

## Theme-oriented discourse analysis of medical encounters

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**APPROACH** Theme-oriented discourse analysis looks at how language constructs professional practice. Recordings of naturally occurring interactions are transcribed and combined with ethnographic knowledge. Analytic themes drawn primarily from sociology and linguistics shed light on how meaning is negotiated in interaction. Detailed features of talk, such as intonation and choice of vocabulary, trigger inferences about what is going on and being talked about. These affect how interactants judge each other and decisions are made. Interactions also have larger rhetorical patterns used by both patients and doctors to persuade each other.

**EXAMPLES** Two settings are used to illustrate this approach: genetic counselling and primary care consultations in multilingual areas. In genetic counselling, interactions are organised around the tension between the risks of knowing and the risks of occurrence. This can lead to a 'rhetorical duel' between health professionals and patients and their families. In intercultural primary care settings, talk itself may be the problem when interpretive processes cannot be taken for granted. Even widely held models of good practice can lead to misunderstandings under these conditions.

**CONCLUSION** Through discourse analysis, the talk under scrutiny can be slowed down to show the interpretive processes and overall patterns of an activity. Discourse analysts and health professionals, working together, can look at problems in new ways and develop interventions and tools for a better understanding of communication in medical life.

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### INTRODUCTION

'Discourse is a level or component of language use, related to but distinct from grammar. It can be oral or written and can be approached in textual or sociocultural or sociointeractional terms. It can be brief, like a greeting and thus smaller than a single sentence, or lengthy, like a novel or narration of personal experience.'<sup>1</sup>

The notion of 'discourse' encompasses, at a macro level, kinds of knowledge that regulate our thinking, such as discourses of pain or sexuality. At the most micro level, it includes the largely unconscious ways in which we process text and talk. This breadth allows for many different approaches to discourse analysis (hereafter DA), including discursive psychology and conversation analysis. General overviews of DA from a linguistic/sociolinguistic perspective exemplify this breadth.<sup>2–6</sup>

The value of looking at discourse rather than, for example, inner psychological states or more general notions about beliefs, attitudes or behaviour is that language is *a way*, and often *the way*, in which many everyday activities are conducted. Language does not just reflect or express intentions or decisions (the representational role of language); it makes them (the constitutive role of language). In institutional encounters, talk *is* work. In this paper we illustrate what we call a theme-oriented strand of DA that is particularly suited to analysing talk and

## Overview

### What is already known on this subject

Both discourse analysis and conversation analysis are becoming better known in the medical field. However, discourse analysis, in particular, is not easy to pin down because it covers so many levels and types of language and knowledge.

### What this study adds

A theme-oriented approach links analytic themes from linguistics and sociology to focal themes relevant to a professional domain, such as shared decision making or intercultural misunderstanding. Both the detail of moment by moment inferencing and larger rhetorical patterns are analysed to shed light on how meaning is negotiated and judgments made in interaction.

### Suggestions for further research

Any aspect of medical interaction is susceptible to this approach, particularly more patient-oriented concerns.

text in professional and institutional settings (for an overview of DA in medical and health care settings, see<sup>7-15</sup>). We use 'theme-oriented' both in the sense of analytic themes such as frames, footing and facework (see below) and in the sense of focal themes such as (shared) decision making. These, in turn, connect to wider issues of professional practice with a critical stance; for example, the social consequences of living with or without a medical label, and health inequalities more generally. In the rest of the article we focus on talk in medical consultations but the approach is equally relevant to other settings and to the analysis of text. We discuss, first, methodological concerns and key analytic themes. These are both illustrated in example 1. Example 2 shows the way that discourse is organised rhetorically and the impact this has on clinical assessment and decision making. The final example traces misunderstandings in intercultural consultations and discusses how these examples challenge textbook prescriptions of good communication.

## METHODOLOGICAL CONSIDERATIONS

Like other interpretive approaches, DA combines the recording and transcribing of naturally occurring interactions with ethnographic techniques of observation and interviewing. The initial period of ethnographic research identifies the 'communicative ecology' of a particular setting; for example, the identity of participants (e.g. ethnicity, age, gender), what gets talked about (e.g. flow of topics) and in what ways (e.g. tone of voice, directness). Speakers bring to an interaction ideologies, values and beliefs about how people are categorised and these feed into the ways in which participants are treated and decisions are made, without necessarily being explicitly displayed in the interaction. For this reason, it is important to understand the local circumstances and the wider discourses that circulate in the organisation before recording and interpreting discourse data.

As a result of these initial ethnographic insights, and with the initial problem in mind, key interactions are audio- or video-recorded. The first stage in analysing the data is the repeated listening to or viewing of these recordings. This leads to identifying the phases of the interaction that make up the whole. Distinct phases are identified by examining the content, the prosodic cues (including intonation, rhythm, pausing), non-verbal cues and other markers that research in the interactional sociolinguistic tradition<sup>16</sup> has shown people rely on to make inferences.

The second stage of the analysis involves transcribing the data (with line or turn numbers), using transcription conventions at different levels of fineness depending on the features of difference between participants and our own thematic focus<sup>17</sup> (see Appendix). The next stage is to go back to the whole interaction, examine its outcomes and, wherever possible, gain feedback from participants on their interpretation of the events. The final stage of the analysis involves a process of constant reading and re-reading of transcripts, informed by linguistic, sociological and cultural concepts that include those described below. This then leads either to case studies of whole interactions, or comparative analysis of distinct phases of an interaction across a larger amount of data.

The selection of data to transcribe depends partly on a problem-based thematic approach and partly on initial ethnographic observation. Consider, for instance, the focal theme of possible misunderstandings in intercultural communication in the following example.

### Data example 1

A mother (whose first language is Twi, a language of Ghana) has come to have her 8-week-old baby checked at the baby clinic. The general practitioner (GP) already knows she has 3 daughters. The GP punctuates the silence of the physical examination with brief sequences such as the following:

- 1 D so your 3 daughters must *love* having little babies  
 2 P (1)  
 3 3 D your other children (.) the girls do they help you with =  
 4 P = yeah the first one help me  
 5 D I bet  
 6 D ((you're very lucky having all those sisters (..) yes))  
 ((D turns to address the baby))

D then continues to examine the baby.

We notice here the mother's lack of uptake of the GP's comment (at line 2 where there is a 1-second pause) until it is reformulated and becomes a much more direct question (line 3). The patient then latches on immediately to the question and gives a relevant response (line 4). This moment of 'trouble' suggests a problem of understanding. Before analysing the data further, we will outline some key analytic themes used in DA.

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## ANALYTIC THEMES

A number of analytic concepts, drawn primarily from linguistics and sociology, provide the theoretical backdrop. All of them relate to the overarching preoccupation with how meaning is negotiated and how the outcomes from these negotiations feed into assumptions and knowledge.

### Interactive frames and footing

Framing works as a filtering process or membrane through which general values and principles of conduct are reworked to apply to the particular encounter in hand.<sup>18</sup> These frames trigger inferences by constructing possible scenarios. For example, doctors may have different frames from patients as to what counts as healthy or not.<sup>19</sup> Related to this is the idea of 'footing'.<sup>20</sup> Goffman reworked the general idea of 'putting something on a proper footing' to

describe the way in which during an interaction the roles and relationships of participants can change. He also talks about 'participant frameworks' in which people align themselves to others by the way they manage their talk in the context of a given activity.<sup>21</sup>

### Contextualisation cues and inferences

Talk only has meaning in context and this has to be actively constructed as the interaction proceeds. Contextualisation cues are the hidden underbelly of this meaning making. They are the signs that invoke the context that gives each utterance a specific meaning. They channel the inferencing processes in a particular direction by calling up the frames and affecting the footing of each moment of an interaction.<sup>22,23</sup> These linguistic and prosodic signs include words such as 'so' and 'well', intonation, stress, pausing and rhythm. They tend to be used unconsciously and their function in establishing or reinforcing social relations and negotiating shared meaning goes largely unnoticed.

### Face and facework

There is a ritual element to interaction that is concerned with the fragility of social relations. We spend a lot of time in talk 'saving face' – both our own and that of others. This is largely done through politeness strategies which determine how direct or indirect to be and how far to claim relative closeness and informality or relative distance and formality.<sup>24</sup> Disagreeing with more powerful people or managing uncertainty, for example, involve politeness strategies. So, a stark request or attempting to challenge or disagree are softened, or mitigated, by phrases such as 'I think' or the use of auxiliary verbs such as 'could' or 'would'.

### Social identity

Our social identity includes our gender, our social standing, regional and ethnic backgrounds and so on. These identities are *brought into* the encounter but are also *brought about* in it. For example, we can make our powerful status or our ethnicity more or less relevant in the interaction. This 'performed social identity'<sup>25</sup> affects how we get along together in an encounter and how we judge each other. Shared ways of speaking or finding something in common can oil the wheels of the interaction and create a positive assessment of the other.

### Rhetorical devices

Rhetoric is the use of language to influence or persuade. Although associated with political

speeches (Martin Luther King's 'I have a dream' is perhaps the most famous modern example), these patterns of argumentation are used routinely as part of institutional encounters. Rhetorical devices include the organisation of talk around contrasts, repetition of words and grammatical structures, metaphor, analogy, reported speech and lists (often of 3 items). Rhetorical devices and styles are often crucial in the assessment of speakers and, in medical settings, of patients and their conditions.

Let us revisit data example 1 to illustrate some of these analytic themes. As the GP examines the baby, her comment, in line 1, sets up the *frame* of 'having a chat' about the rest of the patient's family, but like many utterances it may also have another function: in this case, to check that the mother is managing at home. So the frame should trigger inferences that encourage the patient to talk about life at home and in this way share information with the doctor about older girls loving to look after younger siblings (or not!). The 'having a chat' frame also shifts the doctor–patient *footing* so that the relationship is more like that of 2 equals having a conversation. This frame is marked by several *contextualisation cues*: the marker 'so' at the beginning, the emphasis on 'love' and the falling tone on 'babies'. 'So' marks a shift in topic, 'must love' suggests informality and relative closeness and the falling tone marks a statement rather than a question (of the kind which doctors usually ask patients). These cues, that there is a shift in context, are all conventions used unconsciously to call up assumptions about informal doctor–patient relationships. The patient does not appear to pick up on the contextualisation cues, or infer the purpose of the doctor's remark, and she may be unfamiliar or uncomfortable with the idea of chatting with the doctor. Also worth noting is the doctor's on-record, positive orientation to the mother's *face*, with the remark to the baby, but with the mother as the intended audience: 'You're very lucky having all those sisters'.

The mother's initial silence, however, causes the GP to reformulate in a more doctorly way and so shifts the footing back to a question and answer session within the frame of 'physical examination'. This fleeting moment in the interaction has not gone smoothly. In such an encounter, these less than comfortable moments may be insignificant. However, patients and doctors are more likely to feel satisfaction and reach shared agreement about how to proceed if the basic building blocks of under-

standing are in place or at least repaired as soon as trouble is located.

What can be seen from the above discussion is that DA is sensitive to the unfolding argument of the whole encounter and the patterns of interaction that this reveals. One way of identifying this is through a process of thematic mapping in which the content of the encounter is related to the interactional and rhetorical organisation of it.<sup>26</sup> This is illustrated in data example 2, which, like many medical encounters, is multiparty and deals with uncertainties. Discourse analysis is also sensitive to the processes of interpretation that help people to negotiate meaning, illustrated in data example 3. Both examples, in different ways, illustrate the problems inherent in attempting shared decision making, which involves shared understanding and reciprocity of perspectives. Both are complicated by social and clinical factors, but of very different natures. In both cases, our interpretive process is helped by the ethnographic knowledge we have obtained from the setting and participants over a period of time via interviews, observations, informal conversations, etc.

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## (NON-)DIAGNOSTIC REASONING IN GENETIC COUNSELLING

Genetic counselling has been characterised as a hybrid activity situated between mainstream medical consultation and other types of counselling and therapy consultations.<sup>27</sup> This hybridity is manifest at the interactional level, especially when there is uncertainty about one's genetic status and there is the need to strike a balance between *risks of knowing* and *risks of occurrence*.<sup>28</sup> Uncertainty about diagnosis can be challenged by clients, who tend to expect certainty, with the assumption that naming a condition leads to cure, and by extension, delaying naming amounts to delaying treatment. The extract below deals with a situation where it is difficult to apply a diagnostic label that accounts for a child's behaviour patterns and skills development.

### Data example 2

The extract begins about 3.5 minutes into the session, which is attended by the child-patient (C), her mother (M) and grandparents (GF and GM). In addition to the geneticist (GEN), a nurse specialist and the researcher-observer are also present.

- 1 GEN okay I (.) yeah I mean (.) just from looking at her  
 2 GF <sup>o</sup>you don't think<sup>o</sup>  
 3 GEN I I don't think she does have it  
 4 C [((babbling))]  
 5 GEN 'cause er (.) I I can absolutely see why it crossed ((name of doctor's)) mind  
 6 M mm  
 7 GEN and er and like I said I think when when ((name of child)) came in it it sort of crossed my mind in a very quick sort of way =  
 8 GF = mm that's what she said =  
 9 GEN = as (.) as a poss- as just a possibility but (.) but looking at her (.) moving about she's actually rather more (.) steady on her feet =  
 10 GF steady =  
 11 GEN = rather a lot of (..) yeah (.) whereas a lot of (.) children with Angelman syndrome at her age (.) wouldn't be (.) still wouldn't be as good on their feet as she is and  
 12 GM she's still off balance a bit though  
 13 GEN oh yes  
 14 GF she's you know she's not as steady as as a with the you know normal children =  
 15 GEN I can see she's got a little bit of a (.) [problem] with balance and so =  
 16 GF [yes yes]  
 17 GEN = on but (.) but I think she's better than children with Angelman's syndrome usually would be (..) and also they often have a particular look (.) in their [face]  
 18 M [their face]  
 19 GEN which she doesn't really have (.)  
 20 GF mm  
 21 GEN and (.) and the blood test doesn't (.) *prove* she doesn't have it  
 22 GF mm  
 23 GEN because it it only shows up in about 80% or so of (.) children with Angelman but but I think the other (.) with her not having the other features of it th- then then I wouldn't be going down that road (.) ((general background noise 1.0))  
 24 GM with regard to the eyes rolling back  
 25 GF oh yeah that's right [that's what I was going to say to you] when she =  
 26 GM = [her eyes roll back]  
 27 GF = it's often when she eats and when she gets tired her eyes roll in the back of her head a lot (.) it's only the past year she's been doing this now

In the opening phase of the encounter (not shown here), GEN explores the background and agenda of the session, and the family members indicate that they are expecting GEN to decide whether the child has Angelman's syndrome (AS) or not, mainly based on the child's babbling noise and the referring doctor's assessment (turn 5). In turn 9, GEN introduces a contrast between the 'babbling noise' and the child's physical movement. The contrast helps to bring out the differences between the referring doctor's initial assessment and GEN's evidence-based explanation. As far as GEN is concerned, speech delay is a single factor among many to be accounted for in diagnostic reasoning about AS. This can be referred to as the part-whole categorisation which underpins much of (non)diagnostic reasoning in genetic counselling. The part-whole reasoning may be formulated as 'A has X but he or she doesn't have Y', where both X and Y have to be present to merit membership within a category.

In what follows, different weight is accorded to different types of evidence through the rhetorical

devices that organise the discourse. GEN moves to consider other physical features, which also do not fit into AS. There is evidence of shared understanding about the child's steadiness on her feet, which is worked up by GEN to reaffirm his earlier assessment of non-diagnosis of AS. The contrast here is explicit: the child is 'more steady on her feet', whereas 'children with AS at her age wouldn't be as good on their feet as she is' (turn 11). In turn 12, GM signals disagreement by drawing attention to the child being 'off balance', followed by GM's contrast of the child with normal children. Keeping with the part-whole categorisation, GEN shifts his gaze to other features such as 'look in the face' in his attempt to keep the contrast focused on what is known about AS.

The entire session from which we have taken this data extract can be mapped as a contrastive list of behavioural and physical features associated with AS: physical balance, seizures, eating habits, play patterns, look in the face, etc. In each case the prototypical features of AS are used by the counsellor

to offset the contrast between the child and ‘normal children’ used by the grandparents. The overall mapping of the encounter shows a kind of rhetorical duel, where GEN gives reasons for non-diagnosis and the clients partially agree with GEN’s assessment, followed by the clients offering new symptoms (e.g. eyes rolling back, turn 24) as a way of pushing GEN to rethink his earlier assessment and so on. GEN’s expert explanation poses a challenge to the clients’ demand for a diagnostic label, supported by any other medical assessments prior to this occasion. In the post-clinic interview, however, GEN stresses the need for second opinions (e.g. discussion of the physical features of C with colleagues), while acknowledging individual differences within the profession: ‘...people will be able to be quite sure about a diagnosis and a child’s growing into a diagnosis sooner than others’.

The relative uncertainty on both sides is indicated by high levels of mitigation. This is striking in the clients’ shared perspective and disagreement surrounding GEN’s assessment of the child’s condition. It is matched by the mitigation from the counsellor, given the uncertainty in offering a diagnostic label. This mitigation represents part of the face-saving strategies used by both sides. What we find in such negotiations for/against a definitive diagnosis includes the interplay of the expertise of the health professional (e.g. clinical reasoning), the appeal to expert peer group networks (also used as resource by clients to either endorse or challenge a given assessment) and the use of direct evidence from expert systems (e.g. blood test results). This interplay is constructed through rhetorical devices such as reported speech, contrast and listing. As we have begun to show, they play an integral part in determining the process and outcome of such encounters.

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### SHARED UNDERSTANDING IN INTERCULTURAL PRIMARY CARE SETTINGS

Primary care settings, where time is at a premium, provide less scope for exploring patients’ concerns than genetic counselling and some kind of decision must be arrived at rapidly. Added to this is the element of cultural and linguistic diversity in contemporary societies, where not only have health care providers been recruited internationally, but the patient population is diverse in its linguistic and cultural backgrounds. Such diversity may not allow for a smoothly structured interaction. For instance,

the telling of symptoms can be a long and diffused process.<sup>29</sup> For shared decision making to be effective in intercultural settings, GPs and patients need to orient themselves to potential misunderstandings and try to repair them without delay.

Different ethnic groups, whether they use English as their heritage language or not, may use culturally specific styles of communicating which are different from local or standard English (which are themselves culturally specific). These different ways of speaking combine both linguistic and rhetorical styles and affect both how speakers talk and how they interpret others’ talk. Differences include: how personal or impersonal to be, what to stress and what to play down, how direct to be in self-presentation, how to sequence responses, choice of words and idioms, and a range of prosodic features, including intonation and rhythm. The content and style of talk is also determined by assumptions and values based on shared experience, such as how to relate to the doctor’s perceived authority (as we saw in example 1). So both background knowledge and ways of speaking may be different. These differences can not only lead to overt misunderstandings,<sup>30</sup> but also to difficult or uncomfortable moments and to some of the small tragedies of everyday life: for example, when patients do not get access to scarce resources. The key question is: how does diversity affect interpretation of meaning in interactions and how do differing interpretations lead to misunderstandings and potentially less favourable outcomes for less powerful groups?

#### Data example 3

In the following example, a young mother (M) from Somalia has brought her baby daughter to see the family doctor because she has been suffering from diarrhoea. At this stage in the consultation, the doctor has already taken a brief history from the patient’s mother and, before examining the baby, has asked her some initial questions about breast-feeding.

- |   |   |   |
|---|---|---|
| 1 | D | little bit (.) right so you’re virtually stopped (.)                            |
| 2 |   | so what sort of questions have you got in your mind for me today (.)            |
| 3 |   | what do you want me to do   |
| 4 |   | (..)  |
| 5 | M | mm no: [she say]  |
| 6 | D | [today]   |
| 7 | M | eh: the lady she say if you want to contacting doctor eh: you want eh: talk him |
| 8 | D | yeah =  |
| 9 | M | = I say yes I am happy with e- with [you]                                       |

- 10 D [right] right ok =  
 11 M = because (.) definitely when I am coming  
 with you  
 12 when I go back I will go back happy  
 13 D ((laughs)) I hope so  
 14 M because I will look to see you and your doctor  
 K (.)  
 15 I like it  
 16 D good =  
 17 M = (cos) when when I come in will come in  
 the you know ((tut))  
 18 when I go back my home I'm happy  
 19 D right  
 20 M ((laughs))  
 21 D so you want me to- (.) check her over

At line 1, the doctor uses a number of contextualisation cues to show that she is about to shift topic from discussing breast-feeding. She pauses, uses the discourse marker 'right' and sums up the patient's contribution. She then moves, at line 2, to eliciting the patient's concerns in classic patient-centred mode. However, patient-centred models have not been designed for intercultural communication. Shared decision making assumes that, through talk, the patient and doctor will tune into each other's way of thinking.<sup>31</sup> But what happens when talk itself is the problem, as is the case here?

The mother may well have missed the contextualisation cues that mark the shift in topic and this exacerbates the difficulty in processing the questions in lines 2–3. But the main difficulty seems to be that she cannot interpret the shift in frame marked by these open questions. She responds with a negative and then refers to the 'lady' (probably the receptionist) and how she is happy to see this particular doctor. This is the beginning of a narrative account about coming in to see the doctor rather than an analytical account of her concerns. Unlike the mother in data example 1, here M offers a life-world account that can contribute to a potential frame mismatch. M then reformulates her perception of the doctor twice more (lines 12 and 18). This repetition of how she likes this doctor and her colleague seems to shift the topic from the question she asked the receptionist (about seeing the doctor) to some general display of satisfaction. This may be because she is uncertain of how to take the doctor's elicitation and/or because she sees it as culturally appropriate to praise her. This is not the footing that the doctor had anticipated. When there is only a minimal response from the GP at line 19 ('right'), the mother laughs. The doctor then speaks *for* the patient in line 21, thus undermining her original attempt to be patient-centred and shifting back to a more orthodox frame

in which she pushes on with the next phase of the consultation.

This short extract shows us several things. Firstly, we cannot take interpretive processes for granted in intercultural communication. When there is no obvious coherent link between a question and answer, we have to look outside, to ethnographic data to answer the question 'What is going on here?' In this instance, it is important to know that the baby's mother comes from a rural area of Somalia, where strictly hierarchical relationships exist between medical professionals and other healers and their patients. Empowerment, participatory encounters and shared decision making are not in the frame. Secondly, we can see how talk itself can be a problem and so widely held models of good practice, which assume that more talk means better communication, may not hold in intercultural encounters. Finally, related to this, is the fact that in order to increase shared decision making, doctors resort to metacommunication – more talk about talk – as in lines 2–3. As the notion implies, this is a more abstract and more general level of talking which seems to cause particular problems for patients with limited linguistic competence in English.

In the video feedback session, the doctor commented on how she had used patient-centred questions in a mechanical way and that it was 'worrying' that she had not been aware at the time that these questions had, paradoxically, created more misunderstandings. She had also identified the mother who, along with her baby, was also registered with this doctor, as an anxious patient. The misunderstandings that arose in this consultation might well feed into this social evaluation. The mother's failure to produce an analytical response to the doctor's elicitation was part of her 'performed social identity' as someone perceived as responding (over)emotionally to her situation. An alternative interpretation might be that she was concerned that the doctor might see her as over-anxious (not aware perhaps that in Somalia her baby daughter's condition might be life-threatening) and wanted to mitigate this by declaring how happy she was with this doctor.

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## CONCLUSION

Discourse analysis works at the level of whole encounters and at the micro level of detailed features of talk to focus on analytic themes, some of which are discussed above. It explores how interac-

tions are organised thematically and rhetorically, and how people make sense to each other moment by moment through subtle yet taken for granted processes of framing and cueing in talk. These analytic themes align with professional concerns in medicine (what we have called focal themes). This alignment is reflected in the collaboration between discourse analysts and health professionals in the joint problematisation of health-related concerns.<sup>32</sup> Discourse analysts have a responsibility to make descriptions adequately transparent for health professionals as well as clients and to present analysis in illuminating ways. By slowing down the activity – the consultation, meeting, oral examination or the research interview – it is possible to show how interpretive processes work and how patterns emerge across the whole activity.<sup>26</sup>

Joint problematisation is a relatively modest and so achievable goal. It does not assume that collaboration will lead to problems being solved. But it provides a new lens for looking at an identified problem. It can lead to the development of practical tools. Generally speaking, the type of data and detailed analysis illustrated in this paper can be used for training purposes, as the following examples illustrate. As the result of a recent publication,<sup>33</sup> the authors were invited to supply a series of questions based on the published article that could be used in the assessment of genetic counsellors as part of continuing professional development. In another collaborative venture, with the Royal College of General Practitioners, the analysis of the college's oral assessment identified the hybrid discourses of the examination that were disadvantaging doctors trained overseas.<sup>34</sup> Educational interventions in the form of training videos have also been made from the original recorded research data for undergraduates and GP registrars.<sup>35,36</sup>

There is always the danger of borrowing in a new methodological approach and crediting it with powerful and exhaustive properties to the exclusion of others. A theme-oriented approach encourages a free-range DA, drawing inspiration from many approaches. In this strand of DA, analytic and focal themes overlap. The analyst needs a bi-focal gaze, noticing both the health content and the means of structuring talk and sustaining relationships. So, at its heart DA remains an ethnographically grounded study of language in action, connected to broader themes such as health and inequality. Silverman recently argued that we should be collaborators, not warriors, in our methodological debates.<sup>37</sup> We take this collaboration a step further by arguing for joint

activity between discourse analysts and health professionals in the pursuit of better understanding of communication in medical life and research based educational interventions.<sup>38</sup>

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## REFERENCES

- 1 Sherzer J. A discourse-centred approach to language and culture. *Am Anthropologist* 1987;89:295–309.
- 2 Cameron D. *Working with Spoken Discourse*. London: Sage 2001.
- 3 Jaworski A, Coupland C, eds. *Discourse: A Reader*. London: Routledge 1999.
- 4 van Dijk T. ed. *Discourse Studies: A Multidisciplinary Introduction*. Volumes 1 & 2. London: Sage 1997.
- 5 Sarangi S, Coulthard M, eds. *Discourse and Social Life*. London: Longman 2000.
- 6 Schiffrin D, Tannen D, Hamilton H, eds. *Handbook of Discourse Analysis*. Oxford: Blackwell 2001.
- 7 Candlin CN, Candlin S, eds. Expert Talk and Risk in Health Care. [Special issue of:] *Research on Language and Social Interaction* 2002;35 (2).
- 8 Barrett R. *The Psychiatric Team and the Social Definition of Schizophrenia*. Cambridge: Cambridge University Press 1996.
- 9 West C. *Routine Complications: Troubles in Talk Between Doctors and Patients*. Bloomington, Indiana: Indiana University Press 1984.
- 10 Ainsworth-Vaughn N. *Claiming Power in Doctor–Patient Talk*. New York: Oxford University Press 1998.
- 11 Fisher S, Todd AD, eds. *The Social Organisation of Doctor–Patient Communication*. Washington DC: Centre for Applied Linguistics 1983.
- 12 Freeman S, Heller M, eds. Medical Discourse. [Special issue of:] *Text* 1987;7 (1).
- 13 Ribeiro BT. *Coherence in Psychotic Discourse*. Oxford: Oxford University Press 1994.
- 14 Sarangi S, Roberts C, eds. *Talk, Work and Institutional Order: Discourse in Medical, Management and Mediation Settings*. Berlin: Mouton de Gruyter; 1999.
- 15 Sarangi S, Candlin CN, eds. Categorisation and Explanation of Risk: A Discourse Analytical Perspective. [Special issue of:] *Health, Risk Society* 2003;5 (2).
- 16 Gumperz J. On interactional sociolinguistic method. In: Sarangi S, Roberts C, eds. *Talk, Work and Institutional Order*. Berlin: Mouton de Gruyter 1999;453–71.

- 17 Roberts C. *Transcription*. London: King's College London; Fund for the Development of Teaching and Learning DfES. <http://www.kcl.ac.uk/education/ftdl/docA.shtml>.
- 18 Goffman E. *Frame Analysis*. New York: Harper & Row 1974.
- 19 Tannen D, Wallat C. Doctor/mother/child communication: linguistic analysis of a paediatric interaction. In: Fisher S, Todd AD, eds. *The Social Organisation of Doctor-Patient Communication*. Washington DC: Centre for Applied Linguistics 1983;203–20.
- 20 Goffman E. *Forms of Talk*. Oxford: Blackwell 1981.
- 21 Levinson S. Activity types and language. *Linguistics* 1979;17:356–99.
- 22 Gumperz JJ. *Discourse Strategies*. Cambridge: Cambridge University Press 1982.
- 23 Gumperz JJ. Contextualisation and understanding. In: Duranti A, Goodwin C, eds. *Rethinking Context: Language as an Interactive Phenomenon*. Cambridge: Cambridge University Press 1992;229–52.
- 24 Brown P, Levinson S. *Politeness: Some Universals in Language Usage*. Cambridge: Cambridge University Press 1987.
- 25 Erickson F, Shultz J. *The Counsellor as Gatekeeper: Social Interaction in Interviews*. New York: Academic Press 1982.
- 26 Roberts C, Sarangi S. Mapping and assessing medical students' interactional involvement styles with patients. In: Spellman-Miller K, Thompson P, eds. *Unity and Diversity in Language Use*. London: Continuum 2002;99–117.
- 27 Sarangi S. Activity types, discourse types and interactional hybridity. In: Sarangi S, Coulthard M, eds. *Discourse and Social Life*. London: Pearson 2000;1–27.
- 28 Sarangi S, Bennert K, Howell L, Clarke A. 'Relatively speaking': relativisation of genetic risk in counselling for predictive testing. *Health, Risk Soc* 2003;5 (2):155–69.
- 29 Roberts C, Sarangi S, Moss B. Presentation of self and symptom in primary care consultations involving patients from non-English speaking backgrounds. *Comm Med* 2004;1 (2):159–69.
- 30 Roberts C, Moss B, Wass V, Sarangi S, Jones R. Misunderstandings: a qualitative study of primary care consultations in multilingual settings, and educational implications. *Med Educ* 2005;39:465–75.
- 31 Elwyn G, Edwards A, Gwyn R, Grol R. Towards a feasible model for shared decision making: focus group study with GP registrars. *BMJ* 1999;319:753–7.
- 32 Roberts C, Sarangi S. Uptake of discourse research in interprofessional settings: reporting from medical consultancy. *Appl Linguistics* 2003;24 (3):338–59.
- 33 Sarangi S, Bennert K, Howell L, Clarke A, Harper P, Gray J. Initiation of reflective frames in counselling for Huntington's Disease predictive testing. *J Genetic Counseling* 2004;13 (2):135–55.
- 34 Roberts C, Sarangi S, Southgate L, Wakeford R, Wass V. Oral examinations, equal opportunities and ethnicity: fairness issues in the MRCP. *BMJ* 2000;320:370–5.
- 35 Roberts C. *Developing Empathy*. [Video.] London: King's College London 2001. Details of the video can be obtained from Celia Roberts (celiaroberts@lineone.net).
- 36 Roberts C, Moss B. *Doing the Lambeth Talk*. [Video/DVD.] London: King's College London 2003. The DVD is available from the London Deanery, 20 Guildford Street, London, WC1N 1DZ, UK.
- 37 Silverman D. Warriors or collaborators: reworking methodological controversies in the study of institutional interaction. In: Sarangi S, Roberts C, eds. *Talk, Work and Institutional Order*. Berlin: Mouton de Gruyter 1999;401–25.
- 38 Sarangi S. Towards a communicative mentality in medical and health care practice. *Comm Med* 2004;1 (1):1–11.
- 39 Jefferson G. A technique for transcribing laughter and its subsequent acceptance/declination. In: Psathas G, ed. *Everyday Language: Studies in Ethnomethodology*. New York: Ervington 1979;79–96.
- 40 Gumperz J, Berenz N. Transcribing conversational exchanges. In: Edwards J, Lampert M, eds. *Transcription and Coding Methods for Language Research*. Hillsdale, New Jersey: Lawrence Erlbaum Associates 1993.

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## APPENDIX

### Transcription conventions

( )	talk too obscure to transcribe
[	overlapping talk begins
]	overlapping talk ends
○	lower in volume than surrounding talk <sup>○</sup>
(1)	silence timed in seconds or pause of less than half a second (.) or more than half a second (..)
::::	lengthening of a sound
Beau-	cut-off, interruption of a sound
<u>He</u> says.	Emphasis, i.e. perceived stress based on pitch change and/or increased volume
=	latching, i.e. no silence at all between 1 speaker's turn and the next
(( ))	non-verbal communication, anonymised data or other comments
((XXX))	words spoken at the same time as non-verbal communication
\	low falling tone
/	rising tone.

[Based on 'A technique for transcribing laughter and its subsequent acceptance/declination'<sup>39</sup> and 'Transcribing conversational exchanges'.<sup>40</sup>]