

TRAINEE FOCUS

Bedside matters: Acknowledging responsibility in effective doctor–patient conversations

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Attending an ED as a patient or carer can be a daunting experience. Even without considering the stress and concern because of the reason for the visit, the uncertainty of being in a space with what are, for many, unfamiliar social rules or norms can make the experience more difficult. Some of these social norms are related to conversation.¹ Although many people will have been socialised in ‘how to visit the doctor’ in terms of who says what and when, that socialisation primarily occurs within general practice, rather than emergency settings. As a doctor, however, you have been socialised into ‘how to be a doctor’ across many disciplines during early training, and then in a specific specialty moving forward. In your career, you will conduct around 200 000 consultations,² making being a doctor a much more familiar experience than being a patient will be for anyone seeing you.

In becoming a doctor you are entrusted with a level of responsibility to provide care for a patient. This is made possible through a social contract of ‘mutual trust and reasonable demands’³ and can be more tangibly seen in medical training, examinations and various forms of registration and accreditation. In Western biomedicine, as in many other medical models, this trust

involves greater access to and use of knowledge of an immense range of information relating to the human body, diagnostic processes and treatments. It also involves greater access to knowledge of the health system – who to see for what, what gets sent where, who to see in what order, who to talk to to get the care required. With a doctor’s rights and abilities to access domains of knowledge relatively positioned to a patient’s, this difference in epistemic status⁴ influences each participant’s approach to an interaction.

The increased epistemic access given to doctors results in greater deontic, or decision-making, authority at both clinical and interactional levels.⁵ Clinically, you are able to make diagnoses and recommend and provide or refuse treatment and medicines based on the trust society has given you through your epistemic authority. In a consultation, you also have greater deontic authority over how the interaction progresses.⁶ That is, you have greater authority over what occurs and when in a consultation with a patient. You are able to ask deeply personal questions in the pursuit of understanding the patient’s presenting concern, but they cannot ask the same of you. You can create a space for patient questions near the end of the

consultation or you can simply close it and move on.^{7,8}

This is not to say that a patient is powerless or has no agency within the interaction. Patients can and do assert agency within the medical consultation.⁹ This is possible because conversation is co-constructed – it is not message sent and message received. Instead mutual understanding is built turn by turn, with your next move influenced by what was said before and influencing what is going to be said next.¹⁰ Each interlocutor can, by the very design of their turn, change what the other may have planned to say next. Institutional interaction, however, presents an uneven playing field.

The difference between doctors and patients in epistemic and deontic authority, while not static, often results in a ‘power differential’ and this is observable in consultations. Although conversation is co-constructed by the participants, the norms of conversation are modified in an institutional setting,¹¹ influenced by this power differential. In a conversation with a friend, someone might complain about their sore back and their friend might suggest doing yoga or recommend seeing a physiotherapist. The person with the sore back can generally disagree with such advice or ignore the suggestion and the conversation can continue on. In a medical visit, however, the patient has sought care and part of the social contract involves the patient accepting the advice.¹² When a patient disagrees, they generally do so in a way that does not obviously breach those social norms of acceptance. Resistance to treatment recommendation often occurs as non-acceptance of the recommendation, or passive resistance, rather than more active resistance.¹³ Both types of resistance require the doctor to respond in order to gain acceptance of

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Accepted 8 February 2022

the recommendation, even if minimally, before the consultation can move forward.

Due to this power differential, ultimately rooted in the social contract between doctors and patients as well as the position afforded to doctors in society more broadly, and the rights and obligations attendant to that social contract, I argue that the responsibility for an effective conversation primarily lies with the doctor. Conceptualisations of communication that focus on ‘sender’ and ‘receiver’ ignore not just the sequential relationship between turns but also the influence of epistemic and deontic authority on interaction. Greater epistemic authority means the doctor is required to lead the process of history taking, collecting relevant information and determining when they have enough. Increased proximal deontic authority (i.e. within the consultation) is required so that the doctor, who is more familiar with what is needed within the consultation (e.g. what questions are asked), is able to move to the next activity. This begins to sound paternalistic, further highlighting the responsibility the doctor has to ensure that the consultation is patient-centred. Giving the patient time to tell their story, attentively listening through the story, designing questions to ensure assumptions do not get in the way of accuracy, allowing the patient to resist transitions to the next consultation activity and creating space for and inviting questions are all ways that doctors can use their proximal deontic authority to support effective conversation in patient-centred consultations.

Just as seeking continuous improvement in other knowledge and skills relevant to clinical practice is required, there is a professional responsibility to seek ongoing improvement of clinical communication. This includes engaging with the ever-growing evidence base for effective communication, including how to teach and supervise.¹⁴ This, however, may appear like an additional burden. If it appears burdensome, broader issues may be at play. Analysis of the barriers to and facilitators of effective communication

with patients in EDs is required to target improvement strategies. Evidence-based training that prioritises individualised feedback on communication is worthwhile, but without support to provide supervisor training and increase time for such activities, along with efforts to reduce stress, exhaustion and insufficient time with patients, the impact of such improvements may be minimal.

Clinician responsibility for ensuring effective communication should be considered as part of the social contract where society entrusts doctors with the rights to knowledge and decision-making. As that social contract continues to shift from the paternalistic to patient- and relationship-centred care, this is actionable within the consultation itself. Beyond this, there is also an institutional responsibility to enable improvement – universities, colleges, workplaces and the health system working to ensure that effectiveness of communication is possible.¹⁵

Acknowledgement

Open access publishing facilitated by University of New South Wales, as part of the Wiley – University of New South Wales agreement via the Council of Australian University Librarians.

Competing interests

None declared.

References

- Heritage J, Clayman S. *Talk in Action: Interactions, Identities, and Institutions*. West Sussex: Wiley-Blackwell, 2010.
- Silverman J, Kurtz SM, Draper J. *Skills for Communicating with Patients*, 3rd edn. Oxford: Radcliffe Publishing, 2013.
- Cruess SR. Professionalism and medicine's social contract with society. *Clin. Orthop. Relat. Res.* 2006; 449: 170–6.
- Heritage J. The epistemic engine: sequence organization and territories of knowledge. *Res. Lang. Soc. Interact.* 2012; 45: 30–52.
- Landmark AMD, Gulbrandsen P, Svennevig J. Whose decision? Negotiating epistemic and deontic rights in medical treatment decisions. *J. Pragmat.* 2015; 78: 54–69.
- Weidner M. Telling somebody what to tell: ‘Proszę mi powiedzieć’ in Polish doctor–patient interaction. *J. Pragmat.* 2015; 78: 70–83.
- White SJ. Closing clinical consultations. In: Busch A, Spranz-Fogasy T, eds. *Sprache in der Medizin [Language in Medicine]*. Berlin: De Gruyter, 2015; 170–87.
- White SJ, Nguyen A, Cartmill JA. Agency and the telephone: patient contributions to the clinical and interactional agendas in telehealth consultations. *Patient Educ. Couns.* 2022; <https://doi.org/10.1016/j.pec.2022.01.004>.
- Koenig CJ. Patient resistance as agency in treatment decisions. *Soc. Sci. Med.* 2011; 72: 1105–14.
- Goodwin C, Heritage J. Conversation analysis. *Ann. Rev. Anthropol.* 1990; 19: 283–307.
- Heritage J. Conversation analysis and institutional talk: analyzing data. In: Silverman D, ed. *Qualitative Research: Theory, Method, and Practice*, 2nd edn. London: Sage, 2004; 222–45.
- Stivers T, Heritage J, Barnes RK, McCabe R, Thompson L, Toerien M. Treatment recommendations as actions. *Health Commun.* 2018; 33: 1335–44.
- Stivers T. Treatment decisions: negotiations between doctors and patients in acute care encounters. In: Heritage J, Maynard DW, eds. *Communication in Medical Care: Interaction between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press, 2006; 279–312.
- Gilligan C, Powell M, Lynagh MC et al. Interventions for improving medical students' interpersonal communication in medical consultations. *Cochrane Database Syst. Rev.* 2021; (2): CD012418.
- White SJ, Preda V. Communication as a clinical skill: a challenge in the delivery of safe and effective patient care. *Aust. Health Rev.* 2021; 46: 62–3.