Unveiling stories to the oncologist: a matter of sharing and healing

Marisa Cordella*

Abstract: This study expands on previous research done on doctor-patient communication in primary care. In particular, it explores the unfolding of patients' personal stories in a check up consultation with a cancer specialist.

The corpus of this study is based on twelve patients ranging from 20 to 80 years of age attending a cancer clinic in Santiago, Chile. The medical consultations were tape-recorded and a total of thirty six stories were collected.
Storytelling is broadly defined here to encapsulate participants' telling of a past event which informs us about patients' and families' attitudes toward the disease and gives us some knowledge as to how they are dealing and coping with the health condition they are experiencing.

The analysis focuses on the micro-analysis of personal stories and the analysis of 'voices' introduced by Cordella (2004) in the context of primary care consultations. Among these 'voices' there are two which are particularly relevant here: the voice of Health-related storytelling and the voice of Social Communicator.

Results show that while the voice of Health-related storytelling includes examples in which patients align to the medical script of the consultation and convey stories around their medical condition, the voice of Social Communicator unveils a wealth of material of personal stories that validates the patient as a person despite being under treatment for a medical condition. Patients in this 'voice' articulate a discourse about their self-identity, which contrasts with the stereotypically portrayed sick image of patients. The outcome creates a unique platform of communication that favours the doctor's understanding of patient's wellbeing.
Key words: doctor-patient communication, medical communication, medical discourse, professional discourse, empathy, discourse analysis.

El desarrollo de las historias personales en la consulta oncológica: una forma de compartir y atender la enfermedad

Resumen: Esta investigación estudia las historias personales que los pacientes oncológicos exponen durante la visita médica, usando como base los estudios que se han llevado a cabo sobre la relación médico-paciente en consultas de atención primaria.

El corpus consta de las historias de doce pacientes, de entre 20 y 80 años, en la consulta de su médico, en una clínica de Santiago (Chile). Las visitas se grabaron y se recogieron un total de 36 historias.
En este estudio, las historias se definen, en términos generales, como narraciones personales que nos dan a conocer la postura que tanto los pacientes como los familiares tienen sobre la enfermedad, además de cómo encaran sus condiciones de salud.

Las historias se analizan en un marco microanalítico narrativo; incluye, asimismo, el análisis de las voces médicas introducidas por Cordella (2004) en el contexto de la medicina primaria. Entre las voces estudiadas hay dos, en particular, que son relevantes en este estudio: la del *health-related storytelling* y la del *social communicator.*

Los resultados indican que, mientras que la voz del *health-related storytelling* se centra en el discurso médico institucional, narrando historias relacionadas con la salud del paciente, la voz del *social communicator* despliega una riqueza narrativa singular, con historias personales que muestran al individuo como ser social, a pesar de estar padeciendo una enfermedad. Al utilizar esta voz, surge en el discurso la identidad del individuo como un modo de rebelarse ante el estereotipo «enfermo de cáncer». Este comportamiento lingüístico favorece la comunicación médico-paciente, porque a través de ella, el oncólogo obtiene un mejor perfil del paciente.
Palabras clave: comunicación médico-paciente, comunicación médica, discurso médico, discurso profesional, empatía, análisis del discurso.

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I remember very clearly than even though I had worked for ten years with cancer patients, when I called them up (family) and told them I had cancer, the first time the word came out of my mouth, it didn't. I said, "The diagnosis is c - " and I couldn't say it. It was something that just couldn't be applying to me.

David Carbone (2005:54)

* School of Languages, Cultures and Linguistics, Monash University, Melbourne (Australia). Address for correspondence: marisa.cordella@arts.monash.edu.au.

1. Introduction

In today's world there is a tendency to live in a frantic and unstoppable way to respond to the many demands placed on us by a globalized society. It is not surprising then, that many individuals just take their health for granted and only become aware of their poor wellbeing when their health fails.

In those cases when a disease (e.g. cancer) affecting the individual is portrayed in the media as a potential life sentence and social fears constantly remind patients of their vulnerable state, the diagnosis and what follows can be very disruptive for patients and families alike. Patients' immediate concern of getting better and restoring their levels of wellbeing takes over. The visits to the oncologist and other health professionals develop into a recurrent routine, altering their daily activity as well as that of those around them.

On this journey, the medical visits may become a site where patients' self-reflection and making sense mechanisms (Capps and Ochs 1995) are likely to manifest themselves following questions routinely asked by health practitioners (e.g. How have you been feeling? How are you? How are you keeping?). Patients' answers may display personal stories that revolve around the disease, themselves and others.

The disclosure and sharing of these personal stories provide a unique opportunity for health professionals to get an insight into patients' lives and assess the effect the disease is having on them, their families and/or friends around them.

This manuscript focuses on cancer patients' personal stories disclosed during a check up visit with the consulting oncologist.

2. Background of the study

Storytelling is a social activity that allows participants to share part of their lives by constructing accounts of their past experiences. The pioneering work of Labov (1972) classified oral narratives as verbal expressions that comprise six main components (abstract, orientation, complication, evaluation, result and coda) and contain an internal structure formed by a set of temporally ordered sequence of clauses.

At the centre of storytelling is 'reportability' (Labov 1972 and Labov Fanshel 1977) which emphasises how a narration justifies 'holding the listener's attention' (Labov and Fanshel 1977:105) for being 'terrifying, dangerous, weird, wild, crazy; or amusing, hilarious, wonderful; more generally, that it was strange, uncommon, or unusual-that is, [it was] worth reporting' (Labov 1972:371). Previous studies have shown, nonetheless, that stories may not necessarily be reported simply for showing something unusual.

Personal stories are usually displayed in dyadic or group communication exchanges, where participants know each other relatively well (e.g. family members, friends, co-workers). Storytelling in this context serves a variety of purposes such as: reviving family stories, sharing the stories of the day in family–dinner conversations (Blum-Kulka 1993, Och 1992), reinforcing group membership, creating and reconfirming feelings of belonging (Norrick 1997, 2000 a, b, c; Georgakopoulou 1995, 1996, 1997, 2002). Many of the personal stories are jointly constructed/co-narrated as they may be familiar to more than one person narrating the story.

The development of storytelling is not only associated with informal settings but less informal situations may also call for the occurrence of storytelling to achieve particular ends. For example, psychotherapy and counselling sessions are established forms which promote the disclosure of personal stories in their consultations following a holistic approach of patients' care (Chatwin 2006).

The display of storytelling in medical discourse has also revealed the identity transformations that patients undergo during and after cancer treatment (Anderson and Martin 2003). Although medical discourse studies have identified the presence of storytelling in this event, what appears to be under-researched is an understanding of how these personal stories are introduced, supported and constructed in the oncologist consulting room, what participatory role does the oncologist and the relative accompanying the patient play in the event and what do they achieve in the medical visit.

For the purpose of this paper storytelling and personal stories/narratives are used interchangeably, although some would differentiate them.

Storytelling is broadly defined here to encapsulate participants' telling of a past event which informs us about patients' and families' attitudes toward the disease as well as giving us some knowledge as to how they are dealing and coping with the health condition they suffer. Through these stories patients make meaning and interpret the changes occurring in their lives. The 'meaning-making unit of discourse' (Riessman 2004:35) is central to all of us, but it appears to be fundamental for patients whose lives may be disrupted by a disease of uncertain prognosis.

This study uses micro-analytical methods building on storytelling and co-narration/joint production storytelling (Blum-Kulka 1993, Holmes 1998, Georgakopoulou 1995, 1996, 1997, 2002, Norrick 1997, Ochs 1992 and Taylor) and employs a participatory framework which comprises a set of 'voices' (forms of talk (Goffman 1981)) that interact in the event (Cordella 2003, 2004) to produce a dynamic medical consultation.

The dynamic medical consultation model put forward by Cordella (2004) distinguishes a set of 'voices' that both doctors and patients use during the medical visit. As follows I will outline a brief description of the doctor and the patient 'voices'.

Doctors use three main 'voices', these are: *Doctor voice*, *Educator voice* and *Fellow Human voice*. These 'voices' correlate with the three functional medical goals identified by Cohen-Cole (1991) that aim at gathering information, educating and providing support.

With the *Doctor voice* the physician seeks information, assesses and reviews the treatment and shows alignment to the medical authority. The *Educator voice* communicates medical facts, provides information regarding available test results, proposes tests to be undertaken, provides information about functioning of the human body and responds to the patient discomfort. The third 'voice', the *Fellow Human voice,* complements both the *Doctor voice* and *Educator voice* by exploring non health-related issues (at least on the surface) and by gaining a holistic view of patients' wellbeing. In this 'voice' the physician facilitates and assists the telling of patients' stories, creates

empathy with the patient and shows special attentiveness to patients' stories. Each of these functions is achieved by a number of linguistic strategies. The Dynamic Model designed by Cordella (2004:215) when used to interpret a GP (general practice/primary care) consultation, suggests that the *Fellow Human voice* makes the medical consultation an event in which the asymmetry between doctor and patient becomes less prominent.

In this work attention will be given to some of the strategies used within the *Fellow Human voice* that are fundamental in prompting the disclosure of patients' stories.

During the interaction that develops in the medical consultation patients also exhibit a set of 'voices' that either respond to physicians' discourse or initiate a new topic of interest. Cordella (2004) found that patients used 4 main 'voices'. The *voice* of *Health-related storytelling*, the *voice* of *Competence*, the *voice* of *Social Communicator* and the *voice* of *Initiator*. In this paper, I focus on two of those 'voices' (i.e. *Social Communicator* and *Health-related storyteller*) in the context of cancer consultations. *Health-related storytelling* is usually elicited by the doctor's questions, which may be of a general nature (e.g. How are you feeling?). Some patients take this opening question as an invitation to introduce the *voice* of *Health-related storytelling* by:

a) Describing their emotional state (e.g. "I feel depressed"; "I feel down")
b) Describing their physical symptoms, such as discomfort or pain (e.g. "stomach ache"; "headache")
c) Expressing concern about their health condition, treatment or management (e.g. "worry about having an operation")
d) Sharing their difficulties in complying with medical recommendations (e.g. "quit smoking") (Cordella 2004: 153-4).

On the other hand the *voice* of *Social Communicator* allows patients to introduce into the consultation stories that reveal their family responsibilities, personal commitments and activities (ibid 2004), moving away from the distinctive health related issues introduced in medical settings. The development of both *Health-related storytelling* and *Social Communicator* is interactional in nature.

Patients' contribution to the event correlates with doctors' participation in the consultation (Ainsworth-Vaughn 1994, 1998; Borges 1986; Cordella 1999, 2007 in press, Fisher 1991; Fisher and Todd 1986a; Holmes *et al*. 1999; Tannen 1987; Todd and Fisher 1993; Wodak 1989, 1996, 1999; Wodak and Matouschek 1993) which, in turn, plays a fundamental role in restricting or encouraging the unfolding of storytelling.

3. Methodology

The corpus was collected in the cancer clinic of the Pontificia Universidad Católica de Chile 'Nuestra Señora de la Esperanza' in 2004 in Santiago. One oncologist with 20 years experience and his patients ranging from 20 to 80 years of age and their relatives provided the corpus of data for this study.

It is not my intention here to claim that patients' storytelling recorded in the consultations of a single oncologist provides an overall picture of how Chileans may exhibit their stories to medical doctors in general, but the trends observed are certainly useful for comparisons with previous work in this field.

Twelve natural tape-recorded Chilean-Spanish consultations were collected and later analysed to identify the occurrence of storytelling events in medical check up consultations with a cancer specialist.

Those examples which have been included in this manuscript were originally translated by the author and subsequently reviewed by an Australian-English and a Spanish native speaker. The Australian-English target text aims to convey the main ideas presented in the original Chilean-Spanish text.

Participants were free to participate in this study and once approval had been granted through a consent form, they could withdraw their participation at any time they felt appropriate even after the recording had taken place. Ethics approval was obtained from both Monash University and the oncologist centre 'Nuestra Señora de la Esperanza' before the commencement of the project.

4. Research questions

1. Does storytelling form part of the oncologist consulting room's discourse?
2. Is there any linguistic feature that favours the development of storytelling in the medical consultation?
3. Who are the participants in the storytelling?
4. What purpose does storytelling play in the discourse?
5. Are personal stories reportable and worth telling in a cancer specialist room?

5. Results and Interpretation

Some consultations (3/12) did not include examples of storytelling. Those were cases of medical visits in which the oncologist maintained an institutional discourse and a medical centred approach throughout the consultation, favouring a discourse where the Doctor *voice* and Educator *voice* prevailed in the event.

The performance of both *Health-related storytelling* and *Social Communicator* in the visits – within which storytelling emerged– was the result of an empathetic discourse that was intended to be in tune with patients' feelings and emotions, in other words those stories represented an expression of the *Fellow Human voice*.

In this case the oncologist made use of repetitive continuer markers (uhm, ya) – also found in teacher-students discourse (Bülow 2004) – allowing patients and/or relatives to continue with their stories, he also used mirroring to indicate that he had been attentively listening to participants' contributions, displaying emotional reciprocity to show involvement and empathy toward a description of a dramatic event, and he asked questions unrelated to the medical condition which allowed patients and/or relatives to tell something more personal about themselves. All of these linguistic features assisted in the unfolding of 36 storytelling events where two participants (patient and doctor or relative and doctor) or three participants (patient, relative and doctor) were involved.

5.1. Health-related storytelling and Social Communicator

Participants used *Health-related storytelling* 24/36 times to narrate events in which patients' treatment and management is under scrutiny, covering topics such as: side effects following the consumption of drugs, diet concerns and general wellbeing. In these examples patients align to the medical institution and the expectations of a medical visit by providing information that assists the doctor in his history taking and an appreciation of the patient's health condition.

The rest of the personal narratives (i.e. twelve) were delivered by using the *voice* of *Social Communicator*. This 'voice' goes one step further than the *Health-related storytelling* focusing primarily on health issues and allowing the disclosure of a discourse in which patients tell about their lives, social identities and the way they are managing the disease.

The following two examples show the contrast between the *Health-related storytelling* and *Social Communicator*.

Example 1 shows a male patient who is in his fifties. He has been treated for acute myeloid leukaemia and he is currently undergoing treatment for non-Hodgkin disease. In the segment below the doctor enquires as to whether his low intake of cow's milk (a concern that the patient's wife has put to him earlier in the discourse) is associated with any after effects he may experience like diarrhoea.

MD: medical doctor, FR: female relative, MP: male patient
MD: ¿Te da diarrea?
FR: [No]
MP: [No] no es que me la leche [lo: lo::] con la quimio a mí de lo que me he percatado
FR: [y es descremada]
MP: Eh trato de no de no comer eh nada que tenga aceite nada cero no eh normalmente me echo un dulce a la boca entonces y trato de hacer hartas cosas para tener la cabeza ocupada y no estar preocupado de que eh me la sensibilidad en la nariz se me ha durado tres cuatro día después lo tolero porque antes me acuerdo que no soportaba no soportaba ni el olor a jabón.

MD: Do you get diarrhoea?
FR: [No]
MP: [No] no the milk [it it] I've noticed that when I'm going through chemo
FR: [and it's skinny milk]
MP: Eh I try not to eat not to eat eh anything that has oil in it nothing zero no eh I usually put a lolly in my mouth and try to have my mind on something else to distract myself and avoid being aware of the hypersensitivity I have with (certain) odours which lasts for up to three four days after this (period) I feel better. In the past I remember I couldn't even bear, couldn't even bear the smell of the soap.

Example 1 (***Health-related storytelling***: Drinking milk).
MD: medical doctor, FP: female patient, MR: male relative

The example above shows the typical characteristics of *Health-related storytelling*. The patient responds to the doctor's question (do you get diarrhoea?) by reflecting upon the discomforts experienced after the administration of a chemotherapy course (hypersensitivity to odours). This example also exhibits a series of events expressed in past tense (I've noticed, I couldn't even… bear the smell of the soap) and adverbs of time such as 'antes' (before) which correlate with the results found in Cordella (2004:154) in general medical practice.

In the following example the patient is a young woman in her twenties. She has had a bone marrow transplant five months before and has come to a check up visit.

FP: Ah tuve vómitos
MD: ¿Cuándo?
FP: ¿Ayer?
MR: Ante=
FP: =Ante anteanoche
MD: ¿Con qué comida?
MR: Mariscos crudos [en el casorio] del sábado
FP: [@@@] Es que se me olvidó. Entonces estaba todo tan rico entonces fui y y lesa porque me eché puras cosas cocidas entonces papitas con mayonesa todo todo cocido y voy y veo y había como eh eran choritos [con::] cebiche de mariscos entonces ah me voy a
MR: [cebiche de mariscos]
FP: servir una cuchara y me voy y me sie::nto y después le digo a Danny y él ya te traigo más y después uu:: eran crudos y ahí quedó la escoba
MD: Ya no todavía para eso falta un poquito
FP: Sí pues sí sé pero a veces se me olvida ese es mi problema que -me olvida que estoy transplantada

FP: Ah I had vomiting
MD: When?
FP: Yesterday?
FP: The day=
FP: =The day before yesterday
MD: What did you eat?
MR: Raw shellfish [at the wedding] on Saturday
FP: [@@@] Well I forgot. Everything was so delicious so I went and and I was silly I put on my plate only cooked food potatoes with mayonnaise, everything, everything was cooked and I go and I saw that there were some mussels [with] marinated raw shellfish and I served myself
MR:[marinated raw shellfish]
FP: one scoop and I went to sit down and then
I told Danny and he said to me I'll bring you some more and then uhm they were raw I ended up very sick
MD: Not yet we'll need to wait some time before that
FP: Yes I know but sometimes I just forget that's the problem I forget that I've had a transplant

Example 2 (***Social Communicator***: Food poisoning).
MD: medical doctor, FP: female patient, MR: male relative

In the above example the oncologist, after patient's initiation (I had vomiting), asked about the timing and content of the event and then allowed her and her partner to develop their story. The result is a co-narration where both participants contribute to the topic of food poisoning. In this section I will not appraise the joint construction of this story as this point will be discussed further on in this manuscript in section 5.2. What is of interest here is to observe how the patient's self-identity defies the 'predictable' medical script of the medical event.

This segment shows the *voice* of *Social Communicator* in full display by telling us about what the patient was doing on Saturday night (wedding), who accompanied her (partner), what she ate on that night (marinated raw shellfish), how she felt about herself (silly) and the effect she had with the consumption of shellfish (food poisoning). All these elements provide us with a picture of a joyful young woman enjoying the pleasure of nice food in good company.

Following Labov's narrative analysis it is possible to interpret this segment as having an a) Abstract: what was this about? –food poisoning; b) Orientation: who, when, what, where? –his patient, the day before, at a wedding; c) Complicating action: then what happened? –the patient was attracted to marinated raw shellfish and ate it; d) Evaluation: so what? – the patient vomited; e) Result: what finally happened? – the patient became sick.

At the structural level of analysis the segment shows the main topic of this personal story (food poisoning) and suspense ('I saw that there were some mussels with marinated raw shellfish and I served myself'). Patients who have gone through a number of chemotherapy courses following a bone marrow transplant, as this patient had, have a depressed immune system which is unable to cope efficiently with infective micro-organisms (e.g. bacteria) that could potentially be found in raw shellfish. This segment also shows a resolution ('I ended up very sick'), doctor's evaluation ('Not yet we'll need to wait some time before that') and patient's acknowledgement of responsibility in the event ('Yes I know but sometimes I just forget that's the problem I forget that I've had a transplant') The display of this story is very powerful as the oncologist was able to get vital information that he would not have obtained had he stayed within the medical 'voice' and restricted the unfolding of the story.

5.2. Co-narration in the medical visit

We observe that relatives participated in 25/36 joint-production storytelling events (patient-relative-doctor and relative-doctor) in contrast with patients who elaborated less than one third 11/36 of the stories in a dyad composition (patient-doctor) (See Table 1).

• 25/36 storytellings are co-narrated in group dyad composition (patient-relative-doctor and relative doctor).
• 11/36 of storytelling in a dyad composition (patient-doctor).
• The difference is statistically significant (X2 1 = 5.44, P < 0.03), indicating a preference for increased co-narration involving the accompanying relative.

Table 1. Results and Interpretation of co-narration

Note that an accompanying person was present in all but one consultation. Looking more closely into the sex composition of participants we observe that every patient was accompanied by a female relative except for one young couple and one female patient in her thirties who went to the check up on her own.

Doctor voice (examen físico)
FR: Sabe que ha estado más animadito que la primera eh::=
MD: =Porque estaba mejor antes de empezar el tratamiento
FR: Ah::
MP: La primera me tuvo como botado con el sentido de que:
FR: Y al pasar esta vez de la segunda de la segunda, el segundo ciclo de ahora ha estado más animado que los días del Año Nuevo y días de Navidad anduvo como cinco o seis días así bien polli::to estaba bien acostadi::to
MP: O sea que me levantaba y me daba sueño más luego entonces que hacía me levantaba un rato y eh de repente antes de ir a almorzar o después del almuerzo ahí me acostaba un rato y se me quitaba yo le decía si lo que tengo es igual [que si]
MD: [ya]
MP: hubiese jugado un partido de fútbol le decía yo estoy amolado pero con que duerma un rato se me quita
FR: ((@@@)) fíjese ahora que tiene más energía que yo ((@@@)
MD: Ya mi pregunta ahora es la siguiente
(Shift to the Doctor voice –tests to be carried out)

Doctor voice (physical examination)
FR: You know he has been feeling in better spirit (than the first course) ehm=
MD: =Because he was in better shape when he started this (chemotherapy) course
FR: Ah::
MP: During the first (course) I felt run down I mean:
FR: And this one this second, second, second course now he has been feeling in much better spirit than those days on New Year's Day and Christmas Day when he felt run down for five or six days he used to lay down most of the time
MP: I mean I'd come out of bed and feel sleepy soon after so what I used to do was to come out of bed for a while and ehm sometimes before or after lunch I'd lie down for a while and I'd feel better I used to say to her (his wife) that I felt as [if I]
MD: [yeah]
MP: had played a soccer match. I'd tell her
I'm feeling run down but if I sleep for a while I feel better
FR: ((@@@)) Look at him he now he has more energy than me ((@@@))
MD: Now I'd like to ask you the following question
(Shift to the Doctor voice –tests to be carried out)

Example 3 (co-narration of ***Health-related storytelling***: I'm feeling better now!).
MD: medical doctor, MP: male patient, FR: female relative.

This co-narration is accomplished by the patient (MP) and his wife (FR) who together construct the story that intends to report to the oncologist how the patient is doing with the current course of chemotherapy.

'Fíjese' (you know) and 'sabe' (look) are used at the initiation and closing of the segment as linguistic indicators that the story is worth telling. The precise set of time (Christmas Day and New Year's Day) and the constructive adverbs of time (now v/s before) create the atmosphere of a *Health-related storytelling* that reflect on the present ('now he has been feeling in much better spirit') while looking back at the past ('on New Year's Day and Christmas Day when he felt run down for five or six days').

The previous chemotherapy course was challenging, making the patient feel exhausted and leaving him with low energy levels ('I'd come out of bed and feel sleepy soon after, 'I felt as if I had played a soccer match').

A sequence of cause/repair ('I'm feeling run down but if I sleep for a while') inform us as to how the patient is managing his state.

At the participatory level of the co-construction MP and FR contribute jointly to the discourse building up the story in each turn. Following Ferrara (1992) they exhibit an example of 'utterance extension' when co-producing the following extract.

FR: And this one this second, second, second course now he has been feeling in much better spirit than those days on New Year's Day and Christmas Day when he felt run down for five or six days he used to lay down most of the times
MP: I mean I'd come out of bed and feel sleepy soon after …

> An *Utterance extension* — "the feasibility that a sentence or sentence analog […] can be extended by a second speaker beyond the point at which the first speaker considered it complete necessitates discourse analysis of all utterances in tandem with the subsequent utterance(s) to determine if they are in fact complete at the first possible completion point or receive continuation by another" [Ferrara 1992: 217–218].

MP completes the semantic intent initiated by his wife in 'this second…he has been feeling in better spirit …he used to lay down most of the times' adding relevant information that completes the picture of that patient's health experience. 'The result is one sentence contributed by two interlocutors' (Ferrara 1992: 219). Similarly Norrick has shown that participants in storytelling may break into the conversation to offer corrections and comments (2000a:23). The use of co-narration in the example 3 illustrates how the story belongs to both the patient and his wife who can jointly put the story together.

In this study female companions looked after their mother, daughter, son or husband and their extensive participation is consistent with previous studies that indicate the role women tend to have in taking responsibility for family health (Chrisman 1977). It is estimated that around 70-90% of health care in western and non-western societies is practiced by females at home (Helman 1994: 65). This also correlates with the greater number of visits females pay to doctors annually in contrast to males (three times higher), making them more knowledgeable and familiar with the medical setting. A previous study shows that Chilean female patients for example, are much more 'competent' than males in the consultation since they tend to initiate more turns during the medical visit than their male counterparts, contest doctor's treatment and actively participate in the consultation (Cordella 2003, 2004).

	Health-related Storyteller	Social communicator
Patient-doctor	0.66 ± 1.07	0.25 ± 0.62
Patient-relative-doctor	0.91 ± 1.16	0.58 ± 0.99
Relative-doctor	0.41 ± 0.90	0.16 ± 0.57
Values are mean frequency per consultation ± standard deviation.	Sample size 12	

Table 2. Use of co-narration in the oncologist consulting room

The distribution of the preference for *Health-related storyteller* and *Social Communicator* indicate that *Health-related storytelling* is preferred in dyad or triad combinations. When we observe the triad and the dyad compositions we realise that triads (patient-relative-doctor) use *Health- related storyteller* and *Social communicator* more frequently. In addition, the dyads patient-doctor and relative-doctor differ in their frequencies of interaction, with the dyad patient-doctor interacting more frequently than relative-doctor.

6. Discussion

It is of interest to realise that the medical consultation, in spite of being carried out in an institutional setting which restricts the building up of relationships, limits consultation time and favours an asymmetrical interaction, could include storytelling as an integral part of the oncology medical visit.

The *voice* of *Health-related storyteller* and the *voice* of *Social Communicator* are interactional in nature as each participant involved in the event needs to contribute to the unfolding of the story. Doctors need to allow their patients to disclose their stories – which are a source of important information - by implementing linguistic strategies which favour the *Fellow Human voice*. Patients and relatives– as this study has demonstrated– also need to be willing to unveil their personal stories in the visit for such stories to be expressed.

While the *voice* of *Health-related storytelling* shows examples in which patients align to the medical script of the consultation and convey stories around their medical condition, the *voice* of *Social Communicator* provides rich personal story material that validates patients as people despite the fact that they are being treated for a medical condition. Patients in this 'voice' articulate a discourse about their self-identity, counteracting with the sick image stereotypically portrayed of patients. The formu-

lation and development of these stories represent a liberating act revealing the individual who is behind the disease.

The elaboration of both *Health-related storytelling* and *Social Communicator* reveals a consultation that considers personal stories as a fundamental component of the visit. As shown by Wolfson (1982) the display of storytelling is feasible when there is affinity with the interlocutor which may indicate that the oncologist's discourse favoured patients' unveiling and sharing.

In this process, the oncologist establishes a bio-medical and a socio-relational consultation where multiple skills come into play (i.e. medical knowledge and socio-cultural interpersonal knowledge). Had the doctor focused primarily on looking after the sick body he might have failed to attend to the socio-cultural expectations placed on the medical visit by patients. It has been widely reported that patients from western societies tend to favour a patient-oriented approach. Similarly, many medical curricula today place attention in teaching a patient-oriented approach as part of the communication skills taught for managing a 'successful' medical consultation.

As this study has shown, the vast majority of storytelling in the oncologist consulting room was co-narrated. Patients jointly constructed the storytelling during the visit with their partners or relatives contributing to each others' discourse.

One possible interpretation for this pattern is that people elaborate co-narratives as an account of and reflection on their daily experiences of living with cancer (i.e. patient) or living with someone who suffers from cancer (i.e. relatives or partners). Cancer, as this study indicates, does not only touch the life of the patient, but the lives of many carers, relatives and friends whose lives are, to variable degrees, altered by the responsibility they take on with a patient's care.

The stories developed in the visits to the oncologist may give us an insight into family commitment and women's roles in that event. Had patients' relatives (women in their majority) not initiated and/or helped in the development of the stories, the oncologist may have not had enough information about patients' condition and this may have given him an inaccurate picture of patients' management of the disease and general wellbeing.

The literature suggests that not uncommonly, personal stories displayed in informal social settings call for a joint-production of storytelling in an attempt to show affinity (Wolfson 1982) and establish or enhance intimacy (Georgakopoulou 1997: 4) between interlocutors. The appearance of joint- production storytelling/co-narration in the medical discourse then raises fundamental questions:

Why does storytelling emerge in the medical discourse? Are personal stories worth telling?

The use of storytelling in a medical consultation can be interpreted as a platform for the building up of trust between participants, because they display a discourse style most widely used in informal events where social bonds are established or confirmed. This relates to Carmichael's finding that the exchange of family-related topics in medical consultations is a sign of trust, 'exposing one's unprotected part in a family relationship is not submission but evidence of trust'

Transcription Symbols

Unit		
	Truncated syllable (middle and final)	-
Speakers		
	Speaker identity/turn start	:
	Speech overlap	[ ]
	Latching	=
Transitional continuity		
	Final	.
	Continuing	,
	Appeal	¿ and ?
	Exclamation	¡ and !
Tone		
	Fall	\
	Rise	/
Pause		
	Long	... (N)
	Medium	...
	Short	..
Vocal Noises		
	Inhalation	(H)
	Exhalation	(Hx)
Quality voice		
	Emphasis	CAPITAL LETTERS
	Laugh quality	<@@@>
Lenghtening		
	Vowel elongation	:
Transcribers' perspective		
	Researcher's comment	(( ))
	Uncertain hearing	<X X>
Speciliazed Notations		
	False start	< >
	Doctor's speech	D
	Patient's speech	P

The symbols of transcription used in this study correspond to Du Bois 1991. Adaptations made to accommodate Spanish data.

(1976:562). The building up of trust appeared to be *vital* in the oncological visit and this might have allowed all participants to form stronger bonds with each other. Such trust may help all individuals concerned going through the challenging journey that awaits them.

Conclusion

This study reports on the powerful information that is gained when participants disclose their personal stories to a cancer specialist during a check up consultation.

The use of the *Fellow Human voice* in the medical consultation facilitated and assisted in the telling of patients' stories which followed a medical and/or personal agenda. The development of storytelling was most frequently exhibited as a joint-production narrative where a family member accompanying the patient contributed to the story being developed.

Future studies should investigate a bigger sample size in a number of health care practices in Chile to investigate the array of strategies that could be used to assist patients sharing information at the visit which could transfer into better and targeted health practices.

In addition, as we are leaving in a global world in which human mobility is recurrent and the chances of meeting medical doctors and patients from a different language and ethnic group is highly possible, then there is a need to explore how diverse language and cultural groups use the *Fellow Human voice*, which linguistic strategies if any are employed to facilitate patients in disclosing their views in the consultation.

It would also be of interest to educate health providers as to the kind of linguistic behaviours that prompt particular communities to interact in a certain manner.

This approach to the medical visit will create a dynamic and self-reflective way of dealing with patients.

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