handle conversational data for education and research, we are in need of a linguistic approach and a practical way of transcribing the dialogue.

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