

# The dialogue of the clinical encounter

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## **DOCTORS AND PATIENTS**

### **Middle East**

The man walked in with his completely veiled wife. I couldn't even see her eyes. The woman stayed in the corner while the man sat down in front of me. He explained something in Arabic and the male interpreter translated it to me in broken English. It appeared that the woman was suffering from abdominal pains of some kind. I tried to inquire more deeply into the woman's problem but the husband refused to offer any more details. I urged the interpreter to ask the woman about her problem but he told me that it was not possible for him to address her directly. It also appeared that I was not allowed to perform a physical examination on her. I solved the problem by inviting a female physician together with female interpreter to take over. We three men left the room while the women stayed behind the closed doors to discuss the patient's problem.

### **Central Africa**

The doctor introduced me to a young boy with newly diagnosed diabetes. He told me with his thick Indian accent how the boy had been carried by his mother from far away to this remote clinic near the Ugandan border. The boy had been severely dehydrated on arrival but he seemed to be quite alright now.

A young visiting internist from a world famous medical school in the US was making notes and asked the doctor how they controlled the patient's 24 hour blood sugar levels. The doctor smiled sadly when he said that they don't. They only have one kind of insulin anyway and when the boy leaves the clinic he is going to die since there is no way he can obtain continuous medication from where he lives. I said hello to the boy but he just stared at us quietly. There was no linen on the rusty hospital bed. The concrete walls were stained and flies were swarming around the boy's head. We went to the next bed where a man was dying from pulmonary tuberculosis. He was gasping for breath as we moved on.

### **Northern Europe**

Two paramedics rushed through the main door pushing stretchers. There was blood all around. 'Male 45, car accident, severe injuries to the head, BP 100/60, P 120 . . .'

The ER nurse took notes while the paramedics were calling out the vital signs. The patient's face was lacerated and his eyes wandered around. He looked at me when I called him by his name. He uttered something before he passed out.

### **Eastern Finland**

The lady was staring at the floor, sobbing. 'He was such a good boy. And now . . . I don't know what I have done wrong'. I was running late, and now this lady whose son had blown his head off with a shotgun the night before . . . I sat quietly, letting the lady cry. Three more patients waiting and I should be on my way in twenty minutes.

### **FRAMES AND AIMS**

We physicians are often accused of not listening to our patients. We are told that we just read laboratory results, stare at our computers and ignore our patients as persons. This claim has been levelled at us for so long that it has created a whole new line of inquiry in medicine and on medicine. Piles of books and articles have been published on doctor-patient communication, and teaching communication skills has become commonplace in many if not most medical schools throughout the world.

I am not convinced that we physicians are as poor communicators as a species as one may assume on the grounds of all this academic activity. Instead, I

would like to claim that on the whole we doctors do listen to our patients and we listen carefully. The question might rather be: what do we actually listen to when we listen to our patients?

Our task as physicians is to understand the workings and frailties of the human body and mind and to find ways to cure and alleviate the problems our patients present to us. To give a simple example: If the patient approaches a physician and complains that there is blood coming from the rectum, our task is to find out exactly where that blood comes from, why is it coming, stop the bleeding and to prevent it from happening again. In order to succeed we need to start our inquiry by listening to what the patient tells us about his or her symptoms. When we listen, we try to discern bits and pieces of information that may help us to decide on the likely nature of the underlying cause for the bleeding. That is to say, we concentrate on what we consider relevant to solve the problem the patient presents as his or her reason for consulting us at that particular moment.

Yet the patients do not automatically disclose all the relevant information. This is why we need to ask questions of our patients, to gain a fuller picture of what is going on in their bodies and minds. We may also need to know where, how and with whom that particular patient lives and what s/he does or does not do for a living. These queries cannot, however, be presented as a set of preformulated questions in the hope of gaining complete and rational answers from our patients. Instead, they need to be formulated and adjusted anew for each and every consultation and its aims.

For example, in a busy Emergency Department the task is to concentrate on immediately life-threatening issues. That limits the scope of communication to the questions relevant for the objectives of the ED. There is not much point in engaging in a discussion of the patient's marital problems or traumatic childhood memories, when the patient is blue and breathless and we don't know why. The communication skill needed is to ask the right questions and ask them quickly. This is why many emigrating physicians prefer to work in emergency departments and in anaesthesia when working in an alien language environment. It is easier to learn to say in any language 'where does it hurt?', 'open your mouth', 'have a deep breath' than to master the language to the full, as needed to be able to practise as, say, a general practitioner or a psychiatrist.

Furthermore, to give another example of the influence of context on the mode of doctor-patient communication: when I was working in Saudi Arabia as a GP it was virtually impossible for me to discuss with my female patients

any of their problems occurring between their navel and knees and, in many cases, in any part of the body. If I managed to get an idea about what was going on through the accompanying male relative and a local interpreter, it was categorically impossible for me to perform a pelvic examination for my female patients even in cases of acute vaginal bleeding. This could be performed by female physicians only. It is quite obvious that there would be no possibility of approaching my female patients in that particular culture, no matter how many courses I took to improve my communication skills

Finally, if one works in a remote makeshift clinic somewhere in Africa, seeing daily a hundred patients who speak a variety of local dialects and having only paracetamol, penicillin, quinine and basic surgery as one's therapeutic arsenal, one does not get involved in discussing the finer points of each and every patient's symptoms or their personal problems. On the other hand, one needs to develop a very special type of communication skills to be able to make sound clinical judgements in those circumstances.

This is not to say, however, that we should not take the issue of the clinical dialogue seriously. On the contrary, it is a more serious issue than we often think. That is to say, proper communication with one's patient is not only a matter of good manners and patient satisfaction. The dialogue between the patient and the physician is, in effect, the most important aspect of medical examination and treatment. After all, most of our clinical encounters take place in non-hurried circumstances with patients who are not critically ill. The patient is talking and the doctor is listening. The patient's problem is unfolding through the dialogue that takes place, guiding the doctor toward a diagnosis and treatment. But how does this actually happen, usually in a matter of a few minutes?

## **THE OPENING**

When the patient approaches a physician s/he has a problem s/he has considered as in need of a medical consultation. Except in emergency situations the patient has usually prepared an opening presentation. When the physician asks why the patient has come to the surgery the patient says, for example, that his or her shoulder has been aching for some time. That opening sentence orients the physician's thinking to follow a certain line of reasoning, which is different if the patient says that s/he is feeling tired all the time. Whatever the patient utters as his or her opening statement leads the physician to set off on the path of reasoning that s/he has adopted through training and experience

for that particular type of problem. One may compare it to a drop-down menu on a computer screen. Press 'aching shoulder' and you get a different menu then when pressing 'tired all the time'. However, the similarities with computing do not go any further than that. Doctor-patient communication does not follow rigid problem-solving algorithms, as we shall see, and this is the reason why the attempts to build clinically reliable computer-based diagnostic programs have not fulfilled the expectations, at least as yet.<sup>1</sup>

The patient expresses in his or her opening statement what s/he considers as relevant to explain his or her reason for seeing the physician. S/he is thus, as Osler once remarked, giving the diagnosis, at least to the point of giving it a working title: 'Aching shoulder'; 'Tired all the time'. The patient's opening presentation is, however, insufficient, vague and perhaps completely wrong from a diagnostic point of view. After all, this is precisely the reason why s/he is seeing the physician. S/he is there to gain better understanding of and/or to find an explanation, cure or alleviation for his or her problem.

Since the patient's opening statement usually discloses the information the patient holds as relevant to his or her problem, interrupting that statement is not just bad manners but plain stupid, because it is the most valuable tool for the physician to make progress. This is why all the textbooks of medicine underline that the patient should be given sufficient time to present his or her case uninterrupted. Studies published on the length of the patients' opening statements show that in most the cases they spend less than a minute in telling the physician the reason for the visit.<sup>2</sup> Even if the opening speech takes longer than that, it is time well spent since it provides more information and, if nothing more, time to observe the patient. And if the patient keeps on talking for ten minutes or so – which is extremely rare in any case – the physician may wonder whether it is a sign of a mental disorder worthy of further exploration.

By the time the patient finishes the opening statement the physician has a drop-down menu, or several menus, open. S/he has also observed the patient's physical appearance, state of mind and emotional status and related all this to his or her previous knowledge of the patient, if there is any. But during the few opening moments of the consultation the patient has done precisely the same. How does the doctor look? Does s/he seem interested in me? Busy? Friendly? Detached? Frightening? Trustworthy? Indeed, can I trust this physician? Does s/he know what s/he is doing? S/he looks so young. S/he does not seem to listen to what I say. S/he is just staring at the computer screen.

**PATIENT'S HISTORY**

When the patient has completed an opening statement s/he waits for the physician's response. This moment is, perhaps, the most crucial of the medical examination. The physician has his or her menus open, but where to go from there?

It seldom, if ever, happens that the physician is able to 'close' the case on the basis of the patient's opening presentation. That may occur, for example, when a young woman who has urinary infections three times a year comes to see her physician and says 'here we go again'. Even then, the physician is not content to be a vending machine and to deliver the prescription wordlessly. S/he observes the patient and engages in a communication of some kind, even a short one, to make sure s/he understands the patient's complaint properly and does not miss a case of chlamydia, for instance. In most cases the physician needs to gain more information than the patient has presented in his or her opening statement. This is why the physician starts to ask questions. S/he starts, as we tend to say, to take the patient's history.

I would like to call into question here, however, the notion of a physician taking the patient's history. That is, I question that there exists such an entity as the patient's history just waiting to be 'taken' and analysed in an objective manner.

First of all, the patient is not an object of inquiry producing full answers to standard questions. The way the physician behaves affects the way the patient presents the opening statement and how s/he responds to the physician's questions and vice versa. That is why the clinical dialogue necessarily varies in words, intonations and gestures and consequently in the way the session proceeds. And this is precisely the reason why the computer analogy does not apply in a medical consultation, since the patient's and the physician's reactions to each other's utterances and behaviour in a living dialogue cannot be anticipated as a predetermined set of responses.

Furthermore, when the physician listens to the patient's opening presentation s/he is not hearing a factual statement as s/he might when a radiologist reports that there is a 2 cm stone in the patient's gall bladder. Instead, the physician is listening to the patient's subjective account of the problem that has brought him or her to the surgery. The way the patient expresses the problem is modified not only by his or her general ability to express symptoms and worries, but also by the language and dialect used, by the local ideas of illness and cure and, as we saw earlier, by the setting of the consultation, that is, whether s/he is talking to an unknown physician in a busy emergency clinic

or to the local GP in the tranquillity of the familiar consultation room.

The notion 'taking the patient's history' is relevant, however, in the sense that patients do have a history. Their symptoms have persisted for some time, sometimes even months or years before they decide to come and see a doctor. 'Taking the patient's history' means, therefore, to construct what has happened before the patient's arrival at the surgery. In this sense a physician works as an historian attempting to find out what has happened before.

Physicians' training consists of a broad spread of natural sciences, accompanied by a side dish of social sciences and psychology and spiced with a hint of humanities. Due to our basic orientation to the human body as natural scientists, or biologists to be more exact, we tend to think of our patients' bodies as objects of inquiry. History to a physician is thus natural history, as when examining the development of an embryo, growth of a tumour or development of cardiac infarction during the critical ischaemic moments of coronary thrombosis. The problem is that when we inquire into our *patient's* history we are not observing specimens in a laboratory. We are conversing with living agents of our own kind.

The problem for a physician in clinical dialogue is that, if we fail to ask relevant questions, we may never get relevant information. And even when we do ask the right questions, we cannot be sure whether the answers we get are valid. Every seasoned clinician can tell endless stories concerning this problem. 'It never crossed my mind that this sweet old lady was an alcoholic when I was trying to figure out why she was getting dizzy every now and then, and having these bruises everywhere. I did ask her about alcohol once but she only smiled and said she would never touch a glass. Well, she must have been drinking straight from the bottle.'

The patient's history cannot, therefore, be taken as an object in its own right. It is, instead, mutually constructed between the physician and the patient during the consultation. To illustrate my argument, let us take a brief look at how professional historians reflect their trade.

The British historian E.H. Carr questioned in his famous Trevelyan lectures, delivered half a century ago, the idea of history as merely collecting the facts and reconstructing the past 'as it was'. He discussed the problem of obtaining facts in historical research by writing how 'the (historical) facts are really not at all like fish on the fishmonger's slab. They are like fish swimming about in a vast and sometimes inaccessible ocean; and what the historian catches will depend, partly on chance, but mainly on what part of the ocean he chooses to fish in and what tackle he chooses to use – the two factors being, of course,

determined by the kind of fish he wants to catch. By and large, the historian will get the kind of facts he wants. History means interpretation.<sup>3</sup> Therefore, for Carr, 'history . . . is a process of selection in terms of historical significance . . . history is a selective system not only of cognitive, but of causal, orientations to reality. Just as from the infinite ocean of facts the historian selects those which are significant for his purpose, so from the multiplicity of sequences of cause and effect he extracts those, and only those, which are historically significant; and the standard of historical significance is his ability to fit them into his pattern of rational explanation and interpretation. Other sequences of cause and effect have to be rejected as accidental, not because the relation between cause and effect is different, but because sequence itself is irrelevant.<sup>4</sup> . . . What, then, do we mean when we praise a historian for being objective, or say that one historian is more objective than another? Not, it is clear, simply that he gets his facts right, but rather that he chooses the right facts, or, in other words, that he applies the right standard of significance.'<sup>5</sup>

If we were to replace the words 'historian' and 'history' with the words 'physician' and 'medicine' in the quotations above, those paragraphs could be, curiously enough, an extract from any textbook of medicine discussing the problem of taking the patient's history. John Vincent writes in a similar vein in his recent book on the problem of evidence in historiography. Creating historical evidence is not, for Vincent, merely collecting facts. It is also about 'hunches, imagination, interpretation, guesswork. First and foremost, though, comes evidence: no evidence, no history.' But, for a historian, history 'is about intrinsically fallible evidence. In this it resembles medicine and the detection of crime. And it is about fallible evidence as interpreted by fallible people.'<sup>6</sup>

Vincent could be describing the medical consultation also when he notes that 'if history is about asking good questions, the evidence will not in itself choose what the questions ought to be . . . Two men digging in the same trench would produce different answers, because they were asking different questions.'<sup>7</sup> This phenomenon is familiar for physicians and patients alike. If a patient were to see different physicians with same complaints s/he would most likely end up having more or less different conversations and therapeutic suggestions with the physicians even when all reach the same diagnosis.

Vincent writes how 'history is about evidence, but only about evidence we approve of. Evidence we disapprove of, might as well not exist. We decide, even before looking at it, what can be evidence and what not.'<sup>8</sup> This observation also applies in medicine. To illustrate this with a clinical example, let us consider an elderly patient I treated in the Arabian Peninsula who pondered whether he

was feeling ill because of the effects of an evil eye. Because in his community 'evil eye' is an everyday etiological possibility for various ailments, I considered the patient's expression as an indigenous metaphor holding no clinical evidence whatsoever. But if a deeply Lutheran bank manager in my hometown Tampere in Finland were to disclose to me that the pain in his tongue must be due to the evil eye cast on him by the mailman, I would consider that statement to be evidence not of tongue pathology but of psychiatric illness.

To conclude, in the medical consultation a physician faces the same epistemological problems as an historian who is interviewing participants in some event of historical interest and who is trying to construct what it was that took place and why in that particular period of time. In his introduction to modern historiography Michael Bentley says in summary that the past does not, by definition, exist. Therefore, it can never be reconstructed but only constructed in our present as a picture or image or model of the event of interest under our investigation.<sup>9</sup>

For the physician the material for diagnostic and therapeutic reasoning is created through the dialogue with the patient here and now. That is, the patient's history is constructed between the doctor and the patient in the always unique event of a medical consultation. The task a physician faces, when deliberating on the material that emerges during the clinical dialogue, is to decide what is relevant and what is not in terms of current medical theory and the aim of the consultation.

## **TWO LANGUAGES**

In a medical consultation a doctor is conversing with one or more persons. Even when the patient is not able to talk (small child, paralysed, unconscious) someone has taken the patient to the surgery or hospital. The question of the conduct of the medical consultation is, therefore, also a question about the use of language and this is why linguists and socio-linguists have taken a central role in studying doctor-patient dialogue as a special form of human communication.

The language with which we converse in our ordinary encounters is not exact, fixed and final but it is open to all kinds of expressions and interpretations, as we can see in our everyday misunderstandings and quarrels. Scientific language, in contrast, attempts to be precise in its concepts and expressions. In the medical consultation ordinary language and scientific language meet. One of the doctor's many dilemmas is how to translate the

patient's everyday language into medical concepts and how to create mutual understanding between medical thinking and the patient's comprehension of what is going on.

The way we express ourselves has developed through continuous interaction with other people. Our speech is thus moulded not only by our individual traits and capacities but also by the time and place we live in and people with whom we live. This is not just a matter of adopting a local language, dialect and style but also of content. The ideas we have about health and illness vary among our local traditions. Today these variations are perhaps greater than ever due to the all-encompassing media and to the commercial exploitation of a great variety of ideas and suggestions on illness and healing.

Physicians are also subjected to all of this. Despite the fact that the medicine we practise is based on scientific ideals and research, we have absorbed ways of thinking and expressing our thoughts from our own culture and immediate surroundings, long before we entered medical schools. Yet we like to think that since medicine is based on science, doctors are free from cultural assumptions and peculiarities. However, it is easy to see that when one goes from one country to another one finds different medical ideas and practices. Furthermore, this is not only the case between different countries, but also within any single country. One only needs to go from one clinic to another to find different practices. And finally, this phenomenon is not apparent just between different clinics but also between physicians within the same clinic. All of us physicians have our own ways of talking with our patients. One likes to have a thorough discussion with his or her patients while the other is rather quiet and asks only a few short questions.

However, despite of all this variability in the way we deal with our patients, we do not simply make a haphazard guess, or toss a coin, or plead for supernatural powers when we establish a diagnosis and prescribe a treatment. Instead, we apply scientific methods in the way we think and practise. That is, we rely on the scientific ideas we have about the structure, workings and malfunctions of a human body and mind as gained through our training. These ideas are expressed in scientific language as written in medical textbooks and journals and as spoken on medical congresses, meetings and bedside consultations.

This creates a certain tension in all doctor-patient encounters. We start with the patient's opening statement on his or her reason for attending the surgery. The physician responds to the patient's opening statement which leads to a discussion and conclusion of a certain kind. This dialogue is carried out in

local language and dialect, coloured with the patient's expressions, ideas, fears and hopes and steered by the physician's responses, questions and answers. During the consultation the doctor's task is to translate the patient's expression into medical language leading to a diagnosis or, at least, to a plausible hypothesis on what might be going on, expressed in medical terms. In this process two languages meet, that of a layperson and that of medicine, which offers a set of possible ways the patient may or may not be considered as ill in a medical sense.

### **POLYPHONY AND MONOLOGUE**

The tension between the patient's expression and the medical language can be seen, to use Russian linguist Mikhail Bakhtin's concepts, as the tension between the polyphony of everyday speech and the monologue of scientific language (Bakhtin 1996, 1997).<sup>10,11</sup> For Bakhtin the way we speak has been developed through continuous interaction with others and our expressions are, therefore, permeated with the voices of those with whom we have been associated. Indeed, we are able to notice in our speech phrases, intonations, opinions and ideas acquired from our parents, spouses, teachers, friends and associates. Every medical student (including myself long ago) has had as his or her hero a senior consultant during clinical training. One finds oneself not only clumsily using the terms and intonations the senior was using, but even imitating his or her mannerisms.

As a counterpoint to our everyday speech, medical textbooks and journals attempt to formalise the language we use, since in order to be scientific an expression cannot have multiple and contradictory meanings. A 2 cm stone in a gall bladder is a 2 cm stone in a gall bladder. A broken collar bone is a broken collar bone. Type A beta haemolytic streptococci in one's throat are type A beta haemolytic streptococci in one's throat. In the attempt to eradicate multiple meanings in their expressions the exact sciences constitute, in Bakhtin's terms, a monologic form of knowledge.

A physician needs to operate with and oscillate between these two modes of expression; the polyphony of everyday life and the monologue of medical language. And it is precisely along this axis that misunderstandings and dissatisfaction between patients and physicians present themselves. While a physician may be correct in medical diagnosis s/he may not notice within the patient's polyphony (approaching sometimes a cacophony) those aspects that are crucial for the patient. 'She did not listen to me,' complains the patient.

On the other hand, if the physician fails to establish a correct diagnosis, the patient may complain: 'He just kept asking these questions about my life while I had this tumour in my breast all the time.'

The tension between the polyphony of the patients' utterances and the monologue of medical terms can be vividly seen in our patient narratives. In our first story a young doctor is having a chat with Rachel, a teenage girl with newly diagnosed diabetes. The doctor explains the nature of her condition and how to treat it and tells her that she can live a normal life despite her disease. We are all assured that from a medical point of view that there is nothing to worry about. The condition can and will be treated. For Rachel this triggers a storm in her mind. 'Of course it worried me . . . so frightened of injections . . . all I could see in my head was that nurse's needle . . . I'm a *diabetic*? The word rang in my head like a hard, cold bell.' And when she encountered her family, the relationships were altered too. 'I could feel an ocean of worry in her . . . I've never known Mum to sit so still . . . I did not know what to do with her.'

The young physician addressing Rachel talked to her, not with her. The physician's position was monologic. She was not entering into a dialogue with the patient. A young, inexperienced physician in a busy hospital ward, tired from all that she has to manage, had a chat with – or to? – the patient and went on with her duties.

Jake, in turn, is visiting his local GP. He is ashamed of his condition with uncontrolled bowel movements and frightened by the appearance of blood in his stools. When he enters the physician's consultation room he enters the medical world. In his case the medical reasoning process requires a rectal examination. Jake isn't used to displaying his body and, what's even worse, the examination is about to be performed by a female physician. The doctor acknowledges the patient's embarrassment and does her best to cause the patient as little discomfort as possible. She keeps on talking while sliding the proctoscope into the anus. The doctor reassures the patient by saying there is nothing to worry about. Just piles, an everyday minor problem. She then explains the medical options and gives Jake some written instructions on how to deal with his bowel condition. The doctor pauses and offers the patient a chance to ask questions. Jake refuses; he has had enough for one day. The doctor then asks about his psoriasis. Jake is on his way out, just wishing to get away. He has used his six minutes and he does not crave for more. He has had a brief encounter with the monologue of medical diagnosis and treatment for IBS. Case closed. Reopening it is left to the patient.

In Liz's case the medical monologue is taken to the extreme. In the midst

of her everyday haste comes a letter. A dry and factual statement about the need to take further smear tests since the previous test showed some minor abnormalities. Medical monology intrudes on the patient's life, triggering a whole symphony of questions, worries and fears. What is going on? Infection? VD? Cancer? Indeed, could it be cancer? Liz cannot concentrate, her hands are shaking, she feels sick. Damocles's sword hangs over her head. She desperately needs to hear a human voice to counter the monology of the letter.

She calls her physician, who instantly understands the patient's overwhelming worry. The doctor attempts to fit the demand of medical logic into the patient's life context. There is no need for her to worry; she should enjoy her holiday and have a day off when she comes back for re-testing, it is easier for her that way. The patient agrees and ends the call. She is shaking with relief.

In our fourth and final story the plot gets more complicated. Geoff has had a stroke. There is a permanent damage in his brain. From a curative perspective, the case is closed. The question is, however, how to offer him proper care while his wife, Jen, is tackling her lung problem.

For Jen the situation is dreadful. There is a shadow on her chest X-ray. From the medical point of view the challenge is to identify the nature of the biological process in her lung tissue causing the anomaly in the picture. For Jen the details of the cellular structure are of secondary importance. For her it is *The Shadow In Her Chest X-Ray*. For Jen the monologic medical expression is a matter of life and death. There comes to the surface the polyphonic story of her life. Her mother died because of a shadow. Her brother had it and became thin and stooped as he went through the agonising treatments.

The medical monologue begins again: Not likely TB though. Cancer, perhaps. An interesting diagnostic problem for a physician, to be solved with scientific methods. For Jen it is so much more than that. There are feelings of guilt because she knew she should not have smoked. And how to deal with her husband if she gets gravely ill? How to tell those closest to her what is going on? She is feeling sick, not because of the cellular process in her lungs but because she does not know how to incorporate all that into her life, for whatever time there is left to live.

Meanwhile, the doctor is assessing Jen's husband's condition. The medical monologue falls short: 'depressed', 'dehydrated'. What is needed, however, is not more medical terms but simply a means of taking care of him. The doctor tries to explain the situation to the patient but the patient is not listening. He is just staring at the wall. How can the doctor enter into a dialogue with this patient? What more should he say?

**WHAT CAN ONE SAY?**

Let us go back to the beginning, to the first moments of a medical consultation. The patient has concluded the opening statement. The physician has the pull-down menus open. How should s/he proceed from here? What reply should s/he make? What question should s/he ask? Since each and every doctor-patient encounter is inevitably unique, there are no standard answers available. No clinical guidelines can tell us what to say. No laboratory readings can steer us here.

Whatever the physician says will lead the dialogue in one direction or another. Yet the consultation is not a one-way logical process. There are always returns, loops and dead ends. During the clinical dialogue both participants respond to each other's questions, answers, gestures and tone in a constant interplay. That is why a medical consultation cannot be cast into a preformulated script or notation. It is rather a moment of improvisation for a duet. Theme and variations. The patient sets the tune, key and tempo. The doctor joins in where the patient pauses and develops the theme further for the patient to continue. The dialogue brings forth new tones, accents and contrasts to proceed if all goes well to a harmonious cadence; that is, to a mutual understanding of what the patient's problem is all about and what should and could be done for it. This is the jazz of medicine. But should no mutual understanding emerge, the consultation falls out of tune and ends up at its worst as mere noise, where the participants are not even able to share the same key.

So, as doctors we converse as best we can. We express ideas and opinions derived from our training and experience and from an understanding of human life in general, entering into a living dialogue with the patient. That dialogue may help us to arrive at a diagnosis and treatment and it may help the patient to feel that his or her plea has been heard and answered. What more can, or should, a physician achieve during the few fleeting moments of dialogue in an everyday clinical encounter?

**NOTE ON MEDICAL HUMANITIES**

The core function of medicine is the consultation. The patient's problem is defined through the dialogue between patient and physician. This dialogue is shaped and modified by various personal, cultural and linguistic factors. Examining the nature of the clinical dialogue clearly demonstrates the need for the humanities, drawing as one must on linguistics, semiotics, historiography, anthropology and more.

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