EXPERTISE, CONTROL, AND RELATIONAL DISCOURSE IN HEALTH CARE SETTINGS[1]

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Abstract

Expertise and control are fundamental, integral and intricately related components constituting human interaction. Previous studies on control in discourse in health care settings have analyzed control predominantly from the perspective of the individual. The main purpose of our study is to investigate it from the *interpersonal perspective*, in which control is seen as a *relational phenomenon*. Our research focuses on language use in expert and lay discourse exploited and realized as *interactive control sequences*. The analysis suggests that the choice of different control mechanisms realized by the interlocutors is motivated by the acknowledgement of and adherence to the institutional framework. Control may well interact with the participants' role expectations, which in turn results in a struggle to fulfil intended roles against conventionally assigned roles. The paper discerns *discourse strategies* as they are applied in both explorative and therapeutic interviewing.

1 Introduction

In everyday interaction speakers and listeners assume social roles, which they put on and take off at will, just as one changes clothes, in order to fit the communicative situation they happen to be in. They make use of a wide variety of socially coded behaviour traits to navigate and define their own positions and those of their partners'. Goffman (1981: 128) refers to this interactional position as *footing,* where speakers express the way they manage the production or perception of an utterance.

The present paper discusses some of the characteristics of footing in a well-defined type of institutional discourse, namely *clinical interviews*. The explorative and therapeutic interview types to be examined here highlight the *institutional footing* initiated (and thus imposed) by the professional (doctor, nurse). The aforementioned footing provides the context in which the discursive situation is supposed to develop. This paper offers an investigation of how the *personal footing* of the patient may reveal the contextual transformation needed to express the self behind the patient. It is presumed that institutional footings provide expertise and control for the professional in the explorative interviews. However, this dominance (and discursive control) can be broken by the patient's more personal footing in the therapeutic interview, where his/her perspective is to be acknowledged to a significant extent.

2 Clinical interviews as a type of institutional discourse

Institutional discourse differs from discourse in everyday context in significant ways. Being conventionalized social events, clinical interviews are structured in a predictable way and are organized to reach a specific end. They must fulfil the organizational constraints of specific settings (Fisher 1984: 202). However, this official communicative orientation is often contrasted with a more personal discourse activity of the patient.

The empirical-pragmatic investigations that Mishler (1984) applied to doctor-patient communications revealed essential linguistic findings. Mishler distinguishes two "voices": the "*voice of medicine"* and the "*voice of lifeworld"*. The voice of medicine is manifested by an expert that reflects a science-based knowledge, identified by and matched with a certain discursive strategy. Therefore, the discourse of an expert-guided interview is asymmetrical by its nature. The professional controls the turn takings as well as the choice of topics. The asymmetry is best manifested in the sequential constraints of the interaction process, which may involve a kind of sequential deference. Consultations in this format show a uniform structure: first, a question asked by the doctor; second, an answer provided by the patient; third, a post-answer assessment by the doctor, followed by a new request, and fourth, a question again for clarification of the patient's response. The sheer fact of asking questions means that the professional places constraints on the patient's next moves, placing him/her in a secondary role as responses always occur second. Experts ask closed questions to reveal the causes and symptoms of a possible disease. Questions serve to detect certain unknown events and, at the same time, remove any personal and social contexts associated with these events. The expert also controls the encounter by neglecting any irrelevant information of the patient, and dissolves his/her self-understanding into the framework of medical science. The "*voice of medicine*" suppresses the "*voice of lifeworld*", which otherwise should be manifested in the patient's personal thoughts and feelings.

We claim, therefore, that medical discourse should be treated as dialectic between the voices of lifeworld (mostly done by the patients) and the voices of medicine (mostly done by doctors). Health care interviews involve conflict and struggle between two domains of meaning (cf. Mishler 1984: 121).

As opposed to the control-driven discourse dominated by the professional, a more balanced, *conversational interaction* appears in patient-guided discourse. It is mostly the patient who proposes a shift to personal context and intends to remain in this context. Personal discourse involves a more symmetrical power distribution where traditional, institutional discourse remains in the background

while the patient's own beliefs play an important role in the foreground. Consultations in this format represent interruptions and disagreements initiated by the patient, revealing her own perspective and a set of informal footings in opposition to the institutionalized speech of the expert. Nevertheless, it should be emphasized that this type of interaction does indeed, in structural terms, show the fragmentation of the dialogue. The meaning of the message in such personal discourse needs to be explored in a joint effort between the interlocutors.

In the literature, personal discourse is considered and termed "a problem interview", because patients are able to express their problems freely, though doctors seldom accept this shift. In this sense, personal discourse can be regarded as a "problem interview" from the point of view of the doctors as well.

In clinical settings patients consult their problems not only with physicians but with other health professionals as well. In institutions of health care, professionals acquire distinct roles that are revealed at different levels of the hierarchy. This fact shows that exploration and physical examination are left to the professional-patient consultations. Thus, the communicative activities of nurses and dieticians are restricted to therapeutic discourse.

Analyzing the institutional and communicative roles of physicians and health professionals Clark and Drinka (2000: 63) claim that physicians follow the traditional *biomedical model* during their consultations where they limit their communication to detecting the somatic problems of their patients. As opposed to these objectives, nurses and dieticians make an attempt to acquire an overall, holistic picture of the "patient as a person" during the consultations. Such a holistic approach is sensitive to the relevance of the psychosocial background or context, to the illness interpretation and the everyday problems of the patients. They make an effort to achieve some level of *shared understanding*, incorporating the patient's illness into the discursive framework of their holistic approach. In this way, the consultations of health professionals may comprise a wider range of communication than those of physicians.

On the basis of their research findings, Clark and Drinka (2000) claim that the communication of physicians can be characterized by an objective, quantitative approach, while other health professionals apply a more patient-centred, holistic perspective in their practice. The difference in the approaches can be put down to the different scopes of their work. It is to be observed that clinical physicians prefer the traditional physician-centred style of interviewing as opposed to other health professionals' practices using a patient-centred style in their consultations.

3 Clinical interviews and control

Within the clinical context, professionals and patients exchange messages to detect the medical condition in question, and establish a mutually negotiated relationship. The role definitions of the participants, for example, crucially define the therapeutic outcomes. Therefore, the *relational approach* to clinical encounters seems to be an intrinsic factor. One of the relational elements involves the attempts of the participants to gain power or control in and despite of their institutionally determined relationship.

According to the literature, clinical interviews can be characterized by alternating or dual property sets. As regards their communication styles, they can be divided into physician-centred and patient-centred consultations. The former type is characterized by a highly directed, controlled way of conducting a dialogue, while the latter is a less directed and less controlled communication which gives way to the patients' critical questions in connection with their problems. Asking critical questions proves to be a challenge to institutional authorities who are willing to share power and communication only in some specific cases.

As physicians do the majority of the explorations and the establishment of the diagnoses, their communication is bound to be a highly controlling type by nature. As compared with this method, other health professionals (nurses, dieticians) deal with therapy in clinical settings, therefore their communication style should take into consideration patients' perspectives, feelings, and thoughts when establishing the therapy. This holistic approach is revealed in a less controlling consultation style, permitting even arguing between professional and patient.

One of the objectives of the present paper is exactly to investigate the controlling manoeuvres of communication related to physicians and other health professionals in the interview types above.

The method we have applied is ethnomethodological conversational analysis that draws conversational sequences under examination. The controlling manoeuvres of communication can be analyzed by the *Relational Control Analysis* described by Rogers and Farace (1975).

4 The method adopted: Ethnomethodological conversation analysis

Conversation analysis originates in ethnomethodology as developed in Garfinkel (1967). According to the theory, language is not an abstract phenomenon but is actually constituted in everyday interactions. Thus, conversation analysis is regarded to be an empirical, data-driven approach to verbal communication.

Conversation analysis – incorporating a good number of different methods – shares the following common characteristics as summarized in Kertész et al. (2006: 113-114):

- Conversations can be considered as the joint communicative activity of the participants.
- Conversations take place in time, therefore the speakers' activities are revealed in the communicative processes as they succeed each other.
- Coming from the succession of communicative events, conversations are made up of a sequence of speech turns produced by the speakers.
- The interactive, processual, and sequential structures represent systematic order in conversations.
- The speakers intend to solve communicative problems and accomplish tasks during interaction.
- The systematic order is not faultless, but involves errors that are constantly repaired by the speakers.
- With the help of the thematic organization speakers keep the dynamics and development of the conversation.

Consequently, the aim of our analysis is to show the sequential and processual structure of clinical consultations to reveal power and control differences and efforts made to balance control between professionals and patients.

5 The Relational Control Analysis

Relational Control Analysis (RCA) is a method of linguistic analysis to highlight the nature of the practice of excercising power and influence with the help of microanalysis in a professional-patient interaction framework. RCA is intended to help professionals in understanding patient satisfaction induced by communication. This method is also applied as an important means for patient education in the therapeutic process.

RCA has been developed on the basis of research carried out by Bateson (quoted in Chenail & Morris, 1995: 292), who first wrote about the concept of "schismogenesis" studied by himself within the Iatnul tribe in New Guinea in the 1930s. His work was responsible for a crucial methodological change in scientific inquiry from the individual as the unit of analysis to the relational (interpersonal). Bateson claimed that communication occurs between individuals whose relationship is decisive in shaping any actual interaction. Subsequently, the relational perspective focuses on how any communication situation determines relational notions such as trust, intimacy or control between the

speakers. Control is the most basic of these human relationships. The control dimension is constantly defined between the speakers during interaction, thus giving dynamism and development to the system of verbal exchanges.

Schismogenesis is "a process of differentiation in the norms of individual behaviour resulting from cumulative interaction between individuals" (ibid.: 293). If behaviour focuses on differences, this attitude attracts subordination and vice versa. In this way, complementary schismogenesis occurs. Symmetrical schismogenesis focuses on similarity, for example, when praising leads to praising, or, on the contrary, opposition or objection results in subsequent opposition or objection.

From the linguistic point of view, complementarity and symmetry can be observed in the turn-takings of the speakers, when a speaker's conversational contribution is followed by the other's response. Each verbal move can be divided into three categories on the basis of the study by Rogers and Farace (1975: 228-230):

- *One-up code*, if the act exerts control over the direction of the conversation or the relationship (searching questions, commands, directives, topic changes, disapprovals, refusals, instructions).
- *One-down code*, if the act yields control over the direction of the conversation or the relationship (allowing, accepting, praising, supporting answers, topic extensions).
- *One-across statements*, which neither gain nor yield control to the other (incomplete phrases or statements, assertions of extensions).

The next step in the *relational coding scheme* is to combine the control directions of the speakers and to form categories of paired sequences. Three categories of pairings can be given (ibid.: 222-239).

1. The *symmetrical transactions* form pairings where the control directions are the same. One type of symmetry is competitive when the responses and both codes are assigned as one-up. Another type of symmetry is called submissive when the speakers give one-down statements. The last type is characterized of neutrality and occurs when the speakers avoid taking control or giving it up. Instead, they take one-across statements.
2. The second type of control codes is called *complementary transactions***.** In this relationship the speaker attempts to achieve control and the other party yields or vice versa.
3. The third type of control codes is called *transitory***.** A type of transitory pair is revealed in the speaker's one-up statement, the other returns with

one-across answer (transitory dominant). If the pair occurs on the contrary, it is called transitory submissive (one-down with one-across code).

With the help of the above categories, the perspectives of the speakers will focus on the negotiating aspect of relational communication. On the basis of this, RCA puts an emphasis on the relational control rather than content, defines the message sequences, and maps the transactional patterns of behaviour and communication.

6 Problem

Against the background outlined in the previous sections the present research focuses on the following issues:

(P1) How is control revealed in the different consultation styles of the health professionals?

On the basis of the previous section, (P1) can be narrowed down to the following question:

(P2) How do sequences reflect the controlling manoeuvres of the speakers?

7 Analysis

The interviews were tape-recorded at the Departments of Internal and Renal Diseases at the University Medical Clinic in Pécs and at the Diabetic Department at Baranya County Hospital in Pécs between 2003 and 2006 by Monika Gyuró, the first author. The head of each department gave their permission and consent for the interviews to be recorded. The length of the interviews varied between ten and 60 minutes. During the interviews, the author's role was that of an observer with a recorder. The patients were informed of the purpose of the research and it was made clear to them that the observer was a teacher of communication at the Faculty of Health Sciences at University of Pécs.

In line with the philosophy of the study, we analyzed whole interviews, not fragments of them. The topics of the interviews involved diabetic counselling, supervision of patients suffering from renal disease and undergoing hypertension therapy.

The participants of the research were as follows: out of the ten patients six were females and four were males. Regarding the professionals, physicians carried out the interviews in five cases, and chief health professionals (such as head nurses, head dieticians) in the other five. The professionals were female persons with one exception, which fact did not seem to alter the results. Physicians carried out

explorations in their interviews, and chief health professionals led therapeutic consultations.

We analyzed the frequencies of control and interaction sequences in the kinds of interviews conducted by the different groups of health professionals. Significant difference between the control types and the interactive types of utterances were presumed among health professionals and also among consultation types. The interview transcripts and statistics were written in Hungarian (cf. Gyuró 2007).

Control and interactive types of utterances	**Physicians**	**Patients**
One-up	139	38
One-down	30	122
One-across	3	2
One-up complementary	101	8
One-down complementary	-	-
Competitive symmetry	25	2
Submissive symmetry	1	2
One-up transition	6	-
One-down transition	2	-
Neutralized symmetry	-	-
Total utterances:	**172**	**162**

Table 1: Control and interactive types by physicians and patients in exploration

Control and interactive types of utterances	**Nurses**	**Patients**
One-up	276	238
One-down	297	273
One-across	20	27
One-up complementary	192	116
One-down complementary	29	2
Competitive symmetry	62	9
Submissive symmetry	44	21
One-up transition	12	9
One-down transition	3	-
Neutralized symmetry	1	1
Total utterances:	**593**	**538**

Table 2: Control and interactive types by nurses and patients in therapy

Of the 1,465 utterances coded (Fig. 1), health professionals contributed 52 per cent of the utterances and patients contributed 48 (47.7) per cent. Of those utterances, the most frequent attempts made by health professionals were one-up (415) and one-down (327). Patients chose the one-down move most (395). Health professionals chose one-down attempts less frequently than one-up control moves (30 : 139) in explorations. One-up moves of the experts (Example 1) were in inverse ratio with one-down moves (Example 2) in therapies. Still, combined control attempts by both patients and health professionals demonstrated one-across moves most often (Example 3).

In therapies the total number of utterances exceeded that of the utterances in exploration. A more balanced picture of interaction can be observed in therapies. In therapies the one-up attempts of patients to control the conversation was less than those of the professionals' attempts (238 : 276), but the difference was not significant. In exploration these attempts were more than three times less frequent than those of the professionals' (38 : 139). Despite the fact that patients applied more one-down moves in both interview types than professionals, in therapies patients' one-down attempts drew near those of the professionals' (243 : 297). In exploration patients' one-down (submissive) moves were almost four times more frequent than those of the professionals' (122 : 30).

The most frequent interactions in these interview types were complementary (one-up) sequences showing the high control made by the professionals in both interview types (Example 4). One-down complementary interactions were less frequent, while in exploration it was totally absent (Example 5). These findings agree with our hypothesis that clinical consultations are highly controlled. Therapies slightly altered this picture, but the findings did not shade the results.

Competitive symmetry occurred as a second frequent interaction type in both interview types, showing the argumentative character of the consultations (Example 6). However, in therapies competition accounted for 8.0 per cent, while in exploration it amounted to 14.7 per cent. Regarding submissive symmetry (Example 7) in both interview types, in therapies it accounted for 5.7 per cent, while in exploration it amounted to 0.5 per cent in the type. The rest of the interactive types did not show significant data from the point of view of the analysis.

Consequently, therapies showed more permissiveness and symmetrical way of interaction than explorations where dominance and competition (one-up moves) characterized the dialogues. In therapies patients initiated more turns than in explorations (one-up complementary: 116; one-up transition: 9; submissive symmetry: 21; that fact demonstrates the appearance of the personal perspective in the interviews.

7. 1 Examples (translation from Hungarian into the English language)

(1) One-up complementary
Doctor: Did your parents or brothers and sisters have diabetes? *(one-up)*
Patient: My parents didn't, but my sister does. She was born in 1927. She has had it for a long time. *(one-down)*
(Gyuró:203)

(2) Submissive symmetry
Patient: I had a… daughter, but she died. (*one-down)*
Nurse: Oh, God! (*one-down*)
(Gyuró: 255)

(3) One-down transition
Patient: Stomach-ache, diarrohea, heart-throbbing…(*one-down)*
Nurse: and then the ambulance…(*one-across)*
(Gyuró: 255)

(4) One-up complementary
Doctor: What kind of pain is it? (*one-up*)
Patient: It's pressing. (*one-down*)
(Gyuró: 248)

(5) One-down complementary sequence
Doctor: As I see, you have low blood pressure. (*one-down*)
Patient: When I take the medicine it lowers pressure a lot, but I feel awfully tired then. (*one-up*)
(Gyuró: 247)

(6) Competitive symmetry
Nurse: What's your problem with the insulin? (*one-up)*
Patient: Well, it's not good. (*one-up)*
(Gyuró: 243)

(7) Submissive symmetry
Patient: I was put next to injured patients. (*one-down*)
Nurse: Next to injured patients. (*one-down*)
(Gyuró: 262)

8 Discussion

Regarding the similarities of the consultation types, we can claim that both types were controlled by the professionals as more utterances were produced by them. By contrast, professionals chose one-up complementary interaction type most for showing their controlling manoeuvres.

The differences of control could be seen between the interview types. In therapies compared with exploration more utterances were produced by both parties. This indicates more discussion between the speech participants. In

therapies more one-up attempts were used by the patients than in explorations, regarding the total utterances in each type. This fact weakens the dominance of the professional in therapies. In therapies the one-down (submissive) moves of the professionals are almost the same as those of the patients. This finding agrees with the conclusion above. In exploration one-down attempts of the patients are four times more than those of the professionals.

In the analyzed interviews mostly professionals initiated the turns, which demonstrates their intention for control. One-up complementary attempts were the most frequent interaction types that support the previous claim. Interestingly, competitive symmetry was found in a greater number in explorations, but submissive symmetry occurred to a greater extent in therapies. These data show the more allowing (permissive) character of therapies as opposed to explorations.

Thus, patient-centeredness was manifested in the therapeutic interviews led by nurses. This fact coincides with the claim by Clark and Drinka (2000) that nurses are more inclined to apply holistic approach in their communication. The findings may originate from therapeutical communication techniques as well. The interviews did not represent non-directivity as it was previously presumed according to the literature.

Professionals (physicians, nurses) appeared as experts in both interview types. In the explorations they embodied the omnipotent expert whose knowledge is unquestionable. In the therapies experts had to answer patients' objections; that made the conversations arguments. At this point the consultation turned out to be a critical discussion where the professional led the conversation without giving up control.

Patients initiated turns in the therapeutic interviews to a greater extent; therefore, changes from institutional to personal discourse could be detected in the consultations. However, the high control (one-up moves initiated by the professional) of both interview types ensured their institutional character.

We can claim that therapies are not as highly controlled by professionals as explorations, thus therapies give way to the "*voice of lifeworld"* embodied by the patients. The control moves could be detected from the relational control interaction sequences.

9 Conclusions

Although we cannot draw a general conclusion from the data above, the analyses demonstrate how health professionals and patients interact and control one another in their communication. We found that patients tried to balance

the control by making one-up moves after the professional's one-down moves in therapies, as well as cases where the professional controlled the interaction with more one-up attempts overall in explorations. The interviews were characterized by mostly institutional discourse. Personal discourse appeared mostly in the therapeutic interviews. In this way, therapeutic consultations are characterized by the parties' more balanced attempts to control the situation, while explorations maintain the traditional, highly controlled communication style of the professionals.

Relational control is an essential issue for both participants in the clinical interview. The speakers' expectations may play an important role in the success of the interview. Control may interact with expectations that results in a struggle to fulfil expectations. In order to reach co-operation speakers need to be aware of one another's expectations and be able to negotiate how expectations can be achieved.

Notes

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