Turn-taking Mechanisms in Dialogues Between General Physicians and Cardiac Patients

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Introduction: The subject of this research is to investigate communication between general physicians and patients by focusing on the mechanism of turn-taking. The study is meant to identify some characteristics of successful doctor-patient communication and will also attempt to analyze a history taking event with regard to its turn-taking structure.

Material and method: The subject of this research is doctor patient dialogues. The transcribed versions of the recordings contain important information about the content and the process of the conversation as well as special signs for interruptions, breaks and intonation. A history taking encounter of a general physicians and a heart patient was analyzed. Doctor-patient communication was studied from the aspect of trustful relationship. The methods, number, and places of turn-taking were explored.

Results: Based on the results, the patient's turns were allocated by self-selection 12 times and there were 10 instances of current – the doctor-selecting next speaker. Table II shows the number and different types of indicating turn allocation in the dialogue. According to the results, turn allocation was indicated by the patient's questions and the doctor's imperative sentences.

Conclusions: The present research is to be extended with further investigations concerning the mechanisms of problem-solving and turn-taking. For the purposes of widening the focus of the present research further doctor-patient encounters will be recorded, and analyzed using the method of conversation analysis.

Keywords: doctor-patient communication, problem oriented interrogation, turn-taking, self-selection

Introduction

The subject of this research is to investigate interaction between general physicians (GP) and patients by focusing on the mechanism of turn-taking. The study is meant to identify some characteristics of successful doctor-patient communication and will also attempt to analyze a history taking event with regard to its turn-taking structure. To find answers to the questions determined by the orientation of the investigation, it was necessary to record the conversation between the GP and the patient. Considering that both the recording procedure and its evaluation is influenced by personal observation, the preparations of the recordings and the selection of a suitable communication event require careful planning and permanent attention.

The present study will focus on a segment of health care from a special point of view investigating the interaction between GPs and patients. It will point out the relevance and necessity of a specific confidential relationship between doctor and patient. The utmost aim of this study is to offer help to physicians reveal and solve problems in the cooperation with patients, through investigating into some implicit feature.

The dialogue presented here was chosen because it was not an ordinary case of history taking when the doctor asks questions and the patient gives answers. In this case it is rather the patient who asks questions and the doctor gives answers [1]. Turn-taking happens according to specific rules, with the help of semantic, pragmatic, syntactic, prosodic and other nonverbal signs. We can draw a distinction between interactional and contra signs according to their nonverbal or verbal characteristics. Gestures like head nodding, mimic, mien or eye contact, even a glance, laughing or head sinking can be considered as nonverbal signs. Verbal signs can be for example reflecting signs such as "ouch", "hmm" or commenting remarks, like "yes" "really" "yes, indeed" "so" etc. [2].

Turn-taking can happen either by current speaker's selecting next speaker or self selection at the suitable points of interaction and can work out as follows:

a. Next turn is allocated by current speaker's selecting next speaker, the selected speaker is allowed or obliged to speak.
b. Next turn is allocated by self -selection. The first to speak has the right to take the turn.
c. In case neither "current selects next" nor self-selection occurs the current speaker can continue [3].

Material and method

The subject of this research is doctor patient dialogues. The recording process was preceded by having the consent and the permission of participants and it was completed by personal observation. Preparations were made regarding the conditions of the recording and also the selection of a relevant communicational event. The transcribed versions of the recordings contain important information about the content and the process of the conversation as well as special signs for interruptions, breaks and intonation. A history taking encounter of a GP and a heart patient was analyzed. Doctor-patient communication was studied from the aspect of trustful relationship. The methods, number, and places of turn-taking were explored.

Table I. Types of Turn-Taking during discourse analysis

	Doctor	Patient	Total
Turn-taking	7	10	17
Current selects next	7	10	17
Self-selection	5	12	17

Table II. Type of questions and number indicating Turn allocation

	Question	Imperative	Answer	Total
Doctor	0	3	4	7
Patient	5	0	5	10
Total	5	3	9	17

One of the conversations went on between the doctor and her 40-year-old patient, who has been suffering from hypertension. The recording was done in the family doctor's office, where the doctor could create an informal and familiar atmosphere.

Results

Table I presents the number of turn-takings by instances of "current selects next" or self-selection in the dialogue analyzed. Based on the results, concerning the patient, turns were allocated by self-selection 12 times and there were 10 instances of current – the doctor-selecting next speaker. The doctor was selected by the patient as next speaker 7 times, and turns were allocated by self-selection 5 times. Nonverbal signs could also be found in the conversation, like the doctor's laughing or the patient's nodding. The patient commented on the doctor's answers, convincing himself with remarks like "yes, that is true" etc. In the present case the doctor was silent because she was considering the therapy of the patient.

Table II shows the number and different types of indicating turn allocation in the dialogue. According to the results, turn allocation was indicated by the patient's questions and the doctor's imperative sentences.

The current speaker's falling intonation signaled that he finished his speech and wanted to give the right to talk to the next speaker. To sum up, the current speaker allocated the turn by addressing questions or with the use of falling intonation.

Discussions

The communication between the doctor and her patient was characterized by an understandable language use. The doctor avoided expressions which were incomprehensible for the patient. This is important as the friendly environment and amity with the doctor can help patients reveal their problems more easily. The effective communication based on mutual understanding also advances the development of a better therapy. As the patient visits the family doctor every month for the prescriptions, a confidential relationship was already established. The doctor called the patient by his first name, she sat near the patient and there was a constant eye contact. She gave sings that the patient's complaints were important, for example she was smiling and listened to the patient carefully. The doctor tried to build a trustful relationship. At the end of the dialogue the doctor laughed to confirm and enable the patient to ask questions. The time devoted to the patient is also a significant factor in effective communication. Although, there were still some patients in the waiting room, the doctor did not rush the conversation. For the purpose of effective communication the doctor has to ask relevant and problem- oriented questions. The patient can describe his problems thoroughly for open questions hereby the doctor can get more information. Thus, it is important to minimize asking Yes/No questions. The adequate questioning is essential from the viewpoint of a successful communication.

The interaction studied is not an example of a previous paternalistic model where the doctor decides for the patient. This model of history taking is characterized by mutual understanding and decision-making process. There are pauses between the doctor's utterances. Her aim is to understand several aspects of the patient's circumstances, including his financial situation to propose the proper therapy. There are also pauses before the patient's utterances, which suggest that he is thinking over what the doctor had said. The silences between the turn-takings can have different lengths. The length of the pause depends on the relationship of the participants, or regional differences etc. [4]. Consequently, there are no pauses with the same length. In doctor-patient interaction the pauses can not be long because of the time limit. The consultation should be prompt as usually there are a lot of patients waiting for the doctor. These gaps without talking can be in many instances embarrassing and inconvenient, but they can also be signs of disinterest for the topic of the discourse (for example, if an old patient tells the same story several times). There are signals at the end of the speakers' utterances, this way the suitable places for turn-taking are indicated. The current speaker can decide to give the listener the right to talk at different points of the interaction. This can happen by the use of an interrogative or imperative sentence. If the current speaker does not select the next speaker, the discourse can be continued by anybody even the current speaker [4]. The dialogue recorded and analyzed suggests that in this case of medical history taking a trustful relationship is established between the doctor and her patient. This fact is reflected by the use of the first name, the comments of the patient, nonverbal signs, the friendly atmosphere and the time devoted to the conversation. Turn-taking took place by the technique of "current speaker's selecting next speaker" and next turn was also allocated by self-selection. The doctor-patient interaction in the present study was not characterized by the usual question-answer sequence. The paternalistic model is increasingly replaced by a history taking process based on mutual decision-making when dealing with young patients. In the doctor-patient encounter presented here it is the patient who asks questions and the doctor gives answers.

Conclusions

The silences during the interaction suggest that both parties took an active part in the conversation, and they considered their answers. The speakers indicated the suitable points for turn-taking. The current speaker selected the next speaker and allocated the right to speak at all relevant places. There were two instances of interruptions by the patient, but they were not considered as impolite utterances.

The present research is to be extended with further investigations concerning the mechanisms of problem-solving and turn-taking. For the purposes of widening the focus of the present research further doctor-patient encounters will be recorded, and analyzed using the method of conversation analysis.

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