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

Marisa Cordella*

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

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

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

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

Key words: doctor-patient communication, medical communication, medical discourse, professional discourse, empathy, discourse analysis.

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

David Carbone (2005:54)

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1. Introduction

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

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

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

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

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

2. Background of the study

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

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

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

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

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

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

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


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

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

With the Doctor voice the physician seeks information, assesses and reviews the treatment and shows alignment to the medical authority. The Educator voice communicates medical facts, provides information regarding available test results, proposes tests to be undertaken, provides information about functioning of the human body and responds to the patient discomfort. The third ‘voice’, the Fellow Human voice, complements both the Doctor voice and Educator voice by exploring non health-related issues (at least on the surface) and by gaining a holistic view of patients’ wellbeing. In this ‘voice’ the physician facilitates and assists the telling of patients’ stories, creates
empathy with the patient and shows special attentiveness to patients’ stories. Each of these functions is achieved by a number of linguistic strategies. The Dynamic Model designed by Cordella (2004:215) when used to interpret a GP (general practice/primary care) consultation, suggests that the **Fellow Human voice** makes the medical consultation an event in which the asymmetry between doctor and patient becomes less prominent.

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

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

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

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


### 3. Methodology

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

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

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

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

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

### 4. Research questions

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

### 5. Results and Interpretation

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

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

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

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5.1. Health-related storytelling and Social Communicator

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

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

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

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

Example 2 is a male patient who is in his fifties. He has been treated for acute myeloid leukaemia and he is currently undergoing treatment for non-Hodgkin disease. In the segment below the doctor enquires as to whether his low intake of cow’s milk (a concern that the patient’s wife has put forward) is associated with any after effects he may experience like diarrhoea.

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

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

Example 1 (Health-related storytelling: Drinking milk).
MD: medical doctor, FP: female patient, MP: male patient
FP: Ah tuve vómitos
MD: ¿Cuándo?
FP: ¿Ayer?
MR: Ante=
FP: =Ante anteanoche
MD: ¿Con qué comida?
MR: Mariscos crudos [en el casorio] del sábado
FP: [@@@] Es que se me olvidó. Entonces estaba todo tan rico entonces fui y y lesa porque me eché puras cosas cocidas entonces papitas con mayonesa todo todo cocido y voy y veo y había como eh eran choritos [con::] cebiche de mariscos entonces ah me voy a
MR: [cebiche de mariscos]
FP: servir una cuchara y me voy y me sie::nto y después le digo a Danny y él ya te traigo más y después uu:: eran crudos y ahi quedó la escoba
MD: Ya no todavía para eso falta un poquito
FP: Si pues si sé pero a veces se me olvida ese es mi problema que -me olvida que estoy transplantada

Example 2 (Social Communicator: Food poisoning).
MD: medical doctor, FP: female patient, MR: male relative
FP: Ah I had vomiting
MD: When?
FP: Yesterday?
FP: The day=
MD: What did you eat?
MR: Raw shellfish [at the wedding] on Saturday
FP: [@@@] Well I forgot. Everything was so delicious so I went and and I was silly I put on my plate only cooked food potatoes with mayonnaise, everything, everything was cooked and I go and I saw that there were some mussels [with] marinated raw shellfish and I served myself
MR:[marinated raw shellfish]
FP: one scoop and I went to sit down and then I told Danny and he said to me I’ll bring you some more and then uhmm they were raw I ended up very sick
MD: Not yet we’ll need to wait some time before that
FP: Yes I know but sometimes I just forget that’s the problem I forget that I’ve had a transplant
In the above example the oncologist, after patient’s initiation (I had vomiting), asked about the timing and content of the event and then allowed her and her partner to develop their story. The result is a co-narration where both participants contribute to the topic of food poisoning. In this section I will not appraise the joint construction of this story as this point will be discussed further on in this manuscript in section 5.2. What is of interest here is to observe how the patient’s self-identity defies the ‘predictable’ medical script of the medical event.

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

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

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

### 5.2. Co-narration in the medical visit

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

- 25/36 storytellings are co-narrated in group dyad composition (patient-relative-doctor and relative doctor).
- 11/36 of storytelling in a dyad composition (patient-doctor).
- The difference is statistically significant ($X^2 1 = 5.44, P < 0.03$), indicating a preference for increased co-narration involving the accompanying relative.

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

<table>
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<th>Example 3</th>
<th>Co-narration of Health-related storytelling: I’m feeling better now!</th>
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### Table 1. Results and Interpretation of co-narration

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<td>11/36 of storytelling in a dyad composition (patient-doctor).</td>
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This co-narration is accomplished by the patient (MP) and his wife (FR) who together construct the story that intends to report to the oncologist how the patient is doing with the current course of chemotherapy.

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

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

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

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

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

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

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

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

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<th>Health-related Storyteller</th>
<th>Social communicator</th>
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<tr>
<td>Patient-doctor</td>
<td>0.66 ± 1.07</td>
<td>0.25 ± 0.62</td>
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<tr>
<td>Patient-relative-doctor</td>
<td>0.91 ± 1.16</td>
<td>0.58 ± 0.99</td>
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<tr>
<td>Relative-doctor</td>
<td>0.41 ± 0.90</td>
<td>0.16 ± 0.57</td>
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<td>Values are mean frequency per consultation ± standard deviation.</td>
<td>Sample size 12</td>
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Table 2. Use of co-narration in the oncologist consulting room

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

6. Discussion

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

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

While the voice of Health-related storytelling shows examples in which patients align to the medical script of the consultation and convey stories around their medical condition, the voice of Social Communicator provides rich personal story material that validates patients as people despite the fact that they are being treated for a medical condition. Patients in this ‘voice’ articulate a discourse about their self-identity, counteracting with the sick image stereotypically portrayed of patients. The formu-
lation and development of these stories represent a liberating act revealing the individual who is behind the disease.

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

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

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

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

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

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

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

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<th>Transcription Symbols</th>
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<td>Unit</td>
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<td>Speakers</td>
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The symbols of transcription used in this study correspond to Du Bois 1991. Adaptations made to accommodate Spanish data.
(1976:562). The building up of trust appeared to be vital in the oncological visit and this might have allowed all participants to form stronger bonds with each other. Such trust may help all individuals concerned going through the challenging journey that awaits them.

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

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

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

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

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

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

Acknowledgments
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I would also like to thank those colleagues who assisted me at the clinic during the period of data collection. Last but not least, I am thankful to every one of the patients who gave their consent to be part of this study and shared their personal stories with me.

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