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INTERACTIONAL DYNAMICS IN MEDICAL ENCOUNTERS: THE PARTICIPANT ROLES AND IDENTITIES

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ÖZET

Doktor-Hasta Görüşmesinde İletişimsel Dinamikler:

Katılımcı Rol ve Kimlikleri

Özge Çağlar

Bu tezin amacı Türkçe'de doktor-hasta iletişiminin dinamiklerini etkileşimsel toplumdilbilim açısından incelemektir. Öncelikle doktor-hasta görüşmelerinde katılımcıların konuşmayı nasıl şekillendirdikleri incelenmiştir. Eldeki veriler doktor-hasta iletişiminde üçüncü bir öğe olarak hasta yakını olgusunun da ele alınmasını zorunlu kılmaktadır. Dolayısıyla bu her üç katılımcının konuşma örüntüleri incelenmiş ve hasta yakınının çoğu zaman hasta kadar hatta bazen ondan daha etkin olduğu görülmüştür. Doktor hasta ve hasta yakınının konuşma sırasındaki rolleri Goffman (1981) "katılımcı statüleri" kavramı altında incelenmiştir. Konuşma sırasında özellikle hasta yakının iletişimsel faktörleri ve diğer iki konuşmacının konuşma akışını nasıl etkilediği araştırılmıştır. İkinci olarak, bu üç konuşmacının konuşma sırasında birbirlerine sesleniş ve atıf biçimleri incelenmiştir. Burada amaç, katılımcıların kendilerinin ve karşılarındakilerin toplumsal kimlik örgüsünü nasıl algıladıklarını ve yansıttıklarını belirlemektir.

ABSTRACT

Interactional Dynamics in Medical Encounters:

The Participant Roles and Identities

by

Özge Çağlar

The aim of this thesis is to analyze the dynamics of doctor-patient interactions in Turkish from an interactional sociolinguistics perspective. First, how the participants establish the medical talk is analyzed taking into account the third participant in the medical talk, the companion. It was found that the companions are as effective as the patient or even more active than them during the interaction. The participants' roles were analyzed according to Goffman's (1981) "participant status" framework. Particularly, the companion's interactional roles and how these roles change the alignments of the doctor and patient were examined. Secondly, the address and reference terms used by the participants were analyzed. By doing this, the aim is to clarify how the participants perceive and reflect their own and others' identity.

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CHAPTER 1

INTRODUCTION

This study examines the discourse of medical encounters between doctor and patient from a social interactionist perspective, based on naturally occurring conversational data collected at a government hospital in Istanbul.

Since the medical discourse should be investigated considering the interactants as the social actors, setting, topic and purpose of the talk as the meaning and interpretation of the interaction cannot be separated from its social and situational context, therefore, as mentioned in Van Dijk (1997), language users engage in interaction not only as speakers but also as women and men, old and young, doctors and patients etc. The speakers are the members of certain social categories and portray a combination of these social and cultural roles and identities. Interactional sociolinguistics is established upon the bond between language and society therefore, it provides a ground for analyzing the linguistic forms used in social groups and situations such as the doctor-patient interaction and examining how medical discourse is structured and reflected.

Analyses of doctor-patient interaction have been studied mainly in two fields, medico-sociology and linguistics. The researchers with a medical background study doctor-patient interactions, observing the medical course

of events during an encounter, with the ultimate goal of describing (even prescribing) the ideal doctor-patient relationship[1]. Researchers with a linguistic background, on the other hand, approach the doctor-patient talk as an instance of institutional discourse and a social situation where issues such as gender, power and status are established and reflected by the participants who are assumed to be in an asymmetrical relationship. Frequently asked questions in such studies include how doctors convey their power, which power registers can be identified, what the courses of events in a medical encounter are and how these vary depending on the identities of the doctor and the patient (e.g., their social class and gender).

Up until now, the doctor-patient interaction has always been conceived of as essentially limited to two persons (Bloom, 1965) and examined as a dyadic interaction; however, the real-life data collected at a Turkish hospital indicate that this is not usually the case. Medical encounters are, in fact, triadic conversations between the doctor, patient and the patient's companion. Of the 25 medical encounters recorded in the course of five months, only four encounters were between the doctor and the patient. The rest involved either all three participants or just the doctor and the companion. Furthermore, the companion's participation in the encounter is well beyond that of a passive bystander. Therefore, it is imperative that an adequate description of the

[1] Also among their purposes are to develop new modes of conveying diagnostic and therapeutic information, to improve the decision-making process and to examine how patients' satisfaction are linked with the communicative behavior of the doctor.

medical discourse should take into consideration the companion as a participant.

1.1. Defining the Medical Encounter

Doctor-patient talk has been defined as being different from normal daily talk in many respects. West (1993) claims that the flow of talk in medical encounters does not proceed as a two-way exchange as it is presumably the case in normal conversations. Questions raised by the patients are often ignored; however, when raised by the doctors, the patients are to provide an answer. The topics raised by the patient are again likely to be ignored or not developed by the doctor. Shuy (1993) claims that doctor-patient interaction does not evolve in such a way to ensure balanced participation, which is common in normal conversation. In medical interaction, the participants are not expected to introduce new topics and talk and respond in balanced quantities.

As a consequence of unbalanced question-answer sequences, Frankel as cited in Todd & Fisher (1993: 129), uses the term 'interview' for doctor-patient talk. He claims that interviews are prestructured types of talk (made up of questions and answers) where an asymmetry in question-answer sequence is present. In interviews, one party is the questioner and the other is the answerer, and this is pre-established. The turn-takings and their length and content are relatively fixed during an interview (Sacks, Schegloff and Jefferson 1974). However, in normal conversation there is an expectation of

balanced participation where such an asymmetry of question and answers are not observed. One party does not undertake the role of questioning and other answering. Normal conversation is not prestructured and restricted in the way interviews are.

Medical talk may have some common characteristics with other spoken genres such as interviews, however, this does not necessarily entail that doctor-patient dialogues are interviews. Medical talk should be considered as a genre on its own. A two-way swap may also be seen in medical talk; the patient may also question the doctor and other characteristics of normal conversation even may occur. Therefore, medical talk should be analyzed as a genre on its own within the general framework of institutional discourse.

1.2. Previous Research on the Medical Discourse Analysis

Medical discourse analyses have basically power and gender issues as their starting points. The following two sections summarize the pioneering studies in the medical discourse and discuss the linguistic features taken as characterizing doctor-patient talk.

1.2.1. Power in Medical Discourse

Studies in medical discourse have widely claimed that doctors are the dominant and patients are the passive participants in medical encounters thus medical discourse relies on doctor's paternalism.

Parsons (1951) suggests that contemporary medical talk rests on an asymmetrical relationship between patient (lay person) and doctor (professional expertise). Fisher (1982:162) also underlines the asymmetrical relationship between the doctor and the patient in medical talk:

> "...medical practitioners not only have technical skills and medical knowledge that patients lack but they also have the potential to control patients' access to and understanding of the information on which they will make their treatment decisions. This power imbalance increases when practitioners perceive patients as poor and powerless.'

Power is claimed to be reflected by use of certain linguistic features during the talk such as questions, interruptions, topic management etc.

The number of questions doctors and patients ask is a central issue in medical discourse research as questioning[2] claims power over emerging talk (Ainsworth-Vaughn, 1998). West (1984) and Wodak (1997) analyze the question sequences in doctor-patient interaction and conclude that the doctor is the powerful party as doctors ask more questions when compared to patients, and patients answer questions instead of asking. The claim that patients are passive as a result of not asking but answering questions is modified by Ainsworth-Vaughn (1998). She points out that questions cannot be assumed to be serving one-to-one index to the entire power balance in the medical encounter as there are many kinds of questions and many ways of

[2] Ainsworth-Vaughn (1998:99) claims that questions are directives which claim power by choosing the next speaker and the topic that the speakers will discuss.

exercising power other than questions such as turn takings, address terms, topic management etc.

Goodyear-Smith and Buetow (2001: 449, 450) on the other hand, analyze the power issue from a different perspective; "...power includes social power, that is, the ability to influence interpersonal relationships and the parties engaged in them". They also point out that both parties in the medical encounter need and use power. Doctors have specialized knowledge and they need power to share the information with the patient, respond to the patients' questions and demands, to help patients tell their stories, formulate and express preferences and make informed decisions on treatments (2001:452). In other words, doctors need power to facilitate the healing and in order to maintain their professional integrity; they need to accomplish trustworthy diagnosis and treatment. Patients, on the other hand, need power to have their health needs met and to actively participate in the shared-decision making process. Goodyear-Smith and Buetow also claim that how power occurs in medical talk is influenced by the personal qualities of the doctor and the patient such as trust, ethics, communication skills, assertiveness and the sense of confidence within the interaction.

Topic management in the medical encounters has been seen as one of the primary ways of exercising power. Beckman and Frankel (1984) claim that

topics raised by the patients were likely to be lost as the doctors took control in the encounter.

1.2.1.1. Gender and Power

The 'differences approach' in the 'language and gender' studies claims that the way women and men speak is shaped by their gender, and, thus taken gender as an independent sociolinguistic variable.

Gender as a social reality, is constructed, accomplished and reflected in the communication by the doctor and the patient. It is argued in the medical literature that male doctors play a more dominant role in the encounters than female doctors. It has been claimed that female and male doctors claim power to different extents and ways (Ainsworth-Vaughn, 1998). West (1984) suggests that female doctors were interrupted more often than men in the encounters and they were more egalitarian in their use of directives or commands. West also claims that male doctors use aggravated forms that emphasize differences between their patients and themselves, and proposed hierarchical doctor-patient relationships. Female doctors employed mitigated directives, which minimized status differences between doctor and patient (West also underlines that female doctors can use aggravated directives on occasions of conflict with patients). Moreover, she finds that female doctors are more successful in compliance gaining despite their mitigated directives. Similarly, Pizzini (1991) and Ainsworth-Vaughn (1992) claim that female

doctors are more cooperative and male doctors are more competitive in medical discourse.

Regarding patient's gender, Fisher (1989: 294) points out that female patients have been seen as "emotionally unstable and unable to understand complex assumptions" by doctors. However, she finds in her analysis that female patients have the power to change the direction of the treatment decision by asking strong, clear questions or resisting the doctor's authority during the medical encounter. This analysis reveals that female patients are not simply powerless actors in the medical interview but have the potential to participate in the decision making process in the medical conversation. Ainsworth-Vaughn (1998:93) finds in her study that female patients asked more questions than male patients. Thus, she argues that both the doctor's and patient's gender have significant effects on question asking.

Davis (1993) analyzes power from a feminist perspective in medical encounters with male doctor and female patient as participants. In her study, she underlines that so far power has been linked to domination and subordination which means that power is employed by men in order to keep women down, silence them or prevent them from acting, thinking, feeling as they would do without the pressure. However, according to Davis, this concept of men power embodies some difficulties in analyzing friendly or intimate medical talks with a friendly and sympathetic male doctor.

Therefore, Davis (1993:261) aims to create a perspective of power, which is also capable of dealing with power in friendly encounters and claims that:

> "Power needs to be conceptualized in a way which is complex and subtle enough to account for relations involving domination, coercion, or repression as well as relations which are positive, productive, or enabling. Understanding asymmetrical power relations will often entail sorting out just how these two dimensions are intertwined within concrete instances of interactions as well as interactional outcomes".

1.2.2. Other Issues

The setting of doctor-patient communication has been claimed to be playing a significant role in the process of medical talk and, in a way, organizing the flow of talk. The setting is owned by the doctor awhile the patient is unfamiliar with the environment and with medical talk being used in that environment. The environment, medical knowledge, medical jargon and power are also owned and used by a single participant. The other participant, namely the patient, not only lacks all these but also is in an uneasy situation because of the disease s/he suffers or may suffer (Fisher 1982: 168).

Additionally, social class is one variable that has been studied in medical discourse. For instance, Blair (1993) argued that marked social class differences are found in the use of terms for illness. Working class patients employed more 'physicalistic' terms than middle class patients; that is, they

referred to sensations and disorders of the body and categories of physical illness experience. On the other hand, middle class patients described their illness by using psychological or emotional expressions. This suggests that patients from a different social class behave differently and use a different language during the medical discourse.

Time is another issue in medical communication, which is again said to be asymmetrical. In medical talk, a budgeted time is operative. Doctors have limited time for patients and to reach a conclusion (making a diagnosis or recommending treatments). Patients, in most cases, do not have a time constraint and for patients "the focus is on the meaning of their medical problem and how it will affect their everyday lives" (Fisher, 1982: 168).

1.3. Theoretical Framework

Theoretical framework for this study is interactional sociolinguistics as it provides a framework within which to analyze medical talk from sociological, interactional and cultural perspectives. Generally put, interactional sociolinguistics studies linguistic and social construction of interaction.

Interactional sociolinguistics is based on three fields, anthropology, sociology and linguistics and ideas of Goffman and Gumperz are regarded as the building blocks of the framework. Regarding the contributions of Gumperz, he introduces the concepts and concerns that are related to language and

culture. In depth, Gumperz analysis of verbal communication provides an understanding in how people sharing a grammatical knowledge differently contextualize what is said in such a way that different messages are produced and understood and he aims at "developing interpretative sociolinguistic approaches to the analysis of real time processes in face to face encounters" (Gumperz 1982: vii).

Regarding Goffman, he introduces concepts of self and society and aims to construct the relationship of these two concepts at a microlevel of analysis (everyday encounters, interactions, and activities in which the participants routinely engage) "the microlevel processes help organize and give meaning to our everyday behaviors and help provide us with a sense of self" (Schiffrin 1994: 308). Goffman's analysis provides an understanding of how language is situated and how it reflects and adds meaning and structure to those circumstances (Schiffrin, 1994).

Goffman also introduces the concept of "participant framework" which will be applied in the analysis of participants' roles and inputs in this study. With this framework, the alignments of the doctor, patient and the companion in the encounters are discussed and how the triadic encounter is structured will be examined.

1.4. Aim and Overview of the Study

This study aims to contribute to the medical discourse analysis, as it examines a multi participant structured medical talk. Different from what has been done so far, this study analyzes encounters where a third participant as the companion is also present and tries to account for the interactional and participant structure of a triadic encounter. The specific questions are, during medical interaction how the participants align (Goffman, 1981) themselves and others and how this is reflected in the language, how the participation framework is invoked and abided by or rejected by the participants. Assuming that address terms are one of the linguistic cues in establishing the dynamics of the talk, what kind of information do we get out of their use, during the interaction and alignment process how the participants employ address terms and what is the significance of the address terms in terms of formality degree and preferences of the parties.

The organization of the thesis is as follows: Chapter 2 presents information on the setting, subjects and the methodology of the study. Chapter 3 discusses the alignments of participant roles in the medical encounter using Goffman's (1981) concept of "participation framework". Goffman's participation framework provides a way to describe spoken discourse in terms of the roles occupied by the participants. The focus is on the contribution of the patient's companion since this third party of the medical encounter has hardly ever been studied in the literature. Chapter 4 deals

with the interactional patterns among the doctors, the patient and the companion. However, this time two specific linguistic behaviors are singled out in order to shed light on how the participants construct self and other's identities: The address terms and reference term usage. In this chapter I also argue whether there is a relationship between the roles that the participant occupies and use of address terms and if so, how. Finally, chapter 5 summarizes the findings of the study and raises questions for further studies.

CHAPTER 2

DATA AND METHODOLOGY

This chapter gives information about the data collection in this study.

2.1. Setting

Doctor-patient encounters have been recorded in the radiation oncology clinic of a state education and research hospital in Istanbul in a lower middle class neighborhood. The hospital has a central location with 600 beds on the European side and is well known for its radiation oncology treatments among the government hospitals. The clinic receives 4 to 6 patients per day and works part-time until lunch break. The room in which the encounters have been recorded has three tables, one occupied by the nurse (the table closer to the door), and the other two tables available for the encounters. These tables are frequently occupied at the same time, which means two encounters take place at the same time. Consents for the recording were secured beforehand.

As the hospital is a state education and research hospital, the encounters between doctors and patients almost always take place in other peoples' presence such as the nurse and/or other doctor(s) of the clinic, companions, other patients, their companions etc. Thus, the presence of

the researcher[1] does not intrude the privacy of the doctor-patient encounter and the researcher is not the only outsider during the encounters.

2.2. Subjects

2.2.1. Doctors

Three doctors participate in the recordings for the study. Two of the doctors in the clinic are female and one is male. All doctors are in their late thirties and they belong to upper middle class. The male doctor of the clinic is the assistant doctor specializing in oncology. One of the female doctors is the associate head of the radiation oncology clinic (participates in organizational meetings when the clinic head is not present) and all three doctors have been working in the same place for about five years or more.

	Female Patient	**Male Patient**	***Total***
Female Doctor 1	6	X	*6*
Female Doctor 2	2	1	*3*
Male Doctor	*6*	*3*	*9*

Table 1. Number of female and male patients that were examined by the doctors.

[1] Me as the data collector.

2.2.2. Patients

The patients in this study are all cancer patients visiting the oncology clinic after their operations. Cancer patients have been chosen as subjects as their illness requires a long-term treatment period during which they establish a relatively close relationship with their doctors. In addition to long-term familiarity, the serious and life-threatening nature of the disease and the invasive and disabling nature of the cancer treatment (chemotherapy and radiation therapy) strengthen the bond between the doctor and the patient.

Eighteen patients, fourteen female and four male, have been recorded for this study. The patients' age range is 8 to 78. 84% of the patients are above the age of 50. The patients belong to lower or lower-middle class. 80% of the patients are long-term patients of the clinic and 20% are newcomers. The patients receive a range of cancer treatments such as breast, larynx, lung, prostate and some of the patients are referred to the clinic only for evaluation after operation. The names of the patients and doctors are changed for the protection of their privacy. The information about the patients is obtained from the patient's individual files in the clinic. Each patient is given a number in the database and the relevant information is provided about the patient, the age of the patient, presence of a companion and the disease in Appendix 1.

2.2.3. Companions

The companions not only accompany the patients during their visits to the doctor but also visit the doctor on behalf of the patient when the patient is not present due to his/her critical conditions. In such cases, the companion provides necessary information on the latest condition of the patient as they are (mostly) the caregivers of the patient and the doctor informs the companion about care-taking, use of medicine etc. Elder patients may also not be present in the encounters. If the patient's presence is not necessary (i.e., unless an x-ray, blood test or physical examination is required), the doctors do not prefer them to visit the hospital. In such cases, the companions undertake the responsibility of paperwork, document transfers etc. When both the patient and the companion are present, companions participate in the talk and do not remain silent.

Daughter	**Husband**	**Son**	**Sister**	**Wife**	**Mother**	In-Law Relative
7	5	4	3	1	1	1

Table 2. Companion distribution in the encounters.

As seen in table 2, the companions tend to be close relatives of the patients. The patients' daughters constitute the majority of the

companions. Daughters are followed by spouses. Mother as the companion is not observed frequently since the patients are usually old. The only case where the mother is the companion is with a child patient[2].

In one case, in-law relative of a patient also serves as a companion as she is employed in the same clinic as a nurse. In that particular case the patient's wife was also present.

2.3. Recordings

The database includes 25 encounters (29 encounters were audio taped and 25 transcribed as 4 encounters were undecipherable). The male doctor has total number of 10 encounters and the female doctors have 15 encounters. The encounters were classified according to the presence or absence of the companion. 14 encounters have triadic nature and involve doctor, patient, and companion. In 7 encounters, the doctor and the companion are the only participants.

Doctor-Patient-Companion	Doctor- Companion	Doctor-Patient
14	7	4

Table 3. Doctor, patient and companion's presence in the encounters.

[2] In this encounter, the patient is an eight year old child. Therefore, the mother may not be considered as a real companion as the child would not be able to visit the clinic and talk about his treatment without the presence of an adult. According to Van Dulmen (1998), the contribution of children to the medical conversation is very slight or absent and there is a positive correlation between the age of the child and his/her participation in the encounter.

As indicated in table 3, in 14 of the encounters out of 25, doctor, patient, and companion are present. This is the most common type of encounter throughout the data. This triadic encounter is followed by dyadic encounters that doctor and companion are present. The least observed type is the encounters where the participants are the doctor and the patient.

All of the male doctor's encounters with the patient include a physical examination phase. The female doctors' encounters with the patients do not all include physical examination phase (5 encounters include the physical examination out of 9). This difference leads to a variation in the length and type of the encounters. The male doctor has longer encounters than the female doctors.

All medical encounters were recorded between January and May 2004. To record the encounters, a high sensitive tape-recorder was used and was placed on the doctor's table. The duration of the encounters ranges from two minutes to an hour and a half and the average encounter is 30 minutes. The clinic was visited every week for the recordings[3].

All the recordings of the encounters are transcribed. The transcriptions save and reflect the way the participants speak. In other words they reflect the casual speech as it helps the reader to recreate the sound of the talk (Ainsworth-Vaughn, 1998). Complete list of transcription conventions used for this study appears in Appendix 2.

[3] Due to practical and institutional reasons such as holidays, radiation machine's being out of order etc. certain weekly visits did not take place. In those cases, the recordings were collected twice a week.

CHAPTER 3

COMPANION AS THE THIRD PARTICIPANT

Medical talk research has mostly focused on dyadic conversations between the doctor and the patient. However, our data indicate the presence of a third participant, the companion, in the encounter. Companions are a crucial part in the interaction as they are present in the majority of the encounters so much that in some cases, only the companion is present. The companion is an active interactant in the encounters; therefore, it is crucial to account for the effects and functions of the companion talk during the encounter. The aim of this chapter is to analyze the interaction as the doctor-patient-companion *triad* in order to make a comprehensive analysis of medical talk. In particular, first, the reasons for the presence of the companion will be discussed as this plays a crucial role in understanding their interactional input. Secondly, the interactional roles of the companion will be examined according to Goffman's (1981) 'participation framework'. The answers for the questions of what roles the participants undertake, what contextual features determine the roles and under which conditions these roles may change will be sought.

Bloom (1965:72) emphasizes that "The doctor patient relationship is conceived of as a system of social roles, derived from culture, and learned and controlled by two major social institutions, the medical profession and the family". As presented in chapter 2, the companions are almost always

family members. Being the primary caregivers, they know a lot about the patients, the effects and outcomes of the disease in their daily lives. Therefore, companions can provide significant input to the encounter, undertake different roles during the encounter and effect the course of interaction between the doctor and the patient (e.g.., question-answer sequences, turn-takings, and so forth).

Analysis of the companion's role in the triads may be done from the patient's, doctor's or companion's perspective. In this analysis all three perspectives will be considered for a consistent analysis, as it is necessary to account for how doctor and patient perceive and utilize the third participant in the encounter.

3.1. Triadic Interaction - Reasons for Companions' Presence as the Third Participant

As presented in chapter one, the companions are present in 84% of the encounters analyzed in this study. In order to examine their interactional roles in the medical talk, the motivations for companion's presence need to be made transparent. The cultural and institutional facts, the nature of the disease and the age of the patient seem to be the motivations for the companion's presence.

3.1.1. Cultural Motivation

Bloom (1965:64) emphasizes that "each specific culture constitutes a kind of blueprint for all of life's activities" and medicine is one of these. In Turkish culture, accompanying friends and/or especially close relatives during doctor visits is a prevailing norm. Companionship can be defined as a component of the 'national culture' in Turkey. National culture is defined as "that which distinguishes the people of one country from those of another" (Hofstede et al. 2002: xviii), which prescribes what must be, may be and/or must not be done. A discussion of Hofstede et al.'s notions of identity (individualism or collectivism), hierarchy (power distance) and gender as parameters of society that distinguish them from other societies seem to be relevant for the discussion of the Turkish culture and its significance in the presence of a companion.

On the spectrum of individualism and collectivism, Turkish culture may be defined as relatively collectivist. Hofstede (2001:248) claims that "Turkey exhibits strong uncertainty avoidance (what is different is dangerous) and is combined with collectivist particularism". Core values of collectivist cultures are family, tradition, honor, shame, etc. Negative concepts are self, "do your own thing", self-interest, the individual, privacy, etc.

Hierarchy is "the degree of inequality between people that is assumed to be a natural state of affairs" (Hofstede et al. 2002:36). Hofstede (2001:93) mentions that "Turks tend to score higher on most authoritarian values". Turkish

culture tolerates power distance. In other words, people are not assumed to be equal; therefore, the power distance between the doctors and the patients is relatively big. In the data, the patients, especially with a lower socio-economic background, want to see the doctor as a strong leader (to cope with the disease) to whom they can surrender. These attitudes are associated with a large power distance between the doctor and the patient. The companion's presence at this point may function as a mediator between this large power distance. They tend to minimize the power distance by questioning the doctor about the disease, the treatment process, and medications etc. in other words, by being the healthy agent of the patient.

Hofstede et. al. (2002:37) claim that in every culture, there is unequal distribution of roles among men and women and they differenciate between 'feminine' and 'masculine' cultures. Feminine cultures are claimed to be more care-oriented where little difference is observed between men and women and masculine cultures more achievement oriented where men are expected to be tougher than women. In this respect, Turkey seems to have common features of both the feminine and masculine cultures. Feminine in the sense that care-oriented and compromising attitudes are favored in Turkey and masculine in the sense that there is an expectation that men should be tougher than women.

Raffler-Engel (1989:1) mentions that "The participants bring their understanding of the culture-at-large plus their understanding of the culture-

specific rules that govern the particular event. The perception of the appropriate behavioral rules depends on each participant's social, ethnic, religious, professional, age group, and sex perspective". Parallel to this claim, the Turkish society evidently has a certain attitude towards cancer disease and cancer patients.

3.1.2. Nature of the Disease

The nature of the disease is also a crucial factor in forming the social norms and attitudes towards the disease and the patient, and hence the companion's presence.

Turner (1995) discusses a 'sick role' as a social role in the society. He mentions four parameters: first, the sick person has legitimized social withdrawal from work or family duties, second, they should take professional support in order to facilitate recovery, thus, are exempted from responsibility for their medical condition. Third, the sick person has a social obligation to improve, therefore, should cooperate with the medical experts. Finally, the sick person should be seeking a competent health care from a medical expert.

In addition to Turner's discussion on the 'sickrole', cancer patients are mostly physically weakened and in need of special care[1].

[1] Cancer treatment is done by operation, radiotherapy, and chemotherapy or combined modalities and these treatments are highly intrusive. Chemotherapy treatment is referred to

Therefore, the companions already have or develop profound and intense relations with the patient either before or after the disease. It is observed that close relatives (siblings, children, spouses) feel a strong responsibility for the patient; they want to provide both psychological and physical support and perceive this as a kinship duty.

The companions also want to be informed about the disease and prognosis and they want to get this information directly from the doctor who is the primary source rather than indirectly from the patients. In order to avoid confusion or misunderstanding(s) about the treatment process, both the companion and the patient prefer the companion's having access to what is being spoken in the medical encounter. The companions also provide the doctor with certain information such as patient's current condition, complaints and medication use.

In certain cases, the presence of the companion is a must. For instance, the patient may be incapable of talking (e.g., if the patient has larynx cancer) or may have hearing disability. In such cases, the presence of a companion is obligatory in order to provide information about the patient, to answer the questions asked by the doctor and/or to ask the questions coming from the patient.

as a "fist" to the patient, which has various side effects such as nausea, dizziness, lack of appetite etc.

Additionally, the companions are present in the case of cancer patients in order to control the information delivery between the doctor and the patient. Most of the companions do not want the patients to be aware of their disease. The companions mostly prefer to withhold information about the disease from the patient, partly inform the patient or misinform the patient (e.g., the tumor is not malignant but benign). In such cases, the companions behave as barriers between the doctor and the patient in terms of information flow and this gives rise to a crucial variation in information flow from the doctor to the patient.

3.1.3. Institutional Requirements

The companions also deal with the institutional requirements for the treatment procedures. During the treatment period the doctors may ask for previous documents and records of the patient such as diagnosis, examination and biopsy reports, MR results etc. and these are usually directly explained to the companion. Frequently, there is a need for document transfers within the institution and the companions are asked to handle these.

This also reveals that not only the companions but also the doctors see this as a responsibility of the companion, not the patient[2]. In sum, institutional requirements or services that should be provided by a health-care employee

[2] Bloom (1965) also mentions that the family is seen as the primary reference group for the behaviour of the patient.

are, out of necessity, done by the companion and this gives rise to a companion's presence.

3.1.4. Age of the Patient

Age of the patient is another factor for the presence of the companion. Older patients are accompanied by the companions more than younger patients are. In addition, the companions of older patients tend to participate in the talk more actively.

The companion's being more active also arises from the educational background of the patient. Companions are usually more educated than the patients especially when the patient is older than the companion. The generation difference between the doctor and the patient also effects the interaction. Companions seem to be minimizing and/or balancing this generation difference.

Like Turner's "sick role", we can propose a "companion" role based on Bloom's definition of social role as patterns of expected behavior which are regulated by cultural norms or rules of behavior, and organized into rights and obligations generally accepted within a group (Bloom 1965).

As the companions know the normative expectations based on the culture, they also realize what is expected from them in the institution and the encounter based on their experience and act accordingly.

3.2. Inputs of the Companion

Companions as participants influence the interaction and play a multi-functional role during the encounter. The companion fulfills three functions in the interactions:

a) Providing information for the doctor,

b) Gathering information from the doctor,

c) Acting as a bridge (mediator) between the doctor and the patient.

The inputs of the companion given above will be discussed according to the *participation status* and *footing* notions of Goffman (1981). The following section presents Goffman's notions on the multiple roles that the individual may present in an interaction and helps us to uncover what exactly the companion does in the interaction. Participation framework and participant roles provide the tool to analyze roles of the companion with respect to other participants and to identify the triadic structure of a medical encounter.

3.2.1. Goffman's Participant Framework

Participation framework provides a way to describe the roles occupied by the participants and how these roles are defined by the speaker's attitude or orientation to the content of the utterances which comprise the discourse (Haydon, 2004).

Goffman's starting point was to question the traditional dyadic model of talk and its inefficiency and restrictedness of the binary role of the speaker and hearer; especially in interactions that have multi-participant structure. The model of participation framework covers every participant present, their status and roles in the talk. Goffman (1981) claims that being a participant in a talk does not simply mean being either a speaker or a hearer but rather undertaking the roles of "animator", "author" or "principal" of the words being spoken. Goffman mentions three roles that a speaker may occupy; "animator" is the utterance producer in the talk "He is the talking machine, a body engaged in acoustic activity, or if you will, an individual active in the role of utterance production (1981:144)". Reciting a fully memorized text or reading aloud from a text with having no hand in formulating them makes the speaker act as the animator. They would, then, be expressing opinions or beliefs that are not their own and speaking for someone else in someone else's words. Thus, the animator role is assigned to the person who physically produces the utterance.

"Author" is the one "who has selected the sentiments that are being expressed and the words in which they are encoded". The speaker is assigned the role of author if s/he has selected and arranged the words, which express the sentiment of the utterance. "Principal" is "someone whose position is established by the words that are spoken, someone whose beliefs have been told, someone who is committed to what the words say" (1981:144). Principal role is assigned to the person who is responsible for the

sentiments expressed and for any consequence arising from the expression of the sentiments (Haydon, 2004).

Goffman and following researchers have focused on the author and animator roles for the speaker and have not gone into detail in making the principal role transparent. The key points in the further discussion will also be the assignment of animator and author roles. With these two categories, Goffman differentiates a participant who only delivers a message to the recipient (not being responsible for the content of the message) and a participant who expresses her/his own beliefs. Eventually, these two participants have different interactional according to Goffman in the interaction. The distribution of the roles among the participants is known as the participation framework: "When a word is spoken, all those who happen to be in perceptual range of the event will have some sort of participation status relative to it (Goffman, 1981:3)". This is the relative footing of participants in an encounter at that time. Goffman also discusses that individuals have a schema (at least an expectation) about the participation framework for a given setting. Applying this to the medical talk at hand, participation framework in a triadic encounter seems to be complex. Goffman emphasizes that participation frameworks are often transformed in ongoing interaction such that participant's footing can shift in unexpected ways and participant's footing can be predicted when once one knows their role in the type of encounter going on. This point of Goffman makes it clear why the 'experienced' companions are more active during the encounters. As

the companion becomes aware of the doctor's interactional expectations, that he is indeed not only allowed but also asked to actively participate in the interaction, he gets more involved in the talk. Companionship is a tacitly approved 'job' by the doctor, medical institution and the patient.

The companions and their footing may vary according to the nature of the disease; for cancer patients, the companions seem to be taking on a lot from the patient. As the disease requires a long-term treatment process with heavy requirements and side effects for the patient, it is companion's duty to handle matters on behalf of the patient. As companions are with the patient most of the time in patient's daily life, they inevitably change their perspective and try to see things from patient's perspective. As cancer effects patient's social life and society has a certain stance against cancer, companions are affected as a part of patient's social life and undertake different roles such as the expert, caregiver, co-sufferer etc. and also express these social roles with different footings in the interaction.

The following sections analyze the roles undertaken by the companion and what inputs they bring under these roles. Within the participation framework of the talk, the individual role-taking processes of the companion and how these are reflected by language use will be discussed. It is observed that companions act as the animator and/or author of the patient, animator and/or author of the doctor and animator and/or author as himself.

3.2.2. Companion as the Animator of the Patient

The companions may undertake the patient role and speak *for* the patient. As given in section 3.2., when they are the animator of the patient, the companions provide information about the patient's condition, and in addition, they answer the questions that are asked *to the patient* by the doctor. In such cases, the companions act as the animator of the patient. As they use the patient's words, the patient is the author.

Consider (1) where the patient has larynx cancer and incapable of talking and the companion speaks for the patient and provides the information asked for:

(1) **Patient 20**

1*Doctor : Noldu ya sana nazar değdi?*

2*Companion: Göğüste ve sırtta ağrı var.*

Doctor: What's the matter with you?

Companion: There is pain in the breast and back.

The doctor initiates a question to the patient accompanied by eye contact; however, the companion obligatorily speaks *for* the patient and answers the doctor's question. The doctor by making the addressee clear in his utterance sets the participation framework where the roles of author and animator and principal are assigned to the patient. However, as the companion knows that

this participation framework cannot be carried on, she replies the doctor for the patient. In this case, patient's being unable to abide by the participation framework invoked by the doctor creates a new framework where the companion is the animator and patient is the author.

The companion by replying the doctor provides the necessary information to the doctor. As it is impossible for the companion to know where the patient feels the pain unless the patient mentions, the patient is the author. The companion uses *göğüste* and *sırtta* "in the breast and the back" without third person singular possessive suffix *göğsünde sırtında* "in his breast and back". The use of *göğüste* "in the breast" *sırtta* "in the back" without possessive suffix indicates that companion does not emphasize the owner of the body – hence the patient-.

In the encounter above, the companion undertakes the animator role obligatorily. The companion is the daughter of the patient and they share the same house. As the patient is not capable of telling his complaints and providing information to the doctor, the participation framework is subject to change whenever the patient is assigned the animator role. In such cases, the companion has to undertake the animator role and communicates with the doctor. However, certain phases of the encounter require and invoke a certain participation framework. For instance during the physical examination it is obligatory for the patient to respond to the doctor. The physical examination phase assigns the author role to the patient, as s/he has

to provide information asked by the doctor by nodding or other facial gestures. Logically it is impossible for the companion to act as the author in this case. In sum, in addition to participant's own choices of the participation framework and their relative footing, the context also determines and requires certain type of a participation framework where certain roles are assigned to certain participants.

In (1) it was obligatory for the companion to undertake patient role and speak for him because of patient's disability of talking. In (2) however, the patient has hearing difficulty but has no problem in expressing herself and answering the doctor's question. It is seen that even though the patient can be assigned the animator and the author roles in (1), doctor's selecting the companion as the addressee sets a different participation framework in (2):

(2) **Patient 21**

1*Doctor: Hergün böyle olucak zannetme o, ışın bittikten sonra turp gibi olucak,*

2*ondan sonrasını bilmem. Yatar mı?*

3*Companion: Yatar.*

4*Doctor: Refakatçi istemez?*

5*Companion: İstemez.*

6*Doctor: Kendi işini kendi yapar?*

7*Companion: Tabi.*

Doctor: Don't think that she will be like this everyday, she'll be fit as a fiddle when the ray is over, I don't know after that. Will she stay in the hospital?

Companion: She will.

Doctor: She doesn't want an accompany?

Companion: No.

Doctor: She'll manage her things?

Companion: Of course.

The framework in (2) invoked by the doctor assigns the animator, author and principal roles to the companion instead of the patient. It is plausible to say that, doctors prefer the participation framework where the three roles are assigned to the companion especially in information gathering phase. Interestingly, even though the talk is about the patient, the doctor does not address the patient. By not addressing her, the doctor does not invoke the patient to undertake any roles. As there is a decision taken by the companion about the patient, the companion is also invoked to act as the principal and be responsible for what he says. As the decision is about the patient, the doctor cannot assign herself the principal role, but has to assign this either to the patient or to the companion. Because of the reasons discussed in section 3.1, the doctors prefer to assign the principal role to the companion, as they believe that patients are not stable enough to be set as the principal and to be held responsible by their decisions. Thus, the participation framework in (2) is set by the doctor by invoking the companion to undertake certain roles. Alternatively, we may also claim that if the topic has been discussed by the

companion and the patient beforehand and the companion is aware of the needs and wants of the patient, the companion only acts as the animator but not the author. In this case, the companion answers using the patient's words and/or beliefs, and this makes the patient the author. However, when the social class of the patient is concerned[3], it is highly possible that the companion as being male and husband of the patient feels the right to decide for the patient and this permission is given by the patient to her husband tacitly. Concerning this cultural background, the companion is more likely acts as the principal.

3.2.3. Companion as the Animator of the Doctor

Companions perform the animator role of the doctor for two different purposes. First one is to mediate between the doctor and the patient; they restate the words of the doctor to the patient.

This act as a mediator helps to develop the talk more smoothly and makes the patient to participate in the talk. The doctor remains as the author as his/her words are being spoken by the companion. Second purpose is the companions, even though to a lesser extent; act as an expert in the field. They may answer patient's question directed to the doctor or make explanations about the topics discussed. In this case, they speak *for* the doctor and they also become the author.

[3] The patient comes from a lower class and both the patient and the companion belong to an eastern origin.

Let us now analyze the cases where the companion acts as the animator of the doctor, in order to mediate between the doctor and the patient. In (3) the patient does not answer the doctor's questions, therefore, the companion restates doctor's questions to the patient and acts as a mediator:

(3) **Patient 5**

1Doctor: Naber nasılsın? Aç bakalım baş örtünü.

2Companion: İyimisin diyo. Ağır işitiyo da?

3Doctor: İYİ MİSİN NASILSIN?

4Patient: ( )

.....

5Doctor: Şurda varmı? Bak parmağımla bastırıyorum? (3)

6Companion: Ağrı var mı anne bastırınca?

7Patient: Yok bastırınca ağrımıyo.

Doctor: How are you? Take of your headscarf.

Companion: He says how are you. She is hard of hearing?

Doctor: HOW ARE YOU ARE YOU OKAY?

Patient: ( )

.....

Doctor: Is there pain here? Look, I press with my finger? (3)

Companion: Mother is there pain when pressed?

Patient: No it doesn't hurt when pressed.

Similar to excerpt (1), the doctor addresses the patient in his question and invokes a participation framework where the patient is assigned the roles of animator and author. In line 2, the companion first restates doctor's question to the patient and then explains the doctor why the role invoked by him was not acted by the patient. Here, the companion abides by the participation framework invoked by the doctor and she invokes the same participation framework by restating the question to the patient and explaining why the role was not acted by the patient.

The companion's turn in line 2 should be analyzed in two units. First unit *"iyimisin diyo"* "he says how are you" simply restates the doctor's question directly to the patient and in this case the doctor remains as the author as his words are being spoken by the companion. Second unit is addressed to the doctor *ağır işitiyo da?* "she is hard of hearing?" and provides information about the patient (the reason for patient's not answering). Being informed about the hearing disability of the patient, the doctor restates his question with higher pitch for the patient in line 3. In lines 5-7, during physical examination, the doctor asks a question and his addressee is, clearly, the patient. At this point, the participation framework, which is required by the examination phase, is invoked. As this participation framework and the roles it assigns to the patient cannot be changed, the companion in the next turn acts a mediator for the patient and restates the doctor's question to the patient. Only after the companion's mediating, the patient acts the roles assigned for her.

As mentioned above, the companion acts as the expert in some cases by undertaking the author role of the doctor as well as the animator role. In (4) the companion acts as the animator of the doctor but different from the example in (3) she also acts as the author.

(4) **Patient 1**

1*Patient: Bi doktor var orhan bey bu çapada onun kaynısı ameliyat olmuş on sene*

2*evvel onbeş sene evvel, böyle yavrulamış onun, yavrular mı bu yani dişi mi erkek*

3*mi?*

4*Doctor: Şimdi bunlar dişi erkek diye ayrılmıyo tüm meme tümörleri yenileyebiliyo*

5*kemiğe sıçrayabiliyo onun için biz seni sıkı takip ediyoruz anladın mı? Sağ ayağın*

6*ağrıyodu di mi?* ((takes notes))

7*Companion: İlaçlarını düzensiz kullanırsa yeniler o zaman.*

8*Patient: Filmi çektikten sonra buraya getircez di mi onları?*

9*Doctor: Filmlerin sonuçlarını bana getirin tabi.*

Patient: There is a doctor, mr. Orhan, he is in çapa hospital, his mother-in law had an operation ten years fifteen years ago, his has hatched, does this hatch, I mean is it female or male?

Doctor: Now, these don't allocate into two as female and male. All breast tumors may reproduce. May leap to the bone. So we follow you closely right? Your right leg hurts right? ((takes notes))

Companion: It reproduces if she doesn't use the medications regularly.

Patient: After taking the films, we will bring them here right?

Doctor: Bring the results to me. Yes.

The patient's question in lines 1-3 assigns the animator, author and principal roles to the doctor. The doctor by answering the questions, uptakes the roles assigned by the patient. However in line 6, the companion invokes a different participation framework where she assigns the roles of animator and author to herself. The companion also assigns the role of principal, as she is responsible for her claims.

In the previous turns, the companion had complained about the patient for not using the medication regularly. Therefore, line 7 by the companion is meaningful after such a complaint. The companion invokes a new participation framework to induce the patient for using the medications regularly.

The participation framework change invoked by the companion is carried on neither by the doctor nor by the patient. This indicates that companions are allowed to act as the animator and author of the patients but not of the doctors.

3.2.4. Companion as the Author

The companions may also act as the author uttering their own words. They talk about their worries and/or concerns about patient's condition, ask questions to the doctor or provide information for the doctor. However, the

author role requires the companion to be experienced, in other words, informed about the patient's condition. On the other hand, when they are inexperienced, they do not participate much. They only assume the animator role.

As previously mentioned, there are encounters where the patient is not present but the companion is. In such cases, the companion obligatorily undertakes the animator and author role on behalf of the patient:

(5) a. **Patient 22**

1*Doctor: Bunlar kalp ilaçları mı?*

2*Companion: Astım ilaçları.*

3*Doctor: Hem astımı hem kalbi, ee şekeride varmı?*

4*Companion: Hayır yok.*

5*Doctor: Kalp yetmezliği nedeniyle mi ameliyat olmuyo?*

((examines the documents))

6*Companion: Yok, ıı ciğer.*

7*Doctor: Akciğer için mi?*

8*Companion: Evet öyle.*

9*Doctor: Genel durumu nasıl?*

10*Companion: Yani fazla dışarıya falan çıkmıyo zaten. Evde. Yemesi içmesi falan*

11*yerinde.*

Doctor: Are these heart medications?

Companion: Asthma medications.

Doctor: Both asthma and heart, ee does he have diabetes too?

Companion: No he doesn't.

Doctor: He is not operated because of heart insufficiency?

((examines the documents))

Companion: No. Iıı liver.

Doctor: Because of liver?

Patient: Yes.

Doctor: How is his general condition?

Patient: Well, he doesn't go out very often really. At home. He eats well.

The companion is the patient's daughter in (5) and they share the same house. Therefore, she is able and expected to provide information about the patient. Different from the cases discussed so far, the patient's absence in the encounter in (5a) sets the participation framework. As the patient is absent, the doctor assigns the role of the animator to the companion. However, author role is complex. In line 5, the doctor's question requires the companion to be the animator of another doctor who has decided about the operation. The question in line 9, assigns the role of author and principal to the companion as she is expected to answer based on her observations and assumptions. Here, the doctor assigns different roles for the companion by her questions.

In the case below (further in the talk in (5)), doctor directs a question to the companion; however, she is not capable of providing an answer and cannot abide by the participation framework invoked by the doctor:

(5) b.

1*Doctor: Ciddi mi? Hiç şikayeti yok mu?*

2*Companion: Ya vardı işte söyledi, dahiliyede söyledi. Dahiliye istemişti bunları?*

3*Doctor: Hı.*

4*Companion: Göğüse gittik göğüstende şikayeti var diye. Göğüs ya da dahiliyeydi*

5*tam olarak hatırlayamıyorum. Annemle de babamlada ilgilendiğim için?*

6*Gerçekten. Karıştırabiliyorum. Iı işte bunları istediler, yaptırdık. Yani: normal denildi.*

Doctor: Really? He has no complaints at all?

Patient: Well, he had he said. He said at the clinic for internal diseases. The internal disease wanted these.

Doctor: Hıı.

Companion: We went to the heart disease clinic. As he had heart complaints. It was heart or internal diseases I can't remember exactly as I deal with my mother and father at the same time? Really. I can confuse. Well they wanted these, we did them. I mean they said things are normal.

The doctor's question in line 1 indicates her doubt whether she is informed correctly and precisely about the patient. At this point, the companion does

not act as the author and the principal, but only acts as the animator. She drops principal and author roles by referring to patient's words in her utterance, as her knowledge about the patient is not sufficient for her to act the roles assigned to her. As she is well aware that being a companion and sitting there for the patient, the doctor expects her to provide information about the patient; after saying *"tam olarak hatırlayamıyorum"* "I can't remember exactly" she gives an explanation for not acting the role assigned to her and not abiding by the participation framework.

As well as providing information about the patient, the companion as the author may also gather information on the patient's condition:

(6) **Patient 23**

1*Patient: Oğlum evleniyo yirmiyedisinde.*

2*Doctor: Evlensi:n. Yirmidokuzunda yapalım?*

3*Patient: Hı.*

4*Doctor: Yirmidokuzunda.*

5*Patient: İyi.*

6*Doctor: Anlaştık.* ((laughs))

(2)

7*Companion: Kanı mı düşük?*

8*Doctor: Kanı şimdi iyi. şimdi iyi de, yaparsak bi daha düşücek. Ve git-her düşüş bi*

9*öncekinden daha derine iniyo.*

10*Companion: Yine boğazlarında bişey yok diymi?*

11*Doctor: Yo yo. Ben korktum?-*

12*Companion: Yok diymi?*

13*Doctor: Yok hayır.*

Patient: My son is getting married on the twenty-seventh.

Doctor: Oka:y. We can do it on the twenty-ninth?

Patient: Hıı.

Doctor: Twenty-ninth.

Patient: Fine.

Doctor: Settled. ((laughs))

(2)

Companion: Are the counts low?

Doctor: Her blood is fine now. It is fine now but, if we do it again, it will decrease again. And every decrease is lower than the previous one.

Companion: There is nothing in the throat again right?

Doctor: No no. I was afraid though?-

Companion: There is not, right?

Doctor: No there is not.

The companion in line (7), directs a question to the doctor in order to gather information about the patient and invokes a new participation framework which is different from the previous lines in 1-6.

The first question of the companion is about the blood counts of the patient. The second question in line 10 expresses a worry of the companion. The companion's question *"yine boğazlarında bişey yok diymi"* "there is nothing in the throat again right?" indicates that the companion is worried that cancer may metastasize. As the doctor's answer is not satisfying *"yo yo"* "no no" and followed by *"ben korktum"* "I was afraid" the companion asks the same question again with negative existential *"yok diymi?"* "there is not, right?" which indicates her expectancy and/or hope towards that cancer has not metastasized. Here, the companion's participations in the author role indicate that the companion not only provides information about the patient but also gathers information that the patient herself does not ask for.

3.3. Companions' Change(s) in their Footing

Applying the notions of footing to the participants in the medical encounter, we have observed that different roles may be occupied by the participants and these roles may change in relation to the dynamic nature of the encounter as also mentioned by Goffman "A change in footing implies a change in the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance (1981:128)".

The companion's having different footings are observed where they are experienced about the patient, disease and the encounter's interactional

structure. Therefore, we can say that various footings of the companion require him/her to be experienced in terms of:

a. Time: Being the companion of the patient for a time.
b. Disease: Being aware of the reflections, outcomes and requirements (medications, injection, chemotherapy etc.) of the disease and following the patient closely.
c. Environment: Being informed about the hospital, the doctor(s), institutional and bureaucratic requirements.

Knowledge of these is a crucial determinant for the companions to feel the right to act as not only animator but also the author and principal.

Goffman (1973) mentions that past experience or assumptions about the participants or setting are crucial basis for predicting future behaviors of the interactants. Additionally, Tates and Meeuwesen (2001) claim that:

> "Interactive frames are related to 'knowledge schemas': structures of knowledge about situations, actions and actors simply because such schemas provide expectations not only about what can happen, but about how to interpret what is said and done".

In the statements of Goffman and Tates and Meeuwesen, the common claim is that interaction is shaped by the participants' presuppositions and past evidence about what happens in a particular encounter.

In the triadic medical talk, the participants bring their own expectations and knowledge to the situation, which effect the structure of conversation and the participation framework. The companions' knowledge schema of the interaction in the medical encounter is established when they observe the patient for a long time and when they are present during the medical talk. Thus, they know and learn more about the situations and actions during the talk and this constitute their knowledge schema. For instance, they are aware of doctor's and institution's expectations from a companion. The doctors expect the companions to be aware of the patient's condition and complaints. By asking the companions not to bring the patient in certain cases, they imply that the companion will be providing necessary information about the patient; therefore, they should be informed about the patient. Relying on their schema based on their observations and experiences, it is easier for them to predict what is to happen next and to interpret cases regarding the encounter. A new companion (the companion may change for some reason and the new companion will be less experienced than the patient), whose knowledge schemas have not been established yet, will not be active as much as the patient is and will not possibly undertake the roles of animator and author.

Thus, an experienced companion has the necessary bulk of past evidence to rely on, what to expect and what not to. The knowledge of the past evidence about the encounter encourages the companions to act in various footings during the encounter.

The excerpt below is an example for the role changes in an encounter. In (7a), the patient is 67 years old and has a malign salivary gland tumor and her speech is not comprehensible. The doctor directs questions to the patient, however, the companion answers for the patient and changes roles during the interaction:

(7) a. **Patient 11**

1*Doctor: Çizgin çıktı mı Sultan hanım?*

2*Companion: Hayır çıkmadı. Geçen gün yaptık.*

Doctor: Did your lines fade away Ms Sultan? ((to the patient))

Companion: No they didn't. We did them the previous day.

The doctor's participation framework preference is clear in her question as she addresses the patient[4]. However, the framework is not abided by the companion as he answers doctor's question. The swift uptake of the companion creates a new participation framework where he is assigned the roles of the animator and author instead of the patient.

Consider also that the companion uses first plural agreement marker *yaptık* "we did", however, he refers to the doctor's previous treatment (drawing the area to be radiated on the patient's body) which was only performed on the patient. In this sense, the companion's talk for the patient involves the

[4] The doctor's question is about the area drawn on patient's body for the radiology treatment.

cooperative nature of the previous event, because the companion was the witness and the caregiver of the patient during "drawing" and thus is the author as well as the animator. Consider the further talk where the companion changes his role:

(7) b.

3*Doctor: Peki şikayet var mı?*

4*Patient: (Yok)*

5*Companion: Boğazı kuruyo sadece.*

6*Patient: Boğazım kuruyo.*

Doctor: Okay, are there any complaints?

Patient: (No)

Companion: Only her throat gets dry.

Patient: My throat gets dry.

Here, the doctor's turn in line 3 does not involve a second person orientation; rather, it is a vague question, in which there is an existential verb without a possessive marker on the noun *şikayet* "complaint", therefore there is not a definite addressee.

Compared to (7a), in line 3 in (7b) the doctor's choice of addressee has been modified as she may have realized that her first participation framework was

not abided by the companion and changed. Thus, she does not specify an addressee in her second question *şikayet var mı?* "are there any complaints?".

Even though the addressee is not specified here, it is the patient who answers this question unlike the question-answer sequence in (7a). The patient seems to realize that this type of a question sets the participation framework where the author role is assigned to her. Interestingly, after the patient's answer, the companion provides further information, which contradicts the patient's and acts as the animator of the patient. The patient as the first source of information says *yok* "no" to the question *"şikayet varmı?"* "are there any complaints?", however, the companion mentions a complaint of the patient *"boğazı kuruyo sadece"* "her throat gets dry". The patient in the next turn re-states companion's utterance *"boğazım kuruyo"* "my throat gets dry". The companion, as a close follower, is aware of the patient's complaints and aims to provide the most accurate information to the doctor. Only after the companion's answer, the patient re-states the utterance and confirms the companion's statement. In this case, the author is still the patient, as the companion cannot know this complaint unless the patient mentions.

In (7c), the companion shifts to the author role again:

(7) c.

7*Doctor: İlaç verdik mi hiç size?*

8*Companion: Hayır. Hiçbi ilaç kullanmıyoruz.*

Doctor: Did we give any medicine to you?

Companion: No. We don't use any medicine.

This turn is significant in that in the first turn of the doctor in (7a), she addresses the patient with her first question *"Sultan hanım"* "Ms Sultan", her second question has a vague addressee *şikayet var mı?* "are there any complaints?" in (7b) and third question *"ilaç verdik mi hiç size?"* "did we give any medicine to you?" has both the patient and the companion as the addressee. The doctor may be using a second person plural *siz* "you" in her utterance as both the patient and companion have answered her questions in the previous talk (note that she uses second person singular for the patient). Similarly, the question is again answered by the companion *"hayır hiçbi ilaç kullanmıyoruz"* "no we don't use any medicine" who acts as the animator. Here, the use of first person plural is also notable as the medications are used only by the patient. The use of the first person plural 'we' avoids patient's being in an outsider position in the encounter. Instead, the companion shows a collectivist behavior and emphasizes that act of fighting with the disease is a joint act, even though act of using medications is not. Thus the author role is unclear due to the use of collectivist 'we'. Consider (7d) where the companion acts as the animator:

(7) d.

9*Companion: Birazda bi şiş varmış gibi geliyo bize ama? (2) Yok di mi öyle bişey?*

10*Doctor: Bişey takılıyomuş, bişey kaçmış da burda kalmış gibi?*

11*Companion: Hayır hayır ( )*

12*Doctor: Ha yerinde mi? Ona bi bakalım. Anladım bi bakalım.*

Companion: We think that there's a lump or something? (2) There's not right?

Doctor: It's like something is stuck there, something fled there?

Companion: No no ( )

Doctor: Ha. In the area? Let's have a look at that. I see. I will have a look.

(7d) is interesting in that the companion in his first turn asks about their doubts concerning the patient's condition. This condition could have been mentioned by the patient; however, the companion acted as the animator of the patient by asking the question.

Things become more intriguing after the doctor's question "*bişey takılıyomuş bişey kaçmış da burda kalmış gibi?*" "like something stuck there, something fled there?". The doctor's question aims at understanding the nature of the problem by using metaphors. The companion reinvokes the frame in (7b) where he was only the animator. The companion answers the doctor's question although it seems to be answerable only by the patient. No matter how close and informed the companion may be, it is not plausible for him to know the description of the patient's feeling. Therefore, we may claim that the companion cannot be the author but only the animator.

The examples above indicate that the roles are not stable. Cases like in (7a), the companion can be both the animator and author. However, cases like in (7b), the companion cannot be the author as the author role can only be occupied by the patient. The changes in the participation framework and footings of the companion are due to the content of the questions asked by the doctor. The questions that seek for the physical feeling of the patient for instance require the patient to occupy the author role.

3.4 Conclusion

The aim of this chapter was to make the interactional dynamics in the medical triad transparent. The companions fulfill various interactional functions in the encounters and these functions are realized by their footings. Companions by doing so, change the other two participants' alignments. The participation frameworks may be invoked by the doctor (by questions or addressee selection), by the context (patient's being absent, physical examination phase of the encounter) or by the companion's own uptake without being called.

In Goffman's participation framework there is a third production role in addition to the author and animator role, "principal", which Goffman defined as "who is responsible for the talk". By this account we can argue that the patients can also be the principal because after all the medical encounter is for them or in other words, they are responsible for the talk. On the other hand, we may also argue that the doctor and the companion at least

in certain points (when they can be held responsible for what they say) can also be the principal.

Having made the alignments of the participants clear, the next chapter examines how the participants perceive and present others through their use of address and reference terms and if the roles discussed in this chapter are a factor in the use of these terms.

CHAPTER 4

TALKING TO AND ABOUT THE PATIENT

"One of most fundamental ways we have of establishing our identity, and of shaping other people's views of who we are, is through our use of language"
(Thornborrow, 1999:136)

Language as social behavior and identity construction have been seen as directly related to each other. The use of address terms is a crucial component of language in a social context, therefore, is an important factor and cue in the identity construction of the speaker. The speaker's use of address terms indicates his/her perception of the addressee, thus, through establishing other's identity, the speaker establishes and reflects his/her own identity. In this chapter, I will analyze the use of address terms in doctor-patient interaction in order to illustrate the identity construction alignment processes in a triadic medical talk. In addition to identity construction, we can also get information about the politeness strategies and degree of formality, familiarity, and solidarity of the participants through their use of address terms.

Brown and Gilman (1972) draw attention to the address term usage in socially uneven interactions and claim that the speaker's selection of address

terms correlates with the degree of power and/or solidarity existing between the participants. In the medical encounter, the choice of address terms for the doctor is associated with the doctor's power and identity. Ainsworth-Vaughn (1998) discusses two types of power that the doctor has in the encounter. First is the "aesculapian power", which is the doctor's knowledge about healing. "Structural power" is the medical license of the doctor. In addition to these power types, doctor's identity also has a role in patients' choice of address terms. The doctor has three intermingled dimensions of identity: individual, social and institutional. Individual identity involves the identity of the doctor as a whole, his/her personal choices, likes and dislikes, ethical values, etc. Social identity involves mostly the social implications and connotations of the profession as a 'doctor', which may vary from region to region[1]. Institutional identity of the doctor is identical to the structural power defined above.

This chapter first investigates doctors', patients', and companions' use of address terms and their implications in terms of gender, age, familiarity, solidarity, and formality. Secondly, the way the doctors refer to the patients who are not present in the encounter is examined. Additionally, correlations

[1] People in small villages and cities may show different levels of respect, commitment to the doctor.

between the patterns of address term usage and participant roles are briefly discussed.

4.1. Address Terms

Jucker and Taavitsainen (2003:1) define terms of address as "words or linguistic expressions that speakers use to appeal directly to their addressees". The choice of address terms is claimed to be related to the relationship between the participants or the requirements of the setting and/or frame. Thornborrow (1999) states that the use of address terms can depend on the degree of formality, intimacy, and status of the interactants involved in the talk.

Brown and Fraser (1979) on the other hand, claim that address term choices are based on the scene-based definitions of formality. Jucker and Taavitsainen (2003) put the two perspectives together and claim that terms of address choice may depend on both the formality of the setting and the social relationship between the participants. They also add the notion of 'politeness strategy preference' of the speaker that s/he wants to extend to the addressee. Honegger (2003:63) graphically illustrates the situation of address as below:

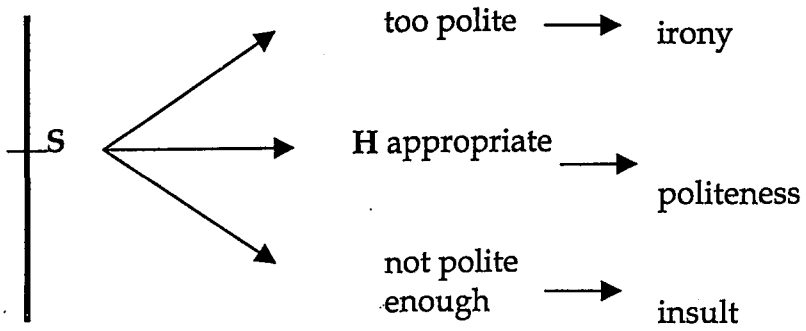


Figure 1. Situation of address. S=speaker, H=hearer (addressee).

As the figure indicates, if the address term is too polite for a particular situation it may be interpreted as irony by the addressee. For example, a patient addressing the doctor as *sayın doktor*[2] "honorable doctor" in an encounter may possibly be interpreted as irony by the doctor. Similarly, addressing the doctor in a way, which is not polite enough, for instance using the first name, may imply an insult as such a usage, may signal the speaker's not acknowledging the addressee's status and institutional role. As mentioned by Dickey (1997), the value of an address term, such as irony and insult, lies in the fact that it is not the normal form for that given situation but rather a marked or an unusual address term.

[2] *Sayın doktor* may be an appropriate address term in a written text or in a spoken text in a conference or meeting etc.

The issue of address term usage between the doctor and the patient has not been studied much in the literature. Wodak (1997) has studied address term usage between doctors and patients in German. Tiernan et. al. (1993) has conducted a survey to determine how elderly patients would like to be addressed by their doctors by giving the patients a questionnaire asking them to state their preference but has not analyzed real life data. Their conclusion is that 4.5% of the patients preferred formal mode of address, 38% mentioned that they do not mind and 57.5% of them preferred to be addressed by their first name.

4.2. Doctors' Address Terms for the Patient

Doctor-patient interaction is claimed to be an asymmetric talk (unequal power distribution) in which the doctor is the so-called 'powerful' party as they are given the right to affect peoples' lives by their professions (Thomas and Wareing, 1999).

Schachtner (2001) finds in her study that the doctors shape the communicational structure. She also claims that the doctor is the one who defines, decides, and leads while the patient is the one being led. She claims that there are two communication models between the doctor and the

patient: active-passive model and guidance-cooperation model[3]. As Schachtner (2001) points out, these two models of relationship between the doctor and the patient highly depend on the consensus in the society about the role of the doctor. The social role ascribed to the doctor by social consensus is a crucial point of departure in determining or shaping the model of the relationship between the doctor and the patient as this will presumably effect doctor's and patient's address term choices for each other.

The professional role of the doctors is also significant for their interactional role as power is based on the degree to which "one person can impose their plans and evaluations at the expense of other peoples" (Holmes 1995:17). The doctor can be considered as the superior party in the talk as s/he has the authority and consent to impose plans and evaluations on the patient. This power imbalance discussed widely in the medical literature is a significant cue for the address term usage of the participants.

The findings in this study indicate that three types of address terms are used by the doctors; kinship terms, first name, and first name+*hanım*/Ms, however, gender of the doctor is a significant determiner in the choice of address

[3] In active-passive model, the doctor is the active party, whereas the patient is the passive. In this model patient's contribution is not regarded. However, in guidance-cooperation model,

forms. The following sections analyze the use of address terms by the doctors and try to explain what factors influence address term choices and what these linguistic choices illustrate in terms of presentation of the self and the other's identity and the formality degree between the speakers.

4.2.1. Kinship Terms

Kinship terms are the most preferred terms in the medical encounters (10 out of 13). These address terms are *amca* "uncle", *baba* "father" and *teyze* "aunt". Interestingly, all kinship terms are employed by the male doctor; female doctors have not used kinship terms when addressing the patients.

In the following excerpt, the male doctor uses *baba* "father", which implies a desire of neutralization of status/rank difference with the patient:

(13) **Patient 20**

1*Companion: Yatağa girdiği zaman özellikle üşüyo. Üzeri kalın olmasına rağmen*
2*yün yorganla dahi üşüyo. Üzerini çıkar* ***baba*** *üzerini.*
3*Doctor: Neyin var ağrın var nerelerin ağrıyo? Şuraların. Şurda ağrı varmı? ((*the
4patient nods*)) var. Bi dön bakıyım şuralarda var mı? Yok. Şuralarda yok. Bi nefes*

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the doctor is the guide of the patient through the treatment process and patient is an active contributor.

5*al bakıyım. Peki yat bakalım sırt üstü, ayakkabıları çıkaralım yalnız, sırtüstü*
6*normal yatar gibi* ***baba*** *.Tamam.*

Companion: He is cold when he is in the bed especially. Even though his clothes are thick and even with a quilt. Take off your clothes **father**.
Doctor: How are you? You have pain. Whereabouts? Here. Do you have pain here? ((the patient nods)) You have. Turn around, do you have pain here? No. Breathe, breathe. Okay. Lie down then, lie back. Let's take off the shoes. Lie back, just like normal **father**. Okay.

As pointed out by Dickey (1997) an address term may not carry its referential meaning but have an address meaning. Obviously, the term *baba* "father" in (13) does not literally mean a real kinship relation between the doctor and the patient. The doctor's address term implies his aim of minimizing the status/rank difference and highlighting solidarity. Also note that the companion's usage of *baba* "father" as the address term in the previous turn (in line 2) may have triggered the doctor's usage of this kinship term for the patient. This address term is observed in cases when there is a generation difference between the doctor and the patient. Therefore, this usage may also be reflecting the doctor's respect to the patient in terms of his age.

Doctors enjoy a certain social status originating from a stereotypical perception of their profession. As claimed by Turner (1995), doctors have a social monopoly of knowledge and expertise in their field. This knowledge and expertise entails a privileged status in the society. By using kinship terms as address terms however, the male doctor establishes his identity in a different way[4].

As pointed out by Horasan (1987), kin terms to non-kins express intimacy and condescension. The use of kinship terms conveys solidarity and they serve to establish a less stressful situation than a typical doctor-patient encounter setting. Such address terms help the patient, especially elderly patients, to be more relaxed and to behave more comfortably. The use of kinship terms is also a positive politeness strategy[5] of the doctor as they

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[4] Terzioğlu talks about a stereotypical image of the doctors in the society. "Doctor is a well-educated intellectual person whose major professional concern is the improvement of living and health conditions of the society in general. (1998:71).". She further claims that until 1980's, attitude towards doctors were based on trust and respect. In those periods, doctors used to play a crucial role in social and ideological movements in the society, therefore, gained social prestige, authority and a socially privileged position. Doctors also were in a certain level of economic wealth as they came from families that belong to a high socio-economic class. However, after 1980's, decline in the quality of medicine education (directly affect Doctor's professional service), government's policy of privatisation in the health sector, bad condition of government hospitals and medical services, negative propagation of the media towards the hospitals and the doctors gave rise to a change in the view of the society towards the doctors.

[5] Positive politeness strategies satisfies the positive face needs of the interlocutors through for instance emphasising reciprocity, common point of view, showing optimism or sympathy, joking, endearments etc.

minimize the distance with the patient and emphasize solidarity (Nevala 2003:151).

The patient and the companion bring their own experiences and notions to the encounter. These previous experiences and notions may effect the address term usage of the participants. In addition to these experiences, the doctors' use of address/reference terms constructs their identity, therefore, helps the patients figure how the doctors perceive themselves and the patients. The following sections will examine the use of address terms by the female doctors.

4.2.2. First Name

Addressing the patient with the first name is observed only once in the data. This usage belongs to the female doctor of the clinic, who is the associate chief and the most experienced doctor. Notice also that the first name is used for a long-term female patient:

(14) **Patient 23**

1*Doctor: Var mıydı boğaz ağrısı?*

2*Doctor 2: Onun için şüpelendim, bi bakalım dedim.*

3*Doctor: Şeyde, muaynede bişey var mı?*

4*Doctor 2: Hayır o zaman yoktu.((*to the patient*)) İyi misin tekrar bakalım.*

5*Doctor: Sen zaten öbür tarafa otur* ((patient goes to the examination desk))

(5)

6*Doctor: Bulantın var mı* ***Lora,*** *bulantı var mı?*

7*Patient: Yerkene çok bulanıyo, yemek yerken.*

Doctor: Did she have pain in the throat?

Doctor 2: I get suspected, I said lets have a look.

Doctor: In that, is there anything in the examination?

Doctor 2: No. There wasn't that time. ((to the patient)) Are you okay? Lets have a look again.

Doctor: You sit there. ((patient goes to the examination desk))

(5)

Doctor: Do you have nausea Lora, nausea?

Patient: I have nausea whilst eating, whilst eating.

In (14) the doctor uses the patient's name to address her even though the patient is much older than the doctor. Addressing a person with her/his first name requires a certain level of familiarity or solidarity[6]. This patient has been treated for a long time (almost a year); hence, there is an established

[6] Raffler-Engel claims that non-reciprocal first name usage is not endearing. This usage is attached with the view that "Doctors apparently assume that everybody, except another doctor, is of inferior social status (1989:32)".

relationship between the doctor and the patient. Based on the notions of established relationship and familiarity, first name usage serves as the positive politeness strategy for the patient. Without an acquaintance or solidarity, this usage would have been threatening the negative face of the patient. The setting may be a formal doctor-patient scene; however, an established relationship between the doctor and the patient gives rise to the use of a less formal address term.

As mentioned above, doctor's gender plays a significant role in the choice of address terms for the patients. The table below illustrates the doctor's address term choices for the female and male patients. (FP: Female Patient, MP: Male Patient)

	Female Patient	*Male Patient*	**Kinship Term**	**First Name**	***First Name +Hanım/Ms***
Female Doctor 1 (FP: 6, MP: None)	2	X	-	1	*1*
Female Doctor 2 (FP: 2, MP:1)	1	-	-	-	*1*
Male Doctor (FP: 6, MP:3)	*3*	*7*	*10*	-	-

Table 4. The doctors' address term usages for female and male patients.

As table 4 indicates, female doctor 1 examined 6 female patients and no male patient and only addressed the patients twice. Female doctor 2 examined 2 female patients and 1 male patient and addressed only the female patient once; did not use any address terms for the male patient at all. Male doctor, on the other hand, examined more female patients than male patients, however, addressed the male twice as many times as he does female patients. As mentioned before, none of the female doctors has used kinship terms as address terms. The common choice of the female doctors is the first name+*hanım*/Ms. The most significant points in the distribution of address term usage in the data are; first, the male doctor uses more address terms than the female doctors, and these address terms are always the kinship terms. This difference is due to the contextual differences in the encounters. As mentioned in chapter 2, the male doctor had longer encounters than female doctors and all of his encounters involved a physical examination phase. These contextual differences are significant as they may lead to differences in the frequency and type of the address terms. Secondly, the male doctor uses address terms more frequently to male patients, even though female patients are twice as many as the male patients.

Instead of highlighting the status difference, the male doctor aims to establish a solidarity-based setting by employing kinship terms. The studies in medical discourse claim that women are more likely to be cooperative and

men more competitive in discourse (Ainsworth-Vaughn, 1998:56). However, the address term usage of the male and female doctors in this study does not support this claim. The male doctor does not display a competitive nature in his discourse. On the contrary, his kinship terms are highly cooperative as they serve the positive face of the patients and convey familiarity. The context also plays a significant role in this choice of the doctor. Out of 10 address terms, 5 is used during the physical examination phase of the encounter[7]. The doctors aim to establish an intimate relationship with the patient in order to comfort him/her both psychologically and physically by using kinship terms during the physical examination.

It should also be noted that the age of the patients also played a role in the address term usage of the doctors. The doctors used address terms when the patients are considerably older. However, with their peers, they do not frequently use address terms. For instance, first name+*hanım*/Ms is just used twice.

Significantly, the doctors used address terms to patients when they are both the animator by definition[8] and author at the same time. Under the author

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[7] Other 5 usages are in the question-answer sequences where the doctor is asking a question to the patient and trying to get information.

[8] As they are the spokesperson, they are by definition animators.

role, there are phases that address terms are more frequently used. The doctors employed address terms 7 times when they are asking a question to the patients, 4 times when they are giving directions during the physical examination and only once when they are giving information.

4.3. Referring to the Patient

In this section, the doctors' ways of referring to the patient when they are not present are considered. Additionally, whether the reference terms used for the patients are different from the address terms will also be examined.

As indicated by Dickey (1997) not only address but also reference terms vary according to the speaker and express the speaker's relationship to the addressee and/or person referred to. The doctors have used different reference terms for the patient: kinship terms, *hasta* "patient", first name, *kadın* "woman" and *annen* "your mother" etc. The important point here is that the use of address terms is related not only to the referee but also to the recipient.

The extracts in (15) and (16), are taken from two different encounters. The patients are not present in the encounters and the doctor uses two different reference terms for the patients:

(15) **Patient 22**

1*Doctor: Ritim bozukluğu var ama yani bütün kapaklarda yetmezlik var. Yani kalple*
2*ilgili bitakım sorunları var.*
3*Companion: Evet.*
4*Doctor:Kalp bi bölümün büyümesi var.* ((examines the x-rays)) *Ha öbüründe alt*
5*tarafı bir geçirilmiş, tüberküloz demişler ama bu akciğer. Ama yok kalbinden*
6*yapmamışlardır.*
7*Companion: Öylemi?*
8*Doctor: Şimdi ıı* ***amcayı*** *getiriceksiniz bi dosya açıcaz. Ondan sonra iki ay süreyle*
9*hormon kullanıcaz. Yani bi ilaç ağızdan ve iğne şeklinde olucak.*
10*Companion: Hıhı.*

Doctor: He has arhytmia but I mean there is insufficiency in all the tricuspids. I mean there are problems in the heart.

Companion: Yes.

Doctor: He has diastole. ((examines the x-rays)). Ha in the other they say tuberculosis but this is lung. But no. They didn't operate because of the heart.

Companion: Is that so?

Doctor: Now ıı you will bring the **uncle** we will open a file. Then during two months we will use hormone. I mean it is a medicine. It will be oral and injection.

Companion: Hıhı.

(16) **Patient 24**

1*Doctor 1: Kemoterapiyle bişey yapılmaz ama lokal nüks riski var.*

2*Doctor 2: ( )*

3*Companion: Tekrar ameliyat olması gibi bi durum mu söz konusu?*

4*Doctor: En iyisi ne onu bilmek lazım yani* ***bu hastanın*** *aynı yerde aynı tümörün*

5*yeniden çıkma ihtimali yüksek.*

Doctor 1: Nothing can be done by chemotherapy but there is a risk of local recurrence.

Doctor 2: ( )

Companion: Does he have to have an operation again?

Doctor: We have to know what the best is. I mean with **this patient** it is very likely that the same tumor will recur in the same area again.

In both of the examples above the patient is a newcomer. The doctor sees the companions for the first time; therefore, the acquaintance level is equal. Both excerpts presented above are taken from the same doctor's encounter. As she has seen the companion and the documents for the first time, and has not seen the patient yet, it is possible to talk about an equal psychological distance. In spite of these similarities, she uses two different reference terms for the patients. In (15) the doctor uses a kinship term in order to refer to the

patient and this usage implies familiarity and sincerity towards the patient and the companion as the recipient. In (16), however, the doctor uses a more formal form *bu hasta* "this patient". This usage implies a distance and formality between the doctor and the patient when compared to the former usage. The only reason for this difference seems to be the topics being handled at the moment of speech. In (16) the doctor is talking about the possibility of the metastasis of the tumor, therefore, she may be trying to create a distance for the companion with the patient. By referring to the patient as *bu hasta* "this patient", the doctor may be psychologically distancing the patient from the companion as she is talking about a negative aspect of the disease. Thus, the contextual difference between the examples, caused by the topic appears to result in different use of reference terms.

It should also be mentioned that, the doctor in (15) and (16), does not use kinship terms when addressing the patients. Interestingly, she uses a kinship term in order to refer to a patient who is a newcomer.

In (17) the doctor refers to the patient with her first name (who is older than the doctor) when talking to her husband in her absence. The patient is a long-term patient in the clinic; therefore, the doctor is acquainted with her unlike (15) and (16):

(17) **Patient 13**

1*Doctor: Sen misin yakını canım?*

2*Companion: Evet.*

3*Doctor:* ***Fahriyenin*** *mi?*

4*Companion: Evet.*

Doctor: Are you her companion dear?

Companion: Yes.

Doctor: **Fahriye**'s?

Companion: Yes.

The first name is very rarely used either as an address (one token) or as a reference term (two tokens) in medical encounters. In (17), the motivation is to ensure that she is talking to the right person because in her previous turn she had used an anaphoric form (*yakını* "companion + 3rd possessive").

In (18), the doctor uses reference term *annen* "your mother" to the patient. The patient is a long-term visitor of the clinic; therefore, the doctor is familiar with both the patient and her companion:

(18) **Patient 18**

1*Companion: Bugün çıkarıyım mı yoksa annemi eve götiriyim öyle mi?*

2*Doctor: **Anneni** eve götür. **Anneni** dolaştırma. **Annen** yattığı zaman çok fazla*

3*panik yaratmana gerek yok. Yani hepsini şey yapma ama **kadın** dolaşmasın önce*

4*onu götür. Sonra sen çapa cerrahpaşa okmeydanı şişli etfal dört tane yer yapıyo*

5*zaten. **Tamam?***

6*Companion: Tamam. Teşekkür ederim.*

Companion: Shall I take it today or after I take my mother home?

Doctor: Take your mother home. Don't make your mother walk around. You don't need to panic when your mother is in bed. I mean don't do all- but don't make the woman walk. Take her first. Then you go[to] çapa cerrahpaşa okmeydanı şişli etfal it makes for hospitals to go anyway. Okay?

Companion: Okay thank you.

Above, the doctor uses the term *annen* "your mother" referring to the patient. This may be due to the usage of the companion in the previous turn. The companion uses the term *annem* "my mother"; therefore, this address term is also picked up and used three times by the doctor. This address term is emotionally very close to the companion (c.f., *hasta* "patient"), serves to highlight familiarity; therefore, functions as a positive politeness strategy for the companion. Interestingly, this term is followed by *kadın* "woman" in line

3. This usage alienates the patient from the companion, and conveys a sense of pity.

The tables below show the reference terms used by the doctor with two different recipients, companion and another doctor in the clinic.

Doctor to Companion					
Hasta "Patient" 12	*Annen "Your Mother"* 4	*Teyze "Aunt"* 3	*First Name* 2	*Amca "Uncle"* 1	*Kadın "Woman"* 1

Table 5. The doctors' use of reference terms when the recipient is the companion.

Doctor to Doctor			
Hasta "Patient" 11	*First Name+Bey/Mr* 1	*First Name+ Last Name* 1	*Kadın "Woman"* 1

Table 6. The doctors' use of reference terms when the recipient is the doctor.

As indicated in table 5 and 6, the doctors refer to the patient by *hasta* "patient" in 62% of the cases. First name is also used when referring to the patient, regardless of the age of the patient, but its use as address and reference term is very rare. The doctors also use *annen* "your mother", *kadın* "woman", *amca* "uncle" and first name+*bey*/Mr when referring to the patient.

It should also be noted that out of 4 kinship terms, 3 of them are again used by the male doctor.

As mentioned earlier, the doctors' reference terms for patients differ according to the recipients. For instance, the doctors use kinship terms as reference terms when talking to a companion but they never use it with another doctor. This suggests that the recipient's relationship with the patient effects the reference term usage by the speaker. If the recipient is closely related to the patient, the doctor is more likely to employ positive politeness by highlighting familiarity or condescension.

The use of reference and address terms for the patients are parallel. However, the male doctor who has preferred to use kinship terms as the only forms of address has used them less as reference terms and preferred *hasta* "patient". This usage is predictable because he does not need to use positive politeness strategies in the talk with companion, compared to the talk with the patient.

4.4. Doctors' Address Terms for the Companion

Throughout the data, doctors address the companions only twice. Even though the doctors explain things to the companion more than the patients,

they address them less (total address of patients: 13)[9]. Both the address terms used for the companions are kinship terms.

Consider (19a) and (19b) where the female and male doctors address the companion:

(19) a. **Patient 13**

1*Doctor: Bi vakayla Maldivlere mi gidilirmiş?*

2*Doctor2: Ama mümkün diil diyosunuz?*

3*Doctor: Bulsun iki vaka, ikisini de yaşatsın, ikisini birden Maldivlere yollamazsam?*

4*multipıl yahu multipıl. Biraz bağırabilir miyim? Multipıl yahu?*

5*Doctor2: Bütün aileyi yolla. Çok cimrisin.*

6*Doctor: Bir yıl yaşıycakmış. Mümkün diil. Al.* ((gives a document to the

7companion)) ***Amcacım*** *ister beşinci kata çık, hocaya orda imzalat, ister bi yarım*

8*saat bekle, burda imzalat?*

9*Companion: Burda bekliyim.*

Doctor: To Maldives with one case?

Doctor 2: But you say it is not possible?

[9] This may be due to the fact that companions prefer to sit more closely than the patient to the doctor (as mentioned in Chapter 3). Because of this, the doctor may be addressing the patient, as there is a more physical distance between them. Additionally, as the doctors talk to the companion more than they talk to the patient in most of the cases, they may be using

Doctor: He should find two cases, make them live, I will send them both to Maldives! That's multiple, hey may I shout out? Multiple!

Doctor 2: Send the whole family. You are very stingy.

Doctor: He would live a year. It' not possible. Take this. ((gives a document to the companion)) **Uncle+dimunitive** go up to the fifth floor if you like, or wait about half an hour here, and get it signed?

Companion: I will wait here.

(19) b.

1*Companion: Yarım saat beklemiyim burda. İlacımı almaya gidiyim.*

2*Doctor: Bi bakarsın. Yarım saatte yetişemezsen çıkar gelirsin.*

3*Companion: Tamam.*

4*Doctor: Tamam.*

5*Doctor2: **Amca** hiç oraya gitme, orda iki saatten önce çıkamazsın.*

6*Companion: Tamam.*

Companion: Lets not wait half an hour here. I will go and take my medicine.

Doctor: Up to you. If you can't make it in half an hour, you can come back.

Companion: Okay.

Doctor: Okay.

---

the address terms in order to get the attention of the patient and to mark that the addressee

Doctor 2: Don't even go there **uncle**. You can't get there out before two hours.

Companion: Okay.

The two cases where the doctors address the companion occur in the same encounter. The patient is not present and the companion deals with the hospital procedures himself. In (19a), the doctors were talking among themselves about a case while preparing the documents that the companion was waiting for. In line 7 the female doctor addresses the companion with *amcacım* "Uncle+dimunitive+1st possessive" to get his attention. She also expresses sympathy as they kept him waiting for quite a long time. This address term also marks the change in the frame of the talk, from doctor-doctor talk to doctor-companion talk.

In (19b), the address term for the companion is used by the second doctor present in the encounter. This address term again marks the topic introduction as the male doctor offers advice to the companion.

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is the patient.

Similar to the case with the patients, the doctors occupy the author role when addressing the companion and use the address terms whilst giving suggestions to the companion about the paper works.

4.5. Patients' Address Terms

As discussed earlier, male doctor's choice of address terms for the patient manifests an attempt to reduce the formality of the setting by using kinship terms frequently as address terms. On the other hand, female doctors preferred more formal address terms and once the first name. The patients, on the other hand have used academic titles, profession titles, endearment terms and honorific terms for the doctor. Let us now examine the patients' use of address terms.

4.5.1. Academic Title[10]

The most frequent address term for the doctors is the term *hocam* "Professor+1st possessive". The patients seem to prefer an address term which they can convey their relationship (with the possessive suffix) and respect at the same time. This term also serves two different faces of the doctor. The use of this term implies that the speaker acknowledges the higher status of the recipient and thus serves the negative face of the doctor.

The possessive suffix on the word also minimizes the distance between the doctor and the patient and saves the positive face[11] of the doctor.

In (20), the patient addresses the doctor by using the academic title:

(20) **Patient 8**

1*Doctor: .....Bi ufak ufak böyle kemik erimesi var sizde tamam mı? O ağrı yapar*

2*ona bağlıdır. Sizin ağrılarınız çok mu şiddetli?*

3*Patient: Hayır o kadar şiddetli pek bi ağrım yok* ***hocam.*** *Ağır bişeyler kaldırdım*

4*ondan sonra oldu bana. Onun haricinde yoktu yani ağrım falan.*

Doctor: ..... You have a little osteoporosis okay? It may make pain, is your pain very severe?

Patient: No. I don't have a severe pain **professor+1st poss.** It happened after I carried something heavy. I didn't have pain before that.

---

[10] The two studies in Turkish on address terms, Horasan (1987) and Bayyurt (1992) have named these titles as academic titles.

[11] Goffman (1967) claims that when the participants interact, they present and maintain a public image of themselves that is 'face': "the positive social value a person effectively claims for himself by the line others assume he has taken during a particular context" (1967:5).. Brown and Levinson (1979) further claim that face is hybrid. One is positive face, individual's concern to be thought well of and be liked by the others. At the same time, the individual wishes to perceive a degree of autonomy and the right no to be imposed upon, this is the negative face. From Brown and Levinson's point, the individual needs the satisfaction of their and also other's positive and negative face needs in a social interaction. There are certain acts that threat faces of the individuals. Directives for instance may challenge the negative face or criticisms may act as a positive face-threatening act of the individual.

Like kinship terms, *hocam* "Professor+possessive" does not carry its referential meaning, but has metaphorical meaning. Teachers may be also addressed with *hocam* "Professor+1st possessive" by people who are not their students. Likewise, the patient may be regarding herself as a student and the doctor as an instructor as the doctor tells what to do during the treatment period.

This term is usually preferred by the experienced patients. As the setting is an education hospital, these patients probably have witnessed cases where hospital staff address or refer to the experienced doctors with *hocam* "Professor+1st possessive" and this usage may have triggered the patients' choice of this term.

The address term *hocam* "Professor+1st possessive" also implies a status difference created by the knowledge of the doctor. By using this address term, the patients acknowledge the doctor's expertise in the field and thus the status difference. As this term is used to address people who are respected in the society for their knowledge and/or education level, it may be regarded as a deference term expressing respect or politeness for the hearer (Thomas and Wareing, 1999). Thus, it functions as a negative politeness strategy towards the doctor by increasing the distance between the speaker and the hearer (Nevala, 2003:151).

4.5.2. Professional Title

Use of professional title as an address term indicates the emphasis of an institutional context and certain level of distance and/or respect. The patients address the doctors by *doktor+hanım/bey* "Doctor+Ms/Mr", which is the most frequent address term following the academic title *hocam* "Professor+1st possessive". The use of profession title may be regarded as an unmarked usage for addressing the doctor and enhances the doctor's negative face[12] by indicating the social distance between the patient and the doctor (acknowledging the institutional role of the doctor):

(21) **Patient 14**

1*Doctor: Gene bizim köylü olucan.*

2*Patient: Buralı olıyım da başka yere gitmiyim.*

3*Doctor: Dur bakalım, ne çıkarsa bahtına.*

4*Patient:* ***Doktor hanım*** *benim neyim var açık konuşur musunuz? Ben açık*

5*konuşmanızı istiyorum.*

6*Doctor: İşte gene o baştaki hastalığın bu sefer karında çıkıyo.*

Doctor: You will come here again.

Patient: I would better come here than going anywhere else.

Doctor: We 'll see.

Patient: **Doctor+Ms** what is wrong with me? Would you tell me frankly? I want you to be frank.

Doctor: Well, your disease again appears in the stomach.

The patient in (21) begins by addressing the doctor in her question in line 4 regarding her exact condition. In this excerpt, the address term acknowledging the doctor's status and institutional role, marks and introduces the patient's question, which can only be answered by the doctor.

4.5.3. Terms of Endearment

Terms of endearment for the doctor are infrequent. The patients do not seem to prefer using terms of endearment when addressing the doctors.

The excerpt in (22) is an example where the patient uses a terms of endearment and the context is significant:

(22) **Patient 10**

1*Doctor: ..... tansiyonunuzu ölçtürün.*

2*Patient: Evde kendim ölçüyorum.*

---

[12] Negative politeness strategies are the ones that enhance the negative face needs of the

3*Doctor: Eğer düşük ise-düşük mü?*

4*Patient: Oniki.*

5*Doctor: Normalmiş. O zaman sıvı kay-ile şey yapıcaksınız.*

6*Patient: Bol bol sıvı.*

7*Doctor: Hıhı eğer düşük gelirse de tuzlu ayran falan da içebilirsiniz.*

8*Patient: Bi de* ***Gülay hanımcım*** *o gece pazar gecesi üç buçukta dilim bu kadar*

9*böyle şişmişti nefes alamıyorum. Ta boynuma vurmuştu.*

10*Doctor: Yazdım bunların hepsini ben.*

Doctor: ..... take your blood pressure.

Patient: I take it at home myself.

Doctor: If it is low-is it law?

Patient: Twelve.

Doctor: That's normal. Then you will take liquid

Patient: Bountiful liquid.

Doctor: Hıhı. If it is low you can drink salty buttermilk.

Patient: Besides **First Name+Ms+dimunitive+possessive** that night, Sunday night at three o'clock, my tongue got swollen, I can't breath. It hit my neck.

Doctor: I noted all these.

---

interlocutor emphasising his/her autonomy and freedom from imposition.

In (22) the patient is female and much older than the doctor and has been visiting the clinic for a long time. Therefore, the participants' being familiar with each other may cause the use of endearment term. Consider also that endearment and possessive marker is attached to the word *hanım* "Ms". This usage implies that the patient employs both the negative politeness (by using *doctor hanım* "Doctor+Ms" and signaling the respect and social distance) and positive politeness strategy by using the diminutive and possessive markers. Even though the setting is formal, the relationship between the parties (familiarity, solidarity) runs over the general frame of formal doctor-patient relationship.

As pointed out by Dickey (1997), an address term has different implications when used by different people. The use of such a term when the doctor and patient are not familiar, when there is no generation difference or when uttered by a male patient might have been taken as inappropriate by the female doctor.

Use of endearment markers and terms may be interpreted as a positive politeness strategy. Jucker and Taavitsainen (2003:11) point out that terms of endearment are "directed at the addressee's positive face, that is to say the desire to be liked and approved by others". However, it is observed that

patients do not prefer to use endearment markers and save the positive politeness of the doctor frequently.

Tables below present the distribution of the address terms used by the patients to the male and female doctors:

To Male Doctor (Total: 20)		
Hocam "Prof.+1st poss." 10	*Doktor+Bey "Doctor+Mr"* 6	*Efendim "Sir"* 4

Table 7. The patients' use of address terms to the male doctor.

To Female Doctor (Total: 8)				
Hocam "Prof.+1st poss." 3	*Doktor+Hanım "Doctor+Ms"* 2	*FN+Hanım "FN+Ms"* 1	*FN+Hanımcım "FN+Ms+dim.+poss."* 1	*Canım "Dear"* 1

Table 8. The patients' address terms to the female doctors.

Table 7 and 8 indicate that the mostly used address term by the patients is *hocam* "Professor+possesive" (13 out of 28), which highlight the

acknowledgement of doctor's knowledge and expertise excluding the gender reference. The ratio of this address term is considerably higher than other terms as it may be used for the addressees in both genders. This term is followed by the profession title *doktor bey* "Doctor+Mr", which is used more than the double number of *doktor hanım* "Doctor+Ms" even tough female and male doctors have the same amount of encounters. Interestingly, we see the use of *Gülay hanımcım* "First Name+Ms+dimunitive+possessive" and *canım* "dear", expressions of endearment, when addressing only the female doctor. Notably, these two address terms are used for a female doctor by an older female patient. Kinship terms are not used by the patients when addressing the doctors. It is also observed that certain address terms (e.g., *efendim* "sir", first name+*hanım*/Ms and endearment expressions) are used for only male or female doctors. The male doctor was addressed once by a female patient and female doctors were never addressed by a male patient.

Significantly, address terms used for the female doctors are more various than for the male doctors. The male doctors for instance never receive endearment terms. As the endearment terms are used by the female patients, we may say that female patients do not prefer endearment terms for the opposite sex.

What is also important is the address term frequency in terms of doctors' gender. Obviously, the male doctor receives address terms almost three times more than the female doctors even though they have the same number of patients. This may be again due to the difference in types and lengths of the male and female doctors. As previously mentioned, the male doctor has longer encounters and this may possibly lead to their receiving more address terms.

In conclusion, the patients prefer to mark the social distance and the professional status of doctors by using address terms such as *doktor bey/hanım* "Doctor+Mr/Ms," *hocam* "Professor+1st possessive"), and honorific terms (*efendim* "sir"). Patients, like doctors, employ address terms when they occupy both the animator and the author role.

4.6. Changes in Address Terms

The doctors and patients may change the address term depending on the previous speaker's usage, to mark their topic change or due to the other dynamics during the flow of talk. The changes in the address terms imply that speaker's perception of the addressee's identity is not fixed. This identity construction is relatively continuous and fluid during the talk. According to Swann (2000), the use of address forms is not fixed or static. They may

change according to the changes in relationship or depending on which aspect of the relationship needs to be emphasized.

(23) below illustrates an address term change triggered by the previous speaker:

(23) **Patient 4**

1*Doctor: ( ) yan yat* ***amca*** *yan yat bakalım.*

2*Companion:* ***Baba*** *geçen yatmıştın ya kolunu altına al.*

3*Doctor: Kolunu altına al.*

4*Companion: Topla bacaklarını topla.*

5*Doctor: Silinmeden bu haldeyken getiriceksiniz ki iyice silininceden daha zor olur o*

6*zaman. Çizicez tabi ama çizgilerin üzerindeyken geçmek daha kolay.* ***Baba*** *otur*

7*bakıyım bi.*

Doctor: Lie on your side **uncle**. Lie on the side.

Companion: Father, you did it a while ago. Take your arm under you.

Doctor: Take your arm under you.

Companion: Put your legs together.

Doctor: Bring him without washing him as it becomes more difficult when the lines have faded away. We will draw surely but when the lines are there it is easier to copy on it. **Father** sit down now.

The doctor in his initial turn uses the kinship term *amca* "uncle" to the patient. After the doctor's turn, the companion talks to the patient and uses the address term *baba* "father". After this usage of the companion, the doctor in line 6 addresses the patient with the term *baba* "father". This change in address term usage is probably triggered by the companion's address term to the patient. After the companion's turn, the doctor uses the same address term *baba* "father" as it is the most active term in the speaker's mind.

The data in (24) is an example for a change in address term, which is due to a topic change in the talk:

(24) **Patient 10**

1*Doctor: Nasılsınız Dilek hanım?*

2*Patient: Çok halsizim be* ***doktor hanım.***

.....

3*Doctor: ..... tansiyonunuzu ölçtürün.*

4*Patient: Evde kendim ölçüyorum.*

5*Doctor: Eğer düşük ise-düşük mü?*

6*Patient: Oniki.*

7*Doctor: Normalmiş. O zaman sıvı kay-ile şey yapıcaksınız.*

8*Patient: Bol bol sıvı.*

9*Doctor: Hıhı eğer düşük gelirse de tuzlu ayran falan da içebilirsiniz.*

10*Patient: Bi de **Gülay hanımcım** o gece pazar gecesi üç buçukta dilim bu kadar*

11*böyle şişmişti nefes alamıyorum. Ta boynuma vurmuştu.*

12*Doctor: Yazdım bunların hepsini ben.*

Doctor: How are you (First Name+Ms)?

Patient: I feel very exhausted **Doctor+Ms.**

.....

Doctor: Take your blood pressure.

Patient: I take it at home myself.

Doctor: If it is low-is it law?

Patient: Twelve.

Doctor: That's normal. Then you will take liquid

Patient: Bountiful liquid.

Doctor: Hıhı. If it is low you can drink salty buttermilk.

Patient: Besides, **(First Name+Ms+dimunitive+possessive)** that night, sunday night at three o'clock, my tongue got swollen, I can't breath. It hit my neck.

Doctor: I noted all these.

The first two lines are typical formal greetings of a doctor-patient encounter. The first address term of the patient is *doktor hanım* "Doctor+Ms" in line 2 and this usage may be due to the previous formal addressing of the doctor

Gülay hanım "First Name+Ms". However, in line 10 the patient changes her address term to a less formal one with *Gülay hanımcım* "First Name+Ms+dimunitive+possessive". She also changes the frame of the talk after this address term. She talks about an unexpected experience and implicitly asks for an explanation from the doctor. This short narrative of the patient is presented by an introductory topic change marker *bi de* "besides" followed by a less formal address term, term of endearment. This use of endearment term is used to mark the change of frame to the personal experience of the patient, which is not very coherent with the previous turns. Here the patient may be avoiding a potentially face threatening discourse move (changing the topic with a question) mitigating her question by using an endearment term (Ainsworth-Vaughn, 1998:49).

4.7. Companions' Address Terms

As mentioned in 4.4., the doctors use address terms less when talking to the companions than to the patients. Similarly, compared to patients, the companions use less address terms (patients 28 times, companions 9 times) for the doctors. The address terms used by the companions are *doktor bey/hanım* "Doctor+Mr/Ms", *hocam* "Professor+possessive." which are the terms that are also used by the patients.

The excerpt in (25) is an example for the mostly used address term *doktor hanım* "Doctor+Ms" by the companion:

(25)a. **Patient 17**

1*Companion1:Benim dünürüm olur* ***doktor hanım****, o yüzden çok bilmiyorum.*

2*kendisi eşi.* ((points to the other companion))

3*Doctor: Tamam tamam.*

4*Companion1:Bizede fazla anlatmaz kendisi.*

.....

5*Companion1: Ondan gün alıcaz, şimdik heralde buna-*

6*Doctor: Ona gösterin. O büyük ihtimalle hastayı ister.*

7*Companion1:Yatma imkanı falan var mı* ***doktor hanım****?*

8*Doctor: Yok.*

9*Companion1:Yok mu?*

10*Doctor: Yok. Yani ışın olucaksa o zaman.*

Companion 2: He is my in-law relative **Doctor+Ms** so I don't know much. She is his wife.

((points to the other companion))

Doctor: Okay okay.

Companion 2: And he doesn't tell us much-

.....

Companion 1: We'll make an appointment with them, as for now-

Doctor: Show it to him. He'll probably want to see the patient.

Companion: Is it likely that he will stay in the hospital **Doctor+Ms**?

Doctor: No.

Companion 1: No?

Doctor: No. Unless there is radiotheraphy.

(25)b.

1*Companion1: Bu arada bir ünite kan verildi askeriyede. Oğluna gitmişti orda gene?*

2*Rahatsızlanmış, gataya kaldırmışlar.*

3*Doctor: Ha o hasta. Anladım.*

4*Companion1: Siz bakmıştınız zaten ilkten* ***hocam.***

5*Doctor: Ha gatalı hasta.*

Companion 1: Meanwhile he received blood transfusion in the military hospital. He went to his son there? He felt sick and they took him to the hospital.

Doctor: That patient. I understand.

Companion 1: You examined him first **Professor+1st possessive.**

In (25b), the patient is not present in the encounter and there are two companions. The companion and the doctor talk about the patient's condition. Significantly, the companion uses *doktor hanım* "Doctor+Ms" in

(25a) twice and changes this term to *hocam* "Professor+1st possessive" later in the talk in (25b). These address terms are parallel in the sense that they both save the negative face of the doctor highlighting the doctor's status.

To the female doctor (Total: 7)		**To the male doctor (Total: 3)**	
Doktor+Hanım	***Hocam***	***Doktor+Bey***	***Hocam***
"Doctor+Ms"	***"Prof.+1st poss."***	***"Doctor+Mr"***	***"Prof.+1st poss."***
5	*2*	*2*	*1*

Table 9. The companion's address terms for the doctors.

As table 9 indicates, the mostly used address term is *doktor hanım* "Doctor+Ms". The second frequent term is *hocam* "Professor+ 1st poss.". These are followed by *doktor bey* "Doctor+Mr". It is observed that, certain address terms used by the patients such as terms of endearment and deferential terms are not preferred by the companions. The address terms both the patient and companions frequently use seem to be the widely used and preferred address terms for the doctors in general e.g., *doktor bey/hanım* "Doctor+Mr/Ms", which highlight the status and role of the doctor and also convey respect. Additionally, the address terms used for the female doctors are all employed by the female companions; similarly, all the address terms for the male doctor are from the male companions. Even though same number of patients were examined by the male doctor and female doctors

totally (9 patients for the male and 9 for the female), the female doctors were addressed double more than the male doctor. Note also that number of companions' gender was also alike in number: 13 female and 9 male companions were present.

Companions have used address terms when they occupy the animator and author role. Like patients, only one address term out of 10, was used when the companion occupied the animator of the patient role. Companions used address terms mostly when the patients were not present in the encounter.

4.8. Conclusion

The findings in this chapter indicate that male and female doctors differ in establishing identities for themselves and others through the use of different address terms. The male doctor prefers to save the positive face of the patients whilst female doctors save the negative face. The patients, on the other hand, prefer honorific and title terms when addressing the doctors. Especially with the male doctor, the patients prefer negative politeness even though they receive positive politeness by the male doctor. The patients may be, being aware that the doctor condescends by using positive politeness, they prefer to use negative politeness and highlight the status and social deference with the doctor.

The address term variations imply that the doctors and the patients establish two different frames for the encounter and perceive the addressee differently. From the companion's perspective, preference of the address terms is likely effected by the gender of the doctor. The companions do not address the doctors of cross-gender and they use very limited types of these terms.

Nevala (2003:152) states that

> "those who have more power are more likely to use more positive politeness in their address forms than those who have less power...inferiority in power increases the use of negative politeness towards a superior recipient."

According to Nevala, as the male doctor uses more positive politeness strategies, he is to be the more powerful party. On the other hand, the patients are the inferior party as they use negative politeness strategies more than the doctors. However, contrary to Nevala, it is observed that female doctors do not use terms that indicate positive politeness towards the patient but prefer negative politeness. This means that there is no one to one correspondence with the politeness strategy preference and the power asymmetry.

From the patient's perspective, the authority of the doctor and the formality of the setting seem to be the greatest factors in the choice of address terms.

Established acquaintance or familiarity does not play a great role in the address term choice of the patients. However, from the doctor's perspective, age of the patient and degree of familiarity seem to be the primary factors for the choice of address terms.

Another crucial factor in the use of address terms is the gender of the doctor. The patients and the companions do not prefer to use address terms for the doctor in the opposite sex.

Considering the roles defined by Goffman, it is observed that the participants use address terms when they are in the author role, e.g., when they talk about their beliefs, thoughts. Whilst they are only the animator, the use of address terms does not seem to be frequent. There is no significant difference in the use of address terms under the roles of animator and author by the participants.

CHAPTER 5

CONCLUSION

In this study, the medical interaction among doctor, patient and companion is analyzed based on Goffman's participation framework. Furthermore, the identity construction of the self and the others through the use of address and reference terms during the medical encounter have been investigated in order to examine the triadic structure of a medical encounter.

As discussed in the third chapter, the companion's presence in the encounters can be explained by the cultural practices and tendencies of Turkish society. The requirements of the institution, the life-threatening nature of the cancer and the age of the patient are the other prominent motivations.

During a medical encounter, the companion effects the turn taking processes and the information flow between the doctor and the patient. This active role is licensed by the doctors' recognition of the companion's status in the treatment process. The companion can play an active role in the medical encounters because both the doctors and the patients sanction their presence.

The doctors provide the companions with more information than the patients, which indicate that the doctors see the companion as the accepted

and sometimes preferred audience. The patients also rely upon the support of the companion in their communication with the doctor. Given the recognition from the parties, it is only natural for the companion to be actively involved in the treatment process.

The companions' presence helps both the doctors and also the patients to reach their communication goals. Since the companions are usually primary caregivers, they have a vested interest in getting as much information as possible and the best way to achieve this is to be present in the encounter. The presence of the companion is the supported choice of all three participants.

Analysis of the participants' use of address terms reveals the doctors' and the patients' identity construction. Looking at the choice of address terms, one can understand how the addressee is perceived by the addressor. The male and female doctors aim to create a different level of solidarity in the encounters. The patients seem to prefer forms that highlight doctor's professional and institutional roles as being a doctor. The male doctor, for instance, used a solidarity-based perspective, however, received more formal address terms that highlight status difference. Additionally, even though the female doctors used more formal terms for the patients, they received more various and less formal address terms than the male doctor

The findings in this study are significant not only in sociolinguistics research but also in medical area. As encounters are heavily effected by the interactional behavior of the companion, being informed on how to involve both the companion and the patient in the treatment would be beneficial for the doctors who are to be specialized in the field of oncology. These findings may also be beneficial for the patients and the companions. The need for the companion's presence may be explained both from the doctor's and the patient's perspective. These findings would help to increase the level of awareness of the patient and the companion and would lead to a more effective doctor-patient encounter.

Needless to say, the findings of this study are not conclusive as this is only a first attempt to examine those particular aspects of the medical discourse in Turkish. Further studies along the following lines would enhance our knowledge on medical interaction. For example, one line of further research would be that the patients in the clinic may be followed to each doctor they visit[1] in the clinic in order to account for the changes in the patient's talk depending on the situation.

Also, in further studies the gender of the doctor, the patient and companion may be included in the analysis. For example, the gender of the doctor may

[1] Besides the oncology cancer patients mostly visit other clinics as well such as the psychology or the pain clinic etc.

effect their approach to the companion, the gender of the companion and the patient may effect their involvement in the encounters etc.

Another topic for research would be recording the same patient in further visits, especially to observe how the interactional patterns of the patients change in time as their relationship with the doctor progresses and at times when the companion is missing or changed.

Analyzing the role of the companion in the other cultures is also a further research topic. In a comparative study, it is possible to observe how the behavior of the companion and the doctor vary from culture to culture.

Conducting a similar study in medical fields other than oncology may also reveal different interactional behavior in a triadic encounter. The cancer disease has fundamental effects on the social and psychological behavior of the patient and the companion. The doctor uses certain communicative strategies in and outside the formal encounter because of the nature of the disease. Observing the strategies of the doctor in other diseases, which are not as destructive as cancer can also be revealing.

It may also be beneficial to study the cases with child patients and companions as their parents. One of the encounters in this data involved a child patient and the companion as his mother; and the behavior of the

companion and the doctor were different from the other encounters, because of the patient's age. Unlike adult patients, the children have less responsibility; therefore, the companions play a more significant role. A study on this case would contribute to the field and reveal the interactional roles and dynamics of a triadic encounter, where a crucial participant, the patient, is less active than any other cases.

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Appendix 1

Information about the patients

Patient 1: Female, 60 yrs, breast cancer.

Companion daughter. Doctor male.

Patient 2: Female, 72 yrs, breast cancer.

Companion daughter. Doctor male.

Patient 3: Male, 53 yrs, lung cancer.

Companion daughter. Doctor male.

Patient 4: Male, 57 yrs, larynx cancer.

Companion son. Doctor male.

Patient 5: Female, 67 yrs, multiple myaloma, hearing disability.

Companion daughter. Doctor male.

Patient 6: Female, 48 yrs, breast cancer

Companion husband. Doctor male.

Patient 7: Male, 53 yrs, melanoma cancer.

No companion. Doctor female.

Patient 8: Female, 55 yrs, sarcoma.

No companion. Doctor female.

Patient 9: Male, 65 yrs, larynx cancer, not present.

Companion son. Doctor male.

Patient 10: Female, 67 yrs, salivary gland cancer.

Companion sister. Doctor female.

Patient 11: Female, 67 yrs, salivary gland cancer, incomprehensible speech.

Companion son. Doctor female.

Patient 12: Female, 65 yrs, larynx cancer.

Companion sister. Doctor female.

Patient 13: Female, 70 yrs, breast cancer, not present.

Companion husband. Doctor female.

Patient 14: Female, 42 yrs, breast cancer.

No companion. Doctor female.

Patient 15: Male, 8 yrs, rhabdomyosarcoma cancer, not present.

Companion mother. Doctor female.

Patient 16: Female, 50 yrs, cervix cancer.

No companion. Doctor female.

Patient 17: Male, 67 yrs, prostate cancer, not present.

Companion wife and an in-law relative (female) who is a nurse in the same hospital.

Doctor female.

Patient 18: Female,70 yrs, myaloma, not present.

Companion daughter. Doctor female.

Patient 19: Female, 63 yrs, breast cancer.

Companion husband. Doctor male.

Patient 20: Male, 50 yrs, larynx cancer, incapable of talking.

Companion daughter. Doctor male.

Patient 21: Female, 68 years, multiple myaloma.

Companion husband. Doctor female.

Patient 22: Male, 70 yrs, prostate cancer, not present.

Companion daughter. Doctor female.

Patient 23: Female, 63 yrs, larynx cancer.

Companion sister. Doctor female.

Patient 24: Male, 62 yrs, sarcoma, not present.

Companion son. Doctor female.

Patient 25: Female, 78 yrs, breast cancer.

Companion husband. Doctor male.

Appendix 2

Transcription Conventions

(2)	Numbers in parentheses indicate intervals either within an utterance or between utterances. They are timed in seconds.
,	A comma indicates a continuing intonation.
.	A period indicates falling or final intonation, as the end of a declarative sentence.
:	Dots indicate vowel lengthening.
?	A question mark indicates a rising intonation, as at the end of an interrogative sentence.
-	A single dash indicates self interruption.
(( ))	The double parentheses give information about the transcriber's description of events in the conversation scene such as a telephone ring, laughter etc.
( )	Single parentheses are for utterances that are inaudible.