MODELS AND METHODS FOR INCREASING THE EFFICIENCY OF INNOVATIVE RESEARCH

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zenodo OpenAIRE | GERMANY 2022 | doi digital object identifier | OPEN ACCESS

ISBN 978-955-3605-86-4

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MODELS AND METHODS FOR INCREASING THE EFFICIENCY OF INNOVATIVE RESEARCH: a collection scientific works of the International scientific conference (11 February, 2022) - Berlin:2022. ISSUE 8 – 233 p.

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Languages of publication: Deutsche, English, Русский, Limba română, uzbek,

The compilation consists of scientific researches of scientists, post-graduate students and students who participated International Scientific Conference " MODELS AND METHODS FOR INCREASING THE EFFICIENCY OF INNOVATIVE RESEARCH ". Which took place in BERLIN on 11- February, 2022.

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PEDAGOGICAL SCIENCES AND TEACHING METHODS

VOLUME 1 , ISSUE 8
FEBRUARY 2022

Collection of Scientific Works

BERLIN 11 FEBRUARY 2022

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MEDICINE AND LANGUAGE

https://doi.org/10.5281/zenodo.6036386

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Annotation: *This article is on the forms and functions of language in medical practice and training has expanded rapidly during the past two decades, a development marked by diversity in theoretical perspectives and methods brought to bear on a variety of problems.*

Key words: *chronic, psychiatry, sociolinguistic approaches, verbal vs. nonverbal behavior.*

INTRODUCTION

Research on the forms and functions of language in medical practice and training has expanded rapidly during the past two decades, a development marked by diversity in theoretical perspectives and methods brought to bear on a variety of problems. Although we label the area as "language and medicine," it includes other health professionals and nonclinical settings. Our discussion is organized under four headings that we believe represent primary topics and domains of interest among investigators as well as the variability within the field: speaking to patients, speaking with patients, speaking about patients, and speaking by patients. A few exemplar studies will be cited in each section and the contributions and limitations of approaches in each topic area will be noted.

SPEAKING TO PATIENTS

An early direction for research in this field, dating back to the mid-1960s and continuing to the present, focuses on ways physicians may improve their communicative skills so as to more effectively perform their clinical tasks: history taking, diagnosis, and treatment. We refer to the central theme of these studies as speaking "to" patients since two primary emphases are stressed: I) how physicians establish relations with patients through their modes of asking for and giving information and 2) how different styles of communication may enhance or diminish patient satisfaction and compliance. Analyses of talk in medical interviews, based typically on observations, audio-, or video-recordings, provide indices of the patient-

physician relationship, and a good relationship is viewed as the basis for effective clinical care. As two proponents of this line of inquiry observe, "Talk is the main ingredient in medical care and it is the fundamental instrument by which the doctor-patient relationship is crafted and by which therapeutic goals are achieved" (Roter and Hall 1992). A similar perspective, expressed in a recent review (Ong, et al. 1995), is that the medical interview has three aims: ro create a positive interpersonal relationship between physician and patient, that is, a working alliance; to offer opportunities for both physician and patient to give and seek information; and to provide the basis for the physician to make medical decisions.

Reflecting this general orientation, studies tend to address how well physicians achieve their clinical tasks, defined within the medical perspective, and findings often lead to recommendations for modifying physicians' practices through better communicative skills (Ptacek and Eberhardt 1996). There is little interest, and few studies, concerned with how patients can enhance their communicative skills in their interaction with physicians (Roter and Hall 1939)

The uncritical reliance of these studies on medical assumptions of good clinical care and on the practical interests and aims of physicians is accompanied by neglect of broader theoretical issues, for example, cultural and social contexts of illness and patterns of care. These concerns rarely enter the design of studies or the analysis and interpretation of findings. Further, there is no consistent theoretical direction that relates various studies to each other. Instead, the unifying factor is methodological: The method of choice is some form of interaction coding based on the model developed in the 1950s (Bales 1950) and modified for application to medical settings (Ong, et al. 1995: For an early detailed study applying a modified Bales system, see Byrne and

Long 1976: and see Mishler 1984 for a critique of the approach). Discussions of method center primarily on which type of code-category system might better suit these encounters-global or exchange-based coding systems (Stiles and Putnam 1992), and whether and how standardized codes that permit quantitative analysis might be combined with qualitative approaches, for example, in Conversation Analysis (Charon, et al. 1994, Roter and Frankel 1992). Types of communicative behavior coded in typical studies include the following: information giving and information-seeking, social or non-medically relevant talk, positive and negative comments, partnership building statements (Roter and Hall 1989, Roter, Hall and Katz 1988), high or low controlling statements, relative use of medical or everyday language, and rates of verbal vs. nonverbal behavior (Beisecker 1990, Ong, et al. 1995)

Underlying much of this research is a three-part model of the communication process, an adaptation of the standard distinctions in the social and behavioral sciences among independent, intervening, and dependent variables. The first (independent variables) refers to 1) differences between physicians and patients in their respective social and cultural backgrounds, including demographic factors such as age, social class, education, and gender; 2) stylistic patterns of verbal and nonverbal communication; and 3) variation in types of illness as acute or chronic, life threatening or not. The influence of these independent variables on outcomes is mediated by intervening communicative behaviors of physicians and patients in the clinical encounter. This process is assessed, as we noted earlier, by applying coding systems with predefined categories and the use of aggregate measures, for example, the total number of questions asked by the physician or patient. Finally, dependent outcome variables are specified, for example, as levels of patient satisfaction with an interview and compliance with physicians' recommendation

An alternative research paradigm for studying medical interviews emerged in the early 1980s (Fisher and Todd 1983, Freeman 1987, Mishler i984, Silverman 1987). Applying various sociolinguistic approaches (for example, discourse and narrative analysis, and conversation analysis), this view respecifies interaction in clinical encounters as speech events (Gumperz and Hymes 1972), and it directs attention to ways physicians and patients engage in a dialogue through which the particular structure and organization of medical interviews is jointly constructed. Thus, how they talk "with" each other is the central topic. Rather than isolating predefined categories of speech units from the stream of talk and aggregating them into global measures, these studies focus on the sequential patterning of exchanges between physicians and patients. The theoretical and research tasks are to locate different types of structures and interpret their functions. Carefully prepared transcripts of audio- or video recordings serve typically as primary data for analyses.

CONCLUSION

We have emphasized the diversity of theoretical and research perspectives in current work on language and medicine, adopting a typology that specified four different foci of interest: speaking "to," "with," "about," and "by" patients. We believe that collectively they represent the major themes and issues of the field as it has developed and is now defined. However, that goal has also limited the scope of our review. In a sense, we were constrained by what might be found in a computer database search of the key words "language and medicine" with their associated terms. Further, research areas "on the borders" of medicine, like psychiatry (Hyd6n

1995, Ribeiro 1994), psychotherapy (Ferrara 1994), and counseling (Perikyli 1995, Silverman 1997) have been excluded. The field as it exists, particularly one as new and expanding as this one, may not be an adequate basis for forecasting future trends. In these concluding remarks, we wish to point to an area that deserves and, we hope, will receive more attention as a further potential extension of the boundaries of this field of study.

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