

# Doctor-patient communication as a linguistic model

Lyubov Kasimtseva

*Astrakhan State Medical University,  
Chair of Latin and Foreign Languages  
Astrakhan, Russia  
bouchmanova@yandex.ru  
<https://orcid.org/0000-0002-2987-4217>*

Lilya Kiseleva

*Astrakhan State Medical University,  
Chair of Latin and Foreign Languages  
Astrakhan, Russia  
lilya.kiseleva.7878@mai.ru  
<https://orcid.org/0000-0003-0251-8324>*

Sara Dzhabrailova

*Astrakhan State Medical University  
Chair of Latin and Foreign Languages  
Astrakhan, Russia  
sara\_dzhabrailova@mail.ru  
<https://orcid.org/0000-0001-9050-6635>*

**Abstract** — This article is devoted to the study of oral medical discourse in doctor-patient communication, which many scientists consider as a linguistic model. The relationship between the doctor and the patient is one of the actual problems in modern society. The relationship between the doctor and the patient has evolved that is why it became necessary to inform and obtain the patient's consent to this or that medical intervention. The doctor has the task to decide which information is the medical secrecy and which is open for the patient. One of the main tasks of the medical discourse is to form the right dialogue between the doctor and the patient in order to identify the cause of the disease, choose a method of treatment and explain actions using the available vocabulary. During the conversation with a patient, the medical specialist uses special terms and chooses the right tactics of behavior, remembering that it is possible to cause not only positive emotion and reaction, but also to provoke a psychological trauma.

**Keywords**—*term, medical term, medical discourse, speech of the doctor, communication, medical language, verbal behaviour, relationship, society, linguistic theory*

## I. INTRODUCTION

Problems of interaction of language and society continue to be relevant for philologists. Globalizations, migration, changes in the structure of society have had a significant impact on the functioning of languages. The modern developing world has influenced on the discourse of different spheres of communication (on medical sphere too).

In modern science, discourse is an object of interdisciplinary study. Except for linguistics, various sciences and directions are associated with its research. Each discipline has its own approach to the study of discourse. As the analysis of scientific literature has shown, one can find a significant number of references to the word "discourse", which will differ from each other. There are many definitions of the term "discourse". For example, in the Linguistic Encyclopedic Dictionary the following definition is given: "Discourse" from French "Discourse – speech", English "discourse" – running back and forth; movement, circulation, conversation, pragmatic, sociocultural, psychological and other factors; text taken in the event aspect; speech considered as a purposeful social action, as a component involved in the interaction of people and the mechanisms of their consciousness (cognitive processes). Discourse is speech, "immersed in life". [1]. In the Newest Philosophical Dictionary, discourse is, in the

broad sense of the word, a complex unity of a language practice and extralinguistic factors, necessary for understanding the text, i.e. giving an idea about the participants of communication, their settings and goals, conditions of production and perception of the message [2].

## II. MATERIALS AND METHODS (MODEL)

Medical discourse has attracted the attention of many scientists, such as V.I.Karasik, V.V. Zhura, S.I. Madzhaeva, M.I. Barsukova, M.A. Makarova and others in recent years. In their works, scientists consider medical discourse and linguistic model, as one of the types of institutional discourse, where "the status-role characteristics of the participants in communication are clearly defined as: "doctor-patient", and the purpose of communication is the delivery of medical care" [3]. They also consider medical discourse and linguistic model as a kind of scientific discourse where participants are scientists, and the purpose of communication is the exchange of new scientific information and the solution of problems in various fields of medicine, including the treatment of patients.

## III. RESULTS AND DISCUSSION

Medical discourse is a combination of verbal and non-verbal structures that have certain pragmatic features. These structures function in the medical sphere for realization of the functions of treatment and prevention [4]. One of the main goals of the doctor is the aiding to the sick it means to have a dialogue to identify the disease, to institute therapy and to explain to the patient what to do to preserve the health. As S.I. Madzhaeva we consider the concept of "doctor" as "a set of professional activities, a set of lexical means, objectifying knowledge about the subject of professional activity, a set of terms existing in a particular field of medicine, received in it, and also arising in speech ..." [5].

Previously mentioned scientists examine the communication "doctor-patient" as a linguistic model which includes also speech behavior. Speech activity is characterized by purposefulness and consists of several successive stages: orientation, planning, implementation and control. Speech activity is a system of actions for the generation and perception of speech, within which information is exchanged. Since the main goal of verbal communication is the exchange of information, it means that the transmission and perception of the meaning of the utterance, the person always, as a rule, strives to be

understood. Communication can be verbal and non-verbal and implements certain functions such as warning, advice, information, persuasion, expression, entertainment [6].

Perception is one of the biological mental functions. It is an integral part of the cognitive process. A complex system of processes of receiving and transforming information obtained through the senses, forming a subjective holistic image of object acting on the analyzers through a set of sensations initiated by this object. The process of perception of information is highly organized inner work in which all mental processes take part: attention, imagination, memory, thinking. In order for information arriving in the brain to be better assimilated, it must be realized or comprehended. Perception serves as a kind of conductor between the new information and its awareness. The correct perception of information is very important during the communication between the doctor and the patient. There are different forms of perception. The perception of space occurs individually for each. Being in a new place, a person cannot immediately navigate until s(he) understands how to behave better and does not develop the necessary tactics. Some people are much faster oriented in changing conditions than others. The perception of time is also different for each person. It is difficult for some people to wake up in the morning, they can stay awake during the day, others need to get up early and just go to bed early, which consequently affects the quality of perception. The perception of movement is fixed by the brain and is realized by the person due to the vestibular apparatus and his own thoughts, subjective moods. Like the perception of time, the impression of movement is individual. Someone just tilts the head forward, take the appropriate position of the body to create the illusion of the ongoing movement. Perception can be intentional and unintentional, in other words, involuntary and voluntary. Voluntary perception is done at the expense of external circumstances that attracted the attention of the person, and unintentional one is guided by consciousness. Intentional perception is characterized by clear goal, defined objectives, clear structure and consistency in the implementation of all necessary steps. Each person approaches the perception of the same events and phenomena very individually, which creates certain difficulties in communication of the doctor with the patient.

Communication between the doctor and the patient is an urgent problem of medicine at all times. The complexity of communication between the doctor and the patient has a huge impact on the quality of provided medical care. Over the years, due to growing social demand, the doctor-patient relationship changes, moving from the traditional model, where the doctor makes a decision, to a model of joint medical decision. S(he) should be involved in the proposed solutions. Modern patients especially want to be informed about their illness and about proper care during the treatment period. This indicates the difficulty of the doctor-patient conversation. The patient wants to receive accurate and specific information about the disease and its course, which should be accessible to the patient. The physician must be able to use proper medical terminology. Such evolution in communication leads to changes in the usual professional speech of the doctor. Terms that doctor operates in the medical community are abundant [7]. Patients always confuse in same terms because information

about same object can be contradictory. A physician must remember that when s(he) explain the diagnosis, terms familiar to the physician in the ordinary world can be thought as obscure and strange, and sometimes cause negative emotions such as “fear”, “anxiety”, and “pain”. For example, while reporting diagnosis, the task of the doctor is “to control *what* the patient means by the words: cancer, tumor, malignant neoplasms, metastases, etc.” [8]. The medical worker must speak distinctly, with clear diction, proper stress and intonation, to avoid the frightening formulations, to “interpret” medical terms into accessible, spoken language. Otherwise, there is a risk of not being understood by the patient, or even unheard.

The art of communication is that part of the doctor-patient relationship that is one of the oldest tools of any doctor's activity, and it is as essential today as it was many years ago. It is not a device or a tablet. The side effects are minimal, and this is one of the cheapest remedies no less important than antibiotics and x-rays. Unlike other components of medicine, the communication is relatively unchanged since the time when the very first healer sat down with his first patient and asked, “So, where does it hurt?”

Despite rapid progress in almost all aspects of medical testing, diagnosis and treatment, the “aural history” is still the mainstay. In his work “What patients say what the doctors hear”, Danielle Ofri informs about the benefits of powerful communications: a rich history, a better understanding of what is important to patients, knowledge of the factors that can limit their recovery, greater satisfaction of patients, improving consistency of medicines, reducing the time of consultation...The key to what patients say, “what doctors hear”, is that empathy is the frame of communication.

Scientists often call medical language impersonal, strictly scientific and largely incomprehensible to the general public. It is the language of medicine, with special terminology for each disease, symptom and treatment. Medical terminology is often misunderstood by patients and may establish a distance between the doctor and the patient. The physician must adapt his speech during the explanation of the diagnosis or disease, consequences or methods of treatment to the patient, so that the patient can understand all transmitted information. The establishment of such dialogue is an important step in creating the trust relationship between the medical staff and the patient. “Do I need to tell everything to the patient? Can my speech affect patient's health?” These are the main questions that are asked by modern doctors. There are different points of view, some researches consider that the patient has the right to know the whole truth about the disease; others have the opposite opinion and believe that words can affect the patient's psyche, aggravating the internal state and speed up death. In medical practice, there are examples when the terminal patient was voiced the outcome of the disease, and then it contributed to apathy and early fading, or this patient ended his life prematurely by suicide. Interfax columnist Ilya Morozov gives some examples in his article “Problem of suicides of cancer patients,”: “Any reasonable person who has known that s(he) has the fatal illness thinks about suicide. This is a normal reaction to this situation. On February 17, a 62-year-old professor of the Moscow

Timiryazev Agricultural Academy, who was a cancer patient, committed suicide right within the walls of the university” [9].

However, there are also some examples when the doctor, using a gentle and calming principle of conversation, positively influenced the psyche, as a result of which the patients collected residual forces and lived much longer than expected forecasts, or were cured of a fatal disease. The Simonton opened a cancer counseling and research center in Dallas, Texas. They also wrote a book “Getting well again” – “To become healthy again”, where one of the foundations of doctors is to “support patients, increasing their will to live, showing and proving that they still have where to strive for, that there is hope for recovery and the achievement of goals” [10]. At the same time, the conversation with relatives should be structured differently; they should be fully aware of the condition of the patient and the course of the disease in order to contribute to the prolongation of life. According to A.V. Gnezdilov, contact with the patient should be as close as possible; the medical worker should see the patient's face, use pauses in conversation, listening to the patient, and support him by using interjections or repeating his last words. The physical contact is an ideal point. During the explanation the medical worker takes the patient's hand or touches his(her) shoulder. Then the negative affect decreases. In fact, the following happens. “Yes, the situation is hopeless, but you will not be left alone. On all your way, we will be with you and alleviate any difficulties” [8].

At different stages of communication between the physician and the patient, the following strategies are distinguished: diagnosing, treating, and recommending [11], through which the main goal of medical discourse is achieved, and which are realized with the help of a specific set of speech tactics. The choice of a particular tactic depends on the situation of communication and the personalities (doctor and patients) involved in it. In the diagnostic strategy can be distinguished tactics: acquaintance, information request, rapprochement, explanation, accusation. The purpose of these tactics is to obtain the necessary information about the patient and to identify problems, to recognize and diagnose possible diseases. They are implemented using interrogative sentences, various types of questions. The purpose of the prosecution tactics in medical discourse has a special function of changing the patient's way of behavior. The tactic of maintaining emotional balance is used to influence on the general mood of the patient. The rapprochement tactic helps to establish contact with the patient, where the doctor calls the patient by name. The healing strategy involves the following tactics: the regulation of the psychological state, consolation, enlightenment, threats. The main goal of this strategy is to conduct effective and painless treatment. The consolation tactic helps to decrease or completely eliminate the negative emotional state. It can return the patient to a normal worldview. In a situation when the patient is not able to sensibly assess his condition, the doctor uses admonitory tactics that have a persuasive character, during which s(he) explains to the patient the complexity of the situation. The recommending strategy considers the tactics of orientation towards the patient's material capabilities, it means that it represents advice,

recommendations, and instruction. Analyzed various possible tactics of the doctor's behavior, we can point several models of dialogues depending on the situation and participants of communication: 1) doctor + another doctor, 2) doctor + nurse, 3) doctor + patient's relative 4) doctor + patient, where the lexical material, as well as the method of its presentation, will vary. In the first case, the dialogue is based on scientific discourse and professional vocabulary and abbreviations, especially if the patient is present nearby, information is coded cautiously, for example, **the process** is an active inflammatory stage of the disease [12]; **hypoperfusion** – weak microcirculation, insufficient blood supply in a certain organ [12]; **VDS** – vegetative dystonia syndrome [13]; **Ultrasound diagnosis** – ultrasound [13]. During the dialogue with the nurse different communication tactic is used, namely, an indication in the form of a request or even an order, because she acts as a link in aiding. For example: “Gurney! Urgently!”; “Measure the patient's pressure!”; “Syringe!”.

Communication with relatives is based on the explanation of information about the patient. It is based on the terms available to the common person but contains full information about the disease and the patient's condition, and also explains in detail the significance of the prescriptions. It shows that the relative has to take care of the patient and do some medical functions. For example: “Your close relative is prescribed mouth feeding through a probe ... You will cook a liquid and semi-liquid nutrient mixture at home ... Food is injected through a probe every 3 hours with 300 ml.” [14].

The doctor-patient relationship implies several types of dialogue. For example: 1) Dialogue – a collection of anamnesis, objective data on physical health: “Have you had any surgery?”, “For how long have you been worried about pain?”; 2) Dialogue during the process of treatment or procedures, containing different types of discursive strategies in the form of appeals: “Open your mouth”, “Do not breathe”, “Be patient”, promises and reassurance: “Now, we will clean it up and everything will be fine!”, Or the same marks and praises “That's the spirit!”; dialogue – an explanation of the diagnosis and of the results of the examination, recommendations: “You must not lift weights” and others. By the way in the speech of the doctor you can often hear comforting words and words of encouragement: “Be patient a little! I'm finishing”, “Do not worry! Our clinic has everything you need for your speedy recovery.” “After this procedure, you will feel much better” A medical worker in any communication, with colleagues or a patient, needs to keep in mind of what to say. S(he) must remember that every word can inspire a person and become a remedy, and, having affected the psycho-emotional state, it means be the cause of injury. You cannot use in the language of vocabulary, which can cause the patient anxiety about their health.

According to our study of doctors' conversations with a patient in 2018, it was revealed that, depending on the words used by them, patients feel differently the symptoms associated with medical intervention. The patient feels more pain and anxiety when the doctor before the intervention tells that the procedure may be painful. This phenomenon is especially vividly seen in patients who are too concerned about the upcoming procedure, for example: pregnant

women and children. The words “pain”, “vomiting”, “panic” especially increase pain. The words “tingling”, “itch”, “anxiety” have less negative effect on the patient. Caregivers should avoid these words as much as possible, except situations when the patient communicates independently and waits for an answer to the questions. According to many doctors, the specialist conducting the intervention should focus on the causes of the intervention, without focusing on what the patient feels. Another interesting way of projecting a patient's recovery is to focus on monitoring the operation and the ways to improve its comfort. It is very important for a medical worker to avoid unnecessary words in speech, especially before medical intervention, which already scares the patient in advance.

It is important to note the fact that it is necessary not only to follow what was said but also how the speech was made. As the Great surgeon N.I. Pirogov “Behave with the patient like not to undermine hope. Give faith in a quick recovery” [15]. When the situation deals with life, little things cannot be neglected, because you can psychologically kill the patient by one word. It is necessary to give an example from practice, which shows situation like this. “At oncological [cancer] institute, a young doctor, while dressing the postoperative wound, involuntarily pursed his lips, and slightly rolled his eyes. The patient trusted the doctor very much and, during the dressing, monitored his face, trying to understand her condition by his reaction. When she returned to the ward, she began to cry. She explained that the doctor changed after opening the wound. He pursed his lips and rolled his eyes. From this she realized that her condition was hopeless. By evening, a heart attack was developed, and she died.” [8]. This example verifies the statement of S.I. Madzhaeva, that “the health and life of a person depend on what information is contained in medical information. In other words, the verbal/non-verbal impact of medical information is an important component of the therapeutic process ... [16].

Intonation is very important in speech. It is able to give words color and can show thoughts and intentions. Speech of the doctor can be calm, or intense, and sometimes monotonic and incoherent. If speech is too slow or fast it leads to a distortion of the perceived information. In this way is the patient feels neglect towards him(her).

It is also necessary to note another important point. The evolution that took place in the relationship between doctor and patient led to the need to inform and obtain the patient's consent to a particular medical intervention. The doctor has the task to decide which information is the medical secrecy and which is open for the patient.

In Russia, the rights and freedoms of citizens are enshrined in the Constitution. The Federal Law “On the Basics of the Protection of Citizens' Health” enshrines the right to keep information if it is medical secrecy. Medical secrecy is a ban for a medical worker to divulge information about a patient's medical condition. It includes following information: visiting a medical institution, the results of the initial examination, state of health, the final diagnosis, information about the presence of mental disorders, the fact of visiting a particular medical institution. This information is a medical secrecy and is not subject to disclosure even after the death of a person. There are cases when the

disclosure of medical secrecy is necessary if the patient agrees. However, as medical practice shows, there are cases when the disclosure of medical confidentiality occurs without the consent of the patient to ensure qualitative treatment. For example, because of his physical health, the patient cannot express goodwill, and medical examination and treatment are necessary; if the disease can lead to mass poisoning and the spread of infection; during medical procedures to a person under 15 years. It is necessary to inform his(her) parents or legal representatives about the state of health. We have given only some of the cases necessary to tell information. The task of the doctor is to control the available information about the patient during his(her) treatment, and, if necessary, to inform relatives. It helps to maintain and improve his (her) health.

Many researchers define medical discourse as one of the types of institutional discourse, a kind of communication between people who may not know each other but must communicate in accordance with the norms of this society. [17]. According to the system of constitutive features inherent in institutional discourse developed by M. U. Oleshkov, medical discourse can be distinguished from a number of professional discourses on the basis of the following parameters:

- the presence of specific objectives of communication, consisting in the delivery of health care;
- the particular circumstances of the communication taking place in a situation of medical, advice bypass;
- conversation is the base of a pair of communicative parties;
- presence of institutional symbols (special clothing, tools, documentation);
- status-role function of participants in communication, performed in accordance with the conventions of the Institute (order, subordination, division of labor in accordance with the level of competence, compliance with etiquette, etc.);
- human life and normal health as the highest values of medical discourse;
- Limited nomenclature of speech genres, complaint, inquiry about complaints, medical history, life history, recommendations, etc.

Along with the general characteristics inherent in the institutional discourse, specific discursive features should be noted. Thus, the peculiarity of medical discourse in the “doctor-patient” dyad is its personality, which is determined by therapeutic purposes and is implemented using various means of deformation to reduce the communicative distance between the participants of communication, which distinguishes this type of discourse strictly regulated by legal and religious discourses [18].

Medical discourse as part of communicative activities integrates language tools and extralinguistic components of professional communication. The study of this phenomenon is relevant from the point of view of efficiency, methods and functions of verbal behavior of the participants of communication, their communicative competence. Based on

the results of previous studies in the framework of cognitive linguistics and pragma linguistics, it can be concluded that the goals of communication between the doctor and the patient are:

- cognitive – facing mental mechanisms, the recipient's voice messages: – changing the world view of the patient;
- discursive – diagnosis, treatment, recommendation, i.e. obtaining, analysis and synthesis of information about the patient's complaints about diagnosis, treatment and elimination of the pathological condition of the patient;
- communicative – request and receipt of information, information, recommendation, explanation, argument, etc. [19];
- pragmatic – interaction, formation and maintenance of image, self-presentation, etc.

These goals define the modern directions of research of the medical discourse:

1. Strategies of persuasion and suggestion have been selected; in accordance with the communicative purposes – informative and interactive strategies (the classification of V.V. Zhura), or auxiliary ones (according to the classification of E.V. Akayeva) have been determined. It is established that certain sequences of speech actions that implement strategies contribute to overcoming the communicative and socio-status asymmetry of communication.

2. In accordance with the specific communicative objectives the original discursive strategies of medical discourse were identified and described (according to the classification of N. U. Sidorova): diagnosing, treating, recommending; developing a system of speech tactics: to tell information in positive way, compliment, silence, mandatory cooperation, consolation, reproach, admonition, control of the topic, empathy, encouragement, etc.[20]

3. The discursive competence of the doctor is studied and described; it is established that it is an integrative form of a number of competences – extralinguistic, interactive, paralinguistic and emotive competences.

#### IV. CONCLUSION

Medical discourse is a specialized kind of communication between people, communicative activity, the object of which is health. A doctor, as a representative of socially relevant profession, must control his(her) speech. Communication between the medical worker and the patient should be remote but at the same time friendly and sincere, because it is the key to a successful dialogue and to the positive result of treatment. Humanistic ideas develop, that is why it became necessary to accommodate patient's point of view. The result of it is the relationship based on cooperation and partnership. It unites the doctor and the patient to fight together against disease and this cooperation influenced good on treatment. The choice of the way of interaction, strategies and tactics depends on the doctor's personality, patient, particularities of the patient's disease, and also on the way of the medical care provided.

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