35 Communication in Paediatrics

Thomas Spranz-Fogasy, Jenny Winterscheid

Abstract: Paediatric consultations differ from other medical consultations with patients in terms of the tasks involved and the constellation of participants. In a triadic constellation with doctor, patient and parent(s), different knowledge and responsibilities of all participants must be adequately balanced and understanding, and the results of the conversation must be ensured. This article begins by outlining the research situation and briefly describing the action scheme for initial paediatric consultations. Subsequently, a case analysis is used to shed light on the multi-layered and complex tasks of those involved in the constitution and performance of the physical examination.

35.1 Introduction

Compared to other medical conversations with patients, paediatric conversations have some particular features that create specific conversational tasks in specific participation constellations and with specific

conditions. A triadic constellation with doctor, patient and parent(s) can be considered the normal case. One particular task here, for example, is to reconcile the different knowledge and responsibilities of all participants to a sufficient extent for the purposes of the conversation and to ensure understanding and the results of the conversation (e. g. Winterscheid 2020).

Studies on paediatric conversations are thematically heterogeneous (see also Winterscheid 2015): Many studies deal with special clinical pictures and disorders such as epilepsy (e. g. Schwabe 2006, Knerich, Opp 2021), borderline (e. g. Streeck-Fischer, Cropp, Streeck, Salzer 2016) or malformations (e. g. Streeck 2002), with conversations in the clinic (e. g. Aronsson, Rundström 1988, van Dulmen 2004) or with psychotherapy sessions (e. g. O'Reilly 2008). In other conversations studied, children are the topic of conversation but are either unable to participate in the communication or are not even present (e. g. Gordon et al. 2009, Tiitinen, Ruusuvuori 2014). Even less research has been conducted on everyday consultations in (paediatric) practices (e. g. Stivers 2001, Spranz-Fogasy, Winterscheid 2013, Winterscheid 2015, Winterscheid 2018), although a considerable proportion of patients in primary care consultations are children (Cahill, Papageorgiou 2007, referring to Saxena et al. 1999, Frank 2019, Bindernagel 2020).

What is often striking in medical consultations with children is the low level of patient participation in the conversation (e. g. Winterscheid 2018: 33-41). In most cases, it is the parents who often speak "about" or "for" the patient with the doctor (for this distinction, see Schwabe 2006 or Winterscheid 2018: 142-164). According to Winterscheid (author's abstract), the proportion of parents speaking is on average 25% compared to 8% of patients (n=35 interviews; see also Winterscheid 2018: 33-41). According to Aronsson and Rundström (1988), the patients' speaking participation is also influenced by the parents' parenting style, while Tates and Meeuwesen (2000) attribute this to their age and the doctors' attribution of competence. In contrast, Winterscheid (2018: 33-41) cannot attribute the low speech participation to age-related differences but can identify a link to action tasks in which the patients can participate more or less proactively or are involved, as well as the temporal involvement of the patients, which depends in particular on the request to describe complaints (e. g. Winterscheid 2020).

Aspects of responsibility are always associated with the role of parents. Parents are the children's first point of contact, also for questions about well-being and illness, and they also decide whether to visit a

doctor. This is also regularly preceded by attempts by the parents to diagnose the complaints and, if necessary, to treat them themselves, before they then have to admit their own helplessness after unsuccessful or insufficient treatment attempts and feel compelled to take their child to a doctor (see also Spranz-Fogasy, Winterscheid 2013). These efforts are also usually discussed during consultations. This is accompanied by the risk of a face threatening act (see also Brown, Levinson 1987: 65ff. and Goffman 1967), as the visit to the doctor may have been unnecessary or too late and their own treatment measures may have been useless or even harmful (see also Spranz-Fogasy, Winterscheid 2013, Winterscheid 2018).

Furthermore, the often-concealed ideas about the causes and diagnoses of illness, the so-called “subjective illness theories” (SIT) (Birkner 2006; term translated by the authors), can represent an additional challenge in the doctor's discussions with parents (see e. g. Spranz-Fogasy, Winterscheid 2013 or Winterscheid 2018: 165-225). Wüstner (2001: 309; translated by the authors) understands subjective theories of illness as "a system of illness-related ideas, beliefs and evaluations. A person forms them when confronted with an illness. The core elements of the concept are ideas about the causation of an illness and about the ability to influence it". The recognition and consideration of SIT is - not only in paediatric doctor-patient conversations - elementary for the relationship between the interaction participants and thus also for compliance (Birkner 2006). For the doctor, it is even advisable to actively ask about SIT that is not explicitly made in order to prevent such considerations from subliminally disrupting the conversation process and, for example, prolonging it unduly due to insistence (Spranz-Fogasy, Winterscheid 2013, Winterscheid 2018, see also Birkner 2006 or - for the context of relevance markers that are not taken into account - Sator et al. 2008).[1]

35.2 Action scheme for initial paediatric consultations

The logic of action development in paediatric consultations is more differentiated in some areas than is the case for other medical consulta-

[1] The following results refer to data collected in various paediatric practices in Germany. As explained in Winterscheid 2015 on the basis of the use of antibiotics, these can only be compared with data from other countries to a limited extent.

tions in private practice with a mostly dyadic structure of participants (see Spranz-Fogasy 2005 for the action scheme of initial medical consultations). The triadic conversation constellation, which is fundamental for paediatric consultations, ensures a split conversation partnership with different contact persons and complementary sequencing tasks (e. g. Spranz-Fogasy, Winterscheid 2013 or Winterscheid 2018: 81-85). In the opening phase of paediatric consultations, for example, there is a clearer separation between the greeting and the task-related opening of the conversation, which often coincide in the dyadic initial consultation.

These analyses[2] are based on the corpus of medical consultations in paediatric practices with four different doctors in the Alemannic and Rhine-Franconian language region, collected by Winterscheid in 2009, and comprises a total of 35 recordings, all of which were captured with the help of an audio device positioned on the doctor's desk and, in around half of the consultations, also using a video camera. For the most part, these were initial consultations, but preventive check-ups for children were also recorded, although these will not be discussed further here, as preventive examinations differ markedly from initial consultations. The patients were between 2 ½ and 16 years old at the time of recording and were all accompanied by at least one parent.

At the beginning of the interview, the paediatrician usually selects one of the parties, i.e. the patient or parent, as responsible for the complaint description, although patients only comply with such a request in 32% of cases and even in these cases parents take over the task of describing the complaint relatively quickly. During the description of the complaint, responsibilities for parts of the report are then negotiated by assignment or on the patient's own initiative (see also Winterscheid 2018: 81-85 or Winterscheid 2020).

In dyadic doctor-patient conversations with adult patients, the physical examination is an optional element depending on the verbal explanation. The doctor can often make a diagnosis from the patient's description with just a few questions and no further examination is necessary (Hampton et al. 1975). In paediatric conversations, on the other hand, the physical examination is a regularly performed action scheme component (see also Güthoff, Rosenecker 2008: 8), which creates further tasks for interaction participation, as the patient becomes the subject of the examination in addition to the communication partnership.

[2] The following examples are taken from the same corpus.

For the doctor, it is then a matter of coping with the two-way communication partnership with the patient and parents in addition to the cognitive and possibly also the practical demands of the examination.

The particular interactional tasks of the paediatric physical examination and the medical approach to them are the focus of the main part of this article (§ 35.3).

In most cases, the paediatrician is able to make a diagnosis based on the patient's and parents' description of their complaint and their own physical examination, which is immediately followed by a treatment plan. Both the diagnosis and the treatment plan are usually negotiated and sometimes discussed between the doctor and the parents. When the doctor addresses the patient and explains the symptoms of the diagnosed illness or points of the treatment plan, this is usually done without putting them up for discussion. When ending the conversation and saying goodbye, the doctor then addresses both parties at the same time. The end of the conversation is often accompanied by important behaviours being addressed again, agreements being recorded and the doctor giving the parents a prescription or referral and the patient a reward. This also reveals a difference in the interactive involvement of the doctor.

35.3 The physical examination

The physical examination is interactionally conspicuous simply because it regularly coincides with a repositioning of the participants in the conversation in the room (see also Winterscheid 2018: 83-84).

In addition, the verbal also plays a rather subordinate role in this action scheme component. The doctor examines the patient's body, whereas previously only the complaints were discussed or at most certain symptoms were pointed out.

In most cases, this is initiated by an announcement from the doctor or a request to the patient or parents to prepare the patient for the examination by removing certain items of clothing. Very rarely, the examination also takes place around the doctor's desk. This is particularly the case if the body part is easily visible or already exposed. In general, however, the patient is examined on a surgery couch in the doctor's consulting room. The parents usually remain seated in their previous position, facing the couch, or they prepare the children for the examina-

tion and then remain standing near the couch or sit down again afterwards. In other cases, they also join the examination later on their own initiative or at the doctor's request.

After the examination, all those involved in the conversation - together with the doctor's return to the desk - then return to the doctor's desk. The doctor often ends the physical examination by saying that the patient can get dressed or be dressed again but occasionally also with a direct transition to the diagnosis.

The physical examination is therefore a significant caesura in the initial consultation, especially as it is occasionally accompanied by a longer verbal pause. However, parents often use this phase to make further points or to further explain points that have already been made (see also Spranz-Fogasy, Winterscheid 2013).

The requirements for the doctor during the physical examination therefore initially consist of the following purely formal steps:

- The action scheme component must be initiated and established by the doctor.
- The doctor must create the conditions for the necessary examination steps (technical/apparative and metacommunicative).
- The doctor must take the initiative to carry out the necessary examination steps (technical/apparative, communicative).
- In many cases, the physician must organize transitions of the participation constellation from triadic to interactional dyadic constellations (see also Schmitt, Knöbl 2013, Schmitt 2013: 54-5). In fact, however, there is still a triadic dialogue situation, which is also used in some cases to bring up topics that have not yet been (sufficiently) addressed (see also Winterscheid 2018: 142-164 or Winterscheid, Kook 2018).
- Finally, the doctor dissolves the apparent interaction dyad and moves on to the next step.

The following case study shows how doctors deal with these requirements.

35.4 Case analysis

The example comes from the aforementioned corpus (see § 35.2). The patient in this example is 5 years old and is accompanied by her mother. She has vomited prior to the visit to the doctor.[3]

35.4.1 Opening the conversation and describing the complaint

When asked *what is going on*, the mother describes the problem that led to the consultation, whereupon the doctor asks the patient about the duration of the condition[4]:

E 35.1	seit WANN has des denn; *how long have you had this*

```
01  M   fr[anziska hat ]BAUCHweh-
        franziska has stomach ache
02  P     [((stöhnt))  ]
           ((groans))
03  D   franzisK[A:,
        franziska
04  D   seit             ]WANN has des denn;
        how long have you had this
05  M           [hm JA- ]
                 hm yes
06  P   (0.49) ((winselt))
               ((whimpers))
07      (0.21)
```

[3] This example is also dealt with in detail in Winterscheid 2018 and Spranz-Fogasy, Winterscheid 2013.

[4] The transcript excerpts were created in accordance with the GAT-2 basic transcript conventions according to Selting et al. (2011; based on Selting et al. 2009) using the transcript editor FOLKER (↗); capital letters stand for accentuation, simultaneous passages are noted in square brackets, descriptions with double round brackets and descriptions of the manner with angle brackets, extensions with a colon, audible breathing with h° or °h and the boundary intonation with punctuation marks (rising with comma, strongly rising with question mark, consistent with dash, falling with semicolon and strongly falling with full stop); transcription translated by the authors.

```
08  M   um ZWÖLfe rum;
        around twelve
09  M   al[S  ]O:-
        so
10  D     [°h ]
11  M   (0.31) im KINdergarten hast auch schon gebrochen-=ge,
                you already vomited in kindergarten didn't you
12  P   (.) <<gedrückt> hm JA >-
            <<pressed> hm yes >
13  M   ja-
        yes
14      (0.2)
15  M   un [um zwölfe          ] hab ich sie dann abjeHOLT-
        and at twelve I picked her up
16  D      [<<piano> oh JE >; ]
            <<piano> oh dear>
```

The mother first takes the floor - simultaneously with her daughter's moaning - and then also describes the answers to the doctor's questions as part of the description of the complaint, after the patient expresses with a whimpering sound that she is not exercising her right to describe her own complaints in this situation (Heritage, Raymond 2005). The patient's posture and body alignment - she turns away slightly from the desk and sits in a slightly slumped position on the chair while resting her head on the arm resting on the back of the chair - also indicate that she does not wish to participate verbally at the moment or does not feel able to do so. However, the mother has the patient confirm her description with a supplementary corrective statement (line 09/11). The patient complies with this request (line 12). However, the confirmation is made in a whining, howling manner, with which the patient simultaneously expresses her acute complaints and emphasizes that she is not exercising her right (Heritage, Raymond 2005) to describe her own complaints in this situation and is instead having her mother reporting for her. The patient's posture and body orientation – she leans away from the desk and sits in a slightly slumped position on the chair while resting her head on the arm resting on the back of the chair – also indicate that she does not wish to participate verbally at the moment or does not feel able to do so. The doctor reacts to her answer and even adopts the pitch and prosodic structure of "oh" in the responsive interjection *oh dear* (line

16). The rest of the anamnesis only takes place between the mother and the doctor after the patient has withdrawn from the interactive process.

35.4.2 Preparing the examination

As a prelude to the next step - the physical examination - the doctor then activates the patient in several ways: he demonstratively puts aside the pen he has been using to take notes during the anamnesis, looks at the patient and addresses her twice, first by calling her by her first name and then by her last name, before asking her to get ready for the examination[5]:

E 35.2	schau ich deinen BAUCH mal an; *I will have a look at your stomach then*

```
01  D   °h
02      (0.33)
03  D   du franzisKA:?
        hey franziska
04  D   jetz legs du dich oben DRAUF-
        now you lie down on top
05  D   ziehst die SCHUhe aus-
        take off the shoes
06  D   (.) schau ich deinen BAUCH mal an;
            I will have a look at your stomach than
07      (0.31)
08      ((die Untersuchung wird vorbereitet ca. 14,1 Sek.))
        ((the examination is being prepared; ca. 14,1 sec.))
```

The doctor asks the patient to lie down on the surgery couch and take off her shoes so that he can begin the examination, which he announces with the words *look at your stomach* (line 06). The mother then helps her daughter prepare.

The transition and preparation of the physical examination represent complex coordination requirements for all three parties (Schmitt, Deppermann 2007, Wiemer 2017). All parties involved must not only

5 In all other transcript excerpts, the lines are numbered consecutively.

carry out actions themselves but also take into account, support and, if necessary, take over the actions of others. For example, some children sit down on the couch on their own and take off the necessary items of clothing while their parents remain seated (e. g. Winterscheid 2018: 81-85). The doctor often takes notes during this phase and then turns to the children. In other cases, the parents join in and help the children prepare for the examination while the doctor is still organizing or taking notes. This must be resolved by the parents moving away a little, moving to the side or sitting down again on the chairs provided for patients and parents.

In this example, the mother has accompanied the patient to the couch and removed her daughter's shoes. In doing so, she blocks the path of the doctor, who has also approached the couch after her. The doctor then asks the patient to lie down again after the shoes have been removed and steps a little closer to the patient. The mother now moves slightly to the left and leans against a shelf right next to the couch.

The fact that the preparations by the mother and the patient are not continued here is due to the fact that the doctor has approached the couch qua role as an "agent" (Ehlich, Rehbein 1979/1994) or "focus person" of the interaction and his "behaviour [...] has coordinative repercussions for others" (Schmitt, Deppermann 2007: 104-5; term translated by the authors).

The mother, who is engaged in "continuous monitoring activities"[6], registers the doctor's movement and immediately withdraws from the couch so that the doctor can approach the patient (Schmitt, Deppermann 2007: 110; term translated by the authors). The doctor does not announce the interruption of the mother's and patient's preparation activities but then takes over the remaining preparation.

Box 35.1 Coordinative relevance
Coordinative relevance arises from a continuous comparison of current constellations and processes with prior professional knowledge regarding general processes, the sequential logic of work steps and the necessary involvement of certain functional roles.

Schmitt, Deppermann 2007: 121; translation by the authors

6 The term derives from Goodwin (1980) and initially describes the perceptual performance of those involved in the conversation.

The mother's knowledge of these situations therefore ensures that she withdraws from the couch and creates the space for the doctor to approach the patient. After asking the patient to lie down, the doctor characterizes the preparation carried out up to this point as inadequate in that he pulls an item of clothing down a little further and has to unzip her pants to do so. He also announces this explicitly:

E 35.3 jetz legs du dich einfach HIN–
now you just lie down

```
09  D   so:-=jetz legs du dich einfach HIN-
        so now you just lie down
10      (5.33)
11  M   ((unverständlich))
        ((incomprehensible))
12  D   (2.6)
13  D   so (.) franzisKA,
        so franziska
14  D   (1.62) jetz mach ich deine HOse mal AUF,
               now I'm going to unzip your pants
15  D   (1.82) po mal hochHEben-
               lift your bum up
16  D   (1.59) noch MAL-
               once again
17  D   (.) SO;
           SO
18  D   (.) wo tut der bauch weh ZEIG mal-
           where does your stomach hurt show me
```

It is not made explicit that the announcement to undo her trousers is the processing of an "incident" (Schmitt 1997: 56) but by repeating his request (line 09) and adding the adjective *just* (line 09), he defines the current situation as not yet corresponding to his instruction. The doctor's original request was for the patient to leave her seated position and lie down barefoot on the couch ready for the examination. By approaching the couch before the patient could comply with all of the doctor's requests, he may have corrected a misunderstanding that may have arisen as a result of his failure to elaborate on his statement. In addition to the repositioning and preparation by removing the shoes, which must necessarily take place before lying down on the couch, he only men-

tioned that he would like to have a look at the "stomach". This means that only the part of the body that is to be examined below has been named. This does not yet include a request to remove certain items of clothing, although this could certainly be interpreted as such, as the abdomen must of course be uncovered in order to "look" at the relevant body part. It remains unclear whether the patient has to take off her T-shirt and/or trousers or whether it is sufficient to push the T-shirt slightly upwards in the lying position. A person's abdomen is located in the "lower part of the torso between the diaphragm and pelvis" (Duden 2015; translation by the authors) but is also often understood to be the area above the waistband of the trousers. To actually be able to examine the abdomen, the area between the diaphragm and pelvis must be exposed, which involves undoing the button on the jeans and pulling them down slightly.

Box 35.2 Recipient design

Assumptions about the partner's knowledge are [therefore] crucial for turn design, because they determine which expressions and formulations we can use to produce a contribution that is sufficiently explicit and therefore comprehensible but also not too redundant with regard to the partner's existing knowledge. These two tasks, which roughly correspond to the fulfillment of Grice's two quantity maxims (Grice 1975), are served by the so-called *recipient design*

Deppermann 2015: 7 (emphasis in the original); translation by authors

By interrupting the mother's and patient's preparation activities, the doctor incidentally prevents unnecessary or inadequate preparation, which could result from the non-explicit request or from the fact that his request was not implemented quickly enough. It cannot be assumed that the mother and patient use the same definition of the abdomen for their preparation. The assumption of this role takes place after he has defined the preparatory activities as not yet sufficient and partly formulates them again as a request but then also carries out certain preparatory activities himself.

By pointing out his actions, the doctor not only secures her cooperation but also informs the patient and her mother about his actions. The doctor thus legitimizes his action of invading the patient's personal space (Heath 2006) by making it transparent to the mother and the patient why sitting on the couch and taking off the shoes does not yet

meet the requirements for looking at the abdomen (line 14-17). His actions serve to "expose" the abdomen and thus create the conditions for the examination.

Another system of reference for the individual results from the "territories of the self" (Goffman 1971/1974), which include, for example, the "personal space" arranged around the body, into which other persons may only enter under special conditions (Miebach 2014: 106). A doctor who is consulted in order to alleviate their own suffering or the suffering of their children is naturally endowed with these rights. Nevertheless, according to Heath (1986, 2006), the main problem in this phase of the consultation is how to deal with territorial self-determination (Goffman 1971/1974), which the participants handle with a "separation practice" (Heath 1986, 2006: 209) in which, for example, the patients treat their body as an object while at the same time overlooking its manipulation and presentation. They thus offer the doctor direct and objective access to the physical condition, which allows an empirically grounded (First 2014:) diagnosis to follow very frequently and routinely, which in turn justifies therapy suggestions. Ripke has also emphasized this "crossing of boundaries [of the] person to the usual medical extent" and even extended it to "all questions that intervene in the patient's private sphere", which can even result in a "disruption of the relationship" between doctor and patient if insufficient preparation is made (Ripke 1994: 80ff; translation by the authors).

In this situation, manipulation must be carried out to obtain the diagnosis in the first place through a well-founded examination. This connection is then clearly emphasized by the *SO:;* (line 09) and the doctor now moves on to the next step, which had to be postponed. At the same time, by announcing his action steps, he also counteracts the problem of territorial self-determination (Heath 1986, 2006).

Thus, all three parties are exceptionally involved in the preparation of the examination: The patient, who leaves the chair and moves to the couch, the mother, who wishes to assist her and also approaches the couch, and the doctor, who undertakes further preparatory measures before he can now begin the examination.

35.4.3 The conduct of the examination

At the beginning of the examination, the doctor turns to the patient, the actual bearer of the complaints, and asks for the exact location of the pain – despite the patient's very limited participation so far – and informs her about all the examination steps:

E 35.4	jetz HORCH ich den bauch mal ab–
	now I'm going to listen to the stomach

18	D	(.) wo tut der bauch weh ZEIG mal–
		where does your stomach hurt show me
19	P	DA::–
		here
20	D	(.) DA in der mitte–
		here in the centre
21	D	(1.68) jetz HORCH ich den bauch mal ab–
		now I'm going to listen to the stomach
22		(17.96)
23	D	und jetz FÜHL ich deinen bauch mal AN–
		and now I'm going to feel your stomach
24		(8.04)
25	P	aua da t[ut_s (.) WEH–]
		ouch that hurts
26	D	[da tut's en]bisschen WEH,
		it hurts a little
27		(3.23)
28	P	da AUCH–
		here too
29		(1.68)
30	P	da jetz (.) NICH;
		here now not
31	D	(.) da nich SO;
		here not so
32	D	na das is ja PRIma–
		well that's great
33	D	(.) also BLINDdarm is nichts–
		so it's not appendicitis

Immediately after the localization by the patient, the doctor notes the painful location in relation to the body (line 20) and begins the examination. The particular examination steps are explicitly named (lines 21/23), also to prepare the patient for the manipulations and actions (Heath 1986, 2006). When the patient points out pain when he touches her (line 25), he repeats the statement and even retains the prosodic contour but weakens the statement by: *a little* (line 26). The patient reacts to another painful area (line 28) and also refers to an area that does not hurt (line 30). This reference is also repeated by the doctor in a modified form (line 31). While the patient identifies the area in contrast to a painful area, the doctor scales the pain and assigns this area less pain than the previous areas.

He now explicitly assesses this finding as positive (*great*, line 32) and follows this up with a diagnosis of exclusion. Simultaneously with the statement *so it's not appendicitis*– (line 33), he continues to palpate the patient's abdomen but fixes his gaze on the mother. After her ratification (see below) and her change of position – she leans closer to her daughter – he turns back to the patient. The doctor not only cites his statement to rule out a possible diagnosis, he also explicitly mentions this to the mother, whom he looks at in this statement, which is thus presented as a conclusion. The doctor thus prophylactically invalidates a possible fear on the part of the mother, as the keyword "appendicitis" has not yet been mentioned or even hinted at in the conversation. (The appellative "appendicitis" here does not refer to a part of the intestinal tract but to an inflammation that is usually associated with this part).

E 35.5		also BLINDdarm is nichts– *so it's not appendicitis*
33	D	(.) also BLINDdarm is nichts– *so it's not appendicitis*
34	M	(.) ja beine konnt se anWINkeln; *yes she could bend her legs*
35	M	((lacht)) (.) ((Lachansatz)) *((laughs)) ((beginnings of a laugh))*

The mother's reaction indicates that she is familiar with the clinical picture of appendicitis and cites a diagnostic observation which, in her eyes, also rules out this diagnosis. She thus confirms the doctor's diag-

nosis of exclusion. Here, the mother presents herself as someone who has certain knowledge of the disease.

Box 35.3	Presentation of knowledge
The display and negotiation of knowledge are [...] closely linked to the self-positioning and other positioning of the interactants and the constitution of social relationships.	

Deppermann 2015: 12; translation by the authors

The diagnostic observation, which must have been made before the consultation, was not addressed beforehand. However, the structure of the mother's reasoning and her subsequent question prove that there was no reason to do so:

E 35.6	muss ma da AUCH erbrechen– *do you also have to vomit then*

```
36      (0.2)
37  M   °hh (2.85) muss ma da AUCH erbrechen-
                    do you also have to vomit then
38  D   (0.7) ja-
               yes
39  M   (.) ja,
            yes
40  D   (0.22) ja MUSS nich;
                yes not necessarily
41  D   aber KAN[N;  ]
        but possible
42  M             [ja, ]
                   yes
```

By asking *do you also have to vomit then* (line 37), the mother indicates that she did not suspect that her daughter's symptoms could be caused by an appendix infection, regardless of the observations made beforehand. Nor does this demand call into question the exclusion of this possible diagnosis but rather underlines the exclusion. Both statements demonstrate a certain amount of experience with inflammation of the appendix and a certain amount of surprise at the explicit mention of the

exclusion diagnosis. The mother asks for information about symptoms that do not match her previous knowledge. She does not attack the doctor's competence but rather uses his expertise to expand her own knowledge, as he has "access to knowledge", "relative priority" and "responsibility for certain knowledge" (Deppermann 2015: 12f with reference to Heritage 2013; translated by the authors).

Her surprise is also shown by the fact that she asks again about the doctor's reactions using yes (line 39). The doctor elaborates on the point and explains that vomiting can be a symptom associated with appendicitis, even if this is not necessarily the case (line 40/45). Simultaneously with the mother's question, the doctor turns back to the mother and continues with the examination but then turns back to the patient by looking parallel to *but possible* (line 41).

35.4.4 Delivery of the diagnosis

The doctor then presents two pre-diagnostic statements (e. g. Spranz-Fogasy 2014) on the palpable condition of the abdominal area and on an audible sign of illness (lines 44/45):

E 35.7	also da geht so_n magenDARMinfekt (.) los *so here a gastrointestinal infection (.) begins*

```
43      (1.49)
44  D   bauch is aber sons_schön WEICH;
        however the stomach is otherwise quite soft
45  D   (.) aber gluckern tut_s ORdentlich;
            but it gurgles properly
46  D   also da geht so_n magenDARMinfekt (.) los;=ne,
        so here a gastrointestinal infection begins right
```

Such pre-diagnostic statements regularly document the epistemic status of the doctor during the diagnosis but also inform the patient or, in this case, the mother and the patient about the current status (Spranz-Fogasy 2014). They are used here in the same way as the reasoning structure for the diagnosis of exclusion to substantiate a subsequent diagnostic statement with evidence. The fact that this diagnosis is to be understood as the conclusion of the pre-diagnostic information result-

ing from the examination is again explicitly emphasized on the surface of the text (line 46). The physical examination in particular is, as here, often the starting point for a diagnostic statement because it provides "empirically grounded observations" (Heath 2006: 213).

The fact that the doctor wants his diagnosis to be ratified by the mother can be seen from the added question tag "ne/*right*", which immediately follows (line 46). The mother, however, initially problematizes this:

E 35.8	is_grad im umLAUF, *is_currently in circulation*

```
46  D   also da geht so_n magenDARMinfekt (.) los;=ne,
        so here a gastrointestinal infection begins right
47  M   (.) gibt's
            is
48  M   (.) is_grad im umLAUF,
            is currently in circulation
49  D   (0.62)
50  M   ja
        yes
```

Once again, the mother's reaction portrays her as someone who has certain knowledge about illnesses. She also knows that a gastrointestinal infection is usually highly contagious and that several cases usually occur at the same time (line 48). The fact that she has not yet heard of this is the basis of this statement, as she asks about the existence of a wave of infection and thus assumes that this is unknown to her.

However, this question is now somewhat more delicate for her self-image (see above), as she also makes it clear through the question that she had not previously assumed a gastrointestinal infection such as appendicitis to be the cause of her daughter's complaints and legitimizes through this question why she did not recognize the known clinical picture of gastrointestinal flu as such. At the same time, however, this question may also indicate that she is not yet completely convinced of the diagnosis. The fact that she was aware of the explosive nature of the question could be a reason why she does not continue the first part of her utterance (*exists*, line 47).

There is eye contact between the doctor and the mother during the mention of the diagnosis, whereby the doctor looks away from the

mother again before he produces the question tag (line 46). However, when the mother asks about the wave of illness, he briefly looks up at her again. He then nods several times in response to her question but is already looking at the patient again. The mother immediately ratifies this reaction (*yes*, line 50).

35.4.5 Subjective illness theory

E 35.9	weil erst hab ich geDACHT– *because first I thought*

```
50  D   ja;
        yes
51      (3.13)
52  M   wei[l erst hab ich ]geDACHT-
        because first I thought
53  D      [PRIma;         ]
            fine
54  M   weil se HALT-
        because she just
55  M   weil ich MAIS gekocht hab-=ne,
        because I had cooked corn you know
```

After a pause of approx. 3 seconds, she then mentions a subjective theory of illness (SIT) (§ 21, 29), namely food intolerance, which she had already put forward during the anamnesis (lines 52/54/55). Through the mental verb “think”, the tense used and the adverb *first* (line 52), “she indicates that [she] assumes no responsibility for the precision and accuracy of [the] statement” (Deppermann 2015: 15; translated by the authors). Although she marks the theory as no longer relevant and the temporal context, namely after the diagnosis, downgrades the mention of SIT, it is nevertheless marked by the repeated reference. The doctor does not react here but concludes this part of the examination with the *fine* addressed to the patient (line 53). He treats the physical examination as the usual one (ten Have 1990) and thus reacts to the downgrading that the mother herself makes with regard to SIT, as well as the fact that the diagnosis has already been made. By not reacting here, however, he additionally emphasizes the diagnosis he has already made. Immediately afterwards, he stands up and goes to the shelf that the moth-

er was leaning against during this part of the examination, fetches a spatula and approaches the patient again.

Once again, the mother's continuous monitoring activities (Schmitt, Deppermann 2007: 110) are evident, as she immediately reacts to the doctor's movements and steps off the shelf to which the doctor turns so that he can reach the shelf on which she had previously leaned without having to walk around her. After the doctor turns back to the patient, the mother follows him to the couch. Both adults stand in front of the couch and while the doctor examines the patient's mouth, who has now sat up again, the mother continues to perform the SIT that was set up before the consultation and already discussed during the consultation:

E 35.10	des wissmer jetz dass ihr DES zu viel war;=ne–
	we now know that it was too much for her

55	M	weil ich MAIS gekocht hab-=ne,
		because I had cooked corn you know
56	M	des wissmer jetz dass ihr DES zu viel war;=ne-
		we now know that it was too much for her no
57		(1.85)
58	M	was heißt ZU viel,
		what do you mean too much
59	M	(.) dass se_s [(net verträgt)]
		that she can't take it
60	D	[weit AUF]machen den mund;
		open your mouth wide
61	D	zunge rausSTREcken-
		stick out tongue

35.4.6 Secondary symptoms

At the end of the second part of the examination, the doctor then mentions to the mother that *the mucous membranes are still moist* (line 62), without going into the details of the SIT. This further examination, which takes place after the diagnosis is communicated, no longer serves to search for the diagnosis but for a possible consequence of a symptom, the vomiting, which could also result in further measures. For example, "the body can "dry out" (=dehydrate) under certain circumstanc-

es, especially if a child vomits as well as having diarrhoea and/or a fever" (Renz-Polster et al. 2012: 317; translated by the authors).

E 35.11 aber sie hat jetz KOmische flecken an den wangen,
but she now has strange spots on the cheeks

62 D die schleimhäute sind noch schön F[EUCHT-
]
the mucous membranes are still moist
63 M [aber sie hat jetz
]KOmische flecken an den wangen,
but she now has strange spots on the cheeks
64 (0.96)
65 M hier-
here
66 D °h ja das is vom ERbrechn;
yes that's from vomiting
67 (0.42)
68 M des is jetz d[urch den WÜR]Greiz-
that's now caused by the retching
69 D [°h]
70 (0.2)
71 ((Arzt klatscht))
((the doctor claps his hands))
72 D durch den würgreiz hat sich das blut im gesicht geS-
TA[UT-]
the retching has caused the blood to dam in the face
73 M [hmhm;]
hmhm
74 M °h
75 D un da sind IN der haut ganz fei[ne BLU]tungn;
and there're very fine haemorrhages in the skin
76 M [ja-]
yes
77 D (.) des-
it
78 D (0.2) dauert also sicher ne WOche bis die weggehn-
will probably take a week for them to go away
79 D diese klein[en][++++++]
these little ++++++
80 M [gut-]

		well
81	M	[eben]dacht ich ja WUI,
		just now I thought woo
82	M	(.) was is [denn]DES-
		what is this
83	D	[ja-]
		yes
84	D	sind sogenannte peTECHien-=ne,
		these are so called petechiae you know
85	M	gut-
		well
86	D	(0.34) KOMM-
		come on
87	D	(0.29) zieh dich wieder AN-
		get dressed again
88	P	+++
		+++
89	M	was könn_wer MAchen-
		what can we do

The mother then takes the doctor's report on the condition of the mucous membranes (line 62) as an opportunity to interrupt the SIT and to mention another visually perceptible skin change that she cannot explain and which the doctor has not yet addressed (from line 63). The doctor explains to her the background to this phenomenon and the period of time after which this skin change is supposed to have disappeared again (line 78).

The adults are both standing in front of the patient and are focused on the patient, who is also the bearer of this newly mentioned phenomenon. The distance between the mother and the patient corresponds to the distance between the patient and the doctor. However, the mother and the doctor are standing very close to each other. The mother seeks eye contact in between, but the doctor only makes eye contact when he talks about *haemorrhages* (line 75). The mother introduces the topic in a marked way by describing the *spots* as *strange* and also introduces this observation with a *but* (line 63). With this introduction, she ties in with the doctor's statement and counters it with something that contradicts her expectation regarding a phenomenon that has not yet been addressed. She also shows the doctor the corresponding position.

The doctor first establishes a connection between the *spots* (line 63) and the patient's illness. The mother then draws a conclusion from this information (line 68). The doctor takes up the wording here (*retching*, line 72) and explains the background to this symptom. At the end of the explanation, he looks at the mother. He then goes on to explain when this symptom should disappear again without further treatment. When the mother again refers to the surprise at the discovery and thus once again makes a relevance upgrade, he mentions the technical term *petechiae-* for this symptom (line 84). By mentioning the technical term, he concludes the discussion about the symptom associated with the disease. He asks the patient to get dressed again and prepares to wash his hands.

With this, the doctor ends the examination and moves on to the next phase of therapy planning, which then consists of negotiating the next steps with the mother. The mother initiates this herself by asking him on the way from the couch to the washbasin and from the washbasin to the desk about the next steps (*what can we do*, line 89).

35.4.7 Overview of the event

In this case, the examination consists of the doctor palpating the patient's abdomen and locating the site of the pain together with her. This and the doctor's further examination results enable a possible problematic diagnosis to be ruled out and an actual diagnosis to be made. However, the examination does not end with the presentation of the diagnosis, as a gastrointestinal infection can lead to drying of the mucous membranes, especially in children (see above), which should be addressed immediately. For this reason, the diagnosis is followed by an examination of the mucous membranes, which, however, does not give rise to any fear of dehydration. In addition, the mother mentions a skin feature that was not previously mentioned and is then explained to her by the doctor. As in the example case, in other conversations after the diagnosis has been mentioned, further examinations are carried out that are related to the general condition of the children or possible consequences of the disease (see graph 1):

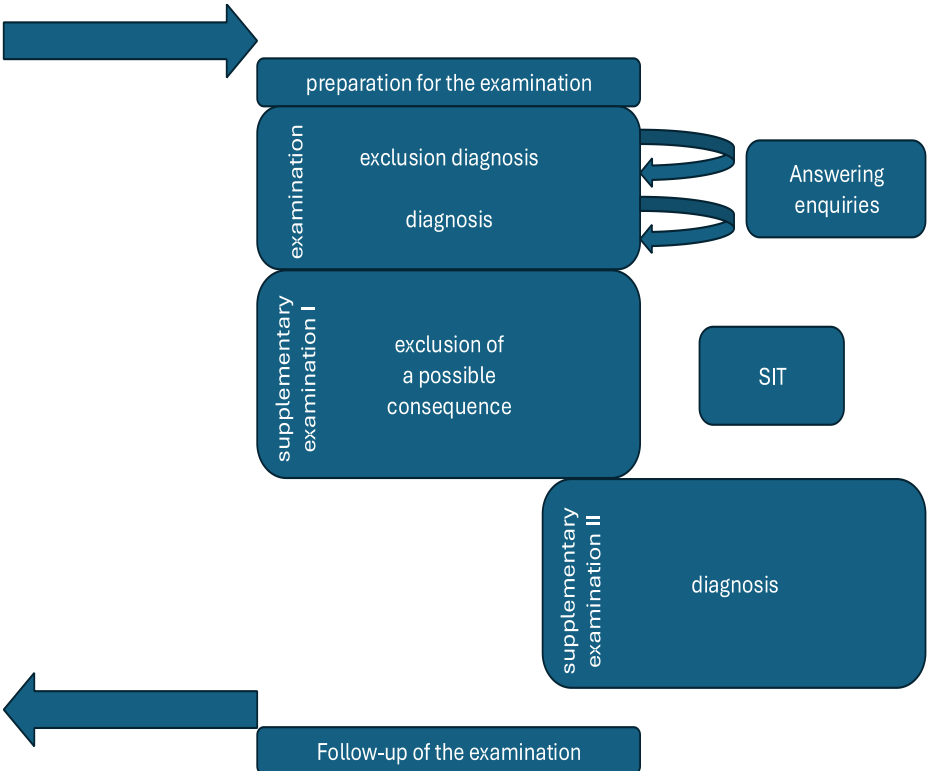

Fig. 1: Schematic sequence of the physical examination in the case study

As shown in the graph, this is a three-part examination, with the third part being initiated by the mother: The doctor presents a diagnosis of exclusion and a diagnosis in the first part of the examination, both of which are negotiated between the mother and the doctor. During the examination of a possible consequence of the disorder, which is the second part of the examination, the mother presents an SIT, which, like the result of this examination, is not processed further. The third part of the examination concerns a phenomenon that the mother addresses. The doctor also diagnoses this phenomenon and then concludes the examination. The doctor then turns to the washbasin to clean his hands and asks the patient to get dressed again.

The doctor takes the child's epistemic authority (Heritage, Raymond 2005) into account to the extent that he has the patient localize the location of the pain, even though the mother has previously denied the description of the complaint more or less alone and the patient has also indicated on several occasions that she is unable or unwilling to dispute the anamnesis with the doctor herself. Her only contribution is a confirmation requested by the mother that she had already vomited earlier

in the day in kindergarten (line 12). By requesting this at the beginning of the anamnesis and then at the beginning of the examination, the doctor signals that he knows that, in addition to the right to report on her own complaints, she also has the competence to represent herself (Schmitt 1997).

Box 35.4 Self-advocacy
In Western societies, fully socialized subjects are always treated as uncriticizable experts on their own mental and emotional states [...] [although children are generally not considered to be] fully socialized subjects

Deppermann 2015: 13f; translation by the authors

The doctor always responds to the patient's comments and, for example, makes them more relevant by using them to justify why a possible diagnosis can be ruled out. He repeats other statements, usually modalizing and differentiating them. During the examination, he sits close to the patient, palpates the patient's body and maintains this "interaction dyad" (Schmitt, Knöbl 2013, Schmitt 2013; term translated by the authors) on the one hand through proximity and on the other hand through further palpation. Even when he is looking at the mother, answering a question from the mother, etc., he continues the examination and always turns his gaze immediately to the patient (see also ten Have 1990).

For her part, the mother uses this phase of the examination to ask questions, address further problems and even to discuss the (exclusion) diagnoses. The doctor also usually processes the mother's contributions relatively quickly, also upgrading their relevance and establishing two different dyadic constellations in precise alternation. In contrast to the patient's contributions, the mother's statements are not repeated and the comments on SIT are not dealt with, but questions from the mother that are directly related to the illness and the diagnoses made. By paying attention to a phenomenon that he identified as harmless and therefore presumably did not mention, it becomes clear that he takes something that the mother may have perceived as worrying seriously and deals with it, even if he himself has classified it as not worthy of attention. The final diagnosis and the diagnosis are communicated to the mother, as is the diagnosis of the symptom that she herself brought up.

However, the repeated mention of SIT indicates that the mother considers it to be unresolved and may not yet be fully convinced of the diagnosis (e. g. Spranz-Fogasy, Winterscheid 2013, Winterscheid 2018: 165-213). The handling of SIT should therefore be made largely transparent even if they are not tenable from the doctor's point of view – parents show themselves to be concerned and under pressure precisely because of their considerations, and a lack of consideration also devalues parental commitment (see also Spranz-Fogasy, Winterscheid 2013). However, disregard at this point upgrades the diagnosis and the early announcement of this diagnosis may also have been a possible way of dealing with this doubt, as the doctor's diagnosis contradicts the mother's SIT (Birkner 2006).

35.5 Discussion

With our analysis, we have shown by way of example how a physical examination in a paediatric consultation is separated out, carried out and then returned to the general framework of action, in this case for treatment planning but often also for diagnosis. While the doctor initiates the necessary steps and makes them explicit, all those involved coordinate the creation of the examination situation. The doctor also names the individual steps to the child in such a way as to address the problem of territorial self-determination and to make the actions predictable for the patient and the mother.

By identifying and specifying the location of the pain and the diagnosis of exclusion in pre-diagnostic messages, a link is also established between the examination and the diagnosis. An early presentation of the diagnosis, as in our example case, can reassure parents just as much as the explicit exclusion of more serious illnesses.

In addition, the diagnoses made during the examination also legitimize the previous examination steps. During the examination, the doctor considers the patient's statements and reactions as well as the mother's questions and explanations. He also establishes the relevant interaction dyads in rapid succession and coordinates this with the various examination steps. The mother and patient are thus involved in the examination, but the main focus can remain on carrying out the examination and the associated search for a diagnosis (see also ten Have 1990). A SIT mentioned by the mother as having already been discard-

ed, and mentioned after the diagnosis, is not dealt with by the doctor but inquiries about symptoms that could tend to be worrying and related to the illness are. However, by "ignoring" the SIT brought up by the mother, the doctor also underlines the diagnosis made.

Despite the enormous complexity of the professional and interactional task the doctor succeeds here in coordinating the various procedural steps, making them transparent and integrating the two interaction partners in terms of information and relationship organization. At the same time, he creates the basis for a trusting and compliance-securing relationship with both the patient and her mother.

References

Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

Aronsson K, Rundström B (1988): Child discourse and parental control in paediatric consultations. In: Text & Talk. An Interdisciplinary Journal of Language, Discourse & Communication Studies 8/3, 159-189.

Bindernagel D (2020): Kommunikation: Wie gute Gespräche mit Kindern gelingen. In: Deutsches Ärzteblatt, 117 (10): [2].

Birkner K (2006): Subjektive Krankheitstheorien im Gespräch. Gesprächsforschung 7, 152-83.

Cahill, P, Papageorgiou A (2007): Triadic communication in the primary care paediatric consultation. The British Journal of General Practice 57 (544), 904-11.

Deppermann A (2015): Wissen im Gespräch: Voraussetzung und Produkt, Gegenstand und Ressource. In: InLiSt - Interaction and Linguistic Structures 57.

Duden (2025): „Bauch, der“ (accessed 26th January 2025).

Dulmen, S van (2004): Pediatrician-parent-child communication: Problem-related or not? Patient Education and Counseling 52 (1), 61-8.

Ehlich K, Rehbein E (1979/1994): Institutionsanlyse. Prolegomena zur Untersuchung von Kommunikation in Institutionen. In: Brünner G, Graefen G (eds.): Texte und Diskurse. Methoden und Forschungsergebnisse der funktionalen Pragmatik. Opladen: Westdeutscher Verlag, 287-327.

First M B (2014): Empirical grounding versus innovation in the DSM-5 revision process: Implications for the future. Clinical Psychology: Science and Practice, 21(3), 262–268.

Frank R (2019): Ärztliche Kommunikation mit Kindern, Jugendlichen und Eltern. Wie schwierige Patientengespräche gelingen. Stuttgart: Kohlhammer.

Goffman E (1971/1974): Territorien des Selbst. In: Das Individuum im öffentlichen Austausch. Mikrostudien zur öffentlichen Ordnung. Frankfurt/M: Suhrkamp, 54-96 (engl. Orig. 1971).

Goodwin M (1980): Processes of Mutual Monitoring Implicated in the Production of Description Sequences. In: Sociological Inquiry 50,1, 303-317.

Gordon C, Barton E, Meert KL, Eggly S, Pollacks M, Zimmerman J, Anand KJ, Carcillo J, Newth CJ, Dean JM, Willson DF, Nicholson C; Eunice Kennedy Shriver National Institute of Child Health and Human Development Collaborative Pediatric Critical Care Research Network (2009): Accounting for medical communication: Parents' perceptions of communicative roles and responsibilities in the Pediatric Intensive Care Unit. Communication & Medicine 6 (2), 177-88.

Grice HP (1975): Logic and Conversation. In: Cole P, Morgan JL (eds.): Syntax and Semantics, Vol. 3. Speech Acts. New York: Academic Press, 41-58.

Güthoff S, Rosenecker J (2008): Anamneseerhebung. In: Rosenecker J, Schmidt H: Pädiatrische Anamnese, Untersuchung, Diagnose. Heidelberg: Springer, 3-16.

Hampton JR, Harrison MJG, Mitchell JRA, Prichard JS, Seymor C (1975): Relative contributions of history-taking: physical examination and laboratory investigation to diagnosis and management of medical outpatients. British Medical Journal 2 (5969), 486-9.

Heath C (1986): Body movement and speech in medical interaction. Cambridge: Cambridge University Press.

Heath C (2006): Body work: The collaborative production of the clinical object. In: Heritage J, Maynard D (eds.): Communication in medical care. Cambridge: Cambridge University Press, 185-213.

Heritage J (2013): Epistemics in conversation. In: Sidnell J, Stivers T (eds.): The handbook of conversation analysis. Malden, Mass.: John Wiley & Sons, 370-394.

Heritage J, Raymond G (2005): The terms of agreement: indexing epistemic authority and subordination in talk-in-interaction. In: Social Psychology Quarterly 68 (1), 15-38.

Knerich H, Opp J (2021): Medizinische und gesprächslinguistische Perspektiven auf Arzt-Patient-Gespräche mit Kindern und Jugendlichen. In: Iakushevich M, Ilg Y, Schnedermann T (eds.): Linguistik und Medizin:

Sprachwissenschaftliche Zugänge und interdisziplinäre Perspektiven. Berlin/Boston: De Gruyter, 491-508.

Miebach B (2014): Soziologische Handlungstheorie. Eine Einführung. 4. Aufl. Wiesbaden: Springer VS.

O'Reilly M (2008): What value is there in children's talk? Investigating family therapists' interruptions of parents and children during the therapeutic process. In: Journal of Pragmatics 40/4, 507-524.

Renz-Polster H, Menche N, Schäffler A (2012): Gesundheit für Kinder: Kinderkrankheiten verhüten, erkennen, behandeln: Moderne Medizin – Naturheilverfahren – Selbsthilfe. 5. Aufl. München: Kösel.

Ripke T (1994): Patient und Arzt im Dialog: Praxis der ärztlichen Gesprächsführung. Stuttgart/New York: Thieme.

Sator M, Gstettner A, Hladschik-Kermer B (2008): "Seitdem mir der Arzt gesagt hat 'Tumor' - Das war's.": Arzt-Patient-Kommunikation an der onkologischen Ambulanz. Eine sprachwissenschaftliche Pilotstudie zu Problemen der Verständigung. Wiener Klinische Wochenschrift 120 (5-6), 158-70.

Schmitt R (1997): Unterstützen im Gespräch. Zur Analyse manifester Kooperationsverfahren. In: Zeitschrift für Sprachwissenschaft 16.1/2, 52-82.

Schmitt R (2013): Körperlich-räumliche Aspekte der Interaktion. Tübingen: Narr.

Schmitt R, Deppermann A (2007): Monitoring und Koordination als Voraussetzungen der multimodalen Konstitution von Interaktionsräumen. In: Schmitt, R (eds.): Koordination. Analysen zur multimodalen Interaktion. Tübingen: Narr, 95-128.

Schmitt R, Knöbl R (2013): „Recipient design“ aus multimodaler Sicht. Deutsche Sprache 3, 242-76.

Schwabe M (2006): Kinder und Jugendliche als Patienten. Eine gesprächsanalytische Studie zum subjektiven Krankheitserleben junger Anfallspatienten in pädiatrischen Sprechstunden. Göttingen: Vandenhoeck und Ruprecht.

Selting M, Auer P, Barth-Weingarten D, Bergmann JR, Bergmann P, Birkner K, Couper-Kuhlen E, Deppermann A, Gilles P, Günthner S, Hartung M, Kern F, Mertzlufft C, Meyer C, Morek M, Oberzaucher F, Peters J, Quasthoff U, Schütte W, Stukenbrock A, Uhmann S (2009): Gesprächsanalytisches Transkriptionssystem 2 (GAT 2). In: Gesprächsforschung - Online-Zeitschrift zur verbalen Interaktion 10, 353-402.

Selting M et al. (2011): A system for transcribing talk-in-interaction: GAT 2. Translated and adapted for English by Elizabeth Couper-Kuhlen and Dagmar Barth Weingarten.

Spranz-Fogasy T (2014): Die allmähliche Verfertigung der Diagnose im Reden. Prädiagnostische Mitteilungen im Gespräch zwischen Arzt und Patient. Berlin/Boston: de Gruyter.

Spranz-Fogasy T (2005): Kommunikatives Handeln in ärztlichen Gesprächen. In: Neises M, Dietz S, Spranz-Fogasy T (eds.): Psychosomatische Gesprächsführung in der Frauenheilkunde. Ein interdisziplinärer Ansatz zur verbalen Intervention. Stuttgart: Wissenschaftliche Verlagsgesellschaft, 17-47.

Spranz-Fogasy T, Winterscheid J (2013): Medizinische Kommunikation. Allgemeine und pädiatrische Gespräche. In: Bentele G, Piwinger M, Schönborn G (eds.): Kommunikationsmanagement, Losebl. 2001 ff, Art. -Nr. 7.42. Köln: Luchterhand.

Stivers T (2001): Negotiating who presents the problem: Next speaker selection in paediatric encounters. In: Journal of Communicaton 51, 1-31.

Stivers T, Majid A (2007): Questioning children: Interactional evidence of implicit racial bias in medical interviews. In: Social Psychology Quarterly 70/4, 424-441.

Streeck S (2002): Dominanz und Kooperation in der neuropädiatrischen Sprechstunde. In: Brünner G, Fiehler R, Kindt W (Hg.): Angewandte Diskursforschung. Band 1: Grundlagen und Beispielanalysen. Radolfzell: Verlag für Gesprächsforschung, 174-96.

Streeck-Fischer A, Cropp C, Streeck U, Salzer S (2016): Borderline-Störungen bei Jugendlichen: Die psychoanalytisch-interaktionelle Methode. Göttingen: Hogrefe Verlag GmbH & Co. KG.

Tates K, Meeuwesen L (2000): Let Mum have her say: turntaking in doctor-parent-child communication. In: Patient Education and Counseling 40, 151-162.

Tiitinen S, Ruusuvuori J (2014): Using formulations and gaze to encourage parents to talk about their and their children's health and well-being. In: Research on Language and Social Interaction 47/1, 49-68.

Wiemer P (2017): Die kommunikative Rolle dritter Personen und ihre sprachlichen Beteiligungsverfahren im onkologischen Aufklärungsgespräch – Eine gesprächsanalytische Untersuchung. Arbeitspapier Nr. 28 (11/2017).

Winterscheid J (2015): Pädiatrische Gespräche. In: Busch A, Spranz-Fogasy T (eds.): Sprache in der Medizin. Berlin/Boston: de Gruyter, 188-207.

Winterscheid J (2018): Triadisch-Pädiatrische Kommunikation in der Kinderarztpraxis (Dissertation). Mannheim: amades.

Winterscheid J (2020): Selbstvertretung und Darstellung der Patientinnen und Patienten in triadisch-pädiatrischen Interaktionen in der Kinderarztpraxis

- auch in Bezug auf Non-Adhärenz, Sprache im Beruf (SpriB), 2020 (3/2), 142-159.

Winterscheid J, Kook J (2018): Rhetorische Ausgestaltung von Äußerungsreparaturen in der Arzt-Patient-Interaktion. In: Hess-Lüttich EWB (eds.): Rhetorik und Medizin. Berlin/Boston: de Gruyter, 134-159. (=Rhetorik. Ein internationales Jahrbuch. Hrsg. v. Wolfgang Neuber, Peter L. Oesterreich, Gert Ueding und Francesca Vidal; Bd. 37)

Wüstner K (2001): Subjektive Krankheitstheorien als Gegenstand der genetischen Beratung am Beispiel des Wiedemann-Beckwith-Syndroms. Psychotherapie, Psychosomatik, Medizinische Psychologie 51 (8), 308-19.

Citation note

Spranz-Fogasy T, Winterscheid J (2025) Communication in Paediatrics. In: Koerfer A, Albus C (eds.): Medical Communication Competence. Göttingen (Germany): Verlag für Gesprächsforschung