

Article Title: Challenging Social Cognition Models of Adherence: Cycles of Discourse,
Historical Bodies, and Interactional Order

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Abstract

Attempts to model individual beliefs as a means of predicting how people follow clinical advice have dominated adherence research, but with limited success. In this article, we challenge assumptions underlying this individualistic philosophy and propose an alternative formulation of context and its relationship with individual actions related to illness.

Borrowing from Scollon and Scollon's three elements of social action – “historical body,” “interaction order,” and “discourses in place” – we construct an alternative set of research methods and demonstrate their application with an example of a person talking about asthma management. We argue that talk- or illness-related behavior, both viewed as forms of social action, manifest themselves as an intersection of cycles of discourse, shifting as individuals move through these cycles across time and space. We finish by discussing how these dynamics of social action can be studied and how clinicians might use this understanding when negotiating treatment with patients.

Keywords

adherence/compliance; communication; discourse analysis; ethnography; health behavior; interviews

Understanding what influences people's ability or willingness to comply or adhere to medical advice has preoccupied researchers for decades. Poor adherence, particularly to medications, remains an important issue for the effective management of chronic illness; the costs of nonadherence often described as a significant burden to health care systems (Barnes, Jonsson, & Klim, 1996). Despite the investigation of nearly 200 potential barriers to adherence (Vermeire, 2001) and numerous models having been used to predict adherence behavior (Christensen, 2004), challenges to understanding adherence issues remain.

The role of individual beliefs in predicting adherence has received much attention since the 1970s and we have already discussed sociological research that has raised questions for social cognitive theories that have linked individual attitudes to adherence behavior (Murdoch et al., 2013b). We discussed how previous research has already shown how people with a range of chronic illnesses can be seen to negotiate medicine-taking in competing social spaces (McCoy, 2009; Peyrot et al., 1987) and that people's decisions about taking medicine are not necessarily based on their attitudes or beliefs about medication or illness, but instead as a means of managing their illness within these different spaces. Individual decisions to not take medicines have been identified as a way to assert control over a condition (Conrad, 1985); because medications are disruptive to lifestyles (Hunt et al., 1989); or as a means of asserting control over patient-provider relationships (Hayes-Bautista, 1979).

We built on this work by arguing that talk about illness management is therefore likely to be a negotiation of these social relationships. We proposed that a key reason why research focusing on individual characteristics has had limited success in predicting adherence might be its conceptualization of talk as providing an accurate representation of individuals' attitudes or beliefs and the formulation of context within social cognition models. Using Goffman's concept of performance (1959) as a starting point to examine talk about taking asthma medications, we proposed that such talk, when provided as a narrative

within interview settings, can be better conceptualized as a performance shaped by the transfer of moral discourses of illness management across contexts.

In this article, we extend both this discussion and our use of Goffman's (1959) work to propose an alternative ontology, epistemology, and consequent methodology pertaining to individuals and their health management. We also draw on the model of social action proposed by Scollon and Scollon (2004) to conceptualize how people perform a variety of actions, taking into account the mediational means (language, technologies, and so on) by which they act. We apply the Scollon and Scollon (2004) model to make sense of one moment of social action, a sequence of talk about taking asthma medicine, taken from an interview conducted by the first author, with someone who, from a medical perspective, was considered to be nonadherent to asthma medications.

Reconstructing Assumptions about Individual Talk and Actions Related to Illness Management

Instead of treating talk and behavior about illness management as an accurate articulation of individual attitudes, distinct from context, all talk and behavior can be viewed as being shaped by and inseparable from the social historical context of its production. However, definitions of context for studying human action vary enormously. For example, researchers analyzing talk within interactions from a conversation analytical perspective (Atkinson & Heritage, 1984) typically (although not exclusively; see Silverman, 1997) adopt the viewpoint that the only context pertinent to the analysis is that in which participants orient their talk within interactions.

Conversely, analysts of structural discourse, as in Critical Discourse Analysis (Fairclough, 1995), typically construct context as linguistic, macro discourses that regulate the meanings made available within any particular discursive framework, including interactional talk. Although very different in analytical foci and assumptions, both

perspectives treat context as largely restricted to identifiable textual forms, offering distinct contrasts to ethnographic analyses of nontextual cultural objects (Hymes, 1996).

Proponents of Linguistic Ethnography in the United Kingdom (Rampton, 2004) have attempted to draw on the respective strengths of these perspectives by arguing context needs to be investigated and not just assumed. Blommaert (2005) sees history as important in such investigations, using terms from linguistics such as “intertextuality,” “interdiscursivity,” and “entextualization” to emphasize how shifting discourse across time and space helps explain power inequalities in the production of meaning and extends analyses far beyond the text of an interactional transcript. However, Blommaert and Huang argue (2009) that sociolinguists have often isolated these terms from the social actors and material objects in the social world where such texts play out.

Scollon and Scollon (2004), using their theory of social action, offered a conceptual toolkit to overcome such isolating effects, proposing that all human action be analyzed as an intersection of three “cycles of discourse”: the individual’s “historical body” (their own goals, skills, and life experience in managing illness, together with their physical health and stamina); the “interaction order” established by participants (other people around the individual and how they mediate action); and the “discourses in place” (such as discourses of appropriate illness management in workplaces, protocols for workplace behavior, and discourses of good parenting). This toolkit sets an analytic task of mapping those cycles of discourses with a bearing on the current situation, the relevant moment of social action.

In research interviews about asthma, we therefore need to investigate this type of interaction as a particular communicative genre and map potentially relevant discourses that circulate through research interviews about asthma management. We can then examine how these elements intersect with the respective historical bodies of the interviewer and interviewee and which version of asthma management is produced as a result.

Studying Cycles of Discourse: Data Requirements

Instead of a snapshot set of responses from a particular moment in time, capturing the circulation of discourse across social space requires a range of data that enable the analyst to identify discourse as historical, moving across time and space. In this article, we draw on data from a study in which the first author attempted to obtain such a history within the constraints of a qualitative sub-study to a clinical trial. The aims of the trial were to investigate the effectiveness and cost effectiveness of two different prophylactic asthma medications (Price et al., 2011) whereas the aim of the qualitative sub-study (Murdoch, 2010) was to understand how people with asthma discursively construct medicine taking. In particular, the focus was the moral construction of asthma management in explanations of nonadherence to medications and we collected data to analyze for evidence of moral discourses of illness management and the consequential discursive positioning of clinicians and patients within these discourses.

After completing analyses for discourses of illness management, we then analyzed the interviews for evidence that similar moral discourses were also activated in discussions about asthma management. Sub-study participants had enrolled in the main quantitative trial and the trial team assessed participants as having “inadequate asthma control” and “impaired asthma-related quality of life” through their responses to asthma quality of life and control questionnaires (Juniper et al., 1999a; Juniper et al., 1999b). Based on this sample of patients, the first author invited a subsample of individuals to participate in interviews about their asthma if they also demonstrated a history of not taking prophylactic medications as prescribed and therefore were, from a medical perspective, considered to be nonadherent. The Eastern Multi Centre Research ethics committee and local ethics and research governance committees approved the study.

The data that were analyzed derived from face-to-face interviews with 26 participants who had provided written consent, historical texts relating to asthma and illness management, clinical asthma guidelines, documents relating to participant recruitment, and a focus group in which anonymized data from the face-to-face interviews were shared with focus group participants in the form of vignettes. The first author selected historical texts from texts typically cited in reviews of the history of asthma (Cosman, 1983; Diamant, Boot, & Virchow, 2007; Muntner, 1968; Opolski & Wilson, 2005; Rosner, 1981) and analyzed these texts for how the authors constructed and positioned both practitioner and patient within discourses of asthma causation and illness management.

The analyzed texts included Maimonides' "Treatise on Asthma" (1135–1204), reviews of Renaissance-era asthma discourses (Cserháti, 2005; Ellul-Micelle, 1976), accounts of asthma causation at the advent of modern medicine (Osler, 1892; H. H. Salter, 1860), psychoanalytical texts on asthma causation developed at the Chicago Institute of Psychoanalysis in the 1930–50s (Alexander, 1952; Dunbar, 1947), and texts marking the shift of the role of individual (unconscious) psychology in asthma causation to texts forming a relationship between conscious psychology and asthma management (Becker & Maiman, 1975) that formed the basis for much of the adherence research since the 1970s. In addition, we examined literature that had also traced morality and discourse in other chronic illnesses to compare findings from the analysis of asthma texts (Horton-Salway, 2001; Sontag, 1991).

We selected the Global Initiative for Asthma (GINA, 2009) and British Thoracic Society (BTS, 2009) asthma guidelines because these recommendations derive from the two most influential governing bodies shaping asthma management in clinical settings globally and in the United Kingdom, respectively. In addition, we examined questionnaires used to recruit participants to the main trial, and therefore the sub-study, to determine how the main trial team discursively constructed the research participants with particular categorizations of

asthma. Finally, the first author conducted a focus group to provide a different set of interactional conditions within which to examine the circulation of a moral discourse of asthma management, which has been discussed in detail elsewhere (Murdoch, Poland & Salter, 2010).

Our analysis approach is one we have discussed previously (Murdoch, Poland & Salter, 2010; Murdoch et al., 2013b) and which uses language as the level of analysis rather than individuals. Individual talk, instead of being viewed as solely a product of that individual's attitude or a window to their experience, can be viewed as a product of discourses that are commonly shared but manifested in novel ways to meet particular interactional demands. When seen within this view, assigning individuals to different categories is a choice of our level of analysis and an artifact of traditional social scientific practice. The process of analysis is to trace "threads" of discourse manifested between different texts or talk as a means of identifying how individuals (clinicians and patients) are positioned within that discourse. We can then examine how the same discourse is reproduced in a range of contextual conditions and how this discourse may then affect the structure of social action (talk and behavior).

Analyzing the threads of discourse called for a linguistic ethnographic methodology (Rampton, 2004), which enabled us to understand how a range of contextual features both within and beyond these interactions shaped the talk of participants. We could accordingly offer a means of engaging with the individual in context and identifying a mechanism (discourse as structuring social action) that might be fundamental to how people manage illness on an everyday basis and which could be traced across contexts. In this article, we present extracts from these data to describe these different contextual features, tracing a thread between the different data sources to demonstrate the circulation of discourse to different social spaces.

In presenting just one interview extract, we are not arguing that this interview was representative of our dataset but instead are offering an example of how to link a discourse manifest within a single interview to discourse identified in texts external to the interview interaction. To examine these features in sufficient depth, we have selected only some types of data; in tracing these threads, we acknowledge that we cannot know or speak of all discourses pertinent to interactions about asthma management nor identify how the speaker manages illness on a daily basis. In tracing these threads, we can feasibly propose a set of concepts and tools that build on a sociological critique of attitudinal adherence research and which might help both researchers and clinicians communicate with and treat patients with long-term conditions.

Data Analysis – Discourses in Place, Interaction Order, and Historical Bodies

Discourses in Place in Asthma Research Interviews

We aim here to identify which discourses might be at play in our moment of social action before examining how these discourses map to the talk of a research participant when discussing asthma management and medicine taking. To do so, we analyzed how the authors of the historical texts, published research, and asthma guidelines constructed and positioned doctors, nurses, and patients as actors in managing an individual patient's asthma.

Our analysis of historical accounts of asthma causation and management revealed how medical conceptualizations of asthma, in moving from psychosomatic to organic origins, shifted the patient's accountability from causes of contracting asthma to personal accountability for the control of asthma symptoms (Murdoch, 2010). Health outcomes were increasingly seen to result from conscious decision making and researchers in the 1970s began to focus more directly on the individual knowledge that would ensure those decisions were the "correct" ones (Becker, Radius, & Rosenstock, 1978). Subsequently, researchers produced a proliferation of evidence that evaluated how far such cognitive approaches could

enhance a patient's compliance or adherence to medications and so inform clinical consultations. Such evidence is manifest within clinical asthma guidelines, the most significant influence on the practice of clinical asthma management today.

A network of asthma care experts, organizations, and public health officials develop the GINA and BTS asthma guidelines and collaborate to disseminate a global strategy for asthma management and prevention, based on available and graded evidence. In reviewing these documents, it is proposed that medical discourses of health behavior are communicated through institutions at least partly through the discursive power of bureaucracy and governance. This proposal does not exclude other possible ways for discourse within medicine to emerge and be disseminated but argues that one important means is the institutional power of formal documentation.

The authors of the GINA and BTS guidelines place three elements as central to the effective management of patients' asthma: the self-management plan (SMP), the doctor-patient relationship, and education. SMPs are documents that incorporate advice about prophylactic medicine taking; adherence to both the plan and medication are key requirements for the plan to be effective. SMPs can therefore be seen as "fixed texts" (Blommaert, 2005), functioning as powerful institutional tools to be transferred across contexts. Asthma guidelines' recommendations guide the SMP text within a clinical context that is then translated to people's everyday lives. Of particular interest to our analysis was how the authors of the guidelines discursively negotiated the SMP within the doctor-patient relationship:

The partnership is formed and strengthened as patients and their health care professionals discuss and agree on the goals of treatment, develop a personalized, written self-management action plan including self-monitoring, and periodically

review the patient's treatment and level of asthma control. Education remains a key element of all doctor-patient interactions. (GINA, 2009 p. xii)

The personalized nature of asthma management is evident throughout the GINA guidelines, emphasized by terms such as "personalized action plans," "patient-centred style of consultation," "ownership," and "patients may have different goals," which reflect an orientation to the post-1970s United Kingdom ideology of patient-centered medicine and shared decision making. However, this orientation creates a discursive tension in the context of asthma guidelines prioritizing evidence and the role of education in determining the patient's asthma management plan:

The purpose of education is to empower patients and/or carers to undertake self-management more appropriately and effectively. Information given should be tailored to individual patient's social, emotional and disease status, and age. Different approaches are needed for different ages. (BTS, 2009 p. 86)

Here, we can see how the provision of information is equated with the individual patient as an empowered decision maker. This positioning of the clinician and patient as informed decision makers places responsibility for treatment decisions with the doctor, nurse, and patient. However, the graded evidence means that if clinicians do decide to reject recommended treatment options they counteract the best practices set out within the guidelines. This contradictory position is reinforced at different points within the document, clearly advising that patient and clinician choices need to take place within the structure of the guidelines:

The ultimate judgement must be made by the appropriate health care professional(s) responsible for clinical decisions regarding a particular clinical procedure or

treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is advised, however, that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes. (BTS, 2009, p. 1)

This discursive framework of the doctor-patient relationship as “concordant,” “proactive,” “empowered,” and set against the need to document “significant departures” from the guidelines arguably creates a decision making paradox whereby patients, doctors, and nurses are simultaneously responsible or empowered yet also restricted by the treatments available and regulated in their decisions. As a result, poor health outcomes or the burden of asthma are potentially positioned as a result of treatment decisions being placed outside of best practice, lacking concordance with patient's perspectives, or clinicians not being proactive enough.

This positioning of clinicians and patients as both accountable and empowered articulates a moral discourse of asthma management that permeates a range of social spaces in which asthma management is discussed. The issue for the present analysis is whether such discourse circulates within the talk of an individual discussing asthma management and how this discourse intersects with the historical bodies of the interviewer and interviewee within the interaction order created by enacting a research interview.

Interactional Order of Face-to-Face Interviews

Qualitative interviews have already been extensively analyzed and critiqued as communicative events (Briggs, 1986; Mishler, 1984; Murdoch et al., 2013a), not simply vehicles for conveying information. This work reminds us that using the term *interview* with participants to describe the conversations taking place imposes a set of conventions on that

situation about who should ask questions and what sort of questions are to be asked, i.e., open ended and aimed at eliciting narratives. Participants vary in their familiarity with this particular genre (Duranti, 2001) influencing, in turn, how they will participate within it.

In this study of how people with asthma discursively construct medicine taking, the researcher's preoccupation was with participants' reasons for not taking their medications. The related choice of questions in the interview schedule therefore controlled what and how topics were discussed, later analyzed, and seen in the data. Setting up a one-to-one interaction about "your asthma" with an interview format of direct questions might reproduce the individualizing discourse being critiqued in this study, demanding that participants justified their medicine taking behavior. The analytical issue being scrutinized here is how this particular interactional dynamic and discourses in place intersected with the historical bodies of the interviewer and interviewee in one particular interview about asthma medicine taking.

Historical Bodies of Interviewer and Interviewee

To participate in the main trial and then be interviewed, participants needed to be categorized in all of the following ways, determined by combining objective breathing tests and questionnaires:

- A person with asthma
- A person with an impaired asthma-related quality of life
- A person with inadequate control of asthma
- A person who is nonadherent to medications

These "pretextual" identities were not explicitly referred to within interviews or at any point in the participant's involvement with the main trial, but were implicit in the process of recruitment and determining eligibility. These discursive identities therefore could be transferred or "resemiotized" (Scollon & Scollon, 2004, pp. 101–103) to the context of the

research interview, activated through question-answer sequences. However, because the trial team did not make these identities explicit, participants' awareness of the identities was likely to vary, potentially generating misunderstandings within the interview, as discussed elsewhere (Murdoch et al., 2013a). How participants enacted their awareness of these identities within the social action of the interview therefore also varied.

In the following extract from the interview with Dave (pseudonym), we can examine the intersection of discourses in place, the interaction order, and the historical bodies of Dave and the interviewer Jamie. Dave was a White British man in his 30s who had had asthma all his life and lived in a detached house in a rural location, where the interview took place. He stated he was a manager of a real estate agency, rugby supporter, golfer and a keen gardener; Dave visited his local pub regularly, where he met with friends and talked about asthma. He also stated that he was wealthy, went on holiday three times a year, and was bequeathing a large sum of money to asthma research: "I have my solicitor raising his eyebrows when he saw how much money I left asthma research in my will." Dave was prescribed an asthma prophylactic tablet to be taken once a day to be effective. This treatment replaced the brown inhaler that he was prescribed prior to participating in the main trial. Jamie worked as a researcher on the main trial and introduced the interviews to participants through their involvement in that trial.

Participants might therefore have viewed the interviewer's role as medical and, despite informing them to the contrary, as an expert on asthma. Jamie was also a White British man in his 30s, a PhD student with a background in psychology. We now examine how Dave talks about not taking his prophylactic brown inhaler by deploying two discourses: a scientific, rational discourse, followed by a psychological discourse. The analytical issue is which version of asthma management these discourses produce in this particular interaction between these particular individuals.

Extract 1: Dave

Interviewer (J): So what, what are the differences do you think, or the relative difference between eh, tablets and the brown inhaler?

Dave (D): I think it's, I think there's an element of psychology comes into it. And I think there's a degree of psychology comes into everything in as much as partly because I think those tablets are doing some good it's certainly got to help the job a lot help the fact that they are.

J: Yeah.

D: Em, the brown one I'm absolutely, I've managed to convince myself beyond a reasonable doubt, it doesn't work or its effects are minimum, minimum effectiveness. I know, I, I've had asthma all my life. I've you know, I started with the little pink tablet but through to the Ventolin, then went on to the big white ones which were foul, before that we had spin halers and all these thing we used to have to put out fucking cups in and things and cracking and things. I've been through the full nine yards with this. As soon as Ventolin appeared instantly you have something which is a cure. You went from having asthma to using it to being perfectly normal again, like that. It was a big, big difference. The brown, I mean with, I've had two or three or four different doses of brown one and I've played about with it for a week, for nine months sort of thing, and I'm adamant that it's not made any difference. It really hasn't. Yeah and I did forget to take it and I did forget to, it was just how and the, this thing about using the two in conjunction. Well, it just, I just never really accepted it.

J: So is it, is it just the eh the drug itself or is it the device that, that's in it as well is there anything else about?

D: Oh no, I don't think there's anything (?). No.

J: It's not like I

D: I, it's, it's, I, I have experimented with it and, and you know a week playing with it and then a week without it and then a week with it and I really can't tell you that there, that there was a great deal of difference among any.

J: Right

D: There really was none (?). I've been better with these tablets in as much as I know for a fact that I have ordered less Ventolin since I've been using those than I was before.

J: Do you think you've eh, taken the tablet more regularly?

D: I've taken the tablet, yeah.

J: Right.

D: Oh definitely, definitely.

J: Given what you've said about psychology, what do you think (are) the possible differences in treatments?

D: Going back to what I said at the beginning I think there's an element of psychology in as much as because I'm pretty adamant I've been told that this will help effectively but, I've been taking it, I've been going along with it, I've certainly as I said, used less Ventolin at the same time. No, no problem at all. Brown one was very hit and miss in as much as I would forget to take it didn't matter where I put the thing. I had them scattered, I had one in the car, one in the, beside my bed, one in my office and I'd still forget to take it. I don't know why but I just did.

J: That's interesting.

D: I think it was, I think it was the fact that it, it's so similar to the original the blue one, the Ventolin. That you use when you've got asthma, when you're having an asthma attack or (?), you use the (?) and it's that's a cure, you pick it up, you reach for it at that point to go to the action of using exactly the same sort of when there's

nothing wrong with you, is not a natural, and I think there is an element of that feeling.

A key way in which Dave explained his use of prophylactic medications, made evident in this dialog, is through his use of a scientific discourse. He constructed his argument using legal and scientific terminology “beyond a reasonable doubt” and “minimum effectiveness,” combined with an empirical approach to test out the brown inhaler “I have experimented with it and, and you know a week playing with it and then a week without it.” This active construction juxtaposes a sense of passivity with the types of medication provided, a dependency on what has been available at different times, emphasized with a sense of frustration: “I’ve been through the full nine yards with this.”

This mixture of articulating objectivity alongside subjective, long-term experience – “I know, I’ve had asthma all my life” – displayed a powerful rhetorical device for demonstrating his account of the effectiveness of the brown inhaler medication as authoritative. The effect was to produce an account of his asthma management and himself as well intentioned, rational, and reasonable, but thwarted by inadequate treatments. In addition, he was not someone who just accepted the advice he was given, but someone who made his own mind up: “I’ve managed to convince myself beyond any reasonable doubt.” This statement is a direct rejection of the notion of patients as passively compliant with instructions to take medications as prescribed, instead asserting active monitoring of the medication’s effects. Dave’s nonadherence within this discourse is credible in the context of recounting work he had himself done to test the effectiveness of brown inhalers.

An important device Dave used was the construction of the brown inhaler as something that was not “natural” to use “when there’s nothing wrong with you.” From a social cognitive perspective, this type of statement has been repeatedly identified and

categorized as an individual attitude where the person does not view his or her asthma as a long-term condition (e.g., Halm et al., 2006). However, here Dave clearly demonstrated that asthma was something he had lived with all his life, repeatedly confronted and treated, and fully understood the function of prophylactic medications in reducing his need for Ventolin. By viewing Dave's talk from a discursive perspective, his statement about the brown inhaler was contextualized in a version Dave produced as the informed scientist and not someone who has incorrect beliefs.

The notion of prophylactic inhalers as not "natural" showed Dave using a psychological discourse to account for his nonadherence. Dave discussed different elements of psychology including forgetting, visual association with blue inhalers, notions of psychological acceptance ("I just never really accepted it."), the placebo effect ("partly because I think those tablets are doing some good it's certainly got to help the job a lot."), and the psychological impact that the introduction of Ventolin as a new treatment had in the management of asthma ("instantly you have something that is a cure."). The detail provided in his endeavor to overcome his poor memory and take the brown inhaler regularly ("I had them scattered.") suggests Dave was attempting to discredit any notion that he did not try hard enough with the brown inhaler.

Notions of being in work or a hard worker are often linked to undermining potential accusations of being a malingerer (Cornwell, 1984; Radley & Billig, 1996). Dave, using a metaphorical scattering of inhalers in key locations, constructed a version of himself as someone who is in many places on a daily basis, of which his office is one. Forgetting to look after his health is set within this context and the scattering strategy is therefore represented as a proactive attempt to overcome the limitations of his own forgetfulness brought about by his busy lifestyle.

Dave's nonadherence was set within a broader cultural discourse of the busy working individual and not within a context where remembering things might be seen as not a problem. This rhetorical work therefore undermined potential criticism that Dave was lazy in his attempts to adhere to the medication. As well as using the scientific discourse in this extract, Dave also undermined any suggestion that he had an irrational and incorrect perception of his medications. This situation was achieved by constructing himself as committed to seeking out the truth through endeavor, objective empiricism, and experience, three attributes that can be widely seen as core values in a working context.

Moving Through Cycles of Discourse and Illness Management

Dave's rhetoric did not deploy a traditional medical idea of the ideal patient within a Parsonian sick role discourse (1951) but is instead a reconstruction of more contemporary notions of the "asthma expert" seen within recent patient-centered initiatives (Department of Health, 2001; Taylor & Bury, 2007), but also within wider ideologies of 21st century working life and of the reflexive consumer. The individual as the reflexive consumer is armed with knowledge and has free will to adopt healthy lifestyles or not, as seen in powerful messages such as "NHS Choices. Your Health. Your Choices" (2012). By positioning himself on the positive end of this moral dimension of illness behavior, Dave provided plausible explanations for his medicine taking behavior, problems with asthma control, and control of his asthma management and health more generally.

We can therefore see a range of discourses circulating through this moment of social action. It is tempting, of course, to view these discourses solely in terms of a product of Dave's linguistic repertoire. However, Dave's rhetoric is not a standardized account, but is a response to this interview being set up as a discussion about "why Dave is not taking his medication." The pretextual identities of "person with inadequate control, quality of life, and nonadherence" were being resisted by Dave through his construction of himself as the

rational, empowered decision maker, an alternative identity circulating within contemporary clinical discourses of illness management and in wider society.

Dave, in not taking his brown inhaler, represented someone making a “significant departure” (BTS, 2009, p.1) from medical advice and nonadherence to this medication. Here, to justify this position, Dave therefore needed to do more within this interaction than just reproducing a medical discourse of illness management, which was illustrated with the mixture of discourses he deployed to justify his position. In doing so, Dave demonstrated that, as well as orienting to a medical discourse of appropriate asthma management, he was also managing moral expectations of being an individual decision maker, a hard worker, a good manager, and someone who has a health problem that is not an illness.

The success of Dave’s rhetoric relied not only on how these discourses worked together but how they made sense in conjunction with Dave’s historical body as a middle class, White British man living in the United Kingdom, as a business manager, and as an experienced active manager of his asthma. Most crucially, Dave’s desired discursive position could only be successfully attained if the interviewer interpreted Dave’s talk in the way Dave had intended. The interviewer, also a White British middle class man in his 30s from the same region of the United Kingdom, had a close appreciation of the particular historical body that Dave presented and discursive devices that Dave deployed, leading to Dave’s talk being interpreted in the ways Dave intended.

Discussion

In advancing the analysis here, we have shed light on how speaking about illness management as an extended narrative involves individuals negotiating complex discursive spaces where they work to present themselves in ways in which they wish to be understood and judged. The analysis does not immediately resolve issues of how such talk accurately reflects how people manage their health on a daily basis. However, an analysis of intersecting

discourse, historical bodies, and interaction order allows us to expose important issues regarding which types of talk are expected and thus produced in discussions about illness management and thus which types of illness management behavior might be expected and produced.

In his account of how metaphor links domains of experience, Radley (1993) discusses how spaces of action are available to people with illness, between what is expected of their behavior and what can be attained, between public morality and private fate, and how this space for agency in behavior is manifested in the discursive positions people adopt when discussing their health. However, how individuals negotiate these moral positions is not trivial, but relies on them being able to draw upon appropriate linguistic resources for successfully responding to what public morality is activated within the interaction taking place.

Dave's case illustrates how the interpretation of talk relies on how the listener's own range of particular skills, histories, and agendas interacts with the speaker's talk. We can therefore argue that if any of the three elements of social action shift through time or place then so too will the meaning of the moment of social action. Different intersections of these elements will facilitate different types of talk while inhibiting others; how speakers respond in these different contexts will affect how their talk is interpreted. For example, interpretations of an individual's presentation of their medicine taking will be shaped in a working context differently than a doctor-patient consultation. Patients reporting that they do not take prophylactic medication when they do not have symptoms is commonly classified as having incorrect beliefs and being nonadherent when produced within a clinical consultation. However, this same perspective might be seen as appropriate in a working context where it is important to present oneself as not being unwell.

Interactional talk about illness can therefore be seen as a complex negotiation of a range of discourses that circulate across social spaces and that intersect with interactants' historical bodies and the communicative expectations of the particular interaction. If we treat how people follow medical advice and manage illness on a daily basis as another form of social action, we can hypothesize that these actions will be structured in a similar way to talk.

The disclosure, display, and management of illness have already been shown to be organized by the social spaces and material circumstances of people's everyday lives (Conrad, 1985; Charmaz, 1991). We can build on this work by suggesting that these moments of social action are similarly determined by the different discourses circulating these spaces (what they are, how they are determined and distributed, and by whom) and the different historical bodies and the communicative (or behavioral) expectations constructed within the particular interactional space. The first issue is how to study such phenomena and the second issue is to study how clinicians can use this understanding when communicating with and negotiating treatments with patients.

Researchers exploring the daily activity of individuals' illness management and adherence typically rely on interviews to access individuals' routine worlds (for example, Hunt et al., 1989; McCoy, 2009). Rosenfeld and Weinberg (2012) have recently proposed the use of ethnographic observation and interviews to capture how "established meanings and routinized activities of the home occasionally interfere with their adherence to medical regimens whether or not patients are intellectually committed to adhere to them."

Viewed as moments within cycles of discourse, decisions about medication or other treatment regimen can only be fully understood by examining the moments of social action themselves, namely how discourse, historical bodies, and interactional order constrain or facilitate such behaviors in different social spaces. This situation calls for a linguistic ethnographic methodology using participant observation or, perhaps more practically

possible, personal audio or video diaries to capture both the semiotic and the linguistic dimensions of everyday illness management. However, examining cycles of discourse using a linguistic ethnographic methodology requires us also to join the dots, connecting different encounters to trace the recontextualization of discourse within clinical consultations and other encounters in which decisions about healthcare are made.

Rapley (2008), drawing on data from across the range of patients' interactional encounters, demonstrated how decision making can be seen as "another-decision-in-a-series," where past decisions are reviewed in light of the patient's new history, examination, and test results. In this article, we have examined an example of how talk within a research interview can be viewed as discourse traced through a series of encounters, involving both individual talk and text within institutionalized documents.

We can apply the same technique to tracing the history of distributed decisions about illness management themselves across a series of encounters. For example, we might observe and record different clinical and social encounters for an individual patient, although, as Rapley pointed out, this methodology poses practical and ethical challenges. Another possibility could be to follow the flow of information held about a patient from one encounter to the next and which individuals became involved in this process. This technique would provide a basis for us to suggest how to change the flow of information across encounters so that patients' concerns and objectives for care can be more appropriately shared and used in the decision making process.

Embracing the complexities of individuals' lives using ethnographic methods to inform treatment choices highlights the tension seen in our data between the power of standardized techniques used to model and treat patients and the complex worlds in which patients manage their illnesses. Developing social cognition models and asthma guidelines can both be viewed as attempts, through conceptual and clinical policymaking activity, to

standardize the individual health behavior of clinicians and patients. This process is what Bowker and Star (1999) defined as “a process of constructing uniformities across time and space, through the generation of agreed-upon rules.”

In the case of asthma guidelines, we saw how such a process created specific difficulties for discursively negotiating research evidence with the ideology of patient-centered medicine. In the case of social cognition models, reducing decisions about illness management to individual statements about disease or medications limited these models’ power to explain patients’ lifeworld perspectives when individual talk is viewed as a contextually situated social action. Both of these forms of standardization have an established professional power base with global appeal offering straightforward, useable tools for clinicians to manage the task of treating patients within limited resources. It is therefore unsurprising that these forms of standardization have persisted in practice across time and space while more complex frameworks of individual behavior are not readily found in clinical practice.

However, discourses such as those held within social cognition models are not seen to transfer uniformly across historical contextual space but will function according to their intersection with diverse historical bodies and interaction orders. Timmermans and Epstein (2010) argued that standards rarely endure in a moving world and here we have shown that social cognition models and clinical guidelines, despite their continuing widespread application, do not capture the complex worlds of individuals managing their illnesses.

Recognizing clinician-patient talk as a manifestation of intersecting cycles of discourse further reveals how notions of shared decision making and concordance, seen by many as the ultimate aim of clinical consultations and decisions about treatment options, fail to take into account the subtlety of the interactional order in the doctor (nurse)-patient consultation. Trostle (1988) reminds us that compliance was “an ideology that transforms

physicians' theories about proper behavior of patients into a series of [standardized] research strategies....that reinforce physicians' authority over health care.”

The same transformative process can be seen to be implicated by clinicians enacting a discourse of concordance using models of patient-centered communication (B. Salter, 2004). One of the consequences of this process is that the patient's interests are assumed to be the same as the doctors. However, we have shown that patients often exhibit diverse historical bodies that are unlikely to fit neatly into the clinical ideology of concordance. If we accept the complex worlds in which individuals manage illness, then a less linear view of the challenges to clinician-patient relationship can be taken and perhaps the place of standardized behavior modeling and practice can be reasonably questioned.

Enabling the history of patient (provider and lifeworld) encounters to be traced and to ask patients to summarize this history within clinical consultations has the potential to produce discussions and treatment decisions of contextual relevance to the patient, recontextualized from the perspective of the patient rather than the doctor. This methodology differs from activating a patient-centered discourse such as that proposed within asthma guidelines, where patients are considered to be empowered and which also needs to be discursively negotiated with a responsibility to follow best practices. Here, we are suggesting that clinicians could orient to how standardizing guidelines and tools for measuring quality of life have the potential to limit the discourses in place circulating through the clinical consultation.

McLeod and Sherwin (2000) referred to this limitation of the relevant knowledge base as “oppression on patients' ability to exercise autonomy” often involving a lack of trust in the health care professionals' own knowledge or in their own judgements and ability to make correct decisions. McLeod and Sherwin argue that clinicians have a responsibility to acknowledge these knowledge limitations and for patients and clinicians to reflect on the

social and political dimensions of their condition. However, encouraging patients to describe the different social encounters, in which decisions are discussed and treatments taken, is not aimed at facilitating some notion of the patient as an autonomous and empowered decision maker, but rather to enable alternative discourses and historical bodies to be activated within the decision making process that might then circulate to subsequent encounters.

Patients and clinicians might then consider alternative responses to managing illness that can be compatible with patients' lives instead of a standard response that may well continue to lead to nonadherence to treatment regimens. Finally, authors of guidelines for clinical practice could support such a process by broadening the evidence base beyond the hierarchy that currently places randomized controlled trials as the gold standard. Recognizing limitations of the discourses of illness management in place within consultations, calls for greater emphasis within guidelines on the social experience of illness and the value in clinicians gaining insight into this experience on the basis of individual patients.

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References

- Alexander, F. (1952). *Psychosomatic medicine: its principles and applications*. London: Allen & Unwin.
- Atkinson, J. M. & Heritage, J. (1984). *Structures of social action: Studies in conversation analysis*. Cambridge: Cambridge University Press.
- Barnes, P., & Jonsson, B., et al. (1996). The costs of asthma. *European Respiratory Journal*, 9, 636–642.
- Becker, M. H. & Maiman, L. A. (1975). Sociobehavioral determinants of compliance with health and medical care recommendations. *Medical Care*, 13, 10–24. Retrieved from http://journals.lww.com/lww-medicalcare/Abstract/1975/01000/Sociobehavioral_Determinants_of_Compliance_wi_th.2.aspx
- Becker, M. H., Radius, S. M., & Rosenstock, I. M. (1978). Compliance with a medical regimen for asthma: a test of the health belief model. *Public Health Reports* 93, 268–277. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1431906/>
- Blommaert, J. (2005). *Discourse: Key topics in sociolinguistics*. Cambridge: Cambridge University Press.
- Blommaert, J. & Huang, A. (2009). Historical bodies and historical space, *Journal of Applied Linguistics*, 6, 267–282. doi: 10.1558/japl.v6i3.267
- Bowker, G. & Star, S. L. (1999). *Sorting things Out*. Cambridge, MA: MIT Press
- Briggs, C. L. (1986). *Learning how to ask: A sociolinguistic appraisal of the role of the interview in social science research*. Cambridge: Cambridge University Press.
- British Thoracic Society and Scottish Intercollegiate Guidelines Network (2009). *British guideline on the management of asthma*. Retrieved from <https://www.brit->

thoracic.org.uk/document-library/clinical-information/asthma/btssign-asthma-guideline-2009/

- Charmaz, K. (1991). *Good Days, Bad Days: The Self in Chronic Illness and Time*. New Brunswick, NJ: Rutgers University Press.
- Christensen, A. J. (2004). *Patient adherence to medical treatment regimens: Bridging the gap between behavioral science and medicine*. New Haven, CT: Yale University Press.
- Cosman, M. P. (1983). A feast for Aesculapius: Historical diets for asthma and sexual pleasure. *Annual Review of Nutrition*, 3, 1–33. Retrieved from <http://www.annualreviews.org/doi/pdf/10.1146/annurev.nu.03.070183.000245>
- Conrad, P. (1985). The meaning of medications: another look at compliance, *Social Science and Medicine*, 20, 29–37. Retrieved from [http://dx.doi.org/10.1016/0277-9536\(85\)90308-9](http://dx.doi.org/10.1016/0277-9536(85)90308-9)
- Cornwell, J. (1984). *Hard earned lives: Accounts of health and illness from East London*. London: Tavistock.
- Cserhádi, E. (2005). The history of bronchial asthma from the Renaissance till the beginning of the twentieth century. *Acta Physiologica Hungarica*, 92, 181–192. doi: 10.1556/APhysiol.92.2005.2.9
- Department of Health (2001). *The expert patient: A new approach to chronic disease management for the 21st Century*. London: Department of Health.
- Diamant, Z., Boot, J. D., & Virchow, J. C. (2007). Summing up 100 years of asthma. *Respiratory Medicine*, 101, 378–388. Retrieved from <http://dx.doi.org/10.1016/j.rmed.2006.12.004>
- Dunbar, F. (1947). *Mind and body: Psychosomatic medicine*. New York: Random House.
- Duranti, A., Ed. (2001). *Key Terms in Language and Culture*. Oxford: Blackwell.

- Ellul-Micallef, R. (1976). Asthma: a look at the past. *British Journal of Diseases of the Chest*, 70, 112–116. Retrieved from [http://dx.doi.org/10.1016/0007-0971\(76\)90016-4](http://dx.doi.org/10.1016/0007-0971(76)90016-4)
- Fairclough, N. (1995). *Critical Discourse Analysis: The Critical Study of Language*. London: Longman.
- Global Initiative for Asthma (GINA, 2009). *Global Strategy for Asthma Management and Prevention*. Retrieved from www.ginasthma.com
- Goffman, E. (1959). *The Presentation of Self in Everyday Life*. Garden City, New York: Doubleday.
- Halm, E. A., Mora, P. & Leventhal, H. (2006). No symptoms, no asthma: the acute episodic disease belief is associated with poor self-management among inner-city adults with persistent asthma. *Chest*, 129, 573–580. doi:10.1378/chest.129.3.573
- Hayes-Bautista, D.E. (1976). Modifying the treatment: Patient compliance, patient control and medical care. *Social Science and Medicine*, 10, 233–238. Retrieved from [http://dx.doi.org/10.1016/0037-7856\(76\)90005-6](http://dx.doi.org/10.1016/0037-7856(76)90005-6)
- Horton-Salway, M. (2001). Narrative Identities and the Management of Personal Accountability in Talk about ME: A Discursive Psychology Approach to Illness Narrative. *Journal of Health Psychology*, 6, 247–259. doi: 10.1177/135910530100600210
- Hunt, L. M., Jordan, B., Irwin, S. & Browner, C. H. (1989). Compliance and the patient's perspective: Controlling symptoms in everyday life. *Culture Medicine and Psychiatry*, 13, 315–334. Retrieved from <http://link.springer.com/article/10.1007/BF00054341>
- Hymes, D. (1996). *Ethnography, Linguistics, Narrative Inequality*. London: Taylor & Francis.

- Juniper, E., Guyatt, G. H., Cox, F. M., Ferrie, P. J., & King, D. R. (1999a). Development and validation of the mini asthma quality of life questionnaire. *European Respiratory Journal*, 14, 32–38. doi: 10.1034/j.1399-3003.1999.14a08.x
- Juniper, E., O'Byrne, P. M., Guyatt, G. H., Ferrie, P. J., & King, D. R. (1999b). Development and validation of a questionnaire to measure asthma control. *European Respiratory Journal*, 14, 902–907. doi: 10.1034/j.1399-3003.1999.14d29.x
- McLeod, C. & Sherwin, S. (2000). Relational autonomy, self-trust, and health care for patients who are oppressed. In C. Mackenzie & N. Stoljar (Eds.), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (pp. 259–279). Oxford: Oxford University Press.
- McCoy, L. (2009) Time, self and the medication day: A closer look at the everyday work of 'adherence.' *Sociology of Health & Illness*, 31, 128–46. doi: 10.1111/j.1467-9566.2008.01120.x
- Mishler, E. G. (1984). *The Discourse of Medicine: Dialectics of Medical Interviews*. Norwood, NJ: Ablex.
- Muntner, S. (1968). Maimonides' treatise on asthma. *Diseases of the Chest*, 54, 128–132.
Retrieved from
<http://journal.publications.chestnet.org/data/Journals/CHEST/21461/128.pdf>
- Murdoch, J. (2010). *The Discursive Construction of Prophylactic Medicine Taking for People with Asthma: Interactional Issues and Moral Discourses*. School of Allied Health Professions: University of East Anglia.
- Murdoch, J., Poland, F. and Salter, C. I. (2010) Analyzing Interactional Contexts in a Data-Sharing Focus Group. *Qualitative Health Research*, 20, 582–594. doi: 10.1177/1049732310361612

- Murdoch, J., Salter, C., Cross, J., Poland, F. (2013a) Misunderstandings, communicative expectations and resources in illness narratives: Insights from beyond interview transcripts. *Communication & Medicine*, 10, 153–163. doi: 10.1558/cam.v10i2.109
- Murdoch, J., Salter, C., Cross, J., Smith, J., & Poland, F. (2013b). Resisting Medications: Moral Discourses and Performances in Illness Narratives. *Sociology of Health & Illness*, 35, 449–464. doi: 10.1111/j.1467-9566.2012.01499.x
- NHS Choices (2012). Retrieved from <http://www.nhs.uk/Pages/homepage.aspx>.
- Opolski, M., & Wilson, I. (2005). Asthma and depression: a pragmatic review of the literature and recommendations for future research. *Clinical Practice and Epidemiology in Mental Health*, 1, 18. doi:10.1186/1745-0179-1-18
- Osler, W. (1892). Bronchial Asthma. In W. Osler (Ed.), *The Principles and Practice of Medicine. Designed for the use of practitioners and students of medicine*. Edinburgh: Young J. Pentland.
- Parsons, T. (1951). Illness and the role of the physician: A sociological perspective. *American Journal of Orthopsychiatry*, 21, 452–460. doi: 10.1111/j.1939-0025.1951.tb00003.x
- Peyrot, M., McMurry, J. F. & Hedges, R. (1987). Living with diabetes: The role of personal and professional knowledge in symptom and regimen management. *Research in the Sociology of Health Care*, 6, 107–46.
- Price, D, Musgrave, S.D., Shepstone, L., Hillyer, E.V., Sims, E.J., Gilbert, R.F., et al. (2011). Leukotriene antagonists as first-line or add-on asthma-controller therapy. *The New England Journal of Medicine*, 364, 1695–707. doi: 10.1056/NEJMoa1010846
- Radley, A. (1993). The role of metaphor in adjustment to chronic illness. In A. Radley (Ed.), *Worlds of Illness: Biographical and Cultural Perspectives on Health and Disease* (pp.109–123). London: Routledge.

- Radley, A. & M. Billig (1996). Accounts of health and illness: Dilemmas and representations. *Sociology of Health Illness*, 18, 220–240. doi: 10.1111/1467-9566.ep10934984
- Rapley, T. (2008). Distributed decision making: the anatomy of decisions-in-action. *Sociology of Health & Illness*, 30, 429–444. doi: 10.1111/j.1467-9566.2007.01064.x
- Rampton, B., K., K. Tusting, et al. (2004). *UK Linguistic Ethnography: A discussion paper*. UK Linguistic Ethnography Forum. Retrieved from www.ling-ethnog.org.uk
- Rosenfeld and Weinberg (2012). Domestic practice, situated contingency, and adherence to medical directives: A call for research. *Social Theory and Health*, 10, 42–60. doi:10.1057/sth.2011.9
- Rosner, F. (1981). Moses Maimonides' treatise on asthma. *Thorax*, 36, 245–251. doi:10.1136/thx.36.4.245
- Salter, B. (2004). *The new politics of medicine*. Basingstoke: Palgrave Macmillan.
- Salter, H. H. (1860). *On asthma: its pathology and treatment*. London: John Churchill.
- Scollon, R. & Scollon, S. W. (2004). *Nexus analysis: discourse and the emerging internet*. New York, London: Routledge.
- Silverman, D. (1997). *Discourses of counselling: HIV counselling as social interaction*. London: Sage.
- Sontag, S. (1991). *Illness as metaphor and AIDS and its metaphors*. London: Penguin.
- Taylor, D. & M. Bury (2007). Chronic illness, expert patients and care transition. *Sociology of Health & Illness*, 29, 27–45. doi: 10.1111/j.1467-9566.2007.00516.x
- Timmermans, S. & Epstein, S. (2010). A World full of Standards but not a Standard World: Toward a Sociology of Standardization. *Annual Review of Sociology*, 36, 69–89. doi: 10.1146/annurev.soc.012809.102629
- Trostle, J. (1988). Medical Compliance as an Ideology. *Social Science & Medicine*, 27, 1299–1308. Retrieved from [http://dx.doi.org/10.1016/0277-9536\(88\)90194-3](http://dx.doi.org/10.1016/0277-9536(88)90194-3)

Vermeire, E., Hearnshaw, H. Van Royen, P., & Denekens, J. (2001). Patient adherence to treatment: three decades of research. A comprehensive review. *Journal of Clinical Pharmacy and Therapeutics* 26, 331–342. doi: 10.1046/j.1365-2710.2001.00363.x

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