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INTRODUCTION

This dissertation research was made in the tideway of interactional linguistics involving the methodology of linguistically adapted conversation analysis. The **object** of research is the phenomenon of speech structure planning of conditionally spontaneous dialogs as part of a medical therapy planning talks. The **subject** of research is the language indicators of intentions of the participants in dialogic communication that are used to actualize and change consultation stages during direct verbal interaction with the patient.

The relevance of this study is determined by the fact that it was carried out within the theoretical context of modern interactional linguistics, prioritizing over the analysis of linguistic means taking into account the specifics of verbal interaction of those engaged in communication under certain, situation-dependent conditions. The relevance of the study is also conditioned by the novelty of the empirical data that became the object of identification, as well as interpretation of language markers that contribute to the implementation of different consultation strategies within narrowly specialized medical communication between a doctor and an oncological patient. Despite its importance in social, moral and ethical, as well as personal and psychological sense, consulting of oncology patients is still poorly studied both from the perspective of general thematic content, as well as from the viewpoint of the lexical and grammatical design of each consultation stage and the language means used to facilitate the transition between these stages. This work is interdisciplinary study and, in some degree, allows us to compensate the lack of humanitarian and verbal basis of interaction with the patient that has developed due to the widespread technologization, standardization, and commercialization of healthcare.

In addition, the demand for the study of dialogical verbal interaction between a doctor and a patient stems from the practical introduction of the principles of patient-centered medicine that belongs to "the cutting-edge approach to the management and assessment of medical care" [L'vova 2020: 35] and obliges the doctor to provide the patient with information on the disease in full and to discuss possible treatment options.

The presence of a universal competence in the general educational standard of higher education (e.g., in the "General Medicine" specialty), whereunder the future medical specialist "should be able to apply modern communication technology, including in foreign language(s) for academic and professional communications" [Order 2020: 9], also indicates the relevance of the issue under consideration.

The objective of the study is to identify the characteristic speech means used to actualize and change the consultation stages initiated by a doctor, as exemplified by institutional communication between a doctor and an oncological patient.

The objective we set implies solving the following **tasks** within the dissertation research:

— to develop an algorithm for describing the medical dialogic discourse;

— to reveal the features of the external structure of dialogs between a doctor and a patient;

— to show the possible options for identifying the internal arrangement of dialogs;

— to identify the components of dialogs' internal structure (stages of consultation);

— to identify lexical units and grammatical structures characteristic of each consultation stage initiated by a doctor, which contribute to actualizing and changing them;

— to conduct a comparative analysis of the most common lexical and grammatical means of different consultation stages;

— to identify the parameters that limit the spontaneity of reproducing dialogs in the context of institutional communication.

The scientific novelty of the study lies in the fact that it is the first work including reinterpretation of doctor and patient's dialogic interaction presented not in the form of absolutely spontaneous dialog (as in the case of regular social interactions) or, on the contrary, of a standardized consultation with the use of permanent stable speech structures (as in the case when a learned scheme of communicative strategic actions dictated by the principles of the social institution, serving as communication environment, is used), but as consistently emerging, fluid structural profiles, that, when verbalized, cause the symbiotic realization of an idea, the essence of which is, on the

one hand, in spontaneity (as in the case of routine communication), and, on the other hand, in planned character of communication actions (according to the requirements dictated by institutionalism principles).

The theoretical significance of this study lies in presenting a model for describing medical dialogic discourse based on theoretical principles of interactional linguistic approaches to the study of conventionally spontaneous colloquial speech in the context of institutional communication. The conducted research also clarifies the distinctive features of the content and structure of verbal doctor- patient interaction in the context of delivering bad news (= a cancer diagnosis), contributes to the theory of effective medical consultation with cancer patients and to the further development of the theory of verbal communication in the field of professional discourse.

The practical prospects for using the obtained research results are seen in the inclusion of its theoretical insights in the language theory and communicative linguistics program. Methodological description of interactional analysis of dialog parts, which presents one of the ways to use conversion analysis for linguistic purposes, can be useful for those language experts who are starting to work with spontaneous speech. The use of strategic doctor-patient interaction profiles developed within the framework of the present study is also practical for the development of special training courses, methodical guidelines, training programs and manuals dedicated to mastering the principles of professional communication in the healthcare field, as well as increasing communicative proficiency of medical students and practitioners during their work with cancer patients. We do not exclude the prospects for using this empirical material for the study of the German language by Russian medical students. We can consider successful the first experience of introducing transcripts of German-language therapy planning talks as additional material in the classes under the "Translator in the Field of Professional Communication (German Language)" program [Imo, Fedorovskaya, Sekacheva 2020].

The material of the study is 51 transcripts of audio records of therapy planning talks with oncological patients in German. The records last from 10 to 40 minutes (20 minutes on average) and are formatted in accordance with the *basic* transcription rules

of the GAT 2 (*Gesprächsanalytische Transkriptionssystem 2* [Selting et al. 2009: 369–377, 392]). The text includes 29,212 transcription lines, which corresponds to ≈ 644 printed pages (for more detailed information about the material, see “1.7 Characteristic of the Research Corpus”).

Research Methods. When working with empirical material in the dissertation research, we used both traditional general scientific methods (observation, logical comparison, and classification of language material; targeted automated and manual sampling) and linguistic methods (descriptive-analytical method, contextual analysis, and semantic analysis). The main method is linguistically adapted conversational (interactional) analysis with sequencing dialogs into interaction-significant units and their intentional pragmatic analysis facilitating the reconstruction of the development prospects for the verbal communication between a doctor and a patient within a specific dialog.

Works by Russian and foreign scientists in verbal communication in general, verbal medical discourse, and the use of conversational analysis in linguistic research served as **the theoretical basis** of this study.

Issues of dialogic colloquial speech and communication theory are covered in the studies by M.M Bakhtina (1986), E.A. Zemskaya (1979), V.B. Kashkin (2000, 2012), M.Yu. Konovalenko (2016), D.E. Krasnyanskiy (2009), M.L. Makarov (2003), L.V. Fadeevф (2009), K.A. Filippov (2016), L.V. Shcherba (1957), L.P. Yakubinskij (1923). The parameters of "verbality" using conversational analysis in Russian science are mainly studied by sociologists and psychologists. For our study, of interest are the researchs by O.G. Isupova (2002), M.A. Korbut (2015); A.V. Turchik (2010); A.M. Ulanovskiy (2016). In Russian linguistics, a large number of studies are devoted to the communicative features of the interaction between a doctor and a patient. The works by E.V. Akaeva (2007), M.I. Barsukova (2007), V.V. Zhura (2008), T.G. Karymshakova (2012); S.V. Majboroda (2021); N.Yu. Sidorova (2008) focus on studying the communicative and strategic characteristics of the doctor's and patient's speech and speech interaction techniques. The studies by S.A. Agadzhanyan (2016, 2018), S.B. Beleckij (2010), V.V. Zhura (2005, 2017), E.Yu. Vasilyeva (2018),

N.V. Goncharenko (2008), S.V. Majboroda (2018, 2020), M.S. Nevzorova (2015, 2017) deal with the doctor's discursive competencies, institutional communication models, suggestive characteristics of medical discourse, functional and stylistic along with functional and pragmatic aspects. The studies devoted to the theory of context by S.T. Nefedov and V.E. Cpernyavskaya are relevant for the analysis of dialog fragments [Nefedov, Chernyavskaya 2020; Chernyavskaya 2021a, 2021b].

In foreign linguistics, the communicative aspect of the interaction between a doctor and a patient is the subject of research on consultation structure Lalouschek 2002; Menz 2015]; the verbal behavior of doctors during consultations, and the role of conversational analysis in research on verbal medical discourse [Byrne, Long 1976; Gill, Roberts 2013; Flader, Koerfer 1983; Maynard, Heritage 2005; Meerwein 1986]; manifestation of the knowledge asymmetry of participants in their interaction [Ariss 2009; Szasz, Hollender 1956; ten Have 1991]; providing information on the disease by both a doctor and a patient [Anderson 1999; Boothe 1994; Deppermann 2003; Gill, Maynard 2006; Kampits 1996; Labov, Fanshel 1977; Lalouschek 2002]; presentation, perception, and discussion of the diagnosis [Heath 1992]; the course, specifics, and ways of making a joint decision on the treatment methods [Collins 2005; Gill, Pomerantz, Denvir 2010; Haakana 2001; Koerfer, Obliers, Köhle 2005; Spranz-Fogasy 1988]; training and advanced training of doctors [Koerfer et al. 2008; Nowak, Wimmer-Puchinger 1990; Spranz-Fogasy 1992], including in oncology [Beach et al. 2005; Coussios, Imo, Korte 2019; Lutfey, Maynard 1998; Maynard 2003; Roberts 1999]. This list mainly includes studies based on the analysis of authentic empirical material using the rules of conversation analysis and/or the interactional linguistics methodology. To acquire a deeper understanding of the extent of standardization of the speech behavior of specialists in the empirical material under study and its compliance with modern ethical requirements, we have considered the studies describing the general behavior rules, the optimal structure, and the content of therapy planning talks [Bub 1998; Kurtz 2002; Kurtz, Silvermann 1996; Kurtz, Silvermann, Draper 2004; Lloyd, Bor 2004; Silvermann, Kurz, Draper 2013].

The following theses are put forward for defense:

1) Verbal medical discourse within the communication between a doctor and a patient can be considered as a *macrodialog* (medical consultation / therapy planning talk), which means: 1) many dialogs of the same topic belonging to a specific medical profile; 2) a series of dialogs of one doctor with different patients or a series of dialogs with one patient.

2) In the context of this study, a medical consultation is defined as a *conventionally spontaneous dialog* between a doctor, a patient, and persons accompanying them, which main purpose is to report a diagnosis and to jointly develop a treatment plan. *Conventionality*, along with the actualization of clichéd phrases typical for communication in the "doctor-patient" system, results from the existence of linguistic, behavioral, and sociocultural prescriptions and reactions — on the one hand, and situational inequality, asymmetry of both knowledge and communicative roles — on the other hand. *Spontaneity* and the associated linguistic variability arise from the doctor's desire to personify their communication with the patient, to create an emotional and communicative contact. Thus, the interaction between a doctor and a patient combines the patient's natural spontaneous speech and the doctor's fictitious (partially thought out) speech.

3) When identifying language markers (frequent lexical units and grammatical structures) of doctor–patient therapy planning talks, using a linguistically adapted conversation analysis that allows for identification of the external and internal communicative structure of the dialog, assessing the nearest (local) and external extralinguistic contexts, revealing the relationship between the speaker's and the listener's utterances, finding out the causes of verbal reactions of the dialog participants, combining the (manual and automated) methods of continuous sampling and controlled selection of language units are advisable.

4) Analysis of the dialog *external structure* reveals each communicant's participation share in the dialog from a quantitative point of view, i.e., it helps identify the most (verbally) active participant. The external structure also allows for a conclusion on the communication emotionality/tension level. The *internal structure* of dialog allows for

revealing the communicative intentions of communication participants, identifying structural components (communicative blocks), and establishing language markers used to verbalize each component.

5) In verbal communication with oncological patients, the doctor has two main tasks: to report the diagnosis and to develop/agree upon a treatment plan. The difficulty is that the actualization of the second speech action requires the patient's calmness and verbal activity. This leads to the main feature of dialogs with patients: the presentation of information containing negative information is in almost all cases followed by a description of the positive aspects of the diagnosis. At the lexical level, this pattern is highlighted within the use of antonymic pairs (positive word/phrase vs. negative word/phrase); at the grammatical level, preference is given to structures that contain opposition.

Evaluation of the Research Results. The main results of this study were reported as presentations at scientific events. The main ones include: 30th International Scientific Conference for Undergraduate and Graduate Students and Young Scientists "Lomonosov-2023" (Moscow, April, 2023); International Conference of German Teachers (Vienna, August 2022); VIII International Scientific and Practical Conference "German Studies in the Modern Scientific Space" (Krasnodar, April, 2022); 29th International Scientific Conference for Undergraduate and Graduate Students and Young Scientists "Lomonosov-2022" (Moscow, April, 2022); Week of Medical Education (Moscow, April, 2022); Virtual Congress WCET — World Congress of Endourology and Urotechnology (Hamburg, October, 2021); "Autumn School" of Vladimir Admoni Program (Voronezh, September, 2021); Congress of the International League of Young Scientists as a part of the International Youth Scientific Forum "Lomonosov-2021" (Krasnovidovo, May 2021); VII International Scientific and Practical Conference "German Studies in the Modern Scientific Space" (Krasnodar, April 2021); 28th International Scientific Conference for Undergraduate and Graduate Students and Young Scientists "Lomonosov-2021" (Moscow, April 2021); International Scientific and Practical Conference "Personality and Society in the Modern Geopolitical

Space" (Volgograd, May, 2020); International Scientific Conference "Health and Well-Being in the Modern Society" (Grozny, April, 2020).

The main theses of this dissertation research were also presented at scientific events under the Vladimir Admoni Program *(Vladimir-Admoni-Programm)* entitled "Linguistics and Speech Studies" *(Sprach- und Sprechwissenschaft)* for graduate and doctoral students conducting research in German linguistics (Program implementation period: January 2020 — December 2022)[1]. The uniqueness of these events is evidenced by the fact that the Program participants (eight graduate students from I.M. Sechenov First Moscow State Medical University / Saint-Petersburg University (the author of this study represents both educational institutions), Voronezh State University, Kazan Federal University, and Far Eastern Federal University) presented the intermediate results of their research not only to scientific supervisors from Russia but also to experts in German linguistics from Martin Luther University Halle-Wittenberg (four representatives) and Hamburg University (one representative).

The main results of this research were presented in four publications that published in journals recommended by the Higher Attestation Commission of the Ministry of Education and Science of the Russian Federation. Two of these journals are also indexed in Web of Science (Q2).

Dissertation Structure. The Dissertation consists of an introduction, two chapters, a conclusion, and a list of references.

[1] For detailed information on the events, refer to the "Aktivitäten"section of the VAP website (http://vap.sprache-interaktion.de/).

CHAPTER 1. METHODOLOGY FOR ANALYSIS OF DOCTOR–PATIENT CONSULTATIONS. CHARACTERIZATION OF EMPIRICAL MATERIAL

1.1 Medical Discourse in Linguistic Research

The importance of medicine for society and the economy, the need for high-quality healthcare, the diversity of diseases, and the various settings in which medical practice occurs are all factors that have contributed to the vast scope of this research field, the diversity of approaches to medical discourse, and the wide range of definitions for this term.

Medical discourse may be characterized from the perspective of pragmatic and sociolinguistic research as "a collection of verbal and non-verbal structures with specific pragmatic features functioning in the medical environment for the objectives of treating and preventing diseases," having informative, cognitive, creative, communicative, and regulatory functions, and communicating social experience [Madzhaeva 2013: 43]. Health is one of the highest priorities for a full life, so the profession and personality of the doctor as a representative of a distinct social occupational group that safeguards the population's health are seen to have particular traits. Therefore, according to L.S. Beylinson, the fundamental components of medical discourse are as follows: 1) sacredness of a doctor's profession notable for its unique character of service; 2) presence of medical ethics and standards of conduct; 3) special vocabulary (terms, including casual and folk medical terms, as well as terminoids approaching the status of terms) distinguishing doctors as a distinct social group; 4) system of ritual signs (white coats, medical instruments, personal seals, etc.); 5) distinct types of communication for doctors (medical councils and commissions) [Beylinson 2001: 16]. According to the definition by V.B. Kurilenko et al., medical discourse is the result of medical professionals' culture, which is founded on the professional community's moral values and standards, as well as goals and objectives of social, cultural, and professional activities of its members [Kurilenko, Makarova, Loginova 2012: www].

S.V. Mayboroda classifies the primary fields of medical discourse research in current linguistics into two categories: 1) medical discourse research from the perspective of cognitive and communicative approach; 2) study of the specifics of medical discourse as institutional discourse. The author also observes that these methods do not conflict, but rather complement one another by focusing on certain parts of medical discourse and revealing the essence of this phenomenon [Mayboroda 2021: 14].

A system of concepts, speech, and thinking that combines specialized and general information acquired through professional medical practice is the emphasis of the cognitive and communicative approach to medical discourse [Alekseeva, Mishlanova 2002: 32–40; Bogatikova, Mishlanova, Filippova 2014: 216]. Verbalization of professional expertise occurs through professional medical terminology. Simultaneously, professional information becomes casual knowledge with the use of common vocabulary and figures of speech (particularly metaphors and comparisons) used to convey specific medical concepts [Dymova 2011; Zubkova 2008; Madzhaeva 2008, 2013]. In some communicative situations, professional knowledge is communicated through medical slang/jargon. The objective of professional slang/jargon is to save speaking efforts while interacting with persons from the same group, to facilitate communication, to speed information transfer, and identify the speaker as a member of a certain professional group [El'kin 2008: 78].

Approaching medical discourse as part of the social institute of medicine entails the existence of unequal and equal participants. The former implies the communication of medical personnel possessing professional knowledge and terminology with non-professionals; the later refers to communicants who have a nearly equivalent thesaurus [Mayboroda 2021: 15].

N.D. Golev and N.N. Shpil'naya distinguish between professional and casual medical discourse as types of communicative interaction [Golev, Shpil'naya 2012: 130]. Professional discourse also includes such genres as an academic conference, difficult case consultations, clinical records, medical history, sick leave documents, certificates, medical consultation, etc. [Barsukova 2007: 21]. Casual discourse is classified into discourse pertaining to the professional community and discourse between a doctor and

a non-professional (a patient, their representatives, family, friends, etc.). Examples of the former include medical stories (tales), jokes, songs, superstitions, sayings, proverbs. In the latter instance, we are talking about the communication with coworkers and patients in a natural environment [Golev, Shpil'naya 2012: 130–131]. Our paper focuses on oral medical discourse, which is defined by V.V. Zhura as a stable, pragmatically conditioned, verbalized form of cognitive and communicative activity that accompanies typical events (with a high degree of repeatability) in professional medicine [Zhura 2008: 90], that is in our case oral communication between a doctor and a patient during consultations.

According to O.V. Blinova's study of publications on the speech and interactional content of medical consultations, there are an "infinitely vast number" of research papers on this subject [Blinova 2016: 29]. For this reason, we will focus on identifying the essential linguistic and structural markers of oral medical discourse in the doctor–patient relationship. To single out the linguistic characteristics defining oral medical discourse between unequal participants, we analyzed scientific publications on verbal interactions between a doctor and a patient by Russian and foreign scientists using Russian, English, and German empirical material.

However, before discussing common linguistic markers, it is important to underline the similarity of communicative structures in consultative conversations between doctors and patients regardless of the language used (Russian, English and German). According to the research by T.A. Osipenko, V.O. Fedorovskaya, D.V. Enikeev, 1) the communicative structure of consultations is determined by its instrumental goals (i.e., therapeutic/practical/medical goals); 2) a certain collection of structural components (semantic/communicative blocks) is repeated in a specific order in practically every consultation; 3) all doctor–patient consultation scenarios include a greeting and farewell, establishing contact, gathering information about the disease and the patient's condition, examination accompanied by speech, recommendations, and therapy planning; 4) the scenario with the structural components described above can be adjusted in actual clinical practice; 5) Russian linguists tend to incorporate predicted patient replies and queries into the structural components of the consultation scenario,

whereas other models reflect simply communication acts initiated by doctor [Osipenko, Fedorovskaya, Enikeev 2022:105].

The following are the main characteristics of oral medical discourse concerning the verbal doctor–patient interaction identified following an analysis of the linguistic research based on the study of Russian-language oral conversations between doctors and patients [Akaeva 2007; Barsukova 2007; Goncharenko 2008; Zhura 2007, 2008] and directed associative experiments with the participation of Russian-language informants [Alekseeva 2002; Madzhaeva 2015].

1) The model of the doctor–patient interaction influences the choice of language means. However, it is not a determining factor in the doctor's verbal conduct. The investigation of the doctor–patient interlocutory verbal contact is critical owing to the implementation of *patient-centered medicine* in practice [L'vova 2020; Taratukhin 2016]. Despite global trends, most doctor–patient contact in Russia is in most cases traditionally paternalistic. According to O.A. Chebotareva, "paternalism is inherent in the national model of medicine" [Chebotareva 2006: 4]. Her sociological research shows that, as a rule, doctors do not engage in partner-like conversations with their patients. Furthermore, doctors frequently do not want to deal with knowledgeable patients. The doctor will typically hold the position of authority, and it is assumed that the patient must adhere carefully to the doctor's orders [Chebotareva 2006: 50–64]. However, according to M.I. Barsukova's study of the communicative strategies and tactics used in medical discourse, requests, advice, suggestions, etc. from doctors nearly always use numerous etiquette formulas to emphasize respect for the interlocutor. The doctor not only makes contact, but also maintains a polite relationship with the patient throughout the communication process. It is also highlighted that violations of speech etiquette might lead to communication barriers [Barsukova 2007: 117–120].

2) In oral medical discourse, medical terminology takes on a consistent emotional dimension, while the same vocabulary in written communication is perceived neutrally [Alekseeva, Mishlanova 2002: 148–155]. According to Madzhaeva's research, medical terminology that elicits strong feelings from respondents includes those semantic groups

that refer to illnesses, medical instruments, medications, and surgical procedures [Madzhaeva 2015: 96].

3) When communicating with patients, using metaphors is more than just a choice of words; it's a whole approach for explaining a situation in a way that a patient can understand. According to E.V. Akaeva, metaphors provide a more figurative and understandable manner to describe an illness and adapt information to the way a patient perceives it, for example, by taking into consideration the patient's occupation. Thus, when explaining the concepts of *glucose*, *insulin*, and *diabetes* to a road worker, the doctor may use the following descriptions: *Glucose* ***is a source of energy.*** *Insulin* ***is the transport*** *that delivers glucose to the cell. <…> Diabetes* ***is a very busy highway*** [Akaeva 2007: 116]. According to O.S. Zubkova, the use of metaphorization in communication with patients improves the perception of new information, makes treatment plans more effective, and is one of the prerequisites for "compact and effective professional communication based on a verbal projection of social and cultural experience" [Zubkova 2008: 134]. Furthermore, the use of medical metaphors has shown to "form a common emotional center of communicants, or their emotional alignment/coherence... " [Shahovskiy 2008: 479], stir up strong emotional reactions and the will to fight to such an extent that such metaphors are used not only in medical, but also in journalistic texts *(the plague of the twentieth century, the epidemic of violence, the pandemic of lobbyism)* [Balashova 2018: 12; Madzhaeva 2015: 102].

4) The emotiogenicity of oral medical communication is also a potential cause of communicative interferences and disruptions. V.V. Zhura's study, which sought to identify emotional topics, discursive emotions, and doctors' emotional responses to them, discusses four emotional topics in doctor–patient communication: previous examinations and therapy; issues related to living with a disease; personal life; and "sensitive" topics [Zhura 2007: 39].

Common emotional expressions include resentment, condemnation, disapproval, despair, fear, frustration, depression, discontent, shame, and embarrassment. These emotions can be expressed verbally as incoherent, brief, or uninformative responses, interjections, and explicates (typical of emotions related to sadness); elliptical

constructions, self-corrections, repetitions, numerous questions (typical of verbalization of fear, anxiety, concern); exclamatory, inverted, elliptical, interrogatory/challenging, prompting sentences, repetitions (typical of anger, resentment, condemnation) [Zhura 2007: 41–42].

Prosodic markers include slower speech, lengthier pauses, lower voice, intonational or prosodic focus on crucial information (expression of fear, grief); faster speech, logical emphasis on semantic components conveying emotions (expression of anger, condemnation, disapproval, irritation) [Zhura 2007: 43].

To soothe negative emotions, doctors use reasoning, offer empathy and encouragement, explain and communicate diagnostic and prognostic information, or disregard the patient's emotive declarations [Zhura 2007: 43].

5) Medical discourse uses suggestive persuasive techniques (Lat. *suggestio* ‘hints, suggestions’). Verbally, it is expressed through 1) (confident) intonation; 2) clichéd expressions, terms, and professional jargon; 3) discursive formulas of direct and indirect persuasion (order, advice, recommendation, instruction, prohibition) [Goncharenko 2008: 5]. The degree of the patient's suggestibility is determined by their disease, stress, fatigue, the doctor's social standing, the correspondence of the suggested information to the patient's needs and interests [Goncharenko 2008: 175].

The analysis of works based on English-language empirical material [Agadzhanyan 2017; Byrne, Long 1976; Collins et al. 2005; Đorđević, Braš, Brajković 2012; Elwy et al. 2012; Palmieri, Stern 2009; Veatch 1972], highlights a number of features of oral medical discourse within the context of a doctor–patient verbal communication in English.

1) According D. Roter, the doctor–patient communication in English has undergone significant transformations as the patient's capacities have expanded. The paternalistic/engineering model has been replaced by the deliberative/collegial model [Roter 1998]. The first model views the patient as a biological machine or an impersonal physiological mechanism. The doctor assumes the role of an impartial expert relying on facts (medical evidence). This model suggests an impersonal approach to the patient whose fears, wishes, and moral values are left aside. The doctor might

select the therapeutic strategies that appear to be the most beneficial to them without regard for the patient's opinion. The latter model is founded on the concepts of equality. The doctor acts as a colleague, friend, and partner, offering accurate information about the diagnosis, potential treatments, and consequences, while the patient makes the final decision. Such relationships are built on trust, respect, confidentiality, the desire to eliminate the disease, and the pursuit of mutual goals [Veatch 1972: 5–6].

2) The shift in the doctor–patient relationship paradigm (paternalistic → deliberative) has led to the activation of the "strategy of honesty and transparency towards patients" [Agadzhanyan 2017: 14]. The term *"informed consen"* means that the patient is fully aware of the situation of their health. This awareness increases the likelihood that the doctor's advice will be followed without being misconstrued or ignored [Palmieri, Stern 2009: 166]. Reliable health information also enables the patient to engage in *shared decision-making*. [Đorđević, Braš, Brajković 2012; Elwy et al. 2012].

This considerable shift in the substance of consultations has led to a change in the lexical and grammatical content of consultative conversations. Predicates expressing suggestions, recommendations, proposals, or advisable ideas are now displacing the once-dominant imperative grammatical forms. The lexical tools in this case include a large number of synonymous units for denoting the same notion, euphemisms, and figures of speech that allow the doctor to provide information in a way that the patient understands and perceives appropriately. In English, euphemisms are used to describe such semantic fields as "death," "cancer," "cancer treatment," "overweight," "intimate body parts," "urination," "defecation" [Biryuk 2020: 186–187]. S.A. Agadzhanyan's findings based on an examination of publications of communication specialists on figurative language in medical discourse show that tropes, particularly metaphors, are the most effective methods for conveying the meaning of medical terminology [Agadzhanyan 2017: 11–12]. At the same time, researchers believe that using slang to explain terms is extremely inappropriate in the context of medical consultations, not only for ethical reasons, but also because of the high likelihood of the patient misinterpreting certain slang expressions and the resulting negative consequences terminology [Agadzhanyan 2017: 13].

3) Despite the fact that the doctor–patient communicative space is becoming increasingly filled with euphemisms and figurative language, verbal interactions between doctors and patients in English are marked by aggression that, according to S.I. Filippchenkova, emerges at the stage of selecting a treatment plan. In most cases, the decision is taken in favor of operations such as cesarean section, aggressive testing, or preventive surgery. As a result of this tendency, vocabulary is being refreshed with expressive terms or even *aggressive language*; "the word ‘aggressive’ is often used in relation to screening, diagnosis, and treatment" [Filippchenkova 2011: 133]. Euphemisms can also have an aggressive role, such as when the doctor wants to scare the patient into taking their health more seriously [Agadzhanyan 2017: 15].

The examination of publications based on the analysis of oral conversations in German between doctors and patients in various situations [Beletskiy 2010; Sidorova 2008; Günthner 2017; Imo 2017; Petzold 2007], allowed us to pinpoint a number of aspects related to language markers.

1) Currently, doctor–patient communication in the German-speaking space is also undergoing changes and is trending towards a patient-centered model. Studies show that not all patients are willing to assume responsibility for decisions pertaining to their therapy. For this reason, doctors try to balance between the two extremes [Beletskiy 2010: 50–68; Klemperer 2003: 28–29; Koerfer et al.: 39–45].

2) To avoid an emotional "outburst" while discussing the unfavorable aspects of an illness, clinicians point to past consultations in which a preliminary diagnosis was addressed or the possibility of worsening was highlighted. History reconstruction (Ger. *Rekonstruktion der Vorgeschichte* [Günthner 2017: 5–14]) as a communicative approach helps the doctor to create the impression that an adverse diagnosis or progression of the illness has been known for a long time, so the information supplied is not unexpected or startling [Günthner 2017: 39].

3) The expressive function of the language of medical communication is manifested at various language levels: phonetic (prosodic tools); lexical (words with evaluative components, intensifying particles, and interjections); and grammatical (inversion, elliptical constructions) [Sidorova 2008: 141, 145]. There is also a tendency to begin a

sentence with the most important part. According to N.Yu. Sidorova, "the relative unpreparedness of colloquial medical speech causes doctors to position words associatively by adding them freely to a statement as necessary" [Sidorova 2008: 109].

4) One of the key objectives of the doctor is to offer verbal comfort. Since practically every major sickness results in new (often unfavorable) living conditions for the patient, the diagnosis takes on a personal importance and causes emotional expression, including crying. In German, there are two types of consolation: *ein spontanes Trösten* 'spontaneous consolation' and *Trostarbeit* 'premeditated consolation' [Imo 2017b; Petzold 2007]. Spontaneous consolation is one that occurs during a consultation and can rarely be anticipated by a doctor, since it is initiated and sometimes deliberately provoked by a patient. Doctors in this situation could verbally demonstrate their empathy for the patient or offer a method for coping with emotions (e.g., controlled slow breathing). Premeditated consolation is one that the doctor can anticipate and plan ahead for. Examples of this kind of consolation include argumentation, such as the presentation of both the disease's positive and negative characteristics, discussion of the length of therapy, potential side effects, and the chances of recovery [Imo 2017b: 39].

The analysis of linguistic works by Russian and foreign scientists studying oral conversations in Russian, English, and German to determine the structural and linguistic markers of doctor–patient verbal communication reveals that the traits inherent, for example, in the English-speaking "world of medicine" can manifest themselves in another language in some situations. As a result, the following may be concluded:

1) The communicative structure of oral medical discourse in the doctor–patient dyad is determined by its instrumental goals. A variety of structural components is used in practically every consultation. Although structural components have quite a stable position in the conversation structure, their sequence may vary in actual conversations.

2) Regardless of the relationship model (paternalistic or deliberative), verbal interactions between doctors and patients are most often based on respect, trust, and support. The model of the doctor–patient interaction influences the choice of language means, but is not a determining factor.

3) Medical terminology, which, as a rule, is functional and stylistically neutral often takes on emotional connotations when verbalized in a conversation with the patient.

4) The use of medical metaphors and other figures of speech increases the explanatory power of the utterance. Experienced doctors use figures of speech to provide an explanation by using patient-friendly vocabulary that takes into account their personal and professional interests.

5) Communication between a doctor and a patient is frequently accompanied by unpleasant emotions (such as despair, fear, frustration, depression, etc.).

6) The emotional aspect of doctor–patient communications is influenced by the external context and emerges at the non-verbal, paraverbal (prosodic), and verbal (lexical, syntactic) levels. Negative themes include prior examinations, concerns associated to living with a condition, personal life, and sensitive topics. Emotions are often triggered by the vocabulary associated with the name of diseases and surgical procedures, medical instruments, medications, etc.

7) The emotiogenicity of verbal interactions is also a potential cause of communicative interferences and disruptions.

8) One of the primary techniques of soothing emotions when talking to a patient is consolation (at the verbal level, for example, through reasoning). Another effective verbal means of avoiding emotional "outbursts" is reconstruction (i.e. repeating of previously reported (e.g., in earlier consultations) unpleasant qualities of the disease.

9) Oral medical discourse has a high degree of suggestibility. In a trustworthy relationship, a doctor is able to suggest attitudes that will eventually lead to the patient's recovery.

1.2 Application of the Conversational Analysis in the Study of Oral Communication

Not linguists, but health workers themselves initially showed interest in the study of colloquial speech in the field of medicine, using the method of conversational analysis. In the latter half of the 1970s, medics got preoccupied with the issue of patients' verbal

behaviour, since the correct interpretation of a patient's speech makes it possible to assess the patient's adherence to treatment, negotiate any objections on his part, prevent conflicts and establish long-term rapport [Byrne, Long 1976; Gill, Roberts 2013]. Linguists commenced to study the oral medical discourse by the method of conversational analysis around the end of the 1970s [Fox et al. 2013]. As we believe, experts from different fields almost simultaneously showed interest in oral communication between a doctor and a patient primarily due to the globalization of the healthcare labour market and the necessity to enhance the services rendered in an increasingly competitive environment, including through effective verbal interaction between medical workers and patients. Mutual understanding, when a doctor clearly and explicitly explains the diagnosis and treatment methods, and the patient understands the current health situation, is essential for both parties. Currently, as part of advanced training, healthcare professionals are offered a variety of courses that enable them to perfect their verbal communication skills in order to establish effective initial contact with the patient, improve information gathering skills through open questions and active listening, clarify a patient's needs, explain risks, establish rapport, etc. [cf. the "Communication with Patients" doctors' training and the "Psychology of Healthcare Workers' Effective Communication" advanced training course]. This approach to verbal interaction with patients makes it possible not only to provide quality care based on personalized approach to a patient, but also ensures that a healthcare facility will further have demand for its services.

Today's attention to the study of colloquial speech in medicine is stimulated by extra opportunities and outcomes of multidisciplinary endeavours that combine the humanities and various medical areas. This multidisciplinary interaction is exemplified by the *Medical Humanities: Doctor as a Humanist* international interuniversity educational project which illustrates successful application of scientific and practical knowledge of the humanities and social sciences in medical education [Markovina, Fedorovskaya 2018; Wald, McFarland, Markovina 2019].

Successfully developed effective methods for colloquial speech analysis became a significant factor in raising attention to the studies of dialogical speech in medicine,

namely in the doctor–patient interaction. Conversational analysis is one of the methods enabling to determine the structural pattern of a consultative conversation, assess the communicants' contributions to the conversation progress and ascertain the speech characteristics of each of them through the prism of context and interaction details.

1.3 Conversational Analysis. Basic Terms, Goals and Explanatory Power

The intention to study oral communication in various professional spheres, i.e. jargons/technical language (Ger. *Fachsprachen*), has resulted in the need for multidisciplinary research taking into account the achievements of other humanities, primarily sociology, psychology, knowledge engineering, anthropology. For the analysis of oral speech within the interactive communication model, in which meanings appear and transform during the direct interaction of the process participants, it is relevant to use linguistically adapted conversational analysis. The traditional function of conversational analysis, which is more relevant for sociologists, is to *describe social practices and expectations* in order to explain the origin of intersubjective action [Isupova 2002: 36]. Applying conversational analysis for linguistic purposes makes it possible to identify and assess the *linguistic means* that influence the implementation of an action.

When reviewing the scientific Russian-language literature, it was revealed that Russian linguistics quite rarely applies conversational analysis to assess oral speech in medical discourse. Oftentimes, expert sociologists and psychologists use this type of analysis when studying the parameters of everyday or scientific communication orality [Isupova 2002; Kolyadov 2020; Korbut 2015; Turchik 2010; Ulanovskiy 2016].

Within the conversational analysis, grammatical structures are considered in a sequential (consistently developing) context (Ger. *sequentieller Kontext*). There is a continuous question why a word, sentence, (linguistic) action, etc. is actualized exactly in this position (*Why that now?* [Sacks, Schegloff 1973: 299], Ger. *Warum wird etwas an genau der Stelle geäußert, an der es geäußert wird?* [Imo, Lanwer 2019: 59]), how it correlates with previous expressions and what interactive effect it has on subsequent

statements and wordings. According to W. Imo and J.Ph. Lanwer, the observation of the sequence of reproduction of language structures is due to the fact that each new linguistic expression bases on the previous one while also projecting the nearest (linguistic) action [Imo, Lanwer 2019: 59]. This explains why oral speech has a great number of *adjacency pairs* (in other terms, Russ. *ad"yacentnye / sosedstvuyushchie pary* ‘adjacent / adjoining pairs’ [Isupova 2002: 41], Russ. *primykayushchie pary* ‘attached pairs’ [Kolyadov 2020: 14], Russ. *smezhnye pary* ‘contiguous pairs’ [Korbut 2015: 135, Ulanovskiy 2016: 230], Ger. *kollaborative Sequenzen* [Imo, Lanwer 2019: 59], Ger. *Nachbarschaftspaar/ Paarsequenzen* [Imo 2019, Lanwer: 177]), such as greeting — farewell, question — answer, offer — consent/refusal, information — confirmation (the so called Ger. *Minisequenzen* ‘small sequences’), traditional speech formulas of the folk tale beginnings and endings (Ger. *Großsequenzen* ‘large sequences’) [Imo, Lanwer 2019: 35].

Any *talk-in-interaction*, despite its verbality and seemingly spontaneity, is strictly arranged. There may be all sorts of "random" sequences/arrangements in it, without which the conversation cannot proceed orderly. E.A. Schegloff, one of the originators of conversational analysis, writes that identification of occurrence patterns for these sequences in a conversation makes it possible to solve

— *the "turn-taking" problem*, that is, the reversal of communicative roles: who will speak next and when? how this will affect the communication structure and understanding of what has been said;

— *the "action-formation" problem*: how the recipient recognizes particular actions, for instance, regret, joy, consent, refusal, invitation, request, etc. by using the resources of language, body and ambience;

— *the "sequence-organizational" problem*: how each *turn constructional unit* (*TCU*[2]) appears in order to become "coherent" with one or more previous turn constructional units;

[2] *TCU* has numerous translation options into Russian such as *dialogovaya edinica* ‘dialog unit’ [Dobrushina 2000: 136], *konstrukcionnaya edinica repliki* ‘communicative unit of the utterance’

— *the "trouble" problem*: how to overcome the difficulties of speaking, information perceiving (listening) or comprehension so that the conversation does not "freeze up," does not break off at the moment of difficulties, but naturally moves towards its logical conclusion;

— *the word-selection problem*: how words have been selected as lexical and grammatical units that "move" the conversation forward; how this selection informs the speaker that the interlocutor comprehends what has been told;

— *the overall structural organization problem*: how the overall composition of verbal interaction is structured; what these structures are, how their position in the overall dialogue structure signalises that there are turn-constructional units that affect the communication of a word to the interlocutor, the selection of the subsequent word, the formation of an action, etc. [Schegloff 2007: xiv].

The dialogue must be correctly divided into sequences for the purpose of oral speech analysis [Auer 2010; Imo, Lanwer 2019: 171–189; Ploder, Mcelvenny 2022; Schegloff 2007]. Sequence, from Latin *sequentia*, means ‘coherence, orderliness’. In linguistics, this term refers to several meaningfully and organizationally related cues. E.A. Schegloff distinguishes *sequential organisation* and *sequence organisation/ organisation of sequences*. The first term is more general and concerns any kind of organizations that affect the positioning of utterances, actions and communicants relative to each other. Thus, prior to acceptance of a dinner invitation, it is highly likely that the invitation itself follows; a farewell is preceded by a greeting; an accusation is followed by an acquittal or admission of guilt.

The second concept, sequence organization, is used to indicate the sequential (consistent, step-by-step) construction of actions using linguistic means and is one of the types of sequential organization. The sequence of verbal actions is activated through the development of the intentional conversation structure (*turns-at-talk*). For instance,

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[Grenobl' 2008: 26], *ochered'-konstituiruyushchaya edinica* ‘"queue"-constituting unit’ [Turchik 2010: 45], *potencial'no zavershennoe vyskazyvanie* ‘potentially completed utterance’ [Kolyadov 2020:14].

one may ask what the organization of sequences looks like when expressing a reproach or compliment, listening to a complaint, scheduling a job interview [Imo, Lanwer 2019: 171–174; Schegloff 2007: 1–3][3].

Based on numerous practicing doctors', psychologists', psychotherapists', anthropologists', ethnomethodologists' and linguists' papers performed by *medical conversation analysis*, sociologist V.T. Gill, in collaboration with linguistic expert F. Roberts, identified three priority research areas in oral medical communication [Gill, Roberts 2013: 574].

The first area includes the interaction between a doctor and a patient (his representatives or accompanying persons) being at an outpatient appointment during the initial examination and repeated follow-up consultations. The second area is related to the study of the interaction between patients and nursing or managerial staff. This interaction can take place not only within the walls of a healthcare facility, but also outside, for instance, while making an appointment with a specialist by phone. The third area represents the interaction between healthcare workers (doctors, nurses, aidmen, medical registrars, etc.) [Gill, Roberts 2013: 578–580].

This distinction is also essential for the general theoretical context of this dissertation, since it emphasizes the difference between individual communicative practices of language use within the general medical discourse. For our research, the first of these areas, studying the interaction between doctors, patients and their accompanying persons, is relevant. A doctor's communicative actions almost always correspond to his direct therapeutic procedures (see L.S. Beylinson for similarities and differences between medical and therapeutic discourses [Beylinson 2001: 17]), therefore, the study of research papers addressing the verbal organization of patient admission and examination (published by healthcare professionals and various humanitarian specialists) is of great applied relevance for conversational analysis.

[3]More details about the sequencing, segmentation parameters and sequence organization of colloquial speech see [Auer 2010; Imo, Lanwer 2019: 171–189; Stivers 2013].

1.4 Main Characteristics of Oral Dialogical Speech

In the Russian linguistics, the issues concerning oral speech have been studied by prominent linguists such as M.M. Bakhtin E.A. Zemskaya (1979), M.L. Makarov (2003), L.V. Fadeeva (2009), K.A. Filippov (2016), L.V. Shcherba (1957), L.P. Yakubinskij (1923). In their research, linguists paid special attention to the dialogic form of communication.

M.M. Bakhtin was the author of the idea of *dialogic relations,* which he presented in his scientific work *The Problem of Speech Genres* created in 1952–1953. He defined the dialogism of relations as "a special type of semantic relations members of which can only be whole statements <…>, behind which real or potential speech subjects (the authors of these statements) stand and in which they express themselves" [Bakhtin 1986: 495]. M.M. Bakhtin noted how wide are boundaries of dialogic relations and also that they do not coincide with the replicas of a given dialog: "Two statements separated from each other both in time and space knowing nothing about each other, upon their semantic comparison, reveal dialogic relations, provided that there is any semantic convergence between them (at least partially common topic, point of view, etc.)" [Bakhtin 1986: 496]. Many European researchers have recognized the influence of Bakhtin's work on the development of European linguistic ideas in dialog theory and analysis.

For the purpose of this study, it is essential to differentiate the concepts of oral and colloquial speech. E.A. Zemskaya noted that oral speech not always can be classified as colloquial one. Thus, the entire domain of mass communication (radio, television) and of public oratory uses a codified language [Zemskaya 1979: 9]. This clarification is valuable in that there are two forms of oral speech in a doctor's office: the doctor's normalized speech going through many "filters" and the patient's speech which is less framed by institutional rules.

Colloquial speech is characterized by its oral form, unpreparedness, and informality which ensures ease of communication, direct involvement of speakers in the act of

communication, and "strong anchorage to the extralinguistic situation, which results in the fact that extralinguistic situation becomes an integral part of the act of communication, being 'fused' into speech" [Zemskaya 1979: 11]. Such a list of distinctive features should have suggested the idea of an absolute spontaneity of colloquial speech. However, there are some peculiarities in this field. L.V. Shcherba stated that there is "a huge range of ready-made patterns, ready-made phrases, and even ready-made ideas" and he calls it natural, since "in the process of everyday communication, one does not have enough time for special language creation, so one uses ready-made phrases in the vast majority of cases" [Shcherba 1957: 131]. In the studies by L.P. Yakubinskij, we can also find ideas about stereotyped, "fossilized" colloquial speech associated with a certain standardization of everyday life [Yakubinskij 1923: 174–175].

The pattern-based nature of colloquial speech allows its analysis. The prospects for and effectiveness of the practical application of the results of linguistic studies of oral speech is proved by the "experimental method" in syntax, lexicography and stylistics, the importance of which was emphasized for the first time in the Russian linguistics by L.V. Shcherba almost 50 years ago [Shcherba 1974: 32]. The need to verify the conclusions of linguistic research based on transcripts of oral texts remains an urgent task for linguists today [Fadeeva 2009: 314].

Another important feature of oral dialogic speech is its proximity to real life and, therefore, the possibility of practical application of research results. In the section "Some Results of the Experimental Dialog Analysis," K.A. Filippov showed that "the speech behavior of speakers in an experimental situation has many similarities with the speakers' behavior in a natural situation of communication;" he gave recommendations that are advisable to follow when conducting classes to develop the skills of oral foreign language speech [Filippov 2016: 184]. Therefore, the results of linguistic research carried out on the empirical basis of foreign (including institutional) colloquial speech are of special practical significance since, after reinterpretation, they can be used as a basis for a dialog-based method of teaching a language.

The extensive appearance in the German humanitarian space of oral speech studies (Ger. *Gesprochene-Sprache-Forschungen*) aimed at the analysis of spontaneous speech dates back to the 1960–70s. These studies were devoted to the development history of the spoken German [Weithase 1961]; forms, typologies, and boundaries of spontaneous speech [Moser 1960, Steger 1967, Zimmermann 1965]; describing and comparing the syntax of written and spoken German language [Höhne-Leska 1975, Rupp 1965], as well as comparing dialect and colloquial speech [Engel 1962]. In general, the linguistic analysis of spontaneous colloquial speech was aimed, at the first stage, at identifying the extralinguistically predetermined peculiarity of these two basic forms of communication and the linguistic variability of the lexical, grammatical, stylistic, and phonetic means used therein.

On the further research horizon, the central socio-communicative differences between the written and oral speech forms (Ger. *Schriftlichkeit* and *Mündlichkeit*) were generalized in the German linguistics in the figurative concepts of Ger. *Sprache der kommunikativen Nähe* ‘language of communicative closeness’ and *Sprache der kommunikativen Distanz* ‘language of communicative distance’ with highlighting their essential differences (in the H. Henne and H. Rehbock's terminology — Ger. *Nah- und Fernkommunikation* [Henne, Rehbock 2001]). The "closeness language" (*conceptually oral speech*), according to P. Koch and W. Oesterreicher, implies the private communication, a familiar interlocutor, a high level of emotionality, spatial and temporal closeness (*face-to-face*), situational and activity involvement, interactivity, dialogism, free change of communicative roles, spontaneity, and thematic unlimitedness. The "distance language" (*conceptually written speech*) implies publicity, an unfamiliar audience, a weak emotional involvement, spatial and temporal remoteness, situational and activity non-representation, minimal manifestation of interactivity, monologism, preparedness, the possibility of reflection, and the presence of a fixed topic [Koch, Oesterreicher 2008: 201]. The conceptually oral and written speeches are the polar points of a continuum where communicative forms develop, which have varying degrees the properties of both oral and written speech. Given the fact that proximity to one of these poles depends on a number of various parameters,

this continuum is not linear, but multidimensional (Ger. *mehrdimensionaler Raum*) [Koch, Oesterreicher 1985: 21].

One of the basic concepts of conceptually oral speech is that of *dialogism*, which is essential for this study (this term has already been mentioned in the interpretation of the domestic scientist M.M. Bakhtin [Bakhtin 1986]). Unlike the concept of *dialog*, defined by foreign linguists as a "product" of the interactive use of language (e.g., telephone conversation or exchange of messages in messengers [Imo, Lanwer 2019: 36]), dialogism means the fundamental understanding of language in terms of the actual or possible potential of its dialogic effect (Ger. *dialogische Wirkung*) [Imo 2016a: 338]. We are talking about the analysis of statements and individual phrases combined as *backwards links* with previous situations and previous contributions to the discourse development, as well as possible future speech actions and situations. These are not separate speech steps verbalized by the speaker as contextless and autonomous replicas, but "inter-acts", *retrospective and prospective aspects*/*responsive and projective properties* [Linell 2009: 296]. Speech constructions originate in conversational practices that are characterized by routinization, conventionality and, sometimes, even ritualization of their lexical and grammatical content [Linell 2009: 302]. Such an approach, according to W. Imo and J.Ph. Lanwer, brings together the concepts of dialogism (Ger. *Dialogizität*) and interactivity (Ger. *Interaktionalität*) [Imo, Lanwer 2019: 37].

The idea of similarity of the concepts of dialogism and interactivity in the context of oral verbal interaction between a doctor and a cancer patient becomes more justified after considering communicative and pragmatic categories by H. Henne and H. Rehbock, intended to specify the "type of conversation" (Ger. *Gesprächstyp*) involving certain social practices. Based on these categories [Henne, Rehbock 2001: 26–32], it can be said that, in terms of the oral speech type, consultative conversation between a doctor and a patient is a combination of natural spontaneous (patient's) colloquial speech and fictitious, intended for specific purposes (doctor's) colloquial speech (Ger. *I Gesprächsgattung*). Spatial and temporal relations are characterized by coincidence in time and closeness in space (Ger. *II Raum-Zeit-Verhältnis: situationeller*

Kontext). The number of communication partners can vary from two (interpersonal conversation: doctor and patient) to a number depending on the number of representatives from the doctor and the patient (group conversation in a small group) (Ger. *III Konstellation der Gesprächspartner*). In terms of formality, it can be semi-official, when interested persons are allowed to take part in the conversation as listeners, or official (Ger. *IV Grad der Öffentlichkeit*). We can see an asymmetry of social relationships due to the difference in professional knowledge (Ger. *V soziales Verhältnis der Gesprächspartner*), and the predominance of directive types of conversational acts of an instructive nature (Ger. *VI Handlungsdimensionen des Gesprächs*). The doctor and the patient usually do not know each other or know each other superficially in case of repeated consultations (Ger. *VII Bekanntheitsgrad*). The preparedness of communicants varies from "not prepared" or "prepared in the usual way" (patient and accompanying persons) to "specially prepared" (medical staff) (Ger. *VIII Grad der Vorbereitetheit*). The consultation topic is usually fixed, but it is fully known only to the doctor (Ger. *IX Themafixiertheit des Gesprächs*). Such a combination of characteristics gives grounds to agree with the idea by W. Imo and J.Ph. Lanwer that the concepts of dialogism and interactivity are synonymous within this type of oral verbal communication [Imo, Lanwer 2019: 37].

1.5 Special Aspects of Doctor-Patient Dialogues

Dialogues analyzed as part of this research are engendered and developed in the conditions of the *institutional professional medical background*. Institutionality implies the communication over an extended social distance (using V.I. Karasik's terminology, it is called superstandard communication). This type of verbal interaction takes place if the communicants are not acquainted, where the status indication is violated, or where the "circumstances of communication dictate a cliché/stereotyped form of utterance exchange, form of starting, continuing and ending the communication" [Karasik 1991: 300]. Verbal interaction between a doctor and a patient is a meeting, sometimes even a confrontation, of two communication types: regulated/partially prepared one and

spontaneous one. When communicating with the patient, the doctor acts in accordance with the rules that are in effect (publicly or privately) within a medical facility. The patient uses mainly instinctive clichés of language behavior mostly borrowed from day-to-day communicative situations.

The process of institutionalization unavoidably puts restrictions on the communicants in terms of formulating their thoughts verbally. One can distinguish a number of obstacles that prevent spontaneous doctor-patient communication. According to our reckoning, they can include a strict schedule of language behavior, a degree of a patient-specific/personalized nature of communication, asymmetry of knowledge and social roles, adherence to a certain model of relationship.

1.5.1 The Strict Schedule of the Language Behavior

The process of institutionalization is based on sedimentation, which means that theoretical and practical knowledge that is obtained during daily living activities retains in a person's conscience and is transferred to other generations via the language. As a result, stable behavior and language habits are formed, and processes are standardized at the level of consciousness. The behavior of the communication partner becomes expected. Due to that, psychological distress is relieved and replaced by a feeling of stability and security [Knoblauch 1995: 25–26]. This means that the doctor and the patient can roughly imagine the sequence of their (verbal) actions. With that, the strict schedule of the doctor's (language) behavior is preconditioned not only by *unspoken rules* that can vary depending on a cultural background of the interacting persons and on the status of a medical institution, but also by the presence of written regulations that are embodied in the code of the doctor's professional ethics. Besides, the rules for conducting consultations are written in the articles, practical guidelines for communication with (cancer) patients, as well as in textbooks for students of medical institutions and practicing doctors who undergo courses of advanced training [Baile et al. 2014; Coussios, Imo, Korte 2019; Gilligan et al. 2017; Kurz 2002; Kurz, Silverman 1996; Kurz, Silvermann, Draper 2004].

The existence of such works and high status thereof prove not only the tendency of medical professionals to master communication skills in a more focused and deliberate way. This also implies that there are rigid communication restrictions and, consequentially, that absolute spontaneity mostly intrinsic to everyday dialogues in a casual atmosphere is impossible. At the same time, the content of these works is indicative of the urge to *make communication more patient-specific*, to get close to the patient. This is shown by a patient-centered approach that is gaining popularity and implementing the idea of active involvement of the patient in the treatment process [Taratukhin 2016; Davis, Schoenbaum, Audet 2005; Olesen 2004]. Therefore, when characterizing the verbal behavior of the doctor and the patient, it is appropriate to mention a conditional spontaneity.

Conditionally spontaneous communication is a communication between unequal subjects, one of whom has special knowledge and patterns of language behavior in a linearly unfolding communicative situation (doctor), and the second (patient) acts according to the general rules of communication learned in the process of socialization. The possibility of spontaneity is ensured by the doctor's desire to make communication more personal, find a patient-specific approach in accordance with the psychological and emotional state of the patient. The conditionality arises due to the institutional rules that are in force.

A specific feature of the doctor-patient verbal interaction is in a stricter adherence of the consulting doctor to prescribed standards. It is important for the patient to know that the same disease manifests differently for each person, and even a serious diagnosis is not always a death sentence. Nevertheless, even after announcing a diagnosis (especially cancer), patients often "experience a whole series of psychogenic reactions in which hope and despair change one another, giving rise to depression, apathy, anxiety, euphoria taking turns" [Gnezdilov 2001]. Due to this, when communicating with patients, even seemingly non-significant verbal manifestations can be important. For example, prolonged pauses when describing the characteristics of the disease may make the patient think that the doctor wants to hide something from him.

1.5.2 Patient-Specific Nature of Communication

Patient-specific (personalized) communication creates space for manifesting spontaneity. It gives the patient an opportunity to feel more confident, not to be afraid of asking questions, bringing into the dialogue extra information about his/her personal life into the medical diagnostics.

In the collection of the studied doctor-patient dialogues, patient-specific communication is manifested at the lexical and grammatical level. For example, the abundance of clauses of reason, conditional clauses, and structures with conjunctive mood II at the stages of clarifying the diagnosis, justifying and recommending the therapy proves that the doctor seeks to provide the patient with the necessary information. The patient-specific nature of communication lies in the fact that the doctor is not limited only by the standard announcement of the diagnosis but specifies and clarifies it, voicing the cause-and-effect relationships between the diagnosis, the proposed therapy and possible side effects.

To make communication more personalized, one can use such expressions as *(immer) unterschiedlich* '(always) differently,' *(nicht) genau sagen können* '(not) to be able to say more exactly / not to know say for sure,' *(nicht) genau wissen* 'not to know exactly,' *höchstwahrscheinlich* 'most likely,' *vielleicht* 'possibly,' *wahrscheinlich* 'probably.' By means of an epistemic modality, the doctor can reduce and increase the degree of finality of his/her statements, demonstrate different degrees of confidence, gently indicate the severity of the disease and at the same time give hope for recovery (cf. Russ. *dopushchenie al'ternativnyh tochek zreniya* 'allowing for alternative viewpoints' [Nefedov 2017: 604]; *uncertainty of diagnosis* [Peräkylä 2006: 228–229]). Timely selected statements with the modality of (un)certainty ensure a stable psychological and emotional state of the patient.

Conversational particles *ja?/okay?* and open-ended questions like *Haben Sie (noch) Fragen?* 'Do you have (more) questions?' serve as means of "contact test" (Ger. *Vergewisserungssignal* [Imo 2013: 191; Weinrich 2005: 833], Ger. *Rückversicherungssignal* [Duden 2009: 595]). The patient-specific nature is

manifested by the fact that by means of such verbal actions, the doctor monitors if the patient understands the information provided, checks if he/she is involved in the dialogue, openly turns the floor over to him/her (passes the communicative initiative), demonstrates his attention, builds trusting relationships.

Questions about hobbies, family, future plans make it possible for the doctor to distract the patient from the unpleasant diagnosis, to remind him/her that life goes on, though it will be necessary to slightly change the conventional schedule. The patient-specific nature in this case is in the desire of the doctor to empathize, support and encourage the patient.

Using a personal pronoun *wir* ‘we’ in an inclusive way functions as support and distribution of responsibility. For example, in the sentence *Deshalb müssen **wir** jetzt in drei Monaten auch nochmal eine Rektoskopie machen* ‘That is why we now have to do a rectoscopy again in three months’ the pronoun *wir* indicates both the patient and the medical staff. The doctor implicitly gives the patient an instruction to come for an extra examination in three months. The division of responsibility areas occurs (the patient must comply with the doctor's orders, and the medical staff must monitor the procedures), and it is emphasized that only together, teamwise, one can cope with the disease (cf. [Mostovaia, Fedorovskaya, Imo 2023]). Here the patient-specific nature is revealed in the form of a growing bond with the patient due to the following message implied in the pronoun *wir*: "You are not alone, we (health workers) are close".

1.5.3 Asymmetry of Knowledge and Social Roles

The presence of a large number of private and public rules of behavior and the tendency to standardize speech actions lead to status marking of situations and increase the degree of formality of relations. Psychologist N.I. Kozlov writes about formality that "this is formal, public, in written form, <…> this is about the letter and not about the spirit, <…> about the dead and not about the living." The formal relations themselves he defines as "relations that strictly and automatically follow from the formally established rules and regulations" [Kozlov 2016: www].

Formality can increase as a consequence of situational and social inequality of the communicants. *The situational inequality* of the doctor and the patient begins when the patient acknowledges his/her physical and/or psychological ailment and is ready to seek help from a competent person. When deciding to consult a professional, the patient privately recognizes a contextually conditioned superiority of the doctor [Izutkin 2012; Kozlov 2010]. *The social inequality* in the doctor-patient relations is worth considering, in our opinion, in terms of specific knowledge that doctors have. With that, inequality can increase when the doctor obtains an academic degree and title. This conclusion has been formed during the analysis of a simultaneously examined collection of Russian-language dialogues with cancer patients who explicitly expressed their gratitude, joy, and even some kind of delight due to the fact that "they managed to consult a specialist of *such* a level" (see also [Osipenko, Fedorovskaya, Enikeev 2022]). In a German-language corpus analyzed in this paper, patients took no interest in the position of their attending doctor and did not express admiration or any other opinion about his/her status.

Situational and social inequality are among the components of *communication asymmetry*. The asymmetry is already included in the interactional model of communication itself. Since the generation of meanings and their interpretation differ, as M.L. Makarov notes, "both in the ways of performing these operations and in the types of forms of cognition, perception and even affect involved in them," it can be difficult to transfer identical meanings. It is more common to face situations when the message recipient perceives meanings that are different from those transmitted by the addressee [Makarov 2003: 39]. It is possible to follow and evaluate this type of asymmetry (when interaction dysfunction occurs at the moment of information decoding and the formation of an inferential meaning) only if the doctor/patient verbally expresses his/her inability to understand or agree and asks to clarify the presented information once again.

Less problematic is a situation with the recognition of *functional and dysfunctional asymmetry* distinguished by A. Koerfer in the study of communicative competence of doctors. In the first case, the point is that any verbal interaction presupposes the

presence of a speaker and a listener. If the doctor and the patient are simultaneously going to ask and answer, inform and ask to repeat, offer and agree, then the communication is unlikely to be successful. The second variant of asymmetry occurs when one of the partners starts interrupting, changing the topic, rebuffing, downplaying the significance of the interlocutor's words, giving instructions, etc. [Koerfer et al. 2008: 42]. S.B. Beletskiy calls this process "abuse" of statements that have a subordinate nature. He considers the dysfunctional asymmetry as superimposed, emphasizing the inequality of roles [Beletskiy 2010: 19]. If the doctor knowingly prefers using a directive (and not recommendation-based) manner of having a dialogue during the interaction with the patient, then, according to the terminology of A. Koerfer and co-authors, we can speak of *a strategic use of language*[4] and not only about implementation of neutral communicative actions [Koerfer et al. 2008: 43].

L. Hydén and E.G. Mishler distinguish three alternative *sources of asymmetry occurrence* in the doctor-patient relationship.

The first approach emphasizes different degrees of power based on a social and class structure of society. It is generally assumed that doctors, with their high level of education and income, occupy a higher step in the hierarchy of social values and statuses than patients [Hydén, Mishler 1999: 178].

The second source is related to a conflict between the patient's practical experience of the disease (*lived experiences*) and theoretical knowledge of doctors about the disease (*medical conceptions of illness*). There is a collision of views of the doctor and the patient. The first ones try to control the topic, specify direction of the consultation, find out information, immediately relevant for establishing the diagnosis and use generalized medical knowledge as a reference. The latter ones, in turn, try to talk about their experience about fighting the disease, share their personal fears and worries, describe day-to-day concerns [Hydén, Mishler 1999: 178]. E.G. Mishler counterposes *the voice of medicine* and *the voice of lifeworld.* Studying medical communication led him to the

[4]The issues of using language strategically within oral medical communication are mainly dealt with in the works of Russian scientists. The results of researches about the functioning of communication strategies and tactics are set forth in detail in the works of [Akaeva 2007; Barsukova 2007; Bejlinson 2001; Zhura 2008; Sidorova 2008; Fedorovskaya, Osipenko 2020].

conclusion that the *voice of medicine* has priority over *the voice of lifeworld*, can drown and interrupt it [Mishler 1984: 14]. The validity of this statement is explained by the fact that the doctor "confirms the state of the disease, controls the patient so that he does not abuse his/her privileges, and is responsible for bringing him/her back to performing normal social functions" [Bazhenov 2019: 81].

The third reason of the asymmetry is the anticipation of a certain behavior within the institution of medicine ingrained in *culturally shared expectations* towards the behavior of experts (doctors) and non-professionals (patients). It is supposed that doctors will show understanding of the patients' problems and the patients will not interfere with the process of identifying the therapy methods [Hydén, Mishler 1999: 179]. In most cases, both parties understand and accept these expectations. That is why asymmetry is not a product of unilateral actions of the doctor, but is created together by both the communicants [ten Have 1991, Maynard 1992].

A degree of asymmetry in the doctor-patient relations can be followed by the example of three models offered by Th. Szasz and M. Hollender and based on the patient's condition and the nature of the disease. The first "Activity—Passivity" model reflects the relations in which the patient is a passive recipient, since due to his/her helpless physical condition (shock, coma, unconsciousness) is not able to conduct a conscious dialogue and make decisions. This model is a prototype of relationship between a parent and an infant. The second "Guidance and Cooperation" model is based on the fact that the doctor determines the rules of behavior and the patient performs all the prescriptions. This type of model is applied while working with an acute form of disease (most of infectious diseases). Relations of a parent and a minor child serve as a prototype of this type of relations. The third model is called "Partnership," in which the doctor acts as a helper and advisor, and the patient takes responsibility for monitoring and sometimes carrying out remedial measures. This model is applicable for chronic diseases (diabetes, asthma, different types of allergies, etc.) and reflects the relations of two adults [Szasz, Hollender 1956: 586].

In the analyzed collection of transcripts, depending on 1) the patient's personality traits and his/her accompanying person(s) and 2) a stage of the consultation, the

dialogue becomes more symmetrical (the share of the patient's and his/her accompanying person(s)' participation in the dialogue increases) or more asymmetrical (the share of the doctor's remarks increases).

In the first case we talk *specifically about the personality traits of the patient and his/her accompanying person(s)*, since in all the dialogues the doctors showed self-restraint and didn't exceed the limits of the professional ethics, acting within the consultation algorithm. The patients and their accompanying person(s), on the contrary, could start talking about their interests, near-term plans, complicated private life, being indignant, complaining about workload and time pressure.

The dependence of symmetry on the consultation stage manifests itself in the following. The analysis of the logical and pragmatic organization of dialogues showed that there are up to 14 communicative blocks[5] therein [Coussios, Imo, Korte 2019: 12–17]. There are six most frequent structural components: establishing connection, updating the medical record, announcing the diagnosis, characterizing tumor parameters, therapy planning, and completing a consultation [Osipenko, Fedorovskaya, Enikeev 2022: 103–105]. If a doctor strives to set forth only basic information, he/she will most likely adhere to exactly this sequence of verbal actions, and the patient's participation will be minimal. If the doctor constantly requests a feedback from the patient, the latter, using different types of questions, can introduce communicative blocks unforeseen by the doctor. Due to that, there is an increase in the patient's verbal activity and, consequentially, less asymmetry.

In the dialogues between the doctor and the cancer patient, a stage of the disease development is not always the reason of the increase or decrease of symmetry. From the models offered by Th. Szasz and M. Hollender, one could expect that during the announcement of the diagnosis related to the surgery, the patient's desire to participate in the dialogue would start growing (as the possibility of the surgery means good or satisfactory state) and decreasing when mentioning the chemotherapy or radiation therapy (since it indicates a serious condition). Nevertheless, the opposite tendency was

[5]See [Krizhanovskaya 2006: 163–167] for more information about the concept of a *communicative block*. Alternative names are *a communicative and pragmatic segment* [Chernyavskaya 2006: 70–71], *a communicative and semantic component* [Nefedov 2013: 199], *a structural component* [Osipenko, Fedorovskaya, Enikeev 2022].

observed in half of the dialogues. After the announcement of the chemotherapy, the patients became more verbally active. They asked information-seeking questions about the procedure itself, were interested in how quickly their hair would grow, how long follow-up would take after the procedure, whether it would be possible to heal completely. Due to active verbal actions, the dialogue tended towards symmetry. On the contrary, the announcement of the future surgery could upset the patient and turn him/her into a silent listener. The communication became more and more asymmetrical.

F. Menz emphasizes that, if the doctor describes the algorithm of the treatment process as recommendations of therapeutic actions and not as strict prescriptions, he/she gives the patient more possibilities to participate in the discussion and decision-making [Menz 2015: 78], that is, to decrease the degree of asymmetry. Lexical and grammatical markers in the analyzed dialogues indicate a non-binding narrative style (for example, sentences with such verbs as *empfehlen* 'recommend' and *vorschlagen* 'offer'), but the verbal activity of the patients doesn't increase because of it.

1.5.4 Doctor-Patient Relationship Model

Considering the models of doctor-patient relationship is important not just for keeping abreast of the existing communicative bases of medical activity in general. Linguistically, the choice of a certain relationship model determines the set and sequence of communicative blocks, lexical and grammatical means and intensity of the patient's involvement in communication.

The currently popular concept was proposed by Ezekiel and Linda Emanuel in the 1990s [Emanuel, Emanuel 1992]. The relationship models developed by them are based on the models that were presented by R. Veatch back in 1970s [Veatch 1972]. The advantage of the models proposed by Ezekiel and Linda Emanuel is that they have developed and supplemented R. Veatch's ideas in response to the current trends in medicine.

They distinguish 1) *the paternalistic model*, 2) *the informative model*, 3) *the interpretative model*, and 4) *the deliberative model*.

In modern conditions, communication within the *paternalistic model* looks the following way: the doctor, who is given the role of guardian and defender, provides the patient with accurate information about the disease, sometimes gives a full list of possible treatment methods, but builds communication in such a way that the patient agrees to the treatment planned by the doctor. Even if the patient does not agree with some methods, restoration of the physical well-being will always have the priority. Recovery "at any cost" and the patient's well-being are of greater value than enabling the patient to make his/her own decisions. In the *informative model*, the objectives of the doctor (expert) include providing comprehensive information about the disease, treatment methods, complications or side affects. The patient selects the type of medical intervention he or she wants, and the doctor is obliged to carry out the selected treatment, even if it seems to the doctor that the patient's choice is biased and may harm his/her health. The *interpretative model* is based on the active speech of the doctor acting as a mentor, advisor and guide. The principles of this model oblige the doctor to provide the patient with full and detailed information about advantages and disadvantages of possible interventions. The doctor assists the patient in realizing his/her life values and based on this specifies a reasonable solution, clarifies and argues the reasons why this or that type of treatment best meets the patient's requirements, but does not impose his/her view. *In the deliberative model*, the doctor acts as a friend or teacher. The doctor's obligations include description of the state, explanation and recommendation of the most preferable methods of treatment that can be implemented in the current clinical situation. The decision is made jointly after an extensive discussion of the issue [Emanuel, Emanuel 1992; Beletskiy 2010: 12–22; Ushakov 2017: 53–59].

The analysis of empirical material shows that the use of the "improved" paternalistic model is typical for counseling cancer patients. Paternalism manifests itself in the fact that the doctor (or board of doctors) most often makes the decision for the patient based on test results and proposes only one option when it comes to therapy development. In our opinion, "modernization" of paternalism is manifested in the fact that 1) doctors use phrases of recommendatory nature in their speech. The recommendation may be strong

or discreet, depending on the patient's state of health and the doctor's personality. 2) Doctors tend to enter into a partnership dialogue with the patient. The explicit expression of politeness and demonstration of involvement are necessary to bring the patient into a dialogue and sway him/her in favor of the option proposed by them. 3) The patient always has the potential to refuse the proposed therapy, get a second opinion or choose another medical institution for observation. Yet, these options are discussed only if there is an explicit disagreement from the patient's side. Articulating one treatment option has nothing to do with manifestation of power and does not mean the doctor's willingness to fully take responsibility for decision-making. The recommendation of only one approach to treatment is based on the specifics of the disease: basically, there is a limited list of methods here. When analyzing the lexical and grammatical structures of dialogues, we will take a more in-depth look at manifestations of paternalistic and deliberative tendencies in verbal interactions between the doctor and the cancer patient.

1.6 Interactional Model in the Description of Communication

One of the fundamental criteria of perception and interpretation of language activity is *interpretation* of the *information obtained*. This concept takes on a different theoretical content, depending on the communication model in which it is considered. In the transition from the mechanical to the activity-based paradigm, *information code, inferential and interactional* theoretical models of communication have evolved [Kashkin 2000, 2012; Konovalenko, Konovalenko 2016; Krasnyanskiy 2009; Makarov 2003].

The *information-code model of communication* (also known as: the linear / mechanical / translational model / Shannon-Weaver model) typically involves: 1) information source (sender), 2) encoder, 3) message (idea, thought) transmitted by the speaker intentionally, 4) channel, 5) decoder and 6) receiver (recipient). In this case, essential conditions for successful communication are knowledge of the code (a sign system of the language) for correlating acoustic signals and semantic meaning

(information coding and decoding) and the presence of shared collective experience. This way, the code model serves only for transition of information = thoughts of the speaker [Kashkin 2000: 12, Makarov 2003: 33].

According to V.B. Kashkin, the advantage of this model is that it has contributed to the development of many fields of science related to information exchange [Kashkin 2000: 11], and D.E. Krasnyanskiy emphasizes that the model has helped to shape an idea of the speed and quantity of transmitted information [Krasnyanskiy 2009: 61].

In M.L. Makarov's opinion, the disadvantage of this model is that it does not "adequately describe real communication processes" taking place in natural language, since this model treats a message as "communicative material" (thoughts expressed intentionally), and "informative material" (meanings that may appear regardless of the speaker's intentions) is not taken into consideration [Makarov 2003: 35]. As explained by Krasnyanskiy, this model does not reflect the fact of feedback. In other words, the communication process is linear and unidirectional [Krasnyanskiy 2009: 61].

In the *inferential model* that was founded by Paul Grice, the main objective of the sender is to make the message clear to the recipient. Inference means inferential value (result) or deductive reasoning made by the recipient who perceives a (non-)verbal signal by extracting and processing the received code. In this case, the message is understood as more than a "thought" (as in the code model), but as a demonstration of intentions, the speaker's intentions.

There are two approaches to the inferential model. On the one hand, it represents a fundamentally new approach to information and communication. The principal difference from the previous model is that communication becomes possible if there is any way to recognize the speaker's *intention.* This indicates that there is no obvious need for (de)encoding the message and direct verbal accompaniment of actions, because demonstration of intentions can occur not only through verbal reproduction of information, but, for example, through silence as well. When this occurs, the code is interpreted as a common set of conventions for speakers and listeners, and the message is derived from *"knowledge of conventions, signal and context"* [Makarov 2003: 37]. In M.L. Makarov's point of view, such a radical approach is suitable for the analysis of

conventional symbols, but not a colloquial language, since "language representations are not always conceptual, and relations between them are not always based on derivability" [Makarov 2003: 37].

On the other hand, the inferential model is considered as an extended version of the code model with the only difference that not only verbal signals should be recognized, but also the speaker's intentions, which, thanks to linguistic manifestation, should be understood in a certain way. J. Searle, one of the supporters of this interpretation of the described model, does not exclude the possibility of using only the inferential form of communication, but insists that such cases are the exception rather than the rule. The American philosopher points out that illocutionary acts are generally implemented within the language by virtue of certain rules. If the language excluded the possibility of presenting the pragmatic component of meaning without verbal accompaniment, the communicative purpose of the speaker would not be clear. Thus, it is possible to transmit illocutionary acts without using speech, but this possibility is due precisely to the existence of language [Searle 1969: 38][6].

The *interactional model* of communication (also known as the interaction, dialogue, activity-based model) assumes that transformation of meanings during the process of communication occurs due to the interaction of communicants under the influence of the socio-cultural environment. It turns out that communication processes arise at the level of the "idealized language system," and at the level of society, we can see the creation of the contexts and local structures, which are reflected in communicative actions [Knoblauch 1991: 447]. Life experience and knowledge of socio-cultural conventions make it easier to recognize the intentions, and any form of behavior may gain additional situational significance under certain conditions. According to M.L. Makarov, *demonstration of meanings* is of great importance in the interactional model (for example, in the code model, it is information transmission, and in the inferential model, it is manifestation of the intention), and the person demonstrates these

[6] "The Fact that one can perform some illocutionary acts while standing outside a natural language, or any other system of constitutive rules, should not obscure the fact that in general illocutionary acts are performed within the language in virtue of certain rules, and indeed could not be performed unless language allowed the possibility of performance" [Searle 1969: 38].

meanings, "whether he or she wants it or not." The listener's *activity becomes more important.* Considering the fact that the speaker and the recipient constantly change places, interpretation of meanings occurs mutually. Thanks to this joint "communicative work," there is a constant movement of meanings with simultaneous "experiencing of common interests and actions" [Makarov 2003: 39].

To describe the therapy planning talks of the doctor and the cancer patient, due to its discursive and communicative specifics (asymmetry of social roles, potential asymmetry in interpretation of communicated meanings due to different levels of medical knowledge, extraordinary nature of the communication situation, etc.), theoretical values of the interactional model of communication appear to be of particular value for this research.

Firstly, this model allows taking into account extralinguistic conditions when it comes to the creation of communication. As part of this work, the analysis of empirical material implied considering, for instance, general rules of counseling cancer patients, the disease stage (the patient's psycho-emotional state depends on it), the presence or absence accompanying persons (this factor may explain the verbal activity or passivity of the patient).

Secondly, the selected model envisages the possibility (even necessity) of receiving some feedback from the recipient (patient) for dynamic construction of further communication, forecasting possible communicative difficulties and, if necessary, adjusting the provided information. Consequently, (adequate) verbal activity and interest of the patient contribute to the productive communicative work. For example, if the patient asks questions or openly states that the doctor's explanations require the different wording, then communication participants are quicker to find mutual understanding.

Thirdly, the interactional model is ultimately intended for coordination of actions, not just for creation of a subsequent speech act. This is important given that the doctor's verbal activity should be structured in a way to organize the control and monitoring of the patient's actions (whether he or she fulfills the doctor's prescriptions, whether he or

she reports all relevant information about the current disease, whether he or she interprets the provided information correctly, in what emotional state he/she is).

1.7 Characteristic of the Research Corpus

In this study we distinguish the following concepts: *dialog* and *macodialog*. By dialog we mean direct, *face-to-face* verbal communication between the doctor and the patient (as well as accompanying persons: partner, children, relatives, friends) during the consultative interview, which is conducted with the purpose of preliminary/final diagnosis' verbalization, and the development of the appropriate therapy plan (announcement and discussion of all its stages).

When analyzing verbal speech, it is important not only to consider the correlation of dialog parties' speech actions, but also to understand the symbolic meaning of their statements, taking into account "the place within the coordinates of culture, institutions, communication and activity norms, values, rituals, conventions," etc. [Makarov 2003: 187]. For this reason, it is relevant to consider interaction not only at the micro-level, i.e., on the level of a single dialog, but also at the macrolevel, uniting the indefinite set of dialogs on similar topics built on the same principle.

In order to define macrodialog within the framework of professional medical interaction, we will review the *macrotext* concept which is described by N.V. Danilevskaya as the "complex of statements or texts consolidated by content or situation, as well as connected on the basis of their structural, compositional and cultural unity" [Danilevskaya 2011: 216]. There are two main approaches to macrotext. On the one hand, it is considered in the aspect of a culture-centered approach, on the other hand — as a unit of text-centered order.

Culture centricity is connected to M.M. Bakhtin's idea of fundamental *dialogism*, discontinuity of the text. Within this concept, dialogism is defined as the "interchange of ideas in time, and the text itself assumes the meaning of inter-text with the status of the cultural and historic paradigm." From this point of view, macrotext is a kind of model of text in general. Each fragment of such a text absorbs "the experience" of the previous

texts, i.e., covers an infinite number of smaller and separate microtexts, the sum of general (cultural) codes and semantic systems [Danilevskaya 2011: 217].

Within the context of the *text-centered* approach, macrotext is viewed as the model of separate text "with the semantic structure including a certain set of hierarchically ordered and interconnected microtexts." From the point of view of this approach, there is a "broader" and a "more limited" definition of macrotext. In the former case, macrotext is connected to a functional and semantic approach to text analysis; in the latter — with structural and semantic one. Within the framework of functional and semantic approach, macrotext is viewed as a semantic whole consisting of microtexts on the basis of their inner interaction, logical interdependence, as well as structural and compositional unity. In this case, subtext, extended variable repetition, communicative block, typical complexes of communicative and cognitive actions are regarded as microtext [Danilevskaya 2011: 217-218]. Within the context of a structural and semantic approach, any text is understood as a separate product presented in the form of a macrostructure occurring due to the logical-semantical interrelation of super-syntax units (e.g., syntactic unity, prosaic verse, super-phrasal unity, paragraph, segment, etc.) [Danilevskaya 2011: 219].

Based on the concepts presented, macrodialog in verbal communication means the series of repetitively reproducible, similar (i.e., developing according to a similar scheme created on the basis of the doctor's cultural and professional experience) consultative interviews with the same or different patients, presented in the form of verbal dialogs. A complex of dialogs with the same topic can serve as an example of a macrodialog: prophylactic, preliminary, periodic, pre-trip, post-shift, etc. examinations; or a series of dialogs with the same patient, starting from the primary consultation and ending with the last visit.

On the one hand, the desire of the researcher to have a macrodialog with one patient, to view the way the doctor carries out consultations from the first to the last visit, and to track the development of their speech interaction for analysis to obtain more accurate research results, is viewed as justified (even perfect). On the other hand, several series of macrodialogs with different patients are also needed to compare the practical

implementation of the "perfect" consultation scheme and the change in speech templates during communication with various types of patients. Due to the complexity of the collection of empirical data connected to the necessity to receive the approval of the healthcare institution's local ethic committee and patients' consent for the collection of data, as well as limited time of the project, dialogs with various patients on the same topic (Ger. *Therapieplanungsgespräche* ‘therapy-planning talks') were used for the analysis of doctor-patient interaction within the framework of the present study.

This paper covers transcripts of 51 audio recordings of consultative conversations with cancer patients in German. A total of 644 printed pages have been obtained using the GAT-2 rules of basic transcription [Selting et al. 2009]. The average duration of one recording was 20 minutes. In order to conceal the identity of the patient and the doctor when transcribing audio recordings, the data was anonymized by removing names/surnames, positions, dates, and other information that could reveal the identity of any of the persons involved. After the transcript was ready, the audio recordings were deleted. That is why the dialogs are only available as text files.

Audio records were collected as part of the project "From Pathology to Patient: Enhancing the Information Transfer Efficiency and Awareness to Increase the Cancer Patients' Safety,"[7] implemented by Prof. W. Imo in collaboration with Prof. Dr. M. Bentz and Prof. Dr. T. Rüdiger with the support of the German non-profit organization to help cancer patients *Deutsche Krebshilfe* between October 2014 and March 2015. Consultations were recorded in four departments of the Karlsruhe City Hospital: Medical Clinic No. 1 (specialization: internal medicine therapy, nephrology, rheumatology, and pulmonology); Medical Clinic No. 3 (specialization: hematology, oncology, infectiology, palliative medicine); the General and Visceral Surgery Clinic; and the Antenatal Clinic (a more detailed description of the process of and conditions for collecting audio records can be found in [Bentz et al. 2017: 3–5, Imo 2017b: 2–4]).

The main tasks of a doctor during a consultation were 1) reporting a confirmed cancer diagnosis and 2) describing or discussing the follow-up treatment. In addition to

[7] Original project name „*Von der Pathologie zum Patienten: Optimierung von Wissenstransfer und Verstehenssicherung in der Onkologie zur Verbesserung der Patientensicherheit,“* project number 111172.

the attending doctor and the patient, the following persons could be present in the office (with the patient's consent): the patient's family members, doctors of the corresponding hospital department, and student trainees. In most cases, the clinic employees contacted the patient by phone as soon as possible after confirmation of a pathological diagnosis to invite him or her for a consultation.

Transcripts were provided to the author of the study as part of the *GIP (Germanistische Institutspartnerschaften),* collaboration in the field of German Studies between the Institute of Linguistics and Intercultural Communication of Sechenov University and the Institute of German Studies of the University of Hamburg.

1.8 The Algorithm of Analysis and Linguistic Tasks of Describing Doctor-Patient Therapy Planning Talks

To identify the typical linguistic and extralinguistic characteristics of medical consultation conversations, a multilevel analysis of their speech structure and situational context was carried out. When analyzing the speech structure, the lexical content and grammatical design of dialogical texts were in the center of consideration, due to which the semantics and actualization of the main (most frequent) stages of consultation during the verbal interaction of the doctor and the patient take place. The pragmatic analysis of situational and local contexts was aimed at identifying the typical communicative structure of the analyzed dialogues. The following research procedures were the elements of the multilevel linguo-pragmatic analysis (cf. [Imo, Lanwer 2019: 132–137]).

1) *Assessment of external dialogues' organization.* This stage of the analysis is based on the calculation of transcription lines and words belonging to the doctor, patient and accompanying persons. Words of certain semantics (professional terms, euphemisms, expressive and evaluative vocabulary, etc.) are also of interest for quantitative evaluation. The results of the analysis allow us to judge the share of participation of the doctor, patient and accompanying persons in the dialogue, the general emotional

background of the consultation, the degree of status-role asymmetry and, in general, the chosen model of speech interaction.

2) *Determination of the internal organization of dialogues.* The main purpose of this stage is to identify the characteristic structural components and their systematization. The communicative-structural component (also known as "communicative block" [Krizhanovskaya 2006: 163–167], "communicative and pragmatic segment" [Chernyavskaya 2006: 70–71], "a communicative and semantic component" [Nefedov 2013: 199]) has a specific function, subordinated, typical subject-denotative content and a system of repetitive lexical and syntax-oriented indicators (cf. [Nefedov 2013: 199, 202]). The parameters of frequency of reproduction and "communicative initiative" were chosen as criteria for systematization. Frequency means, firstly, the occurrence of the analyzed communicative-structural component within the framework of one dialogue and, secondly, the presence of the same structural component in other dialogues. The use of the "communicative initiative" criterion implies an ambiguous research focus: on contextual identification of the target communicative attitude of a dialogue fragment and on explaining the reasons for the generation of a structural component: who initiates its reproduction, whether speech activation occurs due to the patient's question or whether the "trajectory" is set by the doctor.

3) *Selection of structural components for analysis.* Since the analysis revealed a rather extensive number of structural components and due to the limited scope of the dissertation research, it seemed necessary to focus only on some categories. Initially, the choice was between the analysis of the most frequent categories and the analysis of "unique," categories of rare occurrence. The author of the research made a choice in favor of the first. The second aspect is seen as a promising direction for research activity to broaden knowledge about oral communication between a doctor and a patient.

4) *Sequential analysis of selected structural components.* At this stage of the research, it is considered how the "process" of the dialogue (a change of communicative roles) occurs within one structural component, whether difficulties of understanding or interpretation arise at the same time.

5) *Identification of lexical means and grammatical constructions, due to which the verbalization of each structural component occurs.* At this stage of analysis, firstly, the functions of the lexical unit or grammatical structure selected for analysis in the utterance are revealed, taking into account pauses, phrasal stress and intonation features of the line. Secondly, the interactive features of the analyzed speech medium are taken into account, namely: who is characterized by the reproduction of this word/phrase/grammatical structure, is there a relationship between the stage of consultation and the frequency of occurrence of the analyzed language means, does it affect the transmission of the word to the interlocutor, whether there are pauses, confusion, laughter, tears, etc. Thirdly, the influence of the local context is assessed: does the word/ phrase/ grammatical structure have a connection with the previous utterance, does the speaker correct or clarify the already pronounced word/ phrase/ grammatical structure, does it influence the coherence of the text. Fourth, a comparison of the transmission and perception of the analyzed language unit is carried out: whether it serves to mark a certain signal (consent, distrust, self-correction, question), expression of emotions, reduction or increase of the communicative distance for orientation to a certain action.

The application of the stages of the described algorithm for conducting interactive analysis of colloquial speech seems possible not only when evaluating the verbal interaction of a doctor and a patient but also other types of oral dialogues related to the communicative behavior of subjects of institutional discourse with unequal status.

CHAPTER 1 CONCLUSIONS

To study the linguistic features of oral dialogues between a doctor and a patient, it is advisable to use conversational analysis. Linguistically adapted conversational analysis makes it possible to assess the impact of the language tools used on the (verbal) behavior of communicants and the development of dialogue in general, expands the possibilities of linguistic tools and allows for a more in-depth and comprehensive

description of the verbal interaction of competent professional experts and non-specialist consumers.

The verbal behavior of the doctor and the patient in the framework of a consultative conversation has *a conditionally spontaneous character. Conditionality* arises both due to stable behavioral, linguistic and socio-cultural habits, and due to the presence of communicative restrictions enshrined in the code of professional ethics of a doctor. *Situational inequality, asymmetry of knowledge* and *social roles also belong to the "limiters" of spontaneity.* The doctor monitors the structure, content and time of the consultation, has special knowledge in the field of oncology, may have an academic degree and title. In addition, *communicative* and *functional asymmetry may occur in the process of communication.* In the first case, we are talking about decoding the meanings embedded in the message by the sender, in the second — about the mandatory presence of a speaker and a listener. The manifestation of spontaneity is also influenced by *the degree of asymmetry,* which in the analyzed dialogues decreases or increases due to the personal characteristics of the patient and the consultation stage.

Spontaneity, and with it language variability, develops in the dialogue due to the desire of the doctor to individualize communication and act in accordance with the psycho-emotional state of the patient. Communication with cancer patients requires special delicacy from the doctor, since he must provide information about the approaching death in such a way that the patient has a desire to fight the disease. To do this, the doctor has not only to name the diagnosis and to emphasize the positive characteristics of the disease, but also to explain the stages of the fight against it in a language understandable to the patient.

The communicative structure of the consultation, the set of lexical and grammatical means and the involvement of the patient in the dialogue largely depends on *the model of the relationship between the doctor and the patient.* In the case of communication with cancer patients, we are often talking about an improved paternalistic model. The change is seen in the use of recommendation phrases by the doctor; explicit expression of politeness, complicity and support; giving the patient the opportunity to get a second opinion and even refuse the services of this medical organization.

Interpretation of the received information is of particular importance for the interpretation of oral dialogues. Within the framework of verbal interaction between a doctor and a patient, the use of *an interactive communication model* seems to be the most justified, since the transformation of meanings here depends on the activity of the listener, socio-cultural and situational conditions. When analyzing dialogues, this model allows you to take into account the extralinguistic conditions of communication generation, receive feedback from the patient, predict communicative difficulties and adjust the structure of the consultation.

The algorithm for analyzing oral doctor-dialogues includes five main points: 1) assessment of external dialogues' organization; 2) determination of the internal organization of dialogues; 3) selection of structural components for analysis; 4) sequential analysis of selected categories; 5) identification of language markers within each structural component.

The application of the stages of the described algorithm for conducting interactive analysis of colloquial speech seems possible not only when evaluating the verbal doctor–patient interaction, but also other types of oral dialogues related to the communicative behavior of subjects of institutional discourse with unequal status.

CHAPTER 2. INTENTIONAL STRUCTURE OF DOCTOR-PATIENT CONSULTATIONS

2.1 Basic Units of an Interactional Analysis of Doctor-Patient Consultations

To perform the correct analysis on linguistic structures of oral speech within the framework of the interactional communication model, a social real life vision (the sphere of sociolinguistics), which defines the scope of our linguistic research, is used. *Sociocultural reality* is construed as "a stream of peculiar, unique events and situations" that are taking on their constructions and final meanings during verbal communication under the influence of "personal and individual characteristics of its participants" [The Great Russian Encyclopedia: 494].

In our work, we use a narrow understanding of communication which is proposed by D. Gumperz, the ideological father of interactional sociolinguistics, and comes down to (linguistic) actions that are able to cause conversational partner's response (*Only when a move has elicited a response can we say communication is taking place*) [Gumperz 1982: 1]. This definition equates the concept of communication with the concept of *interaction* (cf. Ger. *interaktionistischer* [Imo, Lanwer 2019: 10] / *interaktiver* [Knoblauch 1991: 457] *Kommunikationsbegriff*). Within the most general meaning, the task of interaction, as defined by A. Schmidt, is the coordination of actions' ways and modes, relationship and the mutual influence of two elements, instruments, substances, variables, individuals, etc. (Ger. *Koordination von Verhalten, Wechselbeziehung, Wechselwirkung*) [Schmidt 2018: 17–18].

Social understanding of the *context* is important for our work, since we consider linguistic phenomena not as given values, but as structures that dip into real life conditions, depending on which linguistic phenomena with identical forms may take on various meanings.

There are several approaches to the context in sociolinguistic disciplines. For the traditional conception, the context is defined as an *"invariable number"* of non-linguistic factors and available constant data of social reality (cf. [Habacher 2013: 25;

Schmitt 1993: 332]). A classical understanding of the context P. Auer calls an "aggregate" (a set of elements) of given categories and objects (Ger. *ein Aggregat material gegebener Entitäten*), which are in the surrounding reality independent of the present interaction [Auer 1986: 23]. As for the second approach, the context is considered as a *"dynamic reality"*, since "it is created by common efforts of participants directly during their interaction" [Habacher 2013: 25]. It means that the context is not just a collection of material social factors (for example, place and time of action), but a certain number of cognitive models of things that are relevant for interaction at a particular time [Auer 1992: 22].

Accordingly, it becomes relevant not the observation of static predetermined parameters, but *"speakers' dynamic enaction of social identity"* [Jedema, Wodak 2005: 1608] (cf. [Habacher 2013: 25]). When creating dynamic reality, the simultaneous presence of two contexts is noted: the context of a message sender (the context of utterance creation) and the context of an addressee (the context of the utterance perception). The process of social meaning formation during dialogical interaction of communicants was defined by D. Gumperts as *contextualization*. V.E. Chernyavskaya has specificated this definition and given it a linguistic orientation: "The contextualization is the *speech-thinking process* of the speaker's advancement and the process of addressee's perception of some extralinguistic components representing key and essential semantic supports that form the framework and perspective for interpreting the subject matter expressed *as speech structures*" [Chernyavskaya 2021b: 83]. As a result, the context becomes a "constructed category" [Nefedov, Chernyavskaya 2020: 88]. The similar idea was suggested by M.L. Makarov in the following words: "<...> communication participants cannot predetermine conversation development, however they construct it when changing their communicative positions along the way depending on incessantly varied circumstances" [Makarov 2003:6]. As a result, "in terms of a specific communicative situation, some components of social practice are recognized and put forward as powerful and basic ones for *interpreting semantic language units*" [Nefedov, Chernyavskaya 2020: 88].

Within the specific communication situation, the context narrows down to a *local context* which is construed by O.G. Isupova as a (speech) action configuration that immediately *precedes* an interpreted utterance. Knowledge of previous utterances together with cultural, social and linguistic experience makes it possible to construct probability models of behavior, to predict goals and motives of the conversation participants (cf. [Isupova 2002: 36]).

In the natural conditions of communication, knowledge of a (local) context accompanied by high discursive competence cannot ensure unambiguous prediction of the interaction process. The activity-related understanding of language, *talk-in-interaction* [Schegloff 1987], assumes that the reproduced speech action cannot accurately determine the type and properties of the subsequent action, however it sets conditions, "vague probability dependencies", for generating a more or less expected and appropriate speech response [Makarov 2003: 19].

As for doctor-patient dialogues, understanding of the context is important for the interpreter (the author of this work) due to the fact that the conditions of meaning generation and mainly the conditions of its interpretation are responsible for the formation of a greater or lesser asymmetry, affect the degree of patient-specific nature of the communication and the choice of the relationship model.

2.2 Sequential Organization of Doctor-Patient Dialogues

The analysis of oral communication always begins with *observation* that acts as a basis for the theorization of studied phenomena. H. Sachs explains the priority of this method by the fact that it allows us to finde such things in utterances that are impossible to create with the help of imagination. The reason for it is that many words and phrases do not seem significant or unusual at the moment of speech, cannot be reproduced word for word with the help of original intonations and accents, slip away, transform and fade from our memory [Sacks 1984: 25]. Transcripts, video and audio recordings used for the analysis of oral speech make it possible to reproduce dialogues repeatedly, so that a

researcher has the opportunity to pay attention even to the most unnoticeable (at the first gaze) fragments of utterances.

When using the observation method, it is impossible to make up a complete and reliable list of aspects which should be focused on when listening to audio recordings or reading transcripts, because this would contradict the observation purpose, which consists precisely in the detection of interaction organization peculiarities that the researcher does not even know yet. According to H. Sacks, the only thing that is obvious is that a conversation accompanying any interaction has an initial "organized nature in all parts," since participants of communication put certain meanings into their utterances that create and determine special arragement that can be noticed by conducting an analytical research [Sacks 1995: 484].

E.A. Schegloff expresses the idea of *"unmotivated examination of naturally occurring interactive materials"* that is not performed according to a predetermined pattern, but is a result of the researcher's attentiveness who "notices" at the first sight unremarkable features of conversation or behavior [Schegloff 1996: 172]. Many observations come down to the formulation *"I've seen that before."* Repetitive conversation details and routine constructions create the basis for the detection of identical or similar phenomena [Schegloff 1997: 501].

To point out the distinctive words, in our view, it is necessary to divide dialogues into smaller parts to identify feature words, grammatical structures, remarks, etc. When analyzing some fragments of dialogues we paid particular attention to the semantic meaning of linguistic units and the change of communicative roles. We will use several examples to demonstrate how the dialogue can be segmented based on these parameters.

2.3 The Order of Communicative and Speech Actions as a Reflection of Dialogues' Progression

One of the advantages of the (linguistically adapted) conversational analysis is that studying separate (individual) cases, presented as transcripts in this work, enables a theoretical generalization of the material (cf. [Ploder, Mcelvenny 2022]). During the

analysis, it was established that some words, word groups, and grammatical constructions are repeated. As this refers to a conditionally spontaneous oral speech, one can rarely find remarks that fully coincide. Due to this reason, illustrative examples in some sections are actually adapted fragments of transcripts. If a fragment of the dialogue is adapted, it is presented not as a transcript but as a text in italics. The adaptation involved the elimination of prosodic means (phrasal stress, pauses, inhalations and exhalations, elongated vowels and consonants), cases of self-correction (reparations), repetitions, some auxiliary parts of speech, and interjections that do not have an effect on the organization of the semantic content of the dialogue. In some cases, the word order characteristic of written speech was restored, and punctuation marks were placed according to the standard of the German language. The elimination of prosodic means from the transcripts is caused by the fact that they are not the main subject of our analysis, although when interpreting dialogue fragments presented as transcripts, prosodic features were taken into consideration.

To demonstrate the development of the dialogue dynamics, we propose to study out a fragment where a doctor reports on a patient's recurrent cancer signs (Case 1, Table 1).

Case 1*

60 AM: °h[h] und ((Pathologe)) **hat festgestellt** dass der KREBS,
61 PM: [ja:]
62 AM: (1.1) **NICHT** (.) von der lunge kommt?
63 °hh **sondern** dass der krebs eine ABsiedlung ist-
64 (1.0) von dem beKANNten kre:bs den sie schon HATten.
65 (-)**[er sch]reibt** ganz KLAR= in dem ZWEIten kritischen bericht?
66 PM: [hm;]
67 AM: °hhh das es eine ABsiedlung ist?
68 (.) aus der VORherigen-
69 (0.5) in der diagNOStik schon [bekannten-]
70 PM: [h°]
71 AM: (.) REKTOkarzinom;
72 **ALso,**
73 (0.8) dem (.) UNteren darmkrebs= dem ENDdarmkrebs.

74 PM: ja:.
75 AM: (.) **also** es ist eine ABsiedlung,
76 des vorbekannten enddarmKREbses.
77 PM: ((räuspert sich))
78 AM: °hhh **das heißt** es ist eine so genannte metasTAse,

* Interpretative note to the transcripts:

The following abbreviations are used to denote the dialogue parties:

AM/AW = Arzt (männlich / weiblich) — doctor (male / female)

PM/PW = Patient (männlich / weiblich) — patient (male / female)

Legends in the transcripts:

KREBS — word/syllable under phrasal stress;

°h — breath of 0.2–0.5 sec;

°hh — breath of 0.5–0.8 sec;

°hhh — breath of 0.8-1.0 sec.;

? — high-rise intonation;

, — mid-rise intonation;

– — flat intonation;

; — mid-fall intonation;

. — deep-fall intonation;

[er sch]reibt ganz…
[hm;] — overlapping utterances;

(.) — micropause (up to 0.2 sec);

(-) — short pause (0.2 to 0.5 sec);

(--) — pause of average duration of (0.5 to 0.8 sec);

(---) — long pause (0.8 to 1.0 sec);

(2.5) — measured pause (duration indicated in parentheses);

((Pathologe)) — comments, para- and extra-linguistic phenomena/events.

Table 1. Reflection of Dialogues' Progression

60 AM: °h[h] und ((Pathologe)) **hat festgestellt** dass der KREBS, 61 PM: [ja:]	The verb *feststellen* in *Perfekt* says that later the doctor is going to say *what has been* revealed.
62 AM: (1.1) **NICHT** (.) von der lunge kommt? 63 °hh **sondern** das der krebs eine ABsiedlung ist- 64 (1.0) von DEM beKANNten kre:bs= den sie schon HATten.	The double conjunction *nicht ...*, *sondern ...* demonstrates the presence of negation with clarification.
65 **(-)[er sch]reibt** ganz KLAR= in dem ZWEIten kritischen bericht? 66 PM: [hm;] 67 AM: °hhh das es eine ABsiedlung ist? 68 (.) aus der VORherigen- 69 (0.5) in der diagNOStik schon [bekannten-] 70 PM: [h°] 71 AM: (.) REKTOkarzinom;	The verb *schreiben* in *Präsens* indicates the presence of an expert opinion (the second histological report of the pathologist) and anticipates the voicing of the content of this opinion.
72 **ALso,** 73 (0.8) dem (.) UNteren darmkrebs= dem ENDdarmkrebs 74 PM: ja:.	The colloquial particle *also* 'that is' introduces a terminological synonym to the medical term pronounced before the particle (*Rektokarzinom*), clarifying it.
75 AM: (.) **also** es ist eine ABsiedlung, 76 des vorbekannten enddarmKREbses. 77 PM: ((räuspert sich))	The colloquial particle *also* 'thus, therefore' introduces a new concept of *Absiedlung* and summarizes information about the previous diagnosis.
78 AM: °hhh **das heißt** es ist eine so genannte metasTAse,	The construction *das heißt* introduces the medical term *Metastase*.

Lexemes in bold ensure the progressive development of the dialogue and create the dynamics of the speaker's thought movement. The movement is created due to semantic, lexical, and grammatical valency [Reichardt 2013]. For example, the use of the verb *feststellen* "determin" is indicative of the introduction of a subordinate clause that describes what is exactly determined and, consequently, can have an explanatory or clarifying function [Helbig, Schenkel; 346]. The compound conjunction *nicht ..., sondern ...* assumes that the sentence contains two opposing meanings and/or an unexpected comparison [Mattmüller 2021: 377, 481]. The verb *schreiben*, similar to the verb *feststellen*, requires the use of an explanatory sentence with substantiating information [Helbig, Schenkel; 395]. The informal particle *also* is a tool for organizing a dialogue. When first used in this example, it is indicative of the summarizing, when used the second time, of the start of a new communicative block/topical unit (cf. [Deppermann, Helmer 2013; Dittmar 2002, 2010; Günthner 2019]). The construction *das heißt* anticipates an explanation [Buck 2022: 141].

In Table 1, a fragment of the dialogue is presented in the form of six parts. Each part has a primary language marker that establishes the direction of the doctor's speech. Alternately stated, if we had a chance to pause the dialogue (immediately during the conversation) after voicing the selected word/word combination, the patient would be able to guess what the doctor was about to tell him/her. In the right column, there are explanations given to the language markers highlighted in bold that act as "projectors/spot lights" (Ger. *Projektorkonstruktion* [Günthner 2008, 2017]) that actually "shed light" on the following/subsequent remarks.

Let's take a closer look at the chosen lexical units. The verb *feststellen* 'determin,' used in the Present Perfect tense *hat festgestellt* 'has determined' (60)[8], denotes a pathologist who took a sample of lung tissues containing cancer cells, and indicates the readiness to announce the final diagnosis based on laboratory research.

[8] Hereinafter, when parsing/describing dialogues, the figures in parentheses correspond to the line numbers in the transcripts.

The first part of the compound conjunction *nicht…, sondern…* ‘not…, but…’ (62–64) introduces information about the falsity of the previously stated (i.e., before the histological examination) assumption that the existing cancer was the primary site (= initial tumor). The intonational emphasis of the particle *NICHT* ‘NOT’ in combination with a micropause enhances the meaning of the information conveyed in this part of the phrase. In the second part of the complex conjunction with *sondern,* the diagnosis is clarified. Using the noun *Absiedlung* ‘secondary tumor’ and the phrase *bekannter Krebs* ‘known cancer’, the assumptions about the origin of the tumor are implied.

Then the oncologist again turns to the second histopathology report (= autopsy report) and, using the intonationally highlighted adjective KLAR ‘CLEAR,’ emphasizes the unambiguity of the diagnosis. The origin of the diagnosis is explained using medical vocabulary: *Absiedlung* (67), *Diagnostik* (69), *Rektokarzinom* (71). The highly specialized medical term *Rektokarzinom* ‘colorectal cancer,’ which is most likely unknown to the patient, will be replaced by two synonymous medical terms (*unterer Darmkrebs* and *Enddarmkrebs*), which are more often used among non-specialists.

Employing the discursive markers *also* (72, 75) and *das heißt* (78) in this case is necessary for wrapping up and introducing new wordings (for further information on discursive markers, see [Blühdorn 2017; Dittmar 2002; Gülich, Kotschi 1995; Günthner, Auer 2005; Imo 2012, 2017a]). First, the doctor repeats the term *Absiedlung* again (75), which in its origin ascends to the noun *Siedlung* ‘settlement’ (*Absiedlung* = new settlement separated from the old one) and might be clearer to the patient. The combination of the adjective *vorbekannt* ‘previously known’ and the noun *Enddarmkrebses* ‘cancer of the lower rectum’ (76) is a paraphrase of the previous statements (68–73). At the end of the analyzed passage of the dialogue, using the discursive marker *das heißt,* the oncologist replaces the words *Absiedlung* (75) / *Enddarmkrebses* (76) with the term of Latin origin *Metastase* ‘metastasis’ (to learn more about the *das heißt* construction, see [Buck 2022: 141; Imo 2017a]).

The information verbalized in the above excerpt informs the patient about the suspicion of lung cancer and the need to abandon this suspicion in connection with the pathologist's report, as well as about the final diagnosis, which is articulated both using medical terms and expressions reworded for non-specialists. This type of dialogue analysis demonstrates that the sequence of communicative actions and their dynamics can be provided by individual words and phrases.

2.4 Change of Communicative Roles and its Marking in the Dialogues' Structure

Oral speech can also be analyzed on the basis of the dialogue's segmentation, depending on the change of communicative roles. In Case 2, the patient clarifies if an already diagnosed bladder tumor is related to a recently detected squamous cell carcinoma, which is the reason for the consultation. The following excerpt illustrates the process and the reasons for giving the floor from one communicant to another.

Case 2

68 PM: **HÄNGT** (-) dieser tumor (-)**zusammen** mit diesem blasentumor,
69 AM: (1.1)ne_NE,
70 **[NEIN,]**
71 PM: **[ALso]** dass der BLAsentumor gestreut hat?
72 AM: ne DA sieht man gar nix,
73 PM: **DA::SCH,**
74 AM: ne,
75 ne und **das WÄre** auch was anderes;
76 PM: **das WÄre**=
77 AM: =uroTHELzellen nennen die sich,
78 und **das sind** PLATten die empithelzellen haben;
79 PM: **hängt also** NICHT **zusammen;**
80 AM: [NE ne ne;]
81 PM: [<aHA,>]
82 na GUT,
83 [und-] (--)
84 AM: [u::nd,]
85 jetzt MUSS man natürlich überlegen,
86 welche therapie MACHT man?

The use of a clarifying question with a mid-rising intonation by the patient (68) determines the topic of this excerpt (cf. Ger. *explizite displays von Nichtwissen* [Buck 2022: 106]; [Birkner, Burbaum 2016]). The verb *zusammenhängen* ‘to depend’ indicates an attempt to identify the dependence of the current diagnosis with the bladder tumor that is already known and to close the knowledge gap (Ger. *die Beseitigung einer Wissensasymmetrie* [Buck 2022: 109]; cf. [Imo 2009; Keppler, Luckmann 1991: 158]). Overlapping utterances of communicants (70, 71) may indicate the patient's dissatisfaction with the doctor's response in the form of negation *ne-ne* (69) and the wish to expand the question. On the other hand, overlapping utterances and the negation *ne-ne, nein* (69, 70) indicate that the doctor fully understands the patient's question and there is no need to clarify it (*The primary function of “no” is to treat the content of the prior speaker’s turn as already known or self-evident* [Weidner 2018: 225]).

The next utterance, *also dass der Blasentumor gestreut hat,* shows that the patient is aware of the possible formation of secondary tumors (metastases) and explains the reason for his anxiety. The reformulation marker *also* at the beginning of the utterance indicates that additional meaning has been added to the previous statement [Blühdorn, Foolen, Loureda 2017: 24] and creates a "chain of formulations" (*Formulierungskette* [Mondada 2002: 344]), in which each new statement details the previous one.

The doctor's next remark, *ne da sieht man gar nix* (72), also does not clarify the reason why the doctor denies the interdependence of an old and a new tumor. The patient shows the intention to take the role of the speaker by starting the utterance with *DA::SCH = das ist* (73). Such an opening of the utterance can mean an attempt to ask another clarifying question. The doctor catches this intention and begins to explain before the patient takes the floor. The seizure of the communicative initiative is indicated by the fact that the doctor includes the pronoun *das* at the beginning of the next utterance, *und **das** wäre auch was anderes* (75), as if continuing the patient's phrase. Apparently, the accuracy of the wording *was anderes* does not satisfy the patient again. He reproduces part of the doctor's previous phrase as an echo repetition of *das wäre*, trying to express some thought (76) [Greer et al. 2009; Norrick 1987; Svennevig

2003, 2004] (cf. Ger. *Rezipientenecho* [Günthner 1993: 189]). A very fast change of utterances (76–77) is indicative of the fact that the doctor does not intend to give the role of the speaker. Using medical terminology *(Urothelzellen, Epithelzelle*n), he repeats the idea that diagnosed diseases are independent of each other (77–78). The conclusion phrase *hängt also nicht zusammen* (79) confirms that the patient has understood the provided information. Together with the colloquial particle *also* that indicates summarizing (cf. Ger. *Konklusive Konnektor* [Dittmar 2010: 118]), the phrase contains the verb *zusammenhängen* that introduces this communicative block (cf. 68 and 79). To sound more convincing and to conclude the microtopic, the doctor repeats the negation *ne-ne-ne* and thus confirms the correctness of the thought expressed by the patient. The patient's phrase *aha, na gut, und* (81–83) is a signal of mutual understanding (cf. *acknowledgement token* [Jefferson 1984] and *continuer* [Schegloff 1982: 81]). The doctor uses the conjunction *und* (that the patient verbalized last in his utterance) to get the role of the speaker. The oncologist repeats the same conjunction *u::nd* (cf. 83 and 84) in a drawn-out manner and moves on to the next communicative block (to the therapy discussion). The analysis shows that the change of communicative roles that ensures the development of the dialogue is carried out due to the fact that the patient demonstrates (dis)satisfaction with the doctor's answers, and the doctor is able to perceive these signals and quickly respond to them.

Table 2 presents brief comments on each utterance of the communicants.

Thus, preliminary sequencing of the transcript makes it possible to compare the positioning of separate parts of the dialogue and the utterances that are part of the analyzed dialogue; to study the special aspects of the dialogue's speech composition, namely to select and interpret characteristic lexical units and grammatical structures, to consider utterances in the context of their influence on the addressee, the change of communicative roles, and the entire structure of the dialogue.

Table 2. Change of Communicative Roles

068 PM: **HÄNGT** (-) dieser tumor (-) **zusammen** mit diesem blasentumor, 069 AM: (1.1) ne_NE, 070 [NEIN,]	A closed-type question from the patient activates the doctor's oral behavior. The doctor gives a laconic reply and does not introduce any additional information.
071 PM: **[ALso]** dass der BLAsentumor gestreut hat? 072 AM: ne DA sieht man gar nix,	The short answer of the doctor makes the patient to clarify/reformulate the question. Compared to the previous remark, the doctor responds in a more comprehensive way but still does not give any clarifications.
073 PM: **DA::SCH,** 074 AM: ne, 075 ne und **das WÄre** auch was anderes;	The patient is (most likely) not satisfied with the doctor's response and attempts to take the role of the speaker for the first time. The doctor takes over the speech initiative and starts explaining.
076 PM: das **WÄre=** 077 AM: =uroTHELzellen nennen die sich, 078 und **das sind** PLATten die empithelzellen haben;	The patient tries to take the role of the speaker for the second time. The doctor takes over the speech initiative again and continues his explanation.
079 PM: **hängt also NICHT zusammen;** 080 AM: **[NE ne ne;]**	The patient summarizes the doctor's explanations. The doctor confirms that the patient understood everything correctly.
081 PM: **[<aHA,>]** 082 **na GUT,** 083 (--) **[und-]** 084 AM: **[U::ND,]** 085 jetzt MUSS man natürlich überlegen, 086 welche **therapie** MACHT man?	The patient manifests satisfaction with the answer and at the same time wants to add some information. The doctor takes over the speech initiative and changes the topic (moves on to the matter of choosing the treatment).

2.5 The External Speech Structure of Dialogues as a Reflection of the Behavioral Strategy of Communicants

Describing the features of functioning of all possible institutional speech models in various person-centered discourses, I.V. Tubalova considers the issue of organizing the order in both *everyday* (common, well-practiced, routine, repeating) and *non-everyday* (unusual, developing according to unfamiliar and unproven scenarios) communication situations. While everyday speech activity is close to automatic in the perception of an individual, non-everyday speech patterns may cause psychological discomfort. That is why, when getting into an unusual communication situation, a "typical person" (in I.V. Tubalova's terminology, this is a person whose functional social role position is opposed to the institutionally defined position [Tubalova 2014: 40]) seeks to *restore the order*. In this case, the *order* in the individual's understanding is equivalent to a familiar, stable (in his/her own mind) model of behavior (including a speech model) and it often does not correspond to the institutional pattern [Tubalova 2014: 45]. The desire to restore the order can result in understatements, misunderstandings, and occasionally even conflicts.

In professional medical communication, the situation of patient reception (under *reception* we do not merely mean medical manipulations, but rather *verbal communication* and direct consultation that occurs before, during and after examination) is common for a doctor, which means it is reproduced almost automatically. Automatism in the professional medical field appears to be more purposeful and "polished" than in everyday communication. This is due to the rules governing doctor's activities (including verbal ones) are created at several levels. Primary formation takes place at the state level. Then state-approved regulations are specified precisely in the instructions and guidelines of a particular medical facility and subsequently implemented in a direct communicative situation.

As for the patient, the situation of seeing a doctor is not common. Getting used to non-everyday situations increases along with the frequency of interaction with the doctor. Frequent visitors of medical facilities are more active and tend to make changes in the communicative model. This is expressed in a detailed description of the problem, the way of posing questions (regardless of whether the doctor gives such an opportunity or not), and voicing the point of view and life experience.

Assessment of the external structure of dialogues is seen as necessary to identify the involvement of all those concerned (oncologist, patient and accompanying persons) during the dialogue and to compare the external and internal structures. The analysis of the external speech structure of dialogues was carried out by visual assessment of the line volume of speech fragments (fullness of each transcription line/utterance), on the one hand, and by quantitative calculation of transcription lines and words belonging to the persons involved in communication, without revealing apparent and/or deep meanings, on the other hand.

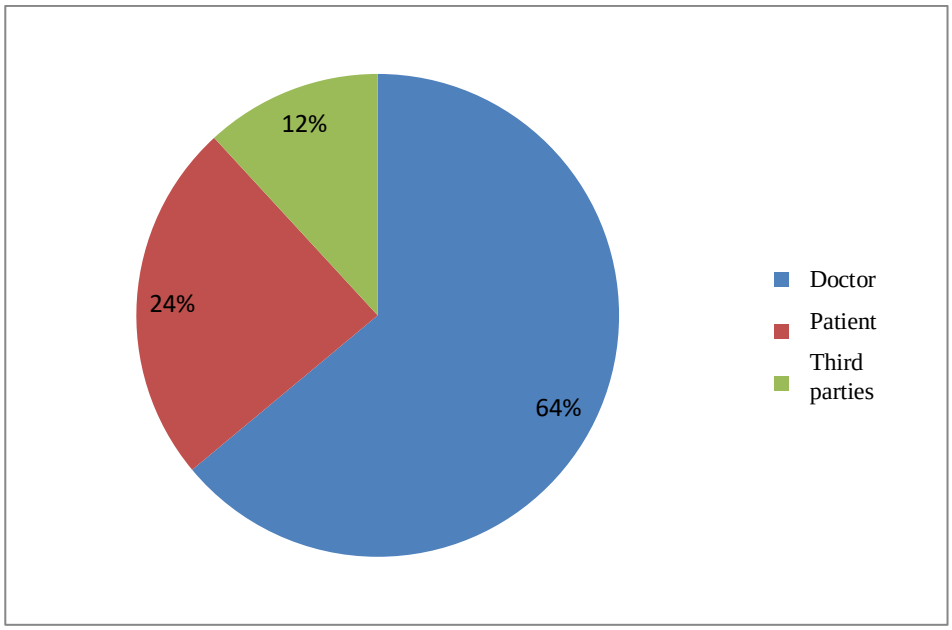
Initially, we deemed it enough to determine the number of transcription lines belonging to each communicant. The analysis of the volume of transcription lines resulted in the following conclusions (cf. Picture 1 and Picture 2):

1) if the patient is accompanied by third parties, they also take part in communication, but the patient remains verbally twice as active;

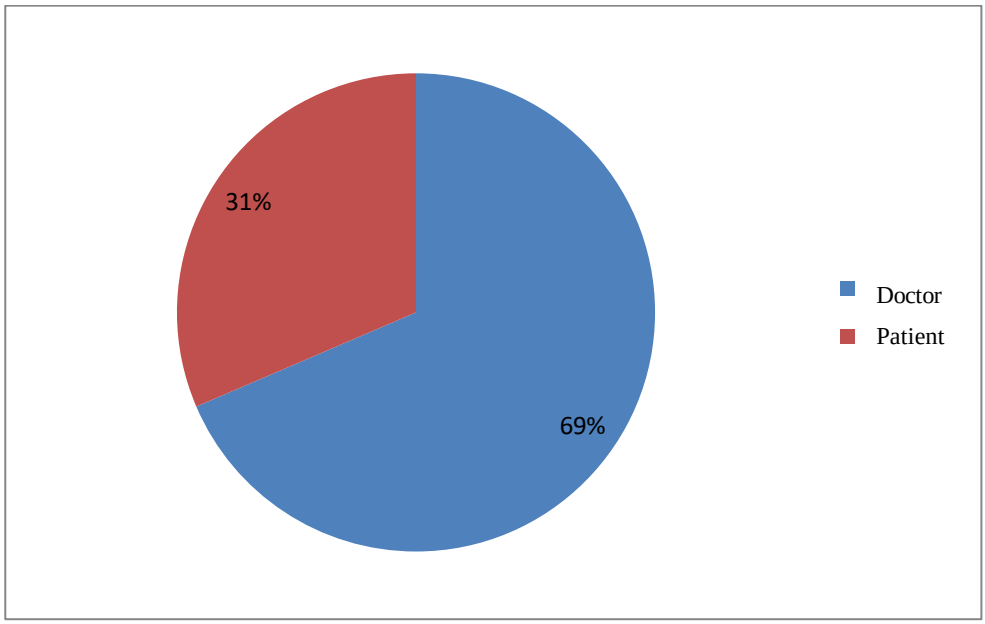
2) in the absence of accompanying persons, the patient becomes more active compared with his / her verbal behavior in the presence of third parties, but not significantly, by only 7 %;

3) the share of the doctor's participation in the dialogue is on average 66.5 % (64 % in the presence of third parties and 69 % in their absence).

Picture 1 — The ratio of the number of transcription lines belonging to the doctor, the patient, and third parties on the patient's side (total number of dialogues is 39)



Picture 2 — The ratio of the number of transcription lines belonging to the doctor and the patient (total number of dialogues is 12)



These conclusions seemed doubtful to us, as at least the first and second points contradict the visual perception of the volume of speech fragments. To assess the conclusions based on the calculation of transcription lines, to demonstrate more clearly the "pattern" of fullness of utterances and how often each of the participants enters the dialogue, it was decided to present the utterances of each participant of communication separately. The pictures 3–6 demonstrate fragments of the doctor's speech (Picture 3a, 3b), fragments of the patient's speech in the presence of accompanying persons (Picture 4), fragments of the speech of accompanying persons (Picture 5), and fragments of the patient's speech in the absence of accompanying persons (Picture 6).

Based on the analysis of the volume of graphically fixed text in each transcription line, we reached the conclusions quite different from those earlier announced.

1) The doctor always stays verbally engaged in a dialogue from the first minutes, regardless of whether there are any accompanying persons on the patient's side (Pictures 3a, 3b). This way, estimation of the volume of speech fragments with the doctor's utterances does not contradict quantitative calculation: the doctor's utterances exceed those of the patient and accompanying persons in volume. The results of similar studies show that the share of the doctor's participation in consulting patients can vary from 40 % to 80 %. One of the main criteria for increasing the percentage is the presence of an informing component in the doctor's speech [Bußmann 2008: 75; Frey 2017: 52; Fritzsche 2016: 306]. In the facility we are evaluating, the percentage of verbal participation exceeds the limit of 60 %. Such a high percentage indicates the informative intensity of oncologists' utterances. This assumption was confirmed when assessing the internal structure of the dialogues under consideration.

Picture 3 — Fragments of the doctor's speech

a) with accompanying persons on the patient's side

```
002     so:,
003     (--) ALso,
004     wir HAben jetzt alle befunde zusammen.
006     (.) befunde sowohl BILder,
007     als AUCH (.) den (-) feingeblichen befund.
008     (--)
010     (--) von GEStern von der bronchoskopie;
011     (--) ja?=als wir uns Oben gerad gesprochen haben,
012     da hatten wir ihn VORläufig,
013     und jetzt ham wa sogar den (.) ENDgültigen befund,
014     und es sind TUmorzellen drin,
015     also es sind (.) BÖSartige zellen,
016     in dieser gebs_oder in DEM gebsprobe die wir entnommen haben,
019     [von dem FLECK] und von den LYMPH[knoten,]
```

moderate fullness of transcription lines

Picture 3 — Fragments of the doctor's speech

b) without accompanying persons on the patient's side

```
001      Ahja,
002      (1.9) genau das kann ich ja auch HIER rüber legen,
003      es isch interessant weil_s was SELtenes is;
004      [< SEHR selten.> ]
006      (--) das is jetzt WEder gut noch schlecht [dass es selten is,]
008      esm_es IS einfach so,
009      °hhh man DACHT ja sie ham ja (--) da IM raum zwischen den
         lungen [isch ja bei ihnen- ]
011      (--) ich glaub MEHR als zufallsbefund isch das [ja aufgefallen
         was da,]
014      ä::hm,
015     (--) wie wir das so schön ein RAUMvordrung,
017      [das heißt dass] da was IS was eigentlich net hingehört,
018     °h und da dachten wa erst am HÄUfigsten sind es ja so (1.4) ä::hm-
019      (1.5) tuMOren die vom (.) von lymphknoten [herkommen; ]
022      (schnalzt) bei ihnen is [ANders;]
```

maximum fullness of transcription lines

2) In the presence of accompanying persons, the patient becomes verbally passive and does not take the initiative to make verbal contact with the doctor (Picture 4). In this respect, the initiative for verbal interaction with medical staff in almost all cases passes to the accompanying person (Picture 5). In addition, the accompanying person often "jumps" into the dialogue in the few first minutes of the consultation and remains verbally active throughout almost the entire consultation.

Picture 4 — Fragment of the patient's speech with accompanying persons

```
010     ja:,
016     ja,
055     [(hustet)]
120     mir wurde aber DAmals nicht [aufgeklärt].
133     hier,
137     ja,
241     HAB ich,
284     [hm, ]
359     ja,
430     hm,
434     GUT.=ja,
436     ja,
437         (1.0)
355     ja,
356     (---)
```

minimum fullness of transcription lines

Picture 5 — Fragment of the accompanying person's speech

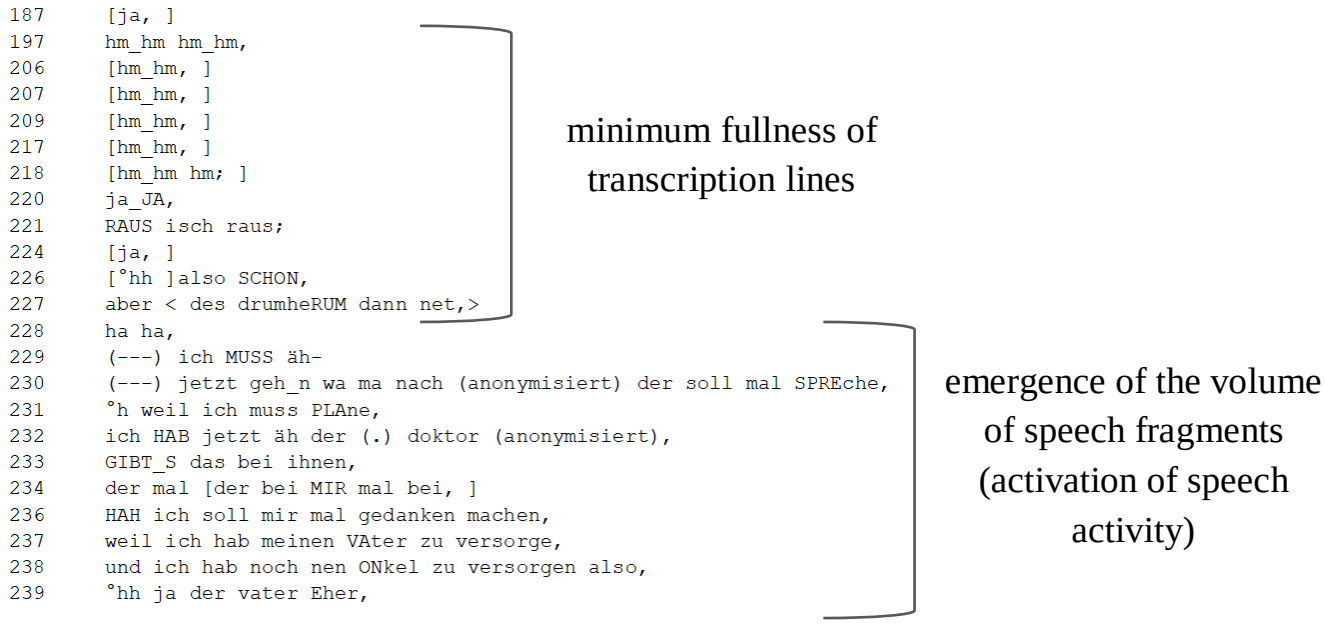
```
003     <<p> ja;>
062     ja,
063     (---) und das war BISher ganz anders,
064     das WAR,
065     der festgeschwulstig opeRIERT worden war,
066     alles gut,
067     alles äh PRIma,
068     °h nich BÖSartig,=
069     =nach VIER woche kam a brief,
070     °h es wäre aber eine (.) BÖSartige zelle gefunde,
071     wir wurde !NICHT! aufgefordert nochmal ins krnankenhaus zu kommen,
072     wir waren in der VORbereitung an november,
073     nach teneRIFfa zu gehen,
074     und haben ALles verschwitzt,
075     und des halt des resulTAT.
078     ja?
118     [ja, ]
121     [ich denk IMmer] der patient is der laie,
122     °h und der doktor is der FACHmann,
123     normal hät er zu uns schreibe müsse wir soll_n uns VORstelle;
124     °h und das hat NIEmand getan,
```

moderate fullness of transcription lines

3) In the absence of accompanying persons, the patient becomes more open to communication only from the second half of the dialogue. Picture 6 shows the moment of transition of the patient's verbal activity from the passive phase to the

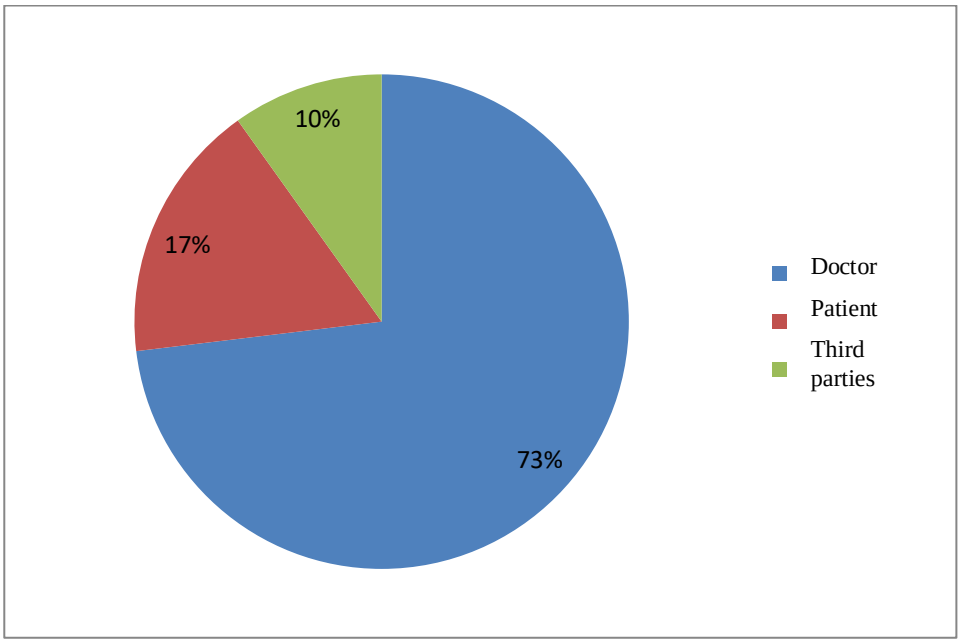
active one. Short verbal sound signals are replaced by sentences, the duration of each utterance increases, and the number of pauses decreases. Confidence in the validity of our conclusions based on the visual assessment of the fullness of the utterances of the persons involved in the dialogue is supported by the results of similar studies in the field of verbal interaction between the doctor and the patient. Thus, S. Dunkelberg, when analyzing the communication between a family doctor and a patient, noticed the following pattern: the patient's participation in the dialogue changes depending on how long the consultation lasts. The longer the communication with the doctor continues, the more verbally active the patient becomes [Dunkelberg 2000: 59].

Picture 6 — Fragment of the patient's speech without accompanying persons (phase of transition from passive verbal actions to active ones)



To verify the results based on a line-by-line visual analysis of speech fragments, it was decided to count the words pronounced by each participant of the dialogue (Pictures 7 and 8; Table 3, lines II, IV, VI). These results also helped to understand the differences between results based on comparing the fullness of utterances and the counting of transcription lines.

Picture 7 — The ratio of the number of words belonging to the doctor, the patient and third parties on the patient's side (total number of dialogues is 39)



Picture 8 — The ratio of the number of words belonging to the doctor and the patient (total number of dialogues is 12)

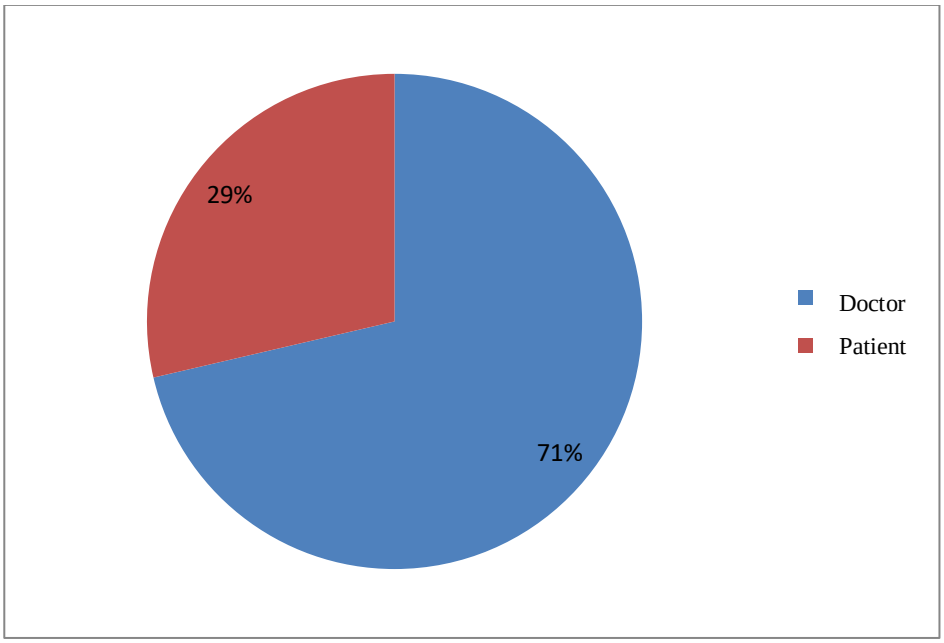


Table 3. The number of transcription lines and words per one communicant *

No	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**
I	397	279	18	456	370	268	474	360	315	17	354	223	288	223	313	524	390	525	15	393	479
II	210	177	94	149	237	174	240	150	210	78	152	119	150	111	157	244	189	297	64	192	272
III	194	15	84	228	180	69	140	161	80	25	188	54	112	153	141	102	58	246	61	113	51
IV	748	25	15	499	630	195	417	425	246	56	922	238	372	178	479	338	169	799	16	297	156
V	93	118	62	32	60	4	78	47	5	54	5	89	91	17	23	38	190	145	14	115	80
VI	269	461	21	45	218	16	279	84	5	18	5	357	275	75	67	70	750	750	30	430	305

№	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	∑ with third parties	Words / transcript lines
I	514	203	657	260	689	216	148	397	366	744	307	436	980	568	832	344	399	485	15694	4,872
II	2075	871	3792	1410	3966	863	741	2186	2055	2603	1264	1554	4343	2583	4318	1339	1493	2245	76455	
III	318	133	226	52	137	140	40	195	149	209	205	159	452	346	351	102	69	199	5937	2,999
IV	920	465	814	125	505	459	112	671	576	530	386	423	1304	948	898	298	125	738	17808	
V	25	19	207	87	99	10	29	94	66	137	103	80	48	66	41	103	266	68	2908	3,554
VI	57	34	890	391	612	28	84	377	329	463	284	231	112	200	105	245	528	208	10334	

№	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**	**50**	**51**	∑ **without** third parties	Words per one person	Total ∑
I	371	171	254	691	605	252	249	475	98	193	305	455	4119	4,343	15694
II	2006	828	1433	3083	2590	1548	1007	1368	377	832	1268	1550	17890		76455
III	283	42	171	178	358	175	135	101	20	91	81	254	1889	3,801	5937
IV	1173	110	502	685	1253	803	498	518	47	417	230	944	7180		17808
V	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2908
VI	0	0	0	0	0	0	0	0	0	0	0	0	0		10334

* Symbols in Table 3:

No – sequence number of the dialogue

I – number of transcription lines belonging to the doctor

II – number of words belonging to the doctor

III – number of transcription lines belonging to the patient

IV – number of words belonging to the patient

V – number of transcription lines belonging to accompanying persons

VI – number of words belonging to accompanying persons

1) The most active party in dialogues, regardless of the presence or absence of accompanying persons, is the doctor, whose speech takes up about three-quarters of the total number of words pronounced. This conclusion highlights the asymmetry in the relationship between the doctor and the patient. This is also indicated by the visual assessment of the fullness of speech fragments and the number of transcription lines belonging to the doctor.

2) By using the data from Table 3, it is possible to count the average number of words pronounced by each participant of the dialogue for one intonation phrase (= the number of words in one transcription line). This way, in the presence of the accompanying person, the average number of words in one line for the doctor is about five words (4.87), for the patient — three words (2.99), for accompanying persons — four words (3.55). At the same time, from the analysis of the line-by-line visual volume of speech fragments (Figure 2), it becomes clear that the words belonging to the patient are sounds that express emotions (mainly interjections *ah, aha, hah, hm, oh* and laughter*).* Therefore, the accompanying person undertakes almost all communication with the doctor.

In the absence of accompanying persons, the number of transcription lines in the patient's speech is reduced, and the number of words in each line increases. This indicates an increase in the intensity of the patient's verbal behavior and a decrease in emotionality. It turns out that the doctor and the patient on average pronounce four words in one transcription line (doctor — 4.34; patient — 3.8). When comparing the fullness of transcription lines in the first part of the consultation and in its second third

(after voicing the diagnosis) (Figure 3), a significant reduction in interjection utterances can be noticed in the patient's speech, and the associated decrease in the emotionality of speech, and an increase in the number contant words. Thus, in the absence of accompanying persons, the patient looks more relaxed from a verbal point of view. Judging by the number of the words uttered (Pictures 7 and 8), the patient "joins" in communication with much greater intensity than third parties (12 % more active verbally than accompanying persons).

The analysis of the patient's utterances from the studied dialogues showed that the patient is generally not inclined to dynamic speech activity, is limited to monosyllabic affirmative or negative statements, and does not attempt to interfere with the doctor's proposed dialogue development. The "novelty" of the situation and the depressing impact of the diagnosis itself can make verbal communication with cancer patients difficult. In the considered dialogues, the doctor often encounters minimal verbal manifestations. These mainly include coughing, neutral or emotional inhalation and exhalation *(°h / h°).* An essential feature of the patient's speech is the abundance of particles *ja/nein,* interjections *ah, aha, hah, hm, oh,* long inhalation and exhalation affecting the intonation structure of the dialogue, for the formal designation of which the transcription lines are used.

Visual assessment of the volume of speech fragments (line-by-line fullness of utterances), counting transcription lines and words allow us to draw a number of conclusions.

First, the asymmetry of the doctor's and the patient's speech (and accompanying persons, if any) is already manifested in the external structure of the transcript: the doctor's utterances comprise three quarters of all utterances. Second, with accompanying persons, the patient is more likely to display his/her emotional instability and is less likely to engage in dynamic verbal actions. Third, accompanying persons often assume the "parent" role and partially or completely conduct a dialogue with the attending doctor. Fourth, the absence of accompanying persons stimulates the patient to be dynamic in his/her verbal actions. The speech acquires a smoother intonation background, and the number of interjections that add emotion to speech decreases.

2.6 Internal Dividedness of Therapy-Planning Talks

The study of the internal dividedness of the doctor's and the patient's macrodialogues is due to the need to determine *the algorithm for conducting a therapy-planning talk* and its verbal design. The sequence of communicative blocks in many cases is based on the practical experience of the doctor. The positive aspect of such linguistic formulations developed in practice is the maximum automaticity when reproducing them. In most cases, this helps reduce the time of admission. The negative side is revealed in the fact that the doctor is not always able to evaluate on their own the effectiveness of the speech patterns he/she has developed and mistakenly believes that his/her verbal behavior is optimal, while the patient has difficulty perceiving information. This is confirmed by the results of a study showing that every fourth patient does not understand his/her doctor [Egger 2012: 2].

The presence of *the algorithm for conducting a therapy-planning talk* is the cause of *conditional* spontaneity and indicates the presence of special *organization* which is necessary for the consciousness of a single field of conversation. Social competence allows participants in the process to create, directly during verbal interaction, a special *order* that is understood by all participants in the process without prior or subsequent explanation (cf. [Isupova 2002: 36]. The plan for conducting a therapy-planning talk is associated with various factors that create conditions for contextualization, for example, the place and time of the appointment, the level of familiarity between the doctor and the patient (primary or repeated appointment), age, sex, severity of the disease, the patient's psychoemotional state, etc.

In this paper, we have considered two ways of internal dividedness of dialogues. The first way is to divide the dialogue into structural components. The second way involves the sequencing of dialogues depending on the speech configurations that are at the center of the research.

2.6.1 Typical Intentional and Pragmatic Organization

The intentional and pragmatic organization of the dialogue is subject to instrumental (= therapeutic/medical) goals, therefore the names of the verbal stages (structural components) of the dialogue often duplicate the sequence of therapeutic actions. Thus, Th. Spranz-Fogasy distinguishes five main stages of a medical consultation identified on the basis of German language resources. The first includes greeting and establishing contact with the patient (Ger. *Begrüßung und Gesprächseröffnung*). At the second stage, the doctor sees the medical record and listens to the complaints (Ger. *Beschwerdenschilderung und Beschwerdenexploration*). Then he/she announces a preliminary or final diagnosis (Ger. *Diagnosestellung*). At the fourth stage, possible scenarios for the disease development and related therapeutic options are discussed (Ger. *Therapieplanung und -entwicklung*). At the last stage, the doctor sums up the results of the consultation and finishes the dialogue (Ger. *Gesprächsbeendigung und Verabschiedung*) [Spranz-Fogasy 2005: 21]. A group of Russian linguists came to similar results. The results of a research devoted to the study of the structural components of consultations based on the resources of Russian, English and German languages show that, regardless of the language resource, the structure of the medical dialogue contains greetings and farewells, establishing contact, collecting information about the disease and the patient's state, physical examination with accompanying speech actions, recommendations and planning of therapy [Osipenko, Fedorovskaya, Enikeev 2022: 105]. The intentional and pragmatic organization of the dialogue is inevitably transformed and expanded when implemented in a specific talk.

When working with transcripts of dialogues between doctors and cancer patients, G. Coussios, W. Imo, L. Korte identified 14 structural components [Coussios, Imo, Korte 2019: 11-17][9]. The presented classification is intended to teach students of

[9] G. Coussios, W. Imo, L. Korte analyzed the same corpus of dialogues that is being worked on in this research, i.e. a corpus created within the project *"Von der Pathologie zum Patienten <...>"*. The purpose of their research work was to create a training aid to improve the quality of professional medical communication between an oncologist and a patient which would equally satisfy the

medical institutions and practicing doctors the basics of communication with cancer patients. The identified components have been pragmatically considered, attention is paid mostly to problem areas of communication. Our tasks include the expansion, classification and linguistic characterization of some of the identified categories.

We noticed that the components can be divided into three groups. It is expedient to place components that verbalization is initiated by the doctor into the first, most numerous group. Their reproduction is determined by institutional rules. A distinctive feature of these components is the frequency of their reproduction, they are found in almost all dialogues: 1) announcement of cancer diagnosis; 2) assessment of tumor parameters; 3) diagnosis clarification/explanation; 4) therapy justification/explanation; 5) therapy recommendation 6) decision-making about the treatment method; 7) planning the time frame of therapy.

We included categories that are not frequently reproduced by the doctor (in every fourth dialogue or less often) in the second group. Their verbalization is basically the doctor's response to the patient's speech actions (but it can be initiated by the doctor). 1) Talking about getting a second opinion. When verbalizing this category, the doctor announces the possibility of obtaining *a second opinion* on the results of tests to clarify the diagnosis or treatment plan. The category is often reproduced when the patient implicitly or explicitly shows distrust, as well as when the doctor wants to "relieve himself/herself of responsibility" for the results of laboratory tests. 2) Announcing the need for additional examinations or tests. The category is intended to describe the actions that must be performed during or after medical manipulations. It also appears if it is necessary to clarify the severity of the disease. Most often, the doctor lists the necessary therapeutic actions and the patient agrees with them. 3) Providing advice on ways to "manage" the disease in everyday life. 4) Stabilization of the emotional state / presentation of good news / consolation. The category is often reproduced as a doctor's response to *fishing* on the part of the patient. *Fishing* includes verbal (for example, "ai-ai-ai") or non-verbal manifestations (crying, increasing pauses duration or silence on the

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institutional requirements for the doctor and the psychoemotional needs of the patient. The training aid can be useful for practicing doctors taking advanced training courses or learning on their own, as well as for students of medical institutions and trainees.

doctor's questions, inappropriate laughter) which indicate the patient's depressed state and the need for emotional support by the doctor [Imo 2017b: 11].

The most "unstable" components (i.e., those that appear in every sixth session or less often) are placed into the third group. Their appearance is due to the patient's speech actions, and their content is determined by his/her personal qualities. 1) *Small talk.* When reproducing this category, the patient often talks about important events in his/her personal life (planning a vacation, attending music classes). 2) The patient's description of his/her current physical and psychological condition. 3) Mentioning the experience of combating the disease. The verbalization of this stage is typical when communicating with patients who have been diagnosed with cancer again or if the patient could observe how one of his/her relatives or friends was combating or is combating cancer.

Analysis of the dialogues showed that the verbalization of the listed structural components can be carried out in different sequences. The same component is often reproduced several times within the same consultation. The reasons for repeated announcement can be 1) an explicit or implicit request from the patient caused by misunderstanding or disagreement, 2) a deliberate summary by the doctor of previously provided information.

In addition to the indicated 14 structural components in the analyzed counseling sessions, it is expedient to single out 1) stage of the beginning of a counseling session (establishing contact) and 2) end of a counseling session including specialized greeting and farewell formulas. Three more communicative units the verbalization of which is commonly initiated by the doctor can be considered as "transitional elements" between larger (in terms of the number of transcriptional lines) structural components. 3) Updating of the medical record. This component is updated by *the doctor* if it is necessary to make a reference to the previous counseling session or get back to any issue discussed in the current dialogue ("Do you remember we discussed this last time / now?"). Most often, this unit serves as a preparatory stage for delivering bad news, i.e. it precedes the "The reporting of the final diagnosis" structural component. 4) Distribution or removal of responsibility. In this case the doctor does not share responsibility with the patient when he/she imposes the obligation on the patient to take

tests every three months after the surgery, but with *other medical workers*, members of the tumor board before which the treatment plan is approved. 5) Checking contact with the patient. This refers to the doctor's speech actions aimed at obtaining information from the patient, when the doctor wants to make sure that the patient listens to him/her, correctly understands what was said and does not need additional information.

2.6.2 Principal Structural Components and their Linguistic Marking

The highlighted categories of intentional and pragmatic organization of therapy-planning consultations will be used to analyze the lexical content and grammatical design of dialogues between the doctor and the cancer patient. Due to the limited volume of the dissertation, the subject of our analysis covers the first seven structural components (1–7). The choice was made due to the high repeatability of these structural components in dialogues. The remaining communicative blocks are also promising for research; therefore, they are considered by the author as empiric material for future linguistic studies.

2.6.2.1 Announcement of Cancer Diagnosis

The cancer diagnosis (or the "bad news" [Maynard 2003]) is most often reported in the first minutes of the dialogue and takes no more than three transcription lines. Depending on the lexical composition of the phrase, which contains details of the medical report, two ways of expressing information about the diagnosis can be distinguished: using 1) the nouns *Karzinom (18/10)*[10], *Krebs* (204/36), *Tumor* (419/42) and their derivatives; or 2) the adjective *bösartig* (60/22) (cf. [Osipenko 2023a: 151]). Statistical data show that these lexical units are used not only when reporting the diagnosis but also in other parts of the dialogue (mainly when describing tumor parameters, explaining the diagnosis and recommending the therapy methods).

[10] The first figure in brackets indicates the number of repetitions of a lexical unit in the texts of transcripts, the second figure, the number of dialogues in which this lexical unit occurs.

When announcing the diagnosis, the noun *Karzinom* is in most cases used as part of word groups, that is highly specialized medical terms denoting a diagnosis, for instance, *Adeno**karzinom*** ‘adenocarcinoma,’ *Mamma**karzinom*** ‘breast carcinoma,’ *Plattenepithel**karzinom*** ‘squamous cell carcinoma,’ *Rektum**karzinom*** ‘rectal carcinoma,’ *Thymus**karzinom*** ‘thymus carcinoma.’ Such medical terms are often voiced in combination with words and expressions that demonstrate the doctor's intention to clarify the meaning of new terminology. Case 3 illustrates one of the options for reporting a diagnosis using the highly specialized medical term *Plattenepithel**karzinom***. The adjective *sogenannt* ‘so-called’ precedes the voicing of the term itself and implies the understanding that the term may be unfamiliar to the patient. The phrase *das SAGT ihnen jetzt nichts* ‘it doesn't say anything to you right now’ explicitly shows the doctor's confidence that the term is incomprehensible to the patient and needs an explanation. The adverb *jetzt* signals the nearest "thematic progress" [Buck 2022: 143] (cf. Ger. *Thematisierungsformel* [Zifonun et al. 1997: 524]) and is an indicator of the transition from reporting a diagnosis to its explanation. Accordingly, the lexical environment of the term (especially the adjective *sogenannt* and the adverb of time *jetzt*) indicates the temporal relevance of what is happening (cf. Ger. *temporaldeiktisch auf den aktuellen Zeitpunkt verweist* [Buck 2022: 193]), determines the structure (cf. Ger. *diskursstrukturierende Funktion* [Imo 2010]) and the theme of the dialogue (cf. Ger. *die Bearbeitung einer neuen Thematik* [Dittmar 2002: 161]).

Case 3

028 AM: das is ein **SOgenanntes plattenepithelkarzinom,**
029 das **SAGT** ihnen **jetzt nichts,**

To balance the emotional state of the patient who is going to or has just become aware of the diagnosis, doctors sometimes use the particle *einfach* (214/43). It works as a means of cushioning the negative impact or distracting the patient's focus from the negative aspects of the situation (cf. [Helbig 1994: 131–134; Thurmair 1989: 131; Weydt, Hentschel 1983: 11]). Case 4 demonstrates the appearance of the particle *einfach* just before reporting the diagnosis (52). In this example, the particle reduces the negative connotation of the medical term *Mammakarzinom* ‘breast carcinoma,’ as if

equating the situation of detecting carcinoma with some ordinary situation. In addition, the negative impact of the medical term is reduced here due to the fact that before reporting the diagnosis, the doctor makes a reference to the previous consultation. Combining the adverb *schon*, demonstrating the final completion of something [Féry 2010; König 1977; Klein 2018], with the verb *denken*, denoting the thought process and actualized in the Present Perfect tense ***schon*** *gedacht hat* (50–51), reminds us that the question of whether the patient has a tumor has already been discussed (cp.: [Klein 2000]). In this regard, a cancer diagnosis seems to be something long expected and predetermined (Ger. *Die Übermittlung der Krebsdiagnose wird als etwas behandelt, das keineswegs unerwartet kommt, sondern bereits im „Raum stand“* [Günthner 2017: 8]). This example demonstrates once more how crucial it is to evaluate the nearby context.

Case 4

050 AW es is **SCHON** was,
051 was ma **schon geDACHT hat;**=gell?
052 dass da **einfach n_MAMmakarzinom** da ist,

The task of highly specialized vocabulary at the stage of reporting the diagnosis also includes the opposition of the current and potential state of the patient. In Case 5, the doctor uses terms *Thymom* ‘thymoma’ and *Thymuskarzinom* ‘thymus carcinoma’ to show the gradation of hazards where *thymoma* does not imply something really hazardous to human health (412), while *thymus carcinoma* is something worth serious concern. The juxtaposition of terms in this case implements the statement *"It could have been worse"* (cf. Ger. *"Das Gute im Schlechten"* [Coussios 2019: 47]; Ger. *"Glück im Unglück" / "Es hätte noch weitaus schlimmer sein können"* [Günthner 2017: 25]; Eng. *"good news exists from the bad news"* [Maynard 2003: 177]). Thus, employing terms denoting various degrees of tumor aggressiveness, the doctor implicitly sends the patient the message: "If you had thymus carcinoma, not thymoma that would be much worse for you."

Case 5

407 AM also das **thyMOM,** (--)
408 sie MERken ja das heißt ja net, (--)

409 **THYmuskarzinom,**
410 es heißt [**thyMOM** bei ihnen,]
411 PM [hm_hm hm_hm,]
412 °hh des is auch **nix richtig BÖSartiges.**

The lexical unit *Krebs* (204/36) occurs 18 times more often in transcripts than the noun *Karzinom (18/10)*. The increase in the frequency of using the term *Krebs* is probably due to its wider use among non-specialists, although the degree of negative impact on patients is not inferior to the term *Karzinom* (cf. [Zhura 2007]). Interestingly, the lexical item *Krebs* occurs only in 36 dialogues; in seven of them, it is reproduced only once. It can be assumed that doctors deliberately avoid using any terms associated with fatal diagnoses (cf. "The general public believes cancer to be a fatal thing, and being diagnosed with it is like being sentenced to death, in the short or long run" [Gnezdilov 2001: 6]).

When reporting diagnoses, the *Krebs* component is most often used as part of word groups, like, *Brust**krebs*** 'breast cancer', *Eierstock**krebs*** 'ovarian cancer,' *Enddarm**krebs**/Rektum**krebs*** 'rectal cancer,' *Haut**krebs*** 'melanoma, skin cancer', *Hoden**krebs*** 'testis cancer', *Knochemark**krebs*** 'marrow cancer,' *Lungen**krebs*** 'lung cancer.' The binary structure of determinative word groups makes it possible to specify the localization of cancer cells without extra explanations as it is denoted by the opening component of the word group.

In other parts of the dialogue, the lexical item *cancer* is used either without modifications or as part of word groups, yet not as the principal component, but as a secondary one, which has the function of clarification: ***Krebs**arten/**Krebs**formen* 'types/forms of cancer,' ***Krebs**erkrankung* 'cancer disease,' ***Krebs**zellen* 'cancer cells,' ***Krebs**station* 'cancer ward,' ***Krebs**erkrankte/**Krebs**patient* 'cancer patient,' ***Krebs**register* 'cancer registry,' ***Krebs**spezialist* 'cancer specialist/oncologist.'

The term *Tumor* (419/42) is the most frequent (compared with *Karzinom* and *Krebs*). It can be inserted in any communicative block. Only a few cases of using this noun as a part of complex words have been identified, where it serves as a defining element. Such complex words have both a highly specialized focus (***Tumor**biologie* 'biology of tumors,' ***Tumor**board* 'tumor conference,' ***Tumor**manifestationen* 'tumor

manifestations,' ***Tumor****marker* 'tumor marker,' ***Tumor****masse* 'tumor mass') and a more colloquial one (***Tumor****erkankung* 'cancer disease,' ***Tumor****zellen* 'cancer cells').

An important role in reporting the diagnosis plays the adjective *bösartig* 'malignant' (60/22) and its substantivized form *Bösartiges*. The introduction of the words is recorded in utterances without highly specialized oncological terminology (i.e., without a medical designation of the diagnosis): *Also das ist ein* ***bösartiger*** *Tumor* 'Well, this is a malignant tumor,' *Es sieht schon so aus, dass dort* ***bösartige*** *Zellen drin sind* 'It looks like there are malignant cells there,' *Man hat tatsächlich eine* ***bösartige*** *Geschwulst in der Lunge gefunden* 'A malignant neoplasm has really been found in the lung,' *Man hat was* ***Bösartiges*** *gefunden* 'Something malignant has been found.'

The situation of reporting a cancer diagnosis can be stressful and the patient is not always ready to accept the fact that he/she has a malignant tumor right away. For this reason, the wording *Sie haben ein Tumor* 'You have a tumor' may not be sufficient to make the patient aware of the seriousness of the situation (because *ein Tumor* may indicate a benign tumor). The appearance of the described adjective (*Sie haben ein* ***bösartiger*** *Tumor*) introduces an element of clarification (cf. Beispiel 2 from the article [Imo, Fedorovskaya, Sekacheva 2020: 59–60]) and avoids further questions from the patient. In Case 6, the doctor uses the term *Tumorzellen* 'tumor cells' to describe the diagnosis, which indicates the presence of a tumor without indicating its malignancy. To clarify the type of tumor, the doctor replaces the component *Tumor* with the adjective *bösartig*, which reflects the negative side of the diagnosis.

Case 6

13 AM: und jetzt ham wa sogar den (.) **ENDgültigen befund,**
14 und es sind **TUmorzellen** drin,
15 also es sind (.) **BÖSartige zellen,**

The "formula" for reporting a diagnosis often consists of two parts: an introductory phrase and a statement about the presence of a malignant tumor. By "introductory phrase" is meant the utterance that informs about the existence of the final diagnosis without naming it. In Case 6, such a formulation is the expression

entgültigen Befund haben (13) (cf. Osipenko 2023a: 151). The statement about the presence of a malignant tumor can be expressed as an accurate/final diagnosis (Cases 3–5) or as a report of the presence of cancer/malignant cells (Case 6).

The lexical composition of the structural component "Announcement of Cancer Diagnosis" shows a high frequency of using the nouns *Karzinom, Krebs* and *Tumor,* used in many cases as part of two-component determinative word groups denoting a (highly specialized) medical terminology. The adjective *bösartig* can also be used in the utterances about a cancer diagnosis. It serves the purpose of taking the place of specialized oncological terminology used to indicate the diagnosis.

2.6.2.2 Assessment of Tumor Parameters and Diagnosis Clarification

The elements of assessing tumor parameters in the analyzed dialogues are often traced in the immediate "proximity" to the structural component "Announcement of Cancer Diagnosis" (cf. *troubles-telling* [Buck 2022: 232, Jefferson 1988]), that is, prior to (as a stage of preparing for bad news) or right after (to relieve emotional stress) the announcement. To assess a tumor, oncologists use highly specialized alphanumeric indicators or describe significant tumor parameters.

The specifics of expressing the assessment results using highly specialized alphanumeric indicators. As alphanumeric indicators are used the data from the global stage-based TNM malignancy classification, widespread among oncologists, where the indicator T (Lat. *tumor* ‘tumor’) stands for the tumor size and may vary from 1 to 4, N (Lat. *nudus* ‘node’) indicates the degree of damage to the lymph nodes and may vary from 1 to 3, M (Greek: *μετάστασις* ‘displacement’) signals the presence (M1) or absence (M0) of distant metastases. The histological degree of tumor malignancy is denoted by letters G1 to G4 (English *grade* ‘degree, level’), where G1 stands for a highly differentiated tumor; G2, for a moderately differentiated one; G3, for a poorly differentiated one; G4, for an undifferentiated tumor [Blinov 2003: 1–18].

Using the alphanumeric indicators clarifies the explanation and increases the patient's trust in what the doctor is saying. Yet, these data require some extra explanations.

In Case 7, the doctor explains to the patient the meaning of the alphanumeric indicator G3 and describes its negative and positive aspects.

Case 7

155 PW: isch das_n SCHNELL wachsender tumor,
156 AW: des schon **ge DREI,**
157 also **ge DREI heißt** schon das was ich ihnen vorhin gesagt hab,
158 dass der schon (.) n_bissl **schneller wächst** als ANdere jetzt;
159 ja?
160 °h **schneller WÄCHST,**
161 u::nd,
162 **Aber,**
163 DANN auch wieder **auf chemo besser anspricht,**

To the closed-type question like "Is it a fast-growing tumor?" that implies either affirmative or negative answer, the doctor responds with the phrase *des schon ge DREI* 'already G3' (156), which replaces the affirmative answer. Upon introducing the alphanumeric indicator, the doctor explains it immediately. The word construction *G3 heißt* 'G3 means' is a bridge to the explanation. In this case, the explanation itself is evaluative in nature and is expressed through a comparative adjective *schneller* 'faster' used as part of a comparative construction with *als* 'than' (*bisschen schneller wächst als andere* 'is growing a little faster than others' (158)). The negative semantic connotation of the combination *schneller wachsen* 'grow faster' is mitigated by the adverb *bisschen* 'a little' and the sentence with an adversative conjunction *aber* 'but,' revealing the positive aspects of the diagnosis (163).

Getting back to the highly specialized indicators, it is worth mentioning once again that introducing alphanumeric indicators is most often accompanied by explanatory constructions with evaluative adjectives and adverbs.

Numerical indicators used to explain the diagnosis can be expressed as percentages or units of measurement, for instance, millimeters or centimeters: *Wachstumsfunktion ist von 10 Prozent. Das sind Tumoren, die nicht schnell wachsen. Der größere Tumorherd ist 2,7 Zentimeter groß.* The examples show how numerical designations make it possible to accurately describe the characteristics of the tumor.

The specifics of expressing the assessment through describing significant tumor parameters. In most cases, doctors avoid using professional alphanumeric indicators to define the tumor. Instead, the behaviour of the disease is assessed through certain indicators such as the activity of cancer cells, in other words, the rate of tumor growth, tumor's actual size, number of harmful tumor foci, stage of the disease (cf. [Osipenko 2023a: 151–152]).

The listed indicators, as a rule, are introduced into the dialogue to cover the positive aspect of the tumor and are announced after updating the second part of the concessive construction *zwar/schon ..., aber* 'although ..., but …' [Osipenko 2023b]. According to S. Günthner, this grammar construction may be referred to as: *zwar..., aber…-Strategie = konzessive Strategie = zweiteilige Strategie* [Günthner 2015, 2017]; according to W. Imo the following: *X aber Y* 'X но Y', *das Schlechte ist X, aber das Gute ist Y* [Imo 2017b: 21; Imo 2016b: 20].

The first part of the construction contains negative information about the disease and its symptoms. The second part of the construction with the adversative conjunction *aber* 'but' bears a supportive connotation, which is associated with the positive parameters of the tumor. This grammatical structure mainly aims at distracting the patient's focus from a bad diagnosis to the positive tumor parameters. Case 8 illustrates the situation of announcing a diagnosis and detailing it step-by-step while emphasizing the tumor's positive characteristics.

Case 8

82 AW: [ja: des]is_n BÖSartiger tumor?
83 PW: ja::,
84 AW: **A::ber** (.) er hat eigentlich **nur gute eigenschaften.**
85 PW: oh;
86 AW: **in bezug auf** er WÄCHST nicht schnell,
87 PW: mh_MH*,
88 AW: e::r sie brauchen keine CHEmotherapie,

*In transcripts, *hm* can be graphically represented as *mh. hm* denotes an ascending/interrogative intonation (das fragende), while *mh* expresses agreement (das zustimmende).

This passage of the dialogue can be sequenced into three parts.

Part 1 (82–83) is the announcement of the diagnosis. The doctor informs the patient about the tumor. The adjective *bösartig* is used as a definition for the word *Tumor*, conveying the negative side of the diagnosis.

Part 2 (84–85) is the assessment of the tumor. Introducing the adversative conjunction *aber* 'but' and the adjective *gute (Eigenschaften)* 'good (metrics),' the positive meaning of which is enhanced by the adverb *nur* 'only,' allows refocusing attention on the good characteristics of the neoplasm (cf. Eng. *optimistic projection* [Jefferson 1988: 431; Maynard 2003: 180f]).

Part 3 (86–88) is a specification of the positive characteristics of the tumor.

The indication of the tumor's slow growth rate (*er wächst nicht schnell*) and the lack of a need for chemotherapy (*Sie brauchen keine Chemotherapie*) justifies the formulation of *er hat eigentlich nur gute Eigenschaften.*

In the analyzed dialogues, the first part of the construction *(zwar) …, aber …* '(although) …, but …' especially often contains the adjective *bösartig* 'malignant:' *Es ist jetzt DOCH ein **bösartiger** Tumor. / Also Sie haben jetzt in dem Polyp einen kleinen **bösartigen** Krebs. / Da gibt es **bösartige** Zellen.* For the first part of the construction is also typical the combination of *nicht (nichts)* and *a (substantiated) adjective* with a positive connotation: *Das Ergebnis ist halt **nicht super**. / Und dieser untere Bereich des Bauchs… da ist das PET-CT **NICHT so gut**. / Also, es ist leider **nichts Gutes.*** The use of positively colored adjectives, as opposed to the use of adjectives with a negative assessment, we believe lessens the emotional impact of bad news on the patient. Adjectives with an obvious negative connotation *schlecht/schlimm* 'bad' are noticed in statements that convey conditionally positive tendencies: *Der ((Tumor)) hat aber **keine so besonders schlimmen Eigenschaften**. / Sie ((die Lunge)) ist **gar nicht SO schlecht**.*

The second part of the construction often contains the evaluative adjectives *gut* 'good' and/or *günstig* 'favorable,' designed to explicitly express a positive assessment of tumor parametres. These adjectives are sometimes emphasized intonationally: *Das sind **GUte** Zusatzkriterien. / Das ist eher was **GÜNStiges***. This highlights the positive side of a bad diagnosis.

Evaluative adjectives are often used in combination with such particles and adverbs as *eher* ‘rather, more likely,’ *eigentlich* ‘actually, in essence, in principle,’ *ganz* ‘quite,’ *nur* ‘only,’ *super* ‘super’: *Er ((der Tumor)) hat* ***eigentlich ganz/nur günstige*** *Tumorkriterien. / Aber man muss dazu sagen, er ((der Tumor)) hat* ***super gute*** *Eigenschaften.* Such particles and adverbs allow strengthening or hedging (weaking/mitigating) the illocutionary charge of the adjective (cf. [DUDEN 2009: 588–596; Pittner 1999]).

Following the utterances announcing the presence of positive tumor metrics, doctors actualize phrases like *Es könnte viel schlechter/schlimmer sein. / Bei dem Schlechten <…> haben Sie sich noch das Beste ausgesucht.* Such utterances are meant to be used as a covert comparison of existing parameters and potential complications and are intended to encourage the patient.

Sentences with the construction *gute Eigenschaften / günstige Kriterien* ‘good characteristics / favorable criteria’ mark the transition from reporting a diagnosis (i.e., from negatively connotated wordings) to describing tumor metrics (i.e., to positively connotated wordings). The absence of such a wording may indicate that it is difficult to identify any positive characteristics of the tumor. In this case, instead of using positively connotated wordings, the doctor clarifies the actual diagnosis (continues to use lexical and grammatical structures with a negative connotation).

To express a positive assessment of the tumor growth rate in the analyzed transcripts, two synonyms are used: (negation) *kein/nicht (so) + schnell wachsen* and *langsam wachen.* E.g.: *Er ((der Tumor)) wächst* ***nicht schnell.*** */ Wir haben* ***keine*** *Eigenschaften, dass der ((Tumor)) irgendwie* ***aggressiv oder schnell wächst.*** */ Aber ihr Tumor der wächst SO* ***langsam,*** *dass <…>.*

It is noteworthy that to express a negative assessment of the tumor growth rate in the analyzed texts, one can rarely find expressions like *Der Tumor* ***wächst schnell*** ‘The tumor is growing fast,’ that is the combination of *schnell wachsen* ‘grow fast’ by analogy with the conveyance of a positive contextual assessment. The preferred way to convey a negative assessment is realized through the word combination *nicht (so) langsam wachsen* ‘grow not (so) slowly.’

The dynamics of tumor growth is ranked by using the adjectives *schnell* and *langsam* in the comparative degree (*schneller* ‘faster,’ *langsamer* ‘slower’), the amplifying adverb *sehr* ‘very’ and the pronoun *so* ‘such.’

Of particular note is the adjective *aggressiv* ‘aggressive,’ which is a contextual synonym for the adjectives *bösartig* and *schnell*; and, depending on the context, can be a means of conveying both a positive and neutral, and a negative assessment of the tumor's condition: *Also, es ist kein **aggressiver** Tumor. / Sie ((die Werte)) sind an der Grenze zum **aggressiven** Wachstum. / Es ist nicht ganz schwach **aggressive.** / Das ist wirklich schon eine **aggressive** Art von einem Tumor.* The above-mentioned adjective can also be used in a substantivized form: *Prognosefaktor für was **Aggressives** hat das nicht.*

The next aspect that helps to characterize the tumor is the actual size of the neoplasm. A small size means the initial stage of the disease or indicates a low rate of cancer cell division, therefore it is evaluated by experts as a positive criterion and expressed through the synonymous set of words *mini* ‘mini’, *klein* ‘small’, *nicht groß* ‘not large’: *Das eine ist ja ganz **mini, klein.** Das andere ist ja jetzt auch **nicht groß**.* / *Also, das ist ein **kleiner** Brustkrebs.*

A growth of the tumor in size indicates a progressive stage of the disease. In the dialogues under consideration, specialists rarely use the adjective *groß* ‘large’ to refer to the increased size of the carcinoma. If doctors use this adjective as an indicator of a negative assessment of the tumor, then use it in combination with the adjective *klein* ‘small’. As a result of combining adjectives with positive and negative connotations within one sentence, the whole statement often acquires a neutral semantic meaning: In the sentance *Die ((die Krebsherden)) sehen einfach in ihren Zellbildern unterschiedlich aus. Die einen haben **kleine** Zellen, die anderen **große** Zellen.*

To indicate the increased size of the carcinoma, the combination of *nicht (ganz) klein* ‘not (so) small’ is more frequent: *Der Tumor ja **nicht ganz**… so **GANZ klein** ist, nun schon etwas größer.* The lexical repetition of the adjective *ganz* and the way it is pronounced emphasizes that the tumor has gone beyond the norm.

An important factor in explaining the diagnosis is an indication of the number of harmful tumor sets. The more damaged areas, the more difficult it is to remove the tumor with the help of surgery and the more dangerous the patient's condition is: *Er ((Tumor)) ist* ***an einer Stelle****. Also nicht an mehreren!* / *Es gibt insgesamt* ***drei Tumorherde****. / Dieser Tumor ist eben NICH nur an einer Stelle, sondern* ***an mehreren Stellen****. / Das Problem bei Ihrem Fall ist, dass das einfach* ***mehrere Tumoren*** *sind.* Instead of der *Tumorherd* 'tumor site' the nouns *der Bereich / der Bezirk / die Stelle*; *ein (kleines, rotes) Pünktchen; der Knubbel* can be used to soften bad news.

The disease's stage serves as one of the criteria for tumor evaluation. The early stage (as opposed to the terminal one) indicates the possibility of combating the disease as such and the prospect of restoring the functions of the damaged organ. A set of combinations is used to express the stage of the disease: *im (nicht so) frühen Stadium; (nicht) im Anfangsstadium;* and *(nicht) lange im Körper*. E.g.: *Man hat was Bösartiges gefunden,* ***im ganz frühen Stadium.*** */ Ich kann es Ihnen nicht sagen, wie schnell das ging, aber* ***es ist noch nicht so lange da.*** */ Der Befund passt zu einem Lungenkrebs, der allerdings* ***nicht im Anfangsstadium*** *ist, sondern der schon eine Weile im Körper ist.* A grammatical pointer to the fact that the tumor in the patient's body has been developing for a long time is a definite article: *Diese Erkrankung, wie ich schon sagte, ist leider nicht heilbar in* ***dem*** *Stadium.* It is possible to focus on the article thanks to the phrasal stress: *Aber den Tumor an sich kriegen wir in* ***DEM*** *Stadium jetzt nicht mehr weg.* Despite the fact that the doctor does not name the stage of the disease (and this information has not been mentioned earlier in the dialogue), it becomes clear from the context that we are not talking about the initial stage.

Mentioning metastases in the dialogue indicates an increase in the number of harmful lesions and the continued presence of cancer cells in the human body. In other words, the presence of metastases is one of the most unfavorable scenarios for the disease to develop.

What is referred to in Case 9 is a daughter tumor (lung adenocarcinoma) formed by seeding from the primary (parent) site localized in the rectum. Through the previous sequential analysis of this passage (see Table 1 for more information), we have

identified linguistic means that ensure the dynamics of the dialogue's development. In the current analysis, we will consider the language tools responsible for creating the explanatory power of the doctor's remarks.

Case 9

60 AM: °h[h] und ((Pathologe)) hat festgestellt dass der **KREBS,**
61 PM: [ja:]
62 AM: (1.1) NICHT (.) von der lunge kommt?
63 °hh sondern dass der krebs eine **ABsiedlung** ist-
64 (1.0) von dem **beKANNten kre:bs** den sie schon HATten.
65 (-)[er sch]reibt ganz KLAR= in dem ZWEIten kritischen bericht?
66 PM: [hm;]
67 AM: °hhh das es eine **ABsiedlung** ist?
68 (.) aus der **VORherigen-**
69 (0.5) **in der diagNOStik schon [bekannten-]**
70 PM: [h°]
71 AM: (.) **REKTOkarzinom;**
72 ALso,
73 (0.8) dem (.) **UNteren darmkrebs= dem ENDdarmkrebs.**
74 PM: ja:.
75 AM: (.) also es ist eine **ABsiedlung,**
76 des vorbekannten **enddarmKREbses.**
77 PM: ((räuspert sich))
78 AM: °hhh das heißt es ist eine so genannte **metasTAse,**

Though the patient is an experienced cancer survivor and must be aware of the terminology oncologists use, the doctor refrains from using the concept of "metastasis" immediately. The sequence *Krebs — Absiedlung — bekannter Krebs — Absiedlung - aus der vorigen, in der Diagnostik schon bekannten Rektokarzinom — unterer Darmkrebs — Enddarmkrebs — Absiedlung — Enddarmkrebs — Metastase* consists of repetitions, clarifications and synonyms. The noted words gradually make clear the origin and cause of lung cancer; by repeating oncological terms time and time again, the doctor explains the process of cell seeding from the primary site to other tissues and avoids the need to give a direct assessment of the patient's condition. Due to the lack of vocabulary with an explicit negative assessment of the disease or a direct assessment of the patient's condition, the explanation becomes informative.

Thus, the assessment of tumor parameters and the diagnosis clarification at the lexical level is manifested through the use of alphanumeric indicators, numerical designations, adjectives that determine significant tumor parameters (cell activity/growth, number of tumor foci, and stage of the disease). The grammatical marker of this stage is the construction *zwar/schon ...*, *aber ...* . Analyzing extracts from dialogues containing an assessment of tumor parametres shows that when announcing a bad diagnosis, doctors tend to focus on the positive aspects of the disease. This way of presenting information allows, in our view, controlling the psychoemotional state of the patient.

2.6.2.3 Therapy Justification

The structural component "Therapy justification" may come before or after the communicative block "Therapy recommendation". The described unit includes general information about possible side effects, forms, efficacy and tolerability of therapy. It also explains why the recommended treatment is preferred in this particular case.

The lexical and grammatical markers of this stage of consultation are causal/consecutive clauses with conjunctions *da*, *weil*, adverbial conjunction *deshalb*; conditional causal clauses with the conjunction *denn* and the compound conjunction *wenn ..., dann ...*; structure *das heißt*, and Konjunktive II.

Example 10 shows a situation where a doctor defends his decision to recommend chemotherapy.

Case 10

083 AM: [u::nd,]
084 jetzt MUSS man natürlich überlegen,
085 welche therapie MACHT man?
086 ähm da gibt_s einmal die drei GROßen,
087 operaTION,
088 STRAHlentherapie,
089 oder CHEmotherapie,
090 oder eine kombinaTION der verschiedenen therapiearten,
091 PM: hm_hm,
092 AM: und (-) **wenn** der tumor (.) im körper an

verSCHIEdenen stellen zu finden ist,
093 beREITS zu finden ist muss man ja sagen,
094 **DANN**,
095 ist das n_HINweis darauf,
096 dass eben man das nicht nur indem man EIne stelle rausschneidet,
097 behandeln KANN.
098 das wäre die [indi]kation für ne Operation;
099 PM: [hm_Hm,]
100 AM: [ja?]
101 PM: [<hm_hm,>]
102 AM: eine STELle,
103 (--) MESser,
104 (-) diese stelle WEG,
105 **dann** is der tumor AUCH weg.
106 **wenn** WIR aber jetzt den (-) TUmor da rechts unten in der lunge wegschneiden,
107 aber die lymphknoten ja drin LASsen **[dann]** im bauch zum beispiel;
108 AM: **dann** sind sie ja die TUmorerkankung durch das rausschneiden nich los.
109 PM: net LOS,
110 AM: ja:?=**das heißt** wir müssen etwas FINden,
111 was (.) an den verschiedenen stellen WIRKT,
112 (--) und das kann EIgentlich nur die chemotherapie sein;

With the phrase *Jetzt muss man natürlich überlegen, welche Therapie macht man* (84–85), the doctor proceeds to explain the choice of treatment and lists the possible options: *Operation, Strahlentherapie, Chemotherapie oder Kombination verschiedener Therapien* (86–90) (cf: *viable solution* [Pudlinski 2009: 448]). The doctor does not immediately make a final proposal for treatment (112). Using the construction *wenn...*, *dann...* and the verb *sein* in the Konjunctive II (92-105), the doctor first illustrates the potential actions of medical staff in the scenario when the patient had one tumor focus (cf. *accounting* [Buttny, Morris 2001: 290]; *accountability* [Robinson 2016: 15f]). As part of the explanation at this stage of the dialogue, the doctor uses the indefinite personal pronoun *man* as the subject in all statements, which performs a generalizing

function (cf. Ger. *eine generische* [Malamud 2012: 5; Zifonun 2000] / *eine generalisierende Funktion* [Eggs 2017: 68ff]) and shows that in similar cases exactly this procedure is established (one tumor focus → operation). When using the *wenn ..., dann ...* construction repeatedly, the doctor reports that cancer cells are located in this case in several organs. The transition from theoretical explanations to this particular case is also signaled by the substitution of the indefinite personal pronoun *man* with the personal pronoun *wir* (106). Using the construction *das heißt,* the doctor comes to the conclusion that chemotherapy should be used as a primary form of treatment as it has the potential to affect distant cancer cells, rendering surgery impractical. Thus, at the beginning of the dialogue, the doctor introduces the patient to possible treatment options, but in the process of explaining and arguing, he narrows the choice to chemotherapy.

It should be noted that in this passage of the dialogue, the patient does not take an active verbal part in the conversation. However, there's some feedback. The frequently used interjection hm (91, 99, and 101) reveals that the patient perceives information and encourages the doctor to provide further explanations.

The conjunctions *da, denn, weil; wenn ..., dann ...,* the adverbial conjunction *deshalb*, the construction *das heißt* and the Konjunktive II are typical for the structural component "Therapy justification". These language markers are required to introduce arguments in support of the doctor's treatment option.

2.6.2.4 Therapy Recommendation and Decision-Making about the Treatment Method

Therapy recommendation (phrases of advisory content) is most often encountered when discussing options and time frame of therapy (cf. [Fedorovskaya, Osipenko 2020: 204]), is expressed explicitly using the predicates *empfehlen* (37/16) or *vorschlagen* (15/8), sometimes combined with Konjunktive II. The subject in sentences with the verbs *empfehlen* and *vorschlagen* is the personal pronouns *ich/wir* or the indefinite personal pronoun *man*. E.g., *Aber* ***ich würde*** *Ihnen* ***nicht empfehlen,*** *noch länger zu*

warten wie ein zwei Monate (meaning to postpone the surgery). *Das werden wir Ihnen am Montag sagen, was **wir** Ihnen da **empfehlen*** (it is expected that a tumor conference will be held before Monday, and at this conference various specialty doctors will discuss the expediency of the chosen treatment or will correct it). ***Man würde** Ihnen trotz alledem, auch wenn es nur so schwach auf Hormone anspricht, eine Antihormontherapie auf jeden Fall **vorschlagen***.

A recommendation can be given without the direct use of recommendation utterances with *empfehlen/vorschlagen*, but it still keeps the personal opinion of the oncologist in its semantic due to the first-person singular personal pronoun in the subjective case. E.g., *Also es muss nicht heute oder morgen sein. Das muss auch nicht nächste Woche sein. Aber so in der nächsten Monat **würde ich** es **Machen.*** / ***Ich würde** das auf keinen Fall nicht operieren*.

The presence of recommendation phrases could show that oncologists tend to adhere to the principles of the deliberative model, acting in line with the current trends concerning the interaction with the patient, and observing dialogical symmetry. However, if the phrases are considered not only in the local context, but also with taking into account the temporal unfolding of sentences from the very beginning of the dialog, the evident paternalistic tendencies can be noticed. During the conversation with cancer patients, recommendations are not used to advise, to discuss, and to make a shared decision, but to smooth the directives, to present the pre-developed treatment plan in a more delicate way, as well as in order to preserve the psychological comfort of the patient. It is not expected that the patient would refuse the treatment plan suggested by the oncologist. If the patient shows any doubts, signs of (emotional) distress, or just keeps silent, the doctor backs up his/her proposal with arguments.

In Case 11, before and after recommending radiation therapy (148), the doctor uses phrases to reinforce the logic of his proposal (to justify the therapy).

Case 11

146 AM: in DEN situationen (-) wo (.) die erkrankung
behandlungsbedürftig ist –
147 und eher an EIner stelle ist (1.6)-
148 **empfiehlt man** zumeist eine beSTRAHlung in dem bereich.

149 PM: hm_hm-
150 AM: dort hat man eine lokale auswirkung (-) auf den beZIRK
aber nicht auf den ganzen körper
151 und erspart sich praktisch reSERven chemotherapie

In the first phrase the phrasal stress is placed on a certain article, *in DEN situationen* (146), which equates the patient's situation with many other similar cases in which the tumor is still curable (*behandlungsbedürftig*) and is localized in one place (*an einer Stelle ist* (147)). By naming these two factors, the physician uses frequent pauses of various length (0.5; 0.2; 0.5, and 1.6 seconds) showing the slow pace of doctor's speech and his intention to give the patient an opportunity to think about the meaning of the words spoken to him. An impersonal sentence with indefinite personal pronoun *man* (*empfiehlt man* (148)), points at generalization of all similar cases, i.e. in all such situations exactly this treatment method is recommended. The adverb *zumeist* shows the high frequency of using such a technique in all comparable cases. The definite article in the word-group *in dem Bereich* (148) shows that there is only one tumor site, and it is known its location in the body. In oncology both criteria are considered as "good" tumor parameters and are used as the arguments capable to improve the emotional condition of the patient.

After receiving a response from the patient in the form of a short sound signal (149), the doctor speaks about the advantages of radiation therapy in detail. First of all, it has *eine lokale Auswirkung auf den Bezirk* (150). We should note that the doctor immediately explains the word-group *eine lokale Auswirkung*, using the clarification *nicht auf den ganzen Körper.* Secondly, the oncologist implicitly compares radiotherapy with chemotherapy that influences the whole body and is used only in extreme cases. This is why the doctor suggests the patient to use chemotherapy as a backup option in case of the spread of cancer cells from the primary locus. So, the doctor suggests using chemotherapy as a fallback solution if the cancer cells break away from cancer's primary site. Therefore, the recommendation consists of only one treatment option (radiation therapy), but instead of its presentation in a directive manner, it was introduced in a smoother way. It is appropriate to talk about a recommendatory tone

which, nevertheless, does not imply rejection or other treatment variations. Such delicate and reasoned recommendations can be seen in seven conversations.

In all other dialogues, we encountered a more strong recommendation. By "strong recommendation" we mean the announcement of a therapy in a rigorous manner without giving the possibility to choose an alternative. It can be introduced into the dialogue with the words *empfehlen/Empfehlung* and *vorschlagen/Vorschlag* or without the words (as in Case 10, line 113).

In Case 12, the doctor insists on the surgery in a persuasive manner.

Case 12

116 AW: (-) **DEfinitiv** die **empfehlung,**
117 **EINdeutig wirklich,**
118 und d_d das muss ich ihnen **SEHR sehr ans herz legen,**
119 son_mach ich sonst mach ich mir **wirklich GROße sorgen um sie,**
120 °h WENN sie operiert werden,
121 dass der tumor RAUS kommt,
122 dann sind sie hinterher mit **so einem guten tumor geSUND,**

According to I.A. Sternin, blandishments are generally based on emotional encouragement of the dialog partner to accept the addressee's point of view by multiple repetitions of an entreaty or a suggestion [Sternin 2012: 49]. The use of adverbs *definitiv* and *eindeutig* shows the intransigence of doctor's decision. At the same time, the imperative nature of the speech is mitigated by using another adverb *wirklich* (117), that doesn't possess any argumentation function but increase the emotional level and show the physician's personal involvement. The demonstration of compassion increases in the next intonational phrase *das muss ich Ihnen SEHR sehr ans Herz legen* (118) due to the personal pronoun *ich* in combination with the modal verb *müssen*, and the phraseological unity *j-m ans Herz legen*. The personal pronoun indicates the person originating the request, i.e. the doctor, on her own behalf, asks the patient to agree to the surgery. Modality expressed through the word *müssen* shows the urgent need to take action. Instead of neutral verbs like *anraten, empfehlen* or *nahelegen* the physician uses the phraseological unity including the word *Herz*, which represents not only the central

organ of the circulatory system, but the repository of ruminations, feelings and moods. The "heartiness" meaning of this collocation is amplified threefold by 1) the semantics of the adverb *sehr* used to show the enhancement of some quality; 2) double reiteration of the same adverb *SEHR sehr,* 3) phrasal stress on *SEHR*. After the emotional representation of this strong recommendation, the physician continues to build the emotional background through the description of her internal state in case she doesn't recommend the *sonst mach ich mir wirklich GROße SOrgen um sie*. In this case, emotional intensity also consists of several components. The adversative adverb *sonst* is used to introduce a certain implicit condition ("I will start worrying if I do not recommend it"). The condition of worrying is expressed by the phraseological combination *sich um j-n Sorgen machen,* which is enhanced due to the adverb *wirklich,* and the adjective *GROße* (having the meaning "strongly").

After the blandishment-phase the physician moves on to persuasion, which has the element of emotional intensity, just like blandishments, but is based on addressing the rational side of the personality. Consistency, evidence basis, and validity play the key role [Pogrebnyak 2018: 132; Sternin 2012: 49]. Persuasion is in the argument that the surgery is the best option for the patient because the removal of tumor will decrease of the risk of cancer cells spreading or its full elimination. Also, compared to more aggressive forms of treatment (radio-and chemotherapy), the surgery is less traumatic procedure for the body (requiring only postoperative rehabilitation). The presences of "good" tumor criteria are considered an indication for the surgery, e.g. cancer is detected at an early stage, is localized, grows slowly, and hasn't spread to other parts of the body. The physician presents this idea using a complex sentence with a conditional clause. Main (120) and subordinate (122) clause is separated by noun clause with explanatory function (121). After the verbalization of the condition *wenn Sie operiert werden,* the physician does not go to the consequence at once, *dann sind Sie hinterher mit so einem guten Tumor gesund*. The explanation *dass der Tumor rauskommt* added between the parts of the complex sentance is used to show the final goal of the surgery: the removal of the tumor from the body. This suggestion can be considered not only as

an explanation, but also as a duplication of the idea of subordinate clause "when you undergo surgery" = "when the tumor comes out."

Personification of the tumor shows the attitude of the oncologist towards the neoplasm. It is shown as something that is alive, that is able to *rauskommen* ‘exit’ the body without causing any more harm. The choice of such a form of showing the attitude towards the tumor can also show that the oncologist still has certain doubts about the one hundred percent possibility of getting rid of the disease (it is known that after the surgery patients undergo several years of active follow-up to control the recovery process). Even if the physician has some doubts concerning the stabilization of the patient's condition, he/she only voices the positive side of the problem, *dann sind Sie gesund*. The reason of such confidence is the presence of the ‘good’ criteria of the tumor, *mit **so** einem guten Tumor*. The amplifying particle *so* makes the phrase more emotional and makes it seem even more confident. The recommendation shown in such a way can also be attributed to "slight" paternalism.

In 9 cases of 51 the doctor presents the ‘recommendation’ of therapy in two stages. On the first stage (that occurs during the current consultation), the physician presents the possible treatment options, but lays emphasis on only one. After that he/she informs the patient that the decision concerning the treatment will be discussed at the tumor board meeting (*das Tumorboard*) with the participation of specialized physicians (oncologist, radiologist, surgeon, and pathologist). Most often, the decision during the tumor board is made in favor of the suggestion that the oncologist mentioned as the most likely one. This way, the final therapy plan will be announced to the patient only at the next consultation. During this time, the patient will have an opportunity to think over the provided information, discuss it with the family members, write down questions, get used to the thought of the upcoming treatment and believe that exactly this decision is the best option (because not only one physician, but a whole team of them made this decision!).

This stage could be also refered to a structural component "Distribution or removal of responsibility," since the doctor often not only mentions the tumor conference, but deliberately focuses on its importance. Instead of *Tumorboard*, nouns *Besprechung*,

Kollegenkreis, and *Sitzung* can be used. Sometimes the doctor names the position (*Oberarzt*), specializations (*Chirurg, Pathologe*), the names and surnames of the persons (*Herr Doktor* ... (doctor's full name)) who will make the decision. Oncologists sometimes use nouns denoting written guidelines for the management of (cancer) patients (*Behandlungsstandard, Leitfaden*) to support a proposed treatment strategy. Lexical means pointing to the specialists involved in the discussion of the patient's health issue allow demonstrating the status of the proposed treatment method, as well as sharing responsibility for the decision-making among all participants in the process.

Thus, at the stage of Therapy recommendation, the doctor suggests the most appropriate treatment option. The use of linguistic means explicitly denoting a recommendation (primarily *empfehlen/vorschlagen*) does not indicate the doctor's intention to change his mind about the proposed option, even if the patient has questions or doubts. The main purpose of using such means is to soften directives. The decision-making about the treatment method in this case occurs "automatically", i.e. the patient accepts the doctor's proposal.

2.6.2.5 Planning the Time Frame of Therapy

If the stage of Therapy recommendation takes place in a rather paternalistic way (the doctor suggests a treatment, and the patient agrees), then during the communicative block Planning the time frame of therapy, elements of a deliberative relationship model and the principle of *shared decision-making* appear [Đorđević, Braš, Brajković 2012; Elwy et al. 2012]. The doctor talks about the time and place of the surgery, its duration, the length of hospital stay and the approximate time frame for rehabilitation (cf. [Osipenko 2023a: 152]).

Consistency of decision-making at this stage of the counseling lies in the possibility of discussing and selecting the optimal date for therapeutic measures, the willingness of the doctor to change the date and time of appointment according to the patient's schedule. Conditional clauses with modal verbs denoting the possibility or ability to do something (*können*), (strong) desire or intention (*mögen* (in the form of *möchten*)

wollen) often indicates that the patient's opinion has been taken into account, he/she was given choice and politeness to him/her has been shown: *Wenn Sie können/möchten/wollen; Wenn es Ihnen (zeitlich) past; Wenn es Ihnen bequem ist*, etc.

In Case 13, the introduction of conditional clauses (132, 134) indicates the possibility of choice and prepares the basis for the creation of a trust relationship.

Case 13

132 AW: **wenn** sie WOLLen: (-)
133 kann ich für sie schon mal termine AUSmachen,
134 **wenn** sie sagen OKAY ich hab jetzt noch was vor
135 **dann** sagen sie mir ab wann sie **KÖNnen?**
136 und ich guck ab wann ((lacht ca. 1.1 Sek.))
<dann was HA:be (.) ja?>

The personal pronoun *ich* demonstrates the doctor's willingness to personally help the patient with making a further appointment and relieve him/her from the necessity to do it on his/her own. The phrase *Wenn Sie sagen "Okay", ich habe jetzt noch was vor, dann sagen Sie mir, ab wann Sie können* (134–135) shows that the doctor puts the patient's personal life first, and tries to choose the time of the appointment in such a way as not to disturb the patient's plans. In addition, with the help of this reply, the doctor implicitly says: "Don't worry, we have enough time, the disease is not progressing." The positive emotional temperature of the consultation is proved by the laughter at the end of the reply (136).

The stage of planning the time frame of therapy allows the doctor to remind the patient about upcoming therapeutic measures, discuss the time frame of treatment, and once again make sure that the patient has no questions. The principle of shared decision-making increases the degree of trust on the part of the patient, reduces his/her anxiety and ensures that the doctor's requirements aimed at maintaining the patient's health are met.

CHAPTER 2 CONCLUSIONS

The developed stages of the linguopragmatic analysis of dialogues between a doctor and a cancer patient include an assessment of the external speech structure and the internal divisibility of consultative conversations between a doctor and a cancer patient.

The analysis of the *external speech structure*, based on a quantitative and qualitative assessment of utterances and their constituent lexical units, showed the presence of asymmetry already at the stage of visual assessment of the volume of speech fragments, which indicates low verbal activity of a patient and accompanying people compared with a doctor. Moreover, relationship between the patient's verbal engagement with the dialogue and the presence of accompanying people has been revealed. Thus, the presence of third parties encourages a patient to remain silent and simultaneously show emotionality, which is verbally expressed through a large number of interjections, audible breathings, unmotivated laughter and tears. The absence of accompanying persons, on the contrary, encourages a patient to be attentive, conduct an active dialogue with a doctor, ask questions and request follow-up information.

The internal divisibility of dialogues is associated with allocation of frequency components in the communicative dialogue structure. Depending on the "level of penetration" into the text, these components are structural components (communicative blocks), individual utterances and linguistic phenomena. The actualization of one or another linguistic element is associated with the consultation algorithm, which a doctor follows based on the professional experience and verbal patient's response.

Nineteen communicative blocks have been revealed in the analyzed empiric material. Seven components are found in almost every consultation and initiated mainly by a doctor. These components include "Announcement of cancer diagnosis," "Assessment of tumor parameters," "Diagnosis clarification/explanation," "Therapy justification/explanation," "Therapy recommendation," "Decision-making about the treatment method," "Planning the time frame of therapy." The components "Getting a second opinion," "Additional examination necessity," "Dealing with the disease in

everyday life," "Stabilization of the emotional state" are less common. Their verbalization can be equally related to both the verbal behavior of a doctor and a patient. Actualisation of structural components of "Small talk," "Description of the current patient's condition," "Disease control experience" is most often due to the patient's initiative. All the consultations are characterized by the following stages: "The beginning of a consultation"/"Establishing contact" and "The end of a consultation." No less significant are "Actualisation of the medical history," "Distribution or removal of responsibility," "Contact verification."

The first seven communication blocks have been considered within the second chapter. The choice is associated with a large number of repetitions of the given structural components in the analyzed dialogues.

The "Announcement of cancer diagnosis" communication block is most often actualized at the very beginning of a consultation. The lexical content of this communicative component is characterized by a high frequency of the nouns *Karzinom*/*Krebs*/*Tumor* and their derivatives. Moreover, the use of the adjective *bösartig*, which allows avoiding highly specialized medical terminology, is recorded. The introduction of this block is intended to announce the cancer diagnosis and dip a patient into in a (specialized) medical terminology.

The "Assessment of tumor parameters" and "Diagnosis clarification" structural components usually follow the diagnosis announcement. The description of tumor characteristics and the explanation of disease occurrence are performed through the use of highly specialized speech alphanumeric indicators of TNM classification (T1-T4, N1-N3, M0 and M1) and the histological degree of tumor malignancy (G1–G4), the adversative construction (*zwar) ..., aber ...*, nouns *Eigenschaft* and *Kriterium*, pairs of antonymic adjectives and adverbs with the value of estimated tumor growth rate and size. This communicative block also discusses criteria concerning the prevalence of cancer cells in a body (tissues, organs), the stage of disease development, existence of secondary tumor sites.

The "Therapy justification" is verbalized before or after the communicative block "Therapy Recommendation" and can be reproduced again in case if the patient shows

doubts or dissatisfaction. The main lexical and grammatical means of contextualization in the described block are causal clauses, conditional clauses, the construction *das heißt* and Konjunktive II. The use of these linguistic markers in speech helps to focus the patient's attention on justification, which is introduced by a doctor to adapt a patient to the disease more quickly through a thorough explanation of the advantages and disadvantages of the key treatment methods.

Such stages as "Therapy recommendation" and "Decision-making about the treatment method" are usually close to each other (i.e., one stage follows another). Specific lexical markers are the predicates *empfehlen*/*vorschlagen* in combination with the form *würde* of Konjunktiv II. The feature of these stages is that, despite the use of recommendation phrases, doctors, in fact, offer only one treatment strategy. Thus, at the verbal level, these stages are close to a consultative doctor-patient deliberative model, while their semantic content shows that they are structural components of an improved paternalistic model. In this case, the recommendation is intended for smoothing directive instructions, presenting delicately the treatment schedule, as well as for the psychological comfort of the patient.

The semantic component "Planning the time frame of therapy" is characterized by an abundance of linguistic elements specific to the principle of *shared decision-making*. When using conditional clauses with modal verbs *können*, *mögen*, *wollen*, a doctor reminds a patient about upcoming therapy measures, verbalizes the time frame of treatment, describes the patient's actions during medical tests or diagnostic examinations. When a patient is provided with the choice of time period for necessary therapeutic measures, the degree of trust between the communicants increases and the patient's anxiety reduces.

CONCLUSION

The research results show that the algorithm for description of medical dialogical (oral) discourse includes five basic research procedures.

1) Description of an external communicative structure of the dialogue. Possible research actions: calculation of transcription lines and words attributed to each communicant; visual assessment of speech fragments.

2) Description of the internal organization of the dialogue. Possible research actions: sequencing of the dialogue depending on the change of communicative roles / language markers that lead to the transfer of communicative initiative; the initial selection of structural components (identifying all the pragmatic/semantic segments that are meaningful for communication).

3) Selection of structural components for further analysis. Research actions: determining principles for choosing structural components according to the research goal (common or uncommon components within a single dialogue or within a group of dialogues; "short" or "long" structural components (the component length can be determined by the number of minutes, transcription lines, words, change of communicative roles, etc.)); establishing the causes of generating and identifying the purposes of the selected components.

4) Sequential analysis of the selected structural components. Possible research actions: determining the reasons of changing communicative roles, establishing excerpts from the dialogues where communication or understanding problems occurred, considering methods of overcoming communicative problems.

5) Selecting language markers that are characteristic of the selected structural components. Possible research actions: establishing linguistic means that cause the "movement" and verbalization of each structural component occur; selecting transcription lines and words of "homogeneous" semantics (medical terms, figurative linguistic means, etc.); establishing the functions of the selected language units, taking into account the context; identifying the person for whom it is common to use the analyzed language unit;

determining the relationship between the language unit and the manifested emotions (at the verbal level), decreasing/increasing the communicative distance.

A linguistically adapted conversational analysis works towards more detailed contextual assessment of linguistic means. This analysis makes it possible to explain the verbalization of language elements taking into account preceding statements; to reveal linguistic means influencing the change of communicative roles; to interpret the lexical composition of statements and the grammatical structures used, based on a consistently (linearly) developing context; to determine the interactive influence that language tools have on subsequent statements and formulations. The explanatory power of a (linguistically adapted) conversational analysis consists, on the one hand, in the necessity of considering/interpreting empirical data sequentially, step-by-step. Following this logic, each sequence of utterances becomes unique, as even minimal lexical, grammatical, or phonetic phenomena can add additional shades of meaning to the statement. The analysis is focused on the "microdynamics" of the conversation and is based on the detailed consideration of each language phenomenon, that is, it works with details in data sets. On the other hand, conversion analysis exhibits generalizing properties. Because of that, frequency cases of the use of linguistic means can be presented in a generic form.

The analysis of the external structure of the dialogues between the doctor and the cancer patient showed: 1) the verbal involvement of the doctor in the dialogue exceeds the verbal involvement of the patient and his accompanying persons (if any); 2) accompanying persons often communicate on behalf of the patient; 3) the presence of accompanying persons can result in a decrease in the verbal activity of the patient and an increase in his emotional intensity; 4) on the contrary, the absence of third parties can stimulate the patient’s dynamic verbal actions. Thus, the external structure of the dialogue allows evaluating the degree of verbal involvement of each dialogue participant (closeness to symmetrical or asymmetrical communication) and determining the influence of accompanying persons on the verbal activity of the patient.

Determination of the internal dialogues organization involves the division of dialogues into structural components. In doctor-patient communication, the structure of the dialogue depends on the therapeutic/practical purposes of the consultation. This work gives a

detailed analysis of seven structural components: "Announcement of cancer diagnosis," "Assessment of tumor parameters," "Diagnosis clarification/explanation," "Therapy justification/explanation," "Therapy recommendation," "Decision-making about the treatment method," "Planning the time frame of therapy." The high frequency of their actualization, as well as the fact that they were almost always reproduced due to the initiative of the doctor, served as a criterion for selecting these categories for analysis.

The most significant contribution in terms of communication effectiveness (that is, when the patient understands all explanations of the doctor and is ready to fulfill his recommendations after the consultation), in our opinion, is made by antonymic pairs at the lexical level and constructions containing opposition at the grammatical level. In both cases, we are talking about the introduction of negative information (diagnosis, its negative impact, limitations, medical procedures, long-term treatment, etc.) and its "immediate cancellation" by focusing on the existing positive aspects of the disease.

The comparative analysis of lexical and grammatical units of different consultation stages showed that the main function of using the described language means is a detailed *explanation* of all the processes related to the disease and maintaining a stable psychoemotional state of the patient.

It is established that a spontaneous nature of the verbal doctor-patient interaction is restricted by the presence of public and private rules of behavior effective within the framework of a medical institution, by a strict schedule of the doctor’s verbal behavior, a degree of a personalization of communication, asymmetry of knowledge and social roles of the communicants, as well as the adherence to a specific model of interaction.

Future prospects for the study of the verbal behavior of the doctor and the patient are seen in the study of language markers that verbalize "unique" (rarely encountered) structural components; determining the relationship between the disease severity and the language means used by the doctor; and creating a corpus containing consultations with one patient to analyze the dynamics and effectiveness of communication throughout the treatment. A separate study requires prosodic means (phrasal stress, tone movement, pauses), which make it possible to get an idea of the patient's unspoken worries or doubts.

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