

1 The practitioner–patient relationship

Doctor–patient encounters

Introduction: spoken discourse in clinical settings

A significant amount of medical practice takes place through verbal interchange. Indeed it is no exaggeration to claim that, over the last three millennia, healthcare has principally been conducted through some kind of face-to-face encounter between patient and health expert (Brown *et al.*, 2006: 81). Yet it is only relatively recently – with the advent of sophisticated tape and video recording (technical advancements that allow researchers to capture naturally occurring spontaneous talk with exceptional degrees of precision) that the patient-provider exchange has been studied in any significant linguistic detail. With the availability of detailed transcripts that faithfully account for not only the content of conversation, but also the precise way in which such content is articulated (including details such as pitch, speed, pauses, false starts, repetitions, overlaps and interruptions), researchers have brought to bear a range of broadly discourse-based approaches on the medical consultation, resulting in a proliferation of studies that have contributed to our understanding of the patient-provider exchange.

In tandem with the aforesaid technological advances, the twentieth century has witnessed what has commonly been described as a ‘linguistic turn’, that is, a concern for ‘the modalities of language use’ that has preoccupied disciplines from sociology and anthropology through to literature and philosophy (Silverman, 1987: 19). The linguistic turn has led to researchers focussing on observable communication in a range of everyday and institutional settings. In particular, the medical setting has become an important research site for investigation, with micro-analytic attention to the discourse of the clinic offering a more precise study of the ‘human social world’ (Brown *et al.*, 2006: 81) than that afforded by other forms of sociological analysis. Although the clinical setting encompasses a range of communicative practices that involve a variety of medical and non-medical personnel, applied linguistic research has favoured doctor–patient interaction, and it is this specific encounter between professional and patient that we explore extensively this chapter.

Putting the doctor–patient encounter in context: themes and issues

Research into doctor–patient interaction to date has been extensive and still continues to grow apace, hence it is impossible to do justice to all the rich variety of work in the area. Nonetheless, there are several broadly applied linguistic research themes that have dictated enquiry into the doctor–patient encounter, chief among them typological/structural concerns, that is, attempts to identify and explicate recurring sequences of talk that make up the consultation process, and issues relating to the enactment of authority and control in the consultation. Since arguably the most outstanding characteristic of the doctor–patient encounter is, at least from an interactional perspective, ‘the unequal nature of the power relationship’ (Gwyn, 2002: 63), we shall devote most of this chapter to exploring the connection between authority and the linguistic resources on which participants draw to enact and negotiate power relations during the consultation.

Among the wide range of practitioner–patient exchanges that routinely take place in clinical settings, the doctor–patient relation has been described as the most interpersonally complex (Ong *et al.*, 1995: 903). Part of this complexity lies in the multi-purpose function of the consultation. For example, three distinct yet connected purposes of doctor–patient communication can be readily identified, namely building a good inter-personal relationship, exchanging information and making decisions about treatment (Ong *et al.*, 1995: 903–4). Moreover, these discursive activities take place in an institutional context where the participants are situated in unequal positions, with patients ‘investing their trust and faith’ (Lupton, 2003: 114) in the clinical proficiency of the doctor. Thus, as Gwyn (2002: 62) observes, asymmetries between doctor and patient can be seen to arise, to some extent, as a consequence of the format of the consultation itself (an issue to which we will return later in this chapter).

As ten Have (1991: 138) observes, medical interviews are tightly organised interactional events, and the doctor–patient consultation is no exception. Given the relatively unvarying format of the exchange, researchers have been able to identify a number of recurring phases of action that take place within it. Two influential typologies are those proposed by Byrne and Long (1976) and ten Have (1989). Byrne and Long, who were among the first researchers to systematically interrogate the structure of the consultation, describe six characteristic sequences of action:

- I Greeting and relating to the patient
- II Ascertaining the reasons for the patient’s attendance
- III Conducting a verbal or physical examination or both

- IV Considering the patient's condition
- V Outlining further treatment
- VI Terminating the consultation.

(Byrne and Long, 1976: 132)

From the doctor's perspective, the value of this structural template is that it forms a model sequence, a logical order, deviation from which, in some instances, can potentially lead to problems for the participants. For example, the sequence I-II-III-V-III-I-VI is identified by Byrne and Long as being particularly indicative of a problematic encounter. This can be seen in the following extract in which the patient, a labourer who has a long history of back troubles, is returning to his GP following a hospital referral. At the start of the sequence, the doctor has already greeted the patient (Phase I) but still has, as the exchanges demonstrate, to fully discover the reasons for his attendance.

- 1 D: (Phase III) What is your job?
- 2 P: Well, I'm on a quarry job, carting clay, as a slagger – it's a very rough job – that's the trouble... well I've been seriously thinking about getting a lighter job if I could and I'm travelling to Denton but it would be out on the moors type of thing.
- 3 D: (V) Oh, well that's no good to you...and this business of turning your head round most of the time, you see you're putting a strain on your neck.
- 4 P: I have to move back into the yards.
- 5 D: Oh that's no good to you. It's enough trouble if you've got your neck normal. It would be better if you could find a job – this is a fairly new job, isn't it? Were you on long distance before that?
- 6 P: Well, I was on middle distance actually, it wasn't as strenuous.
- 7 D: It might be better to look for something lighter. (III) How old are you now?
- 8 P: Fifty-three.
- 9 D: (V) It's not the time of life to start looking for another job, is it?

(Byrne and Long, 1976: 134)

Throughout these exchanges, the doctor shifts between the activities of conducting a verbal examination of the patient (Phase III) and outlining further treatment for his problems (V), missing out Phase IV (considering the patient's condition). According to Byrne and Long, the doctor's leaping back and forth between these two phases betrays the 'mess' in which he finds himself. Although already possessing much

information about the patient's prior clinical treatment and personal biography, the doctor continues to elicit this same information from the patient, details of which he should of course be readily aware. The doctor's reverting to Phase III of the consultation is, Byrne and Long suggest, a means of 'keeping control over of what he is doing' (1976: 135), imposing order on the seemingly erratic development of the interaction.

Byrne and Long's six phases of the consultation serve as what they call 'a checklist' with which doctors might 'facilitate their self-learning' (1976: 132). As Brown *et al.* observe, this typology (and others similar to it) is thus pedagogically motivated, designed to equip medical students with frameworks 'within which to learn and diligently reproduce the lists, typologies and forms of knowledge that would gain them the best marks' (2006: 86). This emphasises the fact that a number of structural typologies (Byrne and Long's included) are designed from the perspective of, and intended for, the medical practitioner. This inevitably downplays the role of the patient in the consultation: consultations are two-way exchanges in which patients, to varying degrees, jointly verbally negotiate clinical outcomes with their doctor. A more sensitive structural typology of the consultation – or at least one that emphasises negotiated speech activities between the participants – is that outlined by ten Have (1989), who describes what he calls the 'Ideal Sequence'. Consultations that feature the Ideal Sequence are resolved into six phases of action which unfold in a predictable order:

- 1 opening
- 2 complaint
- 3 examination or test
- 4 diagnosis
- 5 treatment or advice
- 6 closing

These six phases overlap with Byrne and Long's model typology. However, ten Have is at pains to point out that the sequential structure he describes is only 'ideal' in the sense that there will inevitably be deviations from it, although such departures are still likely to remain acceptable to the participants. For example, both doctors and patients well advanced into the consultation might well return to an earlier phase, particularly if further issues have arisen (ten Have, 1989: 118). Ten Have's approach to the consultation also emphasises the interactive nature of the exchanges between doctor and patient. Phases 2 to 5 of the consultation, for instance, are likely to involve both sets of participants jointly engaged in 'some sort of 'discussion' of what is proposed or done' (ten Have, 1989: 118), even if it is the doctor who

typically initiates the phases and the patient who follows. The following examples are testament to this variety. Both extracts are taken from the early stages of the consultations of which they are part. (For details of the transcription code we use here and throughout the rest of the book, please see Appendix.)

I

- 34 D: well we will take a look it can simply be that that she has
a little blood shortage she is [nine years
35 M: [yes that's what I also
36 D: the ages
...
45 D: I don't know if it's something but we can just prick

II

- 27 P: well (1.2) yes there we are again there we are again yes
28 P: I have two more things that uh you have to take a look at
29 D: and that is?
30 P: first uh at my throat and then at this knee
31 D: okay (.) and how are you doing besides that?
(adapted from ten Have, 1989: 119)

In the first extract the doctor (D) is discussing the problem of a child who has been brought to the surgery by her mother (M). The doctor initiates the examination sequence, proposing – ‘we will take a look’ – a ‘test’ (ten Have, 1989: 119) and then (at line 12) referring to the physical undertaking of this procedure more specifically: ‘we can just prick’. The mother contributes minimally to this sequence of talk (her single utterance, which offers an agreement of the doctor’s assessment, is incomplete, terminating mid-clause). The doctor ignores the mother’s statement, an action which, ten Have remarks, preserves the established distribution of medical knowledge between the participants and the Ideal Sequence in which this distribution is articulated (1989: 120).

In the second extract, however, there is a greater degree of sequential variation, a departure from the Ideal Sequence. In this example, the patient, ten Have observes, appears more ‘forceful’ about his or her medical concerns, introducing (without being prompted by the doctor) two further problems and thereby setting the complaint agenda. The doctor allows the patient to formulate these extra concerns (‘and that is’), but insists on first having a general discussion concerning the patient’s health: ‘and how are you doing besides that’. Thus the doctor forestalls entry into the examination phase of the consultation, further

extending the complaint phase before attending to the patient's knee and throat concerns directly.

What these two extracts demonstrate is that rather than doctors solely leading patients through an agenda, participants tell or show each other what they are doing or what they want the other to do (ten Have, 1989: 119). The various phases of the consultation are typically advanced by the doctor, but as the second extract reveals, patients can (and do) themselves commence sequences, manipulating the structure of the consultation to set the complaint agenda. Thus the notion of the Ideal Sequence affords researchers a useful resource for interrogating the structure of medical interviews, not least its ability to account for sequential variation and the joint negotiation between doctors and patients that gives rise to such variation in the consultation.



Task 1.1 Identifying phases of the consultation

The following short, yet (surprisingly) complete, consultation features a patient who has repeatedly visited her doctor with a persistent problem. On prior occasions she has been given a certain prescription and has been happy to receive it. On this occasion, however, the doctor seeks to persuade the patient to come off this medication and to try a different treatment.

Read through the transcript and then see if you can answer the following questions:

- How many of the six phases described by Byrne and Long and ten Have appear in this consultation?
- In what order and whereabouts do the phases appear and which participant initiates them?
- Does any phase feature less prominently than any of the others?

- 1 D: Come in. Hello. How are you?
- 2 P: I feel shocking. You know, when I came to see you last week and you knocked those capsules off – well, every morning when I get up, and my head – Doctor you could have amputated it. It was a terrible headache and it was as if someone was dragging my eyeballs out. So I took more tablets, I haven't had anything since...swollen, I've had bags under my eyes and all snuffly and watery, and at the moment, all the top of my head here feels as though there's pressure on it and I feel this stuff going down the back of my throat.
- 3 D: Are you coughing any of it out?
- 4 P: No, I can't cough it out as...when I blow my nose it's clear.
- 5 D: Is your nose blocked? Lie your head back and I'll have a look.

- 6 P: Just here and inside of my throat is always very tender and all under here...and with both my hands tucked underneath my ribs and my head feels as if it's going to fall off.
- 7 D: Well, I'll give you a change of tablets for that and when you're over this I'll start you back on the capsules.
- 8 P: Well, all the aches and pains have gone, apart from under my ribs.
- 9 D: Well, leave it a week and come and see me again. It sounds as if it's the cold that's affecting your sinuses. Right, so a week from today.
- 10 P: Bye-bye, now.

(Byrne and Long, 1976: 132-3)

Getting critical: unpacking asymmetry in the doctor–patient consultation

The notion that the doctor–patient relationship is characteristically an inequitable one is well established (Pilnick and Dingwall, 2011). A number of early approaches to the healthcare encounter began with the premise that there was something wrong with the conversation between doctors and patients (West, 1984). Doctors, specifically general practitioners (GPs), were described as verbally dominating the consultation process and not sufficiently listening to their patients (Rowen, 1977 cited in West, 1984). At that time, however, little was known about the precise means through which verbal dominance was linguistically enacted. Despite their emphasis on communication difficulties, these assessments of the consultation, conducted from both lay and scholarly perspectives (including assessments by practitioners themselves), were not concerned with systematically explicating and describing the interactional dynamics of the interview. Rather than empirically studying the clinical interview, their focus was more on medical praxis, assigning, for example, functional meanings to utterances and, through the use of coding schemes, resolving utterances into functional categories (Ainsworth-Vaughn, 2001: 453).

Furthermore, although the aforesaid research often described the imbalance of power between doctor and patient, it was typically conducted without drawing on linguistic theories and insights, and was predicated on the assumption that language is straightforwardly 'a transparent vehicle' (Ainsworth-Vaughn, 2001: 453), that is, something that merely reflects participants' agendas and in no way shapes or determines them. It was only during the 1980s that an emerging body of broadly applied linguistic work provided detailed textual evidence for the asymmetrical relationship between doctors and patients, drawing on contemporary theories of language in use and exploring the situated and sequential nature of spoken discourse.

One of the factors recognised as potentially contributing to restricting the patient's verbal contributions in the consultation is time. Or lack of it. As West (1984: 2) puts it, 'talking with patients takes time'. Yet doctors commonly want to arrive at diagnoses as quickly as possible (Wodak, 1997: 177). Conversely, patients are likely to want to explain their personal circumstances as extensively as possible and to know the implications of their complaints and illnesses (ibid.). This conflict of interests is, understandably, liable to give rise to inter-personal difficulties in the consultation.

The average time of the consultation with a primary care physician is, in the United Kingdom at least, estimated to be on average 13 minutes (Royal College of General Practitioners, 2004). General practitioners typically interview around 177 patients a week and manage 90% of the problems presented in the consultation without referral to other services (Brown *et al.*, 2006). All of these factors unavoidably put pressure on practitioners to be maximally verbally efficient when investigating their patients' problems, factors that potentially contribute to the conversational asymmetry that is characteristic of much doctor-patient talk.

In order to demonstrate how systematic attention to linguistic detail can expose power and dominance in the consultation, we shall consider a sample of doctor-patient analysis conducted by Fairclough, a leading proponent of critical discourse analysis. Critical discourse analysis (often abbreviated as CDA) is a mode of discourse analysis dedicated to exposing how language is influenced by power relations and ideologies, neither of which is likely to be apparent to language users themselves (Fairclough, 1992: 12). But not only does CDA expose the use and abuse of power in discourse, it also condemns such discursive practices, seeing the exercise of power through discourse as being reflective of, and contributing to, broader social inequalities.

The following analysis, which is based on clinical data first presented and discussed by Mishler (1984) in his pioneering work *Discourse of Medicine: Dialectics of Medical Interviews*, serves as an excellent example of a CDA approach to discourse analysis, revealing some of the tensions that can surface in communication between doctors and patients. In this particular encounter the doctor (D) is male, the patient (P) female.

- 1 D: Hm hm (.3) now what do you mean by a sour stomach?
 2 P: (1.1) What's a sour stomach? A heartburn
 3 like a heartburn or someth[ing.
 4 D: [Does it burn over here?
 5 P: Yeah
 6 It li- I think- I think it like- If you take a needle
 7 and stick [ya right [....there's a pain right here [

- 8 D: [Hm hm [Hm hm [Hm hm
 9 P: and and then it goes from here on this side to this side.
 10 D: Hm hm does it [go into the back?
 11 P: [It's a:l up here. No. It's all right
 12 [Up here in the front.
 13 D: [Yeah And when do you get that?
 14 P: (1.3) Wel:l when I eat something wrong
 15 D: How- how soon after you eat it?
 16 P: Wel:l probably an hour maybe [less.
 17 D: [About an hour?
 18 P: Maybe less I've cheated and I've been
 19 drinking which I shouldn't have done.
 20 D: Does drinking make it worse?
 21 P: Ho ho uh ooh Yes (1.0) especially the carbonation and
 the alcohol.
 22 D: Hm hm how much do you drink?
 23 P: (1.5) I don't know enough to make me
 24 sleep at night and that's quite a bit.
 25 D: One or two drinks a day?
 26 P: O:h no no no humph it's more like ten [at night
 27 D: [How many drinks
 – a night.
 28 P: At night.
 29 D: Whaddya ta- What type of drinks? I [((unclear))
 30 P: [Oh vodka yeah
 31 vodka and ginger ale.
 32 D: How long have you been drinking that heavily?
 33 P: (1.4) Since I've been married.
 34 D: How long is that?
 35 P: ((giggle)) Four years. ((giggle))

As Fairclough (1992: 140-4) observes in his commentary on these verbal exchanges, the encounter is clearly organised around the doctor's questions to which the patient then responds. The doctor controls the organisation of the talk by opening and closing each interactional phase of the consultation while acknowledging the patient's answers. (Although this is not always the case, for in some instances the patient's contributions are not acknowledged at all. For example, the doctor's question in line 4, though topically connected to the patient's prior utterance, does not acknowledge the formulation offered by the patient.) The patient's turns at talk, therefore, are limited since she talks only when the doctor elicits a response from her, principally by his asking questions. The doctor, conversely, is not granted turns at talk by another party but initiates them himself,

taking them when the patient has finished her answers or when she has provided sufficient information to satisfy the doctor's query.

Another linguistic feature of the interview which evinces the doctor's authority and control is the introduction, maintaining and changing of topic. In this instance, it is the doctor who sets the topical agenda since, typically, it is he who introduces new subjects and chooses whether to ignore the pursuit of new topics introduced by the patient. For instance, at line 18, the patient discloses that she has 'cheated' – that she's been 'drinking', which she 'shouldn't have done'. The doctor, however, does not follow up this potentially revealing and significant personal admission, instead pursuing a strict line of questioning directed at eliciting medical details relating to her use of alcohol. Fairclough suggests that, given his narrow focus on medical aspects (as opposed to the patient's social and personal concerns), the doctor is limiting topics in accordance with a predetermined clinical agenda which the patient is prevented from disrupting (1992: 141).

Moreover, as well as severely restricting the patient's access to new topics, the doctor further limits her turns through the regular use of polar questions. Such questions (for example, 'Does it burn over here?' and 'Does it go into the back?') produce only information-limited 'yes/no' responses and do not allow the patient to take the floor in the same way that a request for information such as 'Tell me about your concern' would do. Yet, for all that, the doctor does employ a number of more open questions which should, in principle, provide more substantial access to the conversational floor: 'How many drinks a night?', 'What type of drinks?'. But again these questions are closely focussed on specific details (e.g. the kind and quantity of alcohol) in relation to the patient's drinking and do not encourage her (as her subsequent responses demonstrate) to introduce new topics germane to the personal and social context of her medical complaint. As a result, the patient seems to be a rather passive entity who merely responds to 'the stimuli of a physician's queries' (Mishler, 1984: 10).

It is also telling how a number of the doctor's questions (as in lines 4, 17, 23) overlap the patient's as yet to be completed turns. These overlapping instances possibly appear to indicate occurrences where the doctor has received all the information he considers necessary from the patient's replies to his questions and that therefore he is simply cleaving to the pre-set agenda or routine mentioned above, an agenda through which he passes swiftly and efficiently (efficiently in the sense of time and verbal economy). This rapid routine might well be experienced by the patient as a series of what Fairclough refers to as disjointed and unpredictable questions, a strategy of interrogation which might well account for the hesitations before the patient produces a number of her answers (as in lines 2, 14, 23, 33). (However, these pauses might also be due to other factors, such as the high degree

of self-monitoring required by the patient in response to the sensitive subject matter broached by the doctor (Verschueren, 2001: 78.)

This example of linguistic analysis is, as Fairclough himself concedes, one-sided in its focus on interactional authority and control. Furthermore, some of the claims that Fairclough makes concerning the use of certain linguistic forms (such as questions) and their coercive function are, arguably, not fully borne out by the exchanges examined in the extract above. The number of questions that participants ask in medical consultations is indeed an important index of interactional control since ‘to ask a question is to claim power over emerging talk’ (Ainsworth-Vaughn, 1998: 462). However, this is not to say that every occurrence of a question or series of questions is necessarily emblematic of interactional dominance on the part of the questioner. As Verschueren (2001: 77) argues, respondents’ answers to questions might exert similar levels of organisational control over an interaction. Although answers are likely to be constrained by questions that, necessarily, require them to be ‘conversationally appropriate next action[s]’ (Treichler *et al.*, 1984: 68), speakers who respond to questions are not automatically (and on every occasion) powerless: the answers they produce, in turn, are liable to determine the type of turn that follows, thereby contributing to the shape and organisation of the interaction as it develops. A linguistic form itself, such as a question, is not indubitably emblematic of control. When assessing conversational asymmetry, one must consider how participants jointly operate and negotiate meaning in interactions.

Nonetheless, in closely explicating linguistic activity as Fairclough does, the foregoing commentary demonstrates how the doctor, using a number of discursive strategies, dominates the medical encounter, restricting the conversational resources of the patient in order to adhere to a pre-determined medical agenda. The doctor’s authority is manifested in linguistic features (such as turn-taking, topic shifts, interruptions and so on) which collectively evince a clear degree of interactional control. The medical agenda which the doctor pursues requires his attending to clinical and technical matters, rather than his adopting a different approach, a different voice, such as his exploring the personal and social context of the patient’s complaint. Indeed, adopting such an attitude would be counterproductive to the speed and efficiency of the interview.

Task 1.2 Towards a more egalitarian medical encounter?

As noted, Fairclough’s commentary on the language of the doctor–patient consultation depicts an inequitable relationship between the participants. However, in this analysis, he does not explicitly outline



what characterises a more equitable relationship, and nor does he offer any express linguistic recommendations for addressing the conversational asymmetry he identifies. What recommendations would you make? See if you can answer the following questions:

- How would you characterise (if such a thing is possible) an egalitarian relationship between doctor and patient?
- From a linguistic perspective, what would be its key features?

Conflicting interests? The voice of medicine and the voice of the lifeworld

Research suggests that when doctors and patients communicate, they adopt different perspectives from which to view and make sense of the patient's complaint (Mishler, 1984; Todd, 1989; Fisher, 1991). The doctor is seen to exhibit an almost exclusive concern for medical topics at the expense of the social and biographical context of the patient's life (Fisher, 1991: 158). According to Fisher, the doctor–patient relationship rests on a medical model which sees illness as the organic pathology of the individual patient. Thus the problem for the doctor to solve rests in the patient's body: non-organic issues, such as the social context of the patient's life, do not readily fit into this medical model (*ibid.*). Or to put it another way, doctors manifest the 'voice of medicine', whereas patients embrace the 'voice of the lifeworld', that is, the ordinary experience and the natural attitude 'of everyday life' (Mishler, 1984: 14).

'Voice' in this sense has a special meaning beyond its more familiar literal definition. Voice is taken to mean 'the relationships between talk and the speakers' underlying frameworks of meaning' (Mishler, 1984: 14). In the stretch of doctor–patient dialogue examined above, the dominant voice was that of medicine, a voice of medical authority and technical expertise, a voice oriented to by the doctor. The doctor appeared to pursue a time-efficient, pre-set diagnostic agenda, overriding, as a result, the everyday, non-expert voice through which the patient sought to make sense of her problems. The extract revealed how the doctor institutionally adhered to the practices of official medicine. The doctor responded to the scientific, clinical aspects of the patient's complaint, without exploring her condition in the context of other aspects of her personal, social life (such as the reasons for her drinking). Effectively, the doctor reconstructed the patient's 'practical interests into technical ones' (Mishler, 1984: 127).

Mishler's voices of medicine and the lifeworld are effective concepts for making sense of the dynamic tensions at the heart of the doctor–patient consultation. (Moreover, as we shall see throughout this book, the concept of these two voices yields invaluable insights into other

modes of health communication, particularly written documentation, such as patient records/medical case histories.) Although Mishler's (1984) original research from which the concept of the two voices is derived is somewhat dated now, exploring the consequences of doctors' and patients' orientations to these ways of meaning-making has continued to afford medical discourse analysts a promising means of evaluating participant behaviours in the consultation. For example, Barry *et al.* (2001) analysed the discourse of 35 British general practice consultations, looking for communicative patterns across this broad range of interviews. Unlike Mishler's study, in which all the doctor participants were white males, the encounters analysed in this more recent study comprised an equal number of male and female participants, and three Asian physicians. From this diverse collection of doctor–patient consultations the researchers identified four types of encounter, each of which featured assorted combinations of the medicine and lifeworld voices, the categories being: 'Strictly Medicine', 'Lifeworld Blocked', 'Lifeworld Ignored' and 'Mutual Lifeworld'.

What is perhaps most notable about this research into the doctor–patient encounter is that it identifies two types of consultation which are qualitatively distinct from those identified by Mishler in his original, pioneering work. Mishler described what he calls the 'Unremarkable Interview', a baseline or default doctor–patient dyad, the kind of encounter we have previously considered in which the doctor conducts the consultation exclusively in the voice of medicine, using discursive strategies to maintain control of the unfolding spoken exchanges. Although the voice of the lifeworld is sometimes introduced by the patient, the doctor blocks its full emergence. A number of the consultations that Barry *et al.* examined were similar to this kind of voice-of-medicine-dominant encounter. Yet the 'Lifeworld Ignored' and 'Mutual Lifeworld' interviews constitute a different type of consultation, each possessing unique linguistic behaviours.

To illustrate their distinct interactional properties, let us consider extracts from each. First: an example of the 'Lifeworld Ignored', an encounter in which the patient, Steve, a 24-year-old accountant, is presenting with the problem of pilonidal cysts between his buttocks, a chronic problem that causes him extreme pain, discomfort which is aggravated by his having to drive long distances as part of his job.

L=voice of the lifeworld (in bold); M=voice of medicine

- 1 L P: Er during the night er er, I don't know how-
 2 what you say, it burst or something
 3 D: Right. [Right
 4 L P: [I've got a hole in my back and it was
 pouring out with blood and=

- 5 D: [Right. Right. Right.
 6 L P: [(unintelligible) and I'm in quite a lot of pain
 7 M D: Right. Just getting the timescale [sorted out
 8 P: [yeah
 9 M D: so it's been over nine months?
-
- M *Exchange continued in voice of medicine by doctor and patient*
-
- 10 L P: **I can't do any sports, I do a lot of travelling with work**
 11 D: Sure. Yeah.
 12 L P: **and I just don't know where I am from [one day to the next.**
 13 M D: [Did you go you up to the outpatient clinic following on from that at all. Were you actually referred?
-
- M *Exchange continued in voice of medicine by doctor and patient*
-
- 14 L P: **but with the [travelling I d- I do eight- over**
 15 D: [Yeah. Sure sure.
 16 L P: **And that's just going to work and then if I have to travel from work**
 17 M D: Can I just take a look?
 (adapted from Barry *et al.*, 2001: 496)

In these exchanges Steve presents his problem almost entirely in the voice of the lifeworld. He consistently translates his medical (physical) problem into concerns about his personally managing his daily-life activities, such as how his condition chronically impedes his occupational and social life. As he says himself, 'I can't do any sports', 'I do a lot of travelling with work', 'I just don't know where I am from one day to the next'. These lifeworld statements are not merely glimpsed but substantially recur, as can be seen above, throughout the consultation. Steve is evidently determined to highlight to the doctor the extent to which his condition affects his everyday routine. Yet his personal fears and anxieties are overlooked by the doctor, who fails to pick up on, develop and show apparent empathy for his lifeworld concerns, preferring to maintain a close focus on clinical and procedural matters. For instance, the doctor, through the use of backchannelling tokens such as 'Right', 'Yeah', 'Sure', exhibits active listening, but this apparent 'involvement behaviour' is in fact, according to Barry *et al.*, little more than selective listening, used 'more as a way of vetting information in order to dismiss the lifeworld and seek voice of medicine information with which to continue the consultation' (2001: 495).

The rapid cluster of interjections which the GP produces at line 5 – ‘Right. Right. Right’ – appear to have a checking, verifying function rather than encouraging the patient to continue with his current topic, and the fact that these three interjections appear one after the other potentially indicates that the doctor has heard all that she wants to hear about the topic and is impatient to take the floor again and change the topical direction of the exchange, presumably in a more biomedical direction.

This foregoing extract reveals the lengths to which some patients go in order to articulate their lifeworld agendas, resisting, in doing so, the doctor’s interactional control of the consultation. The fact that Steve repeatedly presents his concerns in the voice of the lifeworld suggests that he is not satisfactorily able to convey his problem in the way he wishes, making for what Barry *et al.* consider to be a poor-outcome consultation (in the sense that the doctor fails to address the concerns that the patient persistently seeks to disclose).

This de-personalising ‘Lifeworld Ignored’ type of encounter between GP and patient illustrates how the consultation should ideally be a ‘dialectical process’ (Berger and Mohr, 1976: 74), a contest but also a negotiation between two voices. In order to appreciate the patient’s condition fully (an appreciation that involves responding sensitively to contextualised lifeworld accounts), the doctor ‘must first recognise the patient as a person’ (*ibid.*). Recognising and treating the patient as a person is a characteristic feature of the ‘Mutual Lifeworld’ strain of interview. In contrast to the ‘Lifeworld Ignored’ encounter, the ‘Mutual Lifeworld’ consultation involves both sets of participants routinely employing the voice of the lifeworld. This type of encounter provides an intriguing picture of what a more patient-centred doctor–patient relationship looks like, the type of humanistic encounter that Mishler advocates where the patient is treated as a whole person and the doctor picks up on social-psychological issues rather than dogmatically cleaving to clinical matters.

The following ‘Mutual Lifeworld’ interview neatly evinces the linguistic means by which both doctor and patient jointly collaborate in producing lifeworld interaction. In this extract, Jeremy, a retired senior manager, is presenting with heartburn but is concerned that this complaint is a symptom of a more serious underlying condition. In addition, Jeremy has been experiencing considerable stress regarding his daughter who has been recovering from a serious illness. The GP, Ben, is in his late forties. The letters L and M in the second column represent the voices of medicine and the lifeworld respectively.

- | | | | |
|---|---|----|----------------------|
| 1 | L | P: | Hello Ben |
| 2 | L | D: | Hello |
| 3 | L | P: | [How are you |

- 4 L D: [How are- er how- ((laughs))
 5 L P: ((laughs))
 6 L D: I'm okay
 7 L P: Okay?
 – L *Doctor and patient chat about the patient's previous GP who the doctor knows*
 8 L D: Right. (0.9) Right. What are we talking about?
 9 L P: What are we talking about today I don't know. I just feel slightly (0.3) a bit like a fraud I suppose. But I thought I'd have a word with you.
 10 L D: Yeah.

(Barry *et al.*, 2001: 498-9)

The opening exchange here appears to be one of mutuality and relaxed intimacy. Indeed we might even excuse ourselves for believing that we are witnessing the beginnings of an interchange between intimates rather than the unfolding exchanges of a clinical interview. As Barry *et al.* (2001: 497) remark, there is a 'relaxed feel' to these exchanges, an impression which is supported by the fact that the participants are principally engaged in the interactive business of establishing and maintaining interpersonal relations instead of engaging in the transactional processes of eliciting and disclosing medical information. The doctor's inclusive use of the personal pronoun 'we' in line 4 – 'What are we talking about?' – further indicates that the agenda between practitioner and patient is jointly produced. Humour also plays a part in these opening exchanges, with the participants engaging in laughter together (lines 4 and 5), an interpersonal episode which further contributes to convergence between professional and patient (Grainger, 2002). So far, then, the consultation has been conducted purely in the voice of the lifeworld. The encounter continues:

- 11 L P: Erm (0.3) I'm feeling fine. In in every respect except one.
 M And that is I am getting chronic I suppose for the sake of a better word heartburn
 12 M D: Mhm.
 – M P: *Patient discusses symptoms of heartburn which occur when he consumes hot and cold liquid and feels as though he's been hit in the chest*
 13 M P: And I thought I'd just check it out with you.
 14 M D: Sure. Are you getting any erm water – what's called waterbrush? Are you getting any reflux of acid or any frothy stuff coming up into your mouth?
 L Doctor asks patient where he experiences pain
 – M
 15 M D: Right. How long has it been a problem?

- 16 M P: (0.3) Oh I don't know. Six weeks.
 17 M D: Right
 18 M P: Hoping it's going to go away but it's not.
 19 L D: **Has anything changed in your life over the last five or six weeks? Anything sort of putting you under any undue pressure? Or-**
 20 L P: **Well I had a problem earlier in the year.**
 21 L D: **Yeah.**
 22 L P: **But I think that's er getting- that's okay. Er you know my daughter was [ill**
 23 L D: [Mm. Yeah.
 24 L P: **Er but I mean that's er- [it-**
 25 L D: [Is that- How's that sort-
 26 L P: **Yeah that's sorting itself out. I mean it's er er- but I mean that did put us- you know this is a year and Carol's coming up for its anniversary.**
 27 L D: **Mhm.**
 28 L P: **Erm it was just after Easter [that happened.**
 29 L D: [I think anniver-
I think anniversaries are a constant source of fascination to me. Erm it is con- staggering how often people will start to become unwell
 30 L P: [At the time-
 31 L D: [round about the time of an anniversary and will have completely forgotten that's it an anniversary.
 32 L P: **Yeah.**
 33 L D: **Erm I've seen this happen often.**

(Barry *et al.*, 2001: 498-9)

In the above exchanges the patient first adopts, though briefly, the voice of medicine in order to relay his complaint (heartburn) to the doctor (lines 11-13). The doctor, in response to the patient's disclosure, also adopts the voice of medicine but is evidently careful not to overuse technical terminology to elicit further responses from Jeremy, providing, for instance, a more familiar gloss for the medical term 'waterbrush' ('any frothy stuff coming up into your mouth?'). Thereafter, following a brief discussion about the duration of Jeremy's heartburn, both participants jointly conduct the interaction almost entirely in the voice of the lifeworld. This is achieved through the use of a range of discursive strategies including the doctor's open-ended and lifeworld-probing questions ('Has anything changed in your life over the last five or six weeks? Anything sort of putting you under pressure?'); active listening (use, for example, of the continuers 'Mhm' and 'Mm' which encourage the patient to continue elaborating his problems); and acknowledging the patient's predicament and

reassuring him ('I've seen this happen often'). Collectively these discursive strategies contribute to the patient's being 'treated as an equal partner', a participant who, being allowed (even encouraged) by the doctor to bring his own expertise to the consultation, takes an active part in his diagnosis and treatment (Barry *et al.*, 2001: 497).

Although only a series of extracts from a larger encounter, the above 'Mutual Lifeworld' sequence provides us with an impression of how a medical consultation conducted within the lifeworld might, to an extent, play out. Due to the characteristic conversational unfolding of the exchanges, and the apparent detachment from a strict pre-formulated medical agenda, the patient emerges from the interview as a unique person, someone actively involved, jointly with the doctor, in seeking to contextually understand his problems; problems which are explored from both physical and psychological perspectives. Embracing 'the natural attitude to everyday life' (Mishler, 1984: 14), the 'Mutual Lifeworld' consultation is an example of the kind of humane clinical practice that Mishler advocates in favour of the exclusively voice of medicine interview.

So far we have assumed that imbalances of power in the consultation arise from a clash of distinct perspectives. The concept of the ideal, patient-centred consultation proposed by Mishler rests on the assumption that the two voices of medicine and the lifeworld are discrete and irreconcilable, and that one (medicine) takes preference over and interrupts the other (lifeworld). The voice of medicine is equated with and enacted through response-constraining, interrogative forms of discourse (such as question and answer formats, and the assessment and evaluation of patients' replies), whereas the voice of the lifeworld is realised in forms of everyday ordinary conversation. Yet some health communication researchers claim that this voice division is too divisive. Surely, Silverman argues, the voices of medicine and the lifeworld intersect and overlap each other rather than their being in constant contest and opposition: the 'issue is always the relation between voices rather than establishment of the single authentic voice' (1987: 196). Doctors and patients do not necessarily adopt one particular voice (as we noted in the 'Mutual Lifeworld' encounter above). Consultations are made up of an interplay of voices: participants 'can and do speak in both medical and social voices' (Fisher, 1991: 160).

It is also somewhat problematic to equate the voices of medicine and the lifeworld with particular forms of language. Why, for instance, is ordinary conversation the appropriate medium to communicate the voice of the lifeworld? What essential connection is there between ordinary conversation and the lifeworld and the articulation of lifeworld concerns? Mishler advocates ordinary conversation as the template for the medical consultation, but forms of everyday conversation in

themselves are not inherently democratic and equitable, nor are they shorn of coercive potential. There is no reason why defining features of natural conversation, such as open-ended questions, joint topic development and active and open listening (Barry *et al.*, 2001), can't be manipulated by speakers to coerce fellow participants and steer the course of an interaction in a particular direction.

There is, moreover, a more fundamental challenge to Mishler's advocating ordinary conversation as the baseline of the consultation. Why shouldn't response-constraining language be the principal form of interaction? The medical interview is, after all, a unique type of encounter that has a particular function. Patients (for the most part) expect advice and solutions from their doctors and therefore being subjected to questioning 'is an eminently suitable way of establishing clinical facts' (Gwyn, 2002: 73). Given this expectation, patients might feel uneasy about taking part in a clinical encounter that harnesses seemingly equitable conversational forms of language (Silverman, 1987: 196). Just because a consultation fails to embrace forms of ordinary conversation does not mean that is wrong or inhumane (Gwyn, 2002: 73).

Despite these criticisms, the notion of the voices of medicine and the lifeworld still offer health communication researchers an important resource for interrogating and making sense of the language of medical interviews. Mishler was one of the first (and has certainly been the most influential) scrutineers of the doctor–patient relationship to give close, systematic attention to naturally occurring talk in the consultation and thereby evaluate the communicative significance of language to the participants. For only by focussing on the precise nuances of verbal exchanges is it possible, so Mishler argues, 'to make explicit how conversationalists themselves make sense of what they are saying to each other' (1984: 47), an endeavour which, in turn, affords us a greater understanding of medical practice.

Personal reflection

Pilnick and Dingwall (2011) suggest that medical authority and patient deference are an inescapable part of doctor–patient interaction. Despite advances in clinical communication skills training that promote patient-centred care, asymmetry continues to persist in the consultation. Indeed, unless there is some major reorganisation of medical practice, according to Pilnick and Dingwall, it is almost certain that medical consultations will never be patient led.

Do you agree with this assessment? Or do you see modern medicine moving closer to embracing patient-centred care?

Beyond primary care: exploring encounters in mental health settings

In this chapter so far we have considered doctor–patient interaction solely in the context of general medical care. Yet many of the issues concerning tension and authority in the consultation similarly, if not more urgently, obtain in the discourse of psychiatry and therapy. Language is vitally connected to the domain of mental health: the elicitation and presentation of psychiatric symptoms, and the diagnosis and treatment of many psychological problems are all eminently discursive activities. Language is a crucial aspect of psychiatric practice, and the enactment of power and control through linguistic means can have, as we shall soon see, profound consequences for patients, not least, in some cases, the losing of their liberty. Thus, in the psychiatric setting, the issue of power takes on a special significance.

A key issue for applied linguists investigating interaction in the context of mental health has been the exploration of the link between communication and the outcome of psychiatric interventions. Or to put it another way: does it make a difference how doctors interact with their patients? (Hassan *et al.*, 2007: 150). Relatively little is known about the linguistic routines that occur in psychiatric settings (Buus, 2008) and this fact makes the psychiatric intake interview a particularly significant site of investigation. The purpose of this encounter is to evaluate whether patients, interrogated by psychiatrists, should be committed to hospital on the basis of their responses, or what Jorg Bergmann describes as their ‘observable behaviour’, during the interview (1992: 137).

In his study of mental health communication, Bergmann identifies a number of manipulative linguistic strategies that psychiatrists employ to conduct psychiatric intake interviews. For example, as well as using questions to formally assess the mental well-being of patients, psychiatrists also frequently present interviewees with personal information in order to elicit further responses from them. This type of verbal probing is sometimes referred to as ‘fishing’ (Pomerantz, 1980), an interactional phenomenon whereby a speaker, in this case the psychiatrist, does not present the patient with a direct question but ventures a statement describing the patient’s personal state of affairs (for example, their health, mood and outlook). But, according to Bergmann, such statements are tentative since the psychiatrist, as an outside observer, only has limited access to these details and cannot be certain of their validity. Thus fishing, somewhat artfully, invites patients to talk about their private affairs – their feelings and troubles (Bergmann, 1992: 155). One of the consequences of this type of rhetorical strategy is that, among other things, it helps obscure any overt exercise of power and authority on the part of the psychiatrist:

rather than interrogating patients directly and compelling them to answer, patients are gently solicited to provide accounts of themselves – to talk about issues which they would have otherwise been reluctant to broach.

As interactional strategy, then, fishing is an insidious practice, trapping patients in what Bergmann describes as a ‘double-bind’. For example, if patients provide information voluntarily, then this is to accept what the doctor is insinuating in these (characteristically negative) assertions about their personal predicaments. Yet to reject the psychiatrist’s assertion is an act of resistance, with the patient risking their psychological state being negatively evaluated and, as a result, being subject to continuing psychiatric treatment. The following extract powerfully illustrates the argument.

- Dr. F: You feel angry about being committed by Doctor Kluge
 Patient: No I don’t feel angry about being committed by Doctor Kluge. But that you somehow –
 (1.0)
 Dr. F: What?
 (0.6)
 Patient: hhh
 (3.0)
 Patient: Mhh hh please.
 ((patient sweeps the doctor’s papers with a wave of the hand off the table))
 Patient: I can’t stand you Doctor Fischer.
 (source: Bergmann, 1992: 157)

Doctor Fischer’s exploratory utterance ‘You feel angry about being committed by Doctor Kluge’ takes the form a declarative statement. But its underlying function (its illocutionary force) is that of a question, provoking an answer from the patient. The psychiatrist’s statement contains a negative proposition which tacitly accuses her of being angry about, and therefore resisting, an act of professional decision-making. Thus aggravated, the patient immediately rejects the implication and then produces a ‘fatal’ reaction, a response that exhibits unusual and aggressive behaviour liable to be viewed as being indicative of psychological disturbance. Seeking to induce patients to disclose their feelings and opinions in this way, psychiatrists’ exploratory utterances put patients in an invidious position. It is not surprising then, as Bergmann points out, that many patients chose to reject psychiatrists’ insinuations and round on their interrogators – as this example dramatically illustrates.

These tensions that surface in the intake interview reflect broader problems and contradictions in the institution of psychiatry itself.

According to Bergmann, psychiatry as an institution is ‘caught and twisted between medicine and morality’ (1992: 159). In other words, psychiatry has to manage the contrary requirements of practicing medicine, which involves dealing with mental illness in an impartial, detached way, while at the same time practicing morality, which involves dealing with individuals whose behaviour is evaluated as morally deviant in some way (Hassan *et al.*, 2007: 150). This contradiction, however, is not self-evident. It has, to some extent, become obscured and naturalised. Yet, as Bergmann demonstrates, and we have witnessed, this fundamental, if extremely subtle, tension exhibits itself at the micro level of discourse, in the verbal texture of the intake interview itself. The appeal of this applied linguistic critique rests not only in its exposing the turn-by-turn enactment of control by psychiatrists over individual patients, but also its connecting such intricate linguistic behaviour to more fundamental problems in psychiatric care. Intriguingly, other exercises in psychiatric discourse analysis have revealed similar problems at the heart of psychiatric care, some of which we investigate in the following section.

The psychiatric discharge interview: the consequences of footing

If the psychiatric intake interview commences the patient’s journey through the mental healthcare system, the discharge interview concludes it or at least heralds its conclusion. Considered together, these two discursive events offer revealing insights into the treatment of psychiatric patients. As with the intake assessment, the discharge interview involves doctors evaluating the well-being and communicative performance of patients. However, whereas the intake interview is geared towards diagnosis and the service requirements of the patient, the purpose of the discharge interview is to ascertain the patient’s suitability for release from hospital. The discharge interview marks not only the patient’s release from hospital but also their transition from patient to person (Ribeiro, 1996: 181).

Throughout our exploration of various kinds of doctor–patient encounter in this chapter, we have focussed in some detail on the turn-taking and questioning strategies employed by doctors to achieve certain aims and objectives. Another way of making sense of participants’ behaviours in medical encounters is to consider how doctors and patients align themselves to one another as their verbal exchanges unfold. The process of alignment between speakers and listeners is known as ‘footing’ (Goffman, 1981). Footing relates to participants’ stances, postures and projections of themselves during evolving interaction (1981: 128). Broadly speaking, footings are the various social roles that speakers and listeners continually step in and out of

- 20 P: =I don't take care of her because my daughter-in-law
 21 P: takes very good care, y'know (.) ((short smile))
 22 P: I just see her and all that. (I don't)
 23 D: do you always keep in touch with them?
 24 P: oh, yes, always (.) ((nods))
 25 P: well as much as possible I do, y'know doctor (.)
 26 P: ((nods and smiles, looks at doctor))
 27 D: where do you live, Mrs Cardozo?
 28 P: what? ((lips tighten and frowns))

(source: Ribeiro, 1996: 185-6)

At the beginning of this interview, Ribeiro notes, the patient adopts an institutional footing, clearly and straightforwardly occupying the role of patient. This is borne out by her responses to the doctor's questions: up until line 10 she articulates no more than what is required of her. These early exchanges between the participants clearly establish the roles of doctor and patient, with the psychiatrist controlling the institutional agenda through a series of precisely focussed, topically constraining questions. However, from line 12, the patient becomes increasingly expressive, providing more information than the essential minimum required to answer the questions sufficiently. She offers, for example, evaluative personal information concerning her granddaughter (note her nodding and smiling (lines 13, 15, 18), her production of value-laden remarks ('she's my life'), and her repeated use of the discourse marker 'you know', a feature of talk which could be considered an involvement strategy redolent of normal, everyday interaction). During this expressive sequence of the interview the patient-interviewee footing drifts into the background, giving way to the footing of a gentle grandmother addressing a friendly, personally interested listener (Ribeiro, 1996: 186).

Yet rather disconcertingly, at line 27, the doctor's footing suddenly shifts: she redirects the topic of the interview by abruptly steering it back to eliciting factual responses from her interviewee ('where do you live, Mrs Cardozo?'). Thus, without warning or any other kind of intimation, the doctor disruptively reinstates the roles of doctor and patient, producing, understandably, a reaction of disquiet from Mrs Cardozo:

- 28 P: what? (lips tighten and frowns))

This abrupt jink in footing illustrates how this crucial stage in the interview is oriented to differently by the participants: the doctor evidently views the exchange as a medical encounter, whereas the patient construes it as personal talk. Tension clearly results from the participants' struggle to adopt their preferred footings, and this

mismatch of expectations between them reveals how Mrs Cordozo is caught in a double-bind situation.

As Ribeiro explains, in order to terminate her stay as an inpatient and commence her transition to ex–patient, Mrs Cordozo has to play the official (and passive) role of patient during the interview (discharging her social identities of mother, grandmother, etc.). On the other hand, in order to become a person, she has to reclaim her social roles to be considered suitable for release. As the interview unfolds, the patient’s talk, as we noted, becomes more expressive and involved, reflecting the social roles that, as a person, she has to recover in order to display connection with the outside world. Yet the psychiatrist resists the patient’s personal framing of the encounter, refusing to interact with her for any length of time on a personal footing. The psychiatrist repeatedly confines the patient to the ‘single and limiting role of patient’ (1996: 190). Thus, whether she is aware of this restriction or not, the psychiatrist’s prevailing interactional strategy is at odds with the rehabilitative purpose of psychiatric treatment; treatment which, crucially, should not only permit, but also support the patient’s adoption of a personal footing.

The point, then, is that if the doctor had displayed greater sensitivity to footings, there would inevitably emerge during the interview the woman behind the patient – namely, that sense of personal identity and social competence which Mrs Cordozo is expected to demonstrate if she is to be discharged from hospital (Ribeiro, 1996: 190). Yet given the interactional constraints upon her she is, paradoxically, unable to demonstrate this essential competence and thereby expedite her release from the institution.

Task 1.3 A further look at footings in the consultation



As the foregoing analysis demonstrates, identifying changes in footings (and the consequences of such changes) is an effective means of charting the interpersonal contours and enactments of power in psychiatric discourse. However, changes in footing, of course, are not just present in psychiatric encounters: they regularly occur in various kinds of spoken interaction. Unlike the disruptive footings shift we have just witnessed, changes in alignment can be, and often are, relatively innocuous (if not natural and expected). Indeed, if there were no changes in alignment during interaction, participants would have a troublesome time realising their transactional goals.

We have considered footings in psychiatrist–patient encounters, but consider the following:

- What footing shifts do you think commonly occur between GPs and patients in routine primary care consultations?
- What are the consequences of such changes in footing?

What's wrong with authority? Theorising power in the consultation

Readers would be forgiven for thinking that in our foregoing exploration of the doctor–patient consultation we have construed the exercise of power as an inherently negative operation, a process that leads to nothing but adverse clinical outcomes for the patient. We are, as are a number of health communication researchers, critical of verbal practices that give rise to misunderstandings and breakdowns in interaction – the often extremely subtle disruptions and confusions that only linguistic and other micro-level analyses of doctor–patient talk can apprehend. But, of course, the exercise of some degree of linguistic power is unavoidable, indeed is necessary, in medical encounters, and the doctor–patient exchange is no exception. For example, without recourse to agenda-constraining verbal activities, doctors would be unable to elicit vital information from patients and proceed with appropriate treatment.

Power is a complex issue that is worth exploring further, particularly as there are various ways of making sense of it, and determining the extent to which its effects can be judged as harmful or beneficial. Treichler *et al.* (1984: 63) rightly argue that there is ‘no independent or uncompromised stance from which power can be viewed or interpreted’. As we have seen, many linguistic studies of doctor–patient interaction have variously exposed and criticised the means by which doctors exert control over patients. Yet, for a finer appreciation of the verbal conduct of the consultation, it is important to be aware of contrasting perspectives of power, including what is known as the functionalist perspective, which considers the enactment of control to be relatively unproblematic. Indeed, from a functionalist perspective the relationship between doctor and patient is essentially a reciprocal one: any occasion of conflict arising between the participants is attributable to a failure of individual competence rather than to an imbalance of power inherent in the practitioner–patient relationship itself (Bloor and Horobin, 1975: 271). Thus, according to the functionalist perspective, the consultation is not a site of struggle, a tussle where patients fight to voice their interests. Rather, medical authority is viewed as benevolent, a legitimate means of licensing doctors to perform the role of healing and thereby serve patients’ best interests (Lupton, 2003: 113).

One persuasive explanation that helps to account for this status quo is that the roles of doctor and patient are socially defined and established. For instance, when people fall ill they have to fulfil certain obligations if they wish to have their illness validated and treated – if they are, to put it technically, to occupy the ‘sick role’ (Parsons, 1987).

According to the sick role, illness is not simply a condition but a social role which is characterised by four distinguishing elements:

Sick persons are absolved from certain social responsibilities. For example, they are exempted from being at work, attending school, etc.

The incapacity of sick persons is beyond their ability to overcome. They are not held responsible for their condition. The sick person cannot, in Parson's words, 'pull himself together' [*sic*] by a mere act of will' (1987: 151).

Occupying the sick role involves recognising (if it weren't already obvious) that being ill is an undesirable state, a state that should be got out of as quickly as possible.

Finally, sick persons recognise that being ill requires their seeking out appropriate help, to wit, treatment by professional physicians.

As these criteria make plain, the sick role submits ill people to rather compelling obligations; obligations, nonetheless, which are commonly taken for granted or else treated as common sense. Broadly, it is the duty of the sick to recognise that they cannot get better on their own and that they must therefore obtain professional medical care in order to recover. Naturally, this state of affairs has consequences for the maintenance of power in the doctor–patient relationship and the playing out of authority in the consultation. People experiencing illness need to acquiesce to the advice and injunctions of their doctors: a power differential between doctor and patient is thus unavoidable if doctors are to secure compliance (Lupton, 2003: 114). Indeed, licensed by the sick role, doctors apparently have little choice but to work towards maintaining 'a social difference from patients in order to meet their obligations as objective professionals' (*ibid.*).

There is, then, a powerful social imperative for patients to defer to the authority and technical superiority of health professionals and thereby enter into asymmetrical encounters with their doctors. Indeed, given this expectation, patients would most likely feel discomfited taking part in more symmetrical relationships (Silverman, 1987: 196). Thus it follows that if patients are tolerant of medical authority, they are also tolerant of the linguistic strategies that give rise to interactional authority in the consultation. Moreover, for patients to resist the discourse strategies of the doctors is to run the risk of their being seen to be 'symbolically challenging the status quo of medical discourse, thereby causing covert damage to their chances of recovery' (Gwyn, 2002: 74). It is in patients' interests to acquiesce.

The operation of power in the doctor–patient encounter has thus, to a not insignificant degree, become naturalised, as have the specific linguistic practices which enact power and dominance in the consultation. Naturalisation, in linguistic terms, is the process whereby discourse activities, and the ideological import of these activities, have over time, through routine and convention, become ordinary and unexceptional to the participants involved in them. As Fairclough (2001: 76) puts it, naturalisation is ‘the royal road to common sense’. When an interactional routine such as the doctor–patient encounter becomes naturalised, the underlying assumptions about, and operation of, power become invisible. They are translated into neutral, conventional ways of going about things. We would dare venture that most readers, when in consultation with their doctor, are unlikely to scrutinise the turn-by-turn, moment-by-moment unfolding of interaction and remark the unwritten, yet socially sanctioned, institutional mores that give licence to this particular way of interacting. We might pick up on certain technical terms with which we are unfamiliar but, for the most part, we are unlikely to give much consideration to the linguistic conventions through which we communicate with our doctors.

As Fairclough (2001: 82) argues, the natural or common sense way of doing things is an effect of power, and it is only when communication breaks down during the consultation that conventional routines are rendered problematic and the workings of power exposed. What was intriguing about a number of the consultations that we considered in this chapter (the psychiatric–patient exchanges apart) was the general lack of overt challenge offered by the patients involved. The consultations appeared, at least on the surface, to be smoothly conducted (in the sense that the patients did not expressly appear to regard the doctor’s style of discourse as ‘oppressive or disempowering’ (Gwyn, 2002: 69)). This only underscores the importance of paying micro-analytic detail to medical discourse if we are to expose tensions and problems of which the participants may well be unaware. This, in turn, raises issues about how researchers locate the operation of power in the medical interview and to what extent they consider the institutional context as contributing to the enactment of interactional authority and control.

Broadly, within the tradition of discourse-based studies of doctor–patient interaction, it is possible to identify two different approaches to power and context. Arguably, the dominant view, one espoused by proponents of critical discourse analysis, is that power in healthcare settings is a pre-existing ‘structural phenomenon’ (Wodak, 1997: 175). The differential rights and duties of doctors and patients are determined in advance (Treichler *et al.*, 1984: 63), and this will inevitably influence the linguistic behaviour of the participants during

the consultation. Applied linguists orienting to this position take into account, or at least acknowledge, that doctor–patient talk does not occur in a vacuum, but in a specific (institutional) context, and this context will unavoidably constrain what speakers can or can't say, imposing certain interactional obligations and restrictions on them. (It would, for example, be extremely unusual for patients to interrogate their GPs about medical matters, and doctors, in response, to readily yield intimate details about their health concerns!) Situational considerations, such as the relative status of the speakers, then, are an important factor in locating power. From this perspective, particularly from a critical discourse analysis standpoint, power in medical discourse is, to put it bluntly, to do with powerful participants controlling and constraining the contributions of relatively less powerful participants (Fairclough, 2001: 38-9).

However, other analysts of doctor–patient talk adopt a more cautious approach to the influence of context upon interaction. For example, researchers from the conversation analysis tradition (see Chapter 2) reject what they refer to as the 'bucket' theory of context: treating pre-existing institutional circumstances as enclosing verbal interaction (Heritage, 2004: 224). Analysis of medical discourse, they argue, begins exclusively with the talk of the participants themselves. Talk possesses 'an internally grounded reality of its own' (Schegloff, 1997: 171). Therefore any analysis of spoken interaction must first and foremost commence with conversation, not with any consideration of situational factors.

According to this view, participants do not bring pre-existing roles (such as doctor and patient) with them to the consultation. Rather, in interaction, they orient to and talk these roles into being: they 'do' being a doctor, 'do' being a patient, and, furthermore, they 'do' doing power. All that is required to make sense of the consultation is the participants' talk itself, the spoken data alone. Indeed going beyond the data – for example, considering the institutional context in which the interaction is situated – would be an 'illegitimate move' (Cameron, 2008: 145) that would divert analytical attention away from what is relevant to the participants, to what the researcher deems to be relevant.

The key point from this perspective is that power is not a pre-determined factor liable to influence the verbal conduct of the consultation. Rather, the exercise of power must be demonstrably evident in the participants' talk. The fact that doctors and patients occupy different status positions doesn't necessarily mean that this difference should be the basis for all and every interaction between them.

Here, naturally, is not the place to attempt to resolve this ongoing theoretical debate; it is enough, at this stage of the book, for readers to

be aware of it. What we would like to emphasise is that, whatever the perspective of power one adopts, any linguistic analysis of the medical interview must be based on a close examination of the interactive behaviour of the participants involved. As Treichler *et al.* (1984: 63) observe, ‘power relations are negotiated within the context of face-to-face interaction’. But, of course, such a view must also take into account the institutional norms to which both doctors and patients orient themselves; norms which manifestly exist outside of the consultation and which, in Cameron’s words, ‘constrain participants’ behaviour even if they do not fully determine it’ (2008: 145).

A toolkit for interrogating power in medical interviews

Throughout our survey of the doctor–patient consultation, we have considered a range of linguistic behaviours and discourse strategies. We have argued that close scrutiny of the consultation affords penetrating insights into the linguistic behaviours of doctors and patients, as well as insights into healthcare as mode of social practice.

What we offer now is a toolkit or checklist for readers wishing to conduct their own analyses of medical interviews. The toolkit conveniently brings together many of the analytic themes and linguistic concepts that we considered throughout the chapter, serving, if nothing else, as a kind of practical summary. It is by no means exhaustive, and constitutes a tentative list of features. Nonetheless, it presents readers with a basic framework for beginning to make sense of some of the social processes that occur in the medical interview.

Exchanges

- Which speaker commences sequences of talk?
- What question types predominate: closed questions (which narrow responses) or open questions (which offer greater conversational space)?
- Do speakers interrupt each other? If so, what are the consequences of interruption (for example, how does the direction of talk alter as a result)?

Topic

- Which speaker introduces new topics?
- Are newly introduced topics accepted and sustained by speakers?
- Do doctors offer the floor to patients, allowing them to introduce and develop topics of their own accord?

Footings

- What footings predominate in the interview (do the speakers orient to the participant statuses of doctor and patient throughout or are other roles in evidence)?
- Do footings shift during the interview? If so, which speaker is responsible and how is such a change realised interactionally?
- What are the consequences of any changes in footing? Do participants, for example, realise a footing change has taken place? Do they accept it?

Medicine/Lifeworld voices

Which voice (medicine or lifeworld) dominates the consultation?

- If the patient offers lifeworld statements, does the doctor encourage them?
- What linguistic forms do the voices take? For example, are they realised in conversational forms of talk or more constraining forms of talk?

Terms of address

- How do the participants refer to one another? For example, does the patient use an honorific form such as ‘Doctor’ (a marker of respect that recognises the participant’s status) or a more informal term of address such as a first name?
- Do terms of address change during the interview, potentially indicating a change in footing?
- What personal pronouns are used by the participants? Does, for example, the doctor use an inclusive ‘we’ to signal a practitioner–patient alliance: ‘We should consider reducing the dosage’, or an exclusive ‘we’ that potentially distances the participants: ‘We don’t prescribe that medication nowadays’?

Summary

In this chapter we have explored the doctor–patient consultation, examining its formal structure, as well as the linguistic enactment of power that commonly occurs in this routine healthcare encounter. We noted that, formally, the consultation can be resolved into six distinct phases of action, constituting what has been described as an ‘Ideal Sequence’. Progress, typically, through these phases is doctor-led, but there will be occasions when patients initiate sequences. This emphasises the fact that, even if the doctor typically determines

movement through the sequence, the consultation is an interactive process involving negotiation between the participants.

It was apparent that a number of the problems and tensions evident in the doctor–patient relationship were due to the different perspectives adopted by the participants, with doctors orienting to technical, biomedical matters while patients sought to make sense of their conditions by situating them in the context of their everyday lives. This gives rise to the concepts of the voices of medicine and the lifeworld. These concepts are useful for making sense of the social processes of the consultation, although we were at pains to identify some of the limitations of discretely resolving the voices into two mutually exclusive, clashing perspectives. It is better to see them as inter-penetrating rather than excluding one another.

Finally, we observed that the issue of power in the consultation is intriguingly complex and double-edged. Although many researchers have been critical of the exercise of power in medical encounters, some have described its positive effects, considering it to be an inevitable, and necessary, feature of medical interaction. However, doctors and patients have perhaps become so inured to the operation of power that it has become naturalised. The fact that power is commonly taken for granted highlights the importance of exposing its use and abuse through micro-linguistic attention.

This chapter has begun to introduce you to a number of linguistic issues surrounding the doctor–patient relationship. In the next chapter we will consider health practitioners who have been neglected in health communication research, namely, non-physician personnel, such as nurses, pharmacists and chaplains, who nonetheless substantially contribute to the litany of the clinic.