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Overlapping in Medical Discourse Sessions as Part of Doctor-PatientConversation.

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Abstract

Rhetorical interference is considered one of the most important reasons affecting the relationship between the doctor and the patient. Communication is the prominent factor that documents the good understanding between the patient and the doctor. Moreover, Robert Fillon's study confirmed that interferences and interruptions cause the occurrence of arguments and complexes that may cause confusion in the patient's direction of thought about the doctor, and as Ruusuvuori explained that two speakers may make the occurrence of success, which guarantees the quality of the dialogue, or failure in understanding, which may lead to interferences or rhetorical interruptions. The purpose of this paper is an exploratory and analytical study of the discursive overlaps and discontinuities between the patient and the clinician. This study carried out the analysis of records of patients with epilepsy and the results of dealing with medical specialists. Based on previous studies, medical specialists use some words or phrases that they understand epilepsy patients to facilitate the method of dialogue and interaction between them so as not to generate any interruptions or rhetorical overlaps in dialogue or understanding for thepurpose of flexibility in taking treatment. The results showed that the practice of imparting knowledge is an important means of spreading scientific knowledge through expert discourse itself, which contains its share of paraphrases, metaphors, and other linguistic signs that the study was able to identify and define. This study proposed to present the findings of their theoretical grounding in the linguistic sciences and, more specifically, in the analysis of discourse. Using interaction analysis methodology, it was necessary to collect, transcribe, and analyze a body of authentic speeches to understand the linguistic mechanisms applied in imparting knowledge during the clinician/patient interaction. Doctor-patient communication has shown that the core of important therapeutic and social issues, so understanding and improving them are the subject of real social demand and can, therefore, be of interest to a wide audience. To conclude that, it was necessary to collect, transcribe, and analyze a collection of authentic speeches to understand the linguistic mechanisms applied in imparting knowledge during this interaction between the clinician and the patient. Doctor-patient communication is at the heart of important therapeutic and social issues, so its understanding and improvement are the subject of real social demandand, therefore, can be of interest to a wide audience.

Keywords: *Interaction, Medical discourse, Generalization, and Doctor-Patient Conversation.*

Introduction

Discourse communication is considered a long-term basis for reaching strategies to strengthen trust and interdependence between the doctor and the patient, which receives the quality of health care, as [1] Ong, Haes, Hoos, and Lammes indicate that communication and verbal intervention refer to a different set of interactions that affect the basis of the strategy. [2] Robert Fillon explained that communication betweenthe doctor and the patient plays a prominent role in medical interaction and oral communication as

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Interferences and interruptions affect understanding and communication, and he also stressed that notall medical interventions are interruptions, which affects the verbal interaction between the two parties [3, 4, 5] (Muthuswamy, 2019).

Van Dolmen, Belnick, and Dingwall and [6, 7, 8] focused on the difference of opinions leading to imbalance or differences, as well as the patient's lack of confidence in the direction of the doctor, which causes loss of contact between the doctor and the patient, which allows the creation of interferences and interruptions between the two parties. Ruusuvuori [9] also emphasized that the doctor’s preoccupation with studying, paying attention, and deciding based on medical records may confuse the patient in theevent that the doctor is listening to the patient or not. Bhatia [10] showed that decision-making is participatory on both sides based on the four concepts: 1) Bensing [11] emphasized that decision-makingis shared between the doctor and the patient on the basis of understanding, 2) Baur [12] presented the patient and the doctor exchanging information 3) Bell [13] showed the doctor should listen to the patient, and 4) Boyle [14] indicates a pooled agreement of both parties and the patient in taking treatment. Medical interruptions in the rhetorical dialogue are considered as devices used to control the rhetorical interactions between the doctor and the patient, which may prevent reaching an agreement and trustbetween the two parties, which affects the physical health, the social relationship, and the psychological state of the patient towards the doctor [15]. In another point of view, Zimmerman [16] considers thatthe interruption during the medical discourse represents that it may be mechanical, objective, or constructive and that the interruption of speech leads to a successful or unsuccessful response to the outcome of the dialogue. And to extend the study, they explained [17] (Bennet, Adrian) that most patients do not use a normal dialogue for them, as epileptic patients may ask them words or phrases that may determine the presentation of the topic from all factors such as the context of the topic, dealing,response and interaction without the occurrence of any interruptions or medical interventions that aremore desirable for them to give them confidence and balance in their lives. This paper aims to study the overlapping in medical discourse sessions as part of the doctor-patient conversation.

Methods

Based on the introduction, this study included the importance of medical consultation, which is considered above all as a specific social practice that imposes predetermined roles. In this sense, it is asocial interaction even before it is a verbal interaction. The two speakers define, sometimesunconsciously, what Robert Fillon calls the "interactional framework," that is, the recognition of onespeaker's standing vis-à-vis the other and likewise. There is a meaning to the encounter and a contextthat builds the messages produced. In the case that concerns us, this framework is said to be institutional because the places are institutionalized. In the consultation interaction, the speaker positions himself as the doctor and thus has a certain authority, which includes that he used a certain lexicon and uses a certain formula. A medical spokesperson holds this "high" position because he/she is a socially recognized specialist with knowledge and expertise. Parsons showed that contemporary medical practice is based on an unequal relationship between expert and patient. This high position allows himto lead the interaction. He brings the interlocutor, the patient, into his space; it is he who opens and closes the dialogue, he who asks questions. A nuance must be introduced immediately because if heleads the interaction, he does not manage it alone.

The current study focuses on the conversational characteristics of doctor-patient dialogues in ambiguoussituations of epileptic patients conducted by epilepsy experts, as well as the two sides' communicationstyles. The purpose of this study is to discover which components of dialogue are most commonly used by physician interviewers. Three encounters between physicians and patients were audio-recorded and then transcribed for this purpose. The focus of the analysis is on both the oral and nonverbal parts of

the dialogue. Following a dialogue analysis, it was discovered that taking turns was the most often utilizedpart of the conversation. This study appears to be noteworthy because it is one of the first to use conversational analysis in a physician-patient setting. The patient also participates in the management ofthe exchange by responding, providing information about his condition, asking questions in return, and participating in the negotiation of meaning: “This contrast is defining the situation but does not preclude the local negotiation place between the doctor and the patient on the decision in the significance of the symptoms. It must be determined that the interactive medical consultation framework of this study ofthe group includes transcriptions of patient consultations with epilepsy specialists. They are not general practitioners but specialists. Therefore, the diagnosis is often already established or only needs confirmation at the time of consultation. This study is based on the study of counseling discourse. The methodology used is analyzing recordings of real exchanges in the situation as well as transcription and identification of salient and repetitive facts identified in the same situation. This study is based on a set of on-site controlled consultation sessions with four different epileptologists from different hospitals, job-specific by hospital center or city in question. Other patients are important sources of information for diagnosis and treatment adjustment.

Transcription was also performed without the use of a pre-prepared transcription grid. This study proceeded with transcription with a custom grid following its own criteria because the objectives of the study were neither transversal nor gestural nor tonal, and the need for readability and accessibility was important to the investigator. However, the idea was not to use the first draft syntax where parsing isdone in order to potentially reformat the collection in order to perform lexical parsing through the useof TXM software, which would require careful coding. This is explained by the nature of some of these research objectives that we can classify as linguistic, which include metaphors, paraphrases, and comparative grammatical turns.

Results

This interactive framework demarcates the intersubjective landscape and limits the linguistic exchanges that take place within. Indeed, social roles constrain linguistic "roles" to a certain extent, and therefore, from the point of view of discourse, at least initially. This clear delineation of the frame allows us tosystematically scan the metallic linguistic marks that carve the doctor's discourse but sometimes also thatof the patient. Thus, we find repetitions of the following linguistic signs:

Presenters: "It." " There is, "; "here,"; " there. " Presentations are grammatical devices that allow forassertive actions. In this group, "it" is the most commonly used. It serves to introduce an element butalso serves as a gravitational pull to what precedes it in a kind of piecemeal construction. It, therefore,assumes a pivotal role about "there is" also very frequent, but it is not the effect of highlighting a realphenomenon of investigation. A few verbatim texts have been retained in the collection to make thispoint: "It is a study done" on "it is a table drug" "at the same time it is considered a rare situation"; “There is, for example, Tegretol, which is an anti-epileptic drug that we use frequently.” The presenceof presentations is a common feature of physician discourse, and we find it, particularly in speaking roles. However, it is possible to encounter such signs in the patient's speech. These repetitions in thepatient are actually repetitions, repetitions to show that he has understood.

Connectors: Then. " So,"; " but,"; " the next,"; " because,"; " then,"; " after,"; "now," etc. It is, above all, amatter of logical and temporal links that structure thought and, therefore, discourse. They participate, and at the same time, there are traces of an intellectual course that more or less corresponds to a certain thoughtprocess: diagnosis, auscultation, etc. They build up the spirit of the speaker: the spirit of authority and thespecialization expected of the physician, but also sometimes a spirit "tempted" by the patient who

Appropriates the use of conductors, sometimes not necessarily judiciously, to create an imitation of spirit thatcan be trivially paraphrased with the phrase "I am able to understand the speech of experts.". "

Caption Sequence Changers: "It means." "Do you know," "Let's take an example,"; " In other words,"; "This means,"; "sex,"; "Explain you," etc. This study was borrowed this expression from Ruusuvuoriand Robert Fillon [9, 2]. Paraphrasing sequence shifters allow the speaker to enter paraphrasing. Thus,they are linguistic devices that indicate mediation, a paraphrase. As they interact, they index. In otherwords, denotative sequence shifters show or even highlight discursive mediation at the same time that it is performed. This phenomenon appears in the following verbatim text: "Your MRI is normal, that is,we cannot find it; with what MRI can do in terms of image quality (...), we do not find any abnormalitiesthat explain why you have epileptic seizures"; “There is almost no recurrence between nine months and two years of follow-up, which means that the maximum risk of recurrence will be in the first three months”; "I'm going to start using all the anti-epileptic drugs that don't cause problems with, we'll say,uh, pregnancy and femininity.”

Definite grammatical turns: general comparison: with a construction of the type “chez + definite article…there…” that allows a situation-specific comparison. The preposition "at" introduces a noun group, andeverything means "within a community, an environment made up of" Example: "In patients who are twoyears old without seizures and on normal MRI when we stop treatment, there are 40% who repeat [the crises] Syntactic structure of extraction: close to introductions, bracketing of noun phrases and sentence parts thathighlight the extracted word or group of words. Example: “In case we actually knew about your epilepsywhen we did an MRI of the brain…” To conclude the systematic survey of signs, three characteristics ofpopular discourse related to epilepsy should be pointed out in which such high frequency is explained by the temporal and specific aspects of epileptic seizure that define the disease. In fact, it is characterized by bothrecurrences: epilepsy is defined as the recurrence of epileptic seizures. Moreover, this recurrence is not subject to the principle of regularity, so much so that it cannot be foreseen or foreseen, which is why we are in a stateof accidental and spontaneous. But it is also characterized by incomprehensibility (the order of suddeninference): from its discontinuity, which marks the end of one situation and the beginning of another, toqualify the onset of a crisis, its brief and abrupt nature.

This study adopted the hypothesis according to Ruusuvuori and Robert Fillon [9, 2], in which the two speakers must agree on the meaning they give to the terms they use to ensure the quality of their exchange. Elaboration of meaning is built through interaction. It was noticeable that in the previous survey tags, explanatory sequence shifters were. These variables make it possible to create discursive mediations, the promotionengine. These mediations could be including the order of simple semi-lexical paraphrasing or adjacent lexicalequivalence; “Have they had brain imaging, scanners; “It’s the same molecule, but what surrounds it, theexcipients are not the same?”; “Here we see normal brain activity, brain which works normally"; "And when there are anomalies, we see things a little sharper, i.e., faster" • Order definition of interpretation (naming structure + definition of extension/causal interpretation) emotion regulation, etc. Well, even if we have this effect, that is, everything that is impulsive, emotional disorders are controlled ”; “Head trauma is a majorsource of epilepsy – when you have head trauma you may have damaged a part of your brain which thenbecomes irritated and can cause epilepsy”; "Outside of the underlying disorder, that is, what really characterizes what autism is"; “To avoid the big crisis that is often something to be admired for everyone andthat in any case will change your daily life for a while.

Discussion

Analog mediation allows the creation of a semantic bridge between two languages: the medical, scientificlanguage, and the ordinary language. The trivial images ("electrical cables" of the vagus nerve, the "video

Console" of the programming device, the "peaks" of the waves in progress in the EEG) intentionallyselected by the famous stethoscope have several characteristics in common with the scientific reference universe. There is a group, what Rastier [18] calls a semic molecule, which is shared by the proper (vagusnerve) and metaphorical (electrical cable) here: /connect/ /electricity/ /tubing/ [19]. The prism establishes a structural homogeneity between the scientific knowledge (information to be conveyed) thatit carries and the universes of meaning that it believes are known to its sender. In this study, I proposeto work on the hypothesis of identifying three levels of articulation in the clinician's vulgar speech, which we will have to develop in the following research: [20]

- Reference level: which belongs to the science record and constitutes the world of reference. The disengagement is done completely there as a specialized language (a specific lexicon and grammar) is used. This is a level that we often don't get to during a doctor/patient interaction. [21, 22]
- Ordinary level: which belongs to the patient record shared by all speakers of the same language, including the doctor without his coat. [23, 24]
- Mediator level: which belongs to the doctor's generalized record and is a kind of mediator between the two extreme levels. This level is characterized by the emergence of semi-particles called “bridges” that update structural symmetries between two realms of meaning. [25, 26, 27]

Conclusion

To conclude, it was necessary to collect, transcribe and analyse a body of authentic speeches tounderstand the linguistic mechanisms applied in imparting knowledge during this physician/patient interaction. Doctor-patient communication is at the heart of important therapeutic and social issues, so its understanding and improvement are the subject of real social demand and can, therefore, be of interest to a wide audience. Since cholecystectomy has detrimental consequences on people over the ageof 40, it is thought to be a significant contributor to shoulder discomfort. The findings indicated thatmen were more hurt and in pain than women. The findings demonstrated that age, weight, and the kind of general anesthetic used during the procedure had the biggest influence on the level of discomfort,which occasionally resulted in bleeding. Finally, this study discovered that the pain score was evaluated using the VAS and that the discomfort decreased as the surgery's duration was prolonged. It is criticalnot to overlook the current study's essential impact on both clinician-patient discussions and educational settings, namely the conversational part of the language that is taught for English learners. First, becausethe doctor-patient contact is one of the most significant parts in medical communication, which linguistic scholars must consider, since this study represents the CA case with doctor-patient analysis, the significance of the current study is clearly underlined. Because assisting patients with a health condition is said to be very vital, this study should help professionals comprehend this crucial topic.

Furthermore, because language is seen as a form of social behavior, the current study examining features ofdialogue among interlocutors within society as a whole and between physicians and patients specificallyappears to be influential research. Second, teachers must take responsibility for English language learners inorder to improve their language competency in all elements of language skills as well as components, particularly the discourse aspect. To accomplish this purpose, it is vital to carefully evaluate the conversational characteristics of the language, which is the language that extends beyond the level for sentences, as one ofthe major components taught during the process in teaching English for language learners.

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