COMPANIONS OF ELDERLY PATIENTS – A SOCIOLINGUISTIC STUDY OF TRIADIC MEDICAL ENCOUNTERS IN SOUTHERN TAIWAN

A Dissertation
submitted to the Faculty of the
Graduate School of Arts and Sciences
of Georgetown University
in partial fulfillment of the requirements for the
degree of
Doctor of Philosophy
in Linguistics

By

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Washington, D. C.
May 23, 2000

GEORGETOWN UNIVERSITY

GRADUATE SCHOOL OF ARTS AND SCIENCES

The doctoral dissertation~~/Master's~~ thesis of Mei-hui Tsai entitled Companions of Elderly Patients - A Sociolinguistic Study of Triadic Medical Encounters in Southern Taiwan

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THE COMPANIONS OF THE ELDERLY PATIENTS – A CASE STUDY IN THE TRIADIC MEDICAL ENCOUNERS IN SOUTHERN TAIWAN

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ABSTRACT

This dissertation investigates Taiwanese triadic geriatric encounters between doctors, elderly patients, and patients' adult children who accompany patients on the first visit to their doctor. The two major goals of this research are to propose a systematic framework for analyzing the companion's participation in providing information to the doctor and to account for the dynamic process of the doctor-patient-companion communication by following the principles of interactional sociolinguistics. The data to be examined are fifteen triadic encounters collected in the family medicine department of a teaching hospital in southern Taiwan.

In this proposed framework, the companion's participation is analyzed from four aspects that are grounded in the structural and interactional levels. There are four parts in

this framework. The first part measures the discourse space of the patient party (i.e. the patient and the companion). The second part provides taxonomy of five categories of information provided by the patient party. The third part identifies eight discourse patterns of question-response sequences in which the patient party provides information to the doctor. The fourth part identifies six linguistic and interactional mechanisms that can initiate the companion's participation.

By using the above framework, some interactional patterns can be recognized from the quantitative results. Some of the major findings include the following. Most (80%) of the patients remain the primary information providers. However, when both the patient and the companion provide information, the patient hardly ever completes his or her reply to doctor's questions prior to the companion's intervention. It is also argued that the pedigree section in which the doctor gathers the patient's family history is the most appropriate interactional context to recruit the companion. The related evidence includes the doctor's use of eye contact, relationship deictics, and code-switching to Mandarin which the patient does not speak as initiation cues to prompt the companion's participation.

This research contributes to the field of discourse and medicine by taking interactional aspects into account when examining the participation of the companion. It also adds cultural meaning and medical professionals' insights to the interpretation of the interactional patterns observed in the fifteen doctor-patient-companion triads.

ACKNOWLEDGEMENTS

It would be impossible to mention all the people who brought this dissertation to completion. I sincerely thank each of them, though only some of them will be named here.

I am greatly indebted to Georgetown University which granted me the fellowship to study within the renowned academic environment of the Sociolinguistics Program in the Linguistics Department.

I am truly grateful to Prof. Deborah Schiffrin and Prof. Deborah Tannen. As committee members, their invaluable comments and critiques have to helped improve many parts of this dissertation. Their works and perspectives on interactional sociolinguistics and cross-cultural communication have provided me with the tools to analyze language and social interaction.

I wish to express my deepest appreciation to my dissertation mentor Prof. Heidi Hamilton. Her ‘Discourse Analysis: Narrative’ and ‘Discourse and Medicine’ courses served as my introduction to the fields of discourse analysis and discourse and medicine. She encouraged me to participate in a team project of genetic counseling, from which I

gained insights on team-work and skills in collaborating with medical professionals. Her positive attitudes, open-minded approach, and critical eye have been a source of inspiration as I hone my thinking and writing to finally bring this dissertation to fruition.

I would also like to express my deep appreciation to Prof. Peter Patrick. As a teaching assistant to his course ‘Language and Social Life’, I learned the pedagogical skills it takes to guide students to appreciate the value and fun of sociolinguistics. As my advisor and the reader of my dissertation proposal and other writings, he has been a steady source of patient guidance and enthusiasm for my work.

My former teacher Prof. Feng-Fu Tsao, Director of the Graduate Institute of Linguistics at National Tsing-Hua University, and Dr. Feng-hwa Lu, and Prof. Chih-jen Chang, Director of the Family Medicine Department at the Medical College of National Cheng Kung University (NCKU), must take special credit for this research. Without their open-mindedness and scholastic rigor and enthusiasm, this research would not have been possible in the first place. In that regard, I also thank the National Science Council, Taiwan, for its financial support of a part of my research.

I wish to express my utmost appreciation to all the staff members of the Family

Medicine Department at NCKU. The nurses served in the front-line of my data-collection in locating patients for me. I am also grateful to the doctors, patients, and companions who participated in my study. Allowing me to conduct my research meant allowing me into the intimacy of their lives, an extension of trust that I thank them for. The fifteen-month fieldwork at NCKU had a great effect on me both personally and academically. The scientific approach in the medical field sharpened my thinking (which is where I learned my first lessons in the statistics software SPSS and the presentation software Power Point). Observing doctor-patient communication within a family relationship has provided me a chance to reflect on great many truths about human interactions.

Finally, my profound thanks to my M.A. thesis mentor Prof. Shun-chiu Yau who inspired and encouraged me to go for the Ph.D. study. I would also like to thank my dearest friend Sylvia Chou who has grown with me through my years at Georgetown and Yu-pei Lin who shared the process of my fieldwork in Taiwan. I can recall all the inspiring and intelligent conversations with them. Their support kept me moving ahead. To Andy Wung and Yu-sheng Hwang whose patience never failed with any stupid

problems I had with the computer. Many thanks to the first readers and editors of my dissertation writing, Bill Fox, Roane Beard, and Alex Woods. The language exchange experience with them has been a very pleasant and productive experience for me.

My deepest gratitude to my parents and my brothers. They never questioned my path and always show their unending patience for me. I thank them for their trust and support for my decision to study in the States, which is far from their experience, and a constant source of worry. My conversations with my mother, an illiterate but a witty language user of Southern Min, has inspired me a lot on the discourse analysis of Southern Min conversation. Her years of taking care of my grandparents before they passed away and my monthly companionship with her in the visit to her family doctor at NCKU are the naïve motivations for this research. These experiences offer me a very fundamental understanding of patient-caregiver relationship and doctor-patient-companion communication.

For my parents

This dissertation marks the end of my life as a student

and the harvest of my parents' hard work on the custard apple orchard.

獻給我的父母

此論文象徵我求學生涯的句點，也是他們在釋迦園辛勤農作的碩果

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Chapter 1. Introduction

1.0 Motivation

It's three o'clock already. Mrs. Ong is expecting her son to take her to the hospital, and he isn't in sight yet. She begins to doze off. Since Mrs. Ong became ill, her daughter-in-law has been the one to care for her and accompany her to the hospital. Yet, her boss always gives the daughter-in-law a hard time when she asks for a day off. Her son just started his business and is too busy to help. One minute his mind is on what is going on in the hospital, the next minute his mind is on his company. It's even harder to have her daughter accompany her since the daughter's father-in-law has just been hospitalized recently. Being illiterate, Mrs. Ong can't find her way around the labyrinth-like hospital, and now she can't even walk on her own. Maybe her son's idea of hiring a Filipino maid will work but the language problem….Ah! If only her husband were still alive, she sighed, she would not have to bother the kids! [1]

已經三點啊，阿旺嫂等無伊後生欸人，又擱開始渡咕啊。自伊人開始破病，攏是媳婦咧共照顧，帶伊去病院，是講伊吃人頭路，請假嘛叨看頭家。後生是事業嘟開始，去到病院叨遂煩惱公司。 伊查某子雖然有卡貼心，伊達倌嘛咧住院。啊家己是青瞎牛摸無路，即嘛創這腳擱行無法。後生講卜共伊請菲律賓欸看護，擱驚話未通。哎！若是頭仔擱在欸，叨毋免車煩這欸少年欸啊！

[1] My creation of Mrs. Ong's story is inspired by Hu (1995) and my observation at the field site (see §3.2).

The story of Mrs. Ong depicts the task of caring for the elderly parents in a modern Taiwanese family. Under the practice of *san-dai-tong-tang*, the living arrangement in which the elderly parents live together with their son, daughter-in-law, and grandchildren, family care for the elderly is preferred to institutional care. Mrs. Ong's story also reveals to us how an elderly widow, being illiterate and having difficulty moving around, must rely on her son and daughter-in-law to take her to the hospital during their spare time away from work.

Caring for the elderly involves the whole family, especially on the part of the woman. Under the patriarchal structure of the Taiwanese family, the daughters (in-law) are the ones who physically take care of the elderly patients (Hu 1995). Tsui's observation (1987) further suggests that working daughters who are economically independent are more willing to devote affectionate care to their parents even after they are married while the son and daughter-in-law's care for their parents out of family obligation.

The various motivations and degrees of involvement that family members contribute to the care of elderly patients immediately trigger different pictures of the

triadic medical interaction in which the patients are accompanied by their family member on their visit to doctors. Will Mrs. Ong's daughter-in-law be more helpful to provide information to the doctor since she has been the primary caregiver of Mrs. Ong? Will the son be available to assist his mother for any immediate treatment plan after the medical visit? Will Mrs. Ong feel more comfortable or willing to talk about her health problem had her caring daughter or husband been able to accompany her? Will Mrs. Ong's doctor behave in the same way in interacting with the different companions of Mrs. Ong? For example, how does the doctor choose which languages to use with whom? Should he or she use Southern Min when talking to Mrs. Ong's husband, Mandarin to her children, or English to the Filipino maid? How is the doctor-patient communication reconstructed with the presence of Mrs. Ong's companion? On top of the language switch issue, there are certainly other important concerns that affect the geriatric doctor-patient interaction, such as the relationship between the patients and the companions (e.g. care out of love, family obligation, or employment duty), the living arrangement of the patients and their caregivers, and the family's economic resources.

It is these important issues and concerns that motivate this sociolinguistic study on

the triadic geriatric interaction in Taiwan. The geriatric triads involve the two most important agents in the later life of the elderly people—their caregivers and their doctors—and serve as the foundation to explore further issues regarding the care of the elderly patients. As observed in other research (such as Adelman et al. 1991, Tsao and Lu 1999), most elderly patients (73.1% in Tsao and Lu's research) are accompanied by a third person on their first visit to see the doctor. This statistic further highlights the triadic nature, rather than the dyadic nature, of geriatric encounters and the dependent relationship between the elderly and their caregivers.

1.1 Two goals

As a preliminary sociolinguistic research in exploring the triadic geriatric encounters in southern Taiwan, I decided to narrow my focus on the participation of the elderly patients' adult children—the most commonly observed companion of the elderly patients (Tsao and Lu 1999). The patient's adult child refers to the son or daughter by birth or marriage and will be referred to as **'companion'** in this research. Also, my research will focus on the activities in which the companion provides information

regarding the patient's health problem to the doctors. The data to be examined are fifteen medical encounters which I collected during my fifteen-month ethnographic research in the family medicine department of a teaching hospital in southern Taiwan.

There are two major goals of this dissertation. First, I will set up a systematic framework to measure the companion's participation in providing information to the doctor. The use a quantitative analysis may overlook important contexts to account for speakers' discourse behavior. Thus, it is my second goal to enrich the quantitative findings observed in the fifteen encounters by following the approach of interactional sociolinguistics which integrates the interactional, social, and cultural contexts of the medical encounters.

A medical encounter can be seen as composed of two major activities. First, the doctors gather the first-hand information from the patients regarding their health problem. Then, based on this information, the doctors build on their diagnosis and management plan for the patients. In a dyadic encounter in which the patient visits the doctor alone, all information that the doctor gathers is first-hand information. With the presence of a companion, there will be two potential information-providers (i.e. the

patient and the companion). How the companion's presence affects the doctor's task of gathering first-hand information or the patient's priority of providing information is thus an important issue in the study of triadic medical encounters.

Several research studies are devoted to triadic medical encounters. In the pre-existing frameworks in the analysis of the medical triads (e.g. Aronsson and Rundstrom1988, Baker 1996, Debruyne 1996, and Rosenfeld 1996) grounded from discourse or non-discourse analysis appear to have sporadic focus and remain untested in a Taiwanese context. In a preliminary analysis, I found that these pre-existing frameworks are not fully applicable to my data (§2.4 and §7.1). Thus, the first goal of this research is to propose an alternative framework with a more thorough system in the analysis of the patient's and the companion's participation in providing information.

One of the shared goals among the literature is to see how the presence of the companion might have an effect on patients' autonomy and the doctor-patient communication (such as Greene et al. 1994, Baker 1996, and Debruyne 1996). This research has provided us the foundation to understand the triadic medical encounter in its various aspects. However, it does not appear that any study has employed the approach

of interactional sociolinguistics which views the cultural, social, and interactional contexts as the important factors to account for any linguistic behavior. As a result, many questions concerning triadic encounters are left unanswered. For example, Baker (1996) statistically demonstrated the reduction of the patient's participation because of the third person's presence. However, it remains unclear what happens during the interaction that prompts the third person to participate. It is also unclear how the third person's participation enhances or hinders the doctor-patient communication.

For these reasons, the second goal of this dissertation is to account for the dynamic process of the doctor-patient-companion encounter by following the principles interactional sociolinguistics which emphasizes the importance of the interactional, social, and cultural contexts of any discourse behaviors. The supplementary knowledge to support the quantitative findings includes my knowledge of the Taiwanese cultural and social contexts, my ethnographic observation at the hospital, and the insight provided by the doctors in playback interviews.

1.2 Four research questions

In analyzing the companion's participation, the patient's part can not be ignored. It would be meaningless to talk about the companion's part alone, given the fact that there are two potential information-providers (i.e. the patient and the companion) present in the encounter and they all participate in providing the information to the doctor. (From now on, I will use the term '**patient party**' to refer to 'the patient and/or the companion'). In this proposed framework, the companion's participation will be examined in the following four aspects (thus four parts in this framework):

1) How much does the patient party participate in the encounter?
2) What information does the patient party provide?
3) How is the discourse sequence structured when the patient party provides information?
4) How is the companion's participation initiated?

The first part of this framework (i.e. the first research question) begins with a general picture of the discourse space that the patient and the companion take up in the

two major activities of the medical encounter—the information-providing activity and non-information-providing activity (Chapter 4). In the second part (i.e. the second research question), it moves on to the semantic proposition conveyed in the patient party's contribution in the information-providing activity. A taxonomy of five categories of information is established (Chapter 5).

The third part of this framework (i.e. the third research question) shifts the focus to the discourse structure of the information-providing activity (Chapter 6). That is, how is a piece of information is provided? Is it volunteered by the patient party or elicited by the doctor? Does the patient alone, the companion alone, or both provide the information? The last part (i.e. the fourth research question) tackles the discourse mechanisms that motivate the companion's participation in two ways (Chapter 7). When the companion participates in providing information, who (the doctor, the patient or the companion) initiates his or her participation? What are the related initiation cues, from the linguistic level and interactional level, that prompt his or her participation?

The first and second parts of this framework display the general pictures of the discourse space that the patient party takes part in during the whole encounter and the

information-providing activity. The third and fourth parts examine the companion's participation from the levels of discourse structure (of the question-answer pairs in which the companion does or does not participate) and the discourse mechanism (that motivates the companion's participation). The last two parts are the core parts of this framework in the sense that the companion's participation is scrutinized both from the structural level and the interactional level and reflects the central theme of the approach of interactional sociolinguistics—the interactive nature of conversation.

1.3 A preview to the following chapters

In Chapter 2, I will review seven areas of literature related to my research. It includes the effect of the study of medical discourse (§2.1), communication in old age (§2.2), triadic interaction and the third person in medical triad (§2.3), participant structure in triads (§2.4), effect of the companion on doctor patient communication (§2.5), patients and caregivers in Taiwanese family relationship (§2.6), and studies on doctor-patient communication in other cultures (§2.7).

In section 3.1 of Chapter 3, I will briefly introduce the approach of interactional

sociolinguistics. The content of sections 3.2 to 3.8 includes the following: the field site and my field work of this research (§3.3), the procedure of gathering the videotaped medical encounters (§3.4), detailed background information of the informants involved in this research (§3.5), the task of data transcription (§3.6), the statistical tools for data analysis (§3.7), and my playback interview with the doctors (§3.8).

The four parts of my framework will be presented respectively from Chapters 4 to 7. Chapter 4 examines the amount of the patient party's participation. Chapter 5 focuses on five categories of information provided by the patient party. The third part of my framework identifies eight patterns of discourse structures in which the patient party provides information to the doctor (Chapter 6). The last part focuses on the linguistic and interactional mechanisms that initiate the companion's participation (Chapter 7). Each of these chapters begins with the framework itself, illustrated with excerpts from the data. The second part in each chapter presents the quantitative and statistical findings resulting from applying the framework. Discussions on these findings are also presented in the final part of each chapter. The result and discussion sections of the fourth part of the framework (Chapter 7) will integrate findings from previous chapters and thus are

extended to Chapters 8, 9 and 10. In Chapter 11, I will sum up my findings and tie the findings to the doctor's insights that I gathered in the playback interviews. The discussion will be presented under the following themes: first-hand information and patient autonomy (§11.2), the companion's access to information as the entry to participation (§11.3), pedigree section as the interactional slot for the companion (§11.4), the companion as the facilitator of management plan (§11.5), balance of conflicting needs (§11.6), the companion's degree of participation and the level of activity (§11.7), the patient's priority of providing complete information (§11.8), structural aspect vs. interactional aspects (§11.9), and spatial aspects vs. interactional aspects (§11.10)

In the final chapter, I will state the contributions of this research to the fields of medical discourse (§12.1), interactional sociolinguistics (§12.2), and doctor-patient communication (§12.3). Finally, I will propose the ways in which my findings can be applied to the medical professionals in Taiwan (§12.4), and some potential topics illustrating how this research can be extended in the future (§12.5).

Chapter 2. Literature Review

2.0 Introduction

In this chapter, I will review seven areas of literature related to my research. Sections 2.1 and 2.2. cover a wide range of studies on medical discourse and communication issues related to aging. Sections 2.3 to 2.5 focus on triadic interaction from three aspects: triads as a pervasive form of human interaction and the interactional role of the third person in medical triads (§2.3), the framework of the analysis of participant structure (§2.4), and the effect of the companion on doctor-patient communication (§2.5). Section 2.6 has a specific focus on the patient-caregiver relationship in a Taiwanese family. The last section is a brief review of studies on doctor-patient communication conducted in other non-western societies.

2.1 The study of medical discourse

The study of the language used in doctor-patient communication has a tradition of adopting a quantitative approach (such as Korsch et al. 1968, Korsch and Negrete 1972,

Byrne and Long 1976, Waitzkin and Stoeckle 1976, Waitzkin et al. 1978.) The researchers set up precise coding criteria and taxonomy in analyzing the doctor-patient verbal exchange and test for the statistic correlation between variables. For example, Korsch et al.'s research (1968) which involves a large sample of 285 pediatric encounters examines the correlation between degrees of patient satisfaction and compliance and patterns of doctor-patient interaction. This quantitative perspective adopted by the mainstream tradition echoes the scientific and objective principles in the medical field.

As more and more linguists devote their research to the study of medical discourse, the trend has moved to a qualitative approach. Labov and Fanshel (1977), for example, scrutinize a fifteen-minute talk between a patient and her psychotherapist and present an in-depth analysis of the interactional function achieved in the talk. One of the shared argument conveyed in these qualitative researches is the idea that medical interaction is seen as a joint production by both the doctor and the patient (e.g. Frankel 1983 and 1984), and thus, the interpretation of the medical interaction should be grounded in both the doctor's and the patient's perspectives. Mishler (1984), for

example, strongly calls for the researcher's neutral stance of taking both the doctor's 'voice of medicine' and the patient's 'voice of lifeworld' into account and for avoiding the medical bias which sees patients as passive objects. Heath (1986) and Have (1991), on the other hand, argue that the asymmetrical relationship reflected in most medical interaction is not imposed by the doctor alone but is cooperatively constructed. Paget's research (1983) also presents a similar view that diagnosis is not the doctor's single-handed deduction from the patient's narration but is continuously realized in the dynamic conversation.

The different spirits and interests conveyed in the qualitative and quantitative approaches can be illustrated by the following studies on the discourse element of question-responses.

Among the discourse elements analyzed in medical conversation, the structure of the question-response element has received a great amount of attention and has been examined from various perspectives. The approach of the following studies is more qualitatively grounded than quantitatively. In this group of studies, the scholars' primary concern is to explore how the linguistic construction of question-response element

reflects the clinical reality and social interaction of medical encounters. Researchers have generally found that doctors ask most of the questions and patients respond most of the time (Frankel 1979, West 1983 and 1984, Fisher and Groce, 1990). In White's description (1988), the doctor-patient consultations are characterized by the expression 'stop telling me about your problems and answer my questions!' a statement which reflects the same picture as the title of West's research of 1983 'Ask me no questions…' Frankel (1979) and West (1983) notice that both doctors and patients show a 'dis-preference' for patient-initiated questions. For example, most questions posed by the patients are accompanied by stuttering and hypercorrection. These researches reveal the asymmetrical status between doctors and patients.

In contrast to the widely shared view of the dominant and powerful status of the doctors and the passive status of the patient, Ainsworth-Vaughn's analysis on oncological encounters (1998) displays a partnership relationship, thus a more symmetric relationship, between doctors and patients. Patients are not seen as innocent or hapless bystanders to physician control. Her argument is based on one of her findings that doctors initiated a relatively equal number of questions (61.3%) to that initiated by

the patients (38.7%). This argument presents a sharp contrast to the findings observed in Frankel's (1979) and West's (1983) studies in which patients initiate questions only 1% or 9% of the time.

The tendency of the dominant doctors and the passive patients observed in the above research projects is also present in the following researches whose approach is more quantitative oriented (such as Roter 1977, DiMatteo and DiNicola 1982, Skipper 1992, and Morrow et. al 1993). Nevertheless, the scholars' main interest focuses not on the interactional aspect of how language constructs the clinical reality but on the consequence of the use of language on the doctor-patient relationship.

For example, Roter (1977) conducts a research study which involves an experimental and a control groups of patients. Roter finds that patients of the experimental group, who are instructed to prepare questions prior to consultation with doctors, ask more questions and are more likely to return for follow-up appointments than patients of the control group who were not advised to prepare questions beforehand. In their research which examines the correlation between the timing to pose questions and patient compliance, DiMatteo and DiNicola (1982) observe that the earlier in the

encounter the patients ask their first question, the more questions they ask overall, the shorter the time the encounter takes, and the higher the appointment-keeping ratio.

2.2 Communication in old age

Communication issues related to elderly people have been the object of investigations over recent years. These issues have received attention from two groups of scholars. Researchers from the fields of neurolingusistics, psycholinguists, and speech-language pathology (e.g. Obler and Albert 1980, Beasley and Davis 1981, Bayles and Kasznik 1987, and Ulatowsak 1985) focus on how the linguistic and communicative ability is affected by aging. For example, Nicholas et al. (1985), Au et al. (1990), and Barresi et al. (1999) examine the correlation between the decline in naming ability and age, education, and television viewing among healthy old people. There are also scholars in these fields aiming on the communicative impairment among the individuals with Alzheimer's disease (e.g. Emery and Emery 1983), Parkinson's disease, Huntington's chorea, and related aphasia (Cummings et al. 1985). In contrast to the above quantitative and experiment-based studies, Hamilton (1994) and Sabat (1999)

enriched the theme of communicative ability in aging by examining the spontaneous discourse interaction between the researcher and Alzheimer's patients.

The second group of scholars is mainly composed of psychologists, sociologists, sociolinguists and discourse analysts. By analyzing the elderly people's conversational interaction in various contexts (such as during interviews or interaction with caregivers in the nursing home), the scholars focus on three important questions. First, how does the societal ageism affect the interaction with the elderly (Bulter 1975, Greene et al. 1986, Radecki et al. 1988, Adelman et al. 1991)? Second, how do the elderly people talk and how are they talked to, especially among intergenerational conversations (Ashburn and Gordon 1981, Gold et al 1988, 1994)? Third, how do speakers (the elderly and their conversational partners) construct the old people's social identities (such as 'patient' or 'elderly'), as revealed in their choice of languages (e.g. Boden and Denise 1986, Giles et al. 1990, Coupland et al. 1991, and Hamilton 1996, Rosenfeld 1999)?

The first and second issues have a more direct bearing to my research and will be elaborated in the following.

Scholars who argue for more humane care for the elderly believe that ageism, a

destructive false belief about the elderly, is pervasive in society and in the medical care system. Ageist doctors and patients may mutually reinforce a negative attitude in health care. For example, anecdotal assumptions describe that doctors, seeing the patient's ailment as part of the natural process of ageing, tend to misattribute their problem or trivialize patient's concern, such as 'what do you expect at your age!' Patients, on the other hand, fear their ailment may become a family burden and thus deny their need for care. To examine these assumptions, Greene et al. (1986) conduct a study which compares the doctors' interaction with young patients (45 or younger) and old patients (65 or older). They find that physicians tend to raise fewer psychosocial issues with old patients and respond less well to these concerns when raised by older patients. The researchers believe that this behavioral bias, which may result in the difficulty for elderly patients to have their agendas or concerns addressed, can be seen as subtle evidence for ageism.

Conversational characteristics observed in interacting with the elderly people is another area related to aging and communication. Coupland et al. (1991) note the subconscious over-accommodation by younger generation interlocutors to the (falsely)

perceived needs of their older generation conversational partners. In their interviews with Canadian older adults, Gold et al. (1988, 1994) find the common phenomenon of off-target verbosity among the elderly. Off-target verbosity is characterized by the abundant verbose and the lack of coherence. The extreme case of off-target verbosity may result in a monologue which demands great attention and patience from the listeners and thus risks losing support from the listeners in the interaction level.

Other conversational characteristics of the elderly observed are the phenomena of disclosing chronological age and painful self-disclosure found in the study by Coupland et al (1991). Compared to young adults (aged 30-40), older adults (70-87) tend to reveal their age to their listeners, even in the initial encounter (e.g. 'I haven't been too well .. because .. of course I'm getting on now. I'll be eighty next year'). Also, they spend more time in disclosing their personally painful stories, such as family bereavement, health problems and accidents they had suffered. These phenomena almost never occur in the initial encounter between young adults.

Also, there are studies devoted to the interaction of elderly people and their health care providers. Caporael (1981), for example, notice that nurses tend to use baby talk to

institutionalized older residents. Baby talk refers to a simplified speech register which is characterized by its high pitch, exaggerated intonation, special lexical items and construction. Whether baby talk is favored by the elderly depends on their health status. Caporael and et al. (1983) find that while baby talk is deemed by the elderly with a poor health status as a reassurance of continued care and approval, it is perceived by the capable ones as derogatory. Hamilton (1996:70) further argues that in the former case, baby talk is used as a solidarity strategy to show nurturing, and the latter a power strategy to display condescending.

Though the majority of the above studies describe the communication patterns in western society and in the health care institution, they provide fundamental insights for my research in the Taiwanese geriatric context. For example, is ageism an accountable factor for the doctor-patient encounters in Taiwan? How will the feature of off-target verbosity affect the doctor-patient communication?

2.3 Triadic interaction and the third person in medical triads

The discussion of the intriguing and pervasive phenomenon of triads in human

interaction has received a great deal of attention by many sociologists (Simmel 1950, Borgatta 1961, Caplow 1968). As Caplow states in the preface to his discussion of the coalition in triads (1968), ‘social interaction is essentially triangular rather than linear… Social interaction, the basic social process whereby persons and groups modify each other’s behavior, is triangular—or triadic—because it is always influenced by an audience, present or nearby.’

The discussion of triads was begun by Simmel about 1890. In his work of 1950, he distinguishes three functions for the third party in a triad. He observes

> ‘From the conversation among three persons that lasts only an hour, to the permanent family of three, there is no triad in which a dissent between any two elements does not occur from time to time ... and in which the third member does not play a mediating role… This function makes the round among the three elements, since the ebb and flow of social life realizes the form of conflict in every possible combination of two members." (1950:148-149).

Simmel further distinguishes three possible functions of the third member: 1) as a mediator who stands between the two conflicting parties and prevents them from engaging in conflict, 2) as ‘tertius gaudens’ (enjoying third) who turns the dissention of

the two contending parties to his or her own advantage at the sacrifice of the other's interests, and 3) as an oppressor who stirs up the conflict between the other two parties for his or her own purpose.

Affected by Simmel's theory, Caplow shifts his focus on the pervasive phenomenon of coalition in triads: 'The most significant property of the triad is its tendency to divide into a coalition of two members against the third. The appearance of particular coalitions can be predicted with considerable accuracy if the relative power of the three members be known' (1968:2). He also establishes eight patterns of possible coalitions in triads in terms of power distribution.

Caplow's discussion of coalition carries a similar spirit of Goffman's discussion on participant alignment (1981). The idea of participant alignment, as paraphrased by Schiffrin (1993:233), refers to 'the way interactants position themselves relative to one another, e.g., their relationship of power and solidarity, their afffective stances, their footing participants (Goffman 1981); they are part of the broader notion of participation structure (or framework), i.e., the way that speaker and hearer are related to their utterances and to one another (Goffman 1981:3)'.

The study of the interactional roles that the three parties play in medical triads appears to be a neglected area. Some preliminary studies included the research by Adelman et al. (1987) and two of my own works (Tsai 1997 and 1998). Adelman et al. propose a conceptual framework of the roles of the elderly patient's companion. They categorize three major roles in terms of the degree of support that the third person shows for the patient: 1) patient advocate, 2) passive participant, and 3) patient antagonist. Though valuable for the framework it establishes, Adelman et al.'s research neglects two important considerations. First, in this framework, the roles of the third person are defined solely from the patients' perspective, ignoring how the doctor utilizes the third person. In addition, this hypothesis has not been empirically validated by or extended to other cultures.

In my study of a triadic medical encounter in Taiwan, I analyze the possible roles that the companion plays. By examining the discourse elements such as code-switching and speech acts observed in the companion's participation, I conclude that the companion plays a multi-functional role including the following: 1) doctor facilitator (e.g. the companion serves as an example of healthy status), 2) mediator between doctor

and patient (e.g. the companion restates or interprets the doctor's explanation to the patient), and 3) patient advocate (e.g. the companion argues for the appropriate action that will benefit the patient).

The above discussion of the interactional roles in triads reveals important issues of how the presence of the third party (i.e. the companion) creates an alignment or coalition of any of the two parties. For example, the companion may align with the patient by choosing the pronoun 'we' (e.g. 'We prefer to have the blood test done on Thursday'). The doctor may also form a coalition with the companion in order to persuade the patient to quit smoking. Given the dynamic nature of conversation, it is also important to see how alignment is constantly formed and changed to achieve various goals.

2.4 Participant structure in triads

The next issue related to the triadic interaction is how to identify the participant structure within the triads, i.e. what is the discourse status (e.g. the speaker or the hearer) that each of the three parties plays during any utterance in the flow of the conversation? In this section, I will review Goffman (1981), Aronsson and Rundstrom (1988), Baker

(1996), and Rosenfeld (1996).

Goffman's work provides a basic but subtle analysis on the participant status and can be applied to conversation that is composed of any number of participants (such as dyads, triads, tetrads, pentads etc). Two important notions are 1) the participant's status in the audience of a current utterance can be described in terms of two variables—whether he or she is ratified and addressed, and 2) the 'speaker' of a current utterance can be distinguished into the three categories—the one who animates the utterance (i.e. the animator), the one who authors the utterance (i.e. the author), and the one whose beliefs are expressed through the utterance (i.e. the principal) (Goffman 1981:133-157). For example, when the companion in the medical triad says, 'She (the patient) prefers to have the blood test done on Thursday,' the companion is the animator and the author of the utterance while the patient ('she') is the principal of the idea conveyed in that utterance. Also, by choosing the pronoun 'she' in referring to the patient, the companion marks the doctor as the addressee and leaves the patient as the ratified but un-addressed audience.

The other three works by Baker, Aronsson and Rundstrom, and Rosenfeld (1996)

have a more direct focus on the participant structure in (medical) triads. Baker's research examines 36 geriatric triads (doctor-elderly patient-companion), Aronsson and Rundstrom 32 pediatric triads (doctor-child patient-child's parent), Rosenfeld 6 marital therapy talks (therapist-husband-wife). One of the researchers' shared interests is to identify the (doctor's) addressee (e.g. doctor-patient or therapist-husband dyad, doctor-companion or therapist-wife dyad, and doctor-patient-companion or therapist-couple triad). Among the three works, Rosenfeld's framework provides the most complete and systematic tool for identifying the participant structures. The linguistic and non-linguistic elements that the researchers used in identifying the participant structures include vocatives, personal pronouns, sequential discourse structure and context, and eye contact.

Rosenfeld's finding that the triadic interaction is mainly composed of a series of dyads between constantly shifting combinations of any two of the three parties indirectly suggests that there is always one party left un-addressed in the triadic interaction. The research by Baker and Aronsson and Rundstrom show an unequal distribution of the doctor's questions posed to the patient and to the companion. (More of their findings will

be presented in Chapter 7.)

In my original research plan, I shared the same goal with the above researchers—by identifying the addressee of the doctor's utterances, I expected to see how the doctor distributes his or her attention in the medical triad, indirectly revealing how the presence of a third person affects the doctor-patient communication. However, in applying these three frameworks to my Taiwanese geriatric data, many methodological problems arose and thus most of the addressees of the doctor's questions could not be clearly identified. These problems motivate my current goal of establishing an alternative method for analyzing the companion's participation. This idea will be introduced in Chapter 7, and the frameworks established in the three researches will be examined in detail. The methodological problems and practical concerns of their applicability will be presented as well.

2.5 Effect of the companion on doctor-patient communication

In the above discussion, I have reviewed literature on triadic interaction from the aspect of discourse structure. The next important issue of concern is how the presence of

a third person affects the original dyadic interaction of doctor-patient communication? Several studies are devoted to the study of geriatric encounters (e.g. Rosow 1981, Adelman et al. 1987, LaBrecque et al. 1991, Greene et al. 1994, Marvel et al. 1994, Baker 1996) and pediatric encounters (e.g. Campbell 1978, Pantell et al. 1982, Tannen and Wallat 1982, Friend and Rostain 1985, Maynard 1991, Debruyne 1996) which involve a companion. In the following, I will choose three of them for a detailed review: Tannen and Wallat (1982), Baker (1996) and Debruyne (1996).

Tannen and Wallat (1982) focus on the multiple tasks imposed on the doctor with the presence of more than one audience in the doctor-patient communication. They examine a four-way pediatric interaction among a pediatrician, the patient child, the mother of the child, and a camera to which the pediatrician reports her diagnosis procedure. They found that the pediatrician constantly shifts among three different frames in the discourse by the use of three distinguished linguistic registers: 1) ‘motherese’ in talking to the child, 2) ‘reporting speech’ in talking to the camera, and 3) ‘everyday conversation’ in addressing the child’s mother. The implication of this finding, as Tannen and Wallat have suggested, is that in dealing with more than one audience, the

physician's task in a medical encounter involves a complicated cognitive process and socio-psychological demands. For example, the physician must monitor the accuracy of her diagnostic report to the camera while talking to the mother in the casual way so as not to frighten her that the diagnosis implies a serious health threat.

Baker (1996) and DeBruyne (1996), on the other hand, focus on the potential effects of the companion on patient autonomy. Their main findings include the following: 1) the presence of a companion decreases the amount of participation by the patient, and 2) the triadic encounter tends to form a hierarchy in which patients are subordinate not only to the physician but also to the companion.

Baker's study (1996) compares the information-exchange patterns of 36 triadic geriatric encounters (i.e. the elderly patient is with a companion) with 18 dyadic encounters (i.e. the elderly patient is not accompanied) which were observed at an urban university's medical center in southern America. Her quantitative evidence has shown that the physicians spent a roughly equal amount of time in both the triadic and dyadic geriatric encounters. Also, the unaccompanied patient contributes an amount of participation equal to that of the combined participation from the accompanied patient

and the companion. These findings suggest that the presence of a companion serves to replace portions of patients' participation in the encounter (60). This finding is sustained in other triadic medical encounters. DeBruyne, in her investigation of 30 triadic pediatric encounters (1996), found that, when accompanied by their mothers, children are significantly less likely to think that they are given the chance to talk to the doctor about their own medical problems. In fact, some children (33%) attribute their lack of participation to the fact that their mothers already dealt with the doctors for them.

The second tendency observed in Baker's geriatric data is the hierarchical structure in which patients become subordinate not only to the physicians but also to the companions. For example, in examining the geriatric assessment topics evoked during both triadic and dyadic encounters, Baker noted that certain topics, such as patient's cognition problem and incontinence, are more likely to be discussed in the presence of a companion. Since these problems indicate the patient's dependence on a caregiver, they discredit the patient's ability to function independently. Thus Baker argues that the mere presence of a companion reconstructs the patient as a dependent of the companion.

DeBruyne's pediatric data again supports this tendency. DeBruyne noted that the

physician contributes the greatest number of utterances (i.e., speaking 60.7% of the time), the mother the second (25.9% of the time), and the child-patient the least (13.4% of the time) (p.122). The child's subordinate status is even more obvious in the decision-making process. Pantell et al. (1982), for example, find that during pediatric encounters, physicians tend to recruit the children actively in information gathering and exclude the children when presenting the diagnostic findings or the proposal for future treatment (cited in DeBruyne, p.2).

Both Baker's and DeBruyne's studies suggest how patient autonomy might suffer in the companion's presence, thereby raising two immediate concerns. Does the companion's involvement necessarily sacrifice patient autonomy? Does the companion's involvement enhance or hinder the doctor-patient relationship? These concerns call for an in-depth study with focus on the dynamic interaction among the three participants and their subjective evaluation of that interaction.

2.6 Patients and caregivers in Taiwanese family relationship

In this section, I will focus on the patient-caregiver relationship in modern

Taiwanese society. Two main ideas discussed in the literature include 1) family care as the preferred system for the Taiwanese elderly (Kleinman 1980, Cho 1991), and 2) the son, the daughter-in-law, and the daughter as the caregiver of the elderly Taiwanese (Hu 1995).

Following the prescribed norm of Chinese culture, sons, instead of daughters, are the family members with the traditional right to inherit their parents' property as well as the obligation to take care of their older parents. The family structure is extended with the son's marrying 'in' a daughter-in-law while the daughter departs from the family by marrying 'out' to a another family. (See the concepts of *nan-qu* 'son-marry-in' vs. *nu-jia* 'daughter-marry-out' in Hu 1995:66). Thus, most old parents live with their son, daughter-in-law, and grandchildren in a so-called *san-dai-tong-tang* 'three-generation-residence'. An investigation by the Ministry of the Interior, Republic of China shows that 64.3% of the elderly people live with their adult children, 20.6% live with their spouse, 12.29% live alone, and only 0.09% live in an institution (1997:17). In other words, the culturally prescribed care system for the elderly Taiwanese is family care instead of institutional care, especially care that is provided by the sons. This preferred

care from the sons contrasts with Western society, where older parents prefer daughters as their caregivers (Qureshi and Walker 1989, Abel 1991, cited in Hu 1995:114). Because of the patriarchal structure of the Taiwanese family, however, it is the daughter-in-law who physically takes care of the parents. The role of the son as a caregiver, therefore, remains symbolic and is motivated out of family obligations.

In Hu's in-depth analysis of the issues of *san-dai-tong-tang*, she looks at the consequences of the change in caregivers for the elderly in modern Taiwanese society. Today, the role of caregivers has changed from the daughter-in-law to the daughter. As Tsui's study (1987) has shown, working women who have benefited from the education they received and the freedom of working outside the family are more economically independent than before. Consequently, they are able to support their parents economically and are willing to take care of their parents even after they are married (Tsui 1987, cited in Hu 1995:106). Compared with sons, the daughters' willingness to take care of their parents is motivated out of the intimate and affectionate bond between children and parents rather than out of family obligation (Tsui 1987, cited in Hu 1995:106). Thus, elderly Taiwanese now prefer their daughters to be their caregivers, a

tendency similar to that observed in western society.

The idea of the adult children as the primary caregivers of the Taiwanese elderly and the daughter's contribution in providing care for their old parents are confirmed by a recent research project in which I participated (Tsao and Lu 1999). A total of 221 cases of elderly patients who made their initial visit to the family doctors at NCKU in southern Taiwan are collected. The goal is to examine the social characteristics of the elderly patients who were with or without a companion and the relationship between the patient and the companion. The study found that 73.1% of the 221 elderly patients are accompanied by one (or more) companion. The patient's education level and spousal status are two significant factors related to the frequency of being accompanied by companion. Patients who possess a low education level or whose spouses were no longer alive are more likely to accompanied. These two factors account for why the female patients score a higher rate of being accompanied (82.8%) compared to male patients (62.6%). They receive less education and live longer than their husbands. The researchers further noted that the four major companions are the son (24.2%), the daughter (21.5%), the daughter-in-law (18.1%) and the patient's spouse (16.1%). As we

can see, the role of the elderly patient's companion is mainly taken by the patient's children-generation. Among the children, the daughter scores a higher instance than the daughter-in-law; in contrast, the son-in-law scores a very low frequency of participating in the care task for the elderly (1.3%).

In Baker's study (1996:32), 10 of the 36 (i.e. 38.5%) patients were accompanied by their wives, 10 by daughters, 2 by son (i.e. 5.6%) and 2 by stepdaughters or daughters-in-law. The participation of the children-generation in accompanying their elderly parents takes up a total percentage of 38.9%, a figure which is lower than the total percentage of 65.1% observed in Tsao and Lu's study in the Taiwanese context. Comparable data will be needed in order to make a valid comparison of the children-generation as the elderly patient's companion between the eastern and western contexts; however, Tsao and Lu's study clearly demonstrates that the children-generation participate as the elderly patient's primary caregiver in the Taiwanese context.

2.7 Studies on doctor-patient communication in other cultures

While the study of doctor-patient communication has received a great deal of

attention in western society such as the United States or the United Kingdom, it is still a neglected area in other societies. In the last section of my literature review, I will briefly introduce some research studies conducted in other non-western societies.

Kleinman (1975) and (1980) are two collections which explore the health care system and medical behaviors in a Chinese context (e.g. in Taiwan and in China). Given his anthropological background, Kleinman presents many of his field site observations on the Taiwanese patients' interaction with their Western-style doctors and Chinese-style doctors. Renaud (1998) conducts an ethnographic and quantitative approach to the verbal communication between doctors and patients in Trinidad. One of the Renaud's main findings is that patient's prior acquaintance with the doctor is the most predictive variable of patient satisfaction and compliance. Mitchell's research (1980) describes how social classes play a role in doctor-patient communication in Jamaica. The researcher observes that lower-class patients are more likely to be suspicious of doctors' motives and distrustful of their diagnosis because of the distant social class between them. As a result, lower-class patients tend to resist follow-up visits. Instead, they self-mediate by seeking advice from pharmacists. Patients from the middle and upper

classes, on the other hand, are more likely to build a good and trustful relationship with their doctors, and thus self-medication rarely occurs among them.

Generally speaking, compared to the western society, the research on doctor-patient communication receives less attention in a non-western society. Among the scarce literature, the majority of the studies are mainly quantitative surveys or studies which examine the correlation between interaction patterns and patient satisfaction, such as Bender and Koshy (1991), Asai et al. (1998), Kai et. al (1993), Chan and Goh (2000).

Although the ways in which non-western social and cultural contexts may affect the doctor-patient communication in the native contexts remains primarily unexplored, there is literature that examines the issue of cross-cultural doctor-patient communication in Western society, such as the United States. Most health care professionals are aware that communication is especially problematic between culturally and linguistically different doctors and patients. For example, Glenn (1990) conducts an ethnographic study which examines the conversation between American Indian women and a white male doctor. Prince (1986) focuses on the communication problems between Spanish-speaking patients and their English-speaking doctors. Although the assistance of an interpreter

will facilitate the process of information exchange, Prince's findings show that the use of patients' friends or relatives as interpreters increases communication errors.

With a similar interest, Ranney (1992) compares the American doctors' interaction with Hmong refugee patients who are fluent in English. Her statistic findings show that Hmong patients are interested in obtaining information and less interested in their diagnosis, a phenomenon which the researcher claims is possibly based on standard practices in Southeast Asia. Rehbein (1994) demonstrates the communication breakdown between doctors and their culturally different patients (a Turkish patient and a Spanish patient). By interviewing thirteen Korean patients, Sung (1998) explores Korean patients' interaction with and perception of their American doctors, including the patient's attitude toward Chinese treatment and their belief regarding the body adjustment system. Small et al. (1999) describe the role of culture and communication in Vietnamese, Turkish, and Filipino women's experiences of giving birth in Australia.

Chapter 3. Methodology for Data Collection and Analysis

3.0 Introduction

In this chapter, I will introduce the following: the approach of interactional sociolinguistics (§3.1); my research work at the field site (§3.2), the procedures of how I gathered the videotaped medical interaction (§3.3), my informants (§3.4), the language backgrounds of the informants (§3.5), the task of data transcription (§3.6), the tool for statistics analysis (§3.7), and the playback interview with the doctors (§3.8).

3.1 The approach of interactional sociolinguistics

As introduced earlier, I will set up a framework in measuring the companion's participation. The use of quantitative approach will inevitably obscure the conversational dynamics involved. Thus, in interpreting the quantitative findings, I will integrate with the approach of interactional sociolinguistics. The main spirit of this research is driven by the approach of interactional sociolinguistics. By examining the detailed transcription of audio/videotaped conversation, scholars of interactional

sociolinguistics first identify some interactional patterns. In the interpretation of these linguistic patterns, they take cultural, social, and participant-level contexts into consideration. Compared to other approaches of discourse analysis (such as conversation analysis), the approach of interactional sociolinguistics is the most holistic one because it integrates the disciplines of anthropology and sociology into the interpretation of the interactive meaning conveyed in the linguistic behavior. For example, Gumperz's work (1982) emphasizes the tie between language use and the cultural and social contexts where the language is used. Goffman (1967), on the other hand, focuses on the use of language as a reflection of the 'self' to the social world. Schiffrin's comments (1994:105) on the above two works highlight the interactive nature between language, the self and the other, and cultural contexts:

> 'The work of both scholars also provides a view of language as indexical to a social world: for Gumperz, language is an index to the background cultural understandings that provide hidden – but nevertheless critical—knowledge about how to make inferences about what is meant through an utterance; for Goffman, language is one of a number of symbolic resource that provide an index to the social identities and relationships being continually constructed during interaction.'

Another central concern of interactional sociolinguistics is the interactive nature on the participant level (Tannen 1992:11). Many researchers have argued that conversation is a joint achievement by all participants. For example, Goodwin (1986) shows that the interpretation of a story told during conversation does not emerge from the speaker alone but from the collaborative process of interaction in which the audience plays an active role. Tannen's discussion on interruption and overlapping in conversation (1989:270) also argues that if an overlap is to be interpreted as interruption, both the participants (i.e. the one who interrupts and the other one who is being interrupted) contribute to the process of interruption. Thus, the claim that the interruption is the doing of one party can not be justified in this sense.

In this research project, I will first examine the quantitative aspects of the companion's participation in the triadic medical interaction. In the interpretation of the quantitative results, I will follow the disciplines of interactional sociolinguistics. I will integrate my own knowledge of the Taiwanese cultural and social contexts, the insider's perspectives from the medical professional community as observed in my fieldwork (§3.2), and the three participants' perspectives of the companion's role (see 'playback

interview with doctors' to be introduced in §3.8 and 'initiator of the companion's participation' to be introduced in Chapter 7).

3.2 My participation and observation at the field site

In the gathering the data, I adopted the two field methods of participation and observation commonly applied in an anthropological study. Long-term participation and observation in the field site hospital allowed me to build up rapport with the staff members (such as the doctors and the nurses) and to gain insider's knowledge regarding the communication norms of this speech community. This knowledge serves as an important resource in my interpretation of the linguistic behavior observed on the part of the doctor.

The field site of my research is the outpatient clinics of the family medicine department of the Medical College of National Cheng Kung University (NCKU) in southern Taiwan. With the introduction by the senior visiting staff Dr. Feng-hwa Lu, I was known to the staff members at NCKU as a Ph.D. student of linguistics who was working as a research assistant for a research project entitled 'Doctor-elderly Patient

Communication in Taiwan'.[1]

During my fifteen-month stay at NCKU, I was offered a desk in the residents' office, which provided me the chance to interact daily with the residents and attend two routine training seminars a week. The two most important activities that enhanced my knowledge of doctor-patient communication were the bi-weekly video teaching sections and meetings with Dr. Lu. The bi-weekly or monthly courses of 'video teaching' are offered by the senior visiting staff of the family medicine department to the junior residents and interns. The function of the bi-weekly meeting with Dr. Lu. is to exchange ideas, both on the administrative and academic levels, about the progress of the NSC project and my dissertation.

Some of the examination rooms are equipped with video cameras on the ceiling. Each resident and intern[2] videotapes his or her encounter with a first-time patient, once or twice in a year. The videotape encounter displays all the possible interactional contexts (such as a dominant mother of a teenager patient) that can account for the

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[1] This research project is sponsored by the National Science Council (NSC), Taiwan, , conducted by Prof. Feng-fu Tsao, and Dr. Feng-hwa Lu, (NSC882411H007021).

[2] Every month, there will be 2-3 interns working at the family medicine department for training.

participant's discourse behavior (such as the intern whose agenda is out of control). Based on these problems from the real interaction, the senior visiting staff provides further suggestions to improve the interviewing skills of the participating resident/intern. The bi-weekly meeting with Dr. Lu is to discuss the design and the progress of the research project. These meetings offer me not only the insider's knowledge on doctor-patient communication but also the exchange of research methodology from two academic fields—the science-oriented medical field vs. the social science-oriented approach of interactional sociolinguistics. The former is more inclined to have a pre-set design of what to collect for analysis, while in the latter the design of the research is more driven by what has been collected.

In the initial stage of data-collection, I had the general idea that medical encounters which I will focus on involved an first-time elderly patient in a dyadic (without companion) or triadic (with companion) interaction. Then, it appeared to me that the triads occur more frequently than the dyads. Among the triads, the combination of the elderly patient with an adult child, in contrast to elderly patient with his or her spouse,

compose the majority. Thus I decided to narrow down my focus to the triadic encounter among the doctor of visiting staff, the elderly patient, and the adult child.

3.3 Consent form, videotaped data, and monitoring effect

Once I located the first-time elderly patients, aged 65 or above, who registered for the family medicine department, I approached them wearing a hospital uniform while they were waiting outside the examination room. I told them that I am a research assistant and that it is my job to help them to fill out the required information sheet 'Basic Information of First-time Patients of Family Medicine Department at NCKU'.[3] After they completed the form, I told them about the research project and I emphasized its goal of teaching and research purposes. I also showed them the Chinese version of the consent form and asked if they would allow me to videotape and audiotape the

[3] The two pages of the information sheet are questions regarding the patient's past history, diet habits, and daily routines or activities. The two sheets are usually presented to the patients by the assisting nurse of each examination room and patients are asked to complete the information sheet by themselves before they see the doctor.

interaction.[4] With these procedures, I collected a total of fifteen triadic encounters, which involved five visiting staff members and fifteen patients and companions who consented to participate in this project from September 1998 to May 1999.[5]

The videotaping is done by a color camera set up in the ceiling corner of the examination room.[6] The camera is also equipped with a remote control and monitor in another room where I observed and videotaped the interaction. After the patients agreed to participate in the research, usually they waited another 15-40 minutes for their turn and none of them were aware of the location of the camera. This fact decreased the effect of being monitored on the part of the patient to some degree. The visiting staff consented to being videotaped without their knowledge. Thus, they were aware that they were being monitored occasionally.

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[4] Similar to the practice in the States, to conduct any research at NCKU in which involves human participants, an official consent form is required. However, to gain the official consent from the patient is a big challenge for the purpose of this research, for two reasons. The majority of the elderly patients of this generation are either illiterate or not very well educated. For example, 35.66% of the elderly population is illiterate, and among them, the female takes up 74.49%, and the male, 25.51% (Ministry of the Interior 1997: 8). Also, for some of them, to sign their agreement with a signature or with their thumb print gives the impression that the matter in concern is a serious one.

[5] There are actually more than fifteen encounters collected during the eight months. The fifteen are the encounters in which the patient is accompanied by an adult child and the sound quality of all the three participants are good enough for transcription and analysis.

[6] The cameras are sponsored by the National Science Council.

3.4 The informants

In each of the fifteen encounters, there are actually other participants present—the assisting nurse and the interns. Each examination room has an assisting nurse. My observations showed that each doctor has about 3-5 first-time-visit and 20-35 return-visit patients to take care of in a section (in the morning or in the afternoon). The job of the assisting nurse is to deal with administrative business, such as calling in the patient, preparing the medical record of each patient, assisting the physical examination on bed, checking the patient's body weight and height, and explaining the trivial details of treatment plans to the patient (e.g. the location of the X-ray room). Other than these, they seldom verbally participated in the encounter,[7] although they might sometimes be involved in some social chatter (such as 'Oh, you are eighty years old! Look at the shining hair you have!). My task of data-collection was greatly assisted by the nurses. They informed me once they knew that an elderly patient had registered for the first-time visit. When the patient had agreed to participate in the research, I informed the nurse and

asked her to turn on a tape-recorder under the table.[8] This resulted in even less verbal participation on the part of the nurse.

Four of the encounters involve two or three interns. The interns, though present in the room, hardly ever spoke in the encounter. They are there to observe the interaction. None of the interns spoke during the four encounters, though they were not informed about this research. Most of the time, the doctors do not talk to them except when conducting the physical examination and explaining to the interns what he or she is doing. These utterances of the doctor are not counted or analyzed in this current research. Figures 3-1 and 3-2 give a pictorial illustration of the spatial arrangement of the things and participants in the examination room.[9]

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[7] Among the eight assisting nurses, the leading nurse is inclined to interact with patients, which might be because she has worked in the position for years and has a good rapport with most visiting staff. When she verbally participates in the doctor-patient communication, it is mainly to encourage the patients to follow the doctor's recommendation.

[8] The use of a tape recorder under the table, in contrast to the video-camera on the ceiling, is to get a better sound quality for transcription.

[9] I am greatly indebted to Ling-ying Kuo and Chong-kiat Hong for their artistic works of all the pictorial illustrations presented in this dissertation.

Figure 3-1. An over view of the examining room-1.

(Left to right: doctor, nurse, patient, companion)

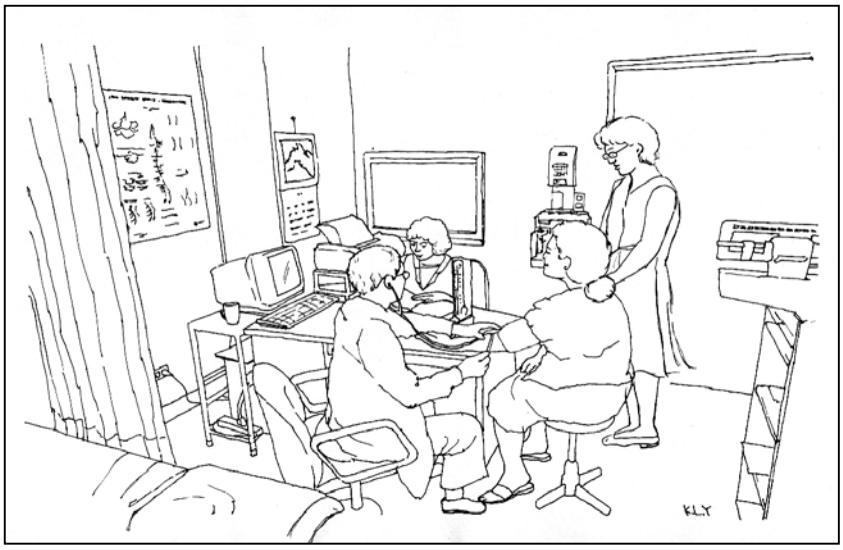

Figure 3-2. An over view of the examining room-2.

(Left to right: doctor, 2 interns, companion, patient)

The fifteen encounters involve five doctors and fifteen pairs of patients and adult children. Table 3-1 presents the demographic and clinical information of each encounter. All the names of each informant are pseudonyms, and the romanization of their name is based on their mother tongue language (to be described in §3.5). The information in the column ‘education’ refers to the patient’s education level and is gained from the ‘Basic Information of First-time Patients of Family Medicine Department at NCKU’. ‘Marital status’ encodes three statuses of the patient’s marital status—single, widow/widower, or divorced. This information is gained from the pedigree section in the encounter. ‘Living with C’ indicates whether the patient currently lives with the companion or not. As shown in Tsao and Lu’s research (1999, see §2.6), the patient’s education level and marital status are two factors related to the probability of the patient’s being accompanied. Also, as we will see in Chapter 5, the amount of information provided by the companion regarding the patient’s health problem might be related to his or her access to that information. Presumably, those companions living with the patients have greater access to information. The information regarding the patient’s education level, marital status, and living arrangement will not be further analyzed in this research but

will be invoked to account for some interactional patterns. The column ‘length’ indicates the duration of the encounter. It begins with the moment when the nurse calls the patient’s name and ends with the point when the patient and the companion step out of the room. The last column, ‘patient’s chief complaint // doctor’s initial impression’, are my summaries gained from the patient’s medical records at the time of the first visit.

3.5 The informants’ use of language and their names

There are two main languages used in South Taiwan—Mandarin, the official language, and Southern Min, the local language. The majority of the elderly people are monolingual in either Southern Min or Mandarin. The Mandarin that most elderly people speak carries the accent of the speaker’s birth place in Mainland China which is different from that of the Taiwan Mandarin used by the younger generation in Taiwan. In my observations, the majority of the younger generation (aged 45 or below) in southern Taiwan are bilinguals in Mandarin and Southern Min. Since Southern Min is the mother tongue of the majority of the informants in this research and Mandarin is the minority, whenever Mandarin conversation is quoted, it will be marked by underlining.

Table 3-1. Demographic and clinical information of the fifteen encounters.

	Patient (age/sex)	Companion	Doctor (age/sex)	Education	Marital status	Living with C	P's language	C's language	D's language
1	Mrs. Zhu (74F)	daughter	Dr. Tiunn (38M)	literate, no formal edu.	widow	yes	Mandarin	Mandarin	Mandarin
2	Mrs. Yiu (65F)	daughter-in-law		illiterate	widow	yes	Southern Min	SM and MD	Southern Min
3	Mr. Ong (72M)	daughter		elementary	married	no	Southern Min	Southern Min	Southern Min
4	Mrs. Pan (68F)	daughter		college	widow	no	SM and MD	Mandarin	SM and MD
5	Mrs. Iunn (71F)	daughter-in-law	Dr. Lau (34M)	illiterate	married	yes	Southern Min	SM and MD	Southern Min
6	Mrs. Gonn (87F)	daughter		illiterate	widow	no	Southern Min	SM and MD	SM and MD
7	Mrs. Lim (73F)	son		illiterate	married	yes	Southern Min	SM and MD	SM and MD
8	Mrs. Su (83F)	son		illiterate	widow	yes	Southern Min	Southern Min	Southern Min
9	Mr. Sim (65M)	son-in-law	Dr. Kang (34F)	elementary	widower	no	Southern Min	Southern Min	Southern Min
10	Mrs. Tenn (66F)	daughter-in-law		junior high	married	no	Southern Min	SM and MD	SM and MD
11	Mrs. Khu (81F)	daughter-in-law		senior high	widow	yes	Southern Min	Southern Min	Southern Min
12	Mr. Tian (72M)	daughter	Dr. Song (34F)	elementary	married	yes	Mandarin	Mandarin	Mandarin
13	Mr. Wang (74M)	son		college	divorced	yes	Mandarin	Mandarin	Mandarin
14	Mr. Tan (76M)	daughter	Dr. Niung (37M)	junior high	married	yes	Southern Min	SM and MD	SM and MD
15	Mr. Khoh (74M)	son		illiterate	married	no	Southern Min	Southern Min	Southern Min

Table 3-1. Demographic and clinical information of the fifteen encounters (Continued).

	Patient	Length	Patient's chief complaint // Doctor's initial impression
1	Mrs. Zhu	13'25"	cough and fever // upper respiratory infection (i.e. common cold)
2	Mrs. Yiu	15'49"	chest pain; loose stool; insomnia // insomnia; right chest pain; suspected irritable bowel syndrome
3	Mr. Ong	12'03"	joint pain (ankle) // hypertension; gout
4	Mrs. Pan	20'57"	short of breath; chest tightness // wheezing sound in the left lung; type A personality
5	Mrs. Iunn	22'50"	dizziness; can't smell any odor // hypertension; dizziness with unknown cause; history of nasal bone fracture
6	Mrs. Gonn	19'34"	dizziness and vomit // isolated systolic hypertension
7	Mrs. Lim	19'47"	left foot hip pain; dry mouth; low-back pain // osteoporosis
8	Mrs. Su	23'03"	poor appetite; postural tremor; easily short of breath // old left Colles' fracture (i.e. left wrist fracture); Parkinsonism
9	Mr. Sim	15'10"	palpitation; chest tightness; hand tremor // anxiety; body weight loss
10	Mrs. Tenn	15'29"	difficulty in falling asleep; poly dreams // insomnia; history of abnormal liver and renal function, and hyperlipidemia
11	Mrs. Khu	16'45"	dizziness, elevated blood pressure; cough; nausea // hypertension; chronic cough; dizziness
12	Mr. Tian	12'07"	general soreness // constipation; history of renal cell carcinoma (i.e. kidney cancer) resulting in left nephrectomy (i.e. kidney removal) and gastric cancer resulting in operation; doctor must rule out bone metastasis
13	Mr. Wang	19'07"	(not available) // insomnia; left supratentorial infarction (i.e. cerebral stroke); patient reports hyperlipidemia
14	Mr. Tan	12'25"	right 2nd toe painful swelling; right foot ankle pain // hypertension; gout
15	Mr. Khoh	12'12"	tongue mass // tongue tumor; upper respiratory infection (i.e. common cold); old tuberculosis, chronic hepatitis, chronic obstructive pulmonary disease

* The underlined family names indicate that the romanization of those names follow their Mandarin pronunciation, and those with underline follows their Southern Min pronunciation (see §3.5)

All the five doctors are bilinguals in Mandarin and Southern Min and their names are presented by their Southern Min pronunciation. The column ‘D’s language’ indicates the languages ever used by the doctor when he or she talks to the patient or the companion during the encounter. For example, Dr. Tiunn uses only Mandarin in Mrs. Zhu’s encounter, SM in Mr. Ong’s and Mrs. Yiu’s, and both Mandarin and Southern Min in Mrs. Pang’s.

Three of the patients (i.e. Mrs. Zhu, Mr. Tian, and Mr. Wang) are judged as monolingual in Mandarin, based on the fact that they do not use Southern Min at all and their Mandarin carries an accent different from that of Taiwan Mandarin. Their family names, which are underlined, are represented in their Mandarin pronunciation. It is not clear to me if Southern Min is one of the mother tongues of their adult child, since the four adult children use only Mandarin during the encounter, as indicated in column ‘C’s language’.

Eleven of the patients are judged as monolingual in Southern Min, based on the fact that they never or hardly ever use Mandarin during the encounter. Their family names, which are not underlined, are represented by their Southern Min pronunciation.

Occasionally, the patients may use some short phrases in Mandarin, at most three to five instances in one encounter, (such as '*xie-xie*' 'thank you', '*Zhang Yi-shi*' 'Dr. Zhang', '*chao-yin-po*' 'sonograph'). They are not considered bilinguals. The only bilingual patient is Mrs. Pang, a retired school teacher, who uses a relatively equal amount of (Taiwan) Mandarin and Southern Min and constantly code-switches between these two languages.

It should be noted that my judgement of the patient's and the companion's language ability may not reflect the real picture of their language ability. It is possible that the patient may understand Mandarin or speak Mandarin, but prefer to use Southern Min during the medical encounter.

3.6 Data transcription

The fifteen encounters are transcribed in detail with Chinese characters.[10] The

[10] The transcription task for Southern Min conversation is a rather arduous one since the writing system is not well established yet and thus is a sticky try for most native speakers. In that regard, I would like to thank two working students at NCKU Jia-yun Tsai and Xiao-pei Chen who stayed with me to accomplish the transcription task.

transcription notation follows Tannen 1984 with slight modifications.[11] The Southern Min data are presented in this dissertation by using the system established by Taiwan Language Society, and the Mandarin data presented in the Pinyin system. When both Southern Min and Mandarin occur in the same interaction, the Mandarin part is marked by underlining.[12] The original data are transcribed in column style, as shown in the following excerpt.

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[11] .. noticeable pause or break in rhythm (less than 0.5 second)
… half second pause
: indicates lengthened vowel sound
, marks phrase-final intonation (more to come)
/?/ indicates transcription impossible
/words/ within slashes indicate uncertain transcription
{}are used to describe events or activities going on with the utterance.
= which following the fist utterances and preceding the second utterances indicates that the second utterance latched onto the first, without perceptible pause.
[indicates overlapping speech.

[12] In presenting the Southern and Mandarin data, abbreviations for some syntactic categories are used in the line for word-to-word gloss. They are:
ASP: aspect marker
CL: classifier
EMP: emphatic marker
INT: interjection
NEG: negation marker
NOM: nominalizer
PASS: passive marker
POS: possessive marker
PRT: (sentential) particle
Q: question marker

Sample excerpt {05’03”}[13] (Mr. Ong 72M; main language: Southern Min)

Dr. Tiunn	Mr. Ong (72M)	Daughter	IP pattern	P- info	C-info
1)等於汝共細漢媳婦啊擱大漢欸攏住做夥叨對啦?= 1) *So-yi li kang se-han sim-po, a koh uah-han-e long tuah tso-hue to tio la=* so/you/with/youngest/daughter-in-law/PRT/also/the oldest/EMP/live/together/EMP/right/PRT			I DCP		
	2) =/??/攏. 攏住做夥 2) *=/??/ long.. long tuah tso-hue* EMP/EMP/live/together	2) =因攏住做夥 2) *=In long tuah tso-hue* they/EMP/live/together		P-PG	C-PG
3) …血壓共汝量一咧 3) *…Hue-ap ka li niung tsit le* blood pressure/for/you/check					

[13] {05’03”} indicates the time point when this excerpt occurs in the encounter (i.e. at the fifth minute and the third second of the encounter).

{The doctor is about to check the patient's blood pressure}		4) hio,伊有高血壓欸彼種hior:: 4) *Hio, i u ko-hue-ap-ei hit tsong hior::* right/he/has/high-blood-pressure/	II 0C		C-BM

Translation

Dr. Tiunn	Mr. Ong (72M)	Daughter	IP pattern	P- info	C-info
1) In other words, you live with (your) youngest (son and his) wife and (your) eldest (son), is that right?=			I DCP		
	2) =/??/(we) all..all..live together	2) =They all live together		P-PG	C-PG
3) Let (me) check your blood pressure					
{The doctor is about to check the patient's blood pressure}		4) Yeah, he also has hypertension, the::	II 0C		C-BM

The presentation of the excerpts in this dissertation adopts the script style (as shown in following chapters) since it may be hard for readers to follow the romanization of the

Chinese conversation with the word-to-word gloss when presented in the column style. However, there are at least three advantages of transcribing the data with the column style for the purpose of this research. First, it is easier for readers to identify each speaker's utterance and to visualize the extent of their contribution to the conversation. (See Ochs 1979 for more discussions on the use of column style.) Secondly, the columns separate the utterances part from the coding part (i.e. the three columns to the right), and the number of columns can be extended as far as needed for further analysis. For example, the coding part indicates that there are two 'information-providing cycles' (i.e. DCP and 0C, see Chapter 6) observed in the excerpt. The first cycle begins with the doctor's question (line 1) which receives reply both from the patient and the companion, thus a pattern of 'DCP'. In the second cycle, no question from the doctor is observed and yet the daughter volunteers information, thus a pattern of '0C'. 'P-PG' and 'C-PG' indicate both the patient and the companion provide 'PediGree information' (see Chapter 4), while 'C-BM' (line 4) indicates that the companion volunteers 'BioMedical information' regarding the patient's health problem. Thirdly, the column style makes further mathematic and statistic processes of the coding an easier job, for example by

using the sorting or counting tools of Microsoft Word 97.

Besides the transcription, the fifteen videotaped interactions have been converted to VCD format so that they can be easily replayed by the software of any media player.[14] The VCD facilitates the analysis task and makes the very best use of the videotaped data, such as the analysis of the eye contact.[15]

3.7 Statistical methods

To facilitate my analysis, two kinds of statistics software (Microsoft Excel 97 and SPSS 8.0 for Windows) are used in this study.[16] All the raw numbers of the coding results, such as the number of instances where the companion replies to questions posed by the doctor, are transformed to percentage numbers with Excel. Two statistic methods ‘paired samples T test’ and ‘bivariate correlations’ from the software SPSS are applied

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[14] The conversion of the VHS data to VCD was greatly facilitated by the welcome assistance of Dr. Chung-ho Chien of NCKU hospital and the graduate student Chian-xin Chiang (of the Graduate School of Electrical Engineering at NCKU).

[15] Because of some technical problems, the synchronization of the audio and video movement of two VCDs (Mrs. Pan and Mrs. Yiu) has a perceptible difference, but it does not have a significant effect on the analysis process.

[16] Excel 97 and SPSS 8.0 round numbers differently. This accounts for any discrepancy in the statistics. For example, the result of subtracting 18.6 from 46.2 is 27.6 with Excel, but using SPSS it is 27.7.

whenever needed.[17] 'Paired sample T test' is applied to test whether the differences between paired data are statistically significant. For example, are the differences between the patient's vs. the companion's number of instances in answering the doctor's questions significant? 'Bivariate correlations' is applied to examine the degree and the direction of the correlation between two variables. For example, does the companion's amount of participation display a significant and positive correlation with the companion's instances of answering the doctor's questions?

3.8 Playback interview with doctors

Finally, after the analysis and statistics are finished, I observed certain interactional patterns. Besides my interpretation of these patterns, I also conducted playback interviews with the five doctors. The use of a playback interview is part of the methodology in interactional sociolinguistics (Gumperz 1982, Tannen 1984, Frankel and Beckman 1989). The interview's goal is to gain the insider's (i.e. the doctor's) subjective

[17] Statistics is not within my expertise. The statistics analysis of my data, especially the choice of methods, was aided enormously by the kind assistance of Dr. Feng-hwa Lu and two graduate students, Chen Wan-zhen (of the Graduate School of the Study of Statistics at NCKU) and Chen Hsiang-hua (of the Graduate School of the Study of Behavior Science at NCKU).

and thoughtful reaction to the speech event (i.e. medical encounter) they have participated in and to facilitate my interpretation of the discourse patterned observed in the videotaped data. The procedure of the interview begins with five general questions which elicit the doctor's perspective of the companion's role. Then, clips from the videotaped medical interviews are viewed, followed by specific question and discussion related to the clips. For the time being, this research conducts the playback interview only on the part of the doctor, not on the patient or the companion.

The following is the list of the five general questions that I posed to the doctor in the playback interview.

Question 1: What are the roles that you expect the companion (i.e. the adult children of the elderly patient) to play?

Question 2: In my analysis, the companion's verbal participation can be either initiated by the doctor (such as the doctor directs a question to the companion) or self-initiated by the companion. In what situations will you invite the companion to participate?

Question 3: The interview of the initial visit can be roughly divided into four sections, namely 1) chief complaint and history taking, 2) pedigree section, 3) physical examination, and 4) diagnosis and management plan. What are the sections that you are more inclined to recruit the companion to participate?

Question 4: In my observation, some of the doctor-companion talks are conducted in Mandarin. In what situations do you use Mandarin while talking to the companion?

Question 5: When a patient of initial visit is with a companion, when do you clarify the companion's identity?

The doctor's comments and responses serve as supports to my interpretation of the discourse patterns that I have observed from the fifteen encounters and will be presented in Chapter 11.

Chapter 4. The Amount of Participation by the Patient Party

4.0 Introduction

In this chapter, I will introduce the first part in my framework in order to tackle the first research question: how much does the patient party (i.e. the patient and/or the companion) participate in the medical encounter? In my analysis, the activities involved in the medical encounters are divided into two groups: information-providing cycles and non-information-providing cycles. The former refers to activities in which the patient party provides information to the doctor, whereas no such activities are observed in the non-information-providing cycles. This chapter begins with my definition of 'information' and 'information-providing acts' in section 4.1, 'information-providing cycles' and 'non-information-providing cycles' in section 4.2. Then in section 4.3 and section 4.4, I will introduce the methods for measuring the amount of the patient party's participation in the two groups of activities and the statistics process. In sections 4.5 and 4.6, I will present the result of the analysis and the implications of the findings. The final section 4.7 is a summary of this chapter.

4.1 Definitions of ‘information’ and ‘information-providing acts’

It is well recognized that a medical encounter is an information exchange activity composed of two distinctive activities (Heath 1992:252, Roter 1992:81, Winefield and Murrell 1992 cited in Baker 1996). These are the information-gathering (or history-taking) phase in which doctors gather information from patients regarding their health problem, and the diagnostic and management phase in which doctors present information regarding the diagnosis and recommendation for treatment. For the purpose of this current research, ‘**information**’ is restricted to information which is provided by the patient party and is in some way related to the patient’s health problems. Based on this information, the doctor builds up his or her diagnosis and the long-term management plan for the patient. ‘**Information-providing acts**’ refers to utterances in which the patient party provides information. The ‘(patient party’s) information-providing acts’, as defined in this current research, are in a similar spirit to ‘the (doctor’s) information-gathering’ or ‘history-taking phase’ in medical literature. However, the term ‘(patient party’s) information-providing acts’ is used to cover two broader senses in this research.

First of all, ‘(patient party’s) information-providing acts’ includes the two

possibilities that information regarding the patient's health problem can be either elicited by doctors' questions or volunteered by the patient party. The term '(doctor's) information-gathering phase' implies a passive role for the patient party – the patient party gives information when the doctor asks for it. Secondly, the term '(doctor's) information-gathering phase' implies a temporal constraint in which the doctor's information-gathering task must be completed at a certain point of time so that the next phase, the recommendation phase, will follow. However, as observed in most cases, the patient party can provide information whenever the interactional context prompts him or her to do so. For example, at the point when the doctor recommends that the patient go on a diet for the relief of her breathing difficulty, the patient mentions that she has been losing her appetite for several weeks. In other words, the '(patient party's) information-providing acts' can occur at any time-point during the medical encounter. This spontaneity goes beyond the temporal constraint implied in the term '(doctor's) information-gathering phase'.

4.2 Definitions of 'information-providing cycles' and 'non-information-providing cycles'

The patient party's participation during the medical encounter is divided into two types of discourse sequences depending on whether or not the patient party provides information. The discourse sequences in which the patient party provides information are **'information-providing cycle'** (a more precise definition of the discourse structures of an information-providing cycle will presented in Chapter 6). For example, the discourse sequences in Excerpt 1 are information-providing cycles. The patient and her daughter-in-law provide information in response to the doctor's three questions regarding to the patient's breathing problem.

Excerpt 1. {00'32"}(Mrs. Yiu 65F; main language: Southern Min; underlined parts: Mandarin)

1. Dr. Tiunn: 汝遮寫講乳房部份講喘氣啊會痛?
Li tsiah sia-kong ni-pang po-hun kong tshuan-khue a e tiann?
you here write-say breast part say breath also will hurt

→2. Mrs. Yiu: *Henn*
yeah

3. Dr. Tiunn: 喔呼, 這是最近卡按吶欸?
O-hoo, tse si tsue-kin kha an-ne e?
oh, this be recently EMP this PRT

→4. Mrs. Yiu: 昨眠二點外=

Tsa-min lng-tiam gua=
last-night two-o'clock more

5. Dr. Tiunn: =喔:
Oh:
oh

→6. D-in-law*: 昨天晚上二點多
Tsuo-tian wan-shang liang-dian duo
yesterday night two-o'clock more

7. Dr. Tiunn: 卡早攏無喔?
Kha-tsah long bo oh?
early on EMP no Q

→8. D-in-law henn, 沒有, 很少
Henn, mei-you, hen shao
yeah, no very seldom

* Daughter-in-law

Translation

1. Dr. Tiunn: Here you wrote that (your) breast also hurt when (you) breath?

→2. Mrs. Yiu: Yeah.

3. Dr. Tiunn: OK, did this happen recently?

→4. Mrs. Yiu: (It's) about 2 am last night=

5. Dr. Tiunn: =Oh::

→6. D-in-law: About 2 am last night

7. Dr. Tiunn: (It) never occurred earlier?

→8. D-in-law: Right, no, (it) seldom occurred.

CODING

P's participation: The patient's amount of participation in the information-providing cycles is 6 (syllables).

C's participation: The companion's amount of participation in the information-providing cycles is 12 (syllables).

The discourse sequences in which no information-providing acts are achieved in the patient party's utterances are part of the '**non-information-providing cycle'**. The non-information-providing cycles include the opening and closing sections and the patient party' questions of or responses to the doctor's diagnosis and management plan. However, the opening and closing sections in the fifteen encounters are usually very short. Ten out of the fifteen encounters are opened with the doctor's greeting, followed by the doctor's eliciting information regarding the patient's chief complaint right away. The following is a typical opening of most encounters. (See §9.6 for more examples of the opening sequence).

Dr. Tiunn: **{Mr. Ong and his daughter came into the room.}**

來,王先生 honn? 啊汝是按吶艱苦?
Lai, Ong-senn-sinn honn? a li si an-na kan-koh
come Mr. Ong, Q PRT you be how sick

OK, Mr. Ong, right? So what's your problem?

Thus, the non-information-providing cycles are mainly composed of discourse sequences related to the patient party's questions of or responses to the doctor's diagnosis and management plans. The discourse sequences in Excerpt 2 are non-information-providing cycles. The patient acknowledges the doctor's prescription (line 2), and her daughter-in-law asks further questions regarding whether or not to take the two types of medicine together (line 4).

Excerpt 2. {12'01"}(Mrs. Yiu 65F; main language: Southern Min)

1. Dr. Tiunn: 啊落的藥仔 honn,我另外開一種予汝.
A lau-e io-a honn, gua ling-gua
PRT diarrhea medicine PRT I additional

khui tsit-tsiong hoo li
prescribe one-type for you

→2. Mrs. Yiu: *M-hng*
m-hng

3. Dr. Tiunn: *Honn, a::=*
PRT PRT

→4. D-in-law*: =這胃是::落的時陣卡食啊是講::和彼做夥食?
=Tse ui si:: lau-e si-tsun kha tsiah,
this stomach be diarrhea when EMP take

a-si kong:: ham he tso-hue tsiah?
or say with that together eat

5. Dr. Tiunn: ..汝會使干那食這叨會使啊

..Li e-sai kan-na tsiah tse to e-sai a
you can only take this EMP OK PRT

→6. D-in-law: 頭先食彼叨好?=
Thau-sin tsiah he to ho? =
initial take that EMP OK

7. Dr. Tiunn: *=Henn,*
yeah

* Daughter-in-law

Translation

1. Dr. Tiunn: As for diarrhea, I will have another prescription for you.

→2. Mrs. Yiu: M-hng

3. Dr. Tiunn: Yeah, and:::=

→4. D-in-law: =This stomach medicine:: (you) take the medicine when (you) have the diarrhea, or take it with the other medicine?

5. Dr. Tiunn: ..(It's) ok if you take this one only.

→6. D-in-law: Taking just this one will be OK?=

7. Dr. Tiunn: =Yeah

CODING

P's participation:	The patient's amount of participation in the non-information-providing cycles is 1 (syllable).
C's participation:	The companion's amount of participation in the non-information-providing cycles is 23 (syllables).

The non-information-providing cycles also include discourse sequences in which the doctors elicit administrative information to schedule the immediate management

plan. For example, is the patient covered by an insurance program? When is the patient available for a follow-up visit (e.g. Excerpt 3)? Had the patient recently eaten and was unable to take the blood test right away (e.g. Excerpt 4)? This administrative information is less related to the information needed for the doctor's diagnosis. Instead, it is more related to the information needed for the doctor's immediate management plan. Thus, it is considered as a non-information-providing activity.

Excerpt 3. {22'25"}(Mrs. Su 83F; main language: Southern Min)

1. Dr. Lau: /??/找另外一個..林至于醫師
   /??/ Tsao ling-wai yi-ge Lin Zhi-yu yi-shi
   refer another one Lin Zhi-yu doctor

2. **{pause for 4 seconds}**

3. Dr. Lau: 汝.汝佗一工方便?
   Li… li.. to-tsit kang hong-pian?
   you you which day convenient

→4. Son: 攏無啊緊
   Long bo-a-kin
   EMP no-matter

Translation

1. Dr. Lau: /??/ Referred to another.. Dr. Lin Zhi-yu

2. **{pause for 4 seconds}**

3. Dr. Lau: What day is more convenient for you... you.. (to come back).

→4. Son: It doesn't matter (what day).

CODING

P's participation:	The patient's amount of participation in the non-information-providing cycles is 0 (syllables).
C's participation:	The companion's amount of participation in the non-information-providing cycles is 4 (syllables).

Excerpt 4. {14'52"}(Mrs. Iunn 71F; main language: Southern Min)

1. Dr. Lau: 所以汝今仔敢有空腹?
So-yi li kin-a-jit kam u khang-pak ?
so you today Q have empy stomach

→2. Mrs. Iunn: ..無
.. *Bo*
no

吃飽啊啦
[*Tsiah pah a*
eat full ASP

3. Dr. Lau: 另天才擱準備一咧好無?
[*Bo honn:::? ling kang tsiah koh tsun-pi-tsit-le, ho bo?*
not Q another day then again prepare OK Q

Translation

1. Dr. Lau: So, is your stomach empty? (Implication: are you ready for a blood test?)

→2. Mrs. Iunn: ..No

[(I) already ate

3. Dr. Lau: [No:::? (we will) schedule (the blood test) for some other day, OK?

CODING

P's participation:	The patient's amount of participation in the non-information-providing cycles is 1 (syllable).
C's participation:	The companion's amount of participation in the non-information-providing cycles is 0 (syllable).

4.3 The measurement of the patient party's amount of participation

In measuring the amount of the patient party's participation in the information-providing and non-information-providing cycles, the Chinese version of Microsoft 97's word count tool is used to count the total number of syllables uttered by the patient and the companion. The use of counting words to calculate a speaker's amount of participation is adopted by the work of Aronsson and Rundstrom (1988). Since the triadic conversation is originally transcribed with Chinese characters in the column style, it is easier to count the characters uttered by each speaker and to visualize the extent of each speaker's contribution to the conversation. Though the Chinese characters are not shown here, it should be indicated that each Chinese character represents one syllable. For example, in Excerpt 1, the patient's amount of participation in the information-providing cycles is 6 (syllables), and that of the daughter-in-law is 12 (syllables). In Excerpt 2, the patient's amount of participation in the non-information-providing cycles

is 1 (syllable), and that of the daughter-in-law is 23 (syllables).

4.4 The process for statistics

In the following, I will briefly explain two statistical processes (i.e. percentage number and discrepancy between the patient and the companion) in the analysis of my data.

4.4.1 Percentage number

First of all, the raw number of the amount of the patient party's participation is transformed into a percentage number. As shown in Table 4-1, each cell displays the raw numbers of the total number of syllables uttered by the patient and the companion in both the information-providing and non-information-providing cycles.

Table 4-1. The amount the patient party's participation in the information-providing and non-information-providing cycles (raw number).

	Patient in IP* cycles	Companion in IP cycles	Patient in non-IP cycles	Companion in non-IP cycles	Total
Mrs. Zhu	415	1077	346	987	2825
Mrs. Yiu	513	206	18	373	1110
Mr. Ong	706	402	194	650	1952
Mrs. Pan	1517	64	313	21	1915
Mrs. Iunn	1965	715	564	285	3529
Mrs. Gonn	898	308	293	339	1838
Mrs. Lim	800	467	346	429	2042
Mrs. Su	858	1017	244	242	2361
Mr. Sim	1375	336	58	178	1947
Mrs. Tenn	805	437	289	219	1750
Mrs. Khu	2022	238	243	57	2560
Mr. Tian	267	348	64	161	840
Mr. Wang	1966	190	350	17	2523
Mr. Tan	790	491	107	167	1555
Mr. Khoh	598	487	35	8	1128
Total-1	15495	6783	3464	4133	29875
Total-2	22278		7597		29875

* 'IP': information-providing.

Each raw number is transformed to a percentage number, with reference to the total number of the two parties' utterances in the whole encounter, as shown in Table 4-2. It is based on these percentage numbers that further analysis is applied.

Table 4-2. The amount the patient party's participation in the information-providing and non-information-providing cycles (percentage number).

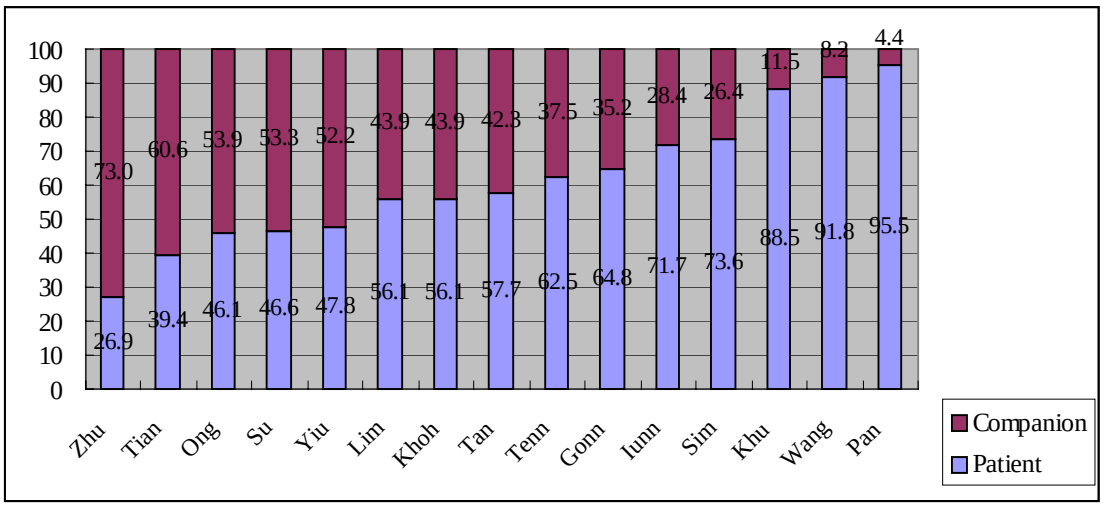
	P in IP* cycles	C in IP cycles	P in non-IP cycles	C in non-IP cycles	Total	P's total	C's total
Mrs. Zhu	14.7%	38.1%	12.2%	34.9%	100.0%	26.9%	73.0%
Mrs. Yiu	46.2%	18.6%	1.6%	33.6%	100.0%	47.8%	52.2%
Mr. Ong	36.2%	20.6%	9.9%	33.3%	100.0%	46.1%	53.9%
Mrs. Pan	79.2%	3.3%	16.3%	1.1%	100.0%	95.5%	4.4%
Mrs. Iunn	55.7%	20.3%	16.0%	8.1%	100.0%	71.7%	28.4%
Mrs. Gonn	48.9%	16.8%	15.9%	18.4%	100.0%	64.8%	35.2%
Mrs. Lim	39.2%	22.9%	16.9%	21.0%	100.0%	56.1%	43.9%
Mrs. Su	36.3%	43.1%	10.3%	10.2%	100.0%	46.6%	53.3%
Mr. Sim	70.6%	17.3%	3.0%	9.1%	100.0%	73.6%	26.4%
Mrs. Tenn	46.0%	25.0%	16.5%	12.5%	100.0%	62.5%	37.5%
Mrs. Khu	79.0%	9.3%	9.5%	2.2%	100.0%	88.5%	11.5%
Mr. Tian	31.8%	41.4%	7.6%	19.2%	100.0%	39.4%	60.6%
Mr. Wang	77.9%	7.5%	13.9%	0.7%	100.0%	91.8%	8.2%
Mr. Tan	50.8%	31.6%	6.9%	10.7%	100.0%	57.7%	42.3%
Mr. Khoh	53.0%	43.2%	3.1%	0.7%	100.0%	56.1%	43.9%
Mean	51.0%	23.9%	10.7%	14.4%	100.0%		
Mean total	74.9%		25.1%		100.0%		

* 'IP': information-providing.

The last two columns in Table 4-2 display the total amount of participation by the patient and the companion. The bar graph of Figure 4-1 shows the sorted distributions by the degree of the patient's and the companion's total amount of participation. It shows that the daughters of Mrs. Zhu and Mr. Tian score the first and second highest amount of participation (73.0% and 60.6%) while the son of Mr. Wang and the daughter of Mrs.

Pan score the lowest amount (8.2% and 4.4%).

Figure 4-1. The distribution of the patient's and the companion's total amount of participation.



4.4.2 Discrepancy between the patient and the companion

In my next step of analysis, I calculate the discrepancy of the amount of participation between the patient and the companion by subtracting the percentage number of the companion's participation from that of the patient's. These discrepancy numbers are presented in the last columns F and G of Table 4-3. For example, Mr. Ong's

participation in the information-providing cycles takes up a portion of 36.2% of the total number of syllables uttered by the patient party while that of his daughter takes up 20.6%. Thus the discrepancy between Mr. Ong and his daughter is ‘15.6%’. This positive discrepancy means that the patient participates more than the companion in the information-providing cycles. However, the discrepancy between Mr. Ong and his daughter in the non-information-providing cycles is a negative number ‘-23.4%’ (9.9%-33.3%). This discrepancy means that the patient participates less than the companion in the non-information-providing cycles.

The first three research questions of my study focus on the evaluation of the companion’s participation in comparison with that of the patient. The way that I quantify the degree of discrepancy between the two parties as shown in columns F and G of Table 4-3 is the major method for any further analysis in following chapters. This method is applied because it takes the patient party’s participation in both cycles into consideration.

Table 4-3. Level of discrepancy between the patient vs. and the companion in the information-providing and non-information-providing cycles.

	Patient in IP* cycles	Companion in IP cycle	Patient in non-IP cycle	Companion in non-IP cycle	P vs. C in IP cycles[1]	P vs. C in non-IP cycles[2]
A	B	C	D	E	F	G
Mrs. Zhu	14.7%	38.1%	12.2%	34.9%	-23.4%	-22.7%
Mrs. Yiu	46.2%	18.6%	1.6%	33.6%	27.7%	-32.0%
Mr. Ong	36.2%	20.6%	9.9%	33.3%	15.6%	-23.4%
Mrs. Pan	79.2%	3.3%	16.3%	1.1%	75.9%	15.2%
Mrs. Iunn	55.7%	20.3%	16.0%	8.1%	35.4%	7.9%
Mrs. Gonn	48.9%	16.8%	15.9%	18.4%	32.1%	-2.5%
Mrs. Lim	39.2%	22.9%	16.9%	21.0%	16.3%	-4.1%
Mrs. Su	36.3%	43.1%	10.3%	10.2%	-6.7%	0.1%
Mr. Sim	70.6%	17.3%	3.0%	9.1%	53.4%	-6.2%
Mrs. Tenn	46.0%	25.0%	16.5%	12.5%	21.0%	4.0%
Mrs. Khu	79.0%	9.3%	9.5%	2.2%	69.7%	7.3%
Mr. Tian	31.8%	41.4%	7.6%	19.2%	-9.6%	-11.5%
Mr. Wang	77.9%	7.5%	13.9%	0.7%	70.4%	13.2%
Mr. Tan	50.8%	31.6%	6.9%	10.7%	19.2%	-3.9%
Mr. Khoh	53.0%	43.2%	3.1%	0.7%	9.8%	2.4%

* 'IP': information-providing.

For example, the companions of Mr. Ong and Mrs. Iunn contribute a relatively equal amount of participation in the information-providing cycles, (i.e. 20.6% 20.3% in column C). However, if we take the patient's portions in the information-providing

[1] P vs. C in IP cycles: The discrepancy between the patients' number of utterances in information-providing cycles and that of the companions, gained by subtracting column C from column B.

[2] P vs. C in non-information-providing cycles: The discrepancy between the patients' number of utterances

cycles into consideration as well, it shows that Mr. Ong's companion is more active than Mrs. Iunn's companion. In Mr. Ong's case, his portion in the information-providing cycles is 36.2%; thus, the discrepancy between him and his companion is 15.6%. However, given Mrs. Iunn's higher participation in the information-providing cycles, the discrepancy between her (55.7%) and her companion (20.3%) is enlarged to 35.4%. Within this comparison, the participation of Mr. Ong's companion in the information-providing cycles is much higher than that of Mrs. Iunn's companion. In other words, the companion's participation is evaluated with reference to that of the patient in both the information-providing and non-information-providing cycles.

4.5 Results

Overall, the last row in Table 4-2 shows that 74.9% of the patient's and companion's utterances are mainly contributed in the information-providing cycles during the medical encounters (51.0 % by the patient and 23.9% by the companion). The

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in non-IP cycles and that of the companions, gained by subtracting column E from column D.

non-information-providing cycles takes up 25.1% (10.7% by the patient and 14.4% by the companion), a minor portion of the patient party's total utterances.

The total row also shows that while the patient participates about twice as much as the companion in the information-providing cycles (i.e. 51.0% vs. 23.9%), the patient's contribution in the non-information-providing cycles is slightly less than the companion's (i.e. 10.7% vs. 14.4%). The percentage numbers of the two members' participation in both cycles are further tested by the 'paired samples T test'. The result is presented in Table 4-4.

Table 4-4. Paired samples T test: the patient party's participation in the information-providing and non-information-providing cycles.

	Number of cases	Paired differences (mean)	Sig. (2-tailed)
P's vs. C's participation in IP* cycles	15	27.1110	.003**
P's vs. C's participation in non-IP cycles	15	-3.7382	.308

* 'IP': information-providing.

** Correlation is significant at the 0.01 level (2-tailed).

These results show that the patients' participation in the information-providing

cycles is significantly higher than that of the companion's ($P<0.01$). Though the companion's participation in the non-information-providing cycle is higher than that of patient, the difference is not statistically significant ($P>0.05$).

Columns F and G in Table 4-1 present the degree of discrepancy between the two parties in the information-providing and non-information-providing cycles. My next interest is to see if a correlation exists between the two groups of discrepancy. They are tested using SPSS's 'bivariate correlations'.

Table 4-5. Correlation of the patient party's discrepancies in information-providing and non-information-providing cycles.

		P's vs. C's participation in IP* cycles
P's vs. C's participation in non-IP cycles	Pearson Correlation	.583
	Sig. (2-tailed)	.023**
	Number of cases	15

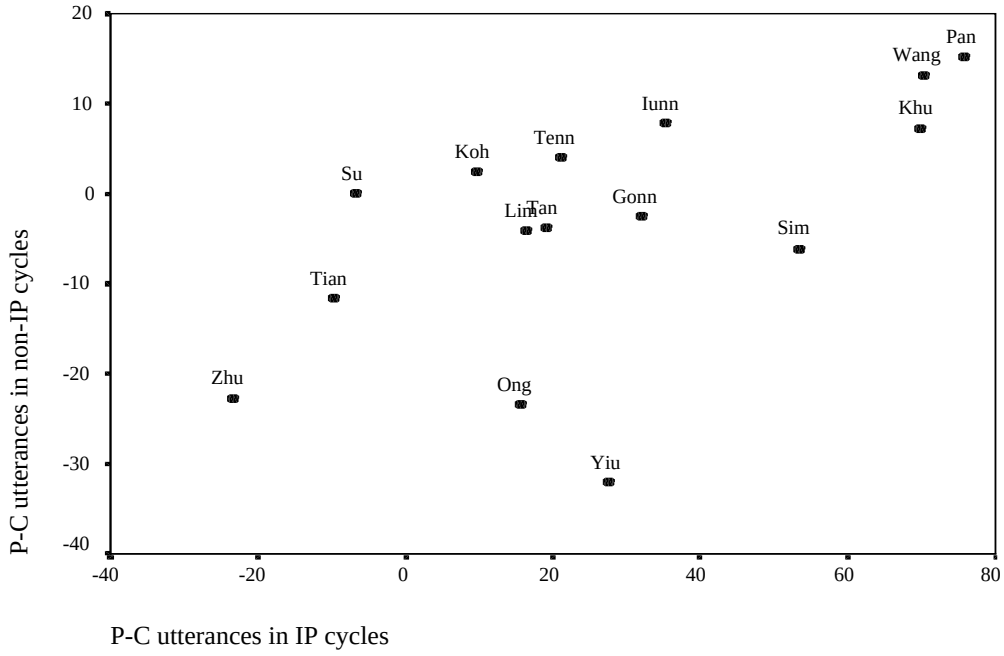
* 'IP': information-providing

**Correlation is significant at the 0.05 level (2-tailed).

Table 4-5 shows that there is a significant positive correlation between the two groups of discrepancies ($P<0.05$). In other words, the party who participates more in the

information-providing cycles than the other party will be inclined to participate more in the non-information-providing cycles also and those who participate less in the information-providing cycles will contribute a lower portion as well in the non-information-providing cycles. The scatter plot in Figure 4-2 presents a pictorial image of this correlation.

Figure 4-2. Correlation of the patient party's discrepancies in information-providing and non-information-providing cycles (Pearson correlation =.583).



Furthermore, there seems to be a predictable pattern between the companion's participation in the information-providing and the non-information-providing cycles. The companion who participates more than the patient in providing information also has a higher amount of participation in dealing with the diagnosis and management plan, while the opposite may not be true. For example, in the case of Mrs. Zhu and Mr. Tian, the companions have a greater participation than the patients in both the information-providing and non-information-providing cycles. However, the companions of Mr. Ong and Mrs. Yiu, who contribute the second and third highest participation in the non-information-providing cycles (i.e.33.3% and 33.6% in column E), are not so active in the information-providing cycles.

4.6 Implication

There are two implications of the above results. First, the fact that the patient's overall amount of participation in the information-providing cycles is significantly higher than that of the companion implies that most of the patients (12 out of 15) remain the primary source of the information that doctors need. Secondly, the companion's level

of participation in the non-information-providing cycles is closer to the patient's level of participation than it is in the information-providing cycles. This fact implies that the patient's and the companion's participation is related to the activities of the encounters.

To be more specific, the role of the patient is mainly related to activities of providing information to the doctors (i.e. the information-providing cycles). The role of the companion (i.e. the adult child of the elderly patient in this research) is related to the activities of gathering or responding to information regarding the diagnosis and management plan (i.e. the non-information-providing cycles). This fact can partially account for the tendency of the companions who are active in the non-information-providing cycles not to be as active in the information-providing cycles. Seeing the task of dealing with the doctor's diagnosis and management plan as their primary role as a 'companion,' most of the companions devote their participation in the non-information-providing activities, if they do participate. In the case where the companions wish to be further involved in the encounter, such as the daughters of Mrs. Zhu and Mr. Tian, then they take up the patients' task of information-providing.

4.7 Conclusion

In this chapter, I introduced the first part in my framework using the syllable count to measure the patient party's participation in two types of activities (i.e. information-providing cycles and non-information providing cycles). The major findings and implications of applying this approach include the following. The patient's overall amount of participation in the information-providing cycles is significantly higher than that of the companion, which implies that the majority of the patients remain the primary source of information. It is also argued that the role of the patients is mainly related to activities of providing information to the doctor and that of the companions is related to the activities of gathering or responding to information regarding the diagnosis and management plan.

Chapter 5. Information Provided by the Patient Party

5.0 Introduction

As we have learned from the previous chapter, the majority (74.9%) of the patient party's utterances are devoted to the activities of providing information to the doctors. In the second part of my framework, I will examine the amount and the categories of information provided by the patient party. The measurement of the amount of information is based on the number of Chinese syllables in their utterances. The motivation for this measurement will be explained in section 5.1. The information provided by the patient party is divided into five categories and will be introduced in section 5.2. The number of the five categories of information provided by the patient and the companion and the discrepancy of their contribution are presented in section 5.3. In section 5.4, I will display the implications of the findings. The conclusion is presented in section 5.5.

5.1 Measurement of the amount of information

In the first part of my framework, a syllable count is used to measure the discourse space of the patient party (Chapter 4). With this measurement, the number of syllables reflects the amount of the patient party's verbal participation. In the second part of my framework, I adopt the approach of syllable count again to measure the amount of information. This second application might be more problematic than the first application because 'the amount of information' involves the amount of semantic meaning or proposition, which is not easy to be quantified by any measurement. In the following, I will present two major problems that I have encountered in the process of measuring information. Then I will explain my reason for preferring the syllable count.

In measuring the amount of information, there are two major problems observed in my data: wordy utterances vs. concise utterances, and expressive vs. unexpressive speakers.[1]

Gold et al. (1988 and 1994) observed that some elderly people display features of off-target-verbosity. These features include abundance and lack of focus. Among the

fifteen elderly patient observed in my data, two of them have a slight degree of off-target-verbosity in the sense that their utterances are comparatively longer, wordier, and more often off-track from the doctor's question. For example, Mr. Wang, who has suffered hypertension for years, repetitively brings up his concern about the increasing rate of his heartbeat. The whole encounter lasts for 19'07''. Mr. Wang brings up this concern about four times in the encounter. Near the end of the encounter (at 17'02"), he brings up this concern again, as shown in Excerpt 1.

Excerpt 1.{17'02"} (Mr. Wang 74M; main language: Mandarin)

→1. Mr. Wang: 我沒.沒.沒看這個藥,沒吃這個藥以前時期啊,我的心跳只有六十幾七十.七十六十幾七十,
Wo mei..mei..mei kan zhe-ge iao, mei chi zhe-ge iao
I not not not see this medicine not take this medicine

yi-qian shi-qi a, wo-de xi-tiao zhi-you liou-shi-ji qi-shi..
before period PRT my heartbeat only sixty more seventy

qi-shi.. liou-shi-ji qi-shi
seventy sixty more seventy

2. Dr. Song: *Mng*
Mng

→3. Mr. Wang: 可是吶,血壓啊,高血壓,是這樣,差不多都是這樣,就是心跳

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[1] Many of the arguments presented in this section are inspired by Prof. Heidi Hamilton.

Ke-shi na, xie-yia a, kao-xie-yia, shi zhe-iang
But PRT blood pressure PRT hypertension be this

cha-bo-duo dou shi zhe-iang, jiou-shi xin-tiao
almost EMP be this EMP heartbeat

4. Dr. Song: *Ho ho=*
oh oh

→5. Mr. Wang: =我從前沒看到來之前,那個心跳啊,就六十幾七十六十幾七十
=Wo chong-qian mei kan-dau lai zhi-qian, na-ge xin-tiao a
I before not see come before that heartbeat PRT

jiou liou-shi-ji, qi-shi liou-shi-ji qi-shi
EMP sixty more seventy sixty more seventy

6. Dr. Song: 七十=
Qi-shi=
Seventy

→7. Mr. Wang: =可是現在這個這個..最低八十幾,九十..,啊!
=Ke-shi xian-zhai zhe-ge.. zhe-ge.. zhui-di ba-shi-ji jiou-shi, ah!
but now this this this lowest eighty more ninty INT

Translation

→1. Mr. Wang: I haven't..haven't..haven't got this medicine, (I mean) before I took this medicine, my heartbeat was only sixty more, seventy..seventy..sixty more or seventy,

2. Dr. Song: Yeah.

→3. Mr. Wang: But, (my) blood pressure, (my) high blood pressure is like this. (It's) almost the same, but the heartbeat,

4. Dr. Song: Oh, I see.=

→5. Mr. Wang: =before I (was hospitalized), umm (my) heartbeat was sixty more, seventy.. sixty..more or seventy,

6. Dr. Song: seventy=

→7. Mr. Wang: =but now this.. umm.. the lowest is eighty more, ninety.., oh!

CODING

P's participation: The patient provides 102 syllables of biomedical information.

Even in this fourth mention of the same concern, some wordy and repetitive expressions are observed (such as 'sixty more, seventy..seventy..sixty more or seventy' in lines 1 and 5). In contrast to Mr. Wang's wordy and expressive style, Mr. Sim seems to be an unexpressive speaker in the sense that there are more speech production difficulties or short phrases observed in his utterances. For example, in response to the doctor's open question regarding the description of his heart problem, Mr. Sim provides two short phrases which convey the two concrete syndromes of occasional palpitation and hand trembling (i.e. '*u-tang-si-a*' 'occasional', '*phi-phok-tshai'* 'palpitation', and '*tshiu long e an-ne tshuan'* 'this hand trembles all the time'). However, producing these two short phrases caused many difficulties in phrasing and word search (as shown in lines 4 and 6 of Excerpt 2).

Excerpt 2. {00'25"} (Mr. Sim 65M; main language: Southern Min)

1. Dr. Kang: 汝心臟艱苦是按吶艱苦?
   Li sim-tsong kan-kho si an-na kan-kho
   you heart hurt be how hurt

2. Mr. Sim: …*Mng?*
What

3. Dr. Kang: 汝心臟按吶. [艱苦?
Li sim-tsong an-na. [*kan-kho?*
you heart how hurt

Son-in-law: 看按吶艱苦?
[*Khuann an-na kan-kho?*
see how hurt

→4. Mr. Sim: …叨若像按吶::有當時仔/??/啊有當時仔叨會按吶,按吶彼落::按吶霹摶喘按吶,
.. To na sionn an-nei:: u-tang-si-a /??/ a u-tang-si-a
EMP as if like this occasional PRT occasional

to-e an-nei, an-nei bit-lor:: an-nei pi-pok-tshai an-nei
will this this umm like this palpitation like this

5. Dr. Kang: 會霹摶喘?
E pi-pok-tshai?
will palpitation

→6. Mr. Sim: 哼,啊彼咧.這手.手攏會按吶顫
Henn, a hit-leh.. tse tshiu long e an-nei tshuah
Yeah PRT that this hand EMP will this way tremble

Translation

1. Dr. Kang: How did your heart hurt?

2. Mr. Sim: …What?

3. Dr. Kang: How did your heart [hurt?

Son-in-law: [(The doctor is asking) how (your heart) hurt

→4. Mr. Sim: …Well (it's) like this:: sometimes /??/ umm sometimes it (will be) like this, like this umm:: like palpitation,

5. Dr. Kang: Like palpitation?

→6. Mr. Sim: Yeah, also umm..this hand trembles all the time.

CODING

P’s participation: The patient provides 40 syllables of biomedical information.

The issues of wordy vs. concise utterances and expressive vs. unexpressive speakers lead to further problems related to measuring the amount of information. For example, are expressive speakers more inclined to convey wordy or concise utterance? How do we draw the line between ‘wordy’ and ‘concise’ utterances? Do wordy utterances convey more information and the concise ones less? What part of an utterance is counted as 'information'?

These problems are important and call for further research. Given my interest in the general picture of the amount of the patient party's contribution in providing information, I will use a more neutral and objective measurement, such as ‘long vs. short utterances’ to avoid evaluative measurements such as ‘wordy vs. concise utterances’ or ‘expressive vs. unexpressive speakers’. Therefore, a syllable count is adopted. Three advantages, or spirits, of adopting a syllable count are described in the following.

First of all, this approach is more objective and straight forward than other measurements such as 'sentence', 'word', 'utterance', or 'turn'. Secondly, within the

utterances of a speaker's turn, there are discourse processes, such as repair, word search, rephrasing, and repetition, involved in the production of the proposition related to the patient's health problem. The use of a syllable count takes these discourse processes into account. Thus, Mr. Sim's contribution in line 6 is counted as 29 syllables of information, instead of 7 syllables (i.e. *'u-tang-si-a phi-phok-tshai'* 'occasional palpitation').

Thirdly, the fact that a speaker produces longer or shorter utterances in delivering information reveals many unexplored interactional contexts. For example, if the doctor had a lower tolerance for the patient's wordy expressions or the companion was dominant, a wordy speaker (such as Mr. Wang) might not have had the chance to produce such a wordy utterance (as in Excerpt 1). Also, if the patients felt their major concern had been addressed thoroughly by the doctor earlier in the interaction, repetition of the same concerns might not have resulted.

A contrastive behavior of Mr. Wang will show that power and solidarity are also factors related to speaker’s concise or wordy expression. The sole feature of repetition observed in Excerpt 1 of Mr. Wang’s encounter might not qualify him as having the style of off-target-verbosity. However, I had observed Mr. Wang’s two different degrees of

off-target-verbosity on two occasions. When I first approached Mr. Wang and his son to assist them in filling out the basic information sheet and to invite them to participate in this research (see §3.3), Mr. Wang was very friendly and was happy to participate. In our conversation, he displayed the style of off-target-verbosity which was so obvious that I constantly interrupted him in order to finish my task on time. However, Mr. Wang's style of off-target-verbosity became less observable during his interaction with Dr. Song. This contrastive behavior on the part of Mr. Wang can be explained with the concept of power and solidarity.[2] With the goal of gaining Mr. Wang's trust, I position myself as an amicable assistant by showing more solidarity and care with him. This behavior, in turn, receives the trust from Mr. Wang, as suggested by his willingness to reveal a great deal of information in the form of off-target-verbosity. When facing an authority figure (such as doctors), Mr. Wang displays his respect and deference to Dr. Song by talking less. Such a contrastive behavior of patients is also reported by many nurses—some elderly inpatients tend to complain more to nurses or to their family members but remain silent when

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[2] Personal communication with Dr. Feng-hwa Lu, 1999, and Prof. Heidi Hamilton 1999.

doctors visit them for routine check. With this concern of power and deferential talk, we may also argue that the Mr. Sim's relatively concise ways of expression, compared to Mr. Wang's, is a sign of his showing more deference to his doctor.

These interactional contexts (doctor's higher tolerance to repetition, less dominant companion, un-addressed concern, and patient's showing deference to doctors), though not completely explored in this current research, are indirectly displayed by the measurement of syllable count. The syllable count reflects the length of time that the speaker takes in delivering information. This measurement shows that Mr. Wang spends 102 syllables to give one piece of information (i.e. the change of his heartbeat prior to and after the hospitalized treatment), while Mr. Sim spends only 40 syllables to deliver the two pieces of information (i.e. heart palpitation and hand trembling). This measurement of 102 vs. 40 syllables, instead of one vs. two pieces of information, leaves us open to any related interactional context involved in the speaker's process of producing the information.

Given the above three advantages, I use syllable count to measure the amount of information provided by the patient party. However, I would like to remind readers of a

potential disadvantage of this practice—the repetition of utterance does not duplicate the amount of semantic proposition conveyed in the utterances.[3] Take Mr. Wang's utterances as examples: 'I haven't..haven't..haven't got this medicine, (I mean) before I took this medicine, **my heartbeat was only sixty more, seventy..seventy..sixty more or seventy**' (line 1) and 'before I (was hospitalized), umm **(my) heartbeat was sixty more, seventy.. sixty..more or seventy**' (line 5). These two repetitive utterances convey one basic proposition (i.e. Mr. Wang's heartbeat increased after the medical regimen). The bold parts are the exact repetition of the same phrase. However, with the measurement of syllable count, the amount of information will be doubled, and thus may not reflect a valid account. This issue could be further complicated when the distinction between repetition and paragraphing is important (such as 'before I was hospitalized' 'before I took this medicine' when uttered in two different contexts).

In my judgement, this disadvantage of syllable count does not have a significant effect on my analysis for the following reason. Among the thirty patient parties, Mr.

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[3] This discussion is inspired by Prof. Deborah Schiffrin.

Wang and Mrs. Khu are the two participants who are more likely to use the repetitive or wordy expressions. The use of syllable count is less problematic since my focus is on the comparison between the patient and the companion rather than among the fifteen patients. Even though the two companions of Mr. Wang and Mrs. Khu do not share the same wordy and repetitive style as their patients, as indicated by the sharp contrast of their significantly lower amount of participation,

(from Table 4-2)

	Patient in IP* cycles	Companion in IP cycle	Patient in non-IP cycle	Companion in non-IP cycle	Total
Mrs. Khu	79.0%	9.3%	9.5%	2.2%	100.0%
Mr. Wang	77.9%	7.5%	13.9%	0.7%	100.0%

* Information-providing

the contrast between the two patients and their companions is so substantial that it is hard to evaluate whether the different expression styles solely account for this contrast. Other unexplored factors (e.g. the companions' respect for patient autonomy or the patients' urgent need for expressing their concerns) will be important to account for such a contrast.

5.2 Five categories of information provided by patient party

The types of information that the family doctors at NCKU hospital need to gather from their patients are based on Hill's ABCX model of family adaptation (1949, cited in Taylor 1983) and Engel's biopsychosocial model (1980). Hill's model includes three aspects for evaluating patients' health problems: A) stressful life events, B) intra-familial and extra-familial resources, and C) the family's coping strategies. These factors produce X, the crisis (i.e. the patient' need for visiting their doctors). In a similar vein, Engel's biopsychosocial model expands the traditional biomedical model by incorporating psychosocial factors into the evaluation of patients' health problems. It considers everything from cells to organs to body to family to social networks to culture as a whole. These factors are linked by circular feedback. For example, a change in our external environment (such as the traumatic experience of the 1999 earthquake in Taiwan) or a worrisome event (such as the unemployment of a family member) might have affected the blood sugar level and blood pressure of people who suffer chronic diabetes and hypertension. Based on these two models, an interviewing guideline has been designed by the senior visiting staff at NCKU (see APPENDIX). In consultation with and

assistance by Dr. Lu, one of the senior visiting staff members, I classify this information into five categories for the purpose of this research. They are biomedical information; management information; pedigree information; daily routines, social activities and personality; and physical examination information.

5.2.1 Biomedical information

Biomedical information refers to the chief complaint, present history, and past history of the patient's health problem, including the following factors: location, character, time of onset, chronology, aggravating factors, alleviative factors, associated syndrome, and spread progress. For example, Mr. Wang provides the information regarding the change of his heartbeat and blood pressure (lines 1, 3, 5, and 7 in Excerpt 1), and Mr. Sim offers the information of the heart palpation and hand trembling (lines 4 and 6 in Excerpt 2). The information provided by them is biomedical information.

5.2.2 Management information

Management information refers to patients' 1) resources for managing their

problems, such as seeking help from family or friends or consulting with doctors, 2) medical knowledge, 3) motivation and expectation for the current visit, and 4) definition and explanation of their health problem and their beliefs. For example, the information provided by the patient and his daughter in lines 3 and 4 in Excerpt 3 concerns the patient's management of his health problem.

Excerpt 3 (Mr. Tan 76M; main language: Southern Min)

1. Dr. Niung: 按吶 honn, 啊最近敢擱有 gia?
An-ne-honn, a tsue-kin kam koh u gia?
I see and these day Q again have attack

2. Mr. Tan: 無, 最近無
Bo, tsue-kin bo
no, these days no

→3. Daughter: … 有當時仔叨去藥房買藥仔來食
… U-tang-si-a to-khi io-pang be io-a lai-tsiah,
sometimes go to drugstore buy drug eat

Henn, 啊有當時仔有效
Henn, a u-tang-si-a u-hau
yeah, and sometimes work

→4. Mr. Tan: Henn 啦,彼是隔壁介紹欸,伊嘛同症頭
Henn la, he si keh-piah kiau-siau e, i ma kang tsing-thau
yeah PRT, that be neighbor recommend, he also same problem

Translation

1. Dr. Niung: I see,….did (it) attack again recently?

2. Mr. Tan: No, not these days

→3. Daughter: …And (he) bought some pills from the..umm.. drug store, yeah , and (it) works sometimes.

→4. Mr. Tan: Yeah, it's from a..um..my neighbor, he had the same problem.

CODING

P's participation: The patient provides 14 syllables of management information. C's participation: The companion provides 20 syllables of management information.

Gathering information regarding the patients' definition, perception, and belief of their health problems and their beliefs is greatly emphasized not only by the medical profession but also by sociologists or anthropologists, for example Kleinmen et al's 'explanatory model' (1978) and Stoeckle and Barsky's idea of 'the patient's attributions' (1981). Given the different cultural and social background, each individual defines his or her health problem in a different way. For example, a common belief of the old Taiwanese generation is that a kidney deficiency or weakness is related to sexual dysfunction and any touchable mass in the body is potential a sign of cancer. If the patient's unstated concern is the chance of having a sexual disorder, instead of his seemingly legitimate complaint of flank soreness, then the doctor's insensitivity to 'the patient's hidden agenda' (Roter 1992:7) may result in dissatisfaction on the part of the

patient .

Also, it is noticed that the patient's concern and belief is sometimes expressed with questions instead of statements. As experienced by many physicians, some patients are reluctant to bring up their hidden agenda until the last minute upon their leaving, such as 'the dreaded doorway question' -- 'By the way doctor, I have chest tightness. That's nothing to worry about, right?' (Roter 1992:7). Ainsworth-Vaughn (1995) observes a similar phenomenon where the patients bring up their concerns or proposal for treatment plan with mitigated questions. For example, in line 1 of Excerpt 4, the patient describes the pains in his toes and the daughter joins in by asking the doctor if the pains in the patient's swelling toes are caused by blood congestion (line 2). While the doctor responds to her question, the daughter asks in a more explicit way: *'Tong feng,, kam si tong-feng ?'* 'That's gout, is that a sign of gout?' (line 4). The information in the daughter's utterances conveys her belief and explanatory model regarding her father's swelling toes. The utterances achieve two functions of eliciting diagnosis information and providing the information of her concern. Thus, the daughter's utterance is coded as providing management information.

Excerpt 4. {00'48"}(Mr. Ong 72M; main language: Southern Min)

1. Mr. Ong: 啊有當時仔佇遮 honn..啊遮嗎是咧痛,
A u-tang-si-a ti tsiah honn .. a tsiah ma si leh tiann
PRT sometimes at here PRT PRT here also be ASP hurt

..找來找去,找來找去
[*..tshue lai tshue khi, tshueh lai tshue khi*
search come search go search come search go

→2. Daughter: [..伊彼敢是..積來佇遐敢是囀..腫.hior:
[*..Ei he kam si .. tsit lai ti hiah? kam si tsuann.. tsing. hior:*
hey that Q be stay come at here Q be turn out swell that

積來佇遐叨.囀::佇遐咧痛,敢是按吶?=
tsit lai ti hiah to. tsuann ti hia leh tiann, kam si an-na?=
stay come at here EMP then at there ASP hurt Q be this

3. Dr. Tiunn: /當然/…若.有.這來講無一定講是::=
=/Tong-jen/…na. u. tse lai kong bo it-ting kong si::=
of course if has this come say not must be say be

[是...是./???/
[*si … si*
be be

→4. Daughter: [=痛風,敢是痛風?
[*Tong feng,, kam si tong-feng ?*
gout Q be gout

Translation

1. Mr. Ong: Sometimes it hurts here..and sometimes there
[It's).. running around, running around, here and there

→2. Daughter: [..Hey, in his situation, is that because that..the blood stays there…that's why it becomes.:: swollen… um it stays there, then:::that's why it hurts, is that right?

3. Dr. Tiunn: Yeah…well..in that situation..
[it's not always the case that::

→4. Daughter: [That's gout, is that a sign of gout?

CODING

C's participation: The companion provides 33 syllables of management information.

In Excerpt 5, the patient's chief complaint is the dream-filled sleep and insomnia which has bothered her for ten years. The doctor recommends that she get more exercise during the day and avoid exciting activities, such as emotional music, before she goes to bed. If the adjustment of daily activities does not improve her sleeping problem, then she may need medicine. At the end of the doctor's recommendation (i.e. 09'32" of the encounter), the patient asks if her sleeping problems will cause any '*phainn-mih-a*' 'bad thing' (line 1). The term '*phainn-mi-a*' is a common Taiwanese expression that implies a fatal disease such as cancer. The patient's utterance indirectly conveys her worry about the chance of having a fatal disease, and thus the information is coded as management information.

Excerpt 5.{09'32"}(Mrs. Tenn 66F; main language: Southern Min; underlined parts: Mandarin)

→1. Mrs. Tenn: 彼是按吶?/是講/這眠無睏 honn,會..會..會引起歹物仔去
He si an-na? /si kong/ tse mi bo khun honn,
that be what be say this night no sleep PRT

e.. e.. e in-khih phainn-mih- a khi?
will will will cause bad thing go

2. Dr. Kang: ..是未啦,只是人會感覺不舒服啦,henn
.. Si bue la, tsi-si lang e kam-kak po shu-fu la, henn
..be won't PRT only body will feel not comfortable ASP yeah

Translation

→1. Mrs. Tenn: Why is that? /(I'm) wondering/ the insomnia, yeah, will.. will.. will (it) cause any bad thing?

2. Dr. Kang: ..No, (it) won't, but (some people) will feel uncomfortable, yeah.

CODING

P's participation: The patient provides 20 syllables of management information.

5.2.3 Pedigree information

Pedigree information refers to the patient's family tree and hereditary factors, marital status, and the living arrangement of the family, e.g. the information provided in lines 2 and 3 in Excerpt 6.

Excerpt 6. {06'17"}(Mr. Tan 76M; main language: Southern Min; underlined parts: Mandarin)

1. Dr. Niung: 啊汝既嘛共誰人住作夥?
A li tsit-ma kah siang tuah tso-hue?
and you now with whom live together

→2. Mr. Tan: [共音
[*Kah in*
with them

→3. Daughter: [共…共阮,迄落:::我是他女兒
[*Kah… kah guan, bit-lor::: wo shi ta nu-er*
with… with us, that::: I be his daughter

Translation

1. Dr. Niung: And who do you live with now?

→2. Mr. Tan: [With them

→3. Daughter: [With…with us, and::: I am his daughter

CODING

P's participation: The patient provides 2 syllables of pedigree information. C's participation: The companion provides 10 syllables of pedigree information.

The elicitation of the patient's family history traces to the parental generation and the children's generation. The information regarding the health status of the patient's parents, brothers, and sisters provides clues to hereditary factors that might be related to chronic disease, such as hypertension. The information regarding the living arrangement of the patient and the number of his or her offspring gives a general picture of the patient's family resources and functions. This information is especially important for elderly patients whose diseases are psycho-socially oriented rather than pathologically oriented.

5.2.4 Daily routines, social activities, and personality

This information concerns the patient's 1) daily routine and social activities, such as diet habits and activity level, 2) personality characteristics, such as dependence vs. independence, 3) social, economic, and educational backgrounds, and 4) stressful life events, such as divorce or the death of a friend or family member, that may have an effect on the patient. The information provided by the patient in lines 2 and 4 of Excerpt 7 is an example of this category.

Excerpt 7. {13'41"}(Mr. Wang 74M; main language: Mandarin)

1. Dr. Song: =對,然後要有規律的運動
   =*Dui, ran-hou yao you gue-lu-de yun-dong*
   yeah, then need have regular exercise

→2. Mr. Wang: 我每天都有運動=
   Wo mei-tian dou you yun-dong=
   I everyday all have exercise

3. Dr. Song: =喔,做什麼運動呢?
   =*Oh, tso she-me yun-dong ne?* **{reading the medical record}**
   oh take what exercise Q

→4. Mr. Wang: 那個走路
   Na-ge tsou-lu
   that walk

Translation

1. Dr. Song: Yeah, also you need regular exercise

→2. Mr. Wang: I exercise everyday.=

3. Dr. Song: =Oh, what kind of exercise do you get? **{read the medical record}**

→4. Mr. Wang: (I) walk

CODING

P's participation: The patient provides 10 syllables of management information.

5.2.5 Physical-examination information

Physical examination is the most essential part of any medical encounter. During the physical examination, doctors sometimes need the immediate feedback from the patients. For example, while the doctor is checking the chest of the patient, the doctor asks 'does it hurt here?' or 'which part hurts?' The answers to these questions require the patient's personal and spontaneous experience on the spot. This information is defined as physical-exam information.

5.2.6 Ambiguous cases

The above classification is based on the data gathered from the fifteen encounters.

In my coding, every piece of information provided by the patient party will be labeled with one, and only one, information category. Occasionally, there are cases where it is hard to distinguish among the three categories of biomedical, management, and daily routine information. For example, Mr. Wang and Mrs. Ku have suffered hypertension for years. Before their initial visit with Dr. Song and Dr. Kang, they have sought professional management and care from other doctors and they are also equipped with knowledge regarding how to adjust their daily diet and activities in order to control high blood pressure. Two further rules are set up for distinction.

Rule 1. **Management information vs. biomedical information:**

Biomedical information focuses on the syndromes that occur to the patient and is related to the patient's chief complaint. Management information focuses on the actions the patient takes, such as seeking professional help.

For example, Mr. Wang complains to the doctor that before he was hospitalized, his heartbeat was about 60, and yet it increased to 80 after he was discharged (Excerpt 1). Mr. Wang's utterance conveys both the management information (he was hospitalized and

took some medicine) and biomedical information (the change of the blood pressure). However, judging from the urgent tone conveyed in his utterance, the change of blood pressure is the focus of his visit with the new doctor. Thus, Mr. Wang's utterance is coded as biomedical information.

Rule 2. **Management information vs. daily routine information:**
Information regarding daily activities or diet habits that are emphasized by the patient as an adjustment to improve the health problem he or she suffers from is coded as management information.

At the end of his encounter with Dr. Song (Excerpt 8), Mr. Wang mentions to the doctor that he always takes a shower with warm water, instead of hot water, and he waits for half hour before he goes to bed so that the heat will not affect his blood pressure. The information is coded as management information. In contrast, the information provided by Mr. Wang in Excerpt 7 ('I exercise everyday') is not explicitly emphasized by him as a way to improve his health problem and is thus coded as information of daily routine.

Excerpt 8. {15'16"}(Mr. Wang 74M; main language: Mandarin)

→1. Mr. Wang: 還有,還有一點啊洗澡啊,洗澡洗熱了,你在睡覺時期,這個.這個人啊,身體上就很暖和很熱, =
Hai-you, hai-you i-dian a, xi-zhao a,
also also one thing ASP taking shower ASP

xi-zhao xi re le, ni tsai shue-jiao shi-qi,
taking shower wash hot ASP you at sleep period

zhe-ge ren a, shen-ti-shang jiou hen nuan-he hen re =
this body ASP body EMP very warm very hot

2. Dr. Song: =嗯哼, 喔 呼呼
=M-hng, o ho-ho
m-hng oh oh

→3. Mr. Wang: 可是呢,我要必須啊,等那個身上熱氣,那個身上的熱氣不熱了,
Ke-shi ne, wo yao bi-xu a, deng na-ge shen-shang re-qi
but PRT I have need PRT wait that body heat

na-ge sheng-shang-de re-qi bu re le, dao xiao-tui la,
that boy heat not hot ASP all cool down ASP

oh, jiou-shi ne, na-ge xie.. na-ge xie-ia dou tue-xia-qu le
oh, EMP PRT, that blood that blood pressure all cool down ASP

Translation

→1. Mr. Wang: Also, there's one more thing, (after I) take a shower, (my body temperature) rises. When you go to sleep, the.. the body, the body is warm and hot.=

2. Dr. Song: M-hng, oh I see.

→3. Mr. Wang: But, I have to, have to wait for the heat within the body, the heat within the body to cool down. (When the heat) is gone, oh, that is, the blood pressure goes down as well.

CODING

P's participation: The patient provides 79 syllables of management information.

5.3 Results

Table 5-1 and 5-2 presents the raw number and the percentage number of the number of the five categories of information provided by the patient party. The number in each cell of Table 5-1 indicates the number of syllables in the utterances which are coded as information provided by the patient party.

Table 5-1. Five categories of information provided by the patient party (raw number).

	Physical-exam info. by		biomedical info. by		management info. by		pedigree info. by		daily routine info. by		Total
	P	C	P	C	P	C	P	C	P	C	
Mrs. Zhu	0	0	330	466	37	423	44	66	4	117	1487
Mrs. Yiu	42	0	260	120	131	73	80	13	0	0	719
Mr. Ong	0	0	264	66	359	212	35	55	48	35	1074
Mrs. Pan	0	0	1034	55	281	0	0	0	202	9	1581
Mrs. Iunn	0	0	685	164	558	245	492	191	230	115	2680
Mrs. Gonn	0	0	266	61	222	128	90	103	320	8	1198
Mrs. Lim	0	0	443	13	294	341	15	92	48	21	1267
Mrs. Su	3	0	604	419	218	508	30	29	3	61	1875
Mr. Sim	0	0	630	72	367	53	252	92	126	22	1614
Mrs. Tenn	0	0	237	81	273	242	92	22	203	65	1215
Mrs. Khu	0	0	302	83	1286	119	334	36	100	0	2260
Mr. Tian	7	0	165	137	95	211	0	0	0	0	615
Mr. Wang	0	0	805	3	819	0	165	79	177	108	2156
Mr. Tan	0	0	428	157	199	69	6	79	157	135	1230
Mr. Khoh	0	0	380	176	140	156	0	97	78	9	1036
Total-1	52	0	6833	2073	5279	2780	1635	954	1696	705	22007 [4]
Total-2	52		8906		8059		2589		2401		22007

[4] The total number 22007 is different from that of 22278 in Table 4-1 of Chapter 4. The latter includes the companion's utterances which occur in the information-providing cycles, but does not provide information, such as the companion rephrases the doctor's question when the patient fails to comprehend the doctor's question.

Table 5-2. Five categories of information provided by the patient party (percentage number).

	Physical-exam info. by		biomedical info. by		management info. by		pedigree info. by		daily routine info. by		Total
	P	C	P	C	P	C	P	C	P	C	
Mrs. Zhu	0.0%	0.0%	22.2%	31.3%	2.5%	28.4%	3.0%	4.4%	0.3%	7.9%	100.0%
Mrs. Yiu	5.8%	0.0%	36.2%	16.7%	18.2%	10.2%	11.1%	1.8%	0.0%	0.0%	100.0%
Mr. Ong	0.0%	0.0%	24.6%	6.1%	33.4%	19.7%	3.3%	5.1%	4.5%	3.3%	100.0%
Mrs. Pan	0.0%	0.0%	65.4%	3.5%	17.8%	0.0%	0.0%	0.0%	12.8%	0.6%	100.0%
Mrs. Iunn	0.0%	0.0%	25.6%	6.1%	20.8%	9.1%	18.4%	7.1%	8.6%	4.3%	100.0%
Mrs. Gonn	0.0%	0.0%	22.2%	5.1%	18.5%	10.7%	7.5%	8.6%	26.7%	0.7%	100.0%
Mrs. Lim	0.0%	0.0%	35.0%	1.0%	23.2%	26.9%	1.2%	7.3%	3.8%	1.7%	100.0%
Mrs. Su	0.2%	0.0%	32.2%	22.3%	11.6%	27.1%	1.6%	1.5%	0.2%	3.3%	100.0%
Mr. Sim	0.0%	0.0%	39.0%	4.5%	22.7%	3.3%	15.6%	5.7%	7.8%	1.4%	100.0%
Mrs. Tenn	0.0%	0.0%	19.5%	6.7%	22.5%	19.9%	7.6%	1.8%	16.7%	5.3%	100.0%
Mrs. Khu	0.0%	0.0%	13.4%	3.7%	56.9%	5.3%	14.8%	1.6%	4.4%	0.0%	100.0%
Mr. Tian	1.1%	0.0%	26.8%	22.3%	15.4%	34.3%	0.0%	0.0%	0.0%	0.0%	100.0%
Mr. Wang	0.0%	0.0%	37.3%	0.1%	38.0%	0.0%	7.7%	3.7%	8.2%	5.0%	100.0%
Mr. Tan	0.0%	0.0%	34.8%	12.8%	16.2%	5.6%	0.5%	6.4%	12.8%	11.0%	100.0%
Mr. Khoh	0.0%	0.0%	36.7%	17.0%	13.5%	15.1%	0.0%	9.4%	7.5%	0.9%	100.0%
Mean	0.5%	0.0%	31.4%	10.6%	22.1%	14.4%	6.1%	4.3%	7.6%	3.0%	100.0%
Mean total	0.5%		42.0%		36.5%		10.4%		10.6%		100.0%

Over all, the biomedical and management information takes up a great proportion of 42.0% and 36.5% (as shown in the last row of Table 2) out of the information provided by the patient party. Information regarding the pedigree and the daily routines and

personality constitutes a minor proportion, 10.4% and 10.6%.[5] Physical-exam information constitutes a very small part, 0.5%.

The 'mean' row in Table 5-2 shows that for each category of information the patients provide a greater number than the companions do. This finding is consistent with the previous finding that the fifteen patients' mean of amount of participation in the information-providing cyclesis greater than that of the companions (51.0% vs. 23.9%; see the raw 'mean' in Table 4-2). The percentage number of four of the five categories information provided by the patient and the companion is further tested by the paired sample T test to see if the discrepancy is significant.[6] The result is presented in Table 5-3.

Table 5-3. Paired samples T test: the patient party's five categories of information.

	Number of cases	Paired differences (mean)	Sig. (2-tailed)
P vs. C biomedical information	15	20.775	.000**

[5] It should be noticed that there are two cases, Mr. Tian and Mrs. Pan, in which the doctor did not elicit the pedigree information. Thus the amount of pedigree information could have been more.

[6] The physical-exam information is not tested since there are only three cases which contain this information.

P vs. C management information	15	7.714	.163
P vs. C pedigree information	13	2.127	.315
P vs. C daily routine information	13	5.313	.037*

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

The analysis shows that the amounts of biomedical information and daily routine information provided by the patient is significantly higher than that provided by the companion ($P<0.05$). Although the patient provides a higher amount of management and pedigree information than the companion, the difference is not significant ($P>0.05$). In other words, while the primary provider of the biomedical and daily routine information is the patient, management and pedigree information is provided about equally by both. As we can see from Table 5-2, there are only one or two cases (such as Mrs. Zhu and Mr. Tian) in which the companion provides a greater amount of biomedical and daily routine information than the patient. However, there are six cases in which the companion provides a greater amount of management and pedigree information than the patient.

5.4 Implication

There is one implication of the above finding. In the following, I will first tie the finding to Lobov and Fanshell's idea of 'A event', 'B event', and 'AB events' (1977:62), and then present the implication. In their study of one conversational interaction between a patient and her psychotherapist, 'A events' are those only the speaker (such as the therapist) has knowledge of, 'B events' are those only the other party (such as the patient) has knowledge of, and 'AB events' are those that are known to both parties in the conversation. In her study of the conversations between doctors and patients of breast cancer, Roberts (1996:72) further argues that the establishment of who has access to what type of knowledge is one conversation mechanism to display the participant's role in the interaction. For example, when the doctor's asks the patient how she discovered the breast lump, thus 'B-event' to which only the patient has the access, the doctor positions the patient as the authority on her medical history and establishes her role as a patient.

Oriented to my interest in the comparison of the patient's and the companion's participation in providing information, I will modify Labov and Fanshel's ideas as follows: 'P-event' refers to information to which the patient has the primary access, and

‘PC-event’ refers to information to which both the patient and the companion could have access. The overall discrepancy between the amount of information provided by the patient and that provided by the companion indirectly suggests a ranked accessibility of the companion’s knowledge to the five-category information about the patient, as shown in the following:

pedigree and management 》biomedical and daily routine 》physical-exam

In this ranking, the companion has the lowest accessibility to the physical-examination information and the highest accessibility to the pedigree and management information.

5.4.1 Physical-exam information

The physical examination is the most essential part of any medical encounter. The examination tasks can be undertaken by the doctor using various channels, such as the visual, tactile, listening, or verbal channels. All of the fifteen encounters include a physical examination. As we can see from Table 5-2, there are only three cases (i.e. Mrs.

Yiu, Mrs. Su, and Mr. Tian) where the doctors ask questions to elicit the patients' physical reaction toward the tests that the doctors are conducting. There are a total of 11 physical-exam questions posed by the doctors. The patients alone respond to them all. As shown in Table 5-1, all of the 52 syllables of physical-exam information are provided by the patient. The nature of these physical-exam questions requires the patient's spontaneous personal reaction to the test item. Thus, it blocks the companion's access to that information and marks the physical-exam information an 'absolute P-event'.

Although the verbal information involved in the procedures of the physical-exam in the fifteen cases takes up only a very small proportion of 0.5% (as shown in Table 5-2), the verbal information plays an essential role in identifying the roles played by the three parties in the medical triad. The party who conducts the examination invokes his or her role as 'the doctor'. The party who takes the examination and thus is able to provide the verbal information invokes his or her role as 'the patient'. The party who does not do either one establishes his or her role as 'the companion'.

Also, in the NCKU hospital, each doctor's office is equipped with a bed to use for physical examination (see Figure 3-1). The bed is surrounded with a curtain to protect the

patient's privacy. Five of the fifteen encounters involve a physical examination using the bed. None of the five companions chooses or asks to be present within the curtain, regardless how actively they have behaved earlier in the information-providing cycles. In other words, although the companion may have the access to be present in the doctor's office during the medical interview, there is an unspoken consensus among the three parties (i.e. doctor, patient, and companion) that the physical examination is a non-intrudable territory between the doctor and the patient.

5.4.2 Biomedical and management information

The access to knowledge also accounts for why the amount of biomedical information provided by the patient is significantly higher than that provided by the companion while the management information provided by the patient is not significantly higher than that by the companion. The biomedical information regards the patients' physical and psychological reaction to disease, most of which is not available to the companion unless he or she has learned the information prior to the medical encounter. The management information, on the other hand, involves the patient's

resources for managing their health problems, in which adult children play the major role as caregivers of their elderly parents in most Taiwanese families. (See Chapter 2 for the literature review of the child's role as the elderly patient's primary caregiver.) Therefore, the access to knowledge can account for the discrepancy that the companions are able to provide more management than biomedical information. Given this significant contrast and the restriction of information access, it will be interesting for us to explore why, markedly, the daughter of Mrs. Zhu provides a greater amount of biomedical information than Mrs. Zhu does (to be discussed in §11.9).

5.4.3 Pedigree information

The companion's access to knowledge also accounts for why the pedigree information provided by the companion is not significantly lower than that provided by the patient. The pedigree information regards the living arrangement and the history of the patient's family members. The companion, as the adult child of the patient, is part of the patient's pedigree, and thus he or she has access to most of the pedigree information. In that sense, the pedigree information is a 'PC-event' which both and the patient and the

companion have access to. The companion, therefore, will be able to provide an amount of pedigree information equivalent to that of the patient. However, as we can see from Table 5-2, out of the six cases where the patients provide a smaller amount of pedigree information than their companions, Mr. Tan and Mr. Khoh provide almost no pedigree information (i.e. 0.5% and 0.0%). It is their companions who provide most of the pedigree information. Obviously the companion's equal access to the pedigree information (to that of the patient) can not fully account for the companion's high participation in the above two cases. In Chapter 9, I will present the interactional contexts that account for the companion's higher participation in providing the pedigree information.

5.4.4 Further discussion of the companion's accessibility to information

In the above sections, I suggest a ranked accessibility that the companion has to the five types of information. I also extend Labov and Fanshell's ideas to 'P-events' and 'PC-events'. However there are three points that I will remind readers. First, this suggested ranking is based on the fifteen companion's 'verbal performance' rather than

their ‘knowledge’. The companion could have known very well about the patient’s health problem but decides to have the patient provide information to the doctor by him/herself. Secondly, the companions may actually have a greater access to the patients’ daily routines (such as going to bed around 9:00 pm) than to the patients’ management of a specific health problem (taking so-and-so pills twice a day). Yet, they do not provide any information of the patients’ daily routine because they are not motivated to do so during the dynamic interaction. For example, they are not given the chance to talk.

Thirdly, the interactive nature of conversation and performance-based measurement of the accessibility results in a vague boundary between ‘P-events’ (information to which the patient has the primary access) and ‘PC-events’ (information to which both the patient and the companion could have access). It seems that only the physical-exam information qualifies as an ‘absolute P-event’. The fact that the companion is part of the patient’s family makes pedigree information a ‘PC-event’. The remaining three categories of information (i.e. biomedical, management, and daily routine information) are ‘possible PC-events’.

5.5 Conclusion

In this chapter, I introduced the second part of my framework— syllable count being applied to measure the five categories of information provided by the patient party. The level of discrepancy between information provided by the patient and the companion shows that, among the five categories of information, the companion provides a greater amount of management and pedigree information and a lesser amount of biomedical and daily routine information (§5.3). None of the companions provide any physical-exam information. Based on the companion's verbal performance, I suggest a ranking of the companion's accessibility to the five categories of information. In this ranking of the companion has the lowest accessibility to physical-exam information (i.e. the absolute P-event) and the highest accessibility to the pedigree and management information (i.e. the possible PC-events).

Chapter 6. The Discourse Structure of Information-Providing Sequence

6.0 Introduction

The third part of my framework examines the companion's participation from the structural aspect. It concerns the structure of the discourse sequence when the patient party provides information to the doctor. The body of this chapter is divided into three parts. In the first two sections, I will introduce my framework. Section 6.1 presents the two key ideas of information-providing cycles: elicited information and volunteered information. In section 6.2, eight discourse patterns of information-providing cycles are identified in terms of who (the patient alone, the companion alone, or both) provides the information and whether they provide the information by volunteering or by responding to the doctor's questions. The relevant coding items, such as information-providing cycles and information-providing patterns, are displayed at the end of each excerpt. In section 6.3, I will present my statistics and the main findings on the patterns of information-providing cycles. The summary for this chapter is in section 6.3.

6.1 Three key ideas in the framework

The three key ideas in my framework are information-providing cycles—the activities in which the patient party provides information to the doctor (§6.1.1). Under this category, there are two main subcategories—elicited information-providing cycles (§6.1.2) and volunteered information-providing cycles (§6.1.4)—depending on the type of discourse mechanisms that initiate the cycle.

6.1.1 Information-providing cycles

I have briefly introduced the idea of 'information-providing cycles' earlier in Chapter 4. In this section, I will give a more precise description. The **'information-providing cycle'** is defined as the discourse sequence in which one unit of information is provided by the patient party. A unit of information retains its continuity even with the doctor's insertion of an acknowledgement or assessment marker. There are two discourse mechanisms that can initiate an information-providing cycle. They start with either the doctor's information-eliciting acts or the patient party's information-volunteering acts. These two mechanisms will be introduced separately in sections 6.1.2

and 6.1.4. These two sections present some details of my definition of the information-providing cycle. Some of them will be presented in rule form for the sake of simplification.

6.1.2 Elicited information-providing cycles and elicited information

The first discourse mechanism which can begin an information-providing cycle is the doctor's information-eliciting act, which in turn receives an information-providing act from the patient party. This information-providing cycle is generally termed 'question-answer pair' in the literature. Information provided with this mechanism is termed **'elicited information'**. The information-providing cycles that contain elicited information are termed **'elicited information-providing cycles'**.

Rule 1. The doctor's information-eliciting acts include two situations:

1a. The doctor directs a yes-no or wh- question which can be interpreted as seeking new information.

1b. The doctor states a piece of information from the patient's medical record which receives a confirmation from the patient party. In the

> situation in which the doctor's statement does not receive further affirmation or negation from the patient party, the doctor's utterance is not considered as an information-eliciting act.

My analysis of whether the doctor's utterance, as described in rule 1b, is an act of eliciting-information relies on the patient party's upcoming response. If the patient party displays a response which confirms or ratifies the information conveyed in the doctor's utterance, then the patient party takes the doctor's utterance as an information-eliciting act. Such a use of the upcoming discourse on the hearer's part to decide the function (e.g. an information-elicitation act) displayed in a previous utterance of the speaker reflects the retrospective analysis employed by some discourse analysts. Kochman (1986), for example, observed that at times, African Americans in daily conversation purposely make statements with double speech acts (e.g. either accusation or insult) and their speech acts are decided only upon how the hearer takes or reacts to them.

In the following, I will use Excerpt 1 to illustrate Rule 1a and 1b. There are three information-eliciting acts observed in the doctor's utterances: lines 1, 5 (wh-question) and 12 (yes-no question). They mark the beginning of three information-providing

cycles, cycle I, II, and III, as indicated in the second column and marked with the bold lines. Each of them receives replies from the patient party. The information provided in the three information-providing cycles is elicited information. The patient's utterances in lines 2 and 4 form one unit of information though they are separated into two turns with the insertion of the doctor's acknowledgement marker, 'm-hng' in line 3.

Excerpt 1--modified.[1] (Mr. Tan 76M; main language: Southern Min)

→I DP	1. Dr. Niung:	**{reading the medical record}** 啊遮寫講…除了高血壓, 汝啊有黑龜喘 *A tsiah siah kong...tu-liau ko-hue-ap, li a u he-ku-tshuan* and here write that besides hypertension you also have asthma
	2. Mr. Tan:	Henn 啊,有黑龜喘足久啊 *Henn-a, u he-ku-tshuan tsiok ku a* yeah, have asthma very long ASP
	3. Dr. Niung:	*Hng* um-hng
	4. Mr. Tan:	自少年啊, 呼, 啊這幾日仔愈來愈嚴重 *Tsu siau-lian a, hoo, a tsit-kui-jit-a lu-lai-lu gian-tiong* since young ASP INT and these days more serious
→II DP	5. Dr. Niung:	這黑龜喘外久啊? *Tse he-ku-tshuan gua ku a?* this asthma how long ASP

[1] Excerpt 1 is based on a real conversation. I have made some modifications in order to illustrate all the ideas introduced in sections 6.1.1 –6.1.4

6. Mr. Tan: 卜三十冬啊
Beh sann-tsap tang a
almost thirty years ASP

IIa DP

7. Dr. Niung: 呼, 三十冬啊
Hoo, sann-tsap tang a
oh thirty year ASP

8. Mr. Tan: *Henn-a*
yeah

IIb DPC

9. Dr. Niung: 按吶足久啊吶
An-ne tsiok ku a ne
this very long ASP PRT

10. Mr. Tan: Henn 啊,足久啊,啊這幾日仔愈來愈嚴重
Henn-a, tsiok ku a, a tsit-kui-jit-a lu-lai-lu giam-tiong,
yeah very long ASP and these days more serious

有當時仔攏喘嘎未睏著
u-tang-si-a long tshuan-kah bue kun-tsit
sometimes all breathing can't sleep

11. Daughter: 連講話嘛無法渡
Lian kong-ue ma bo-hat-too
even talk also can't

→III DP

12. Dr. Niung: 按吶 honn, 啊最近敢擱有 gia?
An-ne-honn, a tsue-kin kam koh u gia?
I see and these day Q again have attack

13. Mr. Tan: 無, 最近無
Bo, tsue-kin bo
no, these days no

IV 0CP

14. Daughter … 有當時仔叨去藥房買藥仔來食
… U-tang-si-a to-khi io-pang be io-a lai-tsiah,
sometimes go to drugstore buy drug eat

Henn, 啊有當時仔有效
Henn, a u-tang-si-a u-hau
yeah, and sometimes work

15. Mr. Tan: Henn 啦,彼是隔壁介紹欸,伊嘛同症頭
Henn la, he si keh-piah kiau-siau e, i ma kang tsing-thau
yeah PRT, that be neighbor recommend, he also same problem

Translation

→I DP	1. Dr. Niung:	**{reading the medical record}** It says here.. that .. you.. besides the high blood pressure, you also have breathing problems,
	2. Mr. Tan:	Yeah, (I) have had asthma for a long time,
	3. Dr. Niung:	Um-hng
	4. Mr. Tan:	Since (I) was young , yeah, and (it) is getting worse these days.
→II DP	5. Dr. Niung:	This asthma, how long have (you) suffered from (it)?
	6. Mr. Tan:	About thirty..years
IIa DP	7. Dr. Niung:	Oh, thirty years?
	8. Mr. Tan:	Yeah
IIb DPC	9. Dr. Niung:	Hng, that's kind of long.
	10. Mr. Tan:	Yeah, very long, and these days, (it) is getting so bad that (I) can not get to sleep.=
	11. Daughter:	=Not even talk
→III DP	12. Dr. Niung:	I see,….did (it) attack again recently?
	13. Mr. Tan:	No, not these days
IV 0CP	14. Daughter:	…And (he) bought some pills from the..umm.. drug store, yeah , and (it) works sometimes.
	15. Mr. Tan:	Yeah, it's from a..um..my neighbor, he had the same problem.

CODING

IP cycles:	3 instances of elicited information-providing cycles, and 1 instance of volunteered information-providing cycle (by the daughter), and 2 embedded cycles.
IP patterns:	4 instances of pattern DP, 1 instance of pattern 0CP, 1 instance of pattern DPC.

6.1.3 Embedded information-providing cycle and supplementary information

As stated in Tsui's study (1989), most question-answer pairs are accompanied with a third part element, such as the doctor's acknowledgement markers '*O, sann-tsap-tang-o*' 'Oh, thirty years' in line 7 of Excerpt 1 and assessment markers '*an-ne-tsiok-ku-a*' 'that's kind of long' in line 9. Most of the time, these markers terminate an information-providing cycle. Yet sometimes they are accompanied by follow-up information provided by the patient party. In that case, either an embedded information-providing cycle or another new information-providing cycle in which the patient party volunteers new information will result. (The latter will be introduced in §6.1.4).

When the third part elements are followed by a piece of 'supplementary information' from the patient party, they mark the beginning of an '**embedded information-providing cycle**.' A piece of information is defined as '**supplementary**

information' when its propositional content is related to that of 'the information provided in the previous adjacent turn of the patient party'. (I will refer the information in quotation as 'the primary information' for now). Usually, the supplementary information adds some new aspects to the primary information. There are two criteria to decide whether follow-up information is supplementary to the primary one.

Rule 2. Two criteria for supplementary information:

2a. The propositional content of the supplementary information can be covered by the doctor's question or is related to the same topic as the primary information.

2b. Usually, there is syntactical or semantic simplification observable in the utterance of the supplementary information.

For example, in Excerpt 1, in response to the doctor's question regarding how long the patient has suffered asthma, the patient replies 'About thirty..years' in line 6. Then, the doctor gives the acknowledgement marker 'Oh, thirty years' in line 7 which is confirmed by the patient's 'yeah' in line 8. The doctor goes on and gives an assessment marker 'Hng, that's kind of long' in line 9, which receives a further response from the patient in line 10

‘Yeah, very long, and these days, (it) is getting so bad that (I) can not get to sleep’. Both of the propositions of lines 8 and 10share the same topic regarding the temporal aspect of the patient’s asthma problem as that of line 6 and can be covered by the doctor’s question in line 5 ‘This asthma, how long have (you) suffered from (it)’. The patient’s utterances of lines 8 and 10 can be seen as supplementary information to the primary one in line 6 ‘About thirty..years.’

At hearing the patient’s complaint in line 10 ‘Yeah, very long, and these days, (it) is getting so bad that (I) can not get to sleep’, the companion adds the information ‘Not even talk’ in line 11. This utterance of the companion is also coded as information supplementary to that in line10 because it meets the syntactical simplification criteria. The more explicit proposition of the companion’s utterance ‘Not even talk’ can be retrieved from that in line 10 ‘The asthma is getting worse so that my father can’t even talk’.

Once I decided that the information in lines 8, 10 and 11 is supplementary information which follows the doctor’s acknowledgement markers of line 7 and the assessment markers of line 9, then lines 7 and 9 are coded as the beginning of two embedded information-providing cycles, i.e. IIa and IIb. The embedded information-

providing cycles are marked by the double thin lines, as shown in Excerpt 1.

My analysis of whether the doctor's third-part element in the question-answer sequence is an act of eliciting-information relies on the patient party's upcoming response. Again, this approach reflects the retrospective analysis that I employed earlier in deciding whether the doctor's action (as described in Rule 1b) is an information-eliciting act or not.

6.1.4 Volunteered information-providing cycles and volunteered information

As mentioned earlier, the second discourse mechanism that starts an information-providing cycle is the patient party's act of volunteering information. Information provided with this mechanism is termed **'volunteered information'** and the information-providing cycles that contain volunteered information will be referred as **'volunteered information-providing cycles'**.

Rule 3. The patient party's act of volunteering information includes two situations:

3a. A follow-up piece of information that does not meet the two criteria of supplementary information is coded as information volunteered by the patient party and it marks the beginning of a new information-providing cycle.

3b. The patient party volunteers new information when there is no information-eliciting acts observed in the doctor's previous turn.

I will use lines 12-15 of Excerpt 1 to illustrate rule 3a. In line 12, the doctor's question '*Tsue-kin kam koh u gia?*' 'Did (the asthma) attack again recently?' starts a new information-providing cycle, cycle III. After the patient replies in line 13 '*Tsue-kin bo*' 'Not these days', the patient's daughter provides a follow-up information in line 14 regarding the patient's management of his asthma problem--the patient bought pills from a drug store, and they worked. However, the proposition conveyed in her utterance is not directly related to the doctor's question in line 12. For example, the doctor does not ask 'What do you do to relieve your asthma attacks?' Therefore, line 14 is coded as information volunteered by the daughter. This utterance marks the beginning of a new information-providing cycle, cycle IV.

Right after the daughter's act of volunteering information, the patient provides

follow-up information in line 15: '*He si keh-piah kiau-siau e, i ma kang tsing-thau*' 'Yeah, it's from a..um..my neighbor, he had the same problem'. Line 15 meets the two criteria for supplementary information (rules 2a and 2b). Its topic is related to that of the daughter's utterance in line 14, and semantic simplification is observed as well. The more complete proposition of line 15 would be 'the pills that I bought from the drug store are recommended by my neighbor who suffers from the same problem.' Thus, it is coded as supplementary information to the primary information volunteered by the daughter in line 14.

Regarding the second rule for volunteered information, there are two typical situations. The patient party volunteers new information while the doctor is occupied with note-taking on the medical record or is conducting a physical examination. Also, there are situations in which the patient party volunteers new information in the negotiation of the doctor's diagnosis or treatment plan.

For example, the conversation in Excerpt 2 shows that the doctor has finished the patient's pedigree and is about to check the patient's blood pressure (line 4). At this point, the patient's daughter volunteers the information that the patient also suffers from

hypertension (line 5). This information by itself forms an information-providing cycle, cycle II, and is coded as ‘volunteered information’. The doctor further directs a question to elicit new information in line 6 ‘*gua ku a?*’ ‘How long is it?’, which receives a reply from the patient. Lines 6-7 are coded as another information-providing cycle of elicited information, namely cycle III.

Excerpt 2. {05’03”} (Mr. Ong 72M; main language: Southern Min)

→I DCP	1. Dr. Tiunn: 等於汝共細漢媳婦啊擱大漢欸攏住做夥叨對啦?= *Ting-yi li kang se-han sim-po,* that is you with the youngest daughter-in-law *a koh tuah-han-e long tuah tso-hue to tio la=* and also the oldest all live together EMP right PRT
	2. Mr. Ong: =[/??/攏.攏住做夥 =[*/??/ Long.. long.. tuah tso-hue* EMP EMP live together
	3. Daughter: =因攏住做夥 =[*In long tuah tso-hue* they EMP live together
	4. Dr. Tiunn: …血壓共汝量一咧 *…Hue-ap ka li niung tsit le* blood pressure for you measure CL PRT
→II 0C	5. Daughter: **{The doctor is about to check the patient’s blood pressure}** hio,伊有高血壓欸彼種hior:: *Hio, i u ko-hue-ap-ei hit tsong hior::* yeah, he has hypertension, that kind that

III DP

6. Dr. Tiunn: 汝啊有高血壓喔?外久啊?
Li a u ko-hue-ap o? gua ku a ?
you also have hypertension Q how long ASP

7. Mr. Ong: 三冬啊喔
Sann tang a o
three year ASP PRT

Translation

→I DCP

1. Dr. Tiunn: In other words, you live with (your) youngest (son and his) wife and (your) eldest (son), is that right?=

2. Mr. Ong: =[/??/(we) all..all..live together

3. Daughter: =[They all live together

4. Dr. Tiunn: Let (me) check your blood pressure

→II 0C

5. Daughter: **{The doctor is about to check the patient's blood pressure}**
Yeah, he also has hypertension, the::

III DP

6. Dr. Tiunn: You also have hypertension? How long has it been?

7. Mr. Ong: About three years.

CODING

IP cycles: 2 instances of elicited information-providing cycles, and 1 instance of volunteered information-providing cycle (by the daughter).
IP patterns: 1 instance of pattern DCP, 1 instance of 0C, 1 instance of DP.

Excerpt 3 is another example of volunteered information. In this dialogue, the doctor recommends that the patient keep a diet (line 1) and that he exercise every day to control his hypertension. In line 2, the patient volunteers the information that he gets exercise every day. Line 2 by itself forms an information-providing cycle of volunteered

information. Based on this information, the doctor initiates another information-providing cycle to elicit the type of exercise that the patient gets.

Excerpt 3. {13'41"}(Mr. Wang 74M; main language: Mandarin)

	1. Dr. Song:	=對,然後要有規律的運動 *=Dui, ran-hou yao you gue-lu-de yun-dong* yeah, then need have regular exercise
→I 0P	2. Mr. Wang:	我每天都有運動= *Wo mei-tian dou you yun-dong=* I everyday all have exercise
II DP	3. Dr. Song:	=喔,做什麼運動呢? **{reading the medical record}** *=Oh, tso she-me yun-dong ne?* oh take what exercise Q
	4. Mr. Wang:	那個走路 *Na-ge tsou-lu* that walk

Translation

	1. Dr. Song:	Yeah, also you need regular exercise
→I 0P	2. Mr. Wang:	I exercise everyday=
II DP	3. Dr. Song:	=oh, what exercise do you get **{read the medical record}**
	4. Mr. Wang:	(I) walk

CODING

IP cycles: 1 instance of volunteered information-providing cycle (by the patient), and 1 elicited information-providing cycle. IP patterns: 1 instance of pattern 0P, 1 instance of DP.

6.2 Eight discourse patterns of the information-providing cycles

In this section, I will introduce the eight discourse patterns of the information-providing cycles. In my following presentation, **'D'** is used for doctor, **'P'** for the elderly patient, **'C'** for companion, and **'info'** for information. My illustration of the eight patterns is based on the various versions of one artificial dialogue. At the end of each pattern box, excerpts quoted from my data will be referred to for more illustration.

6.2.1 Pattern DP vs. pattern DC

In pattern **'DP'**, the patient alone provides information in response to the doctor's act of eliciting information, whereas in pattern **'DC'** the companion alone does.

Pattern DP

Turn	Speaker-act		
1.	D elicits info.	Doctor:	即嘛感覺按怎? *Tsit-ma kam-kak an-tsuann* (now/feel/how) How do (you) feel now?
2.	P provides info.	Patient:	頭殼會暈啦 *Thau-khak e gong la* (head/is/dizzy/PRT) (My) head feels dizzy.

(More examples of pattern DP: cycles I, II, IIa, III in Excerpt 1)

Pattern DC

Turn	Speaker-act		
1.	D elicits info.	Doctor:	*Tsit-ma kam-kak an-tsuann* (now/feel/how) How do (you) feel now?
2.	C provides info.	Companion:	*Thau-khak e gong la* (head/is/dizzy/PRT) (His) head feels dizzy.

(More examples of pattern DC: cycles II in Excerpt 4)

Excerpt 4. {01'27"}(Mrs. Zhu 74F; main language: Mandarin)

I DCP

1. Dr. Tiunn: =那時候有發燒是:: 大概二個禮拜以前就對了
Na shi-hou you fa-shao si:: da-gai liang-ge li-bai yi-qian
that time have fever be about two week before

jiou dui le?
EMP right ASP

2. Mrs. Zhu: [欸, 二個禮拜前
[*Ei, liang-ge li-bai qian*
yeah two week before

Daughter: [欸,對
[*Ei, dui*
yeah right

→II DC

3. Dr. Tiunn: 燒到幾度知道嗎?
Shao-dao ji du zhi-dao ma?
fever how much degree know Q

4. Daughter: 三十八,
San-shi-ba,
thirty eight

IIa DCP

5. Dr. Tiunn: 三十八?
San-shi-ba?

thirty eight

6. Daughter: 對,然後後來下來就三七, 嗯就是..那兩天:::
Dui, ran-hou hou-lai xia-lai jiou san-qi,
right then later decrease EMP thirty seven

en jiou shi .. na liang tian:::
em EMP be that two day

7. Mrs. Zhu: **{turns to her daughter}**
兩天,第三天就沒有了
Liang tian, di-san tian jiou mei-you le=
two day third day EMP no ASP

8. Daughter: =沒有了
=Mei-you le
no ASP

Translation

I DCP
1. Dr. Tiunn: At the time when (you) had the fever, (it) was:: about two weeks ago, right?=

2. Mrs. Zhu: =[Yeah, two weeks ago.

Daughter: [Yeah, right.

→II DC
3. Dr. Tiunn: Do (you) know how high the fever was?

4. Daughter: Thirty eight.

IIa DCP
5. Dr. Tiunn: Thirty eight?

6. Daughter: Right, then, later (it) decreased to thirty seven. um.. yeah, (it) was about two days..

7. Mrs. Zhu: **{turns to her daughter}**
Two days.. On the third day, (the fever was) gone..=

8. Daughter: =(It was) gone.

CODING

IP cycles: 3 instances of elicited information-providing cycles.
IP patterns: 1 instance of pattern DC, 2 instance of DCP.

The above patterns deal with the cases when only one member of the patient party responds to the doctor's question. The following two patterns deal with the cases where both the patient and the companion respond.

6.2.2 Pattern DPC vs. pattern DCP

When both the patient and the companion respond to the doctor's question, my interest is to see whether the patient provides a piece of complete information to the doctor's question before the companion provides any information within the same information-providing cycle. In the situation where the patient visits the doctor alone, naturally there is no doubt that the patient will be the sole agent to take the answer turns and to provide first-hand and complete information. However, with the presence of a companion who also takes the answer turns, it is important to see if the patient's priority in providing the first-hand and complete information is well-maintained.

'Complete information' is defined with either propositional/syntactical or phonological criteria. In the following example, the patient's utterance is judged as a piece of propositional and phonologically complete information.

1. Doctor: *Tsit-ma kam-kak an-tsuann* (now/feel/how)
   How do (you) feel now?

→ 2. Patient: *Thau-khak e gong la* (head/is/dizzy/PRT)
   (My) head feels dizzy.

3. Companion: *A na-au ma e thiann* (and/throat/also/is/hurt)
   And (his) throat also hurts.

In the following two examples, neither of the patient's utterances is complete. The first one does not meet the propositional/syntactical criteria.

1. Doctor: *Tsit-ma kam-kak an-tsuann* (now/feel/how)
   How do (you) feel now?

→ 2. Patient: *Thau-khak e gong la, a na-au=* (head/is/dizzy/PRT/and/throat)
   (My) head feels dizzy, and the throat.=

3. Companion: *=A na-au ma e thiann* (and/throat/also/is/hurt)
   =And (his) throat also hurts.

The next one does not meet the phonological criteria. The '*gong:::'* 'dizzy:::', with a lengthened vowel and a rising intonation, in the patient's utterance indicates that he or she has not finished giving all the information yet.

1. Doctor: *Tsit-ma kam-kak an-tsuann* (now/feel/how)
   How do (you) feel now?

→ 2. Patient: *Thau-khak e gong::=* (head/is/dizzy)
   (My) head feels di::zzy

3. Companion: *=A na-au ma e thiann* (and/throat/also/is/hurt)
   =And (his) throat also hurts.

In my analysis, the cases where the patient provides a piece of complete information before the companion provides any information within the same information-providing cycle is coded as pattern **'DPC'**, as shown in the following.

Pattern DPC

Turn	Speaker-act		
1.	D elicits info.	Doctor:	即嘛感覺按怎? *Tsit-ma kam-kak an-tsuann* (now/feel/how) How do (you) feel now?
2.	P provides info.	Patient:	頭殼會暈啦 *Thau-khak e gong la* (head/is/dizzy/PRT) (My) head feels dizzy.
3.	C provides supplementary info.	Companion:	啊喉嚨嘛會痛 *A na-au ma e thiann* (and/throat/also/is/hurt) And (his) throat also hurts.

(More examples of pattern DPC: cycle IIb in Excerpt 1)

The cases in which the patient does not provide a piece of complete information or does not provide information before the companion does is coded as pattern '**DCP**'. Three kinds of situations are included in this pattern. First, the companion answers before the patient does, as shown in example (1). Second, the companion answers simultaneously with the patient, i.e. example (2). Third, the companion answers before the patient provides a piece of complete information, i.e. (3).

Pattern DCP (1)

Turn	Speaker-act		
1.	D elicits info.	Doctor:	*Tsit-ma kam-kak an-tsuann* (now/feel/how) How do (you) feel now?
2.	C provides info.	Companion:	*Thau-khak e gong la* (head/is/dizzy/PRT) (His) head feels dizzy.
3.	P provides supplementary info.	Patient:	*A na-au ma e thiann* (and/throat/also/is/hurt) And (my) throat also hurts.

(More examples of pattern DCP: cycle IIb in Excerpt 1; cycle IIa in Excerpt 4).

Pattern DCP (2)

Turn	Speaker-act		
1.	D elicits info.	Doctor:	*Tsit-ma kam-kak an-tsuann* (now/feel/how) How do (you) feel now?

2.	P provides info.	Patient:	[*Thau-khak e gong la* (head/is/dizzy/PRT) [(My) head feels dizzy.
2.	C provides info.	Companion:	[*Na-au e thiann* (throat/is/hurt) [(His) throat hurts.

(More examples for DCP: cycle I in Excerpt 2; cycle I in Excerpt 4)

Pattern DCP (3)

Turn	Speaker-act		
1.	D elicits info.	Doctor:	*Tsit-ma kam-kak an-tsuann* (now/feel/how) How do (you) feel now?
2.	P provides info.	Patient:	*Thau-khak* [*e gong la* (head/is/dizzy/PRT) (My) head [feels dizzy.
3.	C provides info.	Companion:	[*Na-au e thiann* (throat/is/hurt) [(His) throat hurts.

(More examples for DCP: cycle I in Excerpt 5)

Excerpt 5. {00’28”}(Mrs. Zhu 74F; main language: Mandarin)

DCP

1. Dr. Tiunn: ..她那個:啊:現在今天是::什麼問題?
..*Ta na-ge: a: xian-zhai jin-tian shi:: she-me wun-ti?*
..She that PRT now today be what problem

2. Mrs. Zhu: 我只是這一天.幾天.
Wo zhi-shi zhe yi-tian. ji-tian.
I just this one day these days

[一直咳嗽
[*yi-zhi ke-shou*
always cough

3. Daughter: [這一個禮拜都有咳嗽, 那在這一個禮拜前.
[*Zhe yi-ge li-bai dou you ke-shou, na zhai zhe yi-ge li-bai qian*
this one week all have cough also at this one week ago

有看那個不知道是感冒還是.honn,
you kan na-ge bu zhi-dao shi gan-mao hai si. honn,
have examine that NEG know be catch-cold or be PRT

Translation

DCP
1. Dr. Tiunn: ..She that: umm: what's the problem for today?

2. Mrs. Zhu: These days, I just [always cough

3. Daughter: [(She) has been coughing this week, and before this week, (She) has been examined by a, I forgot whether it's catching cold or, yeah.

CODING

IP cycles: 1 instances of elicited information-providing cycles.
IP patterns: 1 instance of pattern DCP.

6.2.3 Pattern 0P vs. pattern 0C

This section deals with situations in which the patient party volunteers information. That is, no information-eliciting acts from the doctor are observed; this pattern is symbolized by the number zero. In pattern **'0P'**, the patient alone initiates the act of volunteering information while in pattern **'0C'**, the companion does.

Pattern 0P

Turn	Speaker-act		
1.	P provides info.	Patient:	**{The doctor is writing the medical record}** *A thau-khak e gong la* (PRT/head/is/dizzy/PRT) Also, (my) heads feel dizzy.

(More examples of 0P: cycle I in Excerpt 3).

Pattern 0C

Turn	Speaker-act		
1.	C provides info.	Companion:	**{The doctor is writing the medical record}** *A thau-khak e gong la* (PRT/head/is/dizzy/PRT) Also, (his) heads feel dizzy.

(More examples of pattern 0C: cycle II in Excerpt 2)

6.2.4 Pattern 0PC vs. pattern 0CP

Pattern **‘0PC’** refers to the situations in which the information volunteered by the patient is supplemented by information provided by the companion. Pattern **‘0CP’** refers to situations in which the information volunteered by the companion is further supplemented by the information provided by the patient.

Pattern 0PC

Turn	Speaker-act		
1.	P provides info.	Patient:	**{The doctor is writing the medical record}** *A thau-khak e gong la* (PRT/head/is/dizzy/PRT) Also, (my) heads feel dizzy.
2.	C provides info.	Companion:	*A na-au ma e thiann* (and/throat/also/is/hurt) And (his) throat also hurts.

(More examples of pattern 0PC: cycle I in Excerpt 6)

Pattern 0CP

Turn	Speaker-act		
1.	C provides info.	Companion:	**{The doctor is writing the medical record}** *A thau-khak e gong la* (PRT/head/is/dizzy/PRT) Also, (his) heads feel dizzy.
2.	P provides info.	Patient:	*A na-au ma e thiann* (and/throat/also/is/hurt) And (my) throat also hurts.

(More examples of pattern 0C: cycle IV in Excerpt 1)

In Excerpt 6, before the doctor conducts the physical examination, he gives a preview of the treatment plan— he will have the patient undergo another examination, if necessary, as a supplement to the previous examination the patient has taken in another hospital. At this point, the patient volunteers the information that her kidney was not

checked in the previous exam. The son adds further information that the liver was not checked either.

Excerpt 6. {07’25”} (Mrs. Su 83F; main language: Southern Min)

	1. Dr.Lau:	啊毋過咱即嘛會應欸共汝進一步擱共汝看麥啊,什麼部份無做著欸,honn::,無夠詳細的,啊是有什麼問題 *..A m-koh lam tsit-ma e-ing-e ka li tsin-tsit-po* PRT but we now can for you further *koh ka li khann-mai a, siann-mih po-hun bo tso-tioh e* again for you examine ASP which part not examined PRT *honn::, bo-kau siong-se-e, a-si u siann-mih bun-te* PRT not enough thorough or have what problem [好好啊共汝處理 [*ho-ho-a ka li chu-li* thorough for you manage
→0PC	2. Mrs. Su:	[hio 啦,腰子.腰子無做著啦, [*Hio la, io-tsi. io-tsi bo tso-tioh la* right PRT kidney kidney not examined PRT
	3. Son:	腰子共肝啦 *Io-tsi kah kuann la,* kidney and liver PRT

Translation

	1. Dr.Lau:	..But now we can arrange a further examination for you, (have) a further examination for you, to see if anything was missed (in the previous exam), OK::, (anything) not thoroughly examined or any (related) problem, [(We) will take care of you thoroughly.
→0PC	2. Mrs. Su:	[Yeah, the kidney. the kidney was not examined (last time).

3. Son: The kidney and the liver.

CODING

IP cycles: 1 instances of volunteered information-providing cycle (by the patient).
IP patterns: 1 instance of pattern 0PC.

In cases in which the patient and the companion jointly volunteer information, I made no further distinction between complete and incomplete information volunteered by the patient.

6.2.5 Patterns D0

In the above sections, I introduced the eight patterns of information-providing cycles which cover about 99.9% of the information-providing cycles observed in the fifteen encounters. In this section, I will present the ninth pattern **'D0'** in which the doctor's information-eliciting acts do not receive responses from the patient party. This pattern has the very low occurrence of 3 instances and is thus not included in the final calculation. I introduce this pattern since it does exist and will present my coding criteria for pattern D0 in the following section.

Rule 4. Criteria for pattern ‘D0’:

> After the doctor poses a yes-no or wh- question, silence is observed, and before the doctor moves on to a new utterance which is not a paraphrase or repetition of his or her first question, no verbal response or body language (such as nodding or shaking of the head) is provided by the patient party.

For example, prior to line 1 in Excerpt 7, the doctor has gathered most of the information and is conducting the physical examination for Mr. Khoh. In line 1, while examining the patient’s eyes, the doctor asks whether Mr. Khoh has recently lost some weight (line 2). Neither Mr. Khoh nor his son displays any verbal or body language (such as nodding or shaking of the head) in response to the doctor’s question as is indicated by the three-second silence. The doctor does not pursue this issue further. Instead, he continues the examination on the patient’s eyes (line 4).

Excerpt 7. {07’32”} (Mr. Khoh 74M; main language: Southern Min)

1. Dr. Niung: **{finishing the task of checking the patient’s blood pressure}**
   來,我共汝巡一咧,
   Lai, gua ka li sun-tsit-leh
   come I for you take a look

→D0	2. Dr. Niung:	**{checking the patient's eyes }** 最近人有卡瘦無? *Tsue-kin lang u kha san bo?* recently body have more thin Q
	3.	**{pauses for 3 seconds}** **{The son then looks at the patient}**
	4 Dr. Niung:	頂高…看下腳, *Ding-kuan … khuann e-kha* top look down

Translation

	1. Dr. Niung:	**{finishing the task of checking the patient's blood pressure}** OK, let me take a look.
→D0	2. Dr. Niung:	**{checking the patient's eyes }** Have (you) recently lost weight?
	3.	**{pauses for 3 seconds}** **{The son then looks at the patient}**
	4 Dr. Niung:	Look up, … look down.

CODING

IP cycles: 1 instance of elicited information-providing cycle IP patterns: 1 instance of pattern D0

However, when the doctor or the companion pursues the question and does receive a reply from the patient later on, it is not considered a pattern of D0. Take Mr. Sim's encounter for example. Prior to line 1 in Excerpt 8, the doctor asks Mr. Sim how long it takes for his heart pain to go away, and Mr. Sim replies that he does not know how to

describe the pain. The doctor then gives the measurement words (such as minutes or hours) (line 1). Mr. Sim remains silent for another four seconds (lines 2 and 6). His son-in-law then rephrases the doctor's questions twice in lines 3 and 5. Finally in line 6, Mr. Sim provides the specific information that sometimes his heart pain lasts about half an hour. This instance is considered as a DP pattern rather than a D0 pattern.

Excerpt 8. {01'28"}(Mr. Sim 65M; main language: Southern Min)

DP	1. Dr. Kang:	=差不多叨好,幾秒鐘叨過,猶是幾分鐘,啊是君那點鐘? *Tsha-put-to to ho, kui bio-tsing to gue?* about will fine how many second will pass *a-si kui hun-tsing? a-si kun-na tiam-tsing?* or how many minutes or how many hours
→	2. Mr. Sim:	**{pause for 4 seconds}**
	3. Son-in-law:	/??/是看寡久啊? /??/ *Si kuann gua ku a?* be see how much long PRT [/????/看寡久? [/????/ *Khuann gua ku?* see how much long
	4. Dr. Kang:	[henn,按吶,幾秒鐘猶是君那點鐘,差足濟啊,henn [*Henn an-nei, kui bio-tsing a-si kun-na tiam-tsing,* yeah this how many seconds or how many hour *tsha tsiok-tse a, henn* differ a lot PRT yeah

	5. Son-in-law:	看汝咧 tsat 欲時陣差不多寡久啊?…大約啦 *Khuann li leh tsat e-si-tsun tsa-put-to gua-ku a? ..* see you ASP tight when about how long ASP *…tai-iok la* roughly PRT
→	6. Mr. Sim:	..啊有當時叨:攏.攏彼.差不多半點鐘啦,/??/= *..A u-tang-si to: long..long he.. tsha-put-to puann-tiam-tsing la* PRT sometimes EMP EMP that about half hour PRT

Translation

DP	1. Dr. Kang:	=Just give a general idea. Did (it last) for few seconds or few minutes, or few hours?
→	2. Mr. Sim:	**{pause for 4 seconds}**
	3. Son-in-law:	/??/ See how long did it (last)? [/????/ See how long did it (last)?
	4. Dr. Kang:	[Yeah, (when you felt tight) like this, how many seconds or how many hours (did it last)? (It's) a big difference (between second and hour), yeah.
	5. Son-in-law:	See when you felt tight, about how long did it (last)? … roughly
→	6. Mr. Sim:	..umm sometimes:: it's.. it's.. like half an hour.

CODING

IP cycles: 1 instance of elicited information-providing cycle IP patterns: 1 instance of pattern DP

6.2.6 Summary for the eight information-providing patterns

In the above sections, I introduced the eight main information-providing patterns that I set up in the third part of my framework. These eight patterns are different from

each other in terms of four variables: 1) the discourse mechanisms that start an information-providing cycles, 2) the number of information-providers, 3) the temporal sequence of who provides the information first, and 4) the patient's priority of providing complete information. In the case of joint providers, the volunteered information-providing cycles distinguish whether it is the patient or the companion who starts the information-volunteering acts (i.e. 0PC vs, 0CP). In the case of elicited information-providing cycles, it further distinguishes whether the patient provides complete information in answering the doctor's question prior to the companion's intervention. (i.e. DPC vs. DCP). The following table is a summary of the eight patterns of information-providing cycles.

Table 6-1. Eight patterns of information-providing cycles.

Discourse mechanisms	Volunteered information-providing cycles initiated by				Elicited information-providing cycles answered by			
Number of info. providers	sole provider		joint providers		sole provider		joint providers	
Temporal sequence	0P	0C	0PC	0CP	DP	DC	DPC	DCP
Complete reply by P							DPC	DCP

6.3 The process for statistics and results

In the following section, I will present the statistical evaluation of the above coding data as well as significant findings regarding the distribution of the eight patterns of information-providing cycles (§6.3.1-§6.3.4). There are a total of 1098 information-providing cycles identified in the fifteen cases. The raw numbers of their occurrences are displayed in Table 6-2.

In Table 6-2, the percentage numbers of all the eight patterns in each encounter are provided with the column ‘total’ as the reference of 100.0%. For example, there are a total of 67 information-providing cycles (i.e. 100%) identified in Mrs.Yiu’s case. 46 of them (68.7%) occur in pattern DP (i.e. the patient alone answers the doctor’s questions), while only 5 of them (7.5%) occur in pattern DC (i.e. the companion alone answers the doctor’s question). These percentage numbers will be the base of my follow-up analysis in section 6.3.2.

Table 6-2. Distribution of the eight patterns of information-providing cycles (raw numbers).

	Volunteered information-providing cycles initiated by				Elicited information-providing cycles answered by				
	sole provider		joint providers		sole provider		joint providers		
	0P	0C	0PC	0CP	DP	DC	DPC	DCP	Total
Mrs. Zhu	0	12	0	2	9	11	2	26	62
Mrs. Yiu	1	4	1	1	46	5	4	5	67
Mr. Ong	12	11	2	1	19	6	0	7	58
Mrs. Pan	16	1	0	1	52	1	1	0	72
Mrs. Iunn	26	5	1	5	36	26	8	15	122
Mrs. Gonn	11	3	0	3	50	10	3	8	88
Mrs. Lim	9	4	0	1	27	12	2	6	61
Mrs. Su	3	8	4	3	35	14	6	14	87
Mr. Sim	5	1	0	1	60	1	4	15	87
Mrs. Tenn	9	3	3	2	31	11	6	6	71
Mrs. Khu	21	2	2	5	43	2	3	9	87
Mr. Tian	2	2	0	1	20	13	2	6	46
Mr. Wang	16	0	1	0	43	8	2	6	76
Mr. Tan	10	3	1	2	19	11	5	15	66
Mr. Khoh	4	4	0	1	12	19	1	7	48
Total-1	145	63	15	29	502	150	49	145	1098
Total-2	252				846				1098

Table 6-3 displays the distribution of each of the eight information-providing patterns in the fifteen encounters. In the following section, I will make further comparisons in various ways. Section 6.3.1 presents the contrast between elicited and volunteered information-providing cycles and section 6.3.2, between sole provider and joint providers. Section 6.3.3 has a specific focus on the DP pattern. In sections 6.3.4 and 6.3.5, I will compare the level of discrepancy between the patient's and companion's performance in three paired information-providing patterns with that of the patient

party's amount of participation. Section 6.3.6 focuses on the comparison between pattern DPC and pattern DCP.

Table 6-3. Distribution of the eight patterns of information-providing cycles (percentage number).

	Volunteered information-providing cycles initiated by				Elicited information-providing cycles answered by					Number of information-provider	
	sole provider		joint providers		sole provide		joint providers			Sole	Joint
	0P	0C	0PC	0CP	DP	DC	DPC	DCP	Total		
Mrs. Zhu	0.0%	19.4%	0.0%	3.2%	14.5%	17.7%	3.2%	41.9%	100.0%	51.6%	48.4%
Mrs. Yiu	1.5%	6.0%	1.5%	1.5%	68.7%	7.5%	6.0%	7.5%	100.0%	83.6%	16.4%
Mr. Ong	20.7%	19.0%	3.4%	1.7%	32.8%	10.3%	0.0%	12.1%	100.0%	82.8%	17.2%
Mrs. Pan	22.2%	1.4%	0.0%	1.4%	72.2%	1.4%	1.4%	0.0%	100.0%	97.2%	2.8%
Mrs. Iunn	21.3%	4.1%	0.8%	4.1%	29.5%	21.3%	6.6%	12.3%	100.0%	76.2%	23.8%
Mrs. Gonn	12.5%	3.4%	0.0%	3.4%	56.8%	11.4%	3.4%	9.1%	100.0%	84.1%	15.9%
Mrs. Lim	14.8%	6.6%	0.0%	1.6%	44.3%	19.7%	3.3%	9.8%	100.0%	85.2%	14.8%
Mrs. Su	3.4%	9.2%	4.6%	3.4%	40.2%	16.1%	6.9%	16.1%	100.0%	69.0%	31.0%
Mr. Sim	5.7%	1.1%	0.0%	1.1%	69.0%	1.1%	4.6%	17.2%	100.0%	77.0%	23.0%
Mrs. Tenn	12.7%	4.2%	4.2%	2.8%	43.7%	15.5%	8.5%	8.5%	100.0%	76.1%	23.9%
Mrs. Khu	24.1%	2.3%	2.3%	5.7%	49.4%	2.3%	3.4%	10.3%	100.0%	78.2%	21.8%
Mr. Tian	4.3%	4.3%	0.0%	2.2%	43.5%	28.3%	4.3%	13.0%	100.0%	80.4%	19.6%
Mr. Wang	21.1%	0.0%	1.3%	0.0%	56.6%	10.5%	2.6%	7.9%	100.0%	88.2%	11.8%
Mr. Tan	15.2%	4.5%	1.5%	3.0%	28.8%	16.7%	7.6%	22.7%	100.0%	65.2%	34.8%
Mr. Khoh	8.3%	8.3%	0.0%	2.1%	25.0%	39.6%	2.1%	14.6%	100.0%	81.3%	18.8%
Mean	12.5%	6.3%	1.3%	2.5%	45.0%	14.6%	4.3%	13.5%	100.0%		
Mean total	22.6%				77.4%				100.0%		

6.3.1 Elicited vs. volunteered information-providing cycles

Out of the 1098 information-providing cycles, 252 of them (22.6%) are volunteered information-providing cycles in which the patient party volunteers information. The elicited information-providing cycles, a total of 846 instances, occur 77.4% of the time. The total numbers of volunteered information-providing cycles (i.e. columns 0P, 0PC, 0C, and 0CP) and that of the elicited information-providing cycles (i.e. DP, DC, DPC, and DCP) of the fifteen encounters are examined by the paired samples T test. The result (Table 6-4) shows that the occurrence of elicited information-providing cycles is significantly higher than that of the volunteered information-providing cycles ($P<0.01$). This finding reflects the doctor's role as the agenda-controller as found in the literature of doctor-patient communication (e.g. West 1983, Mishler 1984, Have 1991).

Table 6-4. Paired samples T test: the volunteered vs. elicited information-providing cycles.

	Number of cases	Paired differences (mean)	Sig. (2-tailed)
Volunteered vs. Elicited IP cycles	15	-54.8600	.000**

In conversational interaction, the speaker who initiates questions not only controls the topic (or the information to be elicited) but also designates who is to serve as the information-provider. In that sense, the question-initiator dominates the agenda of the conversation. The doctor, as the institutional agent equipped with the medical expertise, has the power to control what information is elicited from the lay consultant, the patient, to fulfill the task of solving the patient's health problem. The prevalent occurrence of elicited information-providing cycles over volunteered information-providing cycles reflects the doctor's role as the agenda controller.

6.3.2 Sole provider vs. joint providers

Unlike the dyadic doctor-patient interaction in which the patient is the sole agent who provides information to the doctor, there are two information-providers in the doctor-patient-companion triads. In this section, I attempted to discover if any preferences exist between the sole provider (i.e. the patient or the companion alone provides information) and joint providers (i.e. the patient and the companion together provide information). The information-providing patterns which involve a sole provider

are patterns 0P, 0C, DP, and DC (i.e. the patient or the companion alone volunteers information or replies to the doctor's question). The information-providing patterns which involve joint providers are patterns 0PC, 0CP, DPC, and DCP. In these four information-providing patterns, the information offered by the first provider (e.g. the patient) is further supplemented by a follow-up information offered by the second provider (e.g. the companion). The total distribution of sole and joint providers in each case is presented in the last two columns of Table 6-3. These paired data are tested for their degree of difference.

Table 6-5. Paired samples T test: sole provider vs. joint providers.

	Number of cases	Paired differences (mean)	Sig. (2-tailed)
Sole vs. joint information providers	15	56.8200	.000**

The result in Table 6-5 indicates a preference for the sole provider and that this preference is significantly higher than that for joint providers ($P<0.01$). That is to say, in all the fifteen triadic encounters, it is mainly one member of the patient party, i.e. the

patient or the companion alone, who provides information to the doctor. Within this prevalent preference for sole provider in triadic encounter, Mrs. Zhu's case appears to be a marked case. In this case, the instance of jointly provided information-providing cycles is not only the highest among the fifteen cases (48.4 %) but is also almost equal to the instance of singly provided information-providing cycles (51.6%). (A further discussion of Mrs. Zhu's encounter will be presented in Chapter 11).

6.3.3 Patient alone answers the questions

The second-to-last row of Table 6-3 shows that the pattern DP (i.e. the patient alone answers the doctor's question) receives the highest percentage of occurrence (45.0%). There are three patterns that receive a similarly high level of occurrence. They are patterns DC (i.e. the companion alone answers the doctor's question, 14.6%), pattern DCP (i.e. the companion responds to the doctor's question before the patient has provided a complete reply, 13.5%), and pattern 0P (i.e. the patient alone volunteers information to the doctor, 12.5%). Compared to the percentages of the three patterns, that of pattern DP, i.e. 45.0%, is three times higher. The fact that the patient alone

provides 45.0% of the information in response to the doctor's questions resonates with the previous finding in Chapter 4 that most of the fifteen patients remain the primary source of the information that the doctor needs.

6.3.4 Discrepancies of three paired patterns

In the next step of my analysis, I calculate the discrepancy among three pairs of patterns between the patients and the companions. The three pairs of patterns are

1) 0P/0PC vs. 0C/0CP: the patient vs. the companion initiates the volunteered information-providing cycles.
2) DP vs. DC: the patient vs. the companion alone responds to the doctor's questions.
3) DPC vs. DCP: when the patient and the companion both respond to the doctor's questions, the instances in which the patient does vs. does not provide a complete reply before the companion provides one.

My calculation of the discrepancy within each pair is based on the percentage numbers in Table 6-3. For example, in the case of Mrs. Yiu, the discrepancy between pattern DP (68.7%) and pattern DC (7.5%) is '61.2%', as shown in Table 6-6. The discrepancy of this paired pattern in Mr. Ong's case is 22.5% (32.8%-10.3%). The two

positive discrepancy numbers of 61.2% (Mrs. Yiu's case) and 22.5% (Mr. Ong's case) indicate two things. First, compared to their companions, both Mrs. Yiu and Mr. Ong have a higher instance of answering their doctor's questions alone. Second, compared to Mr. Ong, Mrs. Yiu has a higher instance of answering her doctor's questions alone.

Table 6-6. Discrepancies between the patient and the companion in three pairs of information-providing patterns.

	P vs. C initiates the volunteered IP cycles	P vs. C alone answers the doctor's questions	P does vs. doesn't provide a complete reply prior to C's intervention	P's vs.C's amount of participation in IP cycles[2]
	0P/0PC vs. 0C/0CP	DP vs. DC	DPC vs. DCP	
Mrs. Zhu	-22.6%	-3.2%	-38.7%	-23.4%
Mrs. Yiu	-4.5%	61.2%	-1.5%	27.7%
Mr. Ong	3.4%	22.5%	-12.1%	15.6%
Mrs. Pan	19.4%	70.8%	1.4%	75.9%
Mrs. Iunn	13.9%	8.2%	-5.7%	35.4%
Mrs. Gonn	5.7%	45.5%	-5.7%	32.1%
Mrs. Lim	6.6%	24.6%	-6.6%	16.3%
Mrs. Su	-4.6%	24.1%	-9.2%	-6.7%
Mr. Sim	3.4%	67.8%	-12.6%	53.4%
Mrs. Tenn	9.9%	28.2%	0.0%	21.0%
Mrs. Khu	18.4%	47.1%	-6.9%	69.7%
Mr. Tian	-2.2%	15.2%	-8.7%	-9.6%
Mr. Wang	22.4%	46.1%	-5.3%	70.4%
Mr. Tan	9.1%	12.1%	-15.2%	19.2%
Mr. Khoh	-2.1%	-14.6%	-12.5%	9.8%

The purpose of pairing the three discrepancies is to examine their correlation with the discrepancy between the patient's and the companion's amount of participation in the information-providing cycles. This discrepancy is mentioned earlier in Chapter 4 and is displayed here in the last column of Table 6-6. For example, does the patient who participates in the information-providing cycles more than his or her companion also answer the doctor's question alone more frequently? The correlation test is processed by the 'bivariate correlations' of SPSS. Table 6-7 presents the numeric result, and Figures 6-1, 6-2, and 6-3 display the scatterplots.

Table 6-7. Correlation between the amount of participation and information-providing patterns.

		P vs. C initiates the volunteered IP cycles	P vs. C alone answers doctor's questions	P does vs. doesn't provide a complete reply prior to C's intervention
		0P/0PC vs. 0C/0CP	DP vs. DC	DPC vs. DCP
P's vs.C's amount of participation in IP cycles*	Pearson Correlation Sig. (2-tailed) Number of cases	.848** .000 15	.731** .002 15	.574* .025 15

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

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[2] From Table 4-2 in Chapter 4.

Figure 6-1. Correlation between P's vs. C's amount of participation and patterns 0P/0PC vs. 0C/0CP (Pearson correlation = .848, P<0.01)

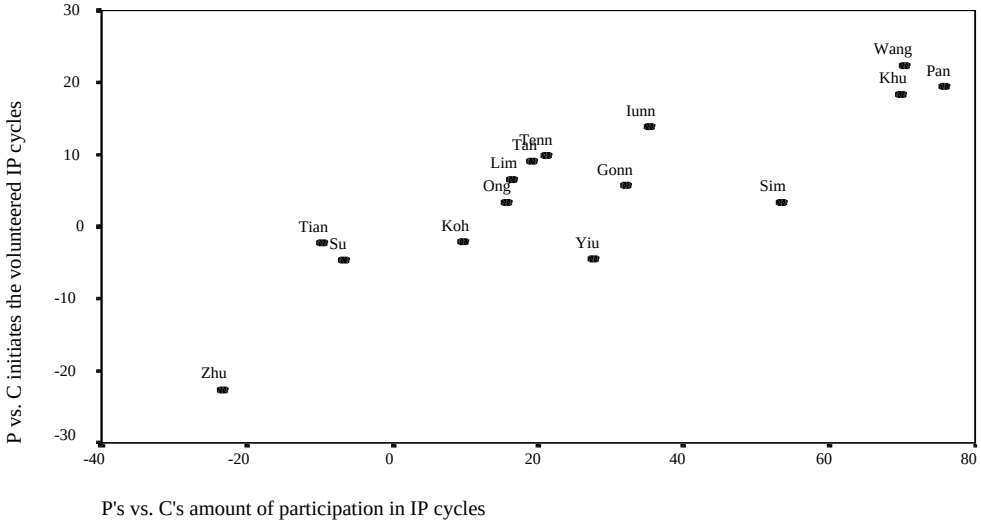

Figure 6-2. Correlation between P's vs. C's amount of participation and patterns DP vs. DC (Pearson correlation = .731, P<0.01)

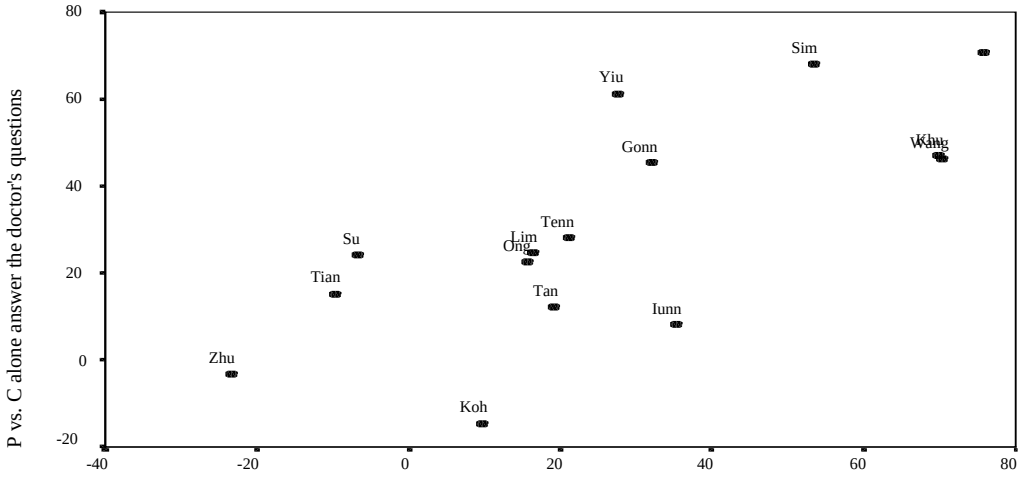

Figure 6-3. Correlation between P's vs. C's amount of participation and patterns: DPC vs. DCP (Pearson correlation = .574, P<0.05)

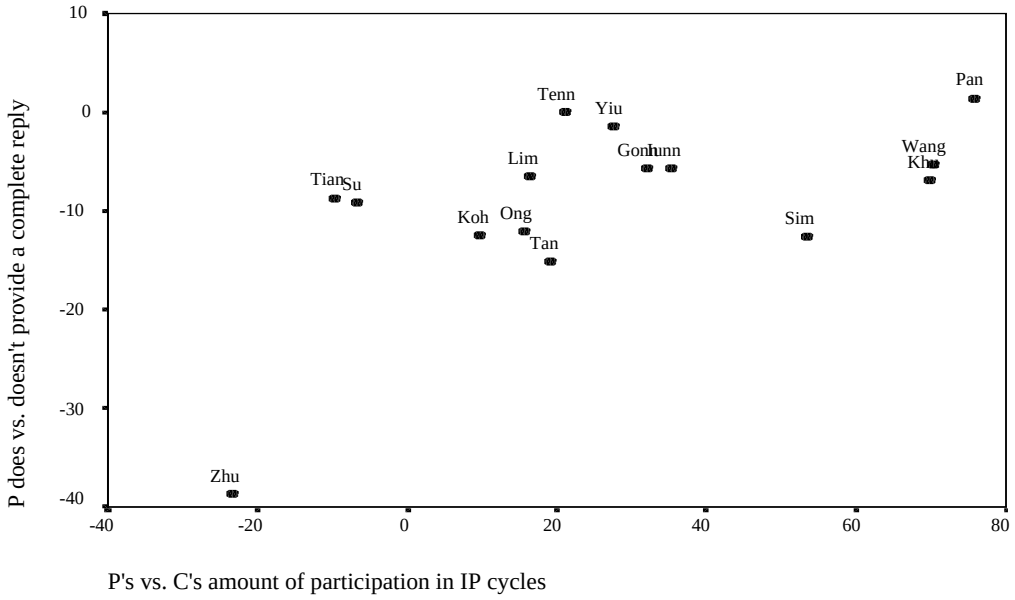

Table 6-7 shows that the positive correlation between the discrepancy of the patient party's amount of participation in the information-providing cycles and the discrepancies of the three paired information-providing patterns are statistically significant (P<0.05). The significant correlation indicates the following tendency with respect to the effect of the companion's participation on the patient's information-providing acts. The more the companion participates in the information-providing cycles, the greater the tendency that the companion will score higher in volunteering

information, answering the doctor's question alone, or answering the doctor's question before the patient has a chance to do so. In other words, the patients will score lower in volunteering information, answering doctor's questions by themselves, and providing a complete reply to the doctor's question prior to their companion's intervention. Mrs. Zhu's and Mrs. Pan's cases serve as two extreme examples of this tendency.

Table 6-8. The distribution of the eight patterns of information-providing cycles in Mrs. Zhu's and Mrs. Pan's encounters.

	Volunteered IP cycles initiated by the P or C		Elicited IP cycles answered by the P or C alone		Elicited IP cycles answered by the P and C together		
	0P/0PC	0C/0CP	DP	DC	DPC	DCP	Total
Mrs. Zhu	0.0%	22.6%	14.5%	17.7%	3.2%	41.9%	100.0%
Mrs. Pan	22.2%	2.8%	72.2%	1.4%	1.4%	0.0%	100.0%

The discrepancies between Mrs. Zhu's and her daughter's amount of participation in the information-providing cycles scores the greatest negative number (–23.4% in Table 6-6), meaning that her daughter makes the highest contribution when compared to the discrepancies of the other fourteen cases. Consistent with the above tendency, Mrs. Zhu scores a 0.0% in volunteering information (Table 6-8) while her daughter scores 22.6%. Mrs. Zhu also scores a lower percentage (14.5%) in answering the doctor's

questions by herself, compared to her daughter's 17.7%. When Mrs. Zhu and her daughter collaboratively answer the questions, there is a very low percentage of cases (3.2%) in which Mrs. Zhu provides a complete reply prior to her daughter's intervention. In most cases (41.9%), Mrs. Zhu does not provide a complete reply prior to her daughter's participation.

In contrast to Mrs. Zhu's case, every paired discrepancy between Mrs. Pan and her daughter scores the top positive number. While Mrs. Pan 22.2% of the provided information (Table 6-8), that volunteered by her daughter is only 2.8%. The instances in which Mrs. Pan alone answers the doctor's questions is the highest in the data (72.2% in Table 6-3 and Table 6-8); in contrast, her daughter answers alone only 1.4% of the time. In the only information-providing cycle in which the two parties ever collaboratively answered the doctor's question, the daughter does not join the information-providing cycle until Mrs. Pan has provided a complete reply.

6.3.5 Volunteering information vs. amount of participation

As we can see from Table 6-6 and Figure 6-1, among the three pairs of

discrepancies, the contrast between the patient's and the companion's acts of volunteering information, i.e. pattern 0P/0PC vs. 0C/0CP, displays the highest positive correlation with the contrast between the patient's vs. the companion's amount of participation in the information-providing cycles (Pearson correlation = .848, $P<0.01$). This high correlation suggests a direct link between 'high participation' and 'active participation'. As I have defined earlier, patterns 0P/0PC and 0C/0CP are the information-providing cycles in which the patient or the companion provides information without being prompted. For example, the patient party brings up the new information when no question from the doctor is observed. By posing a question to the patient party, the doctor yields the floor of the conversation to the patient party. In the case where the patient party volunteers information, the conversational floor is taken by himself or herself, instead of yielded by the doctor. In that sense, the act of volunteering information is more active compared to that of providing information upon the doctor's asking. That is to say, the party who initiates more volunteered information-providing cycles is a more active participant than the one who doesn't. With respect to my interest in the effect of the companion on the patient's information-providing acts, this high

positive correlation indicates that the companion who exhibits a greater amount of participation in the information-providing cycles is a more active participant as well as is exemplified by the case of Mrs. Zhu and her daughter.

6.3.6 Patient does vs. doesn't provide a complete reply

In this section, I will shift my focus to patterns DPC and DCP in which the patient and the companion jointly respond to the doctor's questions. The former refers to the pattern in which the patient provides a complete reply to the doctor's question before the companion provides any information within the same information-providing cycle, whereas in the latter pattern the companion intervenes before the patient has completed a reply. As I have stated in section 6.2.2, my motivation in distinguishing pattern DPC from DCP is to see whether the patient's priority of providing first-hand and complete information is well-maintained in the presence of a companion who also takes the answer turns.

The statistic result in Table 6-7 displays a significant correlation between the discrepancy of patterns DPC vs. DCP and the patient party's amount of participation in

the information-providing cycles (Pearson correlation = .574, P<0.05). In other words, the more the companion contributes in the information-providing cycles than the patient does, the lower the patient's priority is maintained in providing a complete reply prior to the companion's intervention.

In the following, I will present another significant effect of the companion's participation on the maintenance of the patient's priority. Table 6-3 shows that pattern DPC has a very low instance of occurrence, as indicated by its mean percentage 4.3%. In contrast, the occurrence of pattern DCP scores a higher mean percentage of 13.5%. Among the fifteen cases, there are only two cases, i.e. Mrs. Pan and Mrs. Tenn, where pattern DPC occurs an equal or greater percentage of the time. Patterns DPC and DCP in Table 6-2 are further compared by the paired samples T test.

Table 6-9. Paired samples T test: patterns DPC vs. DCP

	Number of cases	Paired differences (mean)	Sig. (2-tailed)
Patterns DPC vs. DCP	15	-9.273	.002**

Table 6-9 shows that the occurrence of pattern DPC is significantly lower than that of pattern DCP ($P<0.01$). This significantly lower occurrence of DPC leads to the following implication: companions who wish to respond to questions posed by the doctor, in most cases do not wait for the patients to provide a complete reply. The companions either go ahead and provide the information by themselves, i.e. pattern DC (mean percentage of 14.6%, Table 6-3), or provide information simultaneously with the patients' utterances, i.e. pattern DCP (13.5%). Only very rarely, 4.3% of the time, do the companions withhold their utterances until the patients have completed their utterances. In other words, regardless of their high or low participation in the information-providing cycles, as long as the companions participate in responding to doctor's questions, there is a lower chance that the patients will provide a complete reply. In contrast to this striking tendency, the collaboration between Mrs. Tenn and her daughter-in-law appears to be a marked one where the pattern DPC (8.5% in Table 6-3) has an equal number of occurrences as that of pattern DCP (8.5%). (Further discussion of Mrs. Tenn's case will be presented in Chapter 11.)

6.4 Conclusion

In this chapter, I have introduced my framework of examining the discourse structure of information-providing cycles. Eight patterns of information-providing cycles are identified in terms of the discourse mechanisms which start the information-providing cycle, number of information providers, and the temporal sequence of who (i.e. the patient or the companion) provides the information first.

The main findings include the following. First, the occurrence of elicited information-providing cycles is significantly higher than that of the volunteered information-providing cycles (Table 6-4). This finding reflects the doctor's role as agenda-controller. Second, although there are two potential information-providers, it is noted that the sole provider is preferred to joint providers in the medical triads (Table 6-5). Furthermore, among the eight patterns of information-providing cycles, pattern DP receives the highest percentage of occurrence. This finding supports my previous argument in Chapter 4 that most of the fifteen patients remain the primary source of the information that the doctor needs.

Fourth, in examining the correlation of three paired information-providing patterns

(0P/0PC vs. 0C/0CP, DP vs. DC, DPC vs. DCP) with the discrepancy level of the patient party's amount of participation in the information-providing cycles, a significant correlation among them is noted (Table 6-7, Figures 6-1, 6-2, and 6-3). This significant correlation reflects the effect of the companion on the patient's information-providing acts in the following way. The more the companion participates in the information-providing cycles, the greater the tendency that he or she will score higher in volunteering information, answering the doctor's question alone, or answering the doctor's question before the patient has a chance to do so. Fifth, I have also argued that the act of volunteering information is an indicator of the degree of activity. The high positive correlation displayed in Figure 6-1 suggests that the companion who exhibits a greater amount of participation in the information-providing cycles is a more active participant as well.

The above findings suggest how the companion with a high amount of participation would have decreased the patient's chance of providing information as reflected in three paired information-providing patterns. A further comparison between the occurrence of patterns DPC and DCP displays a more striking effect of the companion's participation

on the patient's acts of providing information. It is noted that the occurrence of pattern DPC is significantly lower than that of DCP (Table 6-9). This pattern shows that, regardless of the companions' high or low participation in the information-providing cycles, whenever the companions would like to answer the doctor's questions, they do not withhold their utterances until the patients have completed their reply. Thus, as long as the companions participate in responding to the doctor's questions, there is a lower chance that the patients will provide a complete reply.

Chapter 7. The Initiation of the Companion's Participation

7.0 Introduction

In the previous chapter, I discussed the eight discourse structures of information-providing cycles where the patient or the companion provides information. My next step (i.e. the fourth part of my framework) will examine the companions' participation from the interactional aspect. This step's goal is to see how the companion's information-providing acts are initiated, namely whether they are self-initiated by himself or herself or other-initiated by the doctor or the patient.

My original goal of analyzing how the companion's participation is initiated in the interactional contexts is motivated by three research studies on triadic interaction, namely Aronsson and Rundstrom's work (1988), Baker's work (1996), and Rosenfeld's work (1996). I share one of the prevailing goals with the researchers—by identifying the addressee of the doctor's utterances, we expect to see how the doctor distributes his or her attention in the medical triad, indirectly revealing how the presence of a third person affects the doctor-patient communication. However, when I applied the researchers'

frameworks to my Taiwanese geriatric data, they were not as fully applicable as they were in the earlier studies. The methodological problems and practical issues that I have encountered in the application are important considerations for researchers who share the same interest in examining the effect of companions on doctor-patient communication. In section 7.1, I will present this shared goal, briefly review the three frameworks, and present my justifications for making revisions in light of the problems that I came across.

In section 7.2, I will propose an alternative approach for examining the linguistic and interactional contexts that motivate the companion's participation—the fourth part of my framework. In presenting the statistic results of applying my framework and the discussion, I will tie them to those of the previous chapters. These findings and discussions will be presented in Chapters 8, 9, and 10.

7.1 Pre-existing framework dealing with triadic interaction

My original plan for analyzing the companion's participation in the medical triads was to examine how the presence of a third participant, i.e. the companion, reshapes the

participant structure of the question-answer pairs in the doctor-patient interaction. For example, the following questions are ones that I took into consideration:

A) How many questions from the doctor are directed to the patient, and how many are directed to the companion?

B) How are answers or information provided by the patient or by the companion?

In other words, are the 'participant structures' (Rosenfeld 1996:64) of the question part and the answer part a doctor-patient dyad, a doctor-companion dyad, or a doctor-patient-companion triad? This theme is important as it suggests how the presence of the companion affects the doctor's attention to the patient and the patient's task in providing the first-hand information. This theme been tackled by two research projects as well—Aronsson and Rundstrom's work on pediatric triads and Baker's work in geriatric triads. In my application of their frameworks, many methodological problems arose in identifying the participant structures of the question-answer pairs. As a result, in many cases, the addressee of the doctor's questions is left ambiguous. Thus, my questions A and B could not be effectively answered by pre-existing frameworks available in the literature. In the following sections, I will briefly review the three frameworks and

present my justifications for making revisions in light of the problems.

7.1.1 Baker's and Aronsson and Rundstrom's researches

Baker's research in 1996 examines 36 doctor-elderly patient-patient's companion interactions, and while it is not grounded in linguistics, it deals with issues similar to mine in analyzing the effect of a companion on the geriatric triads. She found that the ratio of the physician's questions directed to the elderly patient and to the companion varies during the encounter, as shown in Table 7-1.

Table 7-1. Eliciting Patterns of Physicians (from Baker 1996:36)

	Mean	S. D.	Median	Maximum
Total encounter (N=36)				
Directed to patient	.70	.27	.75	1.00
Directed to third	.24	.26	.16	.98
Ambiguous	.07	.07	.04	.30
Pre-physical (N=34)				
Directed to patient	.70	.28	.74	1.00
Directed to third	.23	.26	.17	1.00
Ambiguous	.07	.09	.04	.35
Physical (N=28)				
Directed to patient	.73	.33	.87	1.00
Directed to third	.20	.29	.09	1.00
Ambiguous	.04	.06	.00	.19
Post-physical (N=33)				
Directed to patient	.49	.38	.50	1.00
Directed to third	.37	.38	.24	1.00
Ambiguous	.12	.18	.05	.75

For the first two parts of the encounters, Baker notes that ‘approximately one question is directed to the companion for every three directed to the patient’ (34), as shown by the mean ratio of 0.70 vs 0.23 in the pre-physical portion and 0.73 vs. 0.20 in the physical portion. However, in the post-physical portion, the mean ratio of the physician’s questions directed to the companion climbs to 0.37 while the ratio of those directed to the patient decreases to 0.49. Baker also noticed ambiguous cases where the addressees of the physician’s questions can not be identified, as indicated by the mean ratio of 0.7, 0.4, and 0.12.

My interpretation of Baker’s findings is that the companion’s participation is more inclined to be addressed by the physician in the portion following the physical exam than in the pre-physical exam and physical exam portions. Thus, the amount of the companion’s participation is related to the portions or phases in the geriatric encounter. This implication is interesting in itself. However, Baker’s methods of identifying the addressees of the physician’s questions are not clearly presented.[1] Thus, her analysis can

[1] To my knowledge, Baker’s framework is based on the ‘Verbal Exchange Initiation System’ developed in her previous work. Yet it is not available in publication. The only description that I can find, which is related to the identification of the doctor’s addressee, is the sentence from the abstract: ‘A measure,

not be duplicated in my data.

The linguistic research by Aronsson and Rundstrom in 1988 is devoted to 32 triadic pediatric interactions among pediatricians, their child patients, and the parents of the children. In their study, they first identify the addressee of the pediatrician's utterances, i.e. how many of them are directed to the child patient and how many to the child's parents. Those directed to the child are called 'child-allocated turn (CAT)' (164). Their first finding shows that most doctors' talk is directed to parents, not to children, and 'child-allocated turns thus constitute but a minority of doctors' talk to parents and child patients' (166). The researchers further examine the response patterns of the child-allocated turns. Overall, they found that only 48% of the child-allocated turns received responses from the child alone, and the other 52% is responded to either by the parent alone or with parental intervention, as shown in Figure 7-1.

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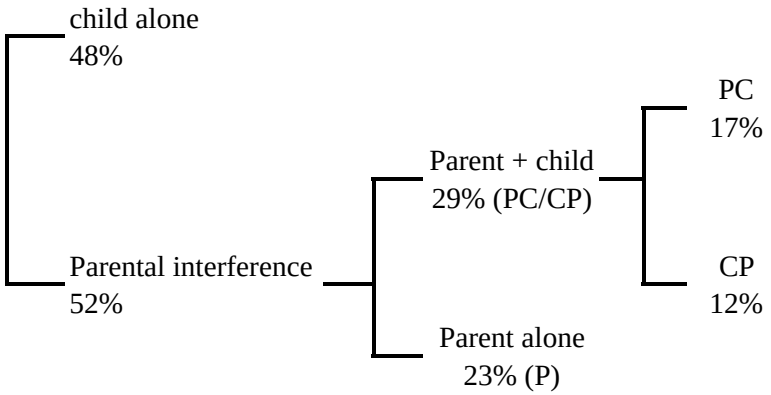
called 'physician orientation,' quantified physician attention to patients and to companion.'

Figure 7-1. Distribution of responses to child-allocated turns

Percentage of responses by child and/or parent
(Adapted from Aronsson and Rundstrom 1988:166).



Based on the amount of the parents' intervention involved in the response patterns, the 32 parents are grouped into two categories, high-control parents (H-group) and low-control parents (L-group) (166). Also, some comparisons of the discourse behavior between the two groups of parents are presented. For example, H-group parents allow their child to answer only one in three CATs (33%), whereas the L-group allows a greater amount of 63%. Arronsson and Rudstrom's findings are important because they show how the active or dominant companion will affect the discourse structure of the doctor-patient interaction.

Though the researchers provide only one paragraph to describe how the addressee is

identified, it is clear that their analysis is based on the pediatrician's use of the first-name of the child and the second person singular form (Swedish 'du'). However, it remains unclear to me if all the addressees of the pediatrician's utterances can be clearly identified by the two criteria.

The work by Tannen and Wallat (1982) deals with a single case study of a pediatric interaction as well. Although their discussion focuses on multiple tasks on the part of the pediatrician, they observe that the pediatrician uses different linguistic registers in addressing different audiences. For example, 'when talking to the child, the pediatrician uses the classic features of 'motherese' (Newport, Gleitman and Gleitman, 1977): high pitch, elongated vowel sounds, sing-song intonation, teasing' (45). When talking to the child's mother, the pediatrician uses a register which is similar to that heard in 'everyday conversation'. This distinction suggests that the identification of the pediatrician's addressee in triad, i.e. the child patient or the child's parent, might not result in as many ambiguous cases as they are in identifying the geriatrician's addressee in triad, i.e. the elderly patient or the adult child as companion.

7.1.2 Rosenfeld's framework

The goal of Rosenfeld's research (1996) is to examine the participant structure in triadic marital therapy talk. For example, is a current utterance of the therapist directed to the husband (thus a therapist-husband dyad), to the wife (thus a therapist-wife dyad), or to both (thus a therapist-couple triad)? Although the nature of a marital therapy session is different from medical encounters such as geriatric or pediatric interaction, the framework that Rosenfeld has established provides me a solid and thorough system of indicators for identifying the participant structure in triadic encounters. I will discuss the four indicators in her framework with examples from my data.

7.1.2.1 Vocatives

Vocatives refer to the name of the addressee. For example, the doctor's use of the patient's name *'Ong-senn-sinn'* 'Mr. Ong' clearly marks Mr. Ong as the addressee.

Dr. Tiunn: **{Mr. Ong and his daughter came into the room.}**
來，王先生 honn? 啊汝是按吶艱苦?
Lai, Ong-senn-sinn honn? a li si an-na kan-koh?
come Mr. Ong, Q PRT you be how sick

OK, Mr. Ong, right? So what's your problem?

→The patient is the addressee.

Vocatives provide the clearest means of identifying the addressee. However, this powerful indicator is not available in my data. In all the fifteen cases that I have collected, the only instances in which doctors address the patients with their family name (such as Mr. Ong) is to greet them as the patients stepped into the room. It is unthinkable that a doctor would address the patient using the patient's first name, e.g. 'Meihui', during a medical encounter, an occurrence which is more commonly observed in Rosenfeld's data.

There are two possible reasons to account for the fact that the use of the addressee's first name as vocative observed in Rosenfeld's data does not appear at all in my data. First, in Taiwanese culture, the use of first name is mostly restricted to older family member to the younger (such as parents to child) or in intimate symmetric relationship (such as friends to friends or couples). Second, the nature of marital therapy in the western context is more to establish rapport and a symmetric relationship between the therapist and the clients. This relationship can be established by the therapist's use of the

client's first name as a vocative. However, in the context of the Taiwanese medical encounter, especially among the elderly generation, the doctor-patient relationship is more an asymmetrical and hierarchical relationship. These two contexts prevent from the doctor's addressing the patients by their first names.

7.1.2.2 Third person participant deictics

Third person participant deictics refers to pronouns, such as *'i'* 'he/she' in Southern Min, and *'ta'* 'he/she' in Mandarin. By referring to one of the participants as 'he/she', that referent is excluded as addressee and the other party is left as the addressee (90). As shown in the following, the doctor refers to the patient as 'she.' It indicates that the other party, i.e. the patient companion, is the addressee.

Dr. Kang: 伊攏無咧做運動 honn?
I long bo leh tso un-tong honn?
she EMP not ASP take exercise Q

She does not get any exercise? right?

→The companion is the addressee.

7.1.2.3 Second person participant deictics

Second person participant deictics refer to second person pronouns, such as *'li'* 'you' in Southern Min and *'ni'* 'you' in Mandarin. It should be noticed that these two pronouns are the singular form. Therefore by referring to one participant with the singular 'you', the pronoun exclusively marks that referent as the addressee, as shown in the following:

Dr. Niung: 啊汝即嘛共誰住作夥?
A li tsit-ma kah siang tuah tso-hue?
PRT you (singular) now with whom live together

and who do you live with now?

→The patient is the addressee.

Third person pronouns and the singular second person pronouns in Southern Min and Mandarin are also powerful indicators for identifying the addressee. However, both languages are pro-drop languages. Subjects can always be deleted as long as they are understood in the context. In the following example (taken from line 5 in Excerpt 1), no subject is observed.

Dr. Niung: 這黑龜喘有外久啊？
Tse he-ku-tshuan, u gua ku a?
this asthma have how long ASP

1) This asthma, how long have (you) suffered from (it)?
2) How long has the asthma lasted?

→The patient or the companion is the addressee?

In my counting, there are a total of 833 'information-providing cycles'[2] that start with the doctor's information-eliciting utterance. Out of the 833 cycles, 18 of them (2.2%) include a third person pronoun, and 254 of them (30.5%) include a singular second person pronoun. These totals leave the addressees of the remaining 67.3% of the doctor's questions ambiguous. Thus, the use of personal deictics to indicate the addressee does not work as efficiently in my Taiwanese data as it does in Rosenfeld's English data or Aronsson and Rundstrom's Swedish data.

7.1.2.4 Sequential discourse structure

Sequential discourse structure refers to the preceding and occurring types of

[2] The term 'information-providing cycle' will be introduced in section 4.3.2.1. Its meaning is similar to the idea of 'question-answer pairs'. 'The doctor's information-eliciting utterance' carries a similar idea to that of 'question'.

discourse acts achieved in the utterance (102). In line 1 of the following hypothetical example, the addressee is ambiguous. However, given the fact that the daughter answers the question in line 2, line 1 is therefore judged as a question directed to the daughter. In this case, the discourse structure of question-answer sequence clarifies the doctor's addressee of line 1.

1. Doctor: 這黑龜喘有外久啊？
   Tse he-ku-tshuan, u gua ku a?
   this asthma have how long ASP

   1) This asthma, how long have (you) suffered from (it)?
   2) How long has the asthma lasted?

   →The patient or the companion is the addressee?

2. Daughter: 卜三十冬啊
   Beh sann-tsap tang a
   almost 30 years ASP

   About 30 years

However, this analysis does not account for the other possibility: namely, that the doctor addresses the question to the patient and the dominant daughter nonetheless responds before the patient does. More ambiguities result as long as both the patient and the companion are active in the interaction.

3. Doctor: 三十冬啊, 按吶足久啊吶？
Sann-tsap tang a? an-ne tsiok ku a ne?
30 years ASP that very long ASP PRT

30 years? that's kind of long.

→The patient or the companion is the addressee?

In line 3, it is unclear to whom the doctor directs his or her comment. If I take the discourse context, such as topic coherence, as an indicator, I then interpret the doctor's comment as being directed to the daughter's reply of line 2. However, this interpretation runs into trouble when the patient speaks in line 4.

4. Patient: Henn 啊,足久啊,啊這幾日仔愈來愈嚴重
Henn a, tsiok ku a, a tsit-kui-jit-a lu-lai-lu giam-tiong,
yeah PRT very long ASP, PRT these days more serious

Yeah, very long, (it's) getting worse these days.

In line 4, the patient shows his affirmative response to the doctor's comment of line 3. In accordance with the discourse structure, such as statement-agreement, as an indicator, the addressee of line 3 will then be interpreted as the patient. This analysis contradicts

the previous one.

My data provides two more indicators – eye contact and code-switching.

7.1.2.5 Eye contact

Since all the fifteen encounters are video-taped, eye contact sometimes works as a good indicator. However, there are some situational factors that prevent eye contact from being a reliable indicator. First of all, the doctors need to complete the written records for each patient and mark the prescription on the computer screen. Also, when the patient and patient companion are facing the doctor from the same angle, then the addressee is again ambiguous. Thus, eye contact is not always a reliable indicator.

7.1.2.6 Code-switching

Given the bilingual background of Taiwan, most doctors and companions are all bilingual in Southern Min, the local dialect, and Mandarin, the official language. Eleven of the elderly patients are judged as monolingual in Southern Min based on the fact that

they use hardly any Mandarin during the entire encounter. (See Chapter 3 for a description of the informant's use of language). Therefore, whenever the doctor code-switches from Southern Min into Mandarin, it is clear that the companion is the addressee. Although code-switching works as a powerful indicator, its power is downgraded because of its low frequency of occurrence. Among the 833 question-answer pairs which begin with the doctor's information-eliciting utterances, only 15 of them (1.8%) are uttered with Mandarin.

7.1.3 Conclusion of the methodological problems

Both the works by Baker and Aronsson and Rundstrom are devoted to the issue of how the presence of a companion affects the doctor's attention to the patient. However, Baker's methods in identifying the addressees are not clearly stated and Aronsson and Rundstrom's work on pediatric triads is not fully applicable in geriatric triads. Rosenfeld's work furnishes us with a more thorough system for analyzing triadic interaction. However, the powerful indicators which Rosenfeld relies on are largely not available in my data. The vocatives do not work at all. Code-switching resolves 1.8% of

the cases. The use of the third person pronoun and the second person singular pronoun resolves 32.7% of the cases. For the remaining of 50-60% of the cases, I will have to make use of indicators which are available but not reliable, such as discourse structure and eye contact.

In my experience, if one member of the patient party, such as the companion, is more inclined to be verbally inactive, then most of the conversation is doctor-patient dyads. Simply because the companion does not talk, we do not need indicators to identify the participant structure. If both the patient and the companion are active, only the powerful indicators will work in clarifying the doctor's addressee. In these cases, discourse structure does not provide a reliable solution, as shown in the example in section 7.1.2.4. In my counting of the amount of participation by the fifteen pairs of patients and companions, there are a total of five companions who provide as much or more information than the patients do. In these five cases, the doctor's addressees are often left ambiguous. If I leave these active cases as ambiguous or mark them as doctor-patient-companion 'triads' (cf. Rosenfeld 1996:107), then my analysis does not resolve the first issue – how much of the doctor's attention is directed to the patient and

how much to the companion. Furthermore, it is these cases, with an active patient and an active companion, which concern the doctors more in terms of their interviewing skills.

The above discussion presents the methodological problems in identifying the addressee of the doctor's questions. This discussion, however, does not suggest that the doctor's addressees are always unidentifiable. When ambiguity is observed, in most cases it is hard to judge whether the ambiguity is intended consciously or unconsciously. However, there are a few marked cases that the doctor or the companion intentionally excludes the patient. For example, when I approached Mr. Tian and his daughter to recruit them in this research, the daughter mentioned to me that her father suffers 'cancer' (uttered in English) and she does not want him to know about that. At one point in Mr. Tian's encounter, the daughter asks Dr. Song: *'ke-shi wo xiang-dao ta you* cancer, *shi-bu-shi ta yi-jing zuan-yi dao na-bian lai le?'* 'but since he has the cancer, I thought about the possibility of metastasis?'. Dr. Song immediately picks up the daughter's concern and aligns with her use of English 'Cancer *dao jiou le?'* 'How long has (he suffered) the cancer*?*'

In this example, both the daughter and the doctor exclude the patient consciously

when dealing with a sensitive topic, such as cancer. Although Dr. Song is not informed of the daughter's intention beforehand (that she prefers her father not knowing about the cancer he suffered), most doctors are trained to be sensitive in dealing with difficult topics. Following Goffman's terms (see review in Chapter 2), Mr. Tian though is 'present' and 'ratified' but not 'addressed' in the interaction. This exclusion of the patient is done in a subtle way by code-switching. However, a clear-cut case like the above example barely exists in the fifteen encounters. In most cases, it is ambiguous whether the doctor picks up one or two addressees, and whether his or her choice is made intentionally or unconsciously.

Besides these methodological problems, there are two more practical and logical concerns worth attention. When doctors are trained to interview, gathering 'first-hand' information is always the top priority. Also, the theme of the medical encounter is the patient's health problem. Thus, the patient has the most direct access to the information which the doctor requests. Therefore, as long as the patient is present and ratified in the encounter, the patient is the legitimate primary addressee of the doctor's questions. Even though there is strong linguistic evidence showing that the doctor is addressing the

companion (such as ‘so, your father suffered from his coughing problem when he was young?’) how could we be justified in stating that the doctor addresses only the companion, when the purpose is the patient’s health problem and first-hand information is considered as the top priority?

On the other hand, even though there is strong evidence indicating that the doctor is addressing the patient (such as ‘Is there anything about your family that worries you recently?’), there is always a possibility that the doctor might expect the companion to facilitate the patient’s information-providing acts whenever needed. This concern captures the holistic characteristic of the biopsychosocial model of the doctor-patient relationship. It emphasizes the importance of information about the family and the social support for the patients, which is sometimes available or observable by interacting with the companions – who, in this research, are the adult children of the elderly patient.

Seen in light of the above problems and concerns, I decided that the issue of how the doctor directs his or her question is not an important concern and is not methodologically workable in my data. Instead, I will focus on the ‘answer part’ of the question-answer pair. When the companions provide information in response to

questions posed by doctors, is their participation motivated by themselves or by others, such as by doctors or by patients? What are the linguistic and contextual mechanisms that initiate their participation?

7.2 The fourth part of my framework

To tackle the above two questions, I will introduce the ideas of 'initiation cues' and 'initiators.' I will first explain how I define 'initiators' in section 7.2.1 and the discourse cues in identifying the initiators in section 7.2.2. It should be noted that the fourth part of my framework deals only with the elicited information-providing cycles in which the doctor poses questions and the companion responds to the question. That is, it does not include the volunteered information-providing cycles in which the companion volunteers information. As I introduced earlier, volunteer information-providing cycles are those where the companion (or the patient) provides information without the doctor's asking. In these situations, the companion is not given the floor of conversation but self-introduces his or her participation (§6.3.5). Thus the companion's participation in the volunteered information-providing cycles are self-initiated implicitly and will not be

examined again in this chapter.

7.2.1 Initiators and initiation cues of the companion's participation

As I discussed in the earlier section, there exist some methodological problems in identifying the addressee of the doctor's utterances. That is to say, when the doctor poses a question, it is not always clear to us whom the doctor is addressing. In this situation, when the companion provides the information in response to the doctor's question, the companion's participation could be interpreted in two different ways. First, the companions feel the doctor's question is directed to them; thus, they provide the information. In that sense, the companion's information-providing act is initiated by the doctor. Secondly, the companions feel that the doctor's question is directed to the patients. However, they choose to answer the question for the patients. In that sense, their participation is self-initiated. In other words, when the addressees of the doctor's questions are ambiguous, then the initiators of the companions' participation remains ambiguous as well.

Therefore, I decided to examine the issue regarding the initiators of the

companion's information-proving acts from the opposite perspective. When the companion provides information in a current turn, is there any obvious linguistic or non-linguistic elements in the utterance of the previous turn that prompt him or her to do so? If yes, these linguistics or non-linguistic elements are termed '**initiation cues**'. The producers of the initiation cues are the '**initiators**'.

I observed six initiation cues and three initiators of the companion's participation in the data. The three initiators are the doctor, the patient, or the companions themselves. The initiation cues can be produced either by the doctor or by the patient. When no initiation cues are observed in the immediately previous turn, the companion's information-providing acts are considered to be '**self-initiated**'. (The situation in which the companion self-initiates his/her participation will be alternately referred to as 'the companion of the initiator'.)

7.2.2 Initiation cues

The six initiation cues observed in the data are eye contact, personal deictics, relationship deictics, code-switching, patient's absence, and patient's trouble. My

review in section 7.1 has briefly examined the applicability of these linguistic or non-linguistic elements to identify 'participant structure'. In this fourth part of my framework, I will make use of these elements in identifying the initiators of the companion's participation. My previous review also showed that the two linguistic elements, vocatives and sequential discourse structures, used in Rosenfeld's framework (1996) are either not available in or applicable to my data. Thus, only personal deictics from her work is adopted here. My framework also includes the use of eye contact which is adopted as well in Aronsson and Rundstrom's research of 1988 (§7.1.1). The remaining three elements, code-switching, patient's absence, and patient's trouble, arises from my data. In the following presentation, the six initiation cues will be introduced in rule form, illustrated with excerpts from my data.

7.2.2.1 Eye contact as initiation cue

Rule 1. **Eye contact as the initiation cue:**

The companion provides information in a current turn, and, in the previous turn, either the doctor or the patient makes eye contact with the companion. In some occasions, eye contact is accompanied with other body language, such as moving of the head, the shoulder, or pointing

with a hand.

For example, in line 4 of Excerpt 1, the patient is not able to provide the exact age of his youngest son; therefore, he turns to his son and gives him eye contact, as shown in Figure 7-2. The son then provides the approximate age of his younger brother.

Excerpt 1. {12'27"}(Mr. Wang 74M; main language: Mandarin)

DP	1. Dr. Song:	小小的兒子最小的幾歲?
		Xiao.. xiao-de er-zi, zui-xiau-de ji sui?
		small small son smallest how age
	2. Mr. Wang:	最小的啊,都二十多歲啦
		Zui-xiao-de a, dou er-shi duo sue la
		smallest PRT EMP twenty more year PRT
DPC	3. Dr. Song:	二十..多多少?
		Er-shi .. duo duo shao?
		twenty more more how much
→	4. Mr. Wang:	二十::: **{Mr. Wang then looks at his son}**
		Er-shi :::
		twenty:::
	5. Son:	二十四二十五
		Er-shi-si er-shi-u
		twenty-four twenty-five

Translation

DP	1. Dr. Song:	How old is the youngest.. youngest son?
	2. Mr. Wang:	The youngest? (He's) already over twenty.

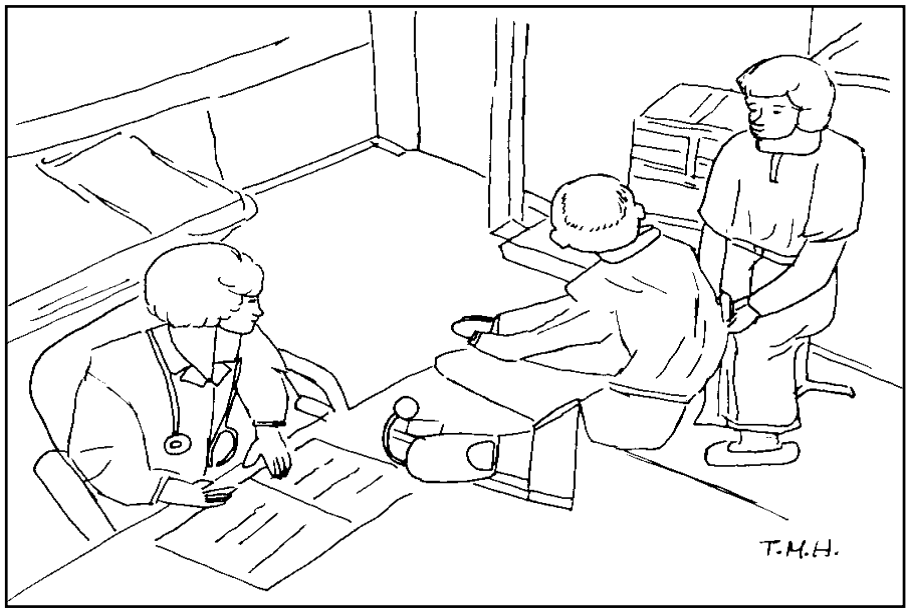
DPC	3. Dr. Song:	Twenty? twenty what?
→	4. Mr. Wang:	Twenty::: **{Mr. Wang then looks at his son}**
→	5. Son:	Twenty four, twenty five.

CODING

Initiators: lines 3-5 -- 1 instance of the patient as the initiator.
Initiation cues: lines 3-5 -- 1 instance of the patient's eye contact and 1 instance of the patient's trouble as the initiation cue.

Figure 7-2. Eye contact as initiation cues.

(Left to right: doctor, patient, companion)



7.2.2.2 Personal deictics as initiation cue

Rule 2. **Personal deictics as the initiation cue**

The companion provides information in a current turn, and in the previous turn

2a. there are third person deictics (*'i'* 'he/she' in Southern Min, or *'ta'* 'he/she' in Mandarin) used in the doctor's utterance in referring to the patient or in the patient's utterance in referring to the companion;

2b. there are singular second person pronouns (*'li'* 'you' in Southern Min or *'ni'* 'you' in Mandarin) used in the doctor's or the patient's utterance in referring to the companion.

In Excerpt 2, the nurse is measuring the patient's weight and height. The doctor is reading the information sheet and then she poses a question in line 1 *'I long bo leh tso un-tong honn?*' 'She does not get any exercise, right?' in which *'i'*'she' refers to the patient with a third person deictic. By doing so, the doctor marks the daughter-in-law as her addressee. The daughter-in-law then provides the information that the patient does not get much exercise. Her participation in line 2 is coded as initiated by the doctor's use of the pronoun 'i' 'she' in referring to the patient.

Excerpt 2. {14'43"}(Mrs. Tenn 66F; main language: Southern Min; underlined parts: Mandarin)

→DC ‖ 1. Dr. Kang: **{The nurse is measuring the patient's height and weight}**

伊攏無咧作運動 honn? 所以遮攏無寫
I long bo leh tso un-tong honn?
she EMP not ASP take exercise Q

[*so-i tsia long bo sia*
therefore here EMP no write

2. D-in-law*: 嗯:沒什麼運動,
[*En: mei-she-me un-dong*
yeah, not much exercies

* Daughter-in-law.

Translation

→DC 1. Dr. Kang: **{The nurse is measuring the patient's height and weight}**
She does not get any exercise? right?
[That's why nothing checked here (the medical record)

2. D-in-law: [Yeah, (she does) not get much exercise.

CODING

Initiators: 1 instance of the doctor as the initiator.
Initiation cues: 1 instance of the doctor's use of personal deictics and 1 instance of the patient's absence as initiation cues.

In Excerpt 3, the doctor had gathered the information regarding the patient's number of offspring and is about to clarify the companion's identity. The question receives replies from the patient ('*sim-poo*' '(my) daughter-in-law'). The doctor further poses the question in line 3 ('*lin:: a. li senn kui-e?*' 'you:: and.you have how many children?') in which '*li*' 'singular you' is used to refer to the daughter-in-law. The daughter-in-law then provides information in the next turn that she does not have any

children (line 4). Her participation in line 4 is initiated by the doctor's use of the personal deictics (i.e. the singular you *'li'*).

Excerpt 3. {02'57"}(Mrs. Yiu 65F; main language: Southern Min)

DP	1. Dr. Tiunn:	**{look at the companion}** 所以這咧:是::? *So-yi tsit le: si::?* so this CL be
	2. Mrs. Yiu:	媳婦= *Sim-poo=* daughter-in-law
→DCP	3. Dr. Tiunn:	=喔…恁::啊.汝生幾個? *=O… lin:: a. li senn kui-e*? oh you (plural) PRT you (singular) give birth how many **{the doctor then looks again at the companion}**
	4. D-in-law* :	啊我猶未生欸 hhh**{laughing}**= *A gua iau-bue senn-e hhh* PRT I have not give birth
DP	5. Dr. Tiunn	=喔,猶未 [生欸 *O iau-bue* [*senn-e* PRT have not give birth
	6. Mrs. Yiu:	[/???/ Tann 結婚爾 [*/???/ Tann ket-hun nia* just got married only

* Daughter-in-law.

Translation

DP	1. Dr. Tiunn:	**{look at the companion}** So this is:: ?

	2. Mrs. Yiu:	(My) daughter-in-law
→DCP	3. Dr. Tiunn:	You:: and.you have how many children? **{the doctor then looks again at the companion}**
	4. D-in-law:	I have not given birth yet.hhh **{laughing}**
DP	5. Dr. Tiunn	Oh, you haven't [given birth yet.
	6. Mrs. Yiu:	[(she) just got married.

CODING

Initiators: lines 3-6 -- 1 instance of the doctor as initiator. Initiation cues: lines 3-6 -- 1 instance of the doctor's use of personal deictics and 1 instance of the doctor's eye contact as the initiation cue.

7.2.2.3 Relationship deictics as initiation cue

Rule 3. **Relationship deictics as the initiation cue**

> The companion provides information in a current turn, and a relationship deictic which marks the companion as the addressee is observed in the doctor's utterance in the previous turn.

The idea of relationship deictics is similar to Levinson's 'social deixis'– 'aspects of language structure which encode the social identities of participants, or the social relationship between them, or between one of them and persons and entities referred to' (1983:89). In this research, relationship deictics refers to the lexical items which describe the patient's family relationship and mark the companion as the addressee. For

example, in line 6 of Excerpt 4, the doctor is eliciting the pedigree information regarding the number of the patient's offspring. The doctor phrases his question with two relationship deictics. The first relationship term which is uttered in Mandarin '*Ji-ge xiong-di-jie-mei?*' 'How many brothers and sisters?' has the companion (i.e. the daughter of the patient) as the addressee while the second one uttered in Southern Min, *'kui-e gin-a?'* 'how many children?' has the patient as the addressee. The doctor's use of the relationship deictics '*xiong-di-jie-mei'* 'brothers and sisters' is the initiation cues that prompt the daughter to provide the information that she has six brothers and sisters (line 7). Thus the daughter's participation in line 7 is coded as initiated by the doctor's use of relationship deictics.

Excerpt 4.{06'17"} (Mr. Tan 76M; main language: Southern Min; underlined parts: Mandarin)

DCP	1. Dr. Niung:	啊汝既嘛共誰人住作夥?
		A li tsit-ma kah siang tuah tso-hue?
		and you now with whom live together
	2. Mr. Tan:	[共音(他們)
		[*Kah in*
		with them
	3. Daughter:	[共…共阮,迄落:::我是他女兒
		[*Kah… kah guan, bit-lor::: wo shi ta nu-er*
		with… with us, that::: I be his daughter

4. Dr. Niung: 呼
Hoo
oh

5. Daughter: 哼
Hng
yeah

→DC 6. Dr. Niung: 彼落..幾個兄弟姊妹?歸個孩子?
Hit-lor..ji-ge *xiong-di-jie-me* *kui-e* *ging-a*
that how many brother and sister how many children

7. Daughter: 阮..六個
Gun..lok e
we six CL

→DCP 8. Dr. Niung: 兄弟姊妹六個，男生女生?::六個?
Xiong-di-jie-me *liao* *ge*, *nan-sheng* *nv-sheng* .. *liao ge*
brothers and sisters six CL male female:: six

9. Daughter: 嗯::有::誒..
Mng:: u:: e..
yeah have enn

[五個女的
[*wo* *ge* *nv-de*, *yi* *ge* *nan-de*
five CL female, one CL male

10. Mr. Tan: /五欸??/
[/Go e ??/
five CL

Translation

DCP 1. Dr. Niung: And whom do you live with now?

2. Mr. Tan: [With them

3. Daughter: [With…with us, and::: I am his daughter

4. Dr. Niung: Oh, I see

5. Daughter: Yeah

→DC	6. Dr. Niung:	That..<u>how many brothers and sisters?</u> how many kids?
	7. Daughter:	We.. six
→DCP	8. Dr. Niung:	<u>Six brothers and sisters, male and female:: six</u>?
	9. Daughter:	Yeah::, some::: enn::: [<u>five female, one male</u>
	10. Mr. Tan:	[five/??/

CODING

Initiators:	lines 1-5 -- 1 instances of the companion's self-initiation. lines 6-10 -- 2 instances of the doctor's as initiator.
Initiation cues:	lines 6-10 -- 2 instances of the doctor's code-switching and 2 instances of the doctor's use of relationship deictics as initiation cues.

7.2.2.4 Code-switching as initiation cue

Rule 4. **code-switching as initiation cue**

In the 11 cases where the patients are judged as monolingual in Southern Min, the companion provides information in a current turn, and the doctor's utterance in the previous turn is spoken in Mandarin.

As I have described earlier in Chapter 3, there are 11 elderly patients judged as monolingual in Southern Min, and their adult children and doctors are bilingual in Southern Min and Mandarin. In these cases, the use of Mandarin can occur only in the doctor-companion interaction, given the fact that the patient does not speak Mandarin. In Excerpt 4, when the doctor begins to ask about the patient's pedigree information with

the question regarding the patient's living arrangement (line 1), his question is uttered in Southern Min. However, when the doctor asks about the number of the patient's offspring, he code-switches into Mandarin and phrases his question with the relationship dietetics '*Ji-ge xiong-di-jie-mei?*' 'How many brothers and sisters?' which has the daughter as the addressee. Both the doctor's questions of lines 6 and 8 receive replies from the daughter in lines 7 and 9. Thus, the daughter's participation in lines 7 and 9 are coded as initiated by the doctor's use of Mandarin and the relationship deictics.

7.2.2.5 Patient's absence as initiation cue

Rule 5. **Patient's absence as initiation cue**

During the time when the patient is away from the patient's seat to have his or her weight and height measured by the nurse, the companion provides information in response to a question posed by the doctor.

In other words, the doctor's act of eliciting information at the patient's absence leaves the companion as the sole party to provide information. Within this definition, when 'patient's absence' is coded as the initiation cue, the doctor is the initiator. Recall in Excerpt 2, the doctor poses the question in line 1 'she (the patient) does not get any

exercise, right?' which receives a reply from the patient's daughter-in-law. We argue that the daughter-in-law's act of providing information is initiated by the doctor's use of *'i'* 'she' in referring to the patient. Here one more initiation cue is identified. At the time when the doctor poses this question, the patient is away from the doctor's table so that her weight and height can be checked. Thus, the daughter-in-law's participation in line 2 is coded as initiated by both the doctor's choice of the third person pronoun and patient's absence, and the doctor is the initiator.

7.2.2.6 Patient's trouble as initiation cue

Rule 6. **Patient's trouble as initiation cue**

6a. In the third turn of an information-providing cycle, the companion provides information in response to the doctor's question in the first turn when there are obvious expression dysfluency, such as word searches and pauses more than 2 seconds, observed in the patient's utterance in the second turn.

6b. In the third turn of an information-providing cycle, the companion repeats or rephrases the questions posed by the doctor in the first turn or provides information in response to the doctor's questions when there are obvious comprehension problems expressed by the patients' utterance in the second turn.

Rule 6 extends the companion's acts of information-providing to that of rephrasing the doctor's questions. The description of the patient's utterances in rules 6a is similar to Schegloff et al.'s idea of 'the trouble source of repair' (1977). However, their definition of trouble source—everything is potentially repairable—covers such a wide range of discourse interaction that it is sometimes hard to identify what is being repaired and what is not. Given my interest in exploring the information-providing cycles, the 'trouble source' in this research refers only to the patient's trouble in expression which is so severe that a piece of information can not be elicited if the trouble stays un-repaired. I also extend the idea of 'trouble source' to the situations in which the patient encounters obvious problems in understanding the doctor's questions (i.e. rule 6b).

In the two situations where the patient encounters troubles described in 6a and 6b, and the companion provides information or rephrases the doctor's questions at that point, it is reasonable to argue that the companion's participation is motivated by the patient's trouble with comprehension or expression.

Based on Schegloff et al., I will interpret the sequential structure of a repairing process as the following: the trouble source for repair, the initiation of the repair, and the

completion of the repair. In this process, the initiation of the repair and the completion of the repair can be done either by self or other. There could be repair processes initiated by the patient, the doctor, or the companion and completed by any of the three parties. It should be noticed that my research deals with only one type of repair process in light of my specific interest in exploring the role of the companion in the information-providing cycles. I focus on the cases in which the companion completes the repair. Drawing on Schegloff et al.'s framework, the companion's participation in rules 6a and 6b can be analyzed in the following way:

1) trouble source observed in the patient's information-providing turn	➔	2) initiation of the repair by the patient, the doctor, or the companion	➔	3) completion of the repair by the companion

Recall in line 4 of Excerpt 7 (the English translation is repeated in the following), the patient has trouble telling the doctor the exact age of his youngest son; thus, line 4 is the trouble source of the repair. The patient then turns to his son. The patient's eye contact with his son indicates that a trouble needs to be repaired and he wishes his son to

complete the repair. Thus, the patient initiates both the repair and the companion's participation in the completion of the repair. The son completes the repair in line 5. Thus Excerpt 7 is coded as 1 instance of the patient's eye contact and 1 instance of the patient's trouble as the initiation cues and 1 instance of the patient as the initiator of the companion's participation.

Excerpt 1-- Translation. {12'27"}(Mr. Wang 74M; main language: Mandarin)

DP	1. Dr. Song:	How old is the youngest. youngest son?
	2. Mr. Wang:	The youngest? (He's) already over twenty.
DPC	3. Dr. Song:	Twenty? twenty what?
→	4. Mr. Wang:	Twenty::: **{Mr. Wang looks at his son}**
→	5. Son:	Twenty four, twenty five.

CODING

Initiators:	lines 3-5 -- 1 instance of the patient as the initiator.
Initiation cues:	lines 3-5 -- 1 instance of the patient's eye contact and 1 instance of the patient's trouble as the initiation cue.

In the following example, the patient does not catch the doctor's question about his heart problem in line 1. The patient's silence and the question 'what?' in line 2 indicate that something needs to be repaired. The doctor repeats his question and points to his

own chest; at the same time, he looks at the companion. The companion then provides information in line 4 about an accident which affected the patient's chest. The doctor's shift of his eye contact to the companion is an indicator of encouragement for the companion to complete the repair. Thus, the doctor initiates the companion's participation in completing the repair. Excerpt 5 is coded as 1 instance of the doctor as initiator of the companion's participation, 1 instance of the doctor's eye contact, and 1 instance of the patient's trouble as initiation cues.

Excerpt 5. {03'02"} (Mr. Khoh 74M; main language: Southern Min)

DC	1. Dr. Niung:	啊汝講…卡早有.心臟病喔?
		A li kong.. khah-tsah u sim-tsong-penn o?
		PRT you say earlier have heart disease Q
→	2. Mr. Khoh:	..嗯?
		..Enn?
		what
	3. Dr. Niung:	**{the doctor points to his own chest and looks at the son}**
		心臟是按吶?
		Sim-tsong si an-na?
		heart be what problem
→	4. Son:	..伊卡早是..這叨是卡早.卡早去予 teh 著啦,
		..I khah-tsah si tse to si khah-tsah
		he earlier be this EMP be earlier
		khah-tsah khi-hoo. the-tioh lah
		earlier PASS hit PRT

Translation

DC	1. Dr. Niung:	And did you say.. you suffered heart disease earlier?
→	2. Mr. Khoh:	..What?
	3. Dr. Niung:	**{the doctor points to his own chest and looks at the son}** What's wrong with (his) heart?
→	4. Son:	..He was, in the earlier days..this part, in the earlier days. In the earlier days, it was hit (by something).

CODING

Initiators:	1 instance of the doctor as the initiator.
Initiation cues:	1 instance of the doctor's eye contact and 1 instance of the patient's trouble as the initiation cues.

In Excerpt 6, Mr. Tan can not recall the brand name of the medicines that he bought from the drugstore. However, he does not turn to his daughter for help; instead, he keeps searching for the words of the brand name (lines 2 and 4). The doctor does not turn to the daughter either; instead, he provides the brand name *'A-li-la-min'* based on the patient's previous utterance and indicates that *'A-li-la-min'* is not for hypertension. The daughter joins in at this point by negating the name and provides more clues of the brand name (lines 4 and 5) which prompts the doctor to give the name '*An-xue-li*'.

Excerpt 6. {02'10"} (Mr. Tan 76M; main language: Southern Min; underlined parts: Mandarin)

DPC 1. Dr. Niung: 叨一款汝敢知影?
To tsit-khuan li kam tsai-iann?
which kind you Q know

→ 2. Mr. Tan: …/??/安什麼..什麼..安利拉::
../??/ An siann-mih .. siann-mi .. an /li-la::/
An what what An li-la

3. Dr. Niung: …阿利他命….應該毋是阿利他命喔
….A-li-la-min? Eng-kai m si a-li-la-min o
A-li-la-min should not be A-li-la-min PRT

→ 4. Mr. Tan: [毋是毋是.. 安什麼貨..彼落..薄薄 伊共我講彼個.=
[*M-si m-si..An siann-mih-hue.. hit-lo.. po-po, I ka gua kong hit-e=*
no no An what that thin he to me say that

Daughter: [毋是毋是**{the doctor then looks at the daughter}**
[*M-si m-si*
no no

5. Mr. Tan: =[西藥房 honn,
=[*se io pang*
western medicine store

→ Daughter: =[血..血利安還是安.=
=[*Xue..Xue-li-an hai-si an.=*
Xue.. xue-li-an or An

DCP 6. Dr. Niung: **{looks at the daughter}**
=安血利?=
=*An-xue-li?*=
An-xue-li

→ 7. Daughter: =Hann, hann, [安血利
=*Hann, hann,* [*An-xue-li*
right, right An-xue-li

8. Mr. Tan: [henn安血利,對對,
[*Henn, An-xue-li, tio, tio*
yeah An-xue-li right right

Translation

DPC	1. Dr. Niung:	Do you know which type (of medicine)?
→	2. Mr. Tan:	../??/ (It's) <u>An</u> what?.. um .. <u>An</u> /Li-la::/?
	3. Dr. Niung:	.. Is (it) A-li-la-min… (It) can't not be A-li-la-min
→	4. Mr. Tan:	[No, no, (it's) <u>An</u> something?.. umm.. (it's) thin, and he told me that.=
	Daughter:	[No, no {the doctor then looks at the daughter}
	5. Mr. Tan:	=[the drugstore
→	Daughter:	=[(It's) <u>Xue</u>.. <u>Xue-li</u> <u>An</u>, or An.=
DCP	6. Dr. Niung:	**{looks at the daughter}** =<u>An-xue-li?</u>=
→	7. Daughter:	=Right, right, [An-xue-li=
	8. Mr. Tan:	[Yeah, <u>An-xue-li</u>, right, right

CODING

Initiators:	lines1-5 -- 1 instance of the companion's self-initiation. lines 6-8 -- 1 instance of the doctor as initiator.
Initiation cues:	lines 1-5 -- 1 instance of the patient's trouble as initiation cue. lines 7-8 -- 1 instance of the doctor's code-switching and 1 instance of the doctor's eye contact as initiation cue.

In this case, neither the patient nor the doctor initially turns to the companion for help. Thus, the companion's information-providing act in lines 4 is self-initiated, and her participation is driven to solve the patient's trouble. It is thus coded as 1 instance of the

companion's self-initiated participation, and 1 instance of the patient's trouble as initiation cues.

Excerpt 7 presents a similar pattern to that in Excerpt 6. The patient's 'what' in line 2 and silence in line 4 again shows that he did not comprehend the doctor's question 'what other problems do you have?' The companion completes the repair by rephrasing the doctor's question again in line 5 ('*Khann li u koh.to-tsit-jiah bo hit-lo..*' '(The doctor is asking) if you have other problems that..') The companion's participation in line 5 is coded as 1 instance of the companion's self-initiated participation and 1 instance of the patient's trouble as initiation cues.

Excerpt 7. {02'22"}(Mr. Khoh 74M; main language: Southern Min)

	DP	
		1. Dr. Niung: 啊其他有什麼? *A ki-thann u siann-mih?* PRT others have what
→		2. Mr. Khoh: …哼? *…Mng?* what
		3. Dr. Niung: 其他有什麼問題無? *Ki-thann u siann-mih bun-te bo?* others have what problem Q
→		4. Mr. Khoh: **{silence for two seconds}**

→ 5. Son: **{look at the patient}**
看汝有擱.叨一遮無彼落.
Khann li u koh. to-tsit-jiah bo hit-lo.
see you have more where not that

6. Dr. Niung: ..主要是即咧?=
..Tsu-iau si tsit le?=
main be this CL

7. Mr. Khoh: =我共汝講啦,我這咧.暗滾仔筋 honn…呼,足酸,
=Gua kah li kong lah,
I to you tell PRT

gua tsit le. am-kun-a kin honn… hoo, tsiok sng
my this CL neck muscle PRT INT very sour

Translation

DP 1. Dr. Niung: Do (you) have other problems?

2. Mr. Khoh: What?

3. Dr. Niung: (You) have other problems?

→ 4. Mr. Khoh: **{silence for two seconds}**

→ 5. Son: **{looks at the patient}**
(The doctor is asking) if you have other problems that..

6. Dr. Niung: .. Is this the main (problem)?=

7. Mr. Khoh: =Let me tell you, my this neck muscle, ooh, (gets) very sore.

CODING

Initiators: 1 instance of the companion's self-initiation.
Initiation cues: 1 instance of the patient's trouble as the initiation cue.

7.2.3 Summary of the initiation cues and initiators

So far, I have introduced the six initiation cues that prompt the companion's participation observed in my data.

Table 7-2. Initiators and initiation cues of the companion's participation.

Initiators			**Initiation cues**
Other- initiation		self-initiation	
doctor	patient		eye contact
doctor	patient		personal deictics
doctor	patient		relationship deictics
doctor			code-switching
doctor		companion	patient's absence
doctor	patient	companion	patient's trouble
		companion	none of the above

The first four cues (i.e. eye contact, personal deictics, relationship deictics, and code-switching) can be produced by either the doctor or the patient. Accordingly, when the companion's information-providing acts are preceded by these cues, the initiators of the companion's participation are either the doctor or the patient. In the cases where no initiation cues are preceded, the companion's information-providing acts are self-initiated. That is, the companion himself or herself is the initiator.

The last two cues (i.e. patient's absence and trouble) are the situational contexts which motivate the companion's participation. When patient's absence is coded as the initiation cue, the doctor is the initiator. In the case when the companion's participation is motivated to repair the patient's troubles, the initiators of his or her contribution can be either the doctor or the patient if eye contact is also observed or the companion himself or herself.

In my coding, there is only one initiator identified in each of the companion's utterance in the information-providing cycles. However, there can be more than one initiation cue identified in each utterance. For example, in the doctor's Mandarin utterance of '*Ji ge xiong-di-jie-mei*' 'How many brothers and sisters', there are two initiation cues identified (i.e. relationship deictics and code-switching), and the doctor is coded as the initiator.

Chapter 8. The Patient and the Companion as the Initiators

8.0 Introduction

In Chapter 7, I have introduced the fourth part of my framework—the three initiators of the companion's participation (i.e. the doctor, the patient, or the companion himself or herself), and the associated initiation cues they have employed in recruiting the companion. In this chapter, I will present the overall statistical findings on the distribution of the initiators and the associated initiation cues. In the discussion of these findings, this chapter will start with instances where the patient and the companion initiate the companion's participation (§8.3 to §8.5). In section 8.3, I will present evidence to show the patient's resistance to recruiting the companion from the cases where the patient encounters trouble in expressing or comprehending. In section 8.4, I will discuss the preferences for self-initiation over other-initiation. In section 8.5 I will tie the correlation between a high rate of participation to being an active participant by comparing the companion's amount of participation with the instances of volunteering information and self-initiating in elicited information-providing cycles. The doctor's

role as the initiator of the companion's participation will be discussed in Chapters 9 and 10.

8.1 Overall results

Out of the 1098 information-providing cycles observed in the fifteen cases, 359 of them (i.e. 32.7%) involve the companion.[1] Table 8-1 displays the distribution of the three initiators of the companion's participation of the 359 information-providing cycles. Table 8-2 displays the distribution of all the initiation cues observed in the 359 information-providing cycles.

In the following analysis of this chapter, I will exclude the participation of Mrs. Pan's daughter. As we can see from the total column of Table 8-1, most of the companions participate in at least 13 information-providing cycles except Mrs. Pan's daughter who participates in only 2 information-providing cycles. The very low amount

of her participation is interesting in itself. However, this lowest instance of 2 (i.e. 50% as initiated by the patient and 50% by the daughter) may distort the general distribution of the other 14 cases. Thus, Mrs. Pan's case is excluded in this section.

Table 8-1. Distribution of the initiators of the companion's participation.

	Initiated by doctor		Initiated by patient		Initiated by companion		Total	
Mrs. Zhu	12	(30.8%)	1	(2.6%)	26	(66.7%)	39	(100.0%)
Mrs. Yiu	2	(14.3%)	0	(0.0%)	12	(85.7%)	14	(100.0%)
Mr. Ong	0	(0.0%)	0	(0.0%)	13	(100.0%)	13	(100.0%)
Mrs. Pan	0	(0.0%)	1	(50.0%)	1	(50.0%)	2	(100.0%)
Mrs. Iunn	25	(51.0%)	0	(0.0%)	24	(49.0%)	49	(100.0%)
Mrs. Gonn	13	(61.9%)	1	(4.8%)	7	(33.3%)	21	(100.0%)
Mrs. Lim	14	(70.0%)	0	(0.0%)	6	(30.0%)	20	(100.0%)
Mrs. Su	11	(32.4%)	0	(0.0%)	23	(67.6%)	34	(100.0%)
Mr. Sim	3	(10.7%)	0	(0.0%)	25	(89.3%)	28	(100.0%)
Mrs. Tenn	9	(33.3%)	2	(7.4%)	16	(59.3%)	27	(100.0%)
Mrs. Khu	1	(7.7%)	0	(0.0%)	12	(92.3%)	13	(100.0%)
Mr. Tian	4	(19.0%)	0	(0.0%)	17	(81.0%)	21	(100.0%)
Mr. Wang	10	(62.5%)	2	(12.5%)	4	(25.0%)	16	(100.0%)
Mr. Tan	19	(59.4%)	1	(3.1%)	12	(37.5%)	32	(100.0%)
Mr. Khoh	15	(50.3%)	1	(3.3%)	14	(46.7%)	30	(100.0%)
Total*	138		9		212		359	
Mean*		35.9%		2.4%		61.7%		

* Mrs. Pan's case is excluded.

[1] There are a total of 359 IP cycles in which the doctor poses questions and the companion participates. It includes the three information-providing patterns DC, DPC, and DCP. The total number of these instances (as presented in Table 6-2) is 344, which is 15 instances less than the total number of 359 (Table 8-1). These 15 information-providing cycles are cases where the companion participates without providing information. For example, when the patient fails to catch the doctor's question, the companion rephrases the doctor's question again. (See also the section 'patient's trouble as initiation cues' in Chapter 7).

Table 8-2. Distribution of initiation cues.

	Initiation cues employed by									
	doctor						patient			companion
	eye contact	personal deictics	relation deictics	code-switching	patient's absence	patient's trouble	eye contact	relation deictics	patient's trouble	patient's trouble
Mrs. Zhu	10 (66.7%)	1 (6.7%)	4 (26.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1	0	1	0
Mrs. Yiu	2 (100%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0	0	0	2
Mr. Ong	0	0	0	0	0	0	0	0	0	0
Mrs. Pan	0	0	0	0	0	0	1	0	0	0
Mrs. Iunn	25 (80.6%)	6 (19.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0	0	0	2
Mrs. Gonn	8 (33.3%)	5 (20.8%)	2 (8.3%)	8 (33.3%)	1 (4.2%)	0 (0.0%)	0	1	0	1
Mrs. Lim	13 (61.9%)	4 (19.0%)	3 (14.3%)	1 (4.8%)	0 (0.0%)	0 (0.0%)	0	0	0	1
Mrs. Su	9 (42.9%)	4 (19.0%)	5 (23.8%)	3 (14.3%)	0 (0.0%)	0 (0.0%)	0	0	0	0
Mr. Sim	3 (100%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0	0	0	8
Mrs. Tenn	2 (13.3%)	3 (20.0%)	2 (13.3%)	5 (33.3%)	3 (20.0%)	0 (0.0%)	2	0	2	3
Mrs. Khu	1 (33.3%)	2 (66.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0	0	0	0
Mr. Tian	3 (75.0%)	0 (0.0%)	0 (0.0%)	1 (25.0%)	0 (0.0%)	0 (0.0%)	0	0	0	0
Mr. Wang	9 (60.0%)	3 (20.0%)	3 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2	0	1	0
Mr. Tan	17 (58.6%)	3 (10.3%)	4 (13.8%)	5 (17.2%)	0 (0.0%)	0 (0.0%)	1	0	1	1
Mr. Khoh	13 (50.0%)	5 (19.2%)	5 (19.2%)	0 (0.0%)	1 (3.8%)	2 (7.7%)	1	0	0	5
Total*	115	36	28	23	5	2	7	1	5	23
Mean**	59.7%	17.0%	10.7%	9.8%	2.2%	0.6%				

* Mrs. Pan's case is excluded. ** Mrs. Pan's and Mr. Wang's cases are excluded

8.2 The initiators of the companion's participation

As we can see from the last row of Table 8-1, the companion's participation is mostly initiated by himself or herself (61.7%) and that initiated by the doctor scores the second highest percentage of 35.9%. The patient initiates only a very small proportion (2.4%) of the companion's participation. The percentage numbers in the three columns are tested using the paired samples T test. Table 8-3 shows the difference among the three columns.

Table 8-3. Paired samples T test: initiators of the companion's participation.

	Number of cases	Paired differences (mean)	Sig. (2-tailed)
Initiated by doctor vs. by patient	15	33.521	.000**
Initiated by patient vs. by companion	15	-59.264	.000**
Initiated by doctor vs. by companion	15	-25.743	.068

Table 8-3 shows that the percentages of the patient as the initiators are significantly lower than those of the doctor and the companion. The percentage of the companion as the initiator is higher than that of the doctor; however, this difference is not statistically significant. In other words, the patient seldom initiates the companion's participation.

Instead, the participation is mainly initiated by the companion and secondarily by the doctor.

In the following sections, I will discuss the patient's and the companion's roles as initiators of the companion's participation and the associated initiation cues they have employed.

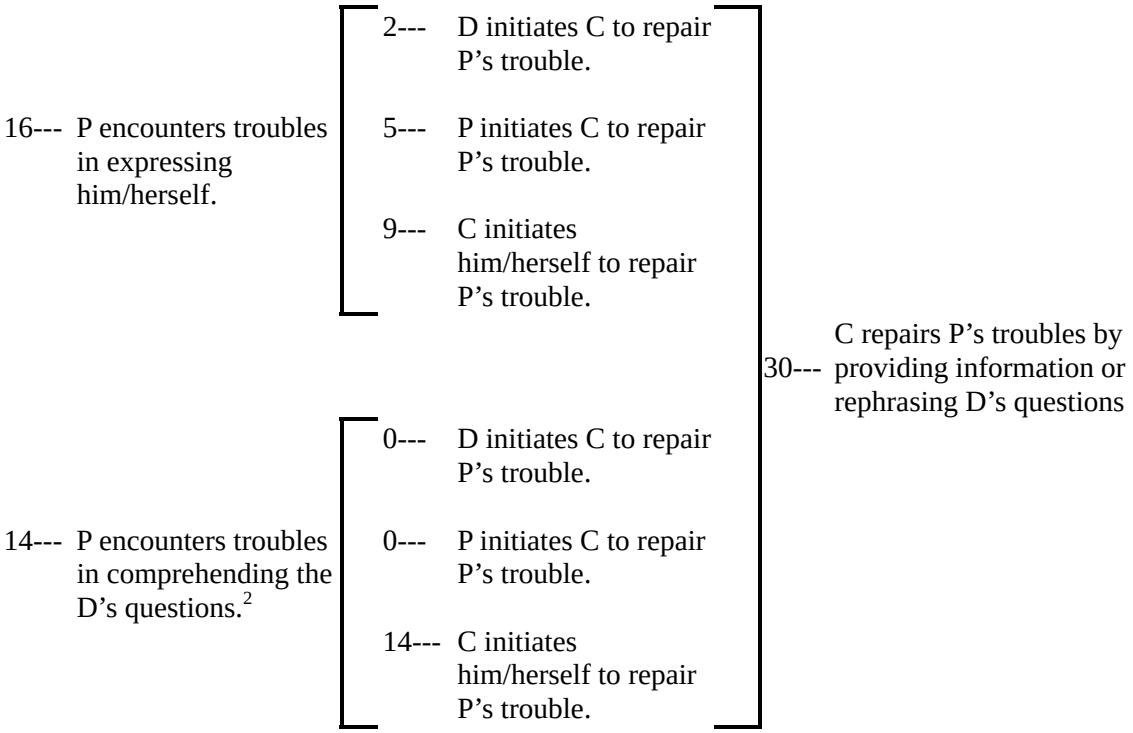
8.3 Patients as the initiators and patient's trouble as the initiation cues

As stated earlier, there is a significantly low frequency of instances where the patient initiates the companion's participation in the information-providing cycles. Table 8-1 shows that there are only 9 instances where the patient ever initiated the companion's participation. In this section, I will present evidence to show that this low frequency reflects the patient's resistance to recruiting the companions, and this resistance indirectly reflects the patient's need for autonomy.

I explained in section 7.2.2.6 how Schegloff et al.'s idea of trouble source of repair is applied in this research by examining one specific type of repair job (i.e. the companion repairs the patient's troubles by providing information or rephrasing the

doctor's questions) to explore the companion's role in the information-providing cycles. Table 8-2 shows there are a total of 30 instances of this repair job identified in the fourteen encounters. The repair processes of these 30 instances are presented in Figure 8-1. The data represent the number of instances that each situation has occurred.

Figure 8-1. The patient's troubles repair processes.



[2] The patient's trouble of comprehending the doctor's question refers only to the situations in which the patient explicitly expresses *'hann?' or 'hng?'* "what?" after the doctor utters a question (such as line 2 in Excerpt 5 of Chapter 7). In the situations where the patient remains silent after the doctor utters a question (such as lines 2, 4, and 6 in Excerpt 3 of this chapter), it is treated as an expressional trouble.

In these 30 trouble instances, the patient turns to the companions for resolution (such as looking at the companion) in only 5 instances (i.e. 16.7%). For example, in Excerpt 1, Mr. Wang turns to his son for help when he is not able to provide the exact age of his youngest son.

Excerpt 1--Translation.[3] {12'27"}(Mr. Wang 74M; main language: Mandarin)

DP	1. Dr. Song:	How old is the youngest. youngest son?
	2. Mr. Wang:	The youngest? (He's) already over twenty.
DPC	3. Dr. Song:	Twenty? twenty what?
→	4. Mr. Wang:	Twenty::: **{Mr. Wang looks at his son}**
→	5. Son:	Twenty four, twenty five.

CODING

Initiators: 1 instance of the patient as the initiator. Initiation cues: 1 instance of the patient's eye contact and 1 instance of the patient's trouble as the initiation cue.

For the 83.3% of the trouble cases, the patient did not seek help from the companion. Excerpts 2 and 3 are quoted here to illustrate the patient's resistance to seeking help from

[3] See Excerpt 1 in Chapter 7 for Chinese version.

the patient. In Excerpt 2, Mr. Tan has a problem recalling the brand name of the medicine that he bought from the drugstore as shown by the pauses and his word search effort (lines 2 and 4). The daughter joins in at this point by providing more clues to the brand name (lines 4 and 5), thereby prompting the doctor to give the name '*An-xue-li*'. As we can see, the patient tries to resolve the trouble by himself. He did not turn to his daughter who he is living with and thus might have the access to the information that he is seeking.

Excerpt 2 – Translation.[4] {02'10"} (Mr. Tan 76M; main language: Southern Min; underlined parts: Mandarin)

DPC	1. Dr. Niung:	Do you know which type (of medicine)?
→	2. Mr. Tan:	../??/ (It's) *An* what?.. um .. *An /Li-la::/*?
	3. Dr. Niung:	.. Is (it) *A-li-la-min*… (It) can't not be *A-li-la-min*
→	4. Mr. Tan:	[No, no, (it's) *An* something?.. umm.. (it's) thin, and he told me that.=
	Daughter:	[No, no **{the doctor then looks at the daughter}**
	5. Mr. Tan:	=[the drugstore
→	Daughter:	=[(It's) *Xue*.. *Xue-li An*, or *An*.=
DCP	6. Dr. Niung:	**{looks at the daughter}**

[4] See Excerpt 6 in Chapter 7 for Chinese version.

		=*An-xue-li?*=
→	7. Daughter:	=Right, right, [*An-xue-li*
	8. Mr. Tan:	[Yeah, An-xue-li, right, right

CODING

Initiators:	lines1-5 -- 1 instance of the companion's self-initiation. lines 6-8 -- 1 instance of the doctor as initiator.
Initiation cues:	lines 1-5 -- 1 instance of the patient's trouble as initiation cue. lines 7-8 -- 1 instance of the doctor's code-switching and 1 instance of the doctor's eye contact as initiation cue.

In Mr. Sim's encounter (Excerpt 3), the doctor poses the question of the duration of the heart pain that attacked Mr. Sim. The patient keeps silent for three seconds before he gives a general description of the duration, '*tsit-tsun*' '(the chest tightness lasts) for a while' (line 2). The doctor rephrases her question by asking how long it takes for the pain to go away. Mr. Sim remains silent for two seconds and then explicitly indicates his expression problem by saying: '*a he ma.. bu-hiau kong*' 'and for that .. (I) don't know how to say' (line 4). The doctor then gives some measurement words such as minutes or hours (line 5). Mr. Sim remains silent for another four seconds. His son-in-law then rephrases the doctor's questions twice in lines 7 and 9. Finally in line 10, Mr. Sim provides the specific information: '*tsha-put-to puann-tiam-tsing la*' 'about half an hour'.

Excerpt 3 {01’12”}(Mr. Sim 65M; main language: Southern Min)

DP 1. Dr. Kang: 汝 tsin tsat-tsat 欸感覺攏一陣一陣,猶是歸日欸?
Li tsin tsat-tsat-e kam-kah long tsit-tsun tsit-tsun, ai-si kui-jit-e?
you now tight feeling EMP a while a while or whole day

→ 2. Mr. Sim: **{pause for 3 seconds}**
有.有當時仔叨卡未,有當時仔叨彼落::算做:::
U.. u-tang-si-a to khah be, u-tang-si-a to hit-lo:: sng-tso:::
some..sometimes EMP NEG sometimes EMP that like

一陣.. [一陣一陣
tsit-tsun.. [*tsit-tsun tsit-tsun*
a while a while a while

DP Dr. Kang: [一陣一陣按吶?
[*tsit-tsun tsit-tsun an-ne o?*
a while a while like that Q

3. Dr. Kang: 啊一陣攏經過寡久卡好欸?
A tsit-tsun long king-kue gua gu khah hau-e?
PRT a while EMP last how long get better

→ 4. Mr. Sim: **{pause for 2 seconds}**
啊彼嘛..未曉講,=
A he ma.. be-hiau kong,=
PRT that also not know describe

DP 5. Dr. Kang: =差不多叨好,幾秒鐘叨過,猶是幾分鐘,啊是君那點鐘?
=Tsha-put-to to ho, kui bio-tsing to gue?
about will fine how many second will pass

a-si kui hun-tsing? a-si kun-na tiam-tsing?
or how many minutes or how many hours

→ 6. Mr. Sim: **{pause for 4 seconds}**

7. Son-in-law: /??/是看寡久啊?
si kuann gua ku a?
be see how much long PRT

[/????/看寡久啊?
Khuann gua ku?

		see how much long
	8. Dr. Kang:	[henn,按吶,幾秒鐘猶是君那點鐘,差足濟啊,henn [*Henn, an-nei, kui bio-tsing a-si kun-na tiam-tsing,* Yeah this how many seconds or how many hour
		tsha tsiok-tse a, henn differ a lot PRT yeah
	9. Son-in-law:	看汝咧 tsat 欸時陣差不多寡久啊?…大約啦 *Khuann li leh tsat e-si-tsun tsa-put-to gua-ku a? ..* see you ASP tight when about how long ASP
		…tai-iok la roughly PRT
→	10. Mr. Sim:	..啊有當時叨:攏.攏彼.差不多半點鐘啦,/??/= *..A u-tang-si to: long.. long he.. tsha-put-to puann-tiam-tsing la* PRT sometimes EMP EMP EMP that about half hour PRT

Translation

DP	1. Dr. Kang:	Now, the chest tight .. feeling you have, (did) the feeling last for a short time or the whole day?
→	2. Mr. Sim:	**{pause for 3 seconds}** Some.. sometimes (it's) not that bad, and sometimes it gets like:: like::: (it lasts) for a while .. [for a while.
DP	Dr. Kang:	[(it lasts) for a while, like that?
	3. Dr. Kang:	And how long did it take to feel better?
→	4. Mr. Sim:	**{pause for 2 seconds}** About that .. (I) don't know how to say=
DP	5. Dr. Kang:	=Just give a general idea. Did (it last) for few seconds or few minutes, or few hours?
→	6. Mr. Sim:	**{pause for 4 seconds}**
	7. Son-in-law:	/??/ See how long did it (last)?

		[/????/ See how long did it (last)?
	8. Dr. Kang:	[Yeah, (when you felt tight) like this, how many seconds or how many hours (did it last)? (It's) a big difference (between second and hour), yeah.
	9. Son-in-law:	See when you felt tight, about how long did it (last)? … roughly
→	10. Mr. Sim:	..umm sometimes:: it's.. it's.. like half an hour.

In the two examples, neither Mr. Sim nor Mr. Tan explicitly turns to the companion for resolution. The same situation occurs in most of the trouble cases (83.3%); the patients abstain from seeking help from their companions. Instead, they either try hard by themselves (lines 2 and 4 in Excerpt 2), remain silent (lines 2, 5, and 7 in Excerpt 3), or ask the doctor to repeat the question by saying *'hann?/hng?'* 'what?' (line 2 in Excerpts 5 and 7, Chapter 7).

The fact that, while responding to the doctor's questions, the elderly patients rarely initiate their adult children's participation even when having trouble may reflect a conflict between the patient's needs for autonomy and care. As observed by many sociologists (Parsons 1951, Suchman 1965, and Lin 1984), during the stage of being ill the patient's sick role is associated with that of a dependent, such as a child, who has the privilege to receive special care and attention from family and medical professions.

However, they also desire to maintain their normal social roles, such as parent, and to return to their daily routine as an independent adult. This conflict between the patient's needs for care and autonomy is similar to Brown and Levinson's ideas of 'positive face', the need to be appreciated or approved, and 'negative face', the need to be unimpeded by others (1987:62). Tannen (1986:101) and Hamilton (1996:70) both evoke the dynamic between 'power' and 'solidarity' to account for a similar conflict between patients and caregivers.

The conflict between the patient's need for care and autonomy might be more common in geriatric encounters when the adult child is the companion of patients who have undergone change in their social role from an autonomous person to a dependent of their children. This conflict between the patient's needs for care and autonomy can be best illustrated in Mr. Sim's case.

The fact that Mr. Sim is the only patient among the fifteen cases who is accompanied by his son-in-law is a marked case in itself. As the Tsao and Lu's study (1999) has shown, among the elderly patient's children generation, the son-in-law rarely participates in the care task for the patient (§2.6). A further look at the pedigree

information gathered by the doctor will show that Mr. Sim does not appear to have many resources for health care. Mr. Sim lives alone in a remote mountain area, and it takes about one-and-a-half-hours to get to the downtown hospital. After the death of his wife and the children's leaving home, Mr Sim's oldest daughter and son-in-law, who live downtown, are his primary caregivers. As his heart problem has become worse recently, he prefers to go to the downtown medical center, which is well-equipped, instead of one closer to his residence. Being ill and without transportation, Mr. Sim must rely on someone to take him to the downtown hospital. The son-in-law is thus recruited.

However, during the 15-minute triadic encounter, Mr. Sim displays resistance to recruiting his son-in-law in the interaction even when he encounters troubles. There are a total of 87 information-providing cycles observed in this encounter (see Table 6-2). The son-in-law participates in 28 of the 87 information-providing cycles. Yet, Mr. Sim initiates none of the 28 instances of the son-in-law's participation. Among the 87 information-providing cycles, Mr. Sim displays obvious troubles in comprehending the doctor's questions in 12 of them. The number 12 is a significantly high one since the total number of cycles involved in the patient's comprehension difficulties observed in

the fifteen encounters is 34 instances.[5] Eight of Mr. Sim's 12 comprehension troubles receive repair from his son-in-law. All of the son-in-law's 8 repair tasks are initiated by himself; none are initiated by Mr. Sim.

The issue of why Mr. Sim displays a high instance of comprehension problems is worthy of further research. When I invited Mr. Sim and his son-in-law to participate in my research, Mr. Sim appeared shy and not inclined to talk, but no obvious listening problems were observed. During my playback interview with Dr. Kang, she did not think that Mr. Sim suffered from listening problems. However, she felt that the patient was depressed, and the fact that the son-in-law occasionally walked around the examination room gave her the impression that he was in a hurry. This background information supports my hypothesis that Mr. Sim lacks resources and has to rely on his son-in-law whose companionship is more out of obligation than affection. This fact may partially account for Mr. Sim's resistance to ask for further assistance from his son-in-law when he encounters trouble with comprehension or expression.

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[5] The 34 instances refer to cases in which the patient explicitly asks the doctor to repeat the question by saying *'hann?' or 'hng?'* 'what?'. The companion repairs 14 of them (Figure 8-1) by rephrasing the doctor's question.

8.4 Self-initiation vs. other-initiation

Table 8-1 shows that the majority of the companion's participation in the elicited information-providing cycles are self-initiated by the companion. For example, there are only three companions (i.e. Mrs. Iunn's daughter-in-law, Mrs. Gonn's daughter, and Mrs. Lim's son) whose participation is initiated by the doctor while there are eleven companions whose participation is self-initiated. In institutionalized talk such as the doctor-patient interaction, the patient is the legitimized participant who provides the information regarding his or her health problem, given the fact that he or she is 'the patient'. The companions, being a third person in the doctor-patient interaction as observed in this research, seem to play a relatively active role in the sense that they self-initiate most of their own participation. This tendency for self-initiation seems to be related to their relationship with the patient, being the elderly patient's adult child and caregiver.

For most Taiwanese elderly of this age group, *san-dai-tong-tang* (three-generation residence) -- the older parents live with their married children and their grandchildren -- is still the preferred practice. Also, under the cultural norm, it is the adult children's

obligation to take care of their elderly parents. (See literature review in §2.6) In other words, the adult children play a crucial role in their elderly parent's health care. This bound and close interaction with their parents not only provides them with access to information about the patient's health problem, but also puts them in a position to participate in the medical event. Thus, as long as the adult children are present in the examining room with the patient, they are in a position to take part whenever needed; they do not wait for the doctor or the patient to grant them the floor of conversation. Imagine if the elderly patient had been accompanied by his or her 14 year-old grandchild or a paid caregiver (e.g. a Filipino maid); the companion's participation would have resulted in different picture.

8.5 Self-initiation and active participant

In this section, I will explore the correlation between the companion's degree of self-initiation and volunteering information. As I have argued earlier in Chapter 6, the companion who initiates more volunteered information-providing cycles is considered as an active participant, given the fact that the companion provides information without

waiting for the doctor to yield the conversational floor. Following the same logic, I will consider that the companion who scores higher in self-initiating his or her participation in the elicited information-providing cycles (either by providing information or rephrasing the doctor's question) is also an active participant. Compared to the companion who responds to the doctor's question because he or she is addressed, the companion who does so without being addressed is a more active one in the sense that the conversational floor of the latter's is not explicitly designated to the companion.

However, it should be noted that the numbers presented in Table 8-1 do not reflect a valid measurement of the companion's degree of self-initiation. Take the two cases of Mrs. Zhu's and Mr. Ong's daughters as an example. Mrs. Zhu's daughter participated in 39 elicited information-providing cycles. Among the 39 instances, 30.8% of her participation is initiated by the doctor and 66.7% initiated by herself. In the 13 elicited information-providing cycles that Mrs. Ong's daughter takes part in, her participation is all self-initiated, i.e. 100.0% of self-initiation. However, it does not mean that Mrs. Ong's daughter has a higher degree of self-initiation than Mrs. Zhu's daughter. Mrs. Zhu's daughter could have self-initiated all of her participation if the doctor had not done

so instead.

To examine the companion's degree of 'self-initiation', my measurement will be based on the elicited information-providing cycles where the companion participates or does not participate when no initiation cue is produced by the doctor or the patient in the previous turn. I will use Excerpt 4 for illustration. There are four elicited information-providing cycles (thus four situations) in Excerpt 4. In the first cycle, there is the initiation cue (i.e. the doctor's eye contact with the companion) observed in the doctor's question (line 1) regarding the identity of the companion, whom the patient identifies as her daughter-in-law. In this situation, the companion was given a chance to provide information but she did not take it.[6] In the second cycle, the doctor yields to the daughter-in-law another opportunity to talk by asking if she has any children (line 3). The doctor's question contains two initiation cues: the singular you *'li'* in referring the daughter-in-law and the doctor's eye contact with her. The daughter-in-law responds in line 4 that she has no children yet. In this second situation, the companion is given the

opportunity to participate, and she does take it.

Excerpt 4. {02’57”} (Mrs. Yiu 65F; main language: Southern Min)

I →DP	1. Dr. Tiunn:	**{look at the companion}** 所以這咧:是::? *So-yi tsit le: si::?* so this CL be
	2. Mrs. Yiu:	媳婦= *Sim-poo=* daughter-in-law
II →DCP	3. Dr. Tiunn:	=喔…恁::啊.汝生幾個? *=O… lin:: a. li senn kui-e?* oh you (plural) PRT you (singular) give birth how many **{the doctor then looks again at the companion}**
	4. D-in-law* :	啊我猶未生欸 hhh **{laughing} =** *A gua iau-bue senn-e hhh* PRT I have not give birth
IIa DP	5. Dr. Tiunn:	=喔,猶未 [生欸 *O iau-bue* [*senn-e* PRT have not give birth
	Mrs. Yiu:	[/???/ Tann 結婚爾 [*/???/ Tann ket-hun nia* just got married only
III →DPC	6. Dr. Tiunn:	Tann 結婚爾喔?...恁後生幾歲? *Tann ket-hun nia o?… lin hau-seen kui-hue?*

[6] There are very few instances, at most one or two instances in one encounter, in which the doctor’s question contains initiation cues, but does not receive a reply from the companion. The reason that the companion does not reply to the doctor might be that the patient has provided the reply, such as the first information-providing cycle in Excerpt 4.

		just married only Q your son how old
	7. Mrs. Yiu:	阮後生三十…六啊.三十七啦= *Guan hau-senn sann-tsap … /lak a. sann-tsap-tshit la/=* my son thirty six PRT thirty seven PRT
	8. D-in-law:	=三十六 */Sann-tsap-lak/* thirty six
IV →DP	9. Dr. Tiunn:	啊恁頭家咧? *A lin thau-ke leh?* PRT your husband Q
	10 Mrs. Yiu:	..頭家::過身二十幾冬啊 *.. thau-ke…. kue-sin ji-tsap kui tang a* husband pass away twenty more year ASP

* Daughter-in-law.

Translation

I →DP	1. Dr. Tiunn:	**{look at the companion}** So this is:: ?
	2. Mrs. Yiu:	(My) daughter-in-law
II →DCP	3. Dr. Tiunn:	You:: and.you have how many children? **{the doctor then looks again at the companion}**
	4. D-in-law:	I have not given birth yet.hhh **{laughing}**
IIa DP	5. Dr. Tiunn:	Oh, you haven't [given birth yet.
	Mrs. Yiu:	[(she) just got married.
III →DPC	6. Dr. Tiunn:	Just got married? … How old is your son?
	7. Mr. Yiu:	My son is thirty … six. thirty seven=
	8. D-in-law:	=Thirty six
IV →DP	9. Dr. Tiunn:	And how about your husband?

10. Mrs. Yiu: (My) husband passed away more than twenty years ago.

CODING

Initiators: lines 3-5 -- 1 instance of the doctor as initiator.
Initiation cues: lines 3-5 -- 1 instance of the doctor's use of personal deictics as the initiation cue.

In the third and fourth cycles, the doctor elicits information regarding the patient's son and husband. However, neither of his two questions in lines 6 and 9 contains initiation cues. The doctor chooses a relationship dietetic which has the patient, instead of the companion, as the addressee (i.e. *'lin hau-senn'* 'your son'), and there is no eye contact projected toward the companion. The companion provides a reply to the question in line 6 but remains silent for the question in line 9. In this third situation (i.e. the third cycle), the companion provides information although she is not offered the floor to do so; in the fourth situation (the fourth cycle), she remains silent when she is not offered the floor.

It is the companion's participation in the third situation that I consider active participation. By comparing the instances of the third and fourth situations, the degree of the companion's self-initiation will be gained. Table 8-4 presents the distribution of the third and fourth situations. Take Mrs. Zhu's encounter, for example. There are a total of 30 elicited information-providing cycles where no initiation cues are observed in the

doctor's or the patient's utterances, and yet the companion provides information or rephrases the doctor's question in response to 26 of the doctor's questions anyway. Thus, the companion's degree of self-initiation is 86.7%.

Table 8-4. The companion's degree of self-initiation.

	IP cycles in which no initiation cues are observed in the D's or the P's utterances						P vs. C initiates volunteered IP cycles[7]	P's vs.C's amount of participation in IP cycles[8]
	and do not receive responses from C		but do receive responses from C[9]		Total			
	A	B	C	D	E	F	G	H
Mrs. Zhu	4	13.3%	26	86.7%	30	100.0%	-22.6%	-23.4%
Mrs. Yiu	44	78.6%	12	21.4%	56	100.0%	-4.5%	27.7%
Mr. Ong	20	60.6%	13	39.4%	33	100.0%	3.4%	15.6%
Mrs. Pan	52	98.1%	1	1.9%	53	100.0%	19.4%	75.9%
Mrs. Iunn	30	55.6%	24	44.4%	54	100.0%	13.9%	35.4%
Mrs. Gonn	45	86.5%	7	13.5%	52	100.0%	5.7%	32.1%
Mrs. Lim	26	81.3%	6	18.8%	32	100.0%	6.6%	16.3%
Mrs. Su	34	59.6%	23	40.4%	57	100.0%	-4.6%	-6.7%
Mr. Sim	53	67.9%	25	32.1%	78	100.0%	3.4%	53.4%
Mrs. Tenn	27	62.8%	16	37.2%	43	100.0%	9.9%	21.0%
Mrs. Khu	42	77.8%	12	22.2%	54	100.0%	18.4%	69.7%
Mr. Tian	19	52.8%	17	47.2%	36	100.0%	-2.2%	-9.6%
Mr. Wang	38	90.5%	4	9.5%	42	100.0%	22.4%	70.4%
Mr. Tan	14	53.8%	12	46.2%	26	100.0%	9.1%	19.2%
Mr. Khoh	8	36.4%	14	63.6%	22	100.0%	-2.1%	9.8%
Total	456		212		668			

[7] The percentage number indicates the discrepancy between the patient's and the companion's acts of volunteering information. A negative number means that the patient volunteers less information than the companion, or the companion is more active in volunteering information than the patient. (See Table 6-6).

[8] See Table 4-2.

[9] The raw numbers in this column are equal to those in the column "Initiated by companion" in Table 8-1.

My next step is to examine the correlation between the companion's self-initiation in the elicited information-providing cycles (column D) and volunteering information in the volunteered information-providing cycles (column G), using SPSS's bivariate correlation tool. The result is presented in Table 8-5.

Table 8-5. The correlation between the companion's amount of participation, self-initiation, and volunteering information.

		P vs. C initiates volunteered IP cycles	P's vs. C's participation in IP cycles
	Pearson Correlation	-.744**	-.771**
The companion's degree of self-initiation in the elicited IP cycles	Sig. (2-tailed)	.001	.001
	Number of cases	15	15

**Correlation is significant at the 0.01 level (2-tailed).

Table 8-5 shows a high correlation between self-initiation and volunteering information (Pearson correlation = -.744).[10] In other words, the companion who

[10] The negative number (-.744) indicates a negative correlation between the companion's degree of self-initiation and the patient's acts of volunteering information, and thus a positive correlation between the companion's self-initiation and the companion's acts of volunteering information.

volunteers more information than the patient is more inclined to self-initiate his or her participation in response to the doctor's question. Early in Chapter 6, a high correlation between the companion's amount of participation and volunteering information in the information-providing cycles is found. (See §6.3.5). Thus, the correlation between the companion's amount of participation (column H in Table 8-4) and self-initiation are tested as well. Again, a high correlation (Pearson correlation = -.771) is displayed, as shown in Table 8-5. As I stated earlier, both the companion's acts of volunteering information and self-initiating in response to the doctor's question are signs of active participation. The findings here further support my previous argument (in Chapter 6) of the direct link between 'high participation' and 'active participation' -- the companion who exhibits a greater amount of participation in the information-providing cycles is a more active participant than one who doesn't.

8.6 Conclusion

In this chapter I presented the statistical findings of the application of the fourth part of my framework-- the distribution of the initiators of the companion's participation and

the associated initiation cues which prompt the companion's participation. In discussing these findings, this chapter focuses on the instances in which the patient and the companion initiate the companion's participation. There are three main discussions. First of all, it was found that the patients hardly ever initiate the companions even when the patients encounter problems with comprehension or expression. This finding reflects the conflicting needs of the elderly patients—they desire care from their adult children as well as autonomy to maintain their normal social roles and independence. Secondly, it was found that the companions' participation is mostly initiated by themselves. I argued that this preference of self-initiation over other-initiation is related to the companions' role. Being the elderly patient's adult children and primary caregivers, they are in the position to participate in their parent's medical events in the sense that they do not need to wait for the doctor or the patient to give them the floor of conversation.

Thirdly, I measured the companion's degree of self-initiation by comparing the instances in which the companion is not yielded the floor of conversation but provides information anyway with those instances in which he or she prefers remaining silent. I argued that both the companion's degree of self-initiation (in elicited information-

providing cycles) and degree of volunteering information (in volunteered information-providing cycles) can be seen as indicators of the companion's degree of activity. This argument is indirectly supported by the correlation test which displays a high positive correlation between the degree of self-initiation and volunteering information. These two indicators are further tested for their correlation with the companion's amount of participation in the information-providing cycles. A high positive correlation is displayed as well—the companion who exhibits a greater amount of participation in the information-providing cycles is a more active participant in volunteering information and self-initiating his or her own participation.

Chapter 9. Doctors as the Initiators: Part One

9.0 Introduction

The findings in Chapter 8 show that the majority of the companion's participation is initiated by the companion himself or herself (61.7%, Table 8-1), and the patient seldom initiates the companion's participation (2.4%). Chapter 8 also presents the associated initiation cues that the patient and the companion employed. From now on, I will shift the focus to the doctor, who scores a second high mean percentage of 35.9% in recruiting the companions' participation, and the initiation cues employed by the doctor. Since there are five initiation cues to be discussed, the discussion will be presented in two chapters (Chapters 9 and 10), to avoid a lengthy chapter. Chapter 9 will discuss the doctor's use of two initiation cues—eye contact and relationship deictics—and Chapter 10, three initiation cues—code-switching, the patient's absence, and the patient's trouble.

Section 9.1 displays the distribution of the initiation cues employed by the doctor. Among them, eye contact is the most frequently used one. I will present three

explanations to account for this high frequency in section 9.2. The occurrence of relationship deictics as initiation cue is closely related to the activities in which the doctor gathers pedigree information (§9.3). The connection between the companion's participation in the pedigree section will be explored in detail from sections 9.4 to 9.6. The discussions include the following topics: first, the majority of the companion's participation in the pedigree section is initiated by the doctor (§9.4); second, the companion is part of the patient's family history (§9.5); finally, in section 9.6, I will present the discourse function achieved by the companion's participation in the pedigree section.

9.1 Distribution of the initiation cues employed by doctors

In discussing the initiation cues employed by the five doctors in inciting the companions to speak, two cases of Dr. Tiunn are excluded, namely Mr. Ong and Mrs. Pan, since in these cases Dr. Tiunn does not initiate companion participation at all. The mean percentages of the instances of initiation cues employed by each doctor are displayed in Table 9-1. It shows that eye contact is the most frequently used mechanism

by all five doctors in initiating the companion's involvement. The initiation cues of personal deictics, relation deictics or code-switching are the second or third most frequently used initiation cue in each case. Consistently, all the doctors seldom initiate the companion's participation at times when the patient is not around or when the patient encounters troubles.

Table 9-1. Distribution of the initiation cues employed by doctors.

	Eye contact	Personal deictics	Relation deictics	Code-switching	Patient's absence	Patient's trouble
Dr. Tiunn (2 cases)	12 (70.6%)	1 (5.9%)	4 (23.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Dr. Lau (4 cases)	55 (56.7%)	19 (19.6%)	10 (10.3%)	12 (12.4%)	1 (1.0%)	0 (0.0%)
Dr. Kang (3 cases)	6 (28.6%)	5 (23.8%)	2 (9.5%)	5 (23.8%)	3 (14.3 %)	0 (0.0%)
Dr. Song (2 cases)	12 (63.2%)	3 (15.8%)	3 (15.8%)	1 (5.3%)	0 (0.0%)	0 (0.0%)
Dr. Niunn (2 cases)	30 (54.5%)	8 (14.5%)	9 (16.4%)	5 (9.1%)	1 (1.8%)	2 (3.6%)
Total	115	36	28	23	5	2
Mean	59.7%	17.0%	10.7%	9.8%	2.2%	0.6%

9.2 Eye contact and patient's trouble as initiation cues

As Table 9-1 has shown, eye contact is the most commonly employed cue (i.e. a

mean percentage of 59.7%) used in recruiting the companions. There are three reasons to account for this high frequency. First of all, eye contact or the gaze is the foundational pre-requisite to any social interaction (Morris 1978, Argyle et al.1981). More specifically, eye contact can serve as a kinesic mechanism to get the addressee's attention, to encourage participation, or to regulate and control the flow of conversation (Dickson et al. 1997). Appropriate eye contact with patient is also emphasized in most guidelines to clinical interview (Larson and Smith 1981, Myerscough 1992, Dickson et al. 1997). Secondly, compared to linguistic mechanisms (such as personal and relationship deictics and code-switching), kinesic mechanisms (such as eye contact) can be easily operated to complement the verbal message. Thirdly, the physical location of the companion in the examination room is likely to be in such a place that it is easy to have direct eye contact with the doctor. There are roughly three spatial arrangements among the three participants in the examination room, as shown in Figures 9-1, 9-2, and 9-3.

Figure 9-1. Spatial arrangement of the medical encounter- 1.

(Left to right: companion, patient, nurse, doctor)

Figure 9-2. Spatial arrangement of the medical encounter- 2.

(Left to right: doctor, patient, companion)

Figure 9-3. Spatial arrangement of the medical encounter- 3.

(Left to right: doctor, companion, patient)

Among them, the configurations in which the companion stands at the patient's side near the door (such as Figure 9-1 and Figure 3-1) or behind the patient (such as Figure 9-2 and Figure 7-1) are the two most common positions that the companion takes. In all the fifteen encounters, it is the patient who steps into the room first and the companion follows and closes the door. After the patient sits down, the companion then stands either behind the patient or to the patient's side near the door instead of between the doctor and the patient (such as Figure 9-3 and Figure 3-2). Ten of the companions stay in these two positions and five of them shift to a location between the doctor and the patient shortly

after the beginning of the interview. Both the configurations shown in Figures 9-1 and 9-2 allow the doctor to have easy eye contact with the companion in the sense that the doctor does not need to turn his or her head.

These preferred locations of the companion and the essential and requisite role of eye contact in human interaction account for the highest frequency of the doctor's use of eye contact to initiate the companion's participation.

9.3 Relationship deictics and pedigree information

As defined earlier (§7.2.2.3), the term 'relationship deictics' refers to the lexical items which describe the family relationship and mark the companion as the addressee. Among the six initiation cues employed by the doctor, relationship deictics scores the third highest mean incidence of 10.7% (Table 9-1). Unlike the initiation cues of eye contact, code-switching, and personal deictics, which are applied to a wider range of discourse contexts, relationship deictics as initiation cues are mostly used by the doctor 'when the doctor elicits pedigree information'. (I will refer the activities in quotes as 'the pedigree section for now'.)

The pedigree information refers to the family history, living arrangement, and hereditary factors of the elderly patient's family. Earlier in Chapter 5, I presented a comparison of the number of the five categories of information provided by the patient and the companion. It shows that the companion provides a relatively equal amount of pedigree information to that provided by the patient. To account for the comparatively equal amount of pedigree information provided by the companion, I invoked the idea of 'access to knowledge' as a possible factor. In this section, I will add in two more arguments: 1) the doctor authorizes the companion's participation in the pedigree section (§9.4); and 2) the companion, i.e. the adult child of the elderly patient, is part of the patient's pedigree event (§9.5). In section 9.6, I will discuss the discourse function achieved by the companion's participation in the pedigree section.

9.4 The doctor authorizes the companion's participation in pedigree section

In my observation, the majority of pedigree information is elicited by the doctor instead of volunteered by the patient party. Most patients who visit the family medicine department at a medical center such as NCKU are prepared to tell their doctors

information regarding the biomedical syndrome, but not the family history.[1] Sometimes doctors are challenged by the patient when they ask about family history. For example, the daughter of Mrs. Zhu complains with a joke (*'Hao xiang shen-jia-diao-cha!'* 'This is like an investigation!') when the doctor asks if she (the daughter) is married and has offspring. In other words, most of the pedigree information is provided by the patient party only upon questioning by the doctors. As shown in columns E and F of Table 9-2, among the 235 pieces of pedigree information, 223 pieces are elicited by the doctor while only 12 of them are volunteered by the patient party.

Column G shows that among the 223 information-providing cycles in which the doctor elicits pedigree information the companion participates in 130, i.e. 64.7%, of them by answering the doctor's questions either by himself or herself alone or in collaboration with the patient. A further examination of the data will show that half of the companion's acts of providing pedigree information are initiated by the doctor, as indicated by the number 52.7% in the last row of Column H. I mentioned earlier that the

[1] This might be related to the general fact that the idea of 'family doctors' is not well-established in Taiwan. Thus, most patients do not have a clear idea of what a family doctor is or for what health problem they will need to visit a family doctor.

Table 9-2. The companion's participation in the pedigree section.

	Amount of pedigree info. provided [2]			Number of IP cycles in which the pedigree info. is			C's participation in pedigree section initiated		
	by P	by C	P vs. C	volunteered	elicited	provided by C	by D	by P	by C
A	B	C	D	E	F	G	H	I	K
Mrs. Zhu	3.0%	4.4%	-1.5%	1	13	12 (92.3%)	6 (50.0%)	0 (0.0%)	6 (50.0%)
Mrs. Yiu	11.1%	1.8%	9.3%	0	12	2 (16.7%)	1 (50.0%)	0 (0.0%)	1 (50.0%)
Mr. Ong	3.3%	5.1%	-1.9%	1	13	8 (61.5%)	0 (0.0%)	0 (0.0%)	8 (100.0%)
Mrs. Pan	--	--	--	--	--	--	--	--	--
Mrs. Iunn	18.4%	7.1%	11.2%	4	26	14 (53.8%)	6 (42.9%)	0 (0.0%)	8 (57.1%)
Mrs. Gonn	7.5%	8.6%	-1.1%	3	20	12 (60.0%)	10 (83.3%)	0 (0.0%)	2 (16.7%)
Mrs. Lim	1.2%	7.3%	-6.1%	0	10	10 (100.0%)	8 (80.0%)	0 (0.0%)	2 (20.0%)
Mrs. Su	1.6%	1.5%	0.1%	0	9	6 (66.7%)	4 (66.7%)	0 (0.0%)	2 (33.3%)
Mr. Sim	15.6%	5.7%	9.9%	0	21	13 (61.9%)	1 (7.7%)	0 (0.0%)	12 (92.3%)
Mrs. Tenn	7.6%	1.8%	5.8%	0	16	9 (56.3%)	7 (77.8%)	0 (0.0%)	2 (22.2%)
Mrs. Khu	14.8%	1.6%	13.2%	3	27	7 (25.9%)	0 (0.0%)	0 (0.0%)	7 (100.0%)
Mr. Tian	--	--	--	--	--	--	--	--	--
Mr. Wang	7.7%	3.7%	4.0%	0	35	16 (45.7%)	10 (62.5%)	2 (12.5%)	4 (25.0%)
Mr. Tan	0.5%	6.4%	-5.9%	0	9	9 (100.0%)	8 (88.9%)	0 (0.0%)	1 (11.1%)
Mr. Khoh	0.0%	9.4%	-9.4%	0	12	12 (100.0%)	9 (75.0%)	0 (0.0%)	3 (25.0%)
Total				12	223	130	70	2	58
Mean						64.7%	52.7%	1.0%	46.4%

[2] The numbers in columns B, C, D are from Table 5-2 in Chapter 5.

cases of Mr. Tan and Mr. Khoh are marked in the sense that it is their companions who provide the majority of the pedigree information to the doctors. In contrast, Mr. Tan and Mr. Khoh provide almost no pedigree information. Further examination shows that the majority of the two companions' acts of providing pedigree information is initiated by the doctors (i.e. 75.0% and 88.9% in column H). Excerpt 1 from Mr. Tan's case is quoted for illustration.

Excerpt 1--Translation.[3]{06'17"}(Mr. Tan 76M; main language: Southern Min; underlined parts: Mandarin)

DCP	1. Dr. Niung:	And whom do you live with now?
	2. Mr. Tan:	[With them
	3. Daughter:	[With…with us, and::: <u>I am his daughter</u>
	4. Dr. Niung:	Oh, I see
	5. Daughter:	Yeah
→DC	6. Dr. Niung:	That..<u>how many brothers and sisters?</u> how many kids?
	7. Daughter:	We.. six
→DCP	8. Dr. Niung:	<u>Six brothers and sisters, male and female:: six</u>?
	9. Daughter:	Yeah::, some::: enn::: [<u>five female, one male</u>

[3] See Excerpt 4 in Chapter 7 for the Chinese version of this excerpt.

10. Mr. Tan: [five/??/

→DC 11. Dr. Niung: And <u>the boy</u> is the youngest?=

12. Daughter: =Hng-hng-hng **{laughs and nods her head}**

→DC 13. Dr. Niung: And <u>you are the?</u>

14. Daughter: <u>I</u>…<u>I'm the oldest.</u>

→DC 15. Dr. Niung: <u>Oldest</u>, and (you) live with him?

16. Daughter: Henn, henn, henn

→DC 17. Dr. Niung: How about (your) mom?

18. Daughter: (My) mom.. yeah, (she) lives with (us) as well.

Following line 10, the doctor poses four other questions (lines 11-18) which all contain initiation cues (e.g. Mandarin in lines 11 and 15, personal deictics in lines 13 and 15, and relationship deictics in line 17). All the four questions receive a reply from the daughter. Near the end of the encounter (11'47"), the doctor recommends that the patient get some exercise. The patient volunteers the information that he often walks the kids to school. The doctor asks two further questions regarding the mother of the kids and their living arrangement. Again, these questions contain initiation cues (e.g. Mandarin in lines 2 and eye contact in line 4) and receive a reply from the daughter instead from the patient.

Excerpt 2. {11'47"}(Mr. Tan 76M; main language: Southern Min; underlined parts: Mandarin)

1. Mr. Tan: 我攏帶…帶囡仔去學校啦,創啥仔按吶叨好,
gua long tshuah … tshuah gin-a khi hak-hau la,
I EMP bring bring kids go school PRT

tshong siann-a to an-ne to ho,
do what EMP like this EMP good

→DC 2. Dr. Niung: 你的小孩?
ni-de xiao-hai?
your kids

3. Daughter: 都是...我妹妹的
dou shi … wo mei-mei-de
all be my sister's

→DC 4. Dr. Niung: **{looks at the daughter}**
呼,啊恁攏住作伙噢,猶是按吶?
hoo, a lin long tuah tso-hue o, a-si an-na?
oh PRT you EMP live together Q or what

5. Daughter: 嗯::我..妹妹::她.. 工作,啊小孩都是放在我家
umm:: *wo*.. *mei-mei*:: *ta*.. *gong zuo*,
umm my sister she work

a xiao-hai dou shi fang-zai wo jia
PRT kids alll be put my house

Translation

1. Mr. Tan: I always walk … walk the kids to school. Yeah, that's what I do.

→DC 2. Dr. Niung: Your kids?

3. Daughter: (They) are…my sister's.

→DC 4. Dr. Niung: **{looks at the daughter}**
Oh, so you all live together or what?

In the 9 information-providing cycles in which Dr. Niung elicits pedigree information from Mr. Tan, the daughter participates in all of them, and it is the doctor who prompts the majority of her participation (88.9%). Dr. Niung's acts of initiation toward the daughter accounts for why the daughter provides the greater amount of the pedigree information (6.4%) while that provided by Mr. Tan is only 0.5% (Table 9-2). More than half of the 13 companions' acts of providing pedigree information (52.7%, Table 9-2) are initiated by the doctor. In other words, the doctor encourages the companion to provide the pedigree information by addressing questions to him or her. It partially accounts for why the 13 companions provide roughly as much pedigree information as do the patients.

9.5 Adult child as part of the patient's pedigree event

My second argument to account for the companion's participation in providing pedigree information is that the adult child is part of the patient's pedigree event. In most of the thirteen encounters, the content of the pedigree information concentrates on the first and second generations of the elderly patient's offspring. In Dr. Kang's three

encounters, she also traces the patient's parent generation. The adult children, being part of the elderly patient's family history, thus have direct access to the pedigree information though they may not have full knowledge regarding the patient's parental generation. The companion's direct access to the pedigree knowledge marks pedigree information as 'PC-event' (§5.4.3). It also allows the doctor to elicit the information either from the patient or the companion since both of them are able to provide first-hand information. The alternative resources of the first-hand information can be observed from the doctor's choice of relationship deictics. For example, there are a total of 7 instances in which the doctors mark the patient as the addressee when eliciting information regarding the health status of the patient's spouse, as does Dr. Tiunn, and 5 more which have the adult child as the addressee, as in the instance of Dr. Lau.

Dr. Tiunn (to Mrs. Yiu): 啊恁頭家咧?
A lin thau-ke le? (PRT/you/husband/Q)
And (how's the health of) your husband?

Dr. Lau (to Mrs. Su's son): 啊恁爸爸咧?
A lin pa-pa le? (PRT/you/father/Q)
And (how's the health of) your father?

There are a total of 10 instances in which the doctors (such as Dr. Kang) mark the patient as their addressee when eliciting the number of their offspring, and 3 instances in which the doctors (such as Dr. Niung) mark the adult child as the addressee.

Dr. Kang (to Mrs. Tenn):	啊囝仔幾欸啊? *A gin-a kui-e a?* (PRT/kids/how old/Q) And how many children [do you have]?
Dr. Niung (to Mr. Khoh's son):	汝有幾欸兄弟姊妹啊? *Li u kui-e hiann-ti-tsi-mue a?* (you/have/how many/brothers and sisters/Q) How many brothers and sisters do you have?

Some doctors even switch their addressees between the patient and the adult child within one utterance, such as

Dr. Lau: (in Mrs. Gonn's case)	所以..啊先生是..啊爸爸咧? *So yi .. a sen-si..a pa-pa le?* (so/PRT/husband/PRT/father/Q) So .. and (how about your) husband .. umm (your) father?
Dr. Niung: (in Mr. Tan's case)	彼落..幾欸兄弟姊妹?幾欸囝仔? *hit-lo .. kui-e hiann-ti-tsi-mue? kui-e gin-a?* (that/how many/brother and sister/how many kids) umm .. how many brothers and sisters? how many children?

Other relationship terms which make the companion as the addressee observed in

the doctor's utterances are presented in the left column of Table 9-3. Their alternative expressions, which would mark the patient as the addressee, are presented in the right column.

Table 9-3. Relationship deictics (Underlined part: Mandarin).

The companion as the addressee	The patient as the addressee
大姊是抱欸啦? *Da-jie si pho-e la?* The oldest sister is adopted?	大漢查某子是抱欸啦? *Tua-han tsa-bo-kiann si pho-e la?* The oldest daughter is adopted?
哥哥幾個小孩? *Ge-ge ji-ge xiao-hai?* How many kids does (your) brother have?	後生歸欸囝仔? *Hau-senn kui-e gin-a?* How many kids does (your) son have?
共恁公公兩欸住作夥? *Kah lin gong-gong lng-e tuah tsho-hue?* (The patient) lives with your father-in-law?	共恁頭仔兩欸住作伙? *Kah lin thau-e lng-e tuah tso-hue?* (You) live with your husband?
大伯敢娶啊? *Da-buo kam tshua a?* Is the elder-brother-in-law married?	大漢後生敢娶啊? *Tua-ham hau-senn kam tshua a?* Is the elder son married?

The doctor can phrase his or her question using either relationship deictics which has the patient as the addressee or using the alternative, which has the companion as the addressee. Either way will provide the doctor with first-hand information because the companion is part of the patient's family history. In the playback interview, Dr. Niung

offers the insight that eliciting the pedigree information from the companion works more efficiently when there is a time constraint. This direct access to the pedigree knowledge accounts for why the companion is able to provide an amount of pedigree information which is roughly equal to that provided by the patient.

9.6 Pedigree information and the identity of the companion

In this section, I will discuss one discourse function achieved by the companion's participation in providing the pedigree information—the identification of the companion.

It is not a common practice that the three participants, namely the doctor, the patient, and the companion, verbally introduce each other at the beginning of the fifteen encounters. This lack of verbal identification may not be a problem on the side of the doctor and the patient. A patient who registered for Dr. Tiunn and waited outside Dr. Tiunn's examination room where a name card reading 'Dr. Tiunn' is placed will have no doubt that it is Dr. Tiunn that he or she is visiting. Dr. Tiunn, who has in hand the patient's medical record with a cover page indicating the full name, age, and gender of

Mr. Ong will have no doubt that the old man who comes in right after the nurse called out the name ‘Mr. Ong Lau-hiong’ is ‘Mr. Ong’. After the patient steps into the room with the companion, there are three opening patterns observed in the fifteen encounters.

Pattern 1: **The doctor greets the patient, addresses the patient with his or her full name (1a) or family name (1b), and then elicits the patient’s chief complaint. There are a total of four instances of pattern 1.**

(1a) Dr. Lau: 林王::::月…我咧唸有對無?
Lim Ong::::guat … honn? gua leh liam u tioh bo?
Lim Ong guat Q I ASP say have correct Q

Lim Ong::::guat … right? Did I say (it) right?

(1b) Dr. Tiunn: 來,王先生 honn? 啊汝是按吶艱苦?
Lai, Ong-senn-sinn honn? a li si an-na kan-koh
come Mr. Ong, Q PRT you be how sick

OK, Mr. Ong, right? So, what’s your problem?

Pattern 2: **The doctor greets the patient, addresses the patient with the honorific term for the elderly, *‘o-ba-sang’* for female elderly (2a) or *‘o-li-sang’* for male elderly (2b), and then elicits the patient’s chief complaint. There is a total of five instances of pattern 2.**

(2a) Dr. Lau: 來,歐巴桑…遮坐 …這汝的收據,hann?
Lai, o-ba-sang … tsiah tse… tse li-e sio-ku hann?
come o-ba-sang here sit this your receipt ok

OK, O-ba-sang … have a seat … this is your receipt, OK?

(2b) Dr. Niung: 來,歐里桑遮坐…歐里桑今仔什麼問題?
Lai, o-li-sang, tsia tse … o-li-sang kin-a siann-mih bun-te?
come O-li-sang here sit O-li-sang today what problem

OK, O-li-sang, have a seat … O-li-sang, what brings (you) here today?

Pattern 3: **The doctor greets the patient and then elicits the patient’s chief complaint. There are a total of six instances of pattern 3.**

(3) Dr. Kang: 來,請坐 hann, 今仔來是什麼問題?

Lai, tsiann tse hann, kin-a lai si siann-mih bun-te?
come please sit PRT today come be what problem

OK, please have a seat, what brings (you) here today?

As we can see, there are only 4 instances, i.e. pattern 1, out of the fifteen encounters in which the doctor clarifies the name of the patient in the opening section. Most of the doctors in the fifteen encounters did not clarify the identity of the companion except in one case[4] though there might have been some eye contact exchanges, nor does any of the fifteen companions introduce himself or herself to the doctor. It is only at the time when the doctor elicits pedigree information that the identity of the companion is revealed by the patient party or explored by the doctor.[5]

A simplified process of the revelation of the companion's identity is presented in Table 9-4. The arrow indicates the utterance in which the companion's identity is

[4] After Mrs. Iunn and the companion came in, Dr. Lau looked at the patient information sheet on the medical record. Before the doctor asked: 'what brings you here today?', he asked about the patient's occupation. Mrs. Iunn replies that she is retired and since her daughter-in-law is busy she does the cooking in the house. Mrs. Iunn's mention of the daughter-in-law triggers the doctor's exploration of the companion's identity: 'So this is ?', to which the Mrs. replies: '(my) daughter-in-law'.

[5] There are two cases, Mrs. Pan and Mr. Tian, in which the doctor did not elicit pedigree information. In Mrs. Pan's case, the companion's identity was made known to the doctor when she volunteered information to him and referred to the patient as 'my mom'. In the case of Mr. Tian, the identity of the companion remains unknown to the doctor.

revealed by the patient (3 instances) or the companion (4 instances) or explored by the doctor (5 instances). The number within the {} indicates the time point of the revelation and the number within the ( ),such as (8th cycle) indicates the order of the cycle within the pedigree section which contains the revelation.

Table 9-4. The revelation processes of the companion's identity.

Doctor	Patient party	Chinese	Translation
Dr. Niung	Mr.Tan Daughter {06'17"} (1st cycle)	D: 啊汝既嘛共誰人住作夥? P: [共音 C: [共…共阮,迄落:::我是他女兒 D: *A li tsit-ma kah siang tuah tso-hue?* P: [*Kah in* C: [*Kah…kah guan, bit-lor:::wo shi ta nu-er*	D: Now you live with? P: [With them. →C: [With us, I'm his daughter.
Dr. Niung	Mr. Khoh Son {05'55"} (1st cycle)	D: 歐里桑共誰住作伙? P: 哼? C: 共阮媽媽住.共阮小弟 D: 汝有幾欸兄弟姊妹仔? C: 兄弟姊妹.七欸 D: *O-li-sann kah siang tuah tso-hue?* P: *Hng?* C: *Kah gun mama tuah, kah gun sio-ti* D: *Li u kui-e hiann-ti-ji-mue?* C: *Hiann-ti-ji-mue.. tshit-e*	D: Now you live with? P: What? →C: With my mom and brother. D: How many brothers and sisters do you have? C: Seven brothers and sisters

Dr. Tiunn	Mr. Ong Daughter {04'22"} (1st cycle)	D: 汝即嘛共誰住? P: **{silence for 2 seconds}** C: 即嘛叨是阮媽來住佇遮哩 D: *Li tsit-ma kah siang tuah?* P: **{silence for 2 seconds}** C: *Tsit-ma to si guan ma lai tuah tsia*	D: Now you live with? P: **{silence for 2 seconds}** →C: My mom is hospitalized (that's why we are here in the hospital today).
Dr. Tiunn	Mrs. Zhu Daughter {03'18"} (2nd cycle)	D: 你現在是跟誰住? C: 跟我 D: 跟妳,henn,妳:= P: =女兒 D: *Ni xian-tsai shi gen she tsu?* C: *Gen wo* D: *Gen ni.. ni*= P: =*Nu-er*	D: Now you live with? C: With me. D: With you.. you.= →P: =(my) daughter
Dr. Tiunn	Mrs. Yiu D-in-law {02'57"} (8th cycle)	D: 所以這咧是:: P: 媳婦 D: *So-yi tsit-le si::?* P: *Sim-po*	→D: So, this is... ? P: Daughter-in-law
Dr. Lau	Mrs. Lim Son {11'16"} (2st cycle)	D: 啊汝即嘛共誰人住? C: 共阮作伙 D: 共恁作伙住,汝排第幾欸?汝兄弟姊妹/??/ C: 老大, D: *A li tsit-ma kah siann-lang tuah?* C: *Kah gun tuah tso-hue* D: Kah lin tuah tso-hue? *Li pai te-kui e?Li hiann-di-ji-mue /??/* C: *Lao-da*	D: Now you live with? C: With us. →D: With you, your *pai-hang*[6] is? You have how many brothers and sisters? C: (I'm) the oldest (son).

[6] '*Pai-hang*' literally means 'rank-line'. The doctor is asking the companion his place in the children's birth order.

Dr. Lau	Mrs. Su Son {05'09"} (1st cycle)	D: 幾個後生啊? P: 叨這個爾啦**{points to C}** D: *Kui-e hau-senn a?* P: *To tsit-e nia* **{points to C}**	D: How many sons? →P: Only this one.**{points to C}**
Dr. Lau	Mrs. Gonn Daughter {02'08"} (1st cycle)	D: 妳是他女兒? 妳今年幾歲? C: **{nodding her head}** D: *Ni shi ta nu-er? ni jin-nian ji-sue?* C: **{nodding her head}**	→D: You are her daughter? C: **{nodding her head}**
Dr. Kang	Tenn D-in-law {06'03"} (9th cycle)	D: 汝即嘛和什麼人住作伙? P: 我家己住爾啦 C: 和阮..公公啊,還有大伯 D: *Li tsit-ma ham siann-mi-lang tsuah?* P: *Gua ka-ki tuah nia la* C: *Ham guan gong-gong.. a hai-you da-bo*	D: Now you live with? P: I live by myself. →C: With my father-in-law.. and brother-in-law.
Dr. Kang	Khu D-in-law {06'38"} (9th cycle)	D: **{looks at C}** 啊汝是伊欸? C: 我媳婦啦 D: **{looks at C}** *A li si i e...?* C: *Gua sim-po la*	→D: **{looks at C}** So you are her…? C: I'm (her) daughter in-law
Dr.Kang	Mr.Sim S-in-law {08'17"} (8th cycle)	D: 啊這是恁::? P: [阮子.子婿. C: [我音子婿 D: *A tse si lin::?* P: [*Gun kiann.. kiann-sai la* C: [*Gua in kiann-sai*	→D: So, this is your..? P: [My-son-in-law C: [I'm his son-in-law

As we can see from Table 9-4, there seem to be two relevant contexts for the revelation -- information regarding the patient's living arrangement or number of

offspring. For example, in the first information-providing cycle of Mr. Tan's pedigree section, the companion replies that the patient lives with 'us' and then explicitly introduces herself: 'I am his daughter.' In Mr. Khoh's case, the companion replies to the doctor that the patient lives with 'my mother and younger brother' which indirectly reveals his identity as the son of the patient. His identity is further confirmed by the doctor's next question 'How many brothers and sisters do you have?' to which the son replies 'seven'. In the case of Mrs. Tenn, the companion indirectly reveals her identity as the patient's daughter-in-law while responding to the doctor's question regarding the patient's living arrangement: '(the patient lives) with my father-in-law and brother-in-law'. At 05'09" of Mrs. Su's encounter, she replies to the doctor that it is her son who bought her a jade bracelet to wish her good health. Her mention of the son prompts the doctor to move on to the pedigree section with the question 'How many sons do you have?', to which the patient points to the companion and says 'Only this one'.

Since most doctors begin the pedigree section with the question 'Who do you live with now?' it immediately triggers the revelation of the companion's identity in the first or second information-providing cycle. If the two relevant contexts do not trigger the

revelation or the two contexts do not occur earlier in the pedigree section, the doctor then explores the companion's identity explicitly. For example, in the three cases of Dr. Tiunn who prefers to begins the section with the question 'How old are you now?', the companion's identity is not revealed until Dr. Tiunn's query in the 8th or the 9th cycle.

Based on the above phenomenon, I have argued that the pedigree section is the interactional context for the revelation of the companion's identity instead of in the very opening section. As the companion is inevitably one of the patient's family, the pedigree section thus becomes the most legitimate interactional slot for the doctor to recruit the companion or for the companion to contribute his or her participation.

It is also noted that when the companion's identify is revealed in the pedigree section, its occurrence seems to be tied to the question regarding the patient's living arrangement (7 instances in Table 9-4). Although more data will be needed to make any conclusion, as an insider of the community in South Taiwan, I consider this phenomenon related to the social issue of *san-dai-tong-tang* 'three-generation-residence' in Taiwan.

The old cultural norm that the older parents live with their married children and their grandchildren prescribes the children's obligation to take care of their parents.

However, this norm may lead *san-dai-tong-tang* to be mistaken for *xiao-shun* 'filial piety' (Hu 1995:53). Those elderly who live with their children are assumed to be the fortunate ones and those adult children who invite their elderly parents to live with them instead of placing them in an institution are assumed to have greater filial piety. Thus, the topic of the parent's living arrangement becomes a subtly handled one in a social interaction concerning the parent's health problem because the children may feel that it is their obligation to account for their parent's living arrangement reasonably. This might explain why the doctor's question about the patient's living arrangement immediately triggers the companion's participation (for example, the companions of Mr. Tan, Mr. Khoh, Mrs. Lim, Mrs. Zhu, Mrs. Tenn), thereby revealing their relationship with the patient.

9.7 Conclusion

In this chapter, I discussed the doctor's use of eye contact and relationship deictics as the initiation cues in recruiting the companion's participation. Eye contact, as the requisite non-verbal element in human communication, is found to be the most

frequently employed mechanism (59.7%) among the six initiation cues. This high instance of occurrence is also related to the preferred spatial arrangements of the triad (Figures 9-1 and 9-2) which allows the doctor to easily have eye contact with the companion.

This chapter devotes a large portion to the discussion of the use of relationship deictics as initiation cues. Although its occurrence takes up only 10.7% among the six initiation cues, there are several important and interesting features related to its occurrence. First of all, its occurrence is tied to the activities in which the doctor gathers pedigree information. During these activities, the companion provides an almost equal, or even greater, amount of pedigree information than the patient does (Chapter 5). Secondly, it is further noted that the majority of the companion's acts of providing pedigree information is authorized by the doctor's addressing questions to the companion, as evidenced by the doctor's choice of Mandarin, relationship deictics and personal deictics which mark the companion as the addressee (§9.4).

Thirdly, I argued that since the companion is part of the elderly patient's family, he or she has access to most pedigree information. This fact provides doctors two

alternatives to get the first-hand pedigree information by addressing either the patient or the companion, as evidenced by the doctor's choice of the relationship deictics (§9.5). Finally, in section 9.6, I presented the discourse function achieved by the companion's participation in the pedigree section—the interactional slot to introduce the companion's identity.

Chapter 10. Doctors as the Initiators: Part Two

10.0 Introduction

In this chapter, I will explore three initiation cues employed by the doctor to recruit the companion's participation– code-switching, the patient's absence, and the patient's trouble. Table 8-2 shows that there are a total of 23 instances (i.e. 9.8%) in which the doctor code-switches into Mandarin, thereby initiating the companion to participate in the information-providing cycles. Although I have not further coded who initiates the use of Mandarin in what specific context, I observed two interesting code-switching phenomena in the geriatric triads: the doctor's alignment and non-alignment with the companion's language choice (§10.1) and the companion's role in the non-information-providing cycles (§10.2). Table 8-2 also shows that the doctor rarely recruits the companion either at the time when the patient is away (i.e. 2.2%) or at the time when the patient encounters problems with comprehension or expression (i.e. 0.6%). Their low occurrence will be discussed respectively in sections 10.3 and 10.4.

10.1 The doctor's alignment or non-alignment with the companion's language choice [1]

As I have introduced earlier in Chapter 3, there are eleven elderly patients judged as monolingual in Southern Min, and their adult children and doctors are bilingual in Southern Min and Mandarin. Among the eleven cases, there are six cases in which both Mandarin and Southern Min are used by the doctor and the companion, as shown in Table 10-1.

Table 10-1. The use of languages in eleven encounters.

Patient		Companion		Doctor	
Mrs. Yiu	SM	Daughter-in-law	SM* MD*	Dr. Tiunn	SM
Mr. Ong	SM	Daughter	SM	Dr. Tiunn	SM
Mrs. Iunn	SM	Daughter-in-law	SM MD	Dr. Lau	SM
Mrs. Gonn	SM	Daugther	SM MD	Dr. Lau	SM MD
Mrs. Lim	SM	Son	SM MD	Dr. Lau	SM MD
Mrs. Su	SM	Son	SM	Dr. Lau	SM
Mr. Sim	SM	Son-in-law	SM	Dr. Kang	SM
Mrs. Tenn	SM	Daughter-in-law	SM MD	Dr. Kang	SM MD
Mrs. Khu	SM	Daughter-in-law	SM	Dr. Kang	SM
Mr. Tan	SM	Daughter	SM MD	Dr. Niung	SM MD
Mr. Khoh	SM	Son	SM	Dr. Niung	SM

*SM: Southern Min; MD: Mandarin

[1] Many of the discussions here are inspired by Elif Rosenfeld (personal communication, 1998).

In my observation of the six cases in which Mandarin is spoken, the companion always starts speaking Mandarin while talking to the doctor. On most occasions, the doctor tends not to follow the companion's choice of Mandarin in the information-providing cycles. However, in the cases when the information is related to pedigree information, the doctor may align with the companion's language. Excerpts 1 and 2 are examples for illustration.

Excerpt 1. {01'10"}(Mrs. Gonn 87F; main language: Southern Min; underlined parts: Mandarin)

DCP	1. Dr. Lau:	啊汝今仔日是按吶? *A li kin-a-jit si an-na?* and you today be what
→	2. Daughter:	…叨伊是:::即嘛是..正常啦呼,啊偶爾honn *…To i si::: tsit-ma si.. tsing-siong la honn, a ou-er honn,* PRT she be now be normal PRT PRT PRT occasional PRT [透早起來頭會暈啦,啊會嘔吐啦 [*thau-tsa khet-lai tou hui yun la, a hui ou-tu la* early morning get up head will dizzy PRT PRT will vomit PRT
	3. Mrs. Gonn:	[啊若無. [*A na-bo..* PRT otherwise
DCP	4. Dr. Lau:	*Oh::*
	5. Mrs. Gonn:	啊卜[三]次咧,會按吶.. *A ben tho- e leh, e an-nei..* PRT will vomit PRT will like this

		[人會憨會喘啦, 哼
		[*lang e gong e tshuan la, hng*
		body will dizzy will breathless PRT yeah
→	6. Daughter:	[啊走路人會不穩按吶
		[*A kiann-lo lang e bu wun an-nei*
		PRT walk EMP will NEG stable like this
DP	7. Dr. Lau:	..啊擱有按吶無?
		.. A koh u an-na bo?
		PRT more have what Q
	8. Mrs. Gonn:	*Hann?*
		what
	9. Dr. Lau:	啊擱有按吶無?
		A koh u an-na bo?
		PRT more have what Q
	10. Mrs. Gonn:	有咧,啊叨按吶.人.人按吶..有一點仔像按吶爾
		U leh, a to an-nei.. lang.. lang an-nei..
		have PRT PRT EMP like this body body like this
		u tsit-tiam-a sionn an-nei nia
		have a little bit like this only

Translation

DCP	1. Dr. Lau:	What's your problem today?
→	2. Daughter:	… She is::: (she) is now.. OK, but sometimes yeah..
		[Early in the morning when (she) wakes up, (her) head feels dizzy and she feels like vomiting, yeah.
	3. Mrs. Gonn:	[Yeah, other than this..
DCP	4. Dr. Lau:	Oh, (I see).
	5. Mrs. Gonn:	And sometimes (I) feel like vomiting, like..
		[(my body) feels dizzy and breathless, yeah,
→	6. Daughter:	[And (she) can't keep stable when (she) walks.

DP

7. Dr. Lau: ..Any other uncomfortable feelings?

8. Mrs. Gonn: What?

9. Dr. Lau: ..Any other uncomfortable feelings?

10. Mrs. Gonn: Yes, (it's) like umm.. (my) body .. (my) body is like .. (it) feels like this.

At 01'10" in Mrs. Gonn's case, the doctor is eliciting the patient's chief complaint with the question 'so, what brings you here today?' The daughter takes the turn and provides the biomedical information that the patient is currently fine but occasionally experiences dizzy and vomiting feelings in the morning (line 2). Notice that the daughter's description begins with Southern Min and then switches into Mandarin ('*Thau-tsa khet-lai tou hui yun la, a hui ou-tu la*' 'Early in the morning when (she) wakes up, (her) head feels dizzy and she feels like vomiting, yeah'). The patient provides the follow-up information that she sometimes feels nauseous, dizzy and breathless (line 5). In the middle of the patient's description, the daughter inserts the information that the patient can not 'keep stable' '*bu-wun*' (also in Mandarin) when she walks. The doctor further asks in Southern Min '*A koh u an-na bo?*' 'Any other uncomfortable feelings?'

(lines 7 and 9). The doctor's utterances in lines 7 and 9 do not align with the daughter's use of Mandarin.

The doctor's non-alignment with the companion's use of Mandarin is also observed in Excerpt 2. At 04'20" of Mr. Tan's encounter, the doctor is eliciting Mr. Tan's intake of alcohol in his daily diet because the doctor suspects it is related to the patient's complaint about his sore joints. In line 1, the doctor asks about the amount of alcohol Mr. Tan drinks each time (*'tsit-puann pue? tsit pue'* 'half cup? one cup?'). Mr. Tan replies that the kind of cup that he uses is like those used on airplanes. Yet, he is not able to give a precise description, and thus he turns to his daughter. The daughter describes the kind of cup and the amount of alcohol mostly in Mandarin ('*hao-xiang::fei-ji shang na-ge xiao pei-zi:: tsha-put-to, jiang-jin::ba-fen man zhe-yang-zi*' '(it's) like:: the kind of small cup used on airplanes::(it's) about, about::eighty percent full, like that'. The doctor then clarifies the amount with measurement of its volume in cubic centimeters. Notice that the doctor's question does not follow the daughter's choice of Mandarin.

Excerpt 2. {04’20”}(Mr. Tan 76M; main language: Southern Min; underlined parts: Mandarin)

DPC

1. Dr. Niung: 一半杯啊?一杯?
Tsit-puann pue? tsit pue?
half cup one cup

2. Mr. Tan: 伫飛機頂迄款杯仔,彼落. **{turns to his daughter}**
Ti hun-lin-ki ting hit-kuan pue-a, hit-lo..=
on airplane on that kind cup that..

→ 3. Daughter: 好像::飛機上那個小杯子::
=Hao-xiang::fei-ji shang na-ge xiao pei-zi::
like airplane on that kind small cup

4. Dr. Niung: *Henn*
yeah

→ 5. Daughter: 差不多,將近::八分滿這樣子,
Tsha-put-to, jiang-jin:: pa-fen man zhe-yang zi,
almost almost eighty percent full like this

6. Mr. Tan: 按吶**{makes a shape with his hands}**
An-nei
like this

[按吶,按吶,按吶
[*An-nei, an-nei, an-nei*
like this like this like this

7. Daughter: [伊.伊攏倒足濟的…henn
[*I .. i long toh tsiok tsue-e … henn*
he he EMP fill very much yeah

DP

8. Dr. Niung: 按吶…差不多..嘛..六十西西有喔..卡加哦?=
An-nei…tsha-put-to..ma.. lak-tsap si-si u o .. khah ke o?=
like this about also sixty c.c. have PRT more much PRT

9. Mr. Tan: =六十西西,
=Lak-tsap si-si
sixty c.c.

Translation

DPC	1. Dr. Niung:	Half cup? One cup?
	2. Mr. Tan:	(It's) like the kind of cup used on airplanes, that..=**{turns to his daughter}**
→	3. Daughter:	=(It's) <u>like</u>:: <u>the kind of cup used on airplanes</u>::
	4. Dr. Niung:	Yeah
→	5. Daughter:	(It's) almost, <u>almost:: eighty percent full, like this,</u>
	6. Mr. Tan:	Like this **{makes a shape with his hands}** [umm like this, like this, this
	7. Daughter:	[He.. he always fills a lot… yeah
DP	8. Dr. Niung:	Like this … about .. umm .. sixty c.c. about .. or more than that?=
	9. Mr. Tan:	=Sixty c.c.

The above two excerpts show the doctor's consistent choice of Southern Min. Yet, the following two examples will present a different behavior on the part of the doctor. In line 1 of Excerpts 3 and 4, the doctor directs the question to the patient in Southern Min to elicit pedigree information regarding the patient's living arrangement. Both the companions provide the information in Mandarin. Dr. Niung and Dr. Kang ask, respectively, two and five follow-up questions, mainly in Mandarin.

Excerpt 3—Translation.[2]{06'17"}(Mr. Tan 76M; main language: Southern Min; underlined parts: Mandarin)

DCP	1. Dr. Niung:	And whom do you live with now?
	2. Mr. Tan:	[With them
	3. Daughter:	[With…with us, and::: <u>I am his daughter</u>
	4. Dr. Niung:	Oh, I see
	5. Daughter:	Yeah
→DC	6. Dr. Niung:	That..<u>how many brothers and sisters?</u> how many kids?
	7. Daughter:	We.. six
→DCP	8. Dr. Niung:	<u>Six brothers and sisters, male and female:: six</u>?
	9. Daughter:	Yeah::, some::: enn::: [<u>five female, one male</u>
	10. Mr. Tan:	[five/??/

Excerpt 4. {05'59"}(Mrs. Tenn 66F; main language: Southern Min; underlined parts: Mandarin)

DPC	1. Dr. Kang:	汝即嘛和什麼人住作伙? *Li tsit-ma ham siamm-mih-lang tuah tso-hue?* you now with who live together
	2. Mrs. Tenn:	我家幾住爾啦 *Gua ka-ki tua nia la* I self live only PRT
	3. D-in-law*:	和阮..<u>公公</u>啊, *Ham guan .. <u>gong-gong</u> a,* with my father-in-law PRT

[2] See Excerpt 4 in Chapter 7 for the Chinese version of this excerpt.

		[還有大伯 [*Hai you da-bo* *also with oldest brother-in-law*
→	4. Dr. Kang:	[和恁公公二欸 [*Ham lin gong-gong lng-e,* with your father-in-law two
DC	5.	大伯? *Da-bo?* oldest brother-in-law
	6. D-in-law:	*Hng* m-hng
→DC	7. Dr. Kang:	老大? *Lao-da?* the oldest
	8. D-in-law:	*Hng* m-hng
→DC	9. Dr. Kang:	老大也結婚了啦honn? *Lao-da ye jie-hun le la honn?* the oldest also married ASP PRT Q
	10. D-in-law:	沒有 *Mei-you* no
→DC	11. Dr. Kang:	沒有結婚喔? *Mei-you jie-hun o?* NEG married PRT
	12. D-in-law:	*Hng* m-hng
→DC	13. Dr. Kang:	那就三個人住這樣? *Na jiou sang-ge ren zhu zhe-yang?* So EMP three people live like this
	14. D-in-law:	對

Dui
right

* Daughter-in-law.

Translation

DPC	1.	Dr. Kang:	Who do you live with now?
	2.	Mrs. Tenn:	I live by myself.
	3.	D-in-law:	With my .. <u>father-in-law</u>, <u>[and (my) oldest brother-in-law.</u>
→	4.	Dr. Kang:	[With your <u>father-in-law</u>, two people,
DC	5.		And the oldest borther-in-law
	6.	D-in-law:	mm hmm
→DC	7.	Dr. Kang:	<u>The oldest?</u>
	8.	D-in-law:	mm hmm
→DC	9.	Dr. Kang:	<u>The oldest (brother-in-law) is also married</u>, right?
	10.	D-in-law:	<u>No</u>
→DC	11.	Dr. Kang:	Not married?
	12.	D-in-law:	<u>mm hmm</u>
→DC	13.	Dr. Kang:	<u>So the three people live together like that?</u>
	14.	D-in-law:	<u>Right.</u>

In other words, it is the companion who tends to initiate the use of Mandarin while providing information to the doctor. When the doctor follows the companion's use of Mandarin, it is a clear cue to encourage the companion to participate more in the

information-providing cycles. And it is found that the doctor follows the companion's language choice only in gathering first-hand pedigree information, which is also available from the companion. However, the doctor is less inclined to align with the companion's language choice in the occasions where the firsthand information is only available from the patient such as biomedical information.

10.2 Code-switching and the companion's role in the non-information-providing cycles [3]

In this section, I will present another code-switching phenomenon related to the role of the companion. The phenomenon is the doctor-companion Mandarin exchanges regarding the explanation of the diagnosis and the treatment plan. The conversations or discourse sequences which are related to the diagnosis and the treatment plan are grouped into the non-information-providing cycles (see Chapter 4). In most occasions, these exchanges occur after the doctor has been provided the information regarding the

patient's health problem and has completed the physical examination of the patient. I observed that both the companion and the doctor are more inclined to use Mandarin when the talk is about the diagnosis and the treatment plan.

For example, at 11'24" of Mrs. Gonn's encounter (Excerpt 5), the doctor has finished the physical examination of Mrs. Gonn and is about to explain his impression of the patient's health problem. The doctor's explanation begins with a Southern Min expression (*'A i tse thau-khah gong honn'* 'about this dizzy feeling she has'). Then he code-switches into Mandarin in stating that the dizzy and vomiting feeling might be related to the sclerosis of the blood vessels and the elevation of blood pressure (lines 1 and 3). The daughter then asks in Mandarin if her mother's health problem has anything to do with the balance of the inner ears (line 4). After the doctor answers the daughter's question, again in Mandarin (line 5), he then addresses the patient, as indicated by the Southern Min vocative *'a-ma'* 'grandma' (line 7), and rephrases in Southern Min what he has explained to the daughter earlier (lines 9, 11, and 13).

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[3] Many of the discussions in this section are inspired from the audience's response to the one-hour talk: 'Code-switching and Doctor-Patient Communication' that I presented in the family medicine department at NCKU on March 24, 1999. I am also indebted to Prof. Feng-fu Tsao and Prof. Bing-hua

Excerpt 5 {11'24"}(Mrs. Gonn 87F; main language: Southern Min; underlined parts: Mandarin)

→ 1. Dr. Lau: 啊伊這頭殼憨 honn…看起來像這個年紀呼,因為血管硬化啦呼,血壓變高,honn,然後引起這個:::所謂的..姿勢性改變/引起的/,血壓呼,一下子改變不過來啦,就是說人.=

A i. tse thau-khah gonn honn…kan-qi-lai xiang zhe-ge nian-ji,
PRT she this head dizzy PRT look like this age

yin-wei xie-guan ing-hua la honn, xie-ya bian-kao
because blood vessel sclerosis PRT PRT blood pressure raise

honn, ran-hao yin-qi zhe-ge::: so-wei-de..zi-shi-xing gai-bian
PRT then cause this so-called postural change

/yin-qi-de/, xie-ya ho, yi-xia gai-bian bu-guo-lai la,
cause blood pressure PRT suddenly change can't PRT

jiou shi shuo ren..=
EMP be say body

2. Daughter: =循環比較..
=*Xun-huan bi-jiao..*
circulation more

→ 3. Dr. Lau: 人的動作可能比你的血管的動作還要快,honn,所以她有時候就會暈,暈了就會想吐,吐是因為暈的關係

Ren-de dong-zuo ke-neng bi ni-de xie-guan dong-zuo
body's movement probably than your blood vessel movement

hai-kuai, honn, so-yi ta you-shi-hou jiou hue yun, yun le
faster PRT, so she sometimes EMP will dizzy dizzy ASP

jiou hue xiang tu, tu shi yin-wei yun-de kuan-xi
EMP will want vomit vomit be due to dizzy cause

4. Daughter: ..那跟::什麼內耳平衡有沒有關係?是不是平衡感/感官/?
.. *Na gen::she-me nei-er ping-heng you-mei-you guan-xi?*
that with what inner ear balance have not have relation

Shi for their insightful comments on this topic

Shi-bu-shi ping-heng gan /gan-kuan/?
be not be balance sense sense

→ 5. Dr. Lau: 嗯::不能說沒有關係啦呼,但是..關係這..已經沒有辦法釐清說一定是跟那個有關係,我想那個老化是多方面的問題,所以我們只能夠多方面把她解決

umm:: bu-neng shuo mei-you guan-xi la ho, dan-shi.. guan-xi
umm can't say no relation PRT PRT but relation

zhe.. yi-jing mei-you ban-fa li-qing shuo yi-ding shi gen na-ge you
this alreay no way clarify say must be with that have

guan-xi, wo xiang na-ge lau-hua shi duo-fang-mian-de wun-ti,
relation I think that aging be many different ways' problem

so-yi wo-men zhi neng-gou duo-fang-mian ba ta jie-jue
so we only can many different ways BA it resolve

6. Daughter: 好
Hao
OK

→ 7. Dr. Lau: 阿媽,來汝::坐過來=
A-ma, lai li:: tse kue-lai=
grandma please you sit toward here

8. Daughter: =坐過來
=Tse kue-lai
sit toward here

→ 9. Dr. Lau: 我即嘛嘎汝講呼,這呼,汝的血壓呼,稍可有卡高啦
Gua tsit-ma ka li kong honn, tse honn, li-e hueh-ap honn,
I now for you say PRT this PRT your blood pressure PRT

sio-khua u khah-kuan la,
a little bit have higher PRT

10. Mrs. Gonn: /一點呼/
/Tsit-tiam ho/
a little bit PRT

→ 11. Dr. Lau: 哼::呼,啊汝這頭殼會憨 honn,

Henn:: ho, a li tse thau-khah e gong honn,
PRT PRT PRT you this head will dizzy PRT

12. Mrs. Gonn: *Hng*
yeah

→ 13. Dr. Lau: 叨是因為這老啊呼,啊血根卡硬,收縮壞,呼,所以動作未使傷緊,
To si yin-ui tse lao ho, a hue-kin khah-genn,
EMP be because this old PRT PRT blood vessel harder

sio-sok bai, ho, so-yi tong-zo bue-sai sionn kin.
contraction bad PRT so movement can't too fast

Translation

→ 1. Dr. Lau: Umm this dizzy feeling she has, yeah … It looks like the sclerosis of the blood vessel due to aging. The blood pressure is elevated, yeah, and it causes this so-called 'postural change dizziness'. /It causes/ the blood pressure, umm, (the blood pressure) can't adapt to the sudden change of posture in time. That is to say, the body..=

2. Daughter: =The circulation is getting..

→ 3. Dr. Lau: The movement of the body is faster than that of your blood vessel, yeah, that's why she feels dizzy sometimes, and (when she) feels dizzy, she feels nauseous as well. Nausea is a result of dizziness.

4. Daughter: .. Well, then:: does it have anything to do with the inner ears' balance? Is it because of the sense of balance, /the sense/?

→ 5. Dr. Lau: umm:: it's not that there is no relation (between the inner year balance and dizziness), but um.. it would be hard to clarify an absolute relationship between them. I think um..the problems of ageing involves multiple aspects. The best thing we can do is to resolve as many problems as we can.

6. Daughter: All right.

→ 7. Dr. Lau: Granda-ma, OK:: would you sit closer=

8. Daughter: Sit closer

→ 9. Dr. Lau: Let me tell you now, OK, this blood pressure you have, OK, is a little bit higher, yeah.

10. Mrs. Gonn: /a little bit/

→ 11. Dr. Lau: Yeah::, OK, and this dizziness of your head, yeah,

12. Mrs. Gonn: Yeah

→ 13. Dr. Lau: (it's) because that (you) are getting old, and the blood vessel is hardening. The contraction is bad. Yeah, so when (you) make any movements, don't move fast.

In this excerpt, the doctor initiates the use of Mandarin to recruit the companion in the non-information-providing cycles. The companion aligns with the doctor's choice of language and asks further questions regarding the diagnosis. The following excerpts (Excerpt 6 and 7) are examples in which the companion initiates the use of Mandarin while asking the doctor about some possible side-effect which might have resulted from the patient's health problems. In Excerpt 6 of Mrs. Lim's encounter, after the doctor has explained his diagnosis and treatment plan to the patient party, he schedules a follow-up visit for the patient. Before the doctor ends the encounter, the son asks the doctor if the injection that his mother took earlier for the relief of her joint problem will cause any side-effects (line 1). The doctor replies that palpitation and facial flush are the possible side-effects and they occur right after the injection (lines 2 and 4). In this case, the son

begins the use of Mandarin, a choice which is followed by the doctor.

Excerpt 6. {17'17"}(Mrs. Lim 73F; main language: Southern Min; underlined parts: Mandarin)

1. Son: …/???/,請問一下那個..那個.像在打那個..針劑的話, 有什麼那個/副作用沒有?應該也是.=

…/???/, Qing wun yi-xia na-ge…na ge..xiang zai da
may ask one moment that that like ASP inject

na-ge..zhen-ji de-hua, you she-me na-ge fu-zuo-yong mei-you?
that injection if has any that side-effect or not

ying-gai ye shi..=
supposed also be

2. Dr. Lau: =打那個有副作用就是打的當時有副作用,
=Da na-ge you fu-zuo-yong jiou shi da de dang-shi
inject that have side-effect will be inject NOM when

you fu-zuo-yong,
have side-effect

3. Son: 打的當時,
Da de dang-shi
inject NOM when

4. Dr. Lau: 打了有時候有些人會潮紅啦,心悸啊,啊伊若注了無叨是無啊
Da le you-shi-hou you-xie ren hue chao-hong la
inject ASP sometimes some people will blush PRT

A i na tsu liao bo to si bo a
PRT she if inject ASP no EMP be no PRT

Translation

1. Son: …/???/, Excuse me, um… um... like when (she) takes the .. um injection, .., does it umm have any side-effects? It should be..=

2. Dr. Lau: =Were there any side-effects, (she) would have felt them (when she took the injection)

3. Son: when she took the injection,

4. Dr. Lau: Some people will blush when (they) get the injection. If she didn't show any reaction, then there's no (after-effect).

Mrs. Tenn's encounter (Excerpt 7) presents a similar phenomenon to that in Excerpt 6. The doctor explains that the patient does not sleep deeply and that is why she can recall the details of her dream. The doctor's explanation is initially conveyed in Southern Min (lines 1 and 3). The daughter-in-law poses a follow-up question in Mandarin, asking if the patient's shallow sleep will have a negative effect in the future (line 4). The doctor answers her question in Mandarin as well.

Excerpt 7. {13'25"} (Mrs. Tenn 66F; main language: Southern Min; underlined parts: Mandarin)

1. Dr. Kang: 但是阮睏了足深,所以阮未去記著夢中的代誌
Tan-si gun khun-liau tsiok tshim,
but I sleep very deep

so-yi gun be-khi ki-tioh ban-tiong-e tai-tsi
so I not to remember in the dreams things

2. Mrs. Tenn: *M-hng*
m-hng

3. Dr. Kang: 啊汝會記著夢中代誌叨是講::夢彼段時間汝卡淺眠..所以

A li e ki-tioh ban-tiong tai-tsi to si kong::
and you able to remember in the dreams things EMP be mean

ban hit tuann si-kan li khah tshian me.. so-yi
dream that section time you more shallow sleep so

[囀擱攏知影
[*tsuann koh long tsai-iann*
therefore again EMP know

4. Mrs. Tenn: [喔,淺眠卡會夢啦
[*oh, tshian me khah e ban la*
oh shallw sleep more inclined will dream PRT

→ 5. D-in-law*: 那怎麼會長期間都這樣的話::敢有.敢有影響?
Na ze-me hue chang qi-jian de-hua:: kam u.. kam u ing-xiang?
then how will long period if Q have Q have effect

→ 6. Dr. Kang: …其實對.健康/沒關/,只是你會覺得有點困擾啊,
..Qi-shi due.. jian-kang /mei-guan/, zhi-shi ni hue
in fact toward health no effect just you will

jue-de you dian kun-rao a
feel have some bothers PRT

* Daughter-in-law.

Translation

1. Dr. Kang: But because I sleep deeply, I will not remember what's in the dream.

2. Mrs. Tenn: M-hng

3. Dr. Kang: And the reason you remember the things in dreams means:: during your dream, you have shallow sleep.. so (you)
[remember everything (in the dream)

4. Mrs. Tenn: [Oh, shallow sleep results in dreams.

→ 5. D-in-law: Well then how.. if it continues in the long term:: does (it) ..does (it) affect (the health)?

→ 6. Dr. Kang: … Actually (it) has.. no effect, but just you may feel bothered, yeah

In the above section, I have shown that the companion is more inclined to initiate the use of Mandarin in the encounter. Also, a contrastive behavior on the part of the doctor is observed. The doctor withholds his or her language alignment with the companion's choice of Mandarin in the information-providing cycles unless the information to be elicited is the pedigree information. However, in the non-information-providing cycles, such as the explanation of the diagnosis and treatment plan, the doctor may choose to direct his or her explanation solely to the companion or aligns with the companion's use of Mandarin in answering the companions' questions.

The doctor's recruiting or aligning with the companion in the non-information-providing cycles reflects most doctors' expectation for the companion—as a facilitator in the implementation of the treatment plan. Dr. Lau expresses the following expectation during my playback interview with him. If there is a caring and affectionate relationship observed between the adult child and the elderly patient, he will deliver the complicated explanation of the diagnosis and the details of the treatment plan to the adult child and then repeat himself to the elderly patient in a simplified way. Sometimes it is much easier to convey the complicated knowledge of western medicine to adult children than to

patients. Also, a good relationship between the caregiver and the patient will be a positive resource in enhancing the patient's compliance, for example, in adhering to the schedule for medicine and diet control. (See Responses 3 and 4 in Chapter 11 for a related discussion on the playback interview with the doctors.)

In the triadic interaction of the doctor, elderly patient, and adult child, the adult child shares more social characteristics with the doctor than the patient does. They both belong to the same age group (30-45 years old); they both have received more education than the elderly patient; and they are Mandarin speakers. Most doctors in South Taiwan, at least in the family medicine department of NCKU, are trained to use Southern Min with the elderly patients, but the adult children are not professionally trained to do so when they speak to doctors. Within the diglossia background in Taiwan where Mandarin is the 'high language' and Southern Min the 'low language' (Ferguson 1972), it is in accordance with the social norm that the educated younger generation chooses the high language (i.e. Mandarin) when they speak to a person with high socioeconomic status (such as doctors or professors) in a public area (such as a teaching hospital).

This practice explains why the companion is more inclined to initiate the use of

Mandarin with the doctor. The doctor, following the top principle of first-hand information, tends not to align with the companion's use of Mandarin while gathering information. When it comes to the task of explaining the diagnosis and treatment with the expectation of the companion's role as the facilitator of treatment plan, it is acceptable to convey the more complicated details to the companion, and Mandarin is allowed if it makes the communication easier for the doctor and the adult child. The companion's role as facilitator of the treatment plan also accounts for the companion's relatively equal participation in the non-information-providing cycles as compared to the information-providing cycles in which the patient has a significantly higher amount of participation than the companion (§4.5).

Finally, the doctor's selective use of code-switching supports the argument of Auer (1984) and Wei and Milroy (1995) that code-switching functions as a contextualization cue or a discourse strategy to achieve various interactional purposes, such as language-alignment for accepting a request and non-alignment for the refusal of a request. In this research, I found that the doctor's alignment with the companion's use of Mandarin is considered to be a way to convey the doctor's expectation that the companion will

facilitate the treatment plan for the patient while the doctor's non-alignment with the companion's use of Mandarin is to achieve the doctor's goal of gathering first-hand information from the patient who does not speak Mandarin.

10.3 The patient's absence as initiation cue

The results in Table 8-2 (of Chapter 8) also indicate that the doctor hardly ever prompts the companion to provide information while the patient is away from his or her seat . In most encounters, the checking of the patient's height and weight occurs after the doctor has already gathered most of the relevant information and has completed most of the physical examination. Thus, the doctor seldom elicits information from the companion when the doctor is with the companion alone. This fact accounts for the low occurrence of the doctor's eliciting information from the companion when the patient is absent. However, it is observed that the doctor tends to recruit the companion by giving information regarding the diagnosis and treatment plan. The companion, on the other hand, also takes this chance to ask further questions or to provide more information. Excerpts 8 to 9 are quoted for illustration.

At 15’24” of Mrs. Khu’s encounter, the nurse is checking Mrs. Khu’s weight and height, as shown in Figure 10-1.

Figure 10-1. The patient’s absence as initiation cues –1.

(Left to right: nurse, companion, patient, doctor)

At this point (Excerpt 8), Dr. Tiunn tells Mrs. Khu’s daughter-in-law that it is good to keep track of the patient’s blood pressure (line 1). It will even better to mark the date and the time when she checks her blood pressure because the blood pressure varies in a day (such as in the morning or in the afternoon) (lines 3 and 5).

Excerpt 8. {15’24”}(Mrs. Khu 81F; main language: Southern Min)

→ 1. Dr. Kang: 這張 honn,會使繼續記啦 honn,若是記欸時陣,阮是希望會當記彼落日期,honn,/血壓/什麼時間量=

Tsit tiunn honn, e-sai ket-siok ki la, honn,
this piece PRT OK continue take note PRT PRT

na-si ki e-si-tsun,guan si hi-bang e-tang ki hit-lo
if take note when we be hope good take note that

jit-ki honn, /hue-ap/ siann-mih si-kang niung=
date PRT blood pressure what time measure

2. D-in-law*: 呼呼呼
ho ho ho
OK OK OK

→ 3. Dr. Kang: /一日/中間欸彼落..血壓無.無一定會同款,啊會當參考是下甫卡敖舉,猶是下早卡敖舉=

/tsit-jit/ tiong-kan hit-lo..hue-ap bo. bo it-ting e kang-khuan,
a day during that blood pressure not not for sure be same

a e-tang tsam-kho si e-po khah gau gia,
PRT can reference be afternoon more easily raise

a-si e-tsai khah gau gia=
or morning more easily raise

4. D-in-law: 呼呼,按吶毋叨愛量.量幾遍?..三遍 honn?
Ho ho, an-nei m to ai niung.. niung kui pian?
oh oh, then NEG EMP need measure measure how many times

.. sann pian honn?
three time Q

→ 5. Dr. Kang: 若::會使下早欸差不多十點左右,下甫六點左右量,/這二欸/時間時間卡敖舉啦,

Na:: e-sai e-tsai-e tsha-put-to tsap tiam tso-yiu
if possible morning’s about ten o’clock around

e-po lak tiam tso-yiu niung, /tsit lng-e/ si-kan si-kan,
afternoon six o'clock around measure this two time time

khah gau gia la
more easily raise PRT

6. D-in-law: honn honn honn,十點左右,好,好
honn honn honn, tsap tiam tso-yiu, ho, ho
oh oh oh ten o'clock around OK OK

* Daughter-in-law.

Translation

→ 1. Dr. Kang: About this note (of the blood pressure), you should keep taking note, yeah, when you measure (the blood pressure), we suggest you also write down the date, yeah, at what time (you measure) the blood pressure=

2. D-in-law: OK, I see.

→ 3. Dr. Kang: During /the day/.. the blood pressure may not stay the same, what will be good reference (for us) are, um.. does the blood pressure raise in the afternoon, or in the morning, =

4. D-in-law: =I see, so umm.. it means we need to measure .. to measure how many times? // three times, right?

→ 5. Dr. Kang: If :: it works then check it around ten o'clock in the morning, or around six o'clock in the afternoon. These are the times that (the blood pressure) rises.

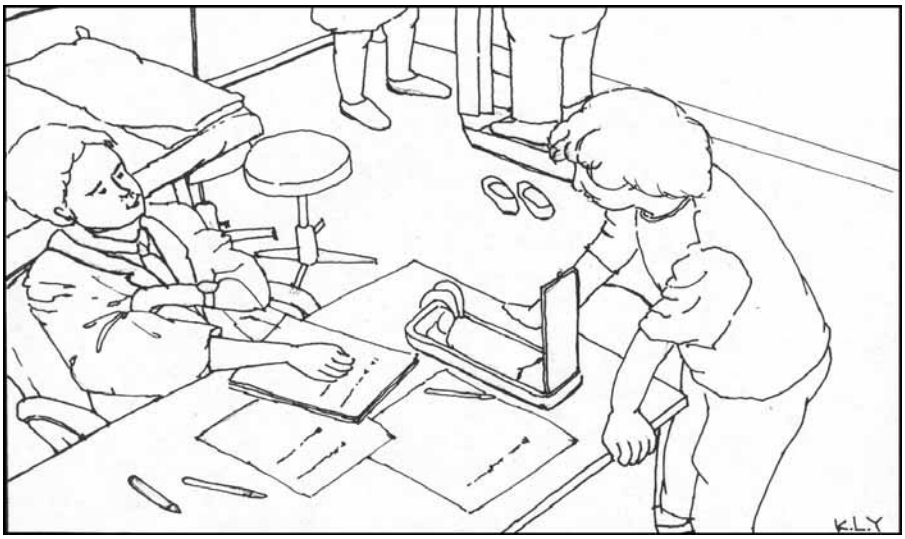
6. D-in-law: Oh I see, around ten o'clock, OK, OK.

At 07'22" of Mrs. Zhu's encounter (Excerpt 9), Dr. Tiunn has just finished the bed physical examination and is moving from the bed to his seat, and the patient is walking toward the scale. Mrs. Zhu's daughter poses a question to the doctor regarding her

mother's coughing problem (line 1), as shown in Figure 10-2.

Figure 10-2. The patient's absence as initiation cues –2.

(Left to right: doctor, nurse, patient, companion)



Excerpt 9. {07'22"}(Mrs. Zhu 74F; main language: Mandarin)

→ 1. Daughter: ..那現在她那個咳的::?
..*Na ta xian-zai na-ge ke-de::?*
and her now that coughing

2. Dr. Tiunn: henn,那個咳 honn,=
Henn, na-ge ke honn,=
Yeah that coughing PRT

3. Daughter: =*Henn*
yeah

→ 4. Dr. Tiunn: 因為沒有痰啦＝
Yin-wei mei-you tan la=
because no saliva PRT

5. Daughter: ＝對,沒有痰
=*due, mei-you tan*
right no saliva

→ 6. Dr. Tiunn: =所以:一般來講像這種情況大部分都是,有沒有?都是:喉嚨 honn,比如說會癢啦 honn,=

=*So-yi: yi-ban lai-jiang xiang zhe-zhong qing-kuang*
so general speaking like this situation

da-bu-fen dao shi … you-mei-you? dao shi: hao-long honn,
majority EMP be right EMP be throat PRT

bi-ru-shao hue yiang la honn,=
for example will allergic PRT PRT

7. Daughter: =*Umm umm umm=*
Umm umm umm

8. Dr. Tiunn: =或者是有什麼::比如說喉嚨比較乾,或者是有一些什麼外來的刺激,
=*Huo-zhe shi you she-me:: bi-ru-shuo hou-long bi-jiau kan*
or be have something for example throat more dry

hao-zhe shi you yi-xie she-me wai-lai-de ci-ji,
or be have some something external stimuli

[它就會想要咳
[*ta jiou hue xian-yao ke*
he EMP will want to cough

→ 9. Daughter: [就會想要咳嗽,像有半夜喔/???/都不好睡
[*Jiou hue xiang-yao ke-sao, xiang you pan-ie oh /???/*
EMP will want to cough like have mid-nigh oh

dao shue bu hao
EMP sleep no good

10. Dr. Tiunn: 這樣子喔=
Zhe-yang-zi oh=
like this oh

→ 11. Daughter: ＝對, **{sits on the patient's seat}**
=*Dui,*

right

她咳嗽咳得.還好我問她喔,
Ta ke-sao de.. *hai-hao wo wun ta oh.*
she cough to (the degree that) good I ask her oh

Translation

→ 1. Daughter: ..So about her coughing problem::?

2. Dr. Tiunn: Yeah, the coughing, um, =

3. Daughter: =Yeah,

→ 4. Dr. Tiunn: Because there is no saliva,=

5. Daughter: =Right, no saliva

→ 6. Dr. Tiunn: =So:: generally speaking, a situation like this, it's because … yeah, it's because the throat, yeah, for example, it gets allergic, yeah=

7. Daughter: = Umm umm umm=

8. Dr. Tiunn: =or it could be:: like, the throat is dry, or some external stimuli (get in) [and cause the coughing

→ 9. Daughter: [She feels like coughing. Sometimes around mid-night /???/ (she) can't get to sleep

10. Dr. Tiunn: I see=

→ 11. Daughter: =Yeah, **{sits on the patient's seat}**
She coughs so bad.. I'm glad I checked that.

In lines 9 and 11 while Mrs. Zhu's daughter volunteers information, she even takes the seat of the patient. Dr. Tiunn explains to the daughter that because no saliva is observed (line 4), it is likely that the patient's coughing is caused by some external

stimuli or dryness of her throat (lines 6 and 8). At this point, the daughter volunteers another piece of information by telling the doctor that sometimes the patient's coughing occurs at mid-night and the coughing is so bad that she (the patient) can not get to sleep (lines 9 and 11). After that point, the doctor-daughter talks compose the majority of the remaining conversation of the treatment plan. As shown in Figure 10-3, the spatial arrangement has the doctor and the daughter as the focus with the patient sitting away from them.

Figure 10-3. The patient's absence as initiation cues –3.

(Left to right: doctor, patient, companion)

The above observation supports my previous discussions of the companion's role in the non-information-providing cycles in which the implementation of the long-term treatment plan (such as the daily check of blood pressure) requires the assistance of and support from the elderly patient's primary caregiver of whom the adult children plays the role.

10.4. The patient's trouble as initiation cue

The results in Table 9-2 (Chapter 9) have shown that the doctor rarely initiates the companion at the time when the patient encounters difficulty in expressing or comprehending. Earlier in Chapter 8, I evoked the patient's need for autonomy to account for a similar phenomenon: the patient hardly ever recruits the companion even when the patient encounters obvious communication problems. The respect for patient autonomy can also account for the doctor's resistance in recruiting the companion to resolve the patient's trouble of expression and comprehension. Most of time, the doctor waits for the patient to complete the reply or rephrases his or her question. For example, even though Mr. Sim has displayed many obvious comprehension and expressional

troubles, Dr. Kang never turns to the companion for help (e.g. Excerpt 3 in Chapter 8.) In my playback interviews with the doctors, most of them confirm that first-hand information and patient autonomy are the top priorities when interviewing the patient. (See also Response 2 in Chapter 11). Contexts related to patient autonomy include the patients' being provided the chance to communicate with the doctor on their own (such as to provide the first-hand information) and being given sufficient information to handle their health problem.

The only two instances where the doctor initiates the companion for the resolution of the patient's trouble occur in Mr. Khoh's encounter with Dr. Niung. Similar to Mr. Sim's case, Mr. Khoh has displayed many listening problems along the interaction.[4] In the playback interview with Dr. Niung, he offers the insight that complete information may override the first-hand information especially when the elderly patients display troubles in recalling their past history of medical treatment (such as the results of earlier medical examinations). The doctor's conflicting needs between first-hand information,

[4] Out of the 39 elicited information-providing cycles in Mr. Khoh's encounter (Table 6-2), 8 of Dr. Niung's questions are followed by Mr. Khoh's question of *'hann?'* 'what?'. (See Excerpt 5 and 7 in Chapter 7.)

complete information, and patient autonomy as observed in the current research reflect the multiple tasks that the doctor has undertaken in the medical interview especially when more than two participants are involved (Tannen and Wallat 1982, see also §2.5 for review).

10.5 Conclusion

In this chapter, I explored the occurrence of the three initiation cues employed by the doctor: code-switching, the patient's absence, and the patient's trouble. First of all, I discussed some code-switching phenomena related to the companion's participation in the medical encounter. I observed that the companion tends to use Mandarin (i.e. the official language) while talking to the doctor. The doctor selectively aligns with the companion's language choice. While gathering information from the patient party, the doctor insists on using the elderly patient's language (i.e. Southern Min) as a strategy to encourage the patient to provide more information. The doctors follow the companion's use of Mandarin only when they gather pedigree information or present their diagnosis and management plan to the companion. The doctor's alignment with the companion's

use of Mandarin in these contexts is seen as a strategy to build rapport and to encourage the companion to facilitate the patient's treatment plan.

The doctor's expectation of the companion's being a facilitator of the management plan is also displayed during the period while the patient is away from his or her seat. Although there are not many information-providing acts observed from the patient party during this period, it is noted that both the doctor and the companion take this chance to discuss issues regarding the diagnosis and management plan. Finally, it is also found when the patient is in trouble with expression or comprehension in the information-providing cycles, the doctor hardly ever recruits the companion to participate. This is seen as a strategy to maintain patient autonomy—to provide patients the chance to handle the communication on their own.

Chapter 11. Conclusion

11.0 Introduction

In the previous chapters, I have introduced the four parts of my framework which is established to tackle the four research questions on the companion's participation in the medical triads. In the interpretation of the findings of applying the framework, I also added the comments and insights offered by the doctors during the playback interview. As I introduced in section 3.8, the goal of the playback interview is to elicit the doctor's perspective on the companion's role and to check the accountability of my interpretation of the findings. Some of the doctor's responses were presented sporadically in previous chapters. In this chapter, I will present them in a more systematic way (§11.1). Secondly, I summarize the findings of my three research questions (namely the participation contributed by the patient party, the information provided by the patient party, and the initiation of the companion's participation) and tie these summaries to the doctor's insights offered in the playback interview. They will be presented under the following five topics:

1) First-hand information and patient autonomy (§11.2)

2) Companion's access to information as the entry to participation (§11.3)

3) Pedigree section as the interactional slot for the companion (§11.4)

4) Companion as the facilitator of the management plan(§11.5)

5) Balance of conflict needs (§11.6)

Thirdly, I will sum up the findings related to my third research question—how the discourse sequence of the information-providing cycles is structured with the participation of the companion. The summary is presented under two topics:

1) Companion's degree of participation and level of activity (§11.7)
2) Patient's priority of providing complete information (§11.8)

The above summary focuses on the structural aspect of the companion's participation, which does not entail an absolutely positive or negative effect on the doctor-patient communication. In sections 11.9 and 11.10 I will present two marked cases (i.e. Mrs. Zhu's and Mrs. Tenn's encounters) for illustration, supplemented with insights from the doctors

11.1 Doctors' playback interviews

The following is a list of the five general questions that I pose to the doctor. (For the procedure of conducting the playback interview, please refer to §3.8.)

Question 1: What are the roles that you expect the companion (i.e. the adult children of the elderly patient) to play?

Question 2: In my analysis, the companion's verbal participation can be either initiated by the doctor (such as the doctor directs a question to the companion) or self-initiated by the companion. In what situations will you initiate the companion to participate?

Question 3: The interview of the initial visit can be roughly divided into four sections, namely information-gathering [1], pedigree section, physical examination, and diagnosis and management plan. What are the sections that you are more inclined to recruit the companion to participate?

Question 4: In my observation, some of the doctor-companion talks are conducted in Mandarin. In what situations do you use Mandarin while talking to the companion?

Question 5: When a patient on an initial visit is with a companion, when do you clarify the companion's identity?

The design of these five questions is to gain the doctors' comments on three

[1] The term 'information-gathering' ('*shou-ji bing-shi*' in Mandarin) used here carries a similar meaning to the terms 'chief complaint' and 'history-taking' known to the medical profession. It does not include pedigree information, which is usually seen as a separate section from the information-gathering section.

interactional patterns that I observed in the fifteen encounters—the companion's more active participation in the non-information-providing cycles and the pedigree section, the Mandarin talk in the doctor-companion dyad, and the revelation of the companion's identity. I did not directly share these observations with the doctors during the playback interview. Instead, I asked some general questions that might lead them to talk about these points, such as question 1. In the cases when doctors never suggest (directly or indirectly) that non-information-providing cycles or the pedigree section are two contexts related to the companion's participation, then I will ask them to talk about questions 2 and 3. All the five doctors involved in this research are interviewed. They do not necessarily respond in the same way, but there are always some shared comments (mentioned by least three doctors). In presenting their comments, I tie the shared ones to a certain theme. Those individual comments offered by one doctor will be indicated by his or her name. The following, Responses 1 to 5, are my summaries of the doctors' responses to Questions 1 to 3.[2]

Response 1: The role of the companion

In the four sections of the medical encounter, the two important sections that need the companion's participation are the information-gathering and the diagnosis and management plans. Physical examination is the section that requires the least verbal participation of the companion.

Response 2: First-hand vs. complete information

Getting first-hand and complete information is the top priority of the doctor's information-gathering task. Thus, it is important to let the elderly patients understand the doctor's questions and provide the information by themselves. However, if the patient is not able to provide complete information (e.g. the elderly who are highly verbose or can not give a chronically-organized account of their past history), then the companion will be recruited as alternative resource of the information. In that sense, the best companion would be one with whom the elderly patient lives and thus has a better understanding of the patient's health situation.

Response 3: Companion as facilitator of the management plan

The companion's participation in the section of the diagnosis and

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[2] It should be noted that the summary presented here is not an inclusive list of the doctor's responses. Only those directly related to the selected themes are presented here.

management plan is extremely important. The management plan of patients who suffer from chronic diseases (such as hypertension) involves examinations to be done in various spots in the hospital (such as taking X-rays and getting medicine from the pharmacy), long term medication, adjustment of daily diet and activities, and monthly return visits. The most successful patient compliance would be with the assistance of family members who are also present during the encounter and understand the doctor's plan. This fact is especially true with the elderly who do not have transportation or who are illiterate. As often complained by the illiterate when they visit the downtown hospital—they feel they are '*tshenn-mei-gu bong bo loo'* 'the blind cow who has huge eyes, but can't find the way.'

Response 4: Patient-companion relationship

However, the doctor's expectation of the companion's role as a facilitator of patient compliance would be a risk if there were no caring relationship between the patient and the companion. Dr. Lau comments that some adult children's companionship with their elderly parents to the hospital is more out of obligation than affection. They may have less patience with the patient and are eager to finish the visit as soon as possible. In these situations, the doctor's recruiting the companion to participate in the management plan may reinforce more stress and tension in the patient-companion relationship. Thus, the doctors must be sensitive to the subtle interaction between the patient and the companion as observed in the less-than-half-an-hour initial visit. Affectionate care for the elderly parents (i.e. '*iu-hau'* or '*xiao-shun*' 'showing filial piety') will be a positive resource in enhancing the patient compliance.

Response 5: The most helpful companion

> From these perspectives, the adult children who live with the companion (thus having a better understanding of the patient's health status) and show affectionate care for the patient (and thus may be more willing to help carry out the management plan) would be the best companion to facilitate the doctor-elderly patient relationship. Dr. Lau further comments that the companionship of a female caregiver (such as the daughter or daughter-in-law) is usually better than that of a male caregiver (such as the son). The daughter's companionship could be better than the daughter-in-law's in the sense that the involvement of the former is more motivated by family affection while that of the latter is more by obligation. Also, more stress on the daughter-in-law could result because the one who lives with the elderly parent has to physically take care of his or her daily life. Dr. Lau's insights have much in common with Tsui's (1987) and Hu's (1995) discussions (see Chapter 2 for literature review).

Response 6 is the summary of the doctor's comment to my observation that some of the doctor-companion dyads are conducted in Mandarin. For this issue, there are many shared responses.

Response 6: The use of Mandarin

> Regarding the use of Mandarin in the doctor-companion talk, there are four common views from the doctor. The doctor will accommodate or follow the companion's choice of language. If the companion does not speak first, the doctor sometimes chooses Mandarin unconsciously when he or she talks to a companion

> who is in the same age group as the doctor. Occasionally both the doctor and companion use Mandarin on purpose to exclude the patient in the discussion of serious matter such as the topic of cancer. Most doctors offer the insight that the explanation of the diagnosis is much more easily conveyed in Mandarin (as opposed to Southern Min) in communicating with the companion. Most of the terms and knowledge of western medicine that the doctor learned are either in English or Mandarin. This partially accounts for why most doctors find Mandarin an easier way to deliver diagnosis information to the companion.

My fifth question is related to my observation that most companions' identities are not revealed until the pedigree section. I was intrigued by this phenomenon since it is emphasized in the NCKU's training courses for interviewing skills that doctors should clarify the relationship between the patients and their companions in the very beginning of the interaction. However, this practice is not observed in twelve of the fifteen encounters (Table 9-4). There are two general comments and some individual comments from two doctors.

Response 7: Clarifying the companion's identity

> It is constantly emphasized in the training of interviewing skills that the doctor clarifies the identity in the very beginning of the encounter. However, when there is time pressure, most doctors tend to skip it because the identity of the companion will eventually be revealed when the companion talks.

Also, most doctors feel awkward or uncomfortable clarifying the companion's identity in the very beginning since they feel it is an invasion of the patient's privacy. Therefore, if the companion's identity remains unknown prior to the pedigree section, it becomes the most relevant, and thus less awkward or rude, context to clarify the companion's identity.[3]

Dr. Song offers the following comments. In the case of a first-time-visit patient, the identity of the companion is sometimes indicated on the basic information sheet which the patients or the companions fill out prior they go into the doctor's examination room (§3.3). It accounts for why sometimes doctors skip the verbal clarification. Sometimes, Dr. Song feels it is important to focus on the patient's chief complaint at the very beginning, and the clarification of the companion's identity may mislead the patient that the he or she is not respected. Thus, she will have the patient describe his or her chief complaint first, then invites the companion to add anything that the patient might have missed. For Dr. Song, the invitation process is the best time to clarify the companion's identify (such as 'You are? …. Oh, the daughter-in-law. Would you like to add in anything about your mom's problems?')

Dr. Song further comments that the clarification of the companion's identity is also a strategy to prevent the companion

[3] As a member of Taiwanese culture, I feel the same way that self-introduction to the conversational party or clarification of a new acquaintance's name or identity are not so important in the social encounters, unless it is relevant in some contexts. This interactional pattern becomes a marked one for me after my three-year's stay in the States where it could be rude if the conversational partners do not identify or introduce themselves to the new acquaintance.

> from being over-active. For example, in the case in which the companions who are so dominating that the patients do not have the chance to express themselves, Dr. Song may turn to the companion and ask: ‘So you are his? … Oh, the daughter-in-law. Would you mind sitting there and listening to him (the patient) first?’ For Dr. Song, the clarification process may serve as an entrance to recruit the companions’ participation or to prevent them from talking too much.
>
> Dr. Lu offers another insight that the clarification becomes important at the point when doctors need to gather certain personal information from the elderly patient (such as ‘how’s your sexual activity?’ or ‘how’s your interaction with children?’) which may not be appropriate to bring up if the companion is the patient’s child.

Finally, time pressure is another shared comment that most doctors bring up in the playback interview.

Response 8: Time pressure

> Most doctors invoke time pressure as a constraint in preventing them from doing something that should have been done but was not, such as clarifying the companion’s identity in the opening section of the encounter or gathering the pedigree information. In the researcher’s observation, the average numbers of patients that each doctor (visiting staff of the family medicine department at NCKU) needs to see in a section (in the morning or in the afternoon) are 3 to 5 patients of first visit and 20-35 patients of return visit.

11.2 First-hand information and patient autonomy

In this discussion, I will present findings to show that the top-priority of gathering first-hand information is achieved, a fact which indirectly suggests that patient autonomy is well respected. Since this research focuses on the activities where the patient party provides information or the doctor gathers information (i.e. the information-providing cycles), contexts related to patient autonomy include situations in which the patients are given the chance to express themselves and to deliver information regarding their health problem.

> Finding 1: The patient's overall amount of participation in the information-providing cycles is significantly higher than that of the companion's (§4.5).
>
> Finding 2: Among the eight patterns of information-providing cycles, the pattern in which the patient alone answers the doctor's question (i.e. pattern DP) receives the highest percentage of occurrence (§6.3.3).

These two findings suggest that most of the fifteen patients remain the primary provider

of the information that the doctor needs.

> Finding 3: Among the various initiation cues observed in the information-providing cycles where the doctor recruits the companion's participation, the doctor seldom initiates the use of Mandarin, which the patient does not speak. The doctor tends not to align with the companion's choice of Mandarin except in the cases where he or she gathers pedigree information, in which the companion has direct access to first-hand information (§10.1).
>
> Finding 4: The doctor rarely initiates the companion in the context where the patient encounters trouble with comprehension and expression. Usually, the doctor waits for the patient to complete the reply or rephrases his or her question so that the patient has a better understanding of the question (§10.4)

The above two findings show during the activities where the patient party provides information the doctor demonstrates a resistance to using a language which is not the patient's mother tongue and a hesitation in seeking help from the companion when the patient has trouble with providing information. These findings reflect the doctor's effort to provide more chances for the patient to participate, an activity which will in turn provide the doctor more complete first-hand information.

11.3 Companion's access to information as the entry to participation

> Finding 5: The overall number of the five categories of information provided by the patient is greater than that by the companion. A further analysis on the discrepancies between the patient's and the companion's contributions shows that the primary provider of the biomedical and daily routine information is the patient; management and pedigree information is provided about equally by both; and the physical-exam information is exclusively provided by the patient (§5.3).

The levels of discrepancies between the patient's and the companion's contributions suggest a ranked accessibility of the companion's knowledge to the five categories of information about the patient. In this ranking, the companion has the lowest accessibility to the physical examination information and the highest accessibility to the pedigree and management information.

11.4 Pedigree section as the interactional slot for the companion

> Finding 6: While most companions provide a significantly lower amount of biomedical information than the patients, most of them provide roughly as much pedigree information as do the patients (§5.4.3).

To account for the relatively equal amount of pedigree information provided by the companion, I invoked the ideas of ‘access to knowledge’ (§5.4.3) and the ‘adult child as part of the patient’s pedigree event’ (§9.5) as possible factors. In section 9.4, I also evoked ‘the doctor’ as a factor to account for the companion’s participation in the pedigree section--it is mainly the doctor who encourages the companion to provide the pedigree information by addressing him or her directly, as shown in Finding 7.

> Finding 7: The doctor’s choice of relationship terms which make the companion the addressee (such as ‘how many brothers and sisters do you have?’) (§9.5) and the doctor’s alignment with the companion’s choice of Mandarin in the pedigree section (§10.1) are evidence that the doctor encourages the companion to participate in the pedigree section.

However, the doctors’ recruiting the companion in the pedigree section seems to contradict their response to my second interview question. As my summary in Response 1 states, most doctors consider the sections of information-gathering and the diagnosis and management plan to be the two main sections that they are more inclined to recruit the companion, rather than the pedigree section. Given the fact that most of the fifteen

patients are capable of handling the conversation with the doctors, it would be interesting to see why the doctor is actually more inclined to recruit the companion in the pedigree section. To account for this tendency, I will argue that the pedigree section is the most appropriate interactional slot for the companion's participation.

Finding 8: Most of the companions' identities (13 out of 15) are revealed in the pedigree section, either by the patient, by the companion himself or herself , or by the doctor (§9.6)

Earlier in Response 7, most doctors share the comment that the clarification of the companion's identity can be delayed until the pedigree section out of consideration for the patient's privacy or because of time constraint. Both Finding 8 and Response 7 show that the clarification of the companion's identity may not be as important as the task of information-gathering in the sense that it can be postponed. Based on the doctor's experience, the companion's identity will be eventually revealed by the patient party later in the interaction, especially in the pedigree section. This is indeed what happens in 12 of the encounters. This pattern implies that the pedigree section is the most neutral

context to engage the companion. In the cases where the companion has remained non-active in the encounter (such as Mr. Wang's son), the pedigree section will be the appropriate context for social interaction and rapport between the doctor and the companion. This rapport will be the warm-up for the doctor to recruit the companion as the facilitator of the management plan later in the encounter.

11.5 Companion as the facilitator of management plan

Finding 9. The companion's level of participation in the non-information-providing cycles (i.e. activities regarding the diagnosis and management plan) is closer to the patient's level of participation than it is in the information-providing cycles (i.e. the information-providing cycles) (§4.5-4.6).

Finding 10. While most companions provide a significantly lower amount of biomedical information than the patients, most of them provide roughly as much management information as do the patients (§5.4.3).

Finding 11. The doctor tends to recruit the companion by giving information regarding the diagnosis and management plan when the patient is away from his or her seat. Similarly, the companion also takes this chance to ask further questions (§10.3).

Finding 12. The doctor is less inclined to align with the companion's choice of Mandarin when he or she gathers information from the patient party, but is more inclined to use Mandarin when he or she (the doctor) gives information regarding the diagnosis and

management plan (§10.2).

The above findings show that when the companions participate, they are more inclined to participate in the non-information-providing cycles, and when they provide information in the information-providing cycles, he or she provides more managementinformation than biomedical information. In these situations, the companions invoke their role as the facilitator of the management plan. The doctor reinforces this role by showing the tendency to engage the companions in the non-information-providing cycles. These findings meet with the doctor's expectation of the companions' role as the facilitator of the management plan, as shown in Response 3, to assist the patient to carry out and keep up with the management plan. The doctor's expectation of the companion's role as the facilitator of the management plan in the geriatric encounter is similar to that of the companion in the pediatric encounter, where the pediatrician is inclined to exclude the children when presenting the diagnostic findings or the proposal for future management (Pantell et al. 1982, cited in DeBruyne, 1996:2).

I also argue that the companion's role as the facilitator of the management plan is constructed under the cultural norm which prescribes that it is the obligation of the companion, i.e. the adult child of the elderly patient, to take care of, even to live with, their elderly parents. This cultural norm may indirectly account for Findings 13 and 14 though more evidence is needed to make any conclusion.

> Finding 13. The majority of the companion's participation in the elicited information-providing cycles is self-initiated by the companion (§8.4).
>
> Finding 14. If the doctor begins the pedigree section with a question regarding the patient's living arrangement, it usually immediately triggers the companion's participation which directly or indirectly reveals his or her identity (§9.6).

The cultural norm presents the companion with not only a legitimate position to participate in the medical event whenever he or she wants (by self-initiating), but also the position to provide a reasonable account of his or her parent's living arrangement.

11.6 Balance of conflicting needs

As observed in Tannen and Wallat's study (1982), there are multiple tasks or needs

which may sometimes be in contradiction to each other on the part of the doctor in medical encounters especially when more than two participants are involved. In this research, I have observed as least two conflicting needs on the part of the patient and the doctor.

Finding 15. Among the three initiators of the companion's participation, the instances of the patient as the initiator are significantly lower than those of the doctor or the companion (§8.3).

Finding 16. The patient rarely recruits (i.e. 16.7%) the companion to resolve his or her troubles with comprehension or expression (§8.3).

The patient's resistance to recruiting the companion, even when he or she has trouble with comprehension or expression, reflects a conflict between the patient's needs for autonomy and care, especially in geriatric encounters when the adult child is the companion of patients who have undergone the change of their social role from an autonomous person to a dependent of their children.

Finding 17. Similar to Finding 16, the doctor rarely initiates the companion at times when the patient encounters difficulty in expressing or comprehending (§10.4).

I argue that the doctor's resistance to recruiting the companion in these contexts reflects the doctor's effort to maintain the patient's autonomy, a practice which will meet his or her needs of gathering the first-hand information as well. However, when the patient is not able to provide complete information or when the doctor is under time pressure (Response 8), the companion will be the alternative or efficient provider of the information. Having the companion engaged in the interaction (e.g. in the pedigree section) can also achieve the interactional function of establishing rapport with the companion so that later expectations to be imposed on the companion (e.g. the facilitator of the management plan) can be more easily achieved. This discussion reflects the multiple tasks that the doctor needs to accomplish in the encounter–respecting patient autonomy, gathering first-hand and complete information under certain time constraints, and building up a rapport with the companion.

In the following sections, I will sum up the findings related to my third research question—how the participation of the companion reshapes the discourse structure of the information-providing cycles. These summary will be presented under two topics:

how the companion's degree of activity is related to the information-providing patterns in which he or she is involved, and how the patient's priority of providing complete information is affected by the companion's participation.

11.7 Companion's degree of participation and level of activity

> Finding 18. There is a highly significant correlation among three variables: 1) the amount of participation that the companion contributes in the information-providing cycle, 2) the number of information-providing patterns in which the companion volunteers information (i.e. patterns 0C and 0CP), and 3) the companion's degree of self-initiation in the elicited information-providing cycles (§6.3.5 and §8.5).

In other words, the more the companions participate in the information-providing cycles, the more likely they will volunteer more information than the patient and be more inclined to self-initiate their participation in response to the doctor's question (such as the daughter of Mrs. Zhu). Those who have a lower amount of participation will behave in the opposite fashion (such as the son of Mr. Wang). I have presented earlier that the companion's degree of self-initiation in the elicited information-providing cycles and

instances of volunteering information are the indicators of the level of activity. Finding 18 suggests a significant correlation between the companion's degree of participation and level of activity.

11.8 Patient's priority of providing complete information

> Finding 19. Though there are two potential information-providers in the triadic encounter, the preference for sole provider (i.e. patterns 0P, 0C, DP, DC) is significantly higher than that for joint providers (i.e. patterns 0PC, 0CP, DPC, DCP). That is to say, it is mainly one member from the patient party (i.e. the patient or the companion alone) who provides information to the doctor (§6.3.2).

Among the patterns which involve a sole information provider, the pattern DP (i.e. the patient alone answers the doctor's question) has the highest percentage of occurrence (Finding 2), and based on that fact, I argue that the patient remains the primary information provider; in that sense, the patient's autonomy is well maintained. However, in the cases when there are two information providers involved in the elicited information-providing cycles, the following is further noted:

Finding 20. The occurrence of pattern DPC (i.e. the patient provides a complete reply to the doctor's question before the companion provides any information) is significantly lower than that of pattern DCP (i.e. the companion provides information in response to the doctor's question before the patient has completed a reply) (§6.3.6).

This finding shows that whenever the companions would like to respond to questions posed by the doctor, they in most cases do not wait for the patients to provide a complete reply. They either go ahead and provide the information by themselves (i.e. pattern DC) or take the answer turn simultaneously with or in the middle of the patients' utterances (i.e. pattern DCP). In other words, the patient's priority of providing the complete information is mostly affected if the companion also takes the answer turns.

Another comparison among the fifteen companions also shows the following:

Finding 21. The more the companion participates in the information-providing cycles, the greater the tendency that he or she will score higher in volunteering information (i.e. patterns 0C and 0CP), answering the doctor's question alone (i.e. pattern DC), or answering the doctor's question before the patient has a chance to do so (i.e. pattern DCP) (§6.3.4).

In other words, patients will score lower in volunteering information, answering doctor's questions by themselves, and providing a complete reply to the doctor's question prior to their companion's intervention, if their companion is a high participant.

11.9 Structural aspect vs. interactional aspects --Mrs. Zhu's encounter

So far, I summed up how the participation of a third person reshapes the discourse sequence of the information-providing cycles. I also related the distribution of the eight patterns of information-providing cycles to the effect of the companion's participation on the patient's priority of providing complete information. Although the patients in the fifteen encounters remain the primary providers of the information, two effects resulting from the companion's participation are found. Whenever both the patient and the companion take the answer turn, there is a lower chance that the patient would have completed his or her information. Furthermore, if the companion is a high participant, the patient will have fewer chances to volunteer information, answer the doctor's questions alone, and provide a complete reply to the doctor's question.

However, these two effects are grounded in the structural aspects of the

information-providing cycles. These structural aspects may not reflect a valid interpretation of the interactional aspect. Neither do they reveal an intimate or indifferent relationship between the patients and their companions.[4] In her discussion of 'overlap' vs. 'interruption' (1989), Tannen alerted discourse analysts of a more objective interpretation for the interactional functions achieved by the phenomenon of overlap speech in conversation. She did so by presenting evidence to show that simultaneous speech (i.e. overlap) can be 'cooperative overlapping' rather than 'obstructive interruption' (272), and if any interruption is achieved in the conversation, it is a joint production of all participants.

In the same vein, I will remind readers that the effect of the companion's participation on the patient's priority of providing complete information, grounded from the structural aspects, does not entail a negative effect on patient autonomy or doctor-patient communication, and whatever function achieved by the companion's participation is a result of the three participants' contribution in the encounter. I will

[4] For example, both the son of Mr. Wang and the daughter of Mrs. Pan have a very low amount of participation in the encounters (8.2% and 4.4%). Their low amount of participation could be interpreted as their high respect for patient autonomy or low interest or care for the patient.

present Mrs. Zhu's case for illustration.

Compared to the other 14 companions, the participation of Mrs. Zhu's daughter is marked in many ways:

1) She scores the highest amount of participation in the information-providing cycles (as indicated by the discrepancy number '-23.4%' in Table 8-4).

2) She provides a greater amount of information in all categories (biomedical, management, pedigree, and daily routine) than Mrs. Zhu does, except for physical exam information which is not elicited by the doctor. Markedly, she is the only companion who provides a greater amount of biomedical information than the patient. (See Table 5-2 and discussion in §5.4.2).

3) She scores the highest percentage in volunteering information and in initiating her participation in the elicited information-providing cycles (as indicated by the discrepancy number '-22.6%' in Table 8-4 and '86.7%' in Table 8-4).

4) When Mrs. Zhu and her daughter both provide information in response to the doctor's question, Mrs. Zhu hardly has the chance to provide complete information prior to her daughter's intervention. (See the numbers '3.2%' for pattern DPC vs. '41.9%' for pattern DCP in Table 6-3).

By these indicators, Mrs. Zhu's daughter has the highest amount of participation and is the most active participant. However,

5) Among the fifteen encounters, Mrs. Zhu and her daughter also score the

highest percentage of jointly providing information to the doctor's question (as indicated by the number '48.4%' for joint provider in Table 6-3).

6) Among Dr. Tiunn's four encounters, he hardly ever initiates the companion to answer his question. Markedly, he initiates 30.8% of Mrs. Zhu's daughter's participation while he initiates only 14.3%, 0% and 0% of Mrs. Yiu, Mr. Ong, and Mrs. Pan's companions' participation.

During the playback interview, I asked Dr. Tiunn why he seems to be more attentive to the daughter of Mrs. Zhuthan the other companions, and he offers the following insight which I summarize in my words.

> There is an intimate rapport observed between the daughter and the patient, as indicated by the constant merry laughing. The daughter is not only an active participant, but she also displays a great deal of knowledge about her mother's medical problem and history. The information provided by the daughter is consistent with that by the patient and is sometimes ratified by the patient; therefore, it encourages the doctor to elicit further details from her.

The doctor's insight that the information provided by the daughter is constantly ratified by the patient reflects the finding in (5) that Mrs. Zhu's case scores the highest percentage of joint providers. Also, the fact that the daughter is not married yet and lives

with her mother, as revealed in the pedigree section, provides her with greater access to information regarding her mother's health problem. As shown in the following two excerpts, most of the time Mrs. Zhu and her daughter collaboratively and simultaneously take the answer turns (e.g. cycles I, II, IIa, III in Excerpt 1). Also, they support each other by ratifying the information (e.g. cycles V and Va in Excerpt 1) or provide follow-up information (e.g. IIa in Excerpt 2). Many of the daughter's utterances convey a similar style of 'high-involvement style' (Tannen 1984:30) such as the faster turn taking and cooperative overlap. It is these supportive and consistent behaviors observed in the patient party's interaction that makes Dr. Tiunn be more attentive to the daughter, as shown by his eye contact with the daughter in lines 1, 3 and 7.

Excerpt 1. {00'51"}(Mrs. Zhu 74F; main language: Mandarin)

I DCP	1. Dr. Tiunn:	所以總共兩個禮拜了？**{looks at the daughter}** *So-yi zong-gong lian-ge li-bai le?* so total two weeks ASP
	2. Mrs. Zhu:	[*Henn* yeah
→	Daughter:	[對 [*Due* right

II DCP

3. Dr. Tiunn: 喔第二天就沒燒了 **{looks at the dauaghter}**
So-yi.. shao.. yi-jing yi-ge li-bai dou mei shao le,=
so fever already one week EMP not fever ASP

4. Mrs. Zhu: [沒有啦,
[*Mei-you la*
no PRT

→ Daughter: [都沒燒,第二天,第三天就沒燒了
[*Dao mei shao, di-er tian, di-san tian jiou mei shao le,=*
EMP no fever second day third day EMP no fever ASP

IIa DCP

5. Dr. Tiunn: 喔第二天就沒燒了
Oh, di-er tian jiou mei shao le,=
oh, second day EMP no fever ASP

6. Mrs. Zhu: [嗯,沒有燒了,=
[*Um, mei-you shao le,=*
um, no fever ASP

→ Daughter: [嗯,對
[*um, due*
um, right

III DCP

7. Dr. Tiunn: =那.所以那個咳一直都從二個禮拜以前.
=Na.. so-yi..na-ge ke yi-zhi dao cong liang-ge li-bai yi-qian
um so that coughing always EMP since two week ago

{looks at the daughter} [就開始了
[*jiou kai-shi le*
EMP begin ASP

8. Mrs. Zhu: [欸::對
[*Ei:: due*
yeah right

→ Daughter: [對
[*Dui*::
right

IV DCP

9. Dr. Tiunn: 喔..那這個咳::是有比較厲害嗎?
Oh..na zhe-ge khe:: shi you bi-jiau li-hai ma?
Oh um this coughing be have more serious Q

		10. Mrs. Zhu:	..嗯:: [這二天好一點點,前一陣子很多. *..en::* [*zhe liang tian hao yi-dian-dian, qian-yi-zhen-zi hen duo..*= um these two day good a little bit a while ago very much
→		11. Daughter:	[差不多 [*Tsha-bu-duo,* so so
	V 0C	12.	她的咳沒有痰 *Ta-de ke mei-you tan* her coughing no saliva
	Va DP	13. Dr. Tiunn:	沒有痰喔? [乾咳就對了? *Mei-you tan o?* [*gan ke jiou due le?* no saliva Q dry coughing EMP right ASP
		14. Mrs. Zhu:	[欸, henn henn henn [*Ei, henn henn henn* yeah, right right right

Translation

	I DCP	1. Dr. Tiunn:	**{looks at the daughter}** So, (the cold) lasted for two weeks?
		2. Mrs. Zhu:	[Yeah
→		Daughter:	[Right
	II DCP	3. Dr. Tiunn:	**{looks at the daughter}** So.. the fever.. has been gone for one week,=
		4. Mrs. Zhu:	=[No more (fever)
→		Daughter:	=[No more fever, on the second day, the third day, the fever was gone=
	IIa DCP	5. Dr. Tiunn:	=Oh, the fever was gone on the second day=
		6. Mrs. Zhu:	=[Yeah, no more fever=

→		Daughter:	=[Yeah, right
III DCP	7.	Dr. Tiunn:	=Um.. so, the coughing, since two weeks ago**{looks at the daughter}** [already started
	8.	Mrs. Zhu:	[yeah:: right
→		Daughter:	[right::
IV DCP	9.	Dr. Tiunn:	Oh.. um this coughing:: is it getting worse?
	10.	Mrs. Zhu:	..um:: [It improved a little bit these days, a while ago, there are a lot of..=
→	11.	Daughter:	[So so,
V 0C	12.		=Her coughing does not contain any saliva
Va DP	13.	Dr. Tiunn:	No saliva? [dry coughing right?
	14.	Mrs. Zhu:	[yeah, yeah, yeah, yeah

Excerpt 2--Translation.[5] {01'27"}(Mrs. Zhu 74F; main language: Mandarin)

I DCP	1.	Dr. Tiunn:	At the time when (you) had the fever, (it) was:: about two weeks ago, right?=
	2.	Mrs. Zhu:	=[Yeah, two weeks ago.
		Daughter:	=[Yeah, right.
II DC	3.	Dr. Tiunn:	Do (you) know how high the fever was?
	4.	Daughter:	Thirty eight.
IIa	5.	Dr. Tiunn:	Thirty eight?

[5] For the Chinese version, please refer to Excerpt 4 in Chapter 6.

DCP		
→	6. Daughter:	Right, then, later (it) decreased to thirty seven. um.. yeah, (it) was about two days..
→	7. Mrs. Zhu:	**{turns to her daughter}** Two days.. On the third day, (the fever was) gone..=
→	8. Daughter.	=(It was) gone.

Also, in most of the information-providing cycles of the two excerpts, Mrs. Zhu's priority of providing complete information prior to her daughter's intervention is not maintained at all. However, there seems to be no negative effect on the doctor-patient communication, at least from the doctor's perspective; the supportive interaction, both from the level of information-providing and the level of patient-caregiver relationship, might have a positive effect in the doctor-patient communication.

11.10 Spatial aspects vs. interactional aspects—Mrs. Tenn's encounter

In this final section, I will discuss another marked case—Mrs. Tenn's encounter from the perspecitve of the patient's priority to provide complete information and the spatial arrangement of the triadic interaction.

In contrast to the high and active participation of Mrs. Zhu's daughter, the

daughter-in-law of Mrs. Tenn is a more moderate participant. She scores the 8th highest in participationg in the information-providing cycles, the 11th highest in volunteering information, and the 8th highest in initiating her participation in the elicited information-providing cycles (as indicated by the two discrepancy numbers '21.0%' '9.9%' and the number '37.2%' in Table 8-4). Markedly, in contrast to the other thirteen companions who mostly will intervene without waiting for the patient to complete a reply (i.e. pattern DCP), the daughter-in-law of Mrs. Tenn is more inclined to withhold her participation until the patient has completed the reply first (i.e. pattern DPC, see §6.3.6).

Take Excerpt 3 as an example. Mrs. Tenn's chief complaint is dream-filled sleep that has bothered her for years. In line 1, Dr. Kang asks how long her sleeping problems has lasted, to which the patient gives a very general reply '*tsiok-ku-a'* 'very long'. Dr. Kang thus asks in a more specific way by giving a measurement in years (line 3); obviously, the patient has a problem with answering the question, as indicated by her silence and eye contact with the daughter-in-law. Based on what follows in lines 9-14, it seems that the daughter-in-law actually has a more specific idea regarding the length of

the patient's sleeping problem: she has suffered from this for about ten years, since her first trip to the States (lines 11-12).

Excerpt 3. {00'32"}(Mrs. Tenn 66F; main language: Southern Min; underlined parts: Mandarin)

DP

1. Dr. Kang: 按吶已經外久啊?
An-nei it-king gua ku a?
this way already how long ASP

2. Mrs. Tenn: 呼,足久啊
Ho, tsiok ku a
oh, very long ASP

DP

3. Dr. Kang: 足久是外久啊?幾冬啊?
Tsiok ku si gua ku a? kui tang a ?
very long be how long ASP how many years ASP

4. Mrs. Tenn: **{pauses for two seconds}{then turns to her D-in-law}**

5. D-in-law*: 幾冬啊?
Kui tang a?
how many year ASP

6. Mrs. Tenn: **{turns to her D-in-law}** 我這歹睏啊,啊啊啊..
Gua tse khun a, a a a ..
My this sleeping PRT PRT PRT PRT

{turns to the doctor}看歹落眠,啊歹睏…
Khuann phainn lo-bin, a phai khun..
see difficult fall asleep PRT difficult sleep

歹睏,啊卡這咧,啊有睏落叨按吶夢嘎霧煞煞,=
phainn khun, a kah tsit-leh, a u khun lo to an-nei
difficult sleep PRT with this PRT have sleep ASP EMP like this

bang kah bu-sah-sah,=
dream to dizzy

7. D-in-law: =啊差不多幾冬啊?
=*A tsha-put-to kui tang a ?*
PRT about how many year ASP

8. Mrs.Tenn: **{turns to her D-in-law}**
啊/?/叨攏足濟冬啊,
A /?/ to long tsiok tse tang a,
PRT EMP EMP very many year ASP

DPC 9. Dr. Kang: 五冬有無?/大概/
Go tang u bo? /tai-khai/
five year have no about

10. Mrs.Tenn: 差不多啦
Tsha-put-to la,=
sort of PRT

→ 11. D-in-law: 不只喔..可能要十年喔,汝
Bu-zi oh.. ke-neng iao shi nian o,
not only PRT probably take ten year PRT

→0CP 12. **{turns to Mrs. Tenn}**
汝第一擺去美國叨按吶啊嘛?
Li te-it-painn khi bi-kok to an-nei a ma?
you first time go USA EMP like this ASP Q

13. Mrs.Tenn: *Hng*
yeah

→ 14. D-in-law: **{turns to the doctor}** 十冬有啊喔
Tsat tang u a o
ten year have ASP PRT

* Daughter-in-law.

Translation

DP 1. Dr. Kang: How long has (the sleeping problem) lasted?

2. Mrs. Tenn: Oh, (it's been) very long.

DP 3. Dr. Kang: How long is it? How many years?

	4. Mrs. Tenn:	**{pauses for two seconds}{then turns to her D-in-law}**
	5. D-in-law:	How many years?
	6. Mrs. Tenn:	**{turns to her D-in-law}** This bad sleep of mine um, um um um.. **{turns to the doctor}** It's hard to get to sleep, and difficult to sleep… difficult to sleep and also, if (I) do fall into sleep, yeah, it's full of dreams,=
	7. D-in-law:	=And it's about how many years?
	8. Mrs.Tenn:	**{turns to her D-in-law}**Um /?/ (it's been) for many years.
DPC	9. Dr. Kang:	About five years? around?
	10. Mrs.Tenn:	Yeah, Sort of=
→	11. D-in-law:	=<u>Not only (five years)</u>..<u>It's about ten years</u>,
→0CP	12.	**{turns to Mrs. Tenn}** (It's been) like this since your first trip to America, right?
	13. Mrs.Tenn:	Yeah
→	14. D-in-law:	**{turns to the doctor}** It's been about ten years.

However, the daughter-in-law does not take the answer turn in line 4, even when the patient remains silent. Instead, she repeats the doctor's question (line 5) which provides the patient the chance to answer on her own. Though the patient's follow-up reply which focuses on how bad her sleeping problem is seems to be off-track from the concern of the doctor's question, the daughter does not cut off the patient's utterance. When the patient finishes her complaint at a certain point, the daughter-in-law rephrases the doctor's

question again (line 7) which provides the patient another chance to answer the question. Still, the patient could not provide a specific length (line 8). Dr. Kang thus proposes: *'Go-tang u-bo?'* 'about five years?' The patient's affirmation (line 10) is immediately modified by the daughter-in-law who proposes that the patient's sleeping problem has been for more than ten years since her first trip to the States (lines 11-12). The daughter-in-law's modification is affirmed by the patient in line 13.

As we can see, there are many interactional points that the daughter-in-law could have joined in to provide the information earlier or to take the answer turn right after the doctor's question (such as the daughter of Mrs. Zhu); however, she withholds her participation. More often, she will have the patient answer the question on her own. When it comes to the need to modify the patient's statement, she is more inclined to wait when the patient finishes her statement first (i.e. pattern DPC). The daughter's moderate participation style shares some features of the 'high-considerateness style' in conversation (Tannen 1984:31).

Dr. Kang offers her impression during the playback interview: the daughter-in-law seems to care a lot about Mrs. Tenn, judging by the fact that she offers detailed

information regarding the patient's health problem. Mrs. Tenn seems to rely on her a lot as well, judging by the fact that she has much eye contact with her daughter-in-law (e.g. Figure 11-2). Dr. Kang is impressed that the daughter-in-law does not live with Mrs. Tenn but would accompany her to the hospital anyway.

The spatial arrangement in this triadic encounter of Mrs. Tenn's case is also a marked one compared to other encounters. As I mentioned earlier in section 9.2, ten of the companions stay at the position on the patient's side near the door (e.g. Figure 9-1) or behind the patient (e.g. Figure 9-2). Five of them stay at the location between the doctor and the patient by either standing or taking a seat (e.g. Figures 11-1, 11-2, and 11-3).

Figure 11-1. Spatial arrangement of the medical encounter – 1.

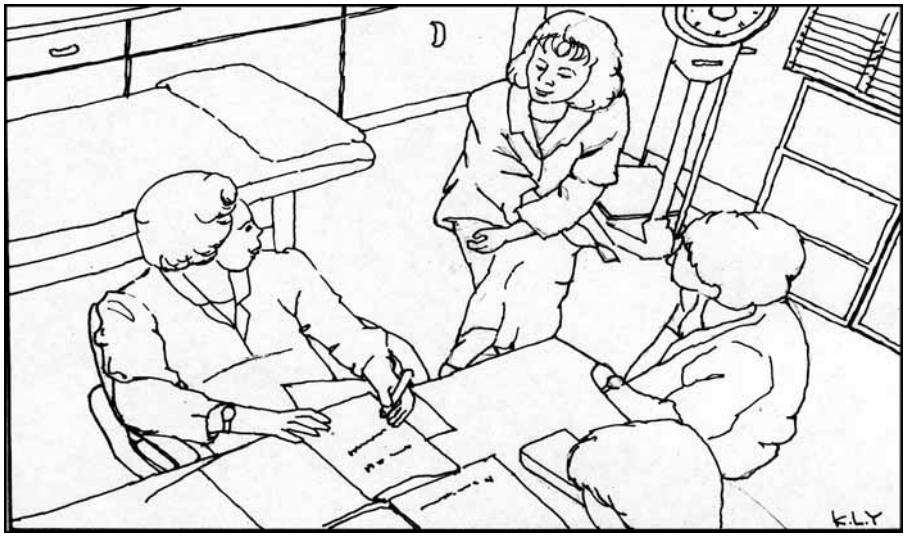
(Left to right: doctor, 2 interns, companion, patient)

Figure 11-2. Spatial arrangement of the medical encounter – 2.

(Left to right: doctor, companion, patient)

Figure 11-3. Spatial arrangement of the medical encounter – 3.

(Left to right: doctor, companion, patient)



The sitting posture at the position between the doctor and the patient (such as Figures 11-2, and 11-3), in my view, is the best spatial arrangement for the triadic geriatric encounter in three ways. First, it places the doctor and the patient as the center of the interaction and the companion as the side. Secondly, it discourages the companion from dominant participation since he or she is not within the range of the doctor's direct eye contact.[6] Thirdly, the sitting position of the companion, as opposed to the standing one, imposes less pressure on the part of the doctor and the patient. Many doctors

express in the playback interview that the companion's standing position imposes not only a spatial pressure but also the stress that he or she is ready to leave at any time. Because of the three advantages of this spatial arrangement[7] within the fifteen encounters,[8] I will refer to it as **'the golden triangle arrangement**'. Mrs. Tenn's daughter-in-law is one of only two companions who take this position.

The moderate style of the daughter-in-law's participation contributes to the doctor-patient communication in the way that it leaves the patient more space to provide first-hand information and adds supplementary information when that provided by the patient is not complete. The daughter-in-law's moderate style of participation is a reflection of the relatively higher occurrence of pattern DPC (in which she withholds her participation before Mrs. Tenn has completed her reply) and also of the supplemental spatial location in which she positions herself.

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[6] Insight offered by Dr. Feng-hwa Lu, 1999.

[7] The fourth advantage of this arrangement is that the discourse analyst will have a less hard time to identify the addressee of the doctor's utterance.

[8] This arrangement may not be appropriate in the cases in which the elderly patients suffer from serious cognition or movement problems.

Chapter 12. Contributions and Further Study

12.0 Introduction

In this final chapter, I will state the possible contributions of this research to the fields of medical discourse (§12.1), interactional sociolinguistics (§12.2), and doctor-patient communication (§12.3). Finally, I will propose the ways in which my findings can be profitably used by the medical professional in Taiwan (§12.4) and some potential directions for related future research (§12.5).

12.1 Contributions to the study of medical discourse

This research contributes to the study of medical discourse analysis in three ways. First, it examines the validity of applying the pre-existing framework for identifying the addressee of the doctor's question in triadic interaction (i.e. the participant framework) to the Taiwanese geriatric medical interaction. Secondly, it proposes an alternative framework which extends the focus on the question-answer pairs discourse unit to four other aspects in measuring the companion's participation. Thirdly, it enriches the study

of medical discourse by following the spirits of interactional sociolinguistics which combines the cultural, social, and interactional contexts in the interpretation of the quantitative findings.

One of the researchers' common goals in the literature (Aronsson and Rundstrom 1988; Baker 1996) is to examine how the presence of a third person affects the doctor's distribution of attention. This aspect is studied by identifying the addressee of the doctor's question (i.e. the participant structure, such as a doctor-patient dyad or doctor-companion dyad). I present arguments, grounded in the syntactical, discourse sequence, interactional and professional aspects to show that the attempt to identify the doctor's addressee in the triadic encounter could be as difficult as identifying the type of speech act achieved in an utterance (§7.1). As a result, most the addressees of the doctor's questions remain ambiguous.

In light of these problems, this research proposes an alternative framework to examine the companion's participation in the activities where the patient and the companion provide information to the doctor. This framework extends the focus from the discourse structure of the question-answer pairs to other aspects of the companion's

participation. It includes the following:

1) Measuring the discourse space of the patient party by counting the number of syllables in the utterance (Chapter 4).
2) Classifying the type and the amount of information provided by the patient party (Chapter 5).
3) Distinguishing eight patterns of information-providing cycles based on the three criteria of elicited vs. volunteered information, sole vs. joint provider, the patient's provision of complete or incomplete information in response to the doctor's question before the companion provides any (Chapter 6).
4) Identifying the initiators of the companion's participation and the initiation cues (i.e. the discourse mechanism and interactional context) that prompt the companion's participation (Chapter 7).

Following the consensus of interactional sociolinguistics that conversation is a joint achievement by all participants (Erickson 1985, Tannen 1992, Schiffrin 1994), the fourth aspect in analyzing the companion's participation takes the perspectives of the doctor, the patient, and the companion into consideration. By using the above framework, some interactional patterns result from the quantitative results. Although these results are

grounded in four different aspects of the companion's participation, they support each other in many ways (Chapter 11).

In interpreting these quantitative results, I add in the five doctors' perspectives gathered from my playback interviews, as well as the knowledge that I learned during the fifteen-month participation and observation at the field site, and my knowledge as an insider of the speech community in southern Taiwan. This knowledge includes the doctor's expectation of the role of the companion, the conflicting needs (such as first-hand but complete information) involved in the doctor's work, the code-switching phenomenon in inter-generation conversation, the preference of family care for the elderly and the living arrangement of *san-dai-tong-tang* 'three-generation-residence' (§2.3), and the cultural norm of *iu-hau / xiao-shun* 'filial piety' (§11.1). In that sense, this research is carried out in the spirit of the interactional sociolinguistics in the way it takes the cultural, social, and interactional meanings of linguistic behavior into consideration.

12.2 Contribution to the approach of interactional sociolinguistics

Interactional sociolinguistics as an approach of discourse analysis takes a

qualitative approach. By analyzing the conversation in a thorough way, the researchers identify some interactional patterns in which the speakers employ certain 'contextualization cues' (Gumperz 1982), 'linguistic devices' or 'discourse strategies' (Tannen 1989) to achieve certain interactional goals. For example, overlap speech can be seen as a strategy to show involvement and solidarity (Tannen 1989).

This current research not only follows the main spirit of interactional sociolinguistics—the interactive nature of conversation—but also attempts to extend its qualitative approach to a quantitative one. By setting up a framework to measure the companion's participation, many quantitative findings result. These findings, though grounded in four aspects, support each other with respect to themes. For example, the doctor's non-alignment with the companion's use of Mandarin in the information-providing cycles and the doctor's resistance to recruit the companion when the patient encounters troubles can be seen as two discourse strategies to achieve the same interactional goal of gathering first-hand information from the patient. This central theme of gathering first-hand information is also reflected by other quantitative results. For example, the patient provides a significantly greater amount of information than the

companion does in the information-providing cycles, and the IP pattern of DP (i.e. the patient alone answers the doctor's question) has the highest rate of occurrence.

12.3 Contributions to the study of doctor-patient communication

This research contributes to the study of doctor-patient communication in three ways. First, it sets up an objective framework to measure the effect of the companion's participation on the doctor-patient communication. Secondly, it identifies discourse mechanisms and interactional contexts related to the companion's participation. Thirdly, it enriches the study of doctor-patient communication with data from a Taiwanese context.

The measurement of the effect of the companion's participation on patient autonomy is a disputable subject since the idea of 'patient autonomy' is hard to define in the first place and there is no clear-cut relation between cause and effect, given the fact that interaction is the joint product of all of the participants. Instead, this research sets up a framework to measure the effect of the companion's participation from a less disputable aspect – the structural aspects of triadic discourse.

More specifically, it constructs a relationship between the companion's amount of participation, ways of participation, and discourse patterns of participation by comparing all these factors to those of the patient's. For example, there is a significant correlation between the companion's amount of participation and level of activity. A companion who has higher amount of participation is also a more active participant in the sense that he or she is more likely to volunteer information or introduce himself or herself in the answer turn. Also, when both the patient and the companion take the answer turn, the chance that the patient will provide complete information prior to the companion's participation is significantly low.

The flip side of this structurally-grounded approach is that it does not predict a positive or negative effect of the companion's participation on patient autonomy or on doctor-patient communication on the interactional level. For example, the active participation style of Mrs. Zhu's daughter and the moderate style of Mrs. Tenn's daughter both have a positive effect, from the doctor's viewpoint, on the doctor-patient communication but in different ways (§11.9 and §11.10).

Secondly, this research contributes to the study of doctor-patient communication in

the way that it identifies the discourse mechanisms and interactional contexts related to the companion's participation. It also identifies the initiator who recruits the companion to participate. In that sense, it takes all three participants' perspectives into consideration. This approach extends Adelman et al.'s framework (1987) which defines the role of the companion solely from the patient's perspective (§2.2).

More specifically, this research found that the companion's participation is mainly self-initiated by himself or herself or by the doctor, but rarely by the patient. The discourse mechanisms employed by the doctor to recruit the companion include eye contact, the use of Mandarin, using a third person pronoun in referring to the patient, and using the relationship deictics which mark the companion as the addressee. The interactional contexts related to the companion's self-initiation or the doctor's initiating the companion include situations in which the discourse topics are the patient's family history or the diagnosis and treatment plan, situations in which the patient encounters problems with expression or comprehension, and those in which the patient is away from his or her seat.

The third contribution of this research is adding to the study of doctor-patient

communication with data collected in a teaching hospital in South Taiwan. Some characteristics observed in South Taiwan include the following: compared to the western societies (such as the United States), there is a relatively closer interaction, in terms of living arrangement and family obligation, between the elderly patient and their adult child; also, the fact that most elderly people of this generation are monolingual in the local language and receive little education or are even illiterate reinforces the elderly patient's dependency on his or her adult child.

Because of different medical and health care systems, the family doctors in the teaching hospital in Taiwan may experience more pressure of time constraint ('Response 8' in Chapter 11). Also, doctors of western medicine in Taiwan learn their medical knowledge mainly via English and Mandarin. Most terms of western medicine do not have corresponding expressions in Southern Min. Therefore, sometimes doctors may avoid complicated expressions while talking to the elderly or are inclined to use Mandarin if they need to convey complicated medical concepts to the companion (§10.2). Again, these Taiwanese cultural and social contexts reinforce the adult child's role as the patient's primary caregiver and the facilitator of the treatment plan and may

shape the triadic medical communication in a different way from that in other societies.

12.4 Applications with the medical profession

The concluding findings stated in Chapter 11 can be applied by the Taiwanese medical professionals in different ways for various interactional needs. The following are some hypothetical situations for illustration.

First of all, the findings show a significant predictability: companions who talk more than patients will be more active participants as well. In these cases, the patient will have less of a chance to provide complete information prior to the companion's intervention. Thus, in contexts in which the companion is active while the patient is not willing to talk, it might be helpful for the doctor to discourage the companion from talking. There are at least two discourse strategies used to achieve this goal. The doctor avoids eye contact with the companion or insists upon the use of Southern Min. In this case, the golden triangle arrangement of the three participants is especially important (§11.10).

On the other hand, if the companion hardly talks in the encounter and the doctor

would like to have the companion be more involved, the pedigree section, especially the question regarding the patient's living arrangement, will be the most appropriate context to achieve the two needs for social interaction and first-hand information. (See discussions on pedigree section in Chapter 9). Also, the interval during which the patient is away from his or her seat is another neutral context to interact with the companion. The alignment with the companion's choice of Mandarin, used in a context where patient's autonomy is not at risk, is another discourse strategy to encourage the companion's participation.

Based on the insights of the doctors, the use of Mandarin can serve as a discourse strategy to exclude the monolingual patient of Southern Min so that the doctor can deal with the companion alone on certain difficult topics, for example, the patient's poor control in keeping up a prescribed diet or a potentially fatal situation (such as cancer). However, the training of greater proficiency in Southern Min is strongly advised in the initial stage (such as the stage of medical school) of the training program in the medical professionals, especially among the younger generation.

12.5 Further study

Several ways of how this research can be elaborated occurred to me during my participation and observation at NCKU. First of all, a relatively large portion of this research is devoted to identifying six initiation cues related to the doctor's recruiting the companion's participation, yet those related to the companion's self-initiation are not examined in detail. It will be important as well to have a further examination of these initiation cues given the fact most of the companion's participation is self-initiated.

Secondly, the fifteen cases analyzed in this study so far can be considered as 'nice interaction' in the sense that there are no obvious communication problems. In the analysis of difficult cases, coalition or alignment becomes more pervasive. One of the difficult cases that I have observed involves an elderly female patient whose Mandarin has a strong accent and who demonstrates a strong tendency toward off-target-verbosity. Her Mandarin is too hard for me to recognize and the transcription is impossible. In my initial interaction with this patient, I noticed that the patient's daughter-in-law and I constantly aligned with each other by cutting off the patient's narration in order to fill out the required information sheet. A similar phenomenon was observed as well when the

patient and her daughter-in-law interacted with the doctor. The dynamic coalition among any two of the three parties in medical triads is also an interesting area to tackle. Besides the language problems (speakers with strong accent or tendency toward off-target-verbosity) that are mentioned above, in what other situations will a doctor-companion, doctor-patient, or patient-daughter coalition be formed? Also, the increasing use of videotaped data in a medical encounter has shown the crucial interrelationship between verbal and non-verbal dimensions of activities. It adds another factor to the discussion of alignment or coalition in triads. For example, the companion may be verbally aligned with the patient but physically aligned with the doctor, as shown with eye-contact exchange with the doctor while talking to the patient.

The methodological problems that I have encountered in identifying the participant structure will be another important issue to explore, especially in the case of code-switching. For example, in the instances in which doctors code-switch into Mandarin while talking to the companion, is code-switching done intentionally or unconsciously? There are some cases in which code-switching serves as a strategy to exclude the patients, such as avoiding the delivery of negative information in the patient's presence. What are

other cases? The distinction of intentional or spontaneous code-switching adds another dimension to Goffman's participant status which distinguishes whether the audience of a current utterance is ratified and addressed.

Also, as shown in this current research, the companion has a greater participation in the activity regarding the diagnosis and treatment plan, which, for the time being, is not examined in a detailed way and will be an important issue to be tackled in the future. Seen in light of language gaps, the issue of how the younger doctors (such as residents) who lack skillful proficiency in Southern Min cope with problems in communicating with the monolingual patients in Southern Min or strongly accented Mandarin is another important area worthy of further attention.

Finally, the story of Mrs. Ong presented in the beginning of this dissertation has shown that the care for the elderly involves all the family members in different ways, especially on the daughter (in-law)'s part. During the playback interview, some doctors also emphasize that the degree of care in the relationship between the companion and the elderly patient is an important factor that affects doctor's expectation of the companion's role. This highlights the importance of the playback interview with the patient and the

companion which, for the time being, is not conducted in this current research yet. Sociolinguistic interviews with the female (the elderly women of this generation, and the daughter, and the daughter-in-law) are also important for the exploration of the woman's role as caregiver. How does Mrs. Ong feel about the transformation of her identity from caregiver to patient? A woman who has spent most of her life time as a caregiver for others--her elderly parent-in-law, her children, and her elderly husband--and is now herself the elderly patient who needs to rely mainly on her daughter-in-law whose care for her is out of family obligation.

APPENDIX

Interviewing Guideline at the Family Medicine Department at NCKU

This guideline is designed by the senior visiting staff at NCKU. There are four parts in this guideline. The following presents only the first and second parts which are related to my framework on the classification of five categories of information (see §5.2).

I. The patient's health problem	一、身體相關問題部份
Chief complaint	主述
Use open questions	給病患開放式的問診引導
Elicit specific information about the duration of all syndromes	清楚症狀發生之時間長短
Present history	現在病史
Location of symptom	疾病發生位置
Nature of symptom	疾病所具特徵
Onset of symptom	疾病發作情況
Chronological order of symptom	疾病時間順序
Aggravating factors of symptom	疾病加重因素
Alleviative factors of symptom	疾病減輕因素
Associated signs of symptom	疾病併發症狀
Radiation of symptom	疾病轉移症狀
Management of disease	疾病診治經過
Motivation for the patient's visit	病患就診動機

Past history and diet habit	過去病史及健康生活習慣
Diseases suffered in the past	過去疾病
Smoking	抽煙狀況
Alcohol intake	喝酒狀況
Physical examination	身體檢查
Blood pressure	血壓是否测量
Body weight and height	身高體重測量
Physical examination on bed	躺於床上檢查
II. The patient's psycho-social status	二、精神社會相關問題部份
About the patient	病患個人
Education	教育程度
Occupation	職業職位
Personality	個性特徵
About the patient's family	家庭狀況
Three generations of the patient's family members	問上下三代的組織結構
The diseases suffered by family members	詢問三代所患疾病種類
Living arrangement	了解同住者有哪些成員
Family functions and supports	詢問家庭功能的健全與否
Life events or family events	問最近重要生活事件

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