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0 Introduction

As it is widely known, communication is not limited to a verbal interaction between two or more interlocutors; rather, it occurs at a multiplicity of levels, including proxemics, body language, and the characteristics of the space where communicative interactions occur. This study, however, centres around one very specific feature of communication that addresses linguistic concerns in doctor-patient interactions and possible solutions to emerging communicative problems when delivering critical information.

Some linguists, like Erving Goffman or Deborah Tannen, claim that our lives can be seen as a series of conversations through which we establish our relationships with the world. This implies that our conversations mirror other aspects of our lives, i.e. our personality, our culture and our presuppositions

about what surrounds us. The linguists' aim is, therefore, to discover and explain how these concealed aspects can be retraced throughout our speech. This is not, however, the only purpose in the field of spoken discourse, because, throughout the years, several varieties of discourse analysis have developed from different disciplines. The result is that the inner mechanisms of the human communicative processes are still a controversial topic among linguists, and the definition of a universal pattern for the analysis of talk seems a distant goal.

Discourse analysis is a general term describing the researchers' efforts to obtain a systematic method for an analytic approach to spoken data. At the moment, discourse analysis is an independent discipline, but its many topics and theoretical frameworks originate from anthropology, philosophy, sociology and linguistics. Later, it developed in different directions, according to which particular concern became central during the analysis of speech data. For example, the "speech event", i.e. a job interview or a seminar, is the main concern of the ethnography of speaking, while the orderliness of interactants' talk is the main concern of conversation analysis.

Talk is usually divided into ordinary talk and institutional talk. Ordinary talk refers to these conversations which occur in a more or less casual context, such as at home, among parents and children or among friends. Throughout the years, it has been considered as the most "natural" form of discourse because of its spontaneity, and consequently it has been considered the most interesting to be analysed. Institutional talk, instead, refers to these conversations which ordinary people have with professionals, such as teacher-student or doctor-patient interactions. Institutional talk is natural as well because it is not simulated for the purpose of research and it is recorded in the setting in which it occurs. Institutional talk is asymmetric, because the participants do not have equal power, status and responsibility during the interaction, i.e. one interactant conducts the talk and the other only has to follow

him or her. Sometimes, its degree of asymmetry can even cause problems for the institution itself.

Doctor-patient interaction is a typical example of institutional talk where participants are positioned asymmetrically. This is evident in everyday experience: when people go to the doctor, they go for advice or for the treatment of an illness and this implies that they address the doctor as an institutional figure who has more extended knowledge than theirs and from whom they expect a service. Institutional talk can be very controversial, because sometimes it seems that patients and doctors belong to different worlds, with no reciprocal understanding during their interaction.

The present study focusses on a particular type of doctor-patient interaction: paediatric surgical visits. These are a special kind of interaction which are problematic for a variety of reasons. First of all, the patient is a child, sometimes a very small child, and the parents are responsible for the operation that will affect him/her strongly. Secondly the operation is on their child, not on themselves, and operating or not is an extremely difficult decision to take. Parents see themselves as adults who can face the impact of the operation, together with its risks and consequences, but they perceive their child as a helpless creature. The surgeon has to face all these implications during the visit, together with the high emotions which usually overwhelm the parents as soon as he conveys the decision to operate on the child. Therefore, this type of visit is difficult not only for the parents but also for him.

The purpose of the research is to ascertain if there exists a pattern to the paediatric surgical visit, if there are moments of the interaction when problematic points usually occur, and, if so, why they occur, how they are revealed, and if it would be possible to avoid them or, at least, to reduce their effects on the interaction itself. Therefore, an analysis of real interactions in a medical settings is performed in order to ascertain how information is exchanged between the surgeon and the parents, and to what extent the way the information is conveyed affects the interactions.

1 Reading the database

In order for the research to be carried out, a database was to be collected of interactions recorded in a surgery, and permission was needed to do so, of course. Two surgeons, two GPs, one psychologist, and one physiotherapist were contacted, in order to conduct the research in at least one of these contexts. Unexpectedly, all the contacts were interested in the research, but the one eventually chosen, the first surgeon contacted, was the one who completely satisfied the purposes of the investigation. He had also specialized in paediatric surgery; therefore his visits were exactly the kind of interactions wanted for the analysis.

The surgeon was also very helpful, because he allowed the visits to be audio-recorded immediately after having explained to him the purpose of the research.

1.2 Hospital visits and private visits: two worlds apart

The database consists of almost one hundred surgical visits, recorded over a total of eight days at the surgeon's paediatric hospital and private surgery, as mentioned above. He usually does a surgery for his patients once a week in each of the two contexts, but many differences arise between these two types of medical visit.

First of all, the small surgery at the hospital is always overcrowded. There is the surgeon, a nurse, his assistant, and some trainees. The children were, moreover, usually accompanied by both parents, and some other doctors sometimes entered the room. Instead, the private medical surgery was more spacious; the surgeon always conducted his visits alone and there were no assistants with him.

The second difference was that more than twenty patients were waiting outside the surgery in the hospital each time, and the visiting hours usually lasted about three hours. On the other hand, twenty visits were usually scheduled for the private surgery, and the visiting hours could last five hours or even more. The striking differences in the length of the visits can have three different explanations. The first is that the young patients who go to the hospital surgery usually have to undergo an operation in 90% of the cases. Their visits are the last phase in the medical iter, for their paediatricians have already signalled their problem and have suggested that they should undergo a visit by a surgeon, who will check the nature of the problem. The patients have already done all the examinations including the echography, so that the surgeon's decision is crucial: he will decide whether they have to undergo an operation or not.

These visits are, therefore, the final phase, and the surgeon only has to check the tests, examine the children and decide whether to operate or not. When the symptoms are clear, he decides quickly,

but if they are not, he prefers to see the young patient again, usually in a fortnight's time. The patients who go to his private surgery, instead, go there for advice about their pathology and to gather more information about whether they should undergo an operation or not. The visits are seldom brief because the surgeon gives them a detailed description of their pathology and what an operation would imply, since he wants to be sure that they have all the necessary information in order to face the prospect of an operation calmly.

The second explanation for this difference lies in the nature of the two types of visit. While the hospital surgery offers a public service, i.e. a small sum has to be paid, the visits in the private surgery are private consultations, i.e. where the patients have to pay a fairly large sum for the medical service they receive. Consequently, as the surgeon himself declared in the follow-up of the study, patients expect a longer visit which justifies the increased expense. They decide to pay for a specialist's advice in a private practice and so he should provide a longer service than in the public one. The third explanation depends on a very practical reason. The visiting hours allowed at the hospital are limited, whereas the hours available at the private surgery may vary according to the patients' different needs.

Finally, one of the basic differences between the public and private surgery "service" depends on the age of the patients. At the hospital surgery, the patients are only small children to teenagers, whereas those in the private surgery are people who go there asking for a private consultation and may vary from teenagers accompanied by their parents to adults to old people. The range of pathologies also widens. The most frequent pathologies at the hospital surgery are malformations of the penis (adhesions, short fraenum), hydrocele, retention of the testicles and small hernias, while the pathologies at the private surgery also include various types of tumours, haemorrhoids and any sort of pathology which requires an operation.

2 | Frame Analysis and Conversation Analysis

A combined methodological approach using some specific tools and concepts of Frame Analysis and Conversation Analysis is used to analyse the database of visits collected. This section will outline the methodological background applied to the study. Conversation Analysis is founded upon the idea that an important area of meaning in an interaction is revealed through the sequences of talk (Cameron 2001; Maynard – Heritage 2005; Hutchby 2019; Pallotti 2007). Along with this theoretical framework, the analysis of the database was first performed using Conversation Analysis to detect a general linguistic pattern in interactions. The concepts of adjacency pairs and dispreferred second acts, and of sequential implicativeness lay the foundations to the study.

Transcription conventions

- [] squared brackets indicate overlapping voices, i.e. two voices are heard at once;
- = the equal sign indicates latching cues, i.e. there is no pause between lines;
- /?/ indicates inaudible words;
- ? indicates a question;
- ↑ ↓ indicate respectively rising and falling intonation;
- (.) indicates a brief pause, lasting less than a second;
- (3.2) indicates the duration, in seconds, of a pause (e.g.: 3.2 sec);
- : following vowels indicates elongation of the sound;
- (()) indicate the actions performed while speaking;
- { } indicate whispered or bad audible utterances;
- // one word or more in slashes indicate a possible transcription;
- one or more underlined syllables indicate higher tone of voice;
- indicates that talk continues without interruption on succeeding lines of text.

3 | Five phases of doctor-patient interactions

3.1 One: establishing contact with parents

The contact with the parents of the patient is the start of the interaction, which is achieved through greetings. The surgeon asserts that both the initial and the final greetings are a basic element for a well-built interaction because they indicate mutual respect, which, according to him, is the basis of every interpersonal relationship. This phase tends, however, to be rather brief, not only in the hospital because of the short time available, but also in the private visits, probably because the parents themselves do not want the surgeon to waste his time.

The following example is taken from interaction 1, which occurred in the hospital:

EXAMPLE 1. INTERACTION 1, HOSPITAL:

ESTABLISHING CONTACT WITH PARENTS.

(*S: surgeon; F: father; N: nurse; A: assistant*)

S: buongiorno (.)
good morning (.)

F: buongiorno::=
good morning::=

N: = [buongiorno]?/ il dottor ((omitted)) (.)
= [good morning]?/ doctor ((omitted)) (.)

A: [buongiorno]
[good morning]

S: buongiorno=
good morning=

F: =buongiorno (.)
=good morning (.)

[...]

The parents greeted the surgeon and his team and then they immediately shifted to the second phase of the interaction stating the reason why their child had to undergo that surgical visit.

The same movement happened at the beginning of interaction 4 in the hospital:

EXAMPLE 7. INTERACTION 1, HOSPITAL:**THE CLOSING SEQUENCE.***(S: surgeon; A: assistant; F: father; M: mother)*

[...]

S: = [scusate il nu]mero del cellular[e se avete bi]sogno=
 = [sorry my cell] phone number if [you need to] call]=

M: [buongiorno] [ah(.) grazie]
 [goodbye] [ah(.) thank you]

F: =si (.) grazie (.)
 =yes(.) thanks (.)

S: *prego (.)*
 you're welcome (.)

M: *arrived[erci]*
 good[bye]

F: [arriv]ederci=
 [good]bye)=

A: =arrivederci
 =goodbye

[...]

In this case, the surgeon provided his mobile number to the parents, who thanked him, greeted him and left the surgery. However, despite its brevity, the closing sequence of the interaction is crucial, because it conveys whether the interaction has had a positive or a negative outcome. The positive outcome can originate from the fulfilment of the participants' structures of expectation, despite a possible initial conflict between them, which can be solved as the interaction develops. This solution is possible if their knowledge schemas accept new information and revisions at the actual moment they are faced with them.

Otherwise, conflicts between the structures of expectation are not solved spontaneously. When they originate, they can affect the interaction in various ways. For example, the surgeon can feel the parents misunderstand his suggestion, while the parents may perceive themselves as incapable of convincing the surgeon of the seriousness of their child's problem, and therefore they feel offended by his refusal to operate.

4 | Assessing conflict in the database

Until now the sequences of speaking turns have been analysed at those points where it was possible to retrace a standard pattern for all the interactions examined. However, if these developed according to a well identifiable pattern, some other interactions showed a lack of orderliness in some of their phases which made them hardly possible to be examined along an expected sequence of speaking turns. This always implied that there was an underlying communicative problem which prevented one speaker from understanding what the other's expectations while speaking were: thus, the reciprocal effective verbal exchange was missed.

5 | Avoiding communicative mismatch: a proposal

After the detailed analysis of the five phases of the visits, the focus will now be on the information exchange between the surgeon and the parents. As previously claimed, the information exchange occurs during the fourth phase of the visit, which appears as the most problematic moment of the consultation. However, there is a significant difference between the hospital and the private visits in this case as well. The private visits do not reveal particular problems during their fourth phase. The surgeon spontaneously tends to convey more information about the young patient's pathology and about the operation throughout the whole visits, even if these information are mainly concentrated after the diagnosis.

5.6 Final remarks and future research possibilities

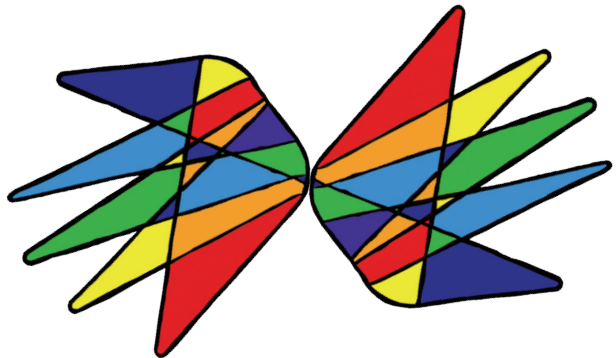
The analysis presented in this study was applied to a small database of paediatric surgical visits collected in an Italian public surgery for the purpose of a small-scale pilot study. Data emerged from the transcription of the interactions were analysed in their organisational structure drawing from the tools of Conversation Analysis and applying the concepts of adjacency pairs, preferred/dispreferred seconds and sequences to, first, segment interactions in a pattern of five phases, and, second, to single out those turns where communicative problems arose. Conversation Analysis helped to locate where communicative issues occurred in the interactions; then, the concept of frame and of structures of expectations were used to examine the problematic points of the interactions to understand how and why communicative issues originated, and to verify if solutions could be applied to prevent them from happening, without exceeding the extremely limited time available to each visit. Based on the most recurrent questions from the parents, a possible solution suggested to the surgeon is to add some small pieces of information while delivering the diagnosis: the type of anaesthesia (whether partial or total); the pre-operating tests needed; something about the pathology (what it is caused by; its name; its features). Despite its limited scope, this study contributed to show that further research in more public healthcare paediatric surgical facilities is needed to provide more structured suggestions to improve the experience of paediatric surgical visits for all their participants.



Part II

Appendix:

1. Transcriptions of the hospital visits
2. Transcriptions of the private visits



The interactions presented in the pages that follow were intentionally left in Italian. They represent selected additional support for those readers who want either to expand the co-text of the examples cited in the first part of the book, or to have access to all the complete interactions available for the study, and read them as they were originally collected when creating the database.

Transcription conventions

- [] squared brackets indicate overlapping voices, i.e. two voices are heard at once;
- = the equal sign indicates latching cues, i.e. there is no pause between lines;
- /?/ indicates inaudible words;
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- one or more underlined syllables indicate higher tone of voice;
- indicates that talk continues without interruption on succeeding lines of text.

I. Transcriptions of the hospital visits

TRANSCRIPTION 1, HOSPITAL.

(S: surgeon; N: nurse; N2: second nurse; A: assistant; F: father; M: mother;
Pt: patient)

- S: buongiorno(.)
 F: buongiorno:: =
 N: = [buongiorno]/?/ il dottor ((omitted)) (.)
 A: [buongiorno]
 S: buongiorno=
 F: =buongiorno (.)
 S: {e gli ho fatto fare il posizionamento del testicolo più in basso}(.) mi dica† (.)
 F: l'ha guardat[o:::] il dottore: e mi ha detto di farlo vedere da lei→
 S: [si†]
 M: →il pipi[no::]
 S: [moti]vo? (.)
 M: c'ha il pipino chiuso: (.) ha detto=
 S: = [si]
 F: [/?]=
 N: =l'impegnativa non ve l'ha fatta il→
 →dottor ((omitted))?=
 N2: =mah (.) glien'ho messe un pacco di là: io 'un so [/?]
 F: [/?] non lo
 so [se](.)
 N2: [non] lo so(.)
 F: via (.) bisogna spogliarlo [/?](.)
 M: [/?] (.)
 S: dove abitate voi?=
 F: = a ((omitted)) (.)
 M: [/?] dammi una mano=

- F: [/?/] =una mano si=
 S: =non l'avete mai aperto? (.)
 ((The surgeon has just begun the examination of the child))
 F: ma=
 M: =ma↑ io::m[a](.) l'ho: sempre:: guardato:: (.)
 F: [ma]
 Pt: ah (.) [ahia↑ Aa::↑ (.) ahia]
 F: [ecco buono buono] oh::: [/?/]
 S: [ha il] frenulo un pochino corto [vero] (.)
 F: [mh] (.)
 M: [mh] (.)
 S: si v[ede eh /?/]
 Pt: [ahi::↑ ahia:↑] mam[ma::↑]
 F: [buo]nhbuono
 M: [/?/]
 N: [fatto] cucciolo↑
 Pt: ahia(.) ahia:=
 F: =ee::=
 S: =vedi(.) ho fatto (.) ho già finito=
 F: = allora::non c'è→
 →niente::=
 S: =m[mno:: bisognerebbe::] (.)
 M: [((omitted)) vieni qui: vieni↓]
 S: fare una plastichina del frenulo perché l'ha un pochino corto sennò quando non gli→
 si apre be::ne se si apre si lacera tutto(.)
 M: e allor[a:↓]
 S: [e:: ni]ente (.) si mette in lista lo facciamo eh?(.) va bene? Vi dico io→
 →qu[ando è possib]ile(.)
 Pt: [attento babbo]
 F: ma guarda che mace::llo (3.2)
 Pt: oh↑=
 M: =t'ha fatto male è cattivo il dottore eh? /?/
 N: lo prendo (.) di qui sotto:: (.) se la trovo (.) sì ce l'ho (.) io gliela faccio→
 →l'impegnati[va il] dottor ((omitted)) non lo trovo /?/ mi dà la→

- F: [sisi]
 N: →data di nascita? (.)
 F: ee:: il ((omitted))=
 N: =nome=
 F: =((omitted))=
 N: =e:: dov'è nato?=
 F: = a ((omitted))=
 N: = è nato a ((omitted)): (.)
 S: dovremo fare un allungamento del frenulo perché è corto e non gli si apre bene→
 →davanti (.) eh↓
 M: no(.) è la prima volta che ci=
 F: = lo deve addormentare tutto?=
 M: =lo deve addormentare→
 →tutto:?(.)
 S: e:::locale i bambini:: nono::n si fanno di s[olito]
 M: [sa per]ché a noi non c'è→
 →mai successo nient[e ci] capit[a pe]r la prima volta (.)
 S: [eh] (.) [eh] (.)
 S: locali no:non si fanno mai ai bambini=
 F: =no:(.)no(.)
 S: non stanno fermi (.) gli si fa un'anestesia brevissima [/?/]
 F: [/?/]
 M: [/?/]
 Pt: [ahi](.)[ahi↑]
 S: si (.) viene qui la mattina:: si opera e poi la sera:: può andare a casa→
 →(.) o il giorno dopo: vediam-vediamo: /?/=
 M: = siamo andati::hhh nel pallone(.)
 ((she giggles))
 S: allora (.) l'interventino lo faremo il (.) giorno quattro: (.) di novembre: eh? La mattina
 martedì mattin[a]
 F: [al] mattino=
 S:=digiuno lo portate: (.)con degli esa:mi che ora vi daremo [/?/]
 M: [e noi gli si] porta tutto
 quel giorno eh? (.)

N: venite (.) vi faccio vedere dove=

M: = [si]

F: = [si]=

S: = se mi chiama intanto l'altra:?=

N: = per ora noi →

siamo a posto eh? (.) 'ndiamo ciccio? (.) ssera →

→arrivato a: =

S: = [scusate il nu]mero del cellular[e se avete bi]sogno=

M: [buongiorno] [ah(.) grazie]

F: = sì (.) grazie (.)

S: prego (.)

M: arrived[erci]

F: [arriv]ederci=

A: =arrivederci