EXPLORING THE RELATIONSHIP BETWEEN AUTHENTIC DIALOGUE AND SPANISH FOR HEALTHCARE PROFESSIONS

Karol Hardin
Department of Modern Languages and Cultures, Baylor University, Waco, USA
karol_hardin@baylor.edu

Abstract: *Although linguistic studies of healthcare communication are common for English dialects, they are less frequent for Spanish. Furthermore, linguistic research is virtually non-existent for Ecuadorian healthcare discourse, primarily occurring in literature on anthropology rather than linguistics per se. The present study therefore uses a qualitative approach to examine videotaped dialogues between ten Spanish-speaking patients and two Spanish-speaking physicians at a hospital in eastern Ecuador. The study's goal was to observe naturally occurring communication to determine how patients and family physicians negotiated meaning in medical interviews. Dialogues were transcribed using a conversational analysis methodology and then were specifically analyzed by applying Cordella's (2004) notion of physician "voices" to investigate ways that doctors conveyed different roles they had during an interview. Examples of the "Doctor, Educator, and Fellow Human" voices were reflected in the data, both in complementary and overlapping contexts. A secondary goal of the study was to provide videos of authentic medical interviews for use in teaching aspects of conversation to students taking intermediate Spanish for pre-health professions. Responses to questions about the video suggested that as students worked to improve their comprehension in a clinical context, the video dialogue raised their awareness about pragmatic notions such as politeness and register, "voices" (or roles) that physicians and patients use in cooperative/non-cooperative interaction, certain discourse markers, and embedded cultural beliefs about health. As a result, authentic dialogue within this specific context, that of medical Spanish interviews, served as a meaningful method for teaching pragmatic concepts, negotiation of meaning, and culturally implied information. It is therefore likely that authentic health conversations such as those in this study can inform language education for medical professionals and, by extension, that domain-specific dialogue likely has practical applications in other areas of instruction in languages for specific purposes.*

Keywords: Medical Spanish; health communication; medical interviews; physician roles; Spanish language education;dialogue.

1. Background

Based on existing studies of medical Spanish discourse, communication between Spanish-speaking patients and their health professionals can be better understood by studying linguistic ways that patients and health professionals convey meaning, not only by what they actually state but also by what they imply. Furthermore, authentic health dialogue can inform language education for health professionals.

Patient-physician communication for English is well documented (Coulthard and Ashby, 1975; Labov and Fanshel, 1977; Fisher, 1991; Todd and Fisher, 1993; Coupland et al., 1994; Drew 2001, among others). Furthermore, various studies have examined communication problems between English-speaking healthcare personnel and Spanish-speaking patients (Triandis et al., 1984, Erzinger, 1989, 1991; Davidson 2002; Aranguri et al., 2006). A growing number of authors have also investigated therapeutic discourse in some dialects of Spanish, such as studies of politeness and sympathetic discourse in Chile (Cordella, 1999, 2003, 2007); rapport management in Spanish and British interactions (de la O. Hernández López, 2008); mitigation in Uruguayan psychotherapeutic sessions (Delbene, 2004); power and face in medical consultations in Uruguay (Madfes, 2003); mitigation in Puerto Rican and Cuban Spanish dialects (Flores-Ferrán, 2010a); and semantic verb categories in therapeutic motivational interviews (Flores-Ferrán, 2010b). Less common are published sources that document Ecuadorian Spanish in health contexts. Such studies reference illness narratives from an anthropological perspective (Price, 1995, 2003; McKee, 2003) and the cultural issues of apparent agreement and power differential between physicians and Spanish-speaking patients, as in Candib (2006).

Cordella defined "voices" as different forms of talk that are adopted in the course of a medical visit. She noted that medical dialogues require a collaborative effort to produce both the patient's story and to enable or constrain the storytelling. Adapting Cohen-Cole's (1991) three functional medical goals of gathering information, educating, and providing support or empathy, Cordella identified three principal "voices" or roles for physicians: the doctor, educator, and fellow human voice. Each of these overarching voices were represented in her data by specific discourse functions and strategies. In negotiating meaning, the physician's "Doctor Voice" seeks information by asking questions, offers assessments and review, and aligns the patient to the doctor as the authority figure (Cordella 2004:85). On the other hand, the "Educator Voice" is used to communicate medical information by communicating medical facts, responding to patient discomfort, and communicating medical treatment and management (Cordella 2004:114). The Educator Voice also assumes an asymmetrical social framework where the doctor is in a position of authority. In contrast, the "Fellow Human Voice" shows empathy and encourages patients to tell their stories, at times even asking questions unrelated to the patient's health (Cordella 2004:146). This voice is often linked to affiliative discourse that is friendly and cooperative (Schiffrin, 1987). Unlike doctor voices, patient voices in her data primarily included the roles of storyteller and initiator. The various participants' voices often complement each other in an effort at communication. For example, in her study of medical interviews, Nithiananda (2016) found that any use of the Educator or Fellow Human Voice was associated with increased patient adherence, whereas the benefits of the Doctor voice were negated when other voices were absent.

2. Method

In this study, I analyzed dialogues between ten Spanish-speaking patients and two Ecuadorian physicians. The patients attended an outpatient clinic located in a rural hospital in Eastern Ecuador. After obtaining human subjects approval from the Institutional Review Board and also consent from the hospital and all participants,

the interviews were video recorded and transcribed using a conversation analysis methodology. The goal was to apply Cordella's (2004) notion of physician voices as a way to examinehow patients and family physicians negotiated meaning in this health context. In a study pertaining to patient adherence, Nithiananda (2016) noted that Cordella'sheathcare voices can serve both as a discourse analysis method to look at patient-physician communication and also as a method for educating physicians. Consequently, a secondary goal of the recordings was to use these videos to teach discourse strategies to university students studying intermediate conversational Spanish for health professionals.

3. Analysis

3.1. The Doctor Voice — Information-Seeking, Assessment, Alignment to Authority

Besides questions, a common feature involving the "doctor voice" in all of the dialogues occurs when physicians redirect patients in order to gather more information. In example one, the doctor has been asking whether the patient comes to the clinic for checkups, to which the patient responds emphatically that she does so each month, but she couldn't come the last time because of a lack of money, something that she has previously mentioned in the interview. Consequently, the physician avoids the topic, responding with a different question related to pregnancy. This method of changing the subject and tacitly ignoring patients' comments commonly occurs throughout the recorded dialoguesand allows physicians to politely control the narrative and thereby elicit desired information. (Note that "PT" and "DOC" represent the Patient and Doctor in the following dialogues.)

(1) PT: *Sí, cadames mehacía. Cadames me hacía. Pero– y la doctora me citó que vengapara hacerme un examen general y porfalta de dinero no pudevenir. Entoncescuandodespués se me hizo un examenenmarzo de la glucosapero de allí no pudevenirmásporfalta de dinero no pudevenir y vengoahora.*
Yes, each month I was doing it. Each month I was doing it. But– and the doctor made me an appointment to come for a general exam and because of a lack of money I couldn't come. So when afterwards I was given a glucose test in March, but since then I couldn't come anymore because of a lack of money I couldn't come and I'm coming now.
DOC: *Ya, ¿cuántasveces ha estadoUd. embarazada?*
Okay, how many times have you been pregnant?

In example two, the physician similarly redirects the patient from a pain narrative (which she has already told) by asking a new question about prior surgery. Various implications may be drawn from the change of subject: the physician does not see this pain as being related to diabetes, high blood pressure or lung and heart problems; she does not want to hear the story related again; or perhaps she just wants to continue obtaining the patient's history.

(2) DOC: *Ya, cuénteme, problemas de saludcomo diabetes, presiónalta, problemasde lospulmones o del corazón. ¿Tienealgúndiagnosticado?*
Okay, tell me, health problems like diabetes, high blood pressure, lung or heart problems. Do you have some diagnosis?
PT: *No, eso no.*

No, not that.
DOC: *Nada.*
Nothing.
PT: *Sino reciente. Sino que ¡taj! Me duele un trocitoasí (P indicates her side), que es un dolor horrible y que me llega al cuerpo a la cinta, y las cosas que me vienencomolosvómitosy::*
Except recently. Except that wham! This part here hurts me, its' a horrible pain and it starts in my body at my waist, and these things that come like vomiting and::
DOC: *¿EstoUd. ha estadonotandoúltimamente?*
Have you noticed that lately?
PT: *Sí, estosdíasnomás que desdelosdíasahh, hoy a nuevedías.*
Yes, just these days since ahh, nine days ago from today.
DOC: *Ya, y cuénteme, le operaron de algo a Ud.?*
Okay, and tell me, have they operated on you for something?

In contrast, the physician becomes serious and more formal with a male patient who extensively consumes alcohol and with diabetic patients who are not careful with their diet. For example, with one diabetic patient, she implores *quierosucompromiso no conmigosinoporUd.* 'I want your promise, not with me, but rather for you (on your behalf),' thereby emphasizing the patient's role, the trust relationship, and promises that should be kept between doctor and patient (assessment of patient adherence and alignment to authority). The physician's "doctor voice" is also apparent in her negative facial expression when a patient indicates that she is not careful about what she eats.

(3) DOC: *Ahora, verá, quieroconversar con Ud. de la comida. Me dice que no se estácuidando nada de la comida.*
Now, let's see, I want to talk to you about food. You tell me that you're not being careful at all about food.
PT: *No cuido nada.*((P laughs)) ((C frowns))
I'm not careful at all. ((P laughs)) ((C frowns))

3.2. Fellow Human Voice — Facilitating Patient Stories, Empathy

Various politeness strategies are also employed in the dialogues to mitigate messages or demonstrate empathy. One example of affiliation is the dialectal use of *ya* as a back-channeling device and a marker for comprehension. Although *ya* is also regularly used as an adverb in Spanish, this particular use has a different meaning and is common throughout Ecuador. In the first portion of the dialogue with Patient 1, the clinician employs*ya* much like the word *okay* in English to indicate that she understands and has heard the patient's narration of symptoms and responses to questions.

(4) PT: *Empecé con, con la tos.*
I started with, with a cough.
DOC: *Ya, ¿desdecuándo?*
Okay, since when?
PT:*Ya, son comoochodías con tos y tambiénquiero que me haga un examende glucosa.*
And, it's about eight days with cough and also I want you to give me a glucose test.
DOC: *Ya, Ud. teníaproblemas con la glucosapreviamente.*

Okay, you had problems previously with blood sugar.
PT: *Sí.*
Yes.
DOC: *Ya. ¿Problemas de saludimportantes que tenga?*
Okay. Any important health problems that you have?

Initially, Patient 1 does not use the expression *ya;* however, in line 46,she inserts the form for the first time to note her comprehension. Later, once the physician begins to use her "educator voice," we see a role shift so that the patient instead expresses*ya* to indicate agreement and comprehension of instructions and explanations. In the course of the interview, the physician says *ya* 21 times as opposed to the nine uses by the patient. In both cases, repeated use produces a rhythmic cadence in the dialogue and serves as a marker for cooperation. Hence the physician's "fellow human voice," or her voice of affiliation and empathy merges with her "doctor voice" when eliciting information.

(5) Lines 45–61

DOC: *Esto le vamos a examinartambién para vercómoestá con esoasí con un chequeo general.*
We'll check that too in order to see how you are with that with a general checkup.
PT: Ya.
Okay.
DOC: *¿Ya? Y ahora con este dolor de la barriguita, cuénteme, ¿cuántotiempoestá?*
Okay? And now with this tummy pain, tell me how long have you had it?
PT: *Sólodesde el díamiércoles, hoy con nuevedías.*
Just since Wednesday, nine days ago from today.
DOC: *¿Tal vezcomióalgo que Ud. cree que le hayahechodaño?*
Maybe you ate something that you think made you sick?
PT: *No sé. Antes yoestababienbien. Me fui a mi tierraen la provinciaenCañar.*
I don't know. Before I was very well. I left for my land in the province in Cañar.
DOC: *¿Ya?*
Okay?
[Physical exam and discussion of results]
PT: *Ya.*
Okay.
DOC: *¿Ya? Y en el examen (...) Puedensercambiosinflamatorios. Pero esonecesitamos saber de qué causa.*
Okay? And in the exam (...) They can be inflammatory changes. But we need to know what causes that.
PT: *Ya.*
Okay.
DOC: *¿Ya? Poresovamos a mandarestamuestra y esteresultado.*
Okay? That's why we're going to order this test and this result.
PT: *Ya.*
Okay.
DOC: *¿Sí? Entonces son trescosas. Aquíes el pedido para el laboratorio.*
Yes? So there are three things. Here is the order for the laboratory.
PT: *Ya.*
Okay.

3.3. The Educator Voice — Educating and Explaining

At times the physician's "fellow human voice" is also interwoven with her "educator voice." The combination is evident in her deictic use of the first person plural pronoun to identify with patients' problems; for example, in the previous dialogue, she states that diabetes is an illness that will cause more problems in the long run if "we don't look after ourselves." In one recording we hear her saying that she has not found any fever and that nothing is worrying "us" at the moment. In another video, the physician tells a diabetic patient, "we" need to control her sugar levels and that "we are failing in our diet." The doctor shows her cultural knowledge when she suggests bringing the rest of the family in for the next visit so that they can all talk about how to accommodate the patient's diet needs.

Use of first person also softens the "educator voice" by personalizing instructions, as in example 6, where she urges the patient to help her. In a sense, the doctor is pleading with the patient and consequently attaches herself to the problem.

(6) DOC: *PorquesiUd. nomeayuda con la dieta, no meayudahaciendoalgunaactividadfísica, no meayudabajando el peso, el medicamento no sirve de gran cosa.*

Because if you don't help me with your diet, you don't help me doing some physical activity, you don't help me losing weight, the medicine won't do much.

The physician's "fellow human voice" is also linked to her "educator voice" when she discusses diabetes with Patient 8. The doctor softens information, employing the diminutive to indicate that the prescription will need to be increased "a little bit more." She comments that she does not wish to scare the patient, yet at the same time explains the negative outcomes associated with uncontrolled diabetes.

Furthermore, in an interview with a nine-year old girl, the doctor's employs her "educator voice" to explain how to wash hands well. The physician then clarifies understanding by asking the girl whether she should wash her hands before or after eating, to which the girl replies "after." When the patient realizes her mistake, all participants laugh and the doctor once again details the importance of hand-washing and keeping nails cut to avoid getting parasites. The doctor speaks using age-appropriate vocabulary and humor.

Finally, reiteration is a key feature of the "educator voice" and is particularly used to clarify dietary requirements, exercise, medications that must be taken, and the importance of returning for a follow-up visit.

At times the three voices occur in complementary distribution, but at other times, the Fellow Human Voice overlaps with the other two voices thereby mitigating the message and/or strengthening the doctor-patient relationship.

3.4 Classroom Implementation of Videos

To this point, negotiation of meaning and also physician "voices" have been examined, the first goal of the study. A second goal was to provide videos of authentic medical dialogueto students taking an intermediate conversational Spanish course for health professions,enabling them to observe discoursestrategies and also gain cultural insights. Thirteen successive classes (310 students) have now viewed and responded to one of the conversations with an elderly diabetic patient. All students answered a written set of questions prior to viewing the video (see Appendix A) and watched the recording as many times as they wished. Recurring responses to the question, "What did you think of the

video?" may generally be categorized as (1) complaints about difficulty understanding the patient; (2) questions about vocabulary and routines at the clinic; (3) evaluative comments about the doctor and patient as well as the usefulness of the video compared to other videos that accompanied textbooks; and (4) exclamations of surprise that the patient had twelve pregnancies.

3.5. Pedagogical Value of Videos.

Specific responses also arose from the question, "What did you learn from the assignment?" a question that always produces interesting discussion. With very few exceptions, students have found the activityworthwhile. The following discussion outlines some examples of what can be learned from this recording. First, much as in real-life medical visits, the video offers a sample patient narrative that rambles and is not necessarily chronological or relevant. The patient's initial complaint of pain in her stomach does not pertain to the larger issue of diabetes that does not arise until later in the visit. Students have the opportunity to see a highly competent young, female Ecuadorian resident physician in an actual clinical context to observe how she directs the dialogue, demonstrates disapproval, and makes recommendations (Doctor Voice),and shows rapport, educates, and softens difficult conversations (Fellow Human Voice). The degree of eye contact and the close proximity between the patient and physician are highlighted as a point of contrast with English DVDs from the U.S. Students also observe the amount of time spent educating, explaining, and reiterating (Educator Voice).

Secondly, students learn dialectal variants, colloquialisms, and new health-related vocabulary in context rather than from a textbook. They learn, for example, the dialectal variant *el fréjol*'bean' and thecolloquialisms *el tiroide*'thyroid' and *vómitos* 'vomit,' rather than *la tiroide* and *vómito* (singular). Students also learn that *panela* is unrefined cane sugar (usually sold in a solid block or cylinder-shaped mound), and we discuss other names for it and where it can be purchased locally. They learn *masa* 'mass/growth' as a vocabulary variant of *tumor* 'tumor' and *bolita* 'growth' and also the variant *quince días* 'fifteen days' to express two weeks or a fortnight. Students are also reminded that the term *aborto*'abortion'is ambiguous but generally refers to a miscarriage in this medical context. The instructor also notes the frequent use of the diminutive not only to indicate size but also for politeness to soften topics (Fellow Human Voice) and we note the dialectal use of *ya*in Ecuador to verify comprehension and agreement,as seen in previous examples within different voices.

Thirdly, the video produces numerous points of reference when discussing culture. Students learn about a typical Ecuadorian menu in the discussion of diet: *caldo*'broth-like soup', the main meal of rice, beans, a little bit of salad, meat, and other starches, as well as fresh juice with *panela*. Both physician and patient perspectives are shown regarding appropriate portion sizes and which foods to avoid. For instance, when asked if she puts sugar in her juice, the patient responds negatively. However, it turns out that she adds *panela* but does not consider it to be sugar. The doctor also uses a drawing of a plate and palm-size portions rather than cup measurements or ounces as are often used for servings in the United States. The patient says she'll start jogging, which she equates with the word "exercise," but her notion of exercise has to be negotiated with doctor.

In addition to cultural context, the video offers an important social context for students to understand. Class discussion includes explanation that the patient has

to return in person for results and cannot simply call the office and reasons why the patient has not returned for a checkup. The instructor explains that the cost of a visit was $4, a seemingly small amount of money in a North American context, but a large amount for this woman. Students also are told about the frequency of having 10-12 children in some rural areas of Ecuador and practical reasons for having a large family.

Finally, the video effectively elicits discussion about medical issues and procedures. Students view conversation related to menopause in an authentic and educational context. They learn about procedures in Ecuadorian hospitals and learn that often patients must take orders and even pap smears to various locations such as radiology and the lab. Procedures for hospital admission are also discussed as well as the fact that many hospitals in Ecuador require patients to purchase their own supplies such as sutures, gauze, and other materials prior to procedures and surgery.

4. Discussion

Perhaps the most important purpose of the video dialogue is to demonstrate how patients speak differently from doctors: they have a variety of accents, social backgrounds, and expectations. What students learn in a medical Spanish class is what *they* should say but is not necessarily what they will hearfrom *patients*. This video is shown at the end of the semester as an object lesson to emphasize how students still have much to learn. Consequently, the video serves as a reality check: students know just enough to be dangerous, and they still need interpreters in order to communicate effectively in an extended dialogue.Nevertheless, Cordella's voices can be used to teach communicative strategies. Even when students have not yet attained advanced proficiency levels, they can at least learn the different roles that they will have as physicians and observe discourse strategies used to carry out various goals.Furthermore, future quantitative research might underscore the effectiveness in teaching such strategies.The notion of voices can likely be applied to other areas of languages for specific purposes including law, business, or social work.

In conclusion, responses suggest the value of authentic video dialogues in raising awareness about pragmatic notions such as politeness, formality, professionalism, and culturally implied information within a clinical context. This type ofinteractionwith its rich features provides a needed contrast with textbook DVDs where "doctors" are actors, professors, or graduate students. Naturally occurring conversation can therefore be effective for language acquisition, particularly when it includes different regions of the Spanish-speaking world instead of constructed or artificial exchanges. Furthermore, Cordella's voices provide an effective means for teaching discourse strategies to convey nuanced meaning within both a social and cultural context.Hence, authentic exchangessuch as those in this study can inform language education not only for healthcontexts, but by extension, domain-specific dialogue likely has practical applications in other areas of languages for specific purposes.

Appendix A
Questions About*Paciente 1—Ecuador*

1. *¿De qué se queja la paciente?*
What is the patient complaining of?
2. ¿Cuándoempezaron el dolor abdominal y el vómito?
When did her abdominal pain and vomiting begin?
3. ¿Porquéva a la clínica?
Why does she go to the clinic?
4. ¿Quétipo de cirugía ha tenido la paciente?
What type of surgery has the patient had?
5. ¿Quétipo de alergiatiene?
What type of allergy does she have?
6. ¿Tomaalgúnmedicamento?
Does she take any medication?
7. ¿De quéenfermedadcrónicasufre la paciente?
From what chronic illness does the patient suffer?
8. ¿Porqué no ha regresado a la clínicapor un chequeo?
Why hasn't she returned to the clinic for a checkup?
9. ¿Cuántospartosnormales ha tenido? ¿Y cuántosabortos (espontáneos)?
How many normal births has she had? And how many miscarriages?
10. ¿A quéedaddejó de menstruar?
At what age did she stop menstruating?
11. ¿Sale bien el examenfísico actual?
Does her current physical exam go well?
12. ¿Para qué son las treshojas de papel?
What are the three sheets of paper for?
13. ¿Adóndetiene que llevarlospapelitos?
Where does she have to take the slips of paper?
14. ¿Cuáles son lostresconsejosprincipales de la médica?
What are three principal pieces of advice from the doctor?
15. Por lo general, ¿qué come la paciente? ¿Quésueleponerenlosjuguitos?
What does the patient generally eat? What does she tend to put in her juice?
16. ¿Cuálesson las tresporciones de comida que la médicaindicaensudibujo?
What are the three servings of food that the doctor indicates in her drawing?
17. ¿Cuándonecesitavolver la paciente?
When does the patient need to return?
18. ¿Cuáles son losresultados que le van a darensupróximaconsultamédica?
What are the results that they are going to give her at her next visit?

Acknowledgements
I am grateful to Clay Butler, Karl Franklin, and Mike Hardin, MD for their input.

References

Aranguri, C., Davidson, B. and Ramirez, R. (2006). "Patterns of Communication through Interpreters: A Detailed Sociolinguistic Analysis". *Journal of General Internal Medicine,*Vol. 21, No. 6, pp. 1525-1497.

Candib, L (2006). "Sí, Doctora". *Annals of Family Medicine*, Vol. 4, No. 5, pp. 460-462.
Cohen-Cole, S.(1991). *The medical interview: the three-function approach*, St. Louis: Mosby Year Book.
Cordella, M. (1999). "Medical Discourse in a Hispanic Environment: Power and *Simpatía* Under Investigation",*Australian Review of Applied Linguistics*, Vol. 22, No. 2, pp. 35-50.
Cordella, M. (2004).*The dynamic consultation: A discourse analytical study of doctor patient communication*, Philadelphia: John Benjamins.
Cordella, M. (2007). "'No, No, I Haven't Been Taking It Doctor': Noncompliance, Face-Saving, and Face-Threatening Acts in Medical Consultations", in Placencia, M.E. and García, C. (eds.). *Research on Politeness in the Spanish-speaking World*, Mahwah, NJ: Lawrence Erlbaum Associates.
Coulthard, M. and Ashby, M. (1975). "Talking with the Doctor", Vol. 1. *Journal of Communication*Vol. 25, No. 3, pp. 140-145.
Coupland, J., Robinson, J., and Coupland, N. (1994). "Frame Negotiation in Doctor-Elderly Patient Consultations". *Discourse and Society*, Vol. 5, pp. 89-124.
Davidson, B. (2002). "A Model for The Construction of Conversational Common Ground in Interpreted Discourse". *Journal of Pragmatics*, Vol. 34, No. 9, pp. 1273-1300.
De la O. Hernández López, M. (2008). "Rapport Management Under Examination in The Context of Medical Consultation in Spain and Britain". *Revistaalicantina de estudiosingleses,* Vol. 21, pp. 57-86.
Delbene, R. (2004). "The Function of Mitigation in The Context of a Socially Stigmatized Disease: A Case Study in a Public Hospital in Montevideo, Uruguay". *Spanish in Context,*Vol. 1, pp. 241-267.
Drew, P. (2001). "Spotlight on the Patient". *Text*, Vol. 21, pp. 261-268.
Erzinger, S. (1989). *Consultasmédicas: A study of communication between Spanish speaking patients and their doctors.*Unpublished doctoral dissertation: University of California at Berkeley.
Erzinger, S. (1991). "Communication between Spanish-speaking Patients and Their Doctors in Medical Encounters". *Culture, Medicine and Psychiatry*, Vol. 15, pp. 91-110.
Fisher, S. (1991). "A Discourse of the Social: Medical Talk/Power Talk/Oppositional Talk?"*Discourse and Society*, Vol. 2, No. 2, pp. 157-182.
Flores-Ferrán, N. (2010a). "Letting Go of the Past in Spanish Therapeutic Discourse: An Examination of Verbs and Discursive Variables". *Pragmatics,*Vol. 20, No. 1, pp. 43-70.
Flores-Ferrán, N. (2010b). "An Examination of Mitigation Strategies Used in Spanish Psychotherapeutic Discourse". *Journal of Pragmatics,*Vol. 42, No. 7, pp. 1964-1981.
Labov, W. and Fanshel, D. (1977). *Therapeutic discourse: Psychotherapy as conversation,* New York: Academic Press.
Madfes, I. (2003). "La confrontación de imágenesenunainteracciónasimétrica: ¿Médico y paciente: Afiliación o conflicto?", in Bravo, D. (ed.) *Actas del Primer Coloquio del Programa EDICE*, Stockholm: Stockholm University.
McKee, L. A. "Ethnomedicine and Enculturation in the Andes of Ecuador, in Koss-Chioino, J., Leatherman, T. and Greenway, C. (eds.) *Medical Pluralism in the Andes,* New York: Routledge.

Price, L.(1995). "Ecuadorian Illness Stories: Cultural Knowledge in Natural Discourse", in Holland, D. and Quinn, N. (eds.), *Cultural models in language and thought,*New York: Cambridge University.
Price, L. (2003). "Illness Management, Social Alliance, and Cultural Identity in Quito, Ecuador", in Koss-Chioino, J., Leatherman, T., and Greenway, C. (eds.) *Medical pluralism in the Andes*, New York: Routledge.
Nithiananda, S. (2016). *The effects of physician voices on interpersonal communication and patient adherence.* Unpublished honors thesis: Baylor University.
Schiffrin, D. (1987).*Discourse markers,* Cambridge: Cambridge University Press.
Todd, A. and Fisher, S. (1993). *The social organization of doctor-patient communication.* Norwood, NJ: Ablex.
Triandis, H., Marín, G., Lisanky, J. and Betancourt, H. (1984). "Simpatía as a Cultural Script of Hispanics". *Journal of Personality and Social Psychology*, Vol. 47, No. 6, pp. 1363-1375.