

Negotiating hearing problems in doctor-patient interaction: Practices and problems of accomplishing shared reality

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This paper deals with a case study of a first visit of a person with hearing loss to her family doctor. In the first part of the paper, basic properties of doctor-patient interaction, which are also relevant for treatment of hearing loss, are outlined: the relevance of institutional conditions for interaction, asymmetries between the participants, goal-orientation, specific conditions of trust, and the relevance of the specific genre of doctor-patient interaction. The second part of the paper presents a case study, which focuses on three interactional phenomena: a) the negotiation of the hearing loss as an existential threat to the patient and her identity; b) the discrepancy of illness theories between doctor and patient; c) the collaborative work of negotiating an intersubjectively viable description of the experience of hearing loss.

I. Introduction

In the last two decades, doctor-patient interaction ("DPI") has become a very prosperous field of Conversation Analysis ("CA"), as evidenced by large bibliographies on English and German speaking research specialized in this field.¹ This is also evidenced by the seminal volume edited by Heritage/ Maynard (2006) and the important contributions by e.g., Brünner/Gülich (2002), Stivers (2007); Neises/Ditz/Spranz-Fogasy (2005) and Thompson/Ruusuvuori/Britten/Collins (2007). Among more than 3500 studies on doctor-patient interaction included in the bibliography assembled by Nowak/Spranz-Fogasy, only one study from nursing research deals with experiences of hearing loss in interaction (Lilgenau 2007).

This lack evidences the need for basic research concerning the interactive tasks, processes, and problems specific to medical interactions dealing with hearing problems. Still, it will be useful first to consider the general specifics of doctor-patient interactions, which also matter to interaction concerning hearing problems. Therefore, I will give a short summary of some major properties which are relevant for virtually every instance of DPI and then deal with the most pervasive genre of DPI, 'history-taking', in more detail. This will set the scene for data from a medical encounter in which a patient discloses a hearing problem to her family physician. The analysis will focus on two problems of accomplishing intersubjectivity and mutual understanding between doctor and patient: The problem of conveying the subjective experience of hearing loss by description and the problem of competing theories of illness, which impede interactional progression.

- Doctor-patient communication has been researched extensively, however,
- there is not a single conversation analytic study on ear, nose and throat doctors on hearing loss in medical interaction.

Research questions:

- How do a family doctor and a patient reporting a hearing problem negotiate mutual understanding?
- How does the patient describe her subjective hearing experience?

¹ See the comprehensive bibliography of research in this field gathered by Peter Nowak and Thomas Spranz-Fogasy, the searchable data-base on studies on doctor-patient interaction in German language published by Florian Menz and Peter Nowak, and the bibliography on English-speaking research collected by Paul ten Have.

2. General properties of doctor-patient interaction

DPIs are a variety of institutional interaction. As such, they exhibit several features which are different from everyday conversations and which are more or less direct repercussions of institutional goals, restrictions and preconditions. Therefore, it would be wrong to evaluate DPI by standards derived from everyday conversation. There are at least four aspects which distinguish DPI from other types of interaction:

1. The relevance of institutional conditions for interaction
2. Asymmetries between the participants
3. Goal-orientation
4. Specific conditions of trust

General characteristics of doctor-patient interaction (DPI)

2.1 Institutional conditions

The most basic institutional restrictions and demands on DPI are:

- Legal requirements which doctors have to observe.
- Organisational aspects: DPIs are conducted under conditions of time-pressure. First visits (as the case in this chapter) are only the first step in a series of medical interactions in which the patient will be involved (Strauss et al. 1985: "arc of work".)
- Economical aspects: How much time the doctor may reserve for the patient also depends on his/her possibilities to get time for talk compensated by the health insurance. Because of this, private patients have much better chances for extensive talk with a doctor than regularly insured patients have (Nowak 2010). However, rates for medical service delivered by talk are in general paid much less than for bodily examination or for the use of technically aided diagnoses.
- Written documents: Requirements for written documentation inform talk-in-interaction and need to be coordinated with face-to-face interaction.

Institutional characteristics include

- legal aspects
- time restraints
- economical concerns
- necessity for talk and written documentation

2.2 Asymmetries

If participants in communicative encounters are not equal in terms of rights and obligations, knowledge or other features which directly impinge on their communicative conduct or which are brought about by different ways of participating in interaction, this is captured by the term 'asymmetry'. There are five sources of asymmetry in DPI (cf. Heritage/Manyard 2006; Thompson et al. 2007):

Communication is characterized by how the doctor and the patient orient to their asymmetrical relationship:

a) Asymmetries of professional knowledge

DPIs are interactions between professional experts and laypersons seeking help, which they cannot provide for themselves. Since help is dependent on professional procedures, the doctor is the one who structures the interaction: He or she needs to ask for relevant anamnestic information, explain findings and diagnoses, and propose treatments. For the patient, this structuring often is neither obvious nor motivated. The medical relevance of questions and information remains opaque, because the patient lacks rules of inference and relevant knowledge about terminology and stocks of professional knowledge, which applies to local questions and statements. As a consequence, he or she does not always understand why which examinations take place and how diagnostic and treatment decisions are arrived at.

- expert-layperson relationships with asymmetrical knowledge

b) Institutional asymmetries

The doctor knows institutional routines of how to deal with medical problems. For him/her, they are predictable and transparent, while the patient often cannot anticipate them, e.g., the kind and the sequence of steps to be taken, or the efforts and restrictions they entail for him/her.

- asymmetrical distribution of access and transparency

c) Asymmetry of existential and experiential relevance

The patient (from Latin *patiens*, 'sufferer') experiences physical and emotional and often also social and economical troubles. Illness and impairment are experiences which produce a breach of expectations about a normal life and a possible and probable future. They thus threaten basic structures of identity and the future biography, e.g., regarding work, social integration, sexual attraction, physical integrity. For the patient, illness and impairment are critical life-events with a unique biographical impact, which may entail a thorough restructuration of identity and everyday practices.

- for the patient there are different things at stake than for the doctor

For the doctor, however, the patient is an instance of a type of illness/impairment, who is to be treated according to what applies to the type in general. Dealing with the patient's illness for him/her is not an exceptional existential situation as it is for the patient, but rather professional routine.

- health issues are routine for doctors and 'exceptional' for patients

These asymmetries of relevance may lead to discrepancies in the patient's and the doctor's expectations about the display and uptake of emotions regarding the illness. There are different approaches to deal with this problem, ranging from a purely biomedical, which discards all other life-world matters, to a psychosomatic approach, which at first focuses on psychological causes and consequences. As we will see when turning to our case study of an interaction between a general physician and a patient reporting hearing problems, competing theories of illness can also be a major source of interactional problems.

d) Asymmetries of power

Because of his/her professional and institutional knowledge, the doctor is basically in a more powerful position than the patient. According to the classical paternalistic conception of medical treatment, the doctor orients to professional and ethical standards, which he or she uses to decide on behalf of the patient. This stance has come under pressure by approaches of evidence-based medicine and shared decision making. According to these latter concepts, the patient is empowered, because the doctor is accountable for his/her decisions on the basis of scientific research, and decisions about treatment are not made by the doctor alone, but in an interactional process. Consequently, clarification, argumentation, and explanation increasingly become core activities in DPI, i.e., securing mutual understanding and gaining a common view of what the problem is and what is to be done. However, since many possible treatments are not paid by insurance companies, professional ethics and economic rationalities can become confounded in a set of mixed motives, which are rather opaque for the patient.

- power is distributed differently

e) Asymmetries of participation

The four asymmetries outlined above are observable in the participation structures in DPI. The doctor structures the interaction by defining the amount of time available for talk, by guiding the interaction and by initiating transitions to new phases. There is also an asymmetry of role-related contributions: While doctors ask questions, instruct, explain and require patients to do things, patients deliver requested information, tell stories, and are asked for consent.

- differential participation is due to these asymmetries

2.3 Goal-orientation

In contrast to everyday conversation, DPI are not conducted for their own sake (i.e., for entertainment, self-presentation, sharing news, becoming acquainted, etc.), but they are instrumental for arriving at diagnoses and treatment decisions. Therefore, a DPI is only successful, if it is successful in fulfilling these tasks.

2.4 Conditions of trust

DPI should convince the patient to comply with the treatment (see also Heinemann et al., ch.12, and Brouwer/Day, ch.13, this volume). This can only be achieved if the patient trusts the doctor both as a person and as an expert. The establishment of trust thus is a major task to be fulfilled during DPI by the doctor, e.g., by displays of competence, showing interest and respect without moral evaluation, attending to the patient's emotions, and warranting confidential treatment.

The above described features of 'the DPI' are rough generalizations. We need to take into consideration that there are different types of DPI, which can be distinguished in terms of

- genre: history taking, bodily examination, delivering diagnoses, prescription, therapy planning, follow-up checks, etc.;
- specific tasks and problems relating to disciplines such as family doctor, ear, nose and throat doctor and specific syndromes such as hearing loss;
- participation frameworks: in addition to the dyadic constellation, there are pediatric DPIs with children and parents, interpreter-mediated DPIs with immigrants, ward rounds with several doctors, nurses, and other medical staff, etc..

The following graph provides a schematic representation of the core sequences and interactional achievements of DPIs:

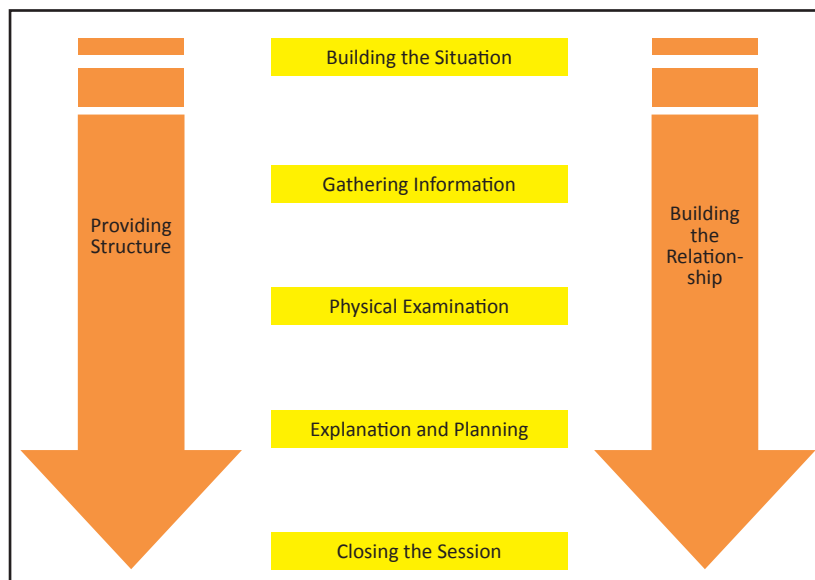


Figure 9: Schematic presentation of the sequence of phases in DPI (adapted from Kurtz et al. 2003)

- the interaction pattern is geared towards diagnosis and treatment

- the patient's trust in the doctor is crucial for compliance

There is variation in DPI depending on the task, doctor's specialization, the patient's illness and whether other persons participate.

In all phases of the interaction, the dimensions of providing structure and relationship building are relevant.

3. The genre ‘history-taking’ and the data to be analyzed

The data to be analyzed below come from the most pervasive genre of DPI, namely ‘history-taking’. It comprises the inquiry into the history of the problem and its relevant preconditions in terms of prior illnesses and related problems in the patient’s family’s history, the anamnesis of the patient’s life conditions and prior attempts at treatment. History-taking is guided by the doctor’s questions (see Spranz-Fogasy 2005; 2010).

Doctors may orient to an agenda of questioning which is derived from some pre-established question-schema. Questions are geared to diagnostic ends in terms of identifying and excluding possible causes of the symptoms reported. Agenda-based questions can lead to misunderstandings and engender fragmented and insufficient reports from the patient’s side, because he or she does not understand the function of the question. The strategy in our case is more patient-oriented. The doctor starts with an open question, encouraging the patient to use conversational narrative practices to represent his/her problems in the context of his/her everyday life. Only after the patient has told his/her story, the doctor turns to aspects of the history which have not been dealt with sufficiently in the patient’s report.

Basic tasks for the doctor during the whole process of history-taking are active listening in terms of acknowledging the patient’s turns at talk, displaying his/her understanding of them and structuring the interaction by providing summaries and concluding upshots in order to secure common ground for next steps.

3.1. First symptom description

We now turn to an extract of a medical encounter in which a patient reports on hearing problems to her family doctor for the first time. The patient has already known the doctor for a long time and they have a very informal relationship, as can be seen by the reciprocal use of the informal second-person address term *du* (informal ‘you’). The first extract shows the beginning of history-taking. It occurs after the opening, where the doctor informed the patient about the fact that the encounter is being recorded (not displayed in transcript). Then the patient self-initiatedly presents the reason for the appointment and describes the problem.

#1 (AA_HD_01_02:21 – 02:57) First description of symptoms²

050 P: und zwar ich komm weil=s mir im moment,
and I come here because

051 (0.2) °also.°
well

052 (0.3) seit drei tagen,
for three days

053 (0.2) °total° komisch geht.
I’ve been feeling absolutely weird

054 (0.5) °dass ich° nämlich (-) ↑ähm:.
namely that I uhm

055 (2.1) so die stimmen >so weiter< weg höre,
hear the voices kind of further away

056 und (selber so.)
and my self like

History-taking is the most pervasive genre of DPI.

Characteristics how the patient describes her reason for the visit:

- vague expressions
- difficulty in describing the problem

Symptom description

- hearing loss impairs participating in social relationships
- threat to cognitive functioning

² I thank Thomas Spranz-Fogasy for granting me access to the recording.

- 057 (1.5)
- 058 D: ↑hmm?
uhum
- 059 P: (0.2) also. h. ähm: wie wenn ich schlafe,
well uhm like when I am asleep
- 060 D: [mHM,]
uhum
[
- 061 P: [und] (a) so am: aufwachen bin
and I am about to wake up
- 062 (0.2) .h (und dann) hört man ja auch so:_n.
and then one hears PRT also kind of a
- 063 (.) so=n hall,
kind of a reverb
- 064 (...) wie (.) wenn jemand redet im raum,
like when someone talks in the room
- 065 °das hört man dann so°
then one hears it like that
- 066 (0.2) im unterbewuss:tsein (noch so=n bisschen.)
subconsciously still a little bit
- 067 oder kurz vorm einschlafen.
or just before you fall asleep
- 068 hh (0.2) °(und/is)° irgendwie (.) so (0.4) uah.
and somehow like ((horrified sound))
- 069 D: (0.8) das [macht dir angst] dann.
it frightens you
[
- 070 P: [schrecklich.]
horrible
- 071 P: ja:.
yes
- 072 D: °hm,°
uhum
- 073 (1.6)
- 074 P: un: (0.2) d ↑ähm:..
and uhm
- 075 h (1.0) am freitagabend hat=s angefangen,
friday evening it started
- 076 (0.3) abends °auf so=ner° fete?
in the evening at kind of a party [...]

metaphorical symptom description

- altered state of consciousness

Doctor attributes an emotional state of anxiety to the patient.

Patient does not expand much more on her psychological state.

The patient is obviously at a loss of how to describe her problems. She starts with a very vague expression *weils mir (...) total komisch geht* ('I feel absolutely weird', lines 050-053). This expression refers to the fact that her condition departs from what is normal, but, just by using it, the expression indexes that she has difficulties in describing the precise nature of the difference. She then goes on to mention a first more definite symptom: She hears voices as if produced from a distance (lines 055-056). In focusing on voices, this first symptom report exhibits an orientation to the impairment of participating in social relationships. At the ensuing turn transition relevance place, the

doctor does not take the turn, and, as the patient does not continue, he produces an acknowledgement token serving as a continuer for her to expand. The patient then compares her state of mind to an altered state of mind (line 061), i.e., when waking up and hearing with some kind of reverb (line 063) like in an almost subconscious state of mind (line 066).

The hearing problem thus is not categorized in terms of a disorder of peripheral sensory perception, but as an altered state of mind, remote from the usual state of awareness and akin to a reduced and even dream-like state of consciousness. We can infer from this description that the hearing problem threatens the most basic foundations of everyday experience, cognitive functioning, and reflexive identity, i.e., the ability to act in routine ways, the confidence to perceive correctly, and to take part in social interactions. While the patient does not make these inferences explicit, she adumbrates the emotional relevance of her situation by a sound expressing horror (line 068) and categorizing her experience as *schrecklich* ('horrible', line 070). The doctor reacts to this expressive display with an explicit attribution of an emotional state *das macht dir angst* ('this frightens you', line 069).

Interestingly, the patient responds only minimally (line 071), and, after a pause, in line 074, she instead resumes the factual description of her problems by telling the history about when the problem started. So, while the patient clearly showed how much she is emotionally upset by the state she is in, she does not take up the doctor's offer to expand on its psychological import. This is a notable observation, because it stands in contrast to a lot of research on DPI. While it is often criticized in the literature that doctors do not attend to psychological and life-world concerns in their patients' reports (cf. Mishler 1984), in the data analyzed in Deppermann/Spranz-Fogasy (accepted), patients regularly do not align with doctors' shifts of the agenda from the report on symptoms and biomedical aspects of problems to the psychological plane. In the case above, the patient has initiated talk about her emotional state herself, but she does not expand on her feelings. This may be due to several reasons, which would have to be explored in more detail in a larger data corpus:

- patients might consider the doctor's move as no serious offer for expanding on psychosocial aspects,
- they might regard doctors as not competent in psychological treatment,
- there might be limitations of trust,
- talk about psycho-social aspects might be avoided due to pain or fear of stigma.

However, there is an affinity between the doctor's initial focus on the patient's feelings, instead of other diagnostic questions, on the one hand, and his final diagnostic hypothesis of a psycho-somatic stress syndrome on the other hand.

As a summary of the first extract we can note that the patient has problems in describing her hearing problems directly and that she resorts to analogy. She reveals that the hearing problem touches the core of her mental state. Thus, the hearing problem has a much wider scope than only being a problem of sensory perception. The extract also shows how the doctor provides opportunities for the patient to expand her account. Indeed, the doctor not taking the turn, the patient produces a more detailed description of her state of mind, which provides important insight into the nature of the symptoms and their psychological relevance.

In general, the hearing problem is described more in its mental, social and psychological repercussion than in its auditory aspects.

For the patient, the hearing problem has a much wider scope than only a problem of sensory perception.

3.2. A clash of theories of illness: Arguing about possible causes of the hearing problem

After #1, the patient tells the story of how the symptoms have developed during the last three days and mentions a cardiovascular problem as a possible explanation. The doctor neither deals with this hypothesis nor does he himself formulate assumptions about possible causes. Instead, he produces continuers and follow-up questions focusing on the precise description of the patient's state of mind and the pragmatic contexts she is in. Finally, the patient states her hypothesis again, namely, that the cause might lie in the cardiovascular system, displayed in excerpt #2 (lines 226-229) below.

#2 (AA_HD_01_05: 30-06: 06) Illness theory

226 P: (5.9) und es is irgend[wie denk] ich (0.2)
 and I think it is somehow
 [

227 D: [mhm.]
 uhuh

228 P: ähm (.) also vielleicht is es äh wirklich was
 uhm so maybe it is really something with
 mi=m kreislauf ne?
 my circulation

229 (0.6) also des is eigentlich so meine erklärung
 so this is actually kind of my explanation

230 ((D writes 4.6 sec.))

231 D: mit=m kreislauf dass der abgesackt [is] (.)
 with the circulation that it subsided
 [

232 P: [ja]
 yes

233 D: oder so was.
 or something like that

234 P: ähem.
 uhuh

235 (-) oder was kann es sonst sein?
 or what else can it be?
 ((D writes 3.1. sec.))

236 D: ((low)) für mich hört sich das so wie so ne
 to me it sounds like a

237 stresssymptomatik an=wie son
 stress syndrome like kind of

238 P: (0.7) mh[m:]
 uhuh
 [

239 D: [ich hab=s] selber mal erlebt äh
 I once experienced it

240 (.) äh vorm examen
 uh before the exam

241 D: so[n zu]stand
 such a condition
 [

242 P: [mhm.]
 umhm

Patient's explanation: Hearing problems are due to the patient's blood circulation

Patient asks for an alternative explanation.

Doctor backs his explanation 'stress syndrom' by reference to personal experience.

- 243 P: m=ja
m=yes
- 244 (0.7) °ja das (.) das hab ich mir halt auch gedacht
yes that that's what I also thought
- 245 weil ich frag mich dann
because I ask myself then
- 246 ja wo ist bei mir der stress ne? (.)
well where is the stress as far as I am concerned right?
- 247 also ich hatte jetzt° .hh
so I just had
- 248 D: ja
yes
- 249 P: ne woche ((lacht))
one week ((laughs))

Patient reports not being stressed.

The doctor reformulates the patient's assumption (line 231), but then he produces the competing explanation that the problem might be a symptom of a stress disorder (line 236-237). The doctor does not give an account why he rejects the patient's theory. Instead, he argues for his competing explanation 'stress disorder' saying that the patient's condition reminds him of something he experienced himself before his exams (line 239-241). This explanation, however, does not fit the patient's prior report of her current conditions of life, which she had given between #1 and #2 (she has just returned from holidays), so it does not work to convince her (lines 244-249). After this extract, the doctor goes on to insist that there might be still other factors which can cause a stress disorder. Only much later after #2 the doctor deals with reasons which rule out the patient's candidate explanation 'cardiovascular problem'.

Doctor and patient do not arrive at a shared explanation.

We can see in extract #2 that the patient comes to the medical encounter with her own theory of her problems, which she formulates as part of her report. The doctor repeatedly does not respond to that theory. The patient, however, is not willing to deal in more depths with the doctor's competing theory. Thus, a problem of cooperation arises, because the patient's own theory of her problems is not taken up by the doctor, having as a consequence that the patient is not ready to cooperate in a collaborative construction of probing the relevance of the doctor's competing hypothesis. Obviously, the patient needed some explanation first, why her theory could not apply, before being ready to reflect on other possible causes.

The doctor does not address the patient's explanation.

In addition to that, the patient seems to expect the doctor to orient more straightforwardly to finding a diagnosis. The doctor's attempts at staying with the patient's report in order to get a broader view of the phenomenology and the context of the hearing problems in the patient's life-world are not taken up enthusiastically by producing a narrative, but only with incremental responses by the patient.

3.3. Working out a collaborative description of the subjective experience of hearing loss

As was already observed earlier, the patient has problems describing her illness. These problems continue. In the segment below, she is at pains how to describe her subjective experience. This is evidenced by various phenomena such as word searches (lines 351-352), the search for telling metaphors by various reformulations and the search for enhancing precision by adding experiential properties (see below).

#3 (AA_HD_01_07: 31_09: 19) Second symptom description

350 P: aber ich bin wieder hoch und
but i got up again and

351 (0.5) o::h da fällt wieder dieser hh.
oh there falls again this

352 (0.5) wie son sone'
like such such a

353 D: (0.2) son vorhang?=
such a curtain

354 P: =son vorhang oder irgend son
such a curtain or some such a

355 block vorm kopp oder irgend °so°
block before the head or some

356 A: so wie jalousien oder wie: (.) irgendwas (.) °'so so°
just like blinds or like something kind of kind of

357 P: (0.6) sone mauer oder so[n gl]as
kind of a wall or kind of a glass
[

358 D: [mh]
uhu

359 D: oder [was?]
or what
[

360 P: [°ja°] tchh (0.5)
yes

361 P: JA ich (.) ja ich fühl mich eigentlich wie im glas
yes I yes I feel in fact like I am in a glass

362 (0.8) weil weil=s so schwierig is <so die::>
because because it is so difficult just the

363 (0.2) die sachen die von außen auf mich
the things which from outside to me

364 D: hmhm.
uhum

366 P: die so richtig zu hören
to hear them properly

367 also so scharf halt ne?
well simply kind of distinctly

368 (0.4) ich hör auch wenn jemand was leises sacht (.)
i also hear it when someone says something softly

369 aber nur ganz=
but just quite like

370 =also (.) wie so watte? (0.3) dazwischen
like there was some cotton wool in between

371 (0.3) .hhh=

372 D: =so als ob es von ganz weit entfernt kommt,
as if it comes from very far away

In the continuation of her symptom description, the patient displays further formulation problems:

- word searches
- reformulations
- metaphor 'curtain'
- metaphor 'head block'
- metaphor 'blinds'
- metaphor 'wall'
- metaphor 'glass'
- reports difficulty to hear clearly
- reports difficulty to hear soft speech
- metaphor 'cotton wool'

- 373 P: mhmh
uhum
- 374 D: (0.7) die distanz viel größer ist als du sie (.) weißt
the distance is much bigger than you know
- 375 [dass sie in wirklichkeit ist]
that it is in reality
[
- 376 P: [mhmh mhmh]
uhum uhum
- 377 D: geht es dir jetzt auch so?
does it nevertheless
- 378 P: bisschen
a little bit
- 379 (0.2) also wie gesagt (1.2) also nich so wie immer
well as I said well not like usually
- 380 D: hmhm (3.0) nich so (.) <natürlich>
uhum not so natural
- 381 also sozusagen alles is gewiss
so as it were everything is certain
- 382 (.) d (.) ((high)) die gewissheiten sind weg
the certainties have gone
- 383 P: [hmhm]
hmhm
[
- 384 D: [kann man] (.) kann man so auch sagen?
can one can one say too
- 385 P: hmm ja? (2.5)
hum yes
- 386 D: des so ne phantasie von mir nich? des (--) könnt ja auch
sein so
that is a fantasy of mine right? it could also be like
- 387 (.) is das jetzt wirklich alles noch realität was läuft?
is that really still all reality what's going on
- 388 P: (0.7) ach so ja
oh I see yes
- 389 D: so was ist nicht der fall=
something like this is not the case
- 390 P: =hm=nee (-) also (-) nee eigentlich
hm well actually no
- 391 also mir macht es am meisten schwierigkeiten eben
what just most difficult for me me most is that
- 392 (0.4) so (0.7) die dass ich mich so konzentrieren
muss um:
like that I have to concentrate so hard to

Doctor interprets symptoms as psychotic.

Patient rejects doctor's interpretation.

- 393 P: um was (.) rich[tig ja]
in order to something right
- 394 D: [was um zu] funktio[nieren]
in order to function
- 395 P: [ja::h.]
yes
- 396 D: mhmhm (1.5) ZUSAMMENREIßEN kann man auch sagen (0.2)
uhum to pull yourself together can one also say
- 397 P: [ja ja]
yes yes
- 398 D: [dass dich zusammenreißen musst]
that you have to pull yourself together
- 399 P: [ja]
yes
- 400 D: [um] ja:: jetzt nicht
in order now not to
- 401 (-) um (.) ((low)) wer weiß was könnte passieren
who knows what could happen
- 402 (1.9)
- 403 P: tja ich krieg wichtige sachen nich mit
well I do not perceive important things

Doctor's completion of patient's turn is syntactically mismatched and moves the focus from the patient's perception of the outer world to the patient's agency herself.

Doctor pursues psychosomatic problems of agency whereas patient pursues perceptual problems.

The doctor deals with the patient's formulation problems by providing candidate completions (*vorhang*, 'curtain', line 353, 393) and alternative descriptions at various points (lines 356, 372, 374-375, 382, 393, 395), which he presents for confirmation. Doctor and patient collectively produce a series of reformulations (see Gülich/Schöndienst 1999) of metaphors to describe the altered hearing experience (*vorhang*, 'curtain', lines 353-354; *block vorm kopf*, 'block before the head', line 355; *jalousien*, 'blinds', line 356; *mauer*, 'wall', line 357; *glas*, 'glass', line 357; *watte*, 'cotton wool', line 370). The doctor thus displays empathy by demonstrating that he is able to complete the patient's unfinished turns and to reformulate her experience in his own words. By this, he simultaneously supports her in finding ways to speak about experiences which are new to her and which she has probably never before put into words. The doctor assures the patient that it is both possible and worthwhile to formulate the extraordinary experience and to arrive at descriptions and categorizations which manage to accomplish an intersubjectively shared sense of what imposes on the patient as a bewildering subjective experience, which separates her from both her (social) surroundings and her taken-for-granted identity as an inhabitant of an intersubjective lifeworld (cf. Schütz 1962).

All metaphors used here center around the experience of some impediment which compromises the perception of the environment. The metaphors come from the visual domain, being spatial metaphors of separating one (subjective) area from another (objective) one. The ordinary, taken-for-granted, direct mode of being-in-the-world (Heidegger 1962[1927]) is disturbed, giving way to the feeling of being secluded and only indirectly connected to the environment (*ich fühl mich eigentlich wie im glas*, 'I feel like I am in a glass', line 361). Interestingly, the sounds which are hard to perceive are characterized as coming *von außen* ('from the outside', line 363) and *von ganz weit entfernt* ('from very far away', line 372), thus highlighting the separation of the experiencing subject from the world as an object, which

The patient's metaphors

- pertain to the perception of the environment
- come from the visual domain
- address her sense of separation from the outer world

is perceived as clearly distinct from the self and which is a recalcitrant matter demanding efforts of deciphering. The patient does a lot of formulation work in order to clarify the nature of her experience. She points out that her perception of quiet sounds is still intact (line 367), while she has troubles in distinguishing sounds (line 368).

The collaborative thread, however, breaks as the patient, responding to the doctor's question of her momentary perceptions, repeats that her hearing is not as usual and not natural as it used to be (lines 379-380). It gets increasingly clear that the doctor interprets the patient's experience in terms of a psychotic syndrome, culminating in line 387, where he asks the patient if she doubts whether her experiences still represent reality. It is only at that point that the patient recognizes her line of reasoning and rejects it (change-of-state token in line 388, cf. Golato 2010). The patient clarifies that the most troublesome property of her perceptual condition is that she has to make an effort to concentrate on what she hears (lines 391-392). As the patient runs into problems how to define precisely what she is aiming at when concentrating, the doctor completes her unfinished turn with a candidate continuation, which does not match the syntactic projections the patient had established (line 392 vs. lines 394/396): While the patient had started a transitive clause, locating the object of her efforts outside of herself (*was*, 'something', line 392), the doctor completes the patient's turn by an intransitive verb (*funktionieren*, 'to function', line 394), adding *zusammenreißen* ('to pull (oneself) together', line 396) as an alternative. The difference between the transitive syntax projected by the patient and the intransitive resp. reflexive syntax of the doctor's completion amounts to more than just a linguistic clash. While in the patient's turn, the object which needs to be treated with enhanced concentration is the outer world, in the doctor's turn, it is the patient herself. Thus, he still sticks to a psycho-somatic hypothesis, which interprets the patient's symptoms as evidence of a psychological disorder, i.e., of reduced agency or cognitive control (*wer weiß was könnte passieren*, 'who knows what could happen', line 401), i.e., again, as an emotionally caused stress syndrome leading to reduced self-management. The patient, however, holds back ratification (cf. lines 385, 396, 402) and finally makes again clear that the problem lies in her perception of the world (line 403). The doctor's reformulations seem to be guided by his own theory of illness already asserted much earlier (cf. #2, line 236) and the analogy he draws to his own past experiences (cf. #2, lines 239-241), which provide for his *phantasie* ('fantasy', line 386) concerning the patient's problem, rather than by close attention to the details of the patient's descriptions and her uptake of his interpretations.

While the doctor effectively manages to collaborate with the patient in bringing about a more comprehensive and detailed intersubjectively viable description of the patient's experience in lines 350-376 using his imagination, we can see how his claims to formulate details of the epistemic realm of the patient fail to match the patient's turns and do not receive her acclaim anymore starting with line 382. Henceforward, displays of empathy, which were successful hitherto, turn into unsuccessful and unsolicited enforcements of the doctor's perspective on the patient's experience. Still, and this seems to be a most general finding, the patient does not overtly contradict, but rather displays disaffiliation more indirectly by lack or delay of uptake, refusal to expand on the doctor's cues or by reformulating her own prior statements.

Although the doctor afterwards tests the patient's hearing by basic audiometrical measures, he stays with his psychological hypothesis, which became already palpable in the first extract. The doctor does not specifically use keywords like 'curtain' and 'cotton' as diagnostic hints which indicate a severe hearing problem calling for a more comprehensive audiometric ex-

The doctor and the patient pursue two different, and mutually exclusive, lines of interpretation.

In encouraging the patient to provide more details, the doctor takes up her line of interpretation and then turns it into his line of interpretation.

Outcome:

- Doctor prescribes a week's sick leave.

amination or for referral to an ear, nose and throat doctor. He signs her off sick for one week, asking the patient to return, if symptoms have not disappeared after that period.

4. Conclusion

The case study shows how the description of a hearing problem, being a new and bewildering experience to the patient, requires the uptake and cooperation of the doctor to become describable. Collaboration is needed in order to share and elaborate on the individual experience and to make it an intersubjective fact, which can be categorized, described and understood. Still, the study shows that the need for the doctor's active collaboration and empathy in bringing off an intersubjectively viable description also implies the danger that the doctor may prematurely or wrongly assume to know and to take on epistemic authority, which, in fact, intrudes unduly into the patient's territory of self-knowledge. It is important for doctors to become sensitive to subtle signs of disconfirmation and disaffiliation from the patient, because patients tend to be rather indirect in refusing doctors' perspectives. As regards the medical examination, the example shows how doctors may adhere to a specific theory of illness from early on in the encounter, leading them to selectively process and subsume the patient's accounts consistently with their illness theory and to disregard important information speaking to competing diagnoses. This may especially be the case with doctors who are not specialized in audiometry and the treatment of hearing loss and who might not be trained to attend to cardinal symptoms of hearing loss as they figure linguistically in patient's accounts. With respect to audiology and medical training, the case analyzed raises the issue that the patient's description of the sudden change in her hearing sensation warrants a referral to the ear, nose and throat doctor in order to check for a sudden hearing loss or a brain tumor. The case therefore is also indicative for a shortcoming in the curriculum in medical education, where general practitioners themselves have voiced a need for improved knowledge about hearing loss.

Interactional achievements:

- doctor insists and uses asymmetrical relationship to pursue his line of action
- no final agreement is reached

Need for collaboration is not met.

The patient's symptoms warrant an examination by specialists, yet the doctor does not provide a referral.

Application of this kind of analysis to

- medical training
- communication training