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Studies

RHETORIC IN DOCTOR-PATIENT COMMUNICATION

MASTER'S THESIS

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Abstract

The Master's thesis 'Rhetoric in Doctor-Patient Communication' study reveals how the asymmetry of doctor-patient power relations can be maintained or changed within the context of an interaction through the use of rhetoric. The study is carried out in a specific children's hospital in Riga, focusing particularly on anethesiologist and allergist consultations.

The aim of the study is to characterise how doctors incorporate rhetorical means, such as narratives and tropes, when communicating with their patients and caregivers, paying specific attention for what purpose is it done and how it affects the power relation dynamic.

My findings reveal that anesthesiologist use narrative dramatization to gently persuade the patient to cooperate. Moreover, in allergist consultations symmetry can be achieved through co-construction of diagnosis using stories.

Keywords: doctor-patient communication, power relations, agency, rhetoric, narrative, sociolinguistic analysis

Anotācija

Maģistra darba "Retorika ārsta-pacienta komunikācijā" pētījums parāda, kā ārsta un pacienta asimetriskās varas attiecības iespējams saglabāt vai mainīt sarunas kontekstā, izmantojot retoriku. Pētījums tiek veikts noteiktā bērnu slimnīcā Rīgā, koncetrējoties konkrēti uz anesteziologu un alergologu konsultācijām.

Pētījuma mērķis is raksturot kā ārsti izmanto retoriskus paņēmienus, kā naratīvus un mākslinieciskās izteiksmes līdzekļus, savā komunikācijā ar pacientiem un viņu aizgādņiem, veltot īpašu uzmanību kādiem mērķiem tas tiek darīts un kā tas ietekmē varas attiecību dinamiku.

Darbs parāda anesteziologi izmanto naratīva dramatizāciju, lai maigā formātā pārliecinātu pacientu sadarboties. Savukārt alergologu konsultācijās simetriju iespējams panākt kopīgi konstruējot diagnozi, izmantojot stāstus.

Atslēgas vārdi: ārsta-pacienta komunikācija, varas attiecības, rīcībspēja, retorika, naratīvs, sociolingvistiska analīze

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INTRODUCTION

Illness and injury are an unavoidable reality of life, which at times compel people to seek out the aid of professional healthcare services. Illness and injury often create a fracture in everyday life, which may cause distress and anxiety. It is such states that patients come to the doctor to find a way to restore balance to their lives. However, due to the difference of discursive worlds the patient and doctor are a part of, as well as the institutional and societal factors that shape the interaction, the patient engages with the doctor in an asymmetrical relationship when deciding the patient's future plan of action. It is in this context that a patient loses his or her agency to a great degree in deciding the unfolding of their life as the doctor possesses superior knowledge of health related issues, furthermore, the clinician has socioculturally and institutionally granted authority to make decisions. However, some anthropologists of the cultural rhetoric school of thought, such as Micheal Carrithers, propose that is possible to overcome the asymmetry of power relations and culturally mediated structures within the context of an interaction via exchanging the positions of *agent* and *patient* (Carrithers' terms) through the use of rhetorical strategies (Carrithers, 2005:440). This idea simultaneously opens up the possibility for a patient to become an agent in the interaction and also provides the doctor the means to maintain the asymmetry.

This is a compelling issue to research in Latvia's healthcare system. Despite the increased recognition for the necessity of good communication in order to negotiate a more effective course of treatment, the Latvian Patient Ombud reports that more than 70% of complaints sent in by patients pertain to doctor-patient communication (Link 3). Considering the present status-quo, my research could provide valuable insights and offer ameliorative propositions based on my findings on doctor-patient communication practices.

> The aim of this research is to analyse from sociolinguistic point of view the various ways rhetorical techniques, particularly the use of figurative tropes and construction of narratives, are used in doctor-patient interactions in order to persuade and negotiate. Specific focus is given to the way agency and power relations are expressed, maintained or changed through rhetorical means within an interaction.

In the context of the main goal of the thesis, the following questions were explored:

- Do doctors and patients use figurative language and rhetorical techniques in their communication? What kind?
- At which point are these used and for what purpose?
- Do the rhetorical techniques serve as a means to influence power relation dynamics or to maintain asymmetry during the unfolding of the interaction?
- What are the most characteristic rhetorical strategies?

In order to reach these goals specific objectives were put forward: (1) research of available theoretical material and anthropological studies that pertain to my theme (2) development of a theoretical framework for analysing rhetoric and power relations within doctor-patient interactions; (3) observation of actual doctor-patient interactions to see how rhetoric is used in practice to maintain or change power relations; (4) micro-level analysis of doctor-patient interaction discursive practices to identify specific rhetorical strategies employed by patients and doctors to negotiate power relations.

The methodology of the master thesis consists of three stages. Firstly, using direct systematic observation, I study doctor and patient behaviour, while recording their conversations and focusing on finding instances where rhetoric is used. The second stage consists of informal semi-structured interviews with doctors and patients in order to glean insights how they construe the interaction and what are their motives for acting or speaking in certain ways. The last part is discourse analysis of transcribed data.

1. THEORETICAL PERSPECTIVE

1.1. Rhetoric in Anthropology

The purpose of this section is to define the concept of rhetoric and situate its role and usage in anthropological research of social and cultural processes. Looking at the genealogy of the study of rhetoric, its key theoreticians and different schools of thought will provide a better understanding of the specific stance and theoretical framework I have chosen for my research on doctor-patient communication, as well as establish rhetorical analysis as a valid method for investigating sociolinguistic phenomena. The part consists of four sections, the first dismisses common misconceptions about rhetoric and gives insight about the overall historical development of rhetoric as a field of study, emphasizing its rise and fall in the academic discourse and prominent resurgence in the mid-twentieth century. The second part looks at the two incarnations of the rhetorical turn in anthropology and the different approaches to the study of rhetoric and key authors. The third section discusses the current state of rhetoric in anthropology, its key concepts, contemporary theories and methodological applications. The last section further narrows down the ideas specific to the understanding of rhetoric relevant to my thesis.

1.1.1. 'Mere' Rhetoric

The term rhetoric usually is understood to signify classical rhetoric which is the art of speech craft and public speaking developed in ancient Rome and Greece that was primarily dedicated to the study of persuasive techniques and ways of presenting knowledge and argumentation in a convincing manner. The term rhetoric also carries a negative connotation of being language that is deceitful and manipulative, thus, it is considered by some a mere play of words, a decorative aspect of language or even trickery. Robert Wess notes that even though nowadays the role of rhetoric has grown considerably, it is still often belittled in common conversation and in the media. (Wess, 1996:1). The origin for this kind of understanding of rhetoric can be traced back to an anti-rhetorical stance in philosophy and science.

The academic community's reception of rhetoric has changed dramatically over the centuries. Michal Mokrzan writes that in both ancient and modern times rhetoric

was incorporated in science and philosophy, however, the period in-between was marked by tendency amongst scholars to discredit the role of rhetoric. (Mokrzan, 2014:4) Prominent thinkers such as Plato, Francis Bacon, John Locke, Immanuel Kant attempted to eliminate rhetoric from their discourse altogether, arguing that, 'it obscures reality and instead of providing true knowledge (*épistemē*), it only provides common opinions (*dóxa*)' (2014:4-5). This perspective laid the foundation for the emergence of positivism and the ideals of the project of modernity. Mokrzan refers to Stephen Tyler's view in his work *The Unspeakable: Discourse, Dialogue and Rhetoric in the Postmodern World* which states that,

> […] Modernism is seen as the triumph of things over signs, plain style over rhetoric and reason over passion. He notes that nothing so clearly highlights the motivation of modernism as the dream of a transparent language. The idea of a transparent language – which implies the correspondence theory of truth – assumes that the words perfectly reflect reality (2014:5).

From the epistemological point of view of modernism rhetoric was unnecessary, which is why it was 'expelled' from the efficient, impersonal, factual discourse of science and placed in the poetic realm of art, literature and humanities. To further iterate this point I refer to Kenneth Burke, considered one of the founding fathers of contemporary rhetorical theory, who suggests that it was due to Enlightenment objectivism and the subjective authenticity of Romanticism that rhetoric's significance was discredited,

> The cogito, the unshakable foundation of certainty, generates at once the impersonal or abstracted subject of science and the creative, self-forming subject of Romanticism. Once these subjective functions took command over the field of discourse and representation, rhetoric could no longer maintain its cultural dominance (Wess, 1996:2-3).

However, the assumption that language can truthfully depict reality was put under scrutiny by postmodern thinkers such as Foucault, Johnson and Lakoff, Derrida, Lyotard, Barthes, among many others as well. There was a change in paradigm which proposed to view language not as one-to-one relation between the signifier and the signified, but instead as arbitrary, fluid and enveloped in power relations. It was within this context of this intellectual movement that linguistic phenomena gained increasingly greater relevance and rhetoric resurfaced as a prominent analytic and explanatory tool. The philosopher, Frederic Nietzsche, nicely problematizes the understanding of language proposed by modernity by pointing out the inseparable nature of language and

rhetoric, ‘there is obviously no unrhetorical ‘naturalness’ of language to which one could appeal; language itself is the result of purely rhetorical arts’ (Nietzsche 1989: 106). This perception actually serves well as the basic premise to characterize the direction in which the linguistic and rhetorical turn would take in reconceptualising the role of rhetoric as a fundamental, indispensable element in various sociocultural and even basic human cognitive processes.

1.1.2. The Rhetorical Turn in Anthropology

Michal Mokrzan writes that in anthropology the Rhetoric Turn manifested itself in two distinct ways. I will briefly describe the main points of the first incarnation, as it illustrates the transition in anthropological paradigm and methodology and helps highlight how the two incarnations of the rhetorical turn interact and influence one another. However, I will mostly focus on the second incarnation, as it validates rhetoric as an important aspect in the study of sociocultural processes and demonstrates various applications by prominent anthropologists.

The first incarnation of the rhetorical turn is characterized by a focus on the rhetorical analysis of anthropological texts and ethnographies, paying particular attention to the modes of representation and knowledge creation. It was through this process that social scientists came to realize the rhetoric nature of human cognitive processes and how it influences and shapes interpretation of sociocultural phenomena. Morkzan explains and neatly captures how the understanding of ethnography changed for anthropologists of the time, namely,

> The reality is available through rhetoric. We cast a narrative net on reality i.e. we interpret it through the process of translation using rhetorical tropes. This in fact means that the transformation from strange to familiar happens via rhetorical operations (2004:5).

Essentially, the main revelation was that knowledge of reality is constructed through culturally specific rhetorical conventions. Another important set of dimensions of rhetoric in anthropological works were persuasion and power relations. Anthropologists such as Richard Geertz emphasized that anthropology is basically the art of persuasion through text. (2004:6) Anthropologists employ a variety of rhetorical techniques to lend credibility to their work. Geertz’s book *Works and Lives* serves as

prime example of using literary theory of rhetoric and poetics to highlight the persuasive nature of anthropological discourse that is constructed through an elaborate use of figurative language. (2004:7) Moving on, this new approach was further supplemented by anthropologists like James Clifford who took a critical stance against 'the politics behind the poetics' (2004:7) which focused on the power relations behind the construction of ethnographic texts. Namely, using a Western model of understanding, which entails adopting one model of language and a set of rhetorical conventions, to explain different cultures is characterized by unequal power relations (2004:8). Stephen Tyler criticizes the inherent power relations that are behind any given model of knowledge creation, he states that, 'the whole ideology of representational signification is an ideology of power' (Tyler, 1986: 131). In summary, these ideas lead to an important revaluation of anthropological approaches and encouraged the search for new ones, taking into consideration the aforementioned proclivities.

The second incarnation is characterized by the application of rhetorical theories in anthropological study of culture and society, particularly focusing on persuasion and figuration. Michal Mokrzan states that the flourishing of rhetorical analysis of sociocultural processes can be traced back to the 'metaphorical turn' and structural anthropology, this marked the beginning of a wide range of research on the rhetorical aspects of cognitive and symbolic mechanisms. (2004:10) Noteworthy authors in this field include Levi Strauss and his work *The Savage Mind*, in which he considered figurative aspects of human cognition in terms of figurative language and rhetorical tropes, discussing metonymy and metaphor as epistemological categories instead of aesthetic ones. (2004:11) The aforementioned interpretative anthropologist, Richard Geertz, contributed to the development of rhetorical analysis by pointing out the shortcomings of his contemporaries in the study of ideology in different cultures and emphasizing the need for an analytical framework for the interpretation of figurative language and symbolic action. (2004:11) The work of paramount importance in the study of rhetoric was the book *The Social Use of Metaphor: Essays in Anthropology of Rhetoric* which helped expand rhetorical conceptions and add more in-depth perspectives on the role of rhetoric in social life. (2004:12) It also helped define the line

of inquiry for anthropologists studying rhetoric by supplementing the structuralist view with the performative aspects of rhetoric,

> The proper aim of the research proposed by anthropologists of rhetoric is the analysis of how the tropes used by social actors operate in specific social contexts. Joining the reflection on the tropes, as symbolic categories, arranging spheres of human experience with the problem of their applicability in everyday social interactions entails the evocation of the rhetorical fundamental concept: the persuasion. (2004:12-13)

This newfound focus laid the groundwork for the contemporary conceptualization of rhetoric which moved away the structuralist cognitive study and focused more on the role of rhetoric in social life.

1.1.3. Contemporary Rhetorical Theory in Anthropology

The International Rhetoric Culture Project continued to expand the ideas and possible theoretical applications of rhetoric. Noteworthy contributions were made by James W. Fernandez and Micheal Herzfeld. The latter departed from the structuralist point of view and adopted notions from both symbolic and interpretative anthropologists, his innovation in this field was the concept of social poetics and the theoretical perspective that looked at the role of rhetoric in constructing social identity and managing power relations. (2004:13) Overall, these new conceptualizations of rhetoric helped expand its theoretical application.

Nowadays the Rhetoric Culture project is still an on-going endeavour with a variety of propositions and new insights for the use rhetoric in the study of social and cultural processes. The primary initiators of the Rhetoric Culture Project, Stephen Tyler and Ivo Steckler, propose the fundamental premise which characterizes the stance of contemporary anthropological theory on rhetoric and culture,

> […] every expression is rhetorically structured and should be grafted in anthropological studies of culture. Anthropologists maintain that ‘'just as there is no ‘zero degree rhetoric’ in any utterance, there is no ‘zero degree rhetoric’ in any of patterns of culture” (2004:14).

The project situates rhetoric as everpresent fundemental dimension that influences the way humans perceive and construct the world. Thus, rhetoric is also seen as the essential element that shapes the reproduction culture and society,

> Rhetoric both enables and constrains us to think, speak and act intentionally in a world which is "neither anarchic nor determined", and it is our innate rhetorical disposition and our culturally acquired rhetorical competence which create the ‘patterns’, ‘styles’, ‘configurations’, ‘habitus’, ‘paideuma’, ‘ethos’, ‘spirit’ etc. of culture (Link 1).

The project is still underway and is attempting to construct a separate branch of rhetorical anthropology. The project takes a crossdisciplinary approach by combining ideas from anthropology, literary theory, philosophy, linguistics and a variety of other disciplines (Tyler & Steckler, 2009:2). It promises a new outlook and analytic methodology for looking at social and cultural processes. However, it must be noted that there is still no concrete theory and understanding of the nature of rhetoric and culture. While the Rhetoric Culture Project does offer a variety of theoretical perspectives, they are quite heterogenous, moreover, the project is still in the process creating specific methodological approaches for studying rhetoric in sociocultural processes. (2009:2-3) Nonetheless, the available theory does offer a compelling insight on a thus far somewhat overlooked aspect in anthropology that merits further investigation and holds promise for insightful new discoveries.

1.1.4. Summary

To summarize, at first glance rhetoric may seem dubious as a lens through which to study sociocultural processes, however, it ought not to be discredited so easily. Rhetoric’s influence has undergone a flux and waning of academic revalence, the pejorative perception of rhetoric is attributable to a specific anti-rhetoric stance that emerged in philosophy and science. However, in recent decades it has been gaining increased attention as a methodological and explanatory tool in anthropology. Rhetoric has been used previously in anthropological research by structuralists like Levi-Strauss and interpretative anthropologists like Richard Geertz, though it has come a long way and its conceptualization and application has changed significantly. Noteworthy is the fact that through its theoretical application rhetoric and figurative language were not regarded as merely aesthetic elements of language, but as imporant aspects of cognitive functioning. Moreover, anthropologists realized that rhetoric and figurative language have a prominent role in social life. The current development of rhetorical theory in anthropology is done by the Internation Rhetorical Culture Project, which features a

broad range of theoriticians from a variety of disciplines. The initiators of the project, Stephen Tyler and Ivo Steckler, propose to view rhetoric as a fundemental dimension of human existence and cultural processes.

It is from this school of thought that the Rhetorical Culture Project proposes that I draw my theoretical outlook for studying rhetoric. I found it important to emphasize the history of rhetoric in anthropological research in order to situate the theoretical stance of my thesis. I chose to adopt the fundamental premise that rhetoric permeates language, human interaction and sociocultural processes. However, as I mentioned previously, the Rhetoric Culture Project still underway which, at this point, offers a large variety of approaches to the study of rhetoric, but still has not produced a specific theory or methodology for the research of rhetoric in sociocultural processes. (2009:3) It is important, therefore, that I narrow down my theoretical framework from the variety of frameworks proposed by authors of the project to further to clarify my position. Thus, the following part is dedicated to explaining Micheal Carrithers', a prominent member of the Cultural Rhetoric Project, key ideas and theoretical framework for rhetoric applied from an anthropological point of view.

1.2. Carrithers' Rhetoric Theory of Culture

The particular stance I take in my thesis in regards to the conceptualization of rhetoric and its relationship with sociocultural phenomena bears similarities with many of the authors and ideas I discussed in the previous section, however, I chose this specific theoretical framework because it, in my opinion, best captures and explains how rhetoric functions in communication and negotiation of social relations, as well as how these processes and rhetoric relate to cultural context and the reproduction society, culture and power relations. I find Micheal Carrithers, who is also a part of the Cultural Rhetoric Project, ideas best suit my needs, as they focus on persuasive aspects of rhetoric and can be nicely combined with other anthropological theories.

Micheal Carrithers provides an explanation of how rhetoric can be viewed and applied from an anthropological perspective,

> Rhetoric adds to that previous depiction of human sociality a more vivid sense of (1) the moving force in interaction, (2) the cultural and distinctly human

> character of that force, and (3) the creation of new cultural forms in social life. (Carrithers, 2005:576)

I will elaborate upon each point in more detail. Carrithers' conceptualization of rhetoric is quite grand in scope, which is why this part is structured in a way to introduce key ideas step-by-step, gradually tying them together in a coherent manner, so as to make sense in the end. The following sections will demonstrate, firstly, how rhetoric and its persuasive function are inseparable components of how people interact, form relations with one antoher, express agency, as well as reason and derrive motivation to act. Secondly, I will briefly explain how Carrithers sees the link between culture and rhetoric. In third part, which makes the bulk of this part, is devoted to an exploration of rhetoric's role as a means to enact agency and change within the reproduction of culture, society and power relations. Lastly, I will also briefly discuss the work and ideas of other prominent anthropologists that echo Carrither's notions.

1.2.1. 'Rhetorical Will' and Persuasion

Carrithers suggests that rhetoric is an inherent part of everday communication in social life. Essentially, rhetoric is used, 'to draw people and effects toward us or push them away and whenever we wish to convince and persuade or discourage and dissuade.' (2005:578) The author provides an ethnographic example of the *Woko* stick used by the Hamar of Ethiopia which serves as excellent example to envision how the usage of rhetoric and persuasion takes place in interactions. It is a peculiar artefact, a stick with a hooked and a pointy end, which is used practically by the tribal people to pull things in and push them back, however, a far more compelling application is its figurative usage in ceremonies, 'the speaker draws good fortune – rain, fertility, and increase – toward himself and his fellows with the hooked end and fends off enemies and bad fortune with the forked end' (2005:577). This is a good way to envision how rhetoric is applied in interaction – it is a sort of force to attract or push away, as well as an enactment of one's will.

Carrithers points out the most important aspect of rhetoric – persuasion. It is basically what is largely understood by the term rhetoric, as already defined in the previous part. Carrithers states that focusing on rhetoric and the practices of persuasion, negotiation and argumentation help illuminate the micropolitics behind human

communication (2005:578). He suggests that there is a distinct pattern in interaction that can be characterized in terms of power relations, namely, 'some act to persuade, others are targets.' (2005:578) Like with the *Woko* stick, people actively draw and push others within interactions. Carrithers even suggests a revision of how agency is conceptualized – he characterizes human interactions in terms of the agent/the persuader and patient/the persuade (2005:578). The aspects of agency are very important and will be elaborated more upon in the section that shows the connection between rhetoric, culture and agency. Nevertheless, this particular understanding of persuasion and rhetoric as something that permeates human interaction and is a form of expressing agency has broad theoretical applications.

Largely, rhetoric can be seen as responsible for moving the events in a person's life and negotiating his or her relationships with others, as well as him or herself. People are driven by what Carrithers terms 'the rhetorical will', something James W. Fernandez explains, thusly – the rhetorical effort 'makes a movement[of mind] and leads to a performance'. (2005:578) To elaborate more upon this point, the movement that happens through persuasion and rhetoric is away from what Fernandez calls the *inchoate,* which signifies the 'the unformed, the uncategorized, the so-far chaotic' (2005:442). The model how to view this process is explained as follows,

> Fernandez uses the idea of the inchoate to capture the general human plight of continually threatening uncertainty, obscurity, and danger, the as-yet-not-grasped, "the dark at the top of the stairs," as he puts it. People respond by applying native wit and contrivances of culture plucked from a common store to make a movement away from the inchoate, which I understand to mean a move toward sense and policy, toward an interpretation of the situation and toward a plan. This movement of mind then leads to performance, to action or reaction (2005:442).

In essence it is the mode through which people make sense and interpret the world and what happens to them within in. This is achieved by arranging various perceived phenomena into some orderly fashion that would lead to a seemingly fruitful resolution.

Rhetoric can be seen as a foundational element – an intrinsic and inseparable component of how humans think, reason and derive motivation to act. Furthermore, it should be noted that persuasion and rhetoric are not something used only on others, but also on oneself and one's own thoughts. (2005:578) Making a decision to do something

can be viewed as engaging a rhetorical debate with one's own thoughts. This idea coincides with Peter L. Ossterreich's notion of *homo rhetoricus*, which entails that,

> Humans are rhetorical beings who use persuasive speech not only to influence others but also to shape themselves. This manifests itself in the acts of prophesizing, narrating, proclaiming, questioning, explicating, contradictig, and everything that belongs to the domain of teaching (*docere*), as well as in pleading, requesting, advising, impelling, prescribing, ordering, seducing, that is, forms of expression that belong to emotion (*movere*) – and, finally, delighting, amusing, diverting, praising, paying tribute, glorifying, and so on, which pertain to pleasing (*delectare*). This interaction of *docere, movere and delectare* shapes the life of homo rhetoricus (Stephen & Tyler, Oestereich, 2009:49).

The idea that people use rhetoric to persuade themselves internally is important in the sense that it helps conceive motivation and actions as something that is rhetorically formed, thus, it is subject to rhetorical conventions of the society and culture one is part of.

1.2.2. The Connection between Rhetoric and Culture

Carrithers' second point about rhetoric's distinctly human and cultural nature helps explain how the interconnectedness between rhetoric and culture works. The basic idea is that rhetoric draws its resources from culture and at the same time expresses culture. This can be understood from two angles.

Firstly, there is cultural content embedded in rhetoric. This can be best understood in Carrithers' ethnographic example of a Sri Lankan mother scolding her child and telling him to stop playing in the mud. Through this scolding the mother conveys a number of things simultaneously,

> In fact this is quite an extraordinary and highly concentrated slice of rhetoric cum-culture, for it conveys to the child, in one short hot virtuoso burst, at once a desired aesthetic of comportment (cleanliness), a classification of the social world (us vs outcastes), and a negative evaluation of the others (dirty in nature, even if not in actual appearance). (Carrithers, 2005:579)

This example demonstration show how persuasion and rhetoric contain within themselves 'cultural matter' such as norms, particular understandings of cultural phenomena, ideological content, etc. The resources and the ways they get configured to deliver a convincing persuasion are deeply rooted in culture and are context-specific.

On the other hand, seemingly mundane phenomena that do not seem rhetorical at first glance can be presented in a persuasive manner, namely, cultural content can be turned into rhetoric. Carrithers gives an ethnographic example of how the cooking of Chapati flatbread in India is used to explain spiritual matters,

> The cooking of the flatbread chapati in India is a distinct and, in my experience, difficult and purely corporeal skill, but it became persuasive when it was used by a Jain ascetic in a sermon to explain that the soul can be separated from its impurities as the top side of a properly made chapati rises away from the bottom as it is heated on the griddle. (2005:442)

Cultural content can be turned into rhetoric by expressing it in figurative way through the clever use rhetorical tropes such as metaphor/analogy in the example above. There is a great deal of persuasive creativity in what Carrithers calls 'social poetics of everyday life' (2005:442) However, the persuasive manner in which things can be expressed in not limited to rhetorical tropes. Narratives and storytelling are also very potent means of persuasion, as they are instrumental in helping a person 'move away' from the *inchoate* towards that which is orderly and makes sense (2005:444). A great deal more can be said about this topic, which will be covered in the following part on narratives and rhetoric.

1.2.3. The Grand Scheme: Rhetoric, Agency and the Reproduction of Culture

Carrithers' conceptualization of culture as a resource illustrates his understanding of the grander scheme of how individuals, society and culture are interlinked. It is a somewhat slightly different take and an insightful perspective on the age old anthropological question of how sociocultural processes are reproduced and where is there space for innovation and agency. The analytical framework I will explain here is important, as it will help explain where there is room for agency and change within the power relations that characterize doctor-patient communication.

It is the question of what shapes human action in certain circumstances and whether there is room for variation and agency. In his article *Anthropology as a Moral Science of Possibilities* Carrithers addresses the question of moral agency, using an example of a psychiatrist in Nazi Germany who refused to paticipate in a program to sterilize the mentally handicapped. It is a compelling context in which to consider the possibility for flexibility and variation of one's expression of agency, especially

considering larger sociocultural processes and restrictions of that particular time, namely, the widespread prevalence of imposed Nazi ideology and the threat of sanctions for not adhering to them. The psychiatrist refused her superior, who tried to convince her that the mentally handicapped are 'not like us', the psychiatrist argued that, 'There are many people who aren't like me, in the first place, you' (Carrithers, 2005:440) An in-depth analysis of this example will help illustrate Carrithers' understanding of the relationship between culture and an individual's agency, moreover, the very nature how culture is constructed from moment to moment through interactions.

Carrithers notes that in the case of the psychiarist, despite the influence and pressures of her cultural milieu,

> [...] we can see that her speech itself refers to the immediate face-to-face situation, a more or less instantaneous and deeply felt response to another person [...] each woman's [psychiatrist and another woman] is a sharp and immediate rejection, an *ad hoc* delimitation between the speaker and others, quite immediately in the case of the psychiatrist and by implication in the case of the other woman, who was surrounded by people conforming to Nazi demands (2005:440).

This example and observation by Carrithers is significant in pointing out an overlooked aspect in explaining what shapes and accounts for expressions of agency. He emphasizes that the response of the psychiatrist was improvisational in nature and that it does not refer to some larger culturally embedded discourse about morality. (2005:440) This is relavent in the context of how anthropologists conceptualize the relation between the self, agency and the role of culture. Carrithers criticizes the proposition made by Mauss that a person's moral agency, 'is always and ultimately subjected to the coercive force of the collective and of collective representations' (2005:440). Within the branch of anthropology that studies the self, personhood and agency early anthopologists echo Mauss' position that emphasizes the role of culture in the formation of the self and agency. Margret Mead, for example, also suggests that the self and the ways people act are more or less a product of interaction within a certain environment (Moore, 2007:25). Carrithers takes the position of anthropologists who are critical of the overemphasis of the significance of culture in the formation of the aforementioned aspects, he states that acccording to Mauss's view, 'individual

judgments and acts are always finally explained by the force of culture and social structure' (2005:440), however, he argues against this notion, highlighting that it excludes any possibility of insight on the behalf of the agent,

> The Maussian idea of the person has room only for "the accident of birth," that is, having been born into a particular society and culture and acting wholly under the influence of that culture, with insight, reason, and choice playing no part. The notion of moral agency, in contrast, allows that people exercise insight (or foolishness) and good (or bad) reason. It entails an awareness of people as both acting and reacting, as both agents and patients (in Godfrey Lienhardt's [1961] terms) in their social world (2005:440).

Carrither's view of the link between the individual, agency, society and culture opens up the space for the individual to go against the structure society and culture places on them. It paints a picture where individual agency, society and culture as not something set in stone, but rather a fluid process where there is space for the unexpected and that which goes against what society and culture imposes,

> And because it allows both agency and patiency we can gain a picture of society as a web of persons both acting upon each other and acted upon and therefore in a state of flux and, to a degree, uncertainty. The Maussian notion, to the contrary, allows for personhood only as patiency, as acting solely according to the dictates of collective representations, and therefore denies uncertainty or choice. (2005:440)

This illustrates Carrithers understanding of where the leeway exists within the reproduction of culture and society, as he himself neatly states, agency-cum-patiency, 'allows for mutability in human society and therefore for historical change' (2005:440). It is important to grasp that at any given moment during an interaction a person can either be an agent or a patient. It is important to also note that, even though Carrithers does not state it explicitly, the social agent can also go against existing power relations as in the case of the psychiatrist who went against her superior. Moreover, Carrithers conceptualization displays culture as something that is formed through interactions and through the reactions and responses of its participants. Thus, culture is not determining, it serves as a resource.

Taking this stance, Carrithers explains how new cultural forms are created in social life. The main point he reiterates and elaborates upon is that,

> [...] the schemas of culture are not in themselves determining, but are tools used by people to determine themselves and others. Then it places agency-and-patiency to the fore; the tools of culture are used by people on one another, to persuade and convince, and so to move the social situation from one state to another (2005:581).

The proposition that 'the schemas of culture are not themselves determining', but instead function as resources illustrates an important point made by Carrithers that is crucial in my thesis, namely, that it is possible to employ rhetoric in a variety of ways during interactions by drawing upon cultural resources to enact one's agency. Rhetoric and persuasive techniques are paramount in the way culture, society and power relations are reproduced and changed.

1.2.4. Similar Views by Other Anthropologists

Before finishing up this part, I will briefly refer to other anthropologists that share Carrithers's ideas, as well as provide an ethnographic example which shows how power relations can sometimes be overcome via rhetorical means. I do this to show that Carrithers' position is supported by others as well. I will, firstly, refer to Stranthen's ideas about the creative self and agency and afterwards I will give a brief overview of the main findings from Bailey's work.

Firstly, the idea of culture as a resource is not something Carrithers alone proposes, for example, in the context of the anthropology of the self, personhood and agency, Stranthen and Moore also suggest that the way culture and the Self interact is by the former serving as resource for the latter,

> Individuals take up sets of notions and/ or cultural materials and use them to make sense of changing circumstances. This process of interpretation and engagement produces new combinations of ideas and theories of relatedness. The result is a creative self that speaks in cultural idiom. (Moore, 2007:31)

His idea of the creative self draws parallels with Carrithers' ideas. In essence culture and its conceptualizations of what the self and personhood are provide the 'source model' around which it is possible to organize one's experience of self-consciousness, agency and personal identity (2007:31). Stranthen also sees culture as a tool for making meanings and developing ideas, desires, motivations and experience. (2007:31) Another point where Stranthen draws parallels with Carrithers position is that he emphasizes that the self is not put in a specific frame by culture. While culture does

influence the self through interactions with cultural categories and the formation of relations with others, however, these do not determine the self, there is space for resistance, change and creativity. (2007:31)

F.G. Bailey's ethnography provides an excellent example where a person, who is in an inferior position in terms of power relations, uses to rhetorical means to stand firm and act according to his own wishes, thus, not succumbing to the other's power. Bailey also gives an insightful explanation of how this is achieved – through appealing to different structures and ideas about the nature of a transaction, where it is possible to defend one's proposed view by using persuasive techniques.

To briefly explain the situation in the ethnography, it features Roberto, a wealthy corporate executive, who wants to purchase a lintel from a local peasant because he finds it a valuable addition to his collection of local memorabilia. The peasant refuses in an elaborate diplomatic manner what Roberto believed to be a good barter, saying that he co-owns the lintel with two of his brothers, thus, it is not solely up to him to sell it. After the interaction Roberto thought that he had been foolish not to send his henchman foreman to close the deal, because, according to Roberto, the peasant would have readily agreed. (Bailey, 2009:107-108) Bailey explains that obviously the peasant intended to show his lack of respect for Roberto and that Roberto, who considered that his henchman could have handled the transaction better, believed this was due to differences in class (2009:108). Moreover, Bailey highlights the elaborate way the peasant refused, a simple 'no' was, 'expanded into a parable about the alternative structures available to define morality in Losa' (2009:108).

He uses a 'simple interactionist and (qualified) intentionalist model' (2009:108) to explain how rhetoric works in social systems, this model consists of 'a repertoire of alternative ideas one is a repertoire of alternative ideas both about how a system should work (a morality) and about how it actually works (a presumed reality)' and also 'a repertoire of persuasive techniques' (2009:108). Bailey discusses a very important notion that is central to the understanding of how rhetoric provides flexibility in interactions where there is an unequal balance of power, namely,

> No structure and, more generally, no idea (including, I suppose, itself) be an eternal verity. All structures and all theories, in varying degrees, are fallible

> insofar as they can be displaced by another structure, which the performers hope will better suit their purposes. Structures are constructs of the mind; they are not entities that exist outside the world of thought. None can be true in the clear and simple correspondence-sense of that word (2009:109).

Essentially, there is no absolute one truth, any position can be argued against or negotiated by offering a different sturcture, interpretation or understanding. This is why no matter what kind of structure someone in a position of power use to justify his or her agenda there is the possibility for the other person to argue against him or her by offering his or her own structure. Bailey gives a quote from Perelman and Olbrecths-Tyteca that describes the rhetorical process that occurs when there are different understandings of a situation, 'there is then a competition to define the situation by the use of techniques that 'increase the mind's adherence to the theses presented for its assent'' (2009:109). Rhetoric gives the means to convince another of one's point of view.

In case of the transaction between Roberto and the peasant there are different structures used by both parties to interpret and act in the specific situation. Bailey explains that Roberto bases his persuasion on the structure on 'the principle of expected utility – of a market economy' (2009:109). This is compelling to consider as the structure chosen by Roberto sets certain expectations on the peasant and the unfolding of the transaction, the neo-classicist economist's expected utility stance presumes that in an exchange,

> [...] no status is of any relevance in understanding what is taking place except that of the rational, self-interested, calculating, economic person. Expected utility is (purportedly) a universal language; it presumes common ground, is neutral, and is without cultural entanglements; it is the extreme of abstraction (2009:109).

According to this structure it is evident why Roberto found the peasant's refusal foolish – he was refusing an easy opportunity to make money. The peasant, on the other hand, felt offended by the offer due to the fact that Roberto did not clearly establish the interaction as that of purely a business deal, he gave off, albeit indirectly, a sense of class antagonism (2009:110). The peasant did not appeal to the economist structure, but rather the structure of moral standards within the local community, which entails that

he was offended by Roberto's suggestion to, in a sense, betray his obligations towards his brothers for monetary gain (2009:110). Bailey further clarifies the situation,

> In this there is an implied assumption that he and Roberto shared – or should have shared – the same moral standards. they were paesani – people who belonged to the same moral community, who define right and wrong in the same way, and who share a relationship of solidarity and mutual consideration (2009:110).

The peasant appeals to a different structure, but it is interesting in the way how it is done. The lack of regard for morality on part of Roberto is never explicity voiced during the conversation, the polite and diplomatic manner the peasant uses to refuse Roberto elaborately hides within itself an implied shaming about the disregard for morality. (2009:111-112) In effect, the peasant not only manages to refuse the rich through rhetorical means, but he does so in a ironic fashion, mocking Roberto and claiming moral highground in the interaction. The message is that he cannot be bought off and Roberto ought to feel ashamed for using his upper-class privilage, but it is never explicitly voiced. Instead the peasant uses the opportunity to implicitly make fun of Roberto by being overly polite, making an absurd proposition (selling his fourth of the lintel) and getting permission from his brothers, which, if taken to actually be sincere, would really make the peasant seem foolish (2009:115). It is an excellent and compelling demonstration of claiming power via rhetoic and the cunning use irony within an interaction by the one who is an inferior position in terms of power. As Carrithers said, namely, that at any given moment the roles of persuader and persuaded can shift in unexpected ways.

1.2.5. Summary

In conclusion, rhetoric can be considered as a moving force in social situations, it is the means by which people persuade, dissuade and move from the *inchoate* towards a plan or a desired outcome. This not only applies to interactions between two or more people, it also refers to the very way people carry out an internal rhetorical negotiation to arrive at a conclusion what action to take. Rhetorical analysis illustrates the power relations inherent in interactions, Carrithers proposes to view agency in terms of agent/persuader and patient/the persuaded. Persuasion is the key function in rhetoric and it can be achieved in a variety of ways by employing figurative language, rhetorical

tropes and narrative elements. It is important to also note that rhetoric draws its persuasive resources from culture and at the same time encompasses and expresses it. An instance of rhetoric can carry within itself the norms of a society, At the same time mundane cultural phenomena that do not seem rhetorical can used in very persuasive ways, such as Carrithers' example of using the process of cooking flatbread as cultural resource to draw parallels and create a comparative framework for understanding spiritual concepts. It nicely illustrates how not only the way of expressing something can achieve a persuasive effect, but also the significance of the content and context.

An important aspect is emphasize from Carrithers' theory of cultural rhetoric is its ability to express agency and create space for expressions of power within unequal power relations. This is based on the author's idea that cultural reproduction occurs from interaction to interaction based on the reactions and responses of its participants. Within every interaction there is room for the unexpected where a participant can become an active agent/persuader at any given instance and draw upon cultural resources to negotiate and argue for his or her position. Of course, by and large there a variety of factors which are impossible to account for that may influence the unfolding of interactions and it is possible that social actors may act in culturally prescribed ways, but it is important to note that the cultural framework should not be regarded as determining. There is space for creative expression of agency and rhetoric serves as a vital tool to achieve it.

On a final note, Carrithers' conception of rhetoric actually goes hand-in-hand with that proposed by the authors of *Contemporary Perspectives on Rhetoric* which entails that, 'Rhetoric is an action human beings perform when they use symbols for the purpose of communicating with one another' (Trapp 1991: 16) Lastly, to reiterate the key idea and tie of notions of culture, agency, rhetoric and persuasion, in a nutshell, rhetoric and persuasion are the tools (within culture that reproduces itself moment-to-moment through interactions) that allow an individual to express his or her agency creatively by drawing on cultural resources to act as an agent/persuader.

1.3. Rhetorical Perspective in Medicine

This part discusses the rhetorical aspects of medical interactions, furthermore, it helps illustrate analytic perspectives that can be applied in a clinical setting.

Moreover, the section dedicates a sizable portion to explaining the theoretical framework for analyzing power relations within the doctor-patient interactions, most importantly, focusing on the ways these power relations get reproduced and where is there space for agency and change within the interaction. Parallels are drawn between the theory of power relations and Carrithers' theory of rhetoric. This part of the thesis features, first of all, an overview of what makes the clinical interactions rhetorical in nature, focusing on broad perspective and on doctor-patient consultations specifically, using Barbara Scharf's theoretical framework. The next section explores in-depth a model for understanding power relations in doctor patient interactions and how these get reproduced, this section is largely based on the well-thought out theory proposed by Marisa Cordella, the author of *The Dynamic Consultation: A Discourse Analytical Study of Doctor-Patient Communication*. This part also provides an ethnographic study by Paul ten Have which somewhat illustrates the notions proposed here.

Undeniably, much of the communication and processes in clinical settings entail rhetoric. Persuasion is a central element in the practice of medicine. Looking at a very basic level – the treatment process involves a doctor convincing and persuading a patient to carry out certain actions like taking medications, adhering to a specific diet or making lifestyle modifications in order to help him or her recover. Looking at a larger scale, the very organization of health-care is governed by a complex interaction between different texts such as medical journals, which hold persuasive influence on the way patients and doctors shape their understanding, experience and actions in different clinical situations. Bio-medical knowledge itself relies on persuasion which draws its power from the method through which data is obtained, namely, science which is treated as a cultural authority on truth. In recent years there has been an increased awareness of the rhetorical nature of clinical interactions which is evidenced by an increasing number of studies applying rhetorical analysis in a variety of clinical situations, as well as initiatives for new inquiries about the subject. (Scott, Segal, Keranen, 2013:1) Rhetoric is recognized as a fruitful means of investigation that offers the possibility for better understanding the social impacts of health-related discourse, clinical practices and, most importantly, issues in regards to doctor and patient interactions.

1.3.1. Doctor Patient Consultations as a Rhetorical Situation

The particular aspect I am interested is how rhetoric is employed in the interaction during doctor-patient consultations. I refer in this section to a number of theoreticians who problematize the doctor-patient consultations and explain in greater detail how exactly rhetoric takes place and why it can be considered a rhetorical situation.

Derkatch and Segal see the doctor-patient consultation as rhetorical situation and a distinct medical genre, as its most compelling features are its interactive nature and the prevalent role persuasion plays in it,

> They [doctor-patient consultations] are dynamic and dialogic; they unfold in real time and depend on the exchange between or among speakers with their own attitudes, beliefs, ideals, priorities, knowledge, and motives. While certain other medical genres (such as case presentations) share elements of dialogue, doctor-patient interviews highlight the different persuasive resources available to speakers from different backgrounds (Derkatch & Segal, 2005:140).

Barbara F. Sharf, using traditional rhetorical concepts, also conceptualizes the doctor-patient interview as a particular kind of genre/rhetorical situation that is distinct from other types of information-gathering interviews. Apart from the already mentioned differing discoursive universes that the patient and doctor belong to (2005:140), Sharf suplements the characterization by adding: that societal role expectations situate the doctor in a more proactive and powerful position while the patient is expected to be passive; the discourse is often of a worrisome nature for the patient; doctors operate under strict time constraints and work with multiple patients during the day, which makes efficiency a priority (Sharf, 1990:219). Compared to an informal conversation or transaction, it is evident that the doctor-patient consultation is marked by a variety of factors that restrict the conversation to a specific framework, where it would appear that the doctor dictates and controls the flow of the interview.

Considering all the unique and limiting charateristics of doctor-patient communication, one might wonder whether there is place for rhetoric or negotiation at all. Sharf clarifies that it is the presence of ‘conjoint occurrance of intentionality and strategy’ (1990:219) that makes doctor-patient consultations similar to other rhetorical situations. The interaction is a goal-orientated speech act where both parties try to elicit

information from one another in order to solve what one or both parties perceive as a medical issue, moreover, it is an important negotiation of how treatment will be carried out that involves strategic choices made by both parties (1990:219). Moreover, the communication between doctor and patient is transactional in nature, meaning that both participants act at the same time as rhetors and audiences who attempt to negotiate a co-authored solution or, in some cases, where the doctor and patient have different goals in mind, each defend their respective agendas. (1990:220) While the overarching goal of the consultation for both parties is determining the course of action to take in order to solve the medical problem, however, at times doctors and patients can have different ideas about how to approach this. Doctor and patient agendas can be aligned or, at times, in opposition. Typical scenarios might involve patients disagreeing with a doctor's interpretation with their explanation of what the problem is, questioning diagnosis, objecting towards a form of treatment or insisting on a different plan of action. Doctors might also object towards a patient's unwillingness to cooporate, their lay understanding of medical phenomena, etc. In the ideal situation the end result and plan of action ought to be a joint effort, as Sharf remarks that, from a rhetorical perspective, relying on the doctor's authrority alone to force cooperation would not be good way to persuade and achieve cooperation. (1990:218) However, as already mentioned, there a variety of factors which put a strain on this interaction and put parties in unequal position in terms of persuasive resources.

Having established the doctor-patient consultation as a particular kind of rhetorical situation where both doctor and patient engaged in negotiating a plan of action, which constructed taking into consideration (in the best case scenario) the agendas of both parties involved, but can also involve a conflict of interests. The question is what are strategies and means through which either doctors or patients effectively persuade one another in cases where agendas are misaligned? In order to answer this question I will first look at some the inherent issues surrounding the power relations in the doctor-patient consultation.

1.3.2. Power Relations in Doctor Patient Consultations

Power relations in doctor and patient interactions are typically described as asymmetrical due to a variety of factors that put doctors in a superior position. There is

a vast amount of literature on this topic, noteworthy are the works of Lieberman and Waitzskin who consider asymmetry as a primary feature of doctor-patient communication. However, there have also been a number of authors in recent years who have argued against this position such as Nancy Ainsworth-Vaughn, Paul ten Have, Marissa Cordella, amongst others, who insist that there are opportunities for power to be claimed within the doctor-patient interaction. A common trend of thought can be found among these authors, first of all, they propose the view that power is dynamic and language/discourse holds the potential for negotiating and controlling how power relations unfold in any given interaction. In this section I will explore the frameworks for the conceptualization of power as a fluid entity and the transformative role of language in the process of forming power relations. The end goal of this section is finding a common link between these ideas with Micheal Carrithers' proposed model of looking at agency and power relations as an interaction between agent/the persuader and patient/the persuaded.

In order to understand the link between power and talking one must first look at the larger structure of how discourse and power are intrinsically linked and produced in interactions. First, I will largely refer to Marissa Cordella's work and theoretical considerations of power in her book *The Dynamic Consultation: A Discourse Analytical Study of Doctor-Patient Consultation* (2004), as it provides an excellent groundwork for studying rhetorical strategies and power dynamics in doctor-patient interactions. Her perspective is practical because she looks at, 'the expression of power as one form of talk that interacts with other forms of talk in medical discourse' (Cordella, 2004:13). Her theory provides the necessary foundation to situate and explain other similar theoretical perspectives and to justify my analytical approach of the relation between rhetoric and power.

Marissa Cordella gives an overall framework of how to conceptualize power and agency, thus, adressing questions how power is reproduced and how it is possible for agents to introduce changes into the reproduction of power. She starts with Michel Foucault's idea of discoursive formations and his conceptualization of how power works. The important aspect of Foucault's explanation of power is its non-localized and omnipresent/circulatory nature,

> Power is employed and exercised through a net-like organization. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target; they are always also the elements of its circulation. In other words, individuals are the vehicles of power, not its points of application. (Michel Foucault, 1980: 98)

The main point Cordella makes is that power is not a static, but rather a dynamic entity that is produced through the actions of individuals (2004:14). Another factor emphasized in Foucault's understanding of power is that it needn't be conceived as something purely negative and opressive, in fact,

> What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression (1980: 119).

Power is not oppressive, but also a postive and productive force that incites social action. Cordella refers to Giddens criticism of Foucault's model of power who highlighs the lack of consideration for the role of agency in his scheme (2004:14). An important contribution to the understanding of how power functions by Giddens is his idea of, 'the capability of the actor to intervene in a series of events so as to alter their course' (Giddens 1976: 11). Cordella explains that Giddens's conceptualization how power operates through social action that takes into account how power is exercised on a social level, taking into consideration factors such as time and space. (2004:15) She also states that authors such as Wodak and Fairclough propose that the same rules Giddens proposes also apply to the creation of discourse, namely, it is created in particular context, at a particular time, in relation to other discourses. (2004:15) Moving on, we come to a significant point made by Cordella, which basically entails that it is possible to bring about changes in the reproduction of power through discourse and at the level of interactions between social actors, since power is dynamic and the discourse is changed by the behaviour and actions of those who shape it,

> [...] The reproduction of a structure is both the means of social practice and the medium through which social practices are preserved in time. Nonetheless, the exercise of *dialectic of control* has the potential to make alterations to those structures,much in the same way as, in the process of reproduction – following a biological analogy –, changes such as mutations may occur. In terms of social

> theory, actors/agents are capable of changing structures in the process of reproducing them (2004:15-16).

To paraphrase and sum up the main argument: power is produced through discourse, discourse production is contextualized in time and space, thus discourse can be affected through the actions of those who participate in the interactions that shape the discourse, thus, power is not static and it can be shaped through social action by social agents. (2004:16-18) What is important to conclude is that there exists a leeway in doctor-patient communication to overcome its inherent asymmetry of power. This can be achieved because, as Cordella explains, 'once there is an understanding of how power is exercised in a particular context, there is a chance of bringing changes into social practice' (2004:16). This is a perspective that is echoed by other authors as well. For instance, Sonja K. Foss and Ann Gill, who look at the role of rhetoric as an epistemological category in Michel Foucault's theory of power and discoursive formations, also conclude that is possible to express one's agency and enact change within a discursive formation, using Foucault's terminology, within interactions through the use of effective rhetoric which is based on understanding of the rules and roles within a discoursive formation and relations of power,

> Foucault's theory gives rhetors the understanding to create change in a discursive formation. When we understand the rules of a discursive formation, we are more able to question why some statements are considered true in a discursive formation and whether we such rules to govern the discourse that creates our knowledge. When we understand how particular roles in a discursive formation are formed and maintained, we are more able to change our role as rhetors within that system and to to explore options for changing other roles that create particular kinds of knowledge as well. Similarly, when we armed with knowledge of how power relations operate in such a discursive formation, we are more able to choose wheter or not we accept the influene of the power in the system [...] (Foss & Gill, 1987:397)

Foss and Gil's conclusion also goes hand in hand with Cordella's theory, which purposes that changes within the production and reproduction of power within certain social group through discourse can be achieved, but it relies on the resources at the disposal of actors (2004:16). The idea of resources is taken from Giddens' structuration theory, in which the term means, '[...]'resources' that make the exercise of power possible' (Giddens, 1993:13). Cordella emphasizes another important point that relates to doctor-patient communication, namely, that regardless of the inequality or

asymmetry of resources in an interaction, namely, the doctor having more resources to enact power, it does not mean that a participant does not have room to claim power in the interaction (2004:16-17).

Refering back to my section on Carrithers' conceptualization of rhetoric and how it is like a moving force in interaction which draws its persuasive resources from cultural context and uses them in creative ways to create new forms of culture, I would like to draw paralels between his model of agency that views power relations in terms of the *agent/the persuader* interacting with the *patient/the persuaded* and the theoretical framework for power, as proposed by Marissa Cordello, taking into consideartion Foss and Gill's theory about the role of rhetoric in changing discoursive formations. Clearly, since it is possible to affect the reproduction of power through discourse in the interactions that form said discourse, then it would also stand true that rhetoric and persuasion play a significant role in these kind of processes. It is important that Cordello states that it is possible to claim power regardless of the asymmetry of resources, as per Giddens' terms, in the doctor-patient interaction. This also echoes Carrithers' proposed idea that there is space for agency and change, Cordella's theory helps provide a suplementing theoretical explanation of this occurs in interactions, focusing more on power relations. Moreover, Carrithers' idea of drawing persuasive cultural resources[1] from culture bears similarity to the idea expressed by Foss and Gill – that it is possible to go against power through the use of rhetoric and knowledge of the particularities of a specific discoursive formation. Taking into consideration both Carrithers and Cordella's proposed ideas, I suggest that while doctors and patients have at their disposal asymmetrical resources, it is still possible to rhetorically negotiate and claim power within the interaction. This stand true for both parties involved, thus, it is possible within the interaction to maintain or change the asymmetrical power structure. At any given instance there is possibility for either the doctor or the patient to be the

[1] In order avoid misinterpretation and to clarify the use of the term 'resources' in this thesis it should be noted that Giddens' conceptualization of resources within his structuration theory, which entails resources of power, is not the same as Micheal Carrithers' rhetoric theory's notion of cultural resources that can serve as persuasive elements.

persuader or the persuaded. According to Carrithers this can be accomplished by drawing on rhetorical techniques and persuasive elements from culture, in my opinion, this a good approach to analyzing doctor-patient communiction.

1.3.3. Ethnographic Example of Power Negotiation in Medical Consultations

Having established that there is room for negotiation of power within doctor-patient interactions through language and, respectively, rhetorical means, I will look at a concrete ethnographic example that has studied how this process occurs in greater detail. Paul ten Have's work also is useful in the sense that it illustrates at a more detailed level the different parts of the doctor-patient consultation and also presents critical evaluation of other theories that view this question. This section should help better identify the particular ways doctors and patients rhetorically claim power during the interaction, as well as the resources that are at their disposal.

Anthropologist Paul ten Have, the author of *Talk and Institution: A Reconsideration of the "Asymmetry" of Doctor-Patient Interaction*, proposes an analytic perspective that echoes the consideration about the nature of power and its reproduction that was discussed by the authors in the previous section. Paul ten Have suggests a different approach to that how asymmetry in doctor-patient interactions is usually studied,

> While traditionally the asymmetry of doctor-patient interaction was considered as an effect of institutional structures, rules or resources, it now becomes possible to think the other way around, in the manner developed over the years by ethnomethodology, and see how asymmetries are produced *in and through the details* of physicians' and patients' situated interactions (Paul ten Have, 1991:138).

Here we have a theoretical proposal that supports Cordella's notion that asymmetrical distribution of resources do not stand in the way of claiming power. Furthermore, Paul ten Have supports my suggestion that it is possible to negotiate power through talking and the use of rhetoric, as he demonstrates in his work a number a ways that participants of the medical encounter, 'talk an institution into being', thus, 'accomplish "asymmetry"' (1991:138). This also coicides with Carrithers' notion that during the unfolding of an interaction there is space for both to be *agent* and *patient*, namely, that

the cultural structure, in this case, the institutional one does not set the interaction in some completely unnegotiable frame. I say ‘completely’ because, undeniably, the institutional structure does place some considerable restraints on the interaction.

Paul ten Have explains that doctor-patient consultations follow a certain organized conventional pattern, which features: complaint presentation, verbal and physical examination, diagnosis, and treatment, prescription and/or advice (1991:139). This structured nature of the consultation is described by other social scientists as well, for example, Baghari, Ibrahim and Hamil also see the consultation as a goal-oriantated speech act with its own contraints where each turn interaction is dedicated to fulfilling the goal of treatment or providing medical service (Baghari, Ibrabim, Hamil, 2015:250).

While the consultation can be characterized by a sequence of phases, Paul ten Have notes that , ‘on a more detailed level, this overall organization has to be realized through series of concerted activities that are sequentially organized [...] It is there that asymmetry seems to be produced’ (1991:139).

When analyzing doctor-patient consultations Paul ten Have describes that are two processes going on simultaneously,

> [...] there is a comparison of what is done, and what may be done, by physicians and patients respectively during the encounter. Secondly, those asymmetries are compared with a model of symmetrical interaction assumed for informal conversation among peers (1991:139).

Paul ten Have warns against taking the comparison of the conversation and consultation as empircal absolute, as these modes conversing occur interchangeably during a consultation, more emphasis ought to be put on the actual dealings within a consultation, which is where the production of asymmetry actually occurs (1991:139). Paul ten Have also makes an important point that within these dealings, ‘institutional structures are not only external constraints on participants' actions; they are also actively used as a resource for those actions’ (1991:139). Doctors used the institutional structure as a means to structure and guide the interaction along. Interestingly, Paul ten Have also makes the point that the view that consultations ought to have a more symmeterical coversation-like format, as expressed by some anthropologists, deserve criticism, as ‘making consultations more like conversations would either tend to be a

hypocritical masking of unavoidable asymmetry or would actually destroy the consultation as such' (1991:140). Essentially, asymmetry will always be present in these kind of interactions due to its very format.

Indeed, there is an unavoidable asymmetry inherent in the interaction. First, of all there is an obvious asymmetry of topic, as Paul ten Have puts it, 'it is the patient's health condition under review, not the doctor's' (1991:140). The second asymmetry is the different tasks in the encounter doctors and patients have (1991:140). It is the patient's initiative to come seek out aid at the doctor's office, thus, a patient's tasks include reporting their complaints and symptoms, going along with the doctor's decisions, the doctor's job is to make the diagnosis based on the information he or she has gathered from the patient (1991:140). Paul tev Have explains that,

> [...] this task distribution involves quite "natural" interactional dominance by the physician, enacted through questioning, investigating, and decision-making behavior, coupled with interactional submission by the patient, achieved through answering, accepting and generally complying with the doctor's orders and suggestions (1991:140).

Coupling this observation with what Schafer commented upon and what I observed myself, the fast-paced and heavy workload environment doctors are a part of, it really is no wonder that the doctor takes the role of guiding and controlling the interaction. Firstly, there is the difference in medical expertise which places the doctor in a superior position, thus, he or she has access to knowledge the patient does not. Then there is the limited amount of time during a consultation, thus, it is essential for the doctor to derrive information that would most efficiently allow him or her to arrive at a diagnosis or a treatment plan, this, however, at times involves silencing and overlooking certain patient's utterances that are not considered 'helpful' to the diagnosis. It is something Kleinman has done research on and proposes the idea that the doctor usually refers to the universe of disease, thus, focusing a reductionist biomedical understanding of disease as symptoms and pathology of the body, as a result excluding the social aspects and subjective undersetanding of the patient's illness universe (Kleinman, 1988:3-6). Overall, this interactional format creates restraints and contributes to a certain asymmetry which affect the interactional style. Paul ten Have, refering to a variety of studies on doctor-patient consultations, makes the conclusion that generally there are

two major trends how doctors interact with patients, ‘one of monopolizing initiatives, and another of withholding information.’ (1991:141) These can both be viewed as expressions of the doctor’s power.

It is worthwhile to consider the asymmetry of initiative in the consultation in each respective phase. A typical doctor-patient consultation starts with the patient’s initiative to visit the doctor, the patient is briefly given the initiative when the doctor asks for the reason of arrival and then initiative is lost once the doctor commences questioning to establish a diagnosis (1991:142). Paul ten Have explains that both doctor and patient contribute to the the start of the interaction, however, most of the times the doctor takes on an active role while the patient remains a respondent (1991:143). However, it ought not to be generalized that this is always the case, as the author notes that,

> [...] one can observe the emergence of a different format oriented to the history and the larger context of the complaint(s), rather than to just the facts. This format implies a more active role for the patient, as a teller of his or her own story.

In these kind of situations it is through the way a patient chooses to structure his or her answer that he or she may overcome the typical interview format that resembles more of an interrogation. In the situation Paul ten Have described, where the doctor asks not just for some facts, but a fuller account, there is the possibility for the patient to structure their story in a way that the 'pressing complaint' is not revealed at once to the doctor (1991:145). This can be achieved in a variety of ways,

> 1 by starting earlier in time (line 24), thus suggesting that the very reason for the present visit has not yet been discussed;
> 2 by mentioning relatively permanent states (lines 24-5), this effect is strengthened, suggesting its status as "background information";
> 3 by adding a second item (line 27) to a previous one (line 24), it is suggested that a "list" is being constructed, which again heightens the expectation of more to come, that is, a third item to the list (1991:145).

It is by using these kind of devices that patients can change, 'their local interactional identity from that of a "respondent" into that of an "informant"' (1991:145), where the

patient has more opportunity to express him or herself. Paul ten Have further explains that,

> What these observations indicate is that although patients generally play their submissive part in the established "asymmetrical" format, possibilities also exist for patients to extend their chances to bring in materials on their own, which are sometimes successfully used. We should note that the devices for doing so are quite ordinary ones, regularly deployed in casual conversations (1991:145)

What is particularly compelling is the way patients maintain their initiative by hiding and avoiding making it explicit, using the various strategies quoted above,

> [...] patients seem to disguise their interactional initiative by refraining from formulating requests, by giving the initiative back to the physician rather quickly, or by using quite subtle and covert devices to hold off the doctor's questioning interventions (1991:145).

Essentially, power can be claimed to some degree within an interaction by not going along the standard interaction structure of a clinical consultation. To some degree, if narrative structuring can be considered a rhetorical action, then parallels can be drawn between what Paul ten Have and Carrithers suggest, namely, that is possible through rhetorical means to overcome an asymmetry of power within the framework of an interaction. It is the way how one chooses to reveal information that allows one to evade the typical dominant interaction structure that characterizes the medical encounter.

Moving on, it is important to consider the next phase of the clinical consultation, namely, the part where the doctor takes control via questioning. Paul ten Have explains that there have been studies that suggest that patient questions are mostly dispreferred during clinical interactions, however, this is too generalized a view, as there are different degrees of restrictiveness for questions in the consultation (1991:149). Largely, questions are dispreferred during the 'differential diagnosis' data gathering phase of the consultation, while afterwards the doctor may be more inclined to listen to a patient's questions concerning treatment or inquiries about medicine-related things (1991:149). The main argument is that question restrictiveness is related to phases, moreover, it depends on the doctor's approach, who can formulate questions in ways that are more or less restrictive (1991:149). In a nutshell, properties such as control or responsibility in the interaction are not given attributes to specific individuals, nor the 'automatic effect of institutional forms', instead it something that is achieved, I cannot

stress this enough, turn by turn during the interaction, hence there is the opportunity for both parties to negotiate during the consultation to achieve a less asymmetrical interaction (1991:149).

Overall, Paul ten Have makes it clear that the asymmetrical relationship of power in doctor-patient communication is unavoidable to certain degree, however, it should not be assumed that it is a constant feature throughout the consultation. What is most important to take away from Paul ten Have's research is the fact that power relation asymmetry is built during the actual interaction turn-by-turn, hence, while there is a tendency for participants to act in accordance with institutional expectations in an asymmetrical way, there is also the possibility for a patient and doctor to claim power in varying degrees, thus to communicate in less asymmetrical ways. Patients, for example, can interact in ways that does not go along with the expected format of the consultation, which in turn gives them the chance to enact their agency to a greater degree.

1.4. Narrative Approach

Having established in previous sections the role of rhetoric in studying sociocultural processes and how rhetoric is a vital tool in managing power relations and the reproduction of culture within interactions, I will now specify and deal in more detail about a particular aspect of rhetoric in more detail, namely, narrative. Anthropologists generally agree that narratives hold an important role in the way people make sense of the world and negotiate their experiences with others. Narratives are also considered to hold rhetorical and persuasive power in the way certain events are structured and presented through the use of narrative forms and various tropological devices. This part will consist of three sections, firstly, I will introduce the perspectives of different anthropologists, as well as other scientists of humanities, in order to establish exactly narrtive holds such a prominent role in social and cultural processes, as well as why can it be considered rhetorical. Secondly, I will discuss the narrative approach in medical anthropology, particularly focusing on in-depth examination of Cheryl Mattingly’s idea of therapeutic emplottment which I will be using for my own analysis of doctor-patient communcation. Lastly, I will look at the Nancy Ainsworth’s work which explains the connection between telling stories within the clinical consultation and claiming power.

1.4.1. Everyday Conversational Narratives

Humans are storytelling creatures by nature, narratives serve more than just reflective accounts of past events, rather they can be viewed as a fundamental lens through which people organize and make sense of their experience. This is kind of view on narratives is somewhat a common trend in anthropology shared by various theorists. Here I will explore some of the most prominent conceptualizations and draw parallels in regards to key ideas.

Cheryl Mattingly made this observation while studying 'how narrative referenced to a world beyond it'(Mattingly, 1998:3) among professional groups. She carried out a study among World Bank workers in charge of organizing urban development projects for third world countries. What is compelling is the way narratives were employed during this process, namely, that, 'stories were not just told after the experience but were constructed while people were still in the very midst of action' (1998:4). This occurred at times when workers from different fields had to make sense of a particular incident or troublesome situation in a limited amount of time, particularly focusing on who to blame and what ought to be next decisive step (1998:4). This was achieved, as Mattingly observed, by jointly co-authoring a narrative – taking in various story bits from different workers, linking them with other previous narratives and piecing together a cohesive actor-centered discourse, which is arranged in a chronological order and where causal links are attributed to human agents (1998:3). The main reason for creating narrative structures for particular situations, as already mentioned, is to situate events in an oderly fashion so that it would be possible derrive a plan of action as to what to do. Hence, narratives can be seen to possess a certain persuasive and rhetorical quality about them, according to Mattingly, however, I will elaborate upon this more in the following section.

The role of narrative as an essential tool for socializing and sense making of experience is well studied and explained in Elinor Ochs and Lisa Capps *Living Narrative: Creating Lives in Everyday Storytelling.* The authors of the book also emphasize, just like Mattingly, that the use of narratives is a very pervasive phenomenon in everyday life and communication. Moreover, they claim that telling narratives is a 'central proclivity of humankind' (Ochs & Capps, 2001:2). Also similarly

to Mattingly, Ochs and Capps make the observation how conversational narratives are usually created in the midst of action or constructed 'on the go', so to say, making adjustments to the story turn-by-turn in co-authored a interactional manner as the narrative unfolds to make sense of some particular life experience (2001:2-3). The roles of teller and listener get exchanged in the construction of a narrative and each puts forward one's version of narrative against another's in order to negotiate a specific interpretation of events (2001:3). Most importantly of all, the authors provide a very insightful observation about the nature of narrative construction, namely,

> [...] ordinary narrative crafted in everyday social encounters elaborately evidences the central tension that drives human beings to narrate. All narrative exhibits tension between the desire to construct an over-arching storyline that ties events together in seamless explanatory framework and the desire to capture the complexities of the event experienced, including haphazard details, uncertainties, and conflicting sensibilities among protagonists. The former proclivity offers a relatively soothing resolution to bewildering events, yet it flattens the experience by avoiding the facets of a situation that don't make sense within the prevailing storyline. The latter proclivity provides listeners and narrators with a more intimate, "inside" portrayal of unfolding events, yet narrators and listeners can find it unsettling to be hurtled into the middle of a situation, experiencing it as contigent, emergent and uncertain, alongside the protagonists (2001:4).

The constructed nature of narratives in social contexts is a very important thing to make note of, as it helps establish the rhetorical nature of narratives. In my opinion, it is negotiated interpretation of events that is produced in manner to satisfy both of the aforementioned proclivities to some extent. This is a valuable perspective that sheds light on a particular way of understanding narratives among other schools of thought on the subject.

1.4.2. Narrative, Experience and Actions

What is important is that these authors illustrate a concrete way of viewing narrative. Mattingly's book *Healing Dramas and Clinical Plots: The Narrative Structure of Experience* features a very helpful overview of prominent approaches to conceptualzing narrative. Firstly, the interpretations by Mattingly, Ochs and Capps go against the mimetic 'realist' stance that makes the assumption that narratives, 'at some deep level there is a natural correspondence between live as lived and life as experienced' (1998:25). It is a very multifacted discussion about the nature of narratives that

possesses a lot of diffuclty in terms of its epistemological character – to what degree do narratives serve as referants to truth and how much of them are actually fiction? Mattingly states that there are actually 'no bare facts' about narratives (1998:32), meaning that the very way experience, at least past experience, is structured is biased in the sense that there is a subjective selection and ordering of events, as well as attribution of meaning to them. Moreover, she further explains that, 'the fictionality of narratives is often linked to its capacity to order experience' (1998:32). Life experience is put into an orderly frame which entails cutting out elements that would contradict this orderliness, which in turn points to the subjective and persuasive nature of narratives.

However, Mattingly does not entirely agree with the contemporary anthropological, as well as modern and postmodern literary theory stances, which abandon referential basis between actions, experience and narratives. She makes an significant point stating that it is not the referential aspect of narratives where its meaning lies, rather, 'what really matters at getting at narrative meaning is the event of narration, because how a story is narrated and how it is understood depends upon who is listening and other relevant features of the context of narration' (1998:43). Rather than the referential functions, the social context and performance are emphasized as important factors in delivering narratives. But even those who take a perfomative perspective on narratives somewhat elude the referential issue, instead, Mattingly argues that it is the question of how the difference between narratives versus actual lived experience is conceptualized (1998:44). This leads to an even more important argument, Mattingly insists that there is actually a deeper, more homologous connection between narrative, actions and experience. She states that,

> [...] narrative imitates experience because experience already has in it the seeds of narrative. Further, the narrative structure of action and experience emerges in large part because actors have a need for narrative [...] Narritves give meaningful structure through time (1998:45-46).

This idea is similar to that of Ochs and Capps' idea of the proclivity to create coherence through narratives. The very way people understand situations and derrive what to do next relies on interpreting and situating their own and others' narratives as episodes in a larger plot. She refers to her work with occupational therapists to evidence this claim

which I will look at in more detail further on. Mainly, what the author tries to say is that one can view an action itself as an 'unyet told story' (1998:46). She also emphasizes her conceptualization of the relation between narrative, actions and experience,

> Contrary to Aristotle and later literary critics, history as lived experience is not formless succession. Life is not experienced as one thing after another because actors work to create a story-like quality to their actions. Being an actor at all means trying to make certain thing happen, to bring about desirable endings, to search for possibilities that lead in hopeful directions (1998:47).

In essence, it would be wrong to try and separate lived experience and narratives because the two are intervowen and fundamental to the way people experience the world and construct their actions. In a sense, I think this can be linked to the notion of 'rhetorical will', if narrative can be considered as a basic mechanism of sense-making and interpreting the world, it also is a rhetorical tool for creating motivation for actions by constructing the meaning of one's actions as a particular episode in a larger narrative framework. This is something I will discuss in more detail in the following section.

1.4.3. Rhetorical Aspect of Narratives

The idea that narratives have rhetorical quality about them have been expressed by a wide range of authors in social sciences, literary theory and philosophy. The same goes for the persuasive aspects of narratives. There is a common trend how narratives are perceived and which elements are taken into consideration that can be found among these authors, namely, the capacity for narratives to make sense and coherence out of inchoate experience through arranging events in a cause-effect logical plot, which is further made persuasive through effective use of cultural resources and rhetorical tropes.

To reiterate, Micheal Carrithers explained that the basic idea of persuasion and rhetoric is to make a movement away from the inchoate towards order and meaning (2005:578). He suggests that narratives are an effective means of doing this, moreover, they are inherent to human cognition and that they serve as an effective means of persuasion. He explains that,

> [...] our capacity to participate in our uniquely human form of complex social life is founded in the ability to find and follow a thread of narrative

> through a skein of events. This capacity has a passive side, being able to interpret human cause and human effect, but also an active one, being able to use storytelling to convince others of our interpretation (443).

Similarly to Mattingly, Ochs and Capps, Carrithers also emphasizes that, 'situations are initially inchoate and require a movement of mind—in this case, a narrative movement—to create significance.' (443) Carrithers gives a brief example of how narratives draw their persuasive power from drawing on cultural resources and rhetorical conventions. He analyzed the storyline structure behind the speech given by George W. Bush after 9/11, focusing on the way the president elaborately changed the inchoate and confusing situation of the terrible disaster into a concrete plan, namely, it marked the beginning for America's retaliation against the evil terrorists from Iraq. Carrithers concludes that,

> [...] Bush lays out for us all the work of culture against the flow of historicity. He and his speech writers, moral agents all, man and woman, take cultural tools lying to hand—a well-practised rhetoric of the national "we," a story line drawn from recent history, a plot rehearsed in fiction—and weld them into a narrative which tames the inchoate and leads with a sense of inevitability to a plan, war on the "axis of evil." (2005:444)

The thing to notice here is how a large variety of cultural resources, each with its own unique significance for society, combined and intervowen in order to deliver a persuasive message.

Moving on, the persuasive and sense making aspects of narratives is something that is also suggested by the philosopher, Walter Fisher, who proposed an overarching narrative theory that has wide crossdisciplinary applications. According to him,

> [...] that human discourse, whatever its specific form, always tells a story; and that to the degree that a story invites listeners to believe or act upon it, it serves a rhetorical function (1990:221).

Barbara F. Scarf explains Fisher's theoretical stance on the rhetorical aspects of narrative, in which Fisher emphasizes the importance of coherence and fidelity as factors for stories to be convincing,

> The distinguishing characteristic of Fisher's rendition of narrative theory is his emphasis on stories providing "good reasons" for convincing others of particular symbolic constructions of human experience [...] Fisher (1987) proposed two criteria that can be used in assessing the rhetorical effectiveness

> of a story, particularly in light of competing stories. These are narrative *coherence*, whether a story is internally free of contradictions and "hangs together", and narrative *fidelity*, whether the story "rings true" with listeners' experiences in terms of its reasoning and values (221).

The coherence aspect draws paralels with both Carrithers' suggestion that persuasion works by moving from the inchoate towards orderliness and planned action, as well as Ochs and Capps' proposition that human have a proclivity towards creating overarching structure that would make a particular experience seem logical. As for the fidelity factor, that is similar to what Ochs and Capps describe as a specific narrative dimension – tellability. The authors quote Marie Louise Pratt, a literary theoritician, and explain that goal of both oral and textual narratives is,

> [...] to elaborately display highly tellable circumstances in "such a way that the addressee will respond effectively in the intended way, adopt the intended evaluation and interpretation, take pleasure in doing so, and generally find the whole undertaking worth it." [...] Personal narratives vary in their quality as tellable accounts, that is, the extent to which they convery a sequence of reportable events and make a point in a rhetorically effective manner. (Ochs & Capps 33)

What is important here is to note that, apart from the oraganization of the events told, there is also the aspect of how these are presented. Moreover, that it can be done in a more or less effective manner.

Overall, the aforementioned authors present narrative as a pervasive phenomenon in social interactions. What is significant is that they do not take the realist referential stance towards narratives, there is an emphasis on the performative and rhetorical side of narratives, moreover, the way they are actively constructed on the go during interactions. What is notable is that both narrative structure itself, namely, the why events are chosen, emphasized and organized (creating order and logic, using specific cultural resources), and rhetorical tropes, the means which add a certain 'colouring' to the events portrayed (fidelity and tellability aspects), serve to create make narratives more or less persuasive.

1.4.4. On Coherence and Mattingly's Understanding of Narrative Persuasiveness

As illustrated by the previous section, the notion of coherence is considered almost by every theoriticians who deals with narrative. This can be seen in Carrithers' idea that

narrative persuasion is achieved via 'moving away from the inchoate' towards an orderly structuring of experience. Ochs and Capps' see that the need for cohesion is an inherent proclivity people possess and that a story can be more or less convincing depending on the way it is structured. Fisher sees that coherence is a necessary factor for a story to be 'free of inconsistencies' in order to be believable. What is noteworthy is that while coherence is considered persuasive it is not elaborated why exactly is that so.

Mattingly looks at the role of narrative at an experiental level and reconsiders the role of coherence in narratives. What Mattingly suggests is that lived experience and narratives are not connected via narrative coherence, but rather narrative drama (1998:154). What makes stories work in a persuasive manner is the way they structure experience in a particular context into a narrative which carries suspense and creates desire to strive for ending it presents (1998:154). She explains in her own words that,

> [...] *narratives do not merely refer to past experience but create experiences for their audiences* [...] Narratives offer meaning through evocation, image, the mystery of the unsaid. It persuades by seducing the listener into the world in portrays, unfolding events in suspense-laden time in which one wonders what will happen next (1998:8).

In effect, the coherence of a narrative is not the end goal, but rather a means to an end, namely, coherence serves as another persuasive element which renders a narrative convincing and seductive. This is supported by Erwig's proposition, which entails that cohesiveness is an illusion achieved through discursive strategies. The sense of continuity and cohesiveness derives not from experience, but from 'culturally informed representational capacities' (1998:106). The way life unfolds is unpredictable most of the time and many of occurrences that take place do not fit into a logical structure, thus, a narrative of one's actions and future plans is something that needs revaluation and adapting over time. Hence, coherence is something people rhetorically construct for themselves in order to derive desire to act.

Mattingly's narrative drama concept nicely supplements and goes well with Carrithers' idea of 'rhetorical will' and his theory of cultural rhetoric altogether. Carrithers suggests that 'rhetorical will' is that which drives a person's actions and events in life, moreover, he claims that people derive motivation through engaging in

rhetorical reasoning in their mind. Furthermore, the essence of rhetoric and persuasion is 'moving away from the inchoate' towards order and coherence. Mattingly's view provides an explanation from a phemenological point of view why coherence and order are persuasive, namely, using a narrative framework to give structure to experience situates one's current or future actions in terms of a larger narrative scheme, which allows to view one's action as meaningful in the specific context, as they will lead to a desired outcome. (1998:69) The desired outcome is, however, always merely a possible future that is seemingly achievable, but not a certainty, therefore it carries with it that which stories and plots generally hold – suspense, anticipation for the desired outcome.

A large part of rhetorically motivating oneself towards certain actions is based on creating suspense and desire for one's self. The narrative one constructs for him or herself is filled, in turn, with a variety of cultural resources arranged and presented in a specific rhetorically convincing manner drawing on the aspects of a person's life that he or she finds meaningful.

1.4.5. Rhetorical Narratives in Doctor-Patient Interactions

Cheryl Mattingly has done extensive research on occupational therapists and the work they do with their patients. It must be noted that the work of an occupational is more of an 'active' endeavour than the doctors I am analysing in the context of my thesis. However, in my opinion, Mattingly's narrative theory is applicable to some degree nonetheless, as it does not necessarily have to be chronic illness or disability to create a disruption in the flow of everyday life, even curable illnesses and ailments create distress and the need to adapt certain narratives that would persuade a patient to follow through particular clinical procedures or treatment plans.

The author believes that narratives play a central role in the clinical interaction between doctors and patients and has a huge influence on treatment, she explains that,

> Narrative is one of the primary modes therapists use to shape experience. They attempt to give unity and coherence to the succession of clinical episodes – to give a plot structure that would otherwise be a sheer succession of doings. This is a rhetorical act of complicated social proportions which requires subtle negotiation and persuasion among actors (1998:82).

A patient's experience is rendered meaningful, according to Mattingly, by employing therapeutic emplottment which helps create significant experiences, which establish a specific clinical episode as meaningful in the specific context, as well situate it as a step within larger whole, which leads to an ending that the patient can strive for. Mattingly emphasizes the importance of making therapy seem meaningful and coherent for patients,

> What gives therapeutic events significance is their connections to life plots, the extent to which they open onto much broader narrative vistas which lead far beyond therapy […] A therapeutic plot only seduces on the extent that it emerges as an episode in an unfolding life story, gives some hope for a life that is still to be lived (1998:71).

Coherence implies a view of the world that makes sense. In terms of dealing with illness, coherence would entail finding a way to carry on life normally by curing a disease or learning to adapt, control its effects. Hence, a coherent narrative of illness would be one where one's actions lead towards a desired result where one can achieve one of the aforementioned results. Mattingly tells us that stories are governed by a lack, a need to figure something out (1998:92), which is why they serve as such an effective rhetorical means for creating desire and influencing one's actions,

> Desire in the face of an uncertain future plays a central structuring role. We hope for certain endings; others we dread. We act in order to bring certain endings about, to realize certain endings about, to realize certain futures, and to avoid others (1998:93).

This is why it is important to construct individualized stories for a patient that matters and is worth striving for. On this note, a compelling ethnographic example, which displays the potential for imaginative and rhetorical creativity of therapeutic emplottment and also illustrates that sometimes a doctor does not need to refer to a patient's life plot in order to create a persuasive narrative. It is the case of a 9-year old girl's treatment which was framed by therapists in the terms of an olympic event. A particular plot was developed in context in which, 'a child is not a disabled patient but a brilliant athelete performing performing her breathtaking feats for admiring audience' (Mattingly, 2000:191). It is an interesting example, as it shows that make-believe can also elicit compliance from a patient and motivate him or her to go through with a treatment plan.

Moving on, it must be noted that plot construction is a joint endeavour in clinical settings. It has to be a narrative that both patients and doctors can agree upon in order for it to be effective in creating desire,

> Action, from a narrative perspective, is deeply and irrevocably social. If therapeutic time takes on a configured unity, a plot, this configuration is fundamentally social. A therapeutic plot emerges in powerful way only if its various players, with their diverse perspectives and interests, operate with some minimal agreement to contribute to the same, unfolding story (1998:158).

The way to achieve collaboration is through matching treatment goals with a patients' own commitments and values (1998:79). Of course this a rather complex process of negotiation that requires constant adaptation in face of changing circumstances. Nonetheless, this kind of collaboration is central to success in occupational therapy and I would argue also in other kinds of medical encounters.).

1.4.6. Claiming Power and Storytelling as Diagnosis

In this section I will look more in-depth at the co-construction of a narrative in doctor-patient communications. The collaborative aspect as a requisite for better results has been proposed by other studies besides Mattingly as well. Barbara F. Scharf, for example, made this point, claiming that relying on a doctor's authority alone to make a patient follow a treatment plan is rarely effective (1990:218). Moreover, she believes that the most effective communication is achieved when both doctor and patient's respective points of view have been taken into consideration. Nancy Ainsworth also holds a similar view to Mattingly and Scharf, she proposes that, 'when things are going right, patients and physicians both contribute to the process of arriving at a diagnosis.' (1998:) Not only that, Ainsworth provides a good framework for analyzing power relations in doctor patient consultations.

For the needs of my thesis Ainsworth stance that, 'diagnoses also can be co-constructed through an essentially social and emotional activity—storytelling' (1998:148) is of vital importance. This is because she makes a link between the process of creating stories and negotiation of power relations. Ainsworth suggests that a patient can claim power in an asymmetrical relation by actively participating and co-authoring a diagnosis together with a doctor,

> Because it can determine the entire course of treatment, and because it embodies our selves, storytelling claims power. No more important claim to power could be imagined than that which aims to co-construct a diagnosis (entailing treatment) and at the same time define who we are and who we will be (1998:148)

This proposition provides a link between Mattingly's theoretical perspective of the persuasive aspect of narratives, as well as Carrithers' rhetorical theory. In regards to Carrithers' position, first of all, it should be noted that Ainsworth is aware of the rhetorical dimension of stories as well and the agent-cum-patient dynamic that takes place during the consultation, as she claims that,

> [...] storytelling is often used for persuasion. Doctors and patients elaborate their diagnostic stories in subtle attempts to persuade others that one diagnosis and its attendant treatment should be chosen.

Secondly, Ainsworth's ideas coincide with Carrithers' and Cordella's notion that power relations and their reproduction can be changed within the framework of an interaction through rhetorical means, even if there is distinct difference in power relations,

> In the bases for claiming power in discourse, medical encounters will always be asymmetrical because physicians have both expert knowledge and socially legitimated authority. But in speech activities and self-definitions, participants in the encounter can approach or achieve symmetry (1998:170).

This view also is supported by Paul ten Have's study, which I discussed in more detail in the previous part of the thesis, that suggests that power relations will be asymmetrical in doctor-patient communication, however, there is a degree of symmetry that can be achieved through the interaction.

As for the link with Mattingly's pespective, there is a similarity between her and Ainsworth's views on co-authoring a diagnosis and therapeutic emplottment. First of all, they look at the doctor-patient collaboratively constructed treatment plan as a joint social activity, where both the patient and doctor combine their efforts and points of view to create a narrative that is meaningful and desired by the patient and goes along with the doctor's intended treatment. This kind of interaction is considered by both authors to be more effective and, in result, it can ensure better compliance with treatment, while ensuring that the patient's view of the illness is not neglected. In terms of power relations, which is not the main point in Mattingly's study, there can be parallels drawn between having both a patient and doctor participate in the construction

of a diagnosis and a therapist and a patient working together in rehabilitation. Of course, it must be noted that the communication between a patient and an occupational therapist is different than that of a doctor and patient in a consultation, as the former is more 'active' and it involves a therapist spending more time with the patient and communicating more as well. Mattingly, for instance, emphasizes that a therapist's job is to make a patient an active actor in his or her treatment so that he or she does not remain a 'passive body' others act upon (1998:92). Actually the occupational therapist approach is somewhat different than standard approach in clinical dealings with patients, which Ainsworth writes about. Mattingly explains that this is because,

> [...] initially the occupational therapy movement was a response and protest to the rising prestige of medicine, particularly, to a physiologically centered approach to medicine [...] Some dissenting physicians were concerned to develop medical therapies that preserved a sense of the mind-body unity, and, even more broadly, recognized the role of social and physical environments influencing mental and physical health (1998:152).

This stanard biomedical approach has a tendency to focus more on a mechanical understanding of the body and fixing the ailment, rather than taking into account the patient's view of how the illness influences his or her life. I believe that Nancy Ainsworth tries to advocate in her study that thė same kind of approach, that is characteristic to the way occupational therapists treat their patients, needs to be implemented more in traditional doctor-patient interactions. Namely, both Mattingly and Ainsworth emphasize the importance of recognizing the social aspects of illness and the patient's input. In essence, I believe that both authors are to some degree speaking about the same issue, hence, the collaborative approach described in Mattingly's research can also, in my opinion, be viewed as a form of patients claiming power by working together with the clinician just as Ainsworth's study proposes. However, while occupational therapists are aware about the importance of involving patients in their own treatment, the standard biomedical approach doctors are often not.

Overall, combining these approaches gives me the analytic framework with which it becomes possible to study the formation of narratives and how rhetorical negotiation of power is achieved in doctor-patient consultations. I will discuss Ainsworth's approach in more detail and relate her ideas to those of the other authors in the following paragraphs.

1.4.7. Ainsworth's Analytical Framework

There are some specific underpinnings of Nancy Ainsworth's theoretical framework that need to be further elaborated upon. These include her own devised dimensions in the doctor-patient consultation that supplement the phase model, the conceptualization of doctor-patient diagnosis contruction as a sociocognitive activity, and a specific categorization of narrative types used in diagnosis.

First of all, as already mentioned in the section on Paul ten Have's study, there is a tendency in academic writings to classify the doctor-patient consultation in terms of concrete phases,

> [Phase] I, relating to the patient; II, discovering the reason for attendance; III, conducting a verbal or physical examination or both; IV, consideration of the patient's condition; V, detailing treatment or further investigation; and VI, terminating (Heath, 1992:237).

Ainsworth, however, considers this too narrow a perspective, as it looks at the interaction as dominated by solely the clinician. What she proposes is another set of dimensions to characterize the interaction, namely, jointly constructed speech activities such as greetins, topic control, questioning, storytelling and devising plans for future action (1998:149). These consideration pertain to my study as well, as these are the dimensions in which, in my opinion, there is space for rhetorical negotiation and exchange of agency and patiency within the interaction, as well the construction of co-authored meaningful treament trajectories.

Moving on, Ainsworth views diagnosis as a sociocognitive process. The cognitive model entails that it is primarily the doctor who formulates in his or her mind a specific diagnosis based on his or her knowledge of disease and by eliciting certain kind of information from the patient. However, Ainsworth proposes that diagnosis can become a sociocognitive interaction when a patient offers a concrete candidate diagnosis during the interaction as well (1998:150). She explains that, for example, in a scenario where a disease is not immediately identifiable,

> [...] doctor and patient may go through a diagnostic process in which
> the doctor and patient work together to construct stories that explain what may have happened in the past and how a possible diagnosis might play out in the future [...] In this process of storytelling, the patient may play a significant role.

> He or she may not simply answer questions posed by the doctor. Instead the patient may offer alternative diagnostic storyworlds or modifications to or negations of a storyworld proposed by the doctor.

The negotiation between different possible storyworlds is of paramount importance, as this is the aspect which allows one to employ rhetorical resources to persuade a particular view and plan of action by both participants during the interaction. Furthermore, this is the time when a doctor and patient can collaboratively work out an emplottment of treatment that incorporates the views of both parties, as well as offers the possibility of constructing a path of action that is desirable, therefore, motivating for the patient.

Lastly, Nancy Ainsworth offers concrete categories of narrtive types that are used during doctor-patient consultations while constructing a diagnosis. Firstly, she makes the distinction between descriptions, reports and stories, all of which fall under the term of narrative,

1. A description is a narrative that aims to provide enough information about an event that the hearer can form a perceptual impression of it.
2. A report is a narrative about a series of events that took place in the past;
3. [...] these two kinds of narratives can become a third kind: stories. A story is any narrative that is evaluated. Either person, doctor or patient, can evaluate the ongoing narrative, turning it into a story. Evaluation is done by indicating the cultural, social, or personal significance of the events (1998:151).

Of course, the reader might remark a different theoretical approach to narrative than that of Mattingly's who took a broader perspective of narratives, looking at how emplottment and significant experiences can create narrative drama, suspense and desire. This view, in my opinion, can be combined with Ainsworth's model, as Mattingly's perception gives an overarching explanation of how narratives function on a phemenological level and Ainsworth's particular categories of narratives serve as concrete models of how narratives can be constructed in an interaction to achieve certain effects. These theories are not mutually exclusive in the sense that one can analyze how narrative drama and persuasion/creation of desire is achieved using certain narrative types.

Moving on, Ainsworth returns to the broader category of narratives and distinguishes three types of narratives that are used in the diagnostic process,

1. *Labovian narrative* is about past events, arranged in chronological order. It has the sort of organization usually associated with narratives and stories. Straightforward illness stories, told in interviews, are usually Labovian narratives.
2. The *habitual narrative* [...] is not organized by chronological order, as Labovian stories must be. Habitual narratives depict events that are typical of a span of time. However, the events are not ordered in time, one after the other, in a certain sequence. Habitual narratives are about the way things usually are, not about a specific series of events. Habitual narratives can be set in the past, present, or future and are often used to describe symptoms.
3. The *hypothetical narrative* is set in some hypothetical time—past, present, or future. Hypothetical narratives offer for our consideration alternative worlds [...] These hypothetical narratives are often evaluated, becoming hypothetical storyworlds. Hypothetical narratives can present events in the order in which they took place (Labovian order), or they can present action as unordered and habitual (habitual narrative). Hypothetical narratives are often used by physicians to persuade (1998:151-152).

These are helpful criteria for analyzing narrative formation and the aspects of rhetorics and persuasion that are used to negotiate and defend one's interests in the interaction. Ainsworth states that her study shows that simple reports and descriptions often become stories, because people tend to give evaluative signals to demonstrate their attitudes or feelings (1998:152). Furthermore, Ainsworth reminds us that the doctor-patient consultation and diagnosis creation is a transactional sort of interaction, where participants are driven to persuade one another, stories are effective in this scenario, because evaluation gives both doctors and patients' accounts more credibility, therefore, more persuasive power (1998:152).

To sum up, combining the theories of Mattingly, Carrithers, Ainsworth and also the ethnographic examples by various authors will provide a flexible theoretical framework for the analysis of power relations and rhetorical techniques in doctor-patient communciation.

2. METHODOLOGY

This section features a closer look at the specific research methods I have chosen for my study and explanation as to why are the best suited for my needs and how they would help me arrive at meaningful conclusions. I also consider issues regarding the validity of the data collected and the possible shortcomings of my chosen approaches, by refering to current theoretical perspectives on methodological approaches. Moreover, I will go in-depth about the research process, explaining step-by-step the choice of informants, activities for observation and setting, as well as how I carried out the actual study itself.

2.1. Preparatory Study

The idea to research doctor-patient communication for my master's thesis came to me a year prior to conducting this study. The initial study was inspired by Cheryl Mattingly's ethnography on occupational therapists, hence, I emulated her approach and did my fieldwork among physical therapists in a rehabilitation centre, analyzing their discoursive practices in interactions with patients. The firsthand experience conducting research in a clinical setting allowed me to put fieldwork methodology into practice, as well as to get acquainted with the innerworkings and social dynamics of a healthcare institution. Moreover, my work in the rehabilitation centre gave me the opportunity to evaluate the shortcomings of my approach and critically appraise what worked well and where there was room for improvement. Most importantly, however, observations in the field prompted me to expand my perspective and problematize other aspects of doctor-patient interactions I previously had not taken into consideration. Thus, the brief fieldwork served as a proto-study which I naturally decided to develop into a more thorough research for my master thesis.

One of the main flaws of the preparatory study was that I started with a theoretical framework before doing any fieldwork. As a result, the study ended up too focused on finding data that would correspond to the theoretical framework and concepts I had devised. For my master's thesis I decided to do the opposite, and for that reason I chose to investigate a completely different institution and different medical profession. Nonetheless, while the findings in the initial study are not relavent to my

current work, some of the theory and methodological approaches serve as an important foundation which I have expanded upon.

2.2. Choice of Field and Informants

My intention for this thesis was to add to the corpus of research available on health institution practices from a stirctly sociolinguistic point of view, as well as contribute in an ameliorative way by indentifying effective communcation practices. It must be noted that complaints about doctor and patient communication is, unfortunately, still a prevalent issue in Latvia, despite the increased recognition by doctors for the necessity of good communication in order to provide effective healthcare. As Liene Šulce-Rēvele, the chairwoman of the patients' ombuds in charge of raising awareness for patients' rights and medical service quality, claims, 'while there is overall high level of medical education, there is still room for growth in the interpersonal communication skills department'[2] (Link 2). This is further evidenced by the fact that 76% of the complaints sent in by patients pertain to communcation issues with medical staff (Link 3). In order to better understand communication practices and observe their particularities I needed to gain access to one of the major hospitals ir Riga. This turned out to be a much more difficult endevour than I orginally anticipated, which I will discuss in further detail in the ethics section.

As Marissa Cordella notes, it is important to describe the research context, as different studies in medical anthropology indicate that, 'patterns of linguistic behaviour appear to be sensitive to environmental context' (2004:45). On this note, the field I mangaged to arrange is particularly compelling in regards to my research subject as it is a children's hospital. I reasonably assumed that I would be able to observe unique discoursive practices in such a setting, because it entails doctors taking different approach than with adult patients. Moreover, communication skills are a necessary requirment for the staff in the children's hospital, as doctors often need to deal with two or more people simultaneously – the patient and his or her caregiver.

[2] Author's translation

The research site, the name of which I will withhold for confidentiality purposes, is one of the biggest specialized multi-profile childrens' hospitals in the country, which boasts an impressive patient traffic of 30000 per year. The setting is fertile ground for investigating doctor-patient communication because it gives the opportunity to observe how different doctors deal with a large variety of multiple patients per day.

However, the number of patients coming and out, as well as the fact that appointments were organized with long time gaps inbetween, made it somewhat difficult to observe an on-going long-term interaction between doctor and patient. This is why I focused on specific doctors of a particular specialization. The conditions for my research set by the hospital's adminstration permitted me to collaborate with doctors that are open and willing to have me sit in and observe their work. Due to this restriction I was limited in the choosing of whom I could study. I managed to make arrangements with doctors from the anethesiology and allergologist departments. Hence, the majority of my fieldwork took place in the respective consultation rooms. Over the course of two months I managed to observe the work of five different anthesiologists and three allergologists who, during the period of my investigation, carried out consultations with approximetly fifty patients. This yielded me a huge corpus of data and insights into the particular interaction styles of each doctor.

2.3. Data Gathering Methods

The study consists of a combination of three approaches, namely, direct observation, semi-structured interviews and discourse analysis. I choose these approaches, as they supplement one another and reveal an overall more encompassing perspective of what goes on during a doctor-patient consultation. Generally, these methods are geared towards a micro-level ethnographic research of discourse.

I choose to do qualitative research due to the nature of my study and how I started it. First of all, I went into the field without a clear hypothesis or idea of what I would encounter, I had a broad idea about what I might find and knowledge of other studies that are similar to the one I intended to conduct. The qualitative approach was the best choice in this scenario, as Nancy Ainsworth explains,

> Much qualitative research is exploratory in nature. Its goal is to identify an important arena for interaction and then gather data on the interaction itself and on the surrounding context. Therefore, studies begin without hypotheses to be proved or disproved. As the study progresses, working hypotheses are developed, but the attempt is to develop reliable generalizations, not absolute hypotheses (1998:20).

This approach allowed me to remain flexible as the fieldwork unfolded, I adopted my theory and approaches in accordance to the data I found.

Secondly, I chose a qualitative approach due to the fact that my study deals with sociolinguistic phenomena, namely, rhetorics and narrative construction, which require a deeper microanalytical investigation of elements characteristic of a concrete social event, in this case, the interaction between doctor and patient within a consultation. I take the stance of discoursive analysts who state that, 'language is constitutive of the event rather than being a transparent medium through which we view the event' (1998:21). The main purpose of such qualitative research is to gain a better understanding how people derrive meanings and construct their responses and actions, especially, particular organizational strategies in a specific social context, taking into consideration surrounding discourses, as well as the cultural and structural milieu that influences the aforementioned activities (1998:22). This is a well-suited approach for my purposes, as it takes into consideration how larger sociocultural and institutional factors influence events at a micro-level interaction, namely, how prevailing cultural and institutional notions about doctor and patient relations affect discoursive strategies employed by doctors and patients and power relation dynamics within the encounter. This method is particularly helpful in the sense that connecting observed data about interactions to larger societal processes and discourses aids the interpretation of why doctors and patients act and talk the way they do (2004:42).

One of the primary methods I used was direct observation. It is a useful means of acquiring a sizable corpus of data. Moreover, there are other considerations for choosing observation instead of other methods. Firstly, it is one of the least intrusive kind of methods of gathering data in the field. For my purposes this was desirable for two reasons. From a purely organizational point of view, direct observation was necessary in order to aquire permission to cooperate and study doctors during their work. One of the conditions for gaining access was that I need an approach that would

not interrupt the normal flow of everday work for doctors or disturb patients. This was mainly due to ethical considerations in order not to interrupt the patient seeking aid and the doctor doing his job. Furthermore, detachment from the interaction would assure that my presence would not affect the unfolding of the doctor-patient consultation, which in turn would provide me with more accurate and 'natural' data on the interaction. The second reason was more related to the manner of data I wished to gather, namely, as objective as possible observations of the process of the medical consultation, focusing on noting behaviour patterns in field notes while capturing the full detailed interaction using a recorder. Russell Bernard claims that direct systematic observation holds distinct advantages over other ethnographic methods specifically when it comes to observing behaviours (Bernard, 1998:308). Unlike participant observation direct observation usually witholds interpretation and focuses on gathering information on concrete chosen phenomena using a rigorous set of criteria, which gives a higher possibility of getting more accurate data on behaviours. Moreover, interviews and informants' reports are not as reliable, because memory is subject to systematic change and distortions, selective remembering and forgetting, which in turn makes a detailed account of behaviour irrelevant (1998:303). In my case I focus on specific actors, namely, doctors and patients, and a specific activity (content of speech) in a fixed setting – the medical consultation room.

Micro-analysis of discourse requires the possibility to analyze and repeatedly go over the minutest of details of an interaction, which is why recording the conversations was of paramount importance. During a consultation I would turn on the recorder as patient entered and then, while sitting in the background, write fieldnotes about key important moments in the interaction and note the specific time when they occured during the recording, in order to facilitate analysis. The duration of each recording is the same as a single consultation – usually half and hour. Each recording is encoded, noting the doctor and what type of consultation it was, patients and their age, gender, and reason for coming. The key moments I noted in the consultations include mainly scenarios: where patients are actively engaging in negotiations with the doctor; figurative language is used; narrative is constructed or rhetorical means are employed.

The recorded sessions and observation data is further supplemented by information gathered from informal semi-structured interviews. Jenny Hockey and Martin Forsey suggest that the purpose of interviews in fieldwork is to gain access to that which we cannot know otherwise, namely, the thought processes, values and motivations that drive their actions (Hockey & Forsey, 2012:71). Most importantly, sometimes one has to remove an informant from their 'natural' setting in order to understand what really is going on (2012:71). There might be pressures and other factors that compel someone to act in a certain way. This stands true for both doctors and patients during a medical consultation. Thus, observation alone as a method is not enough, as it does not reveal the reasons why people act the way they do. Moreover, due to this reason Hockey insists that interviews are especially well-suited as a method and also a 'culturally appropriate means for conducting socially engaged research' in Western settings (2012:74), mainly because it is possible to gain insights that otherwise would be missed.

Of course, going back a little, it should also be noted that 'motivation' is debateable concept, because people might not know at the time why they act in a certain way and only later do they construct a post-factum explanation of past events in that makes sense to them. This is actually why the combination of the observation and interview methods is useful, mainly because it yields insights into the gaps and differences between what people say and what they do (2012:76). Russell Bernard also concurs that observation works best in synergy with other ethnographic methods, such as the interview, because direct observation, 'addresses the potential biases and ambiguities of the interview, helping identify conscious and unconscious deceptions and distortions' (1998:309). Contrasting observations between what doctors and patients do and say during the consultation and how they recollect and construe what they did while being interviewed is an important step in my work that will help me better understand and compare my impressions of what occurred during negotiations.

Preferably, I would have wanted to interview all of the doctors I observed and more patients, however, not everyone was willing, nor did they have any obligation to do so. I did, however, manage to have an in-depth informal semi-structured interview with three anaesthesiologists and two allergologists. Taking into consideration the fast

paced work environment, I managed to conduct most of my interviews with doctors in the consultation office in-between patients when there was no one immediately coming. I also seized opportunities to get one-on-one time with doctors during their short smoking or coffee breaks, which were the most fruitful in terms of valuable insights. Patients, on the other hand, were not as willing to engage in interviews, mostly because they were in a rush to proceed to further clinical investigations or they simply did not feel comfortable discussing their experiences.

2.4. Gaining Permission and Ethical Considerations

Anthropological research requires one to follow a rigorous code of ethics, so as to not cause any harm to the informants and institutions that participated in the study. This is even more so true when conducting with academic research in hospitals, especially in childrens' hospitals. Firstly, I will discuss the process of gaining permissions to conduct research in a hospital. Secondly, I will go over the various measures I took to avoid violating any ethical norms while doing my fieldwork.

Medical consultations are interactions of a very private nature where patients often disclose very intimate information regarding their personal lives and health. Moreover, a doctor's job and reputation, as well the healthcare institution he or she represents is at stake and any kind of information that could potentially be harmful can lead to variety of consequences for the involved parties. These are some on the main reasons among many others that account for the strict screening process that one has to go through in order to gain access to the medical milieu.

Starting from January I attempted to gain access to one of the larger hospitals in Riga, however, my efforts initially were not met success. One hospital rejected my research proposal outright and another never got around to giving a definite answer. The childrens' hospital in which I eventually managed to arrange my fieldwork was more forthcoming than the first two I tried. I was asked by lawyer who worked for the hospital adminstration to clarify a number of aspects in regard to my study: the goal of my research, methods, how I would gain consent from doctors and patients, what kind of personal information would I require access to, where and if I were going to publish any of the data, etc. The adminstration accepted my proposal after an interview and two

weeks of consideration on the condition that I would find doctors willing to cooperate with me. Luckily, a personal acquaitance who worked in the institution helped me out immensely by helping me arrange this. The person in question aided by finding colleagues who were open minded and did not object to having their work observed for academic purposes. On a sidenote, the process of getting access to the last hospital was prolonged due to recent press scandal about one of the hospital's workers, which explains why the adminstration was so reluctant to have any kind of study carried out so soon afterwards.

As I mentioned previously in this thesis, there were certain conditions I had follow in order to carry out my research. First of all, as it is commonly expected from any kind of anthropological investigation (Code of Ethics of the American Anthropological Association, 2009), a study requires to gain 'informed consent' from informants. Since I was working with children, extra precautions had to be taken because children are considered a vulnerable group in the sense that they might only have a limited understanding of the information provided by the investigator, meaning that their 'informed consent' cannot be considered legitamate if they do not understand what they are agreeing to and they cannot properly weigh the risks of participating in such a study (Kimmel, 2009:237). However, this was not that big of an issue, because I could discuss details of my research with the legal guardians who accompanied the children and could adequatly evaluate whether they wished their child to take part. This was accomplished by verbally negotiating whether patients and their caregivers would agree to participate in my study prior to the consultation. I also discussed the aspects of my study and data gathering methods with each of the doctors personally before starting the collaboration. I assured doctors, caregivers and patients that I would provide complete confidentiality and that all sensitive information, such as patient and doctor names, data that could reveal the identity of the institution would be anonymized. Moreover, the recorded data and transcriptions would not be used for anything else other than academic purposes and it would be deleted after completing my research. It should be noted that participants in the study had the option to choose whether or not they wished to be recorded during the consultation. Furthermore, all participants would be given the opportunity to read the end result of my research if they wished to do so.

2.5. Researcher's Position in the Field

Any type of fieldwork requires the researcher to evaluate his or her degree of involvement and to critically reflect how this might affect one's observations and results. Undeniably, while I tried to remain detached and pratically invisible during consultations themselves, in order to refrain from interrupting the 'natural flow' of the interaction, my presence was something out of the ordinary in everyday clinical processes. I will discuss this in more detail how this affected my relations with doctors and patients.

Of course, meeting with the same doctors regularly over the course of two months lead to the formation of a certain familiarity and relationship. With some more than others. Naturally, doctors were interested in what exactly I was researching and I was open and honest about my research goals with doctors. I did not explicitly tell them what I was looking for in their interactions, so as to not influence their behaviour to a great degree, but I did give a general explanation of what aspect of communication I am investigating, so that doctors would feel more at ease with working together and letting me record their sessions. I did, however, after spending some time observing their work, go more in-depth about the particulars of my study with some of doctors I had developed more rapport with. I did this towards the end of my fieldwork in order not to let it influence the results. Overall, I consider this a very good move on my part, because I managed to learn a great deal about the doctors' own interpretations and motivations for interacting in certain ways with patients. The information I gained from these interviews was very beneficial and enlightening for my study. From a self-reflexive point of view, I had to be careful not to let my relationships with doctors influence the way I wrote about their work. One of the biggest issues was writing specifically about power relation related issues, because I did not wish to depict the doctors in my research in way that would reflect badly upon what they do. Moreover, this is due to the fact because in their interviews they revealed that their intentions were good and they considered the patient's wellbeing a major priority.

As for patients, I expected this to be the most troublesome aspect of my work. I originally expected people would be more reluctant about being recorded and interviewed about such sensitive and delicate issues, however, the actual situation

turned out quite differently at least for the recording aspect and, luckily, in my favour. While patients often confused me as another patient or part of the medical staff, after explaining that I am conducting a study for a social sciences' degree on doctor-patient communication, people most of the time did not object to my presence or me recording the interaction. This actually points out a general trend I observed about how patients behave in a doctor's office, namely, they are sort of passive and generally accept that everything what takes place in the office is ok. This could also be observed when medical students came in during an allergologist's consultation to observe the process. The caregiver did not mind that her child was being examined by three doctors simultaneously, two of them trainees who did it for educational purposes. I assume that my presence was tolerated by doctors and patients partly due to the fact that they are more or less accustomed to medical students coming in and observing how their work is done. Moving on, as I mentioned earlier here, I did not manage to get as many interviews as I orginally wanted with patients and caregivers due to their busy schedule. However, the few that I did were quite useful, despite the fact that patients were rather brief and did not go into detail about their points of view.

2.6. Data Processing, Interpretation and Analysis

The recorded consultations and interviews with doctors and patients were transcribed. Since the total of amount of consultation recorded data was over fifty hours, I used my fieldnotes and encoded data in order to single out the fragments of the interactions that were most useful in the context of my study. Of particular interest were certain practiced and spontaneous rhetorical strategies used by doctors for persuasion, risk discussions of clinical procedures and medications, and moments when patients objected or argued for a different treatment solution. These were analyzed in-depth using the discourse analysis based on the theoretical framework I described in the previous chapter.

For ethical reasons the data in the transcriptions was edited to exclude any kind of information that might possible give away the identity of the participants or the institution. Also some of the miscellanous fieldnotes such as spatial arrangements of the consultation room, other details about the hospital in general as well as theoretical considerations made up on the spot were not specifically included. However, the data was taken into consideration when discussing the results.

3. RESULTS AND DISCUSSION

The analysis part is dedicated to a discussion on the findings in the anesthesiologist and allergologist consultations and also relevant themes that came up during fieldwork investigation. It should be noted that anesthesiologist and allergologist consultations are quite different types of medical interactions where the main objectives and phases differ. Hence, some theoretical approaches are more appropriate for explaining the phenomena observed in one, while others are better suited for the other. Generally, Carrithers' approach is applicable to both, but Ainsworth's narrative approach is more appropriate for allergologist consultations, as there is no construction of diagnosis taking place in the anesthesiology consultation. Mattingly's therapeutic emplottment, however, is better for understanding dramatization that takes place in anesthesiology consultations. The following sections will include an overall description of each consultation type and go in-depth about specific rhetorical phenomena characteristic to each medical interaction.

On a sidenote, to clarify the use of abbreviations in this section – P stands for patient, PC means Patient Caregiver and D is for doctor. Transcriptions of interactions are provided both in the orignal language, Latvian, and a translation into in English is provided by the author of this theis. Note that the abbreviations remain the same regardless of the language.

3.1. The Anesthesiologist Consultation

Before moving to the analysis of rhetoric within the consultation, I will first of all give an overall characterizisation of the consultation: what is its purpose, what goes, what are the distinct phases that take place and how does the anesthesiologist, patient or patient and their caregiver generally interact with one another.

The anesthesiologist consultation is, first and foremost, not a characteristic medical consultation where a patient comes in with a complaint and then proceeds to establish a diagnosis and treatment course together with the doctor. A patient goes to an anesthesiologist consultation when he and she has decided to go through with a surgical operation that requires anesthesia to be carried out. Hence, the main purposes of the consultation are: discussing a patient's medical history to rule out any possible

conditions and other factors that might have a bad interaction with anesthesia; signing an agreement to go through with the procedure; giving instructions how to prepare and what to do and expect during the procedure; negotiating the use of sedative medication or particular type of anesthesia (localized or full); answering any questions the patient or caregiver might have about anesthesia. The order of the objectives coincides with the phases of a typical consultation, the patient or the caregiver is given a special form which he or she has to fill out and sign. This takes the majority of the consultation and typically the patient/caregiver and doctor do not interact during this phase, only making brief exchanges to clarify something about the form itself. Children, who are not 14 years old yet, need to be accompanied by a caregiver who is obligated to fill out the form and give an agreement in their place. The interaction during this stage is clearly one sided, the healthcare institution requires the doctor to ask the patient to fill out the proper paperwork, as nothing can proceed without a written agreement. This is mandatory and cannot be objected. As Paul ten Have stated – the degree and interaction and asymmetry varies according to the phases of the consultation. In anesthesiology consultations actual persuasion and rhetorical negotiation primarily takes place during the instruction, procedure description and question phases.

3.1.1. The 'Double Task' in Anesthesiology Consultations

If a child present who is of a conscious age ('*apzināts vecums'*), the doctor will often switch to a different kind of interactional model when addressing him or her. This approach is more or less rehearsed, as I observed it being performed with only slight variations in about 14 sessions with children roughly around the age of 4 to 12 according to my estimation. Basically, when adressing the child, the doctor would switch from a serious tone of voice, used when conversing with the caregiver, to a playful and friendly demeanor. I will provide an example of a typical exchange (the orginal version in Latvian and an English translation done by the author) that plays out at the end of the consultation, note that all the names used in the interaction are pseudonyms and not actual names. This is a brief conversation between Kārlis, a seven year old, who is explained what to expect when he will given anesthesia:

D: Sveiks, draudziņ!

P: Sveiki...

D: Nēkadas šprices mēs tev, Kārli, netaisīsim, mēs tev iedosim masku, tādu kā pilotam, kas reaktīvā lidmašīnā lido, un tur būs otrā pusē baloniņš, nu jā, tev būs mammai jāuzpūš balons 10 – 15 reizes un tad tu pačučēsi, izdomāsi kādu jauku sapnīti, ja? Un tad uzreiz pēc procedūras pamodīsies un mamma būs blakām... Droši bērnam varat paņemt saldējumu pēc procedūras... garšo saldējums? Ja? (Kārlis: Jā!) Tas pat ir ieteicams.

D: Hey, buddy!

P: Hi...

D: We're not going to use any needles, Kārlis, we're going to give you a mask, like the one pilots who fly jets use, and there will be a baloon on the other side, well, you'll have to blow and inflate that balloon for mommy some 10 – 15 times and then you'll take a little nap, you'll have a nice little dream, yes, and then immediately afterwards you'll wake up and mom will be right next to you. You can certainly get an icecream for the child after the procedure... you like icecream, don't you? Yes? (Kārlis: Yes!) That's actually recommended.

The anesthesiologist dramatizes the upcoming experience for the child by talking about and presenting a set clinical of procedures in a make-believe narrative framework that the child can understand and relate to. The small scenario the doctor plays out with the child creatively portrays the experience of anesthesia adminstration, a procedure that would be otherwise confusing and anxiety provoking, as something fun and harmless. In terms of rhetorical tropes this can be considered as a form of metaphor, as it takes one thing, the adminstration of anesthesia, in and explains it in terms of another – putting on a pilot mask.

The example I provided was on of the more elaborate ones I observed, however, out of three anesthesiologists I observed only one, an stoic, elderly and silent clinician, did not use this method. The example of blowing up a balloon was the most commonly used when addressing the child about the upcoming procedure. In the following paragraphs I will analyze the situation given in the example using Mattingly's and Carrithers' theoretical frameworks for rhetoric and narrative, and also look at the power relation aspect in it. The following parts are suplemented refering with interview data I gathered while talking with anethesiologists.

. Using Mattingly's theory, this example is actually quite similar to the dramatization the author described in her ethnography about the girl who was undergoing physical therapy that was presented as preparation for an olympic event. In essence, the same process is taking place in the anethesiologist's consultation, the doctor creates a persuasive therapeutic emplottment that draws upon the ideas and notions from the child's lifeworld to change the clinical episodes of taking the anesthesia, undergoing the operation, waking up in the ward into a story that is aesthetically molded in a rhetorical way that the child finds compelling: the child is a make-believe pilot, who will simply have to blow and inflate a balloon and sleep tight, after which he will get a reward – the icecream. Even if it is a simple plot it still makes the event seem less scary and it does create motivation and desire to collaborate, as the child knows he will be rewarded. The anesthesiologist I interviewed towards the end of my fieldwork revealed that his motivations for talking to child in such a way coincide with the theoretical ideas I forwarded here. He explained, thusly:

> Pieaugušajam tu izstāsti viņam pašam, jā ...un viņš saprot. Bet ar bērnu, kurš jau ir apzināta vecuma, tu izrunājies ar vecāku, tu stāsti, kas tā ir par procedūru, kā viņš jāsagatavo, ko darīs, kāpēc, kā to darīs un pēc tam vēl ir jāizskaidro bērnam tas viss, tāpēc ka tu nevari tagad pateikt vecākiem, ka mēs tagad.. jūs tagad atbrauksiet jūsu bērnu te ņemsim... bērns no rīta vienkārši – kāpēc mani ņem prom no vecākiem? Ja? Kur mani tagad vedīs? Kāpēc man te kaut kāda maska? Ja tu viņam izstāsti konsultācija tādā saprotamā, pēc tam arī no rīta, nu ir, ka pūtīs baloniņu... un ka būs kā lidotājs vai kosmonauts. Ja nav papildus kaut kāda spēļu terapija.. nu tas ir taka papildus darbs ambulatorajā konsultācijā, ka tev ir jāizskaidro šīs lietas bērnam, kas ir atšķirībā no pieaugušajiem... Tev jārada motivācija, ja viņam tāda ir, tad viņš darīs lietas, ko no viņa gaida, jo viņam ir mērķis.

> A grownup... you tell him what he needs to know...yeah, and gets it. But with a child of a conscious age, you talk with the parent, tell them what kind of procedure it is, what needs to be done, then you have to tell all of it to the child... because you can't just tell the parents... that you'll just come here and we'll take your child now... in the morning the child will simply go – why am I being taken away from my parents? Where am I being taken? What's with the mask? ... If you tell him during the consultation in an... understandable way... that in the morning he's going to inflate a balloon... that he's going to be a pilot or an astronaut. If there's no play therapy... then it's a double task during the consultation to explain these things to the child, unlike with adults... You have to create motivation, if he has that... he does the things expected of him with joy, because he has a goal.

I managed to arrange a brief interview with the caregiver and child in question after the consultation. This was their first experience of having an operation, the mother and child were very brief, as they had to hurry to get further testing done, but the caregiver did say that she found the doctor quite reliable and that he managed to relieve most of the anxieties she had about the procedure. The child was a cheerful type, who did not seem all the perturbed about his upcoming operation. When asked about how he felt about the consultation and what he was told to expect, the child said he was not afraid and that the procedure seemed like it was going to be, I quote, 'cool'. Of course, this might differ from patient to patient, but in this case it would seem that the anesthesiologist's approach did its job well.

Moving on, looking at this situation using Carrithers' theoretical point of view, it is evident that the doctor draws upon cultural resources to form his persuasive narrative. It is mainly constructed out of symbols and representation that are considered exciting and enjoyable activities and themes for children, hence, having the child imagine the anesthesia mask is that of a jet pilot is based on the notion that boys in Western culture find flying airplanes interesting. The doctor revealed in the interview that the right imaginative narrative framework varies from patient to patient and each case must be created taking into consideration the specific interests of the individual:

> Tev jārada motivācija. Tas ir tikai iespējams pie apzinīga vecuma... ar zīdaini tur ir jāmeklē cits mērķis, jāasociē ar kaut kādu pasaku tēlu, multenes tēlu, kaut ko tādu, ko tas bērns saprot. Respektīvi pediatrijā ar tiem līmeņiem tu ej tā caur, lai tu, tev ir jānoķer tas, ko tas bērns vislabāk akceptē, tas būs viņa tas mērķis, viņa tas ceļš, tas associācijas ar ko viņš associējs savas darbības. Tas ir īstenībā ļoti svarīgi, jo vienkārši pateikt, nu darīsim to, ieradotaties tur, nu tā jau nav liela māksla.

> You have to create motivation. This is only possible with a child who is of a conscious age... with a toddler you have to form a different kind of association... with a fairy tale or cartoon character. Essentially, in paediatrics you go through different levels until you find something the kid understands and accepts, that will be his goal, his path… the associations he will associate his actions with. That's actually very important, because simply saying, well, we're going to this when we get there, well, there's no art in that.

Furthermore, finding the specific framework that is relatable for the child serves another important function. Namely, the experience that might seem confusing or inchoate is

transformed through the child's familiar symbols and representations, most importantly, the activity of playing and make-believe, into something somewhat more coherent and orderly. In other words, the strange world of adults and incomprehensible medical talk is translated in a way the child understands.

In terms of agency and power dynamics, the doctor is clearly the *agent* and the child is the *patient*, using Carrithers' terms, as the doctor is doing the persuading. However, it is not a coercive kind of persuasion. Indeed, as Marissa Cordella remarks, 'power is always present in the interaction and only the way it is exercised varies from an authoritarian and coercive form to a more subtle, gentle and presumably palatable mode' (2004:19). She means the power to decide and dictate the course of actions and treatment the patient will take. The anesthesiologist's approach clearly falls into the latter category, because he gains the child's collaboration in a very considerate and humane manner by attempting to reduce anxiety about the procedure. However, the persuasion also serves an important role in gaining the child's trust and compliance, as the doctor himself explained in the interview, talking about his experience with a patient:

> Tu atrodi veidus, kā motivēt bērnu, piemēram, viņš ierodas uz operāciju ar foršu kreklu, tu runā par to, kas tam virsū. Pagājušonedēļu man bija bērns ar NHL kreklu, es viņam jautāju par viņa mīļāko komandu un viņš man patieca visus hokeja spēlētājus, ko zina. Tas ir tā teikt, tu uzliec viņu uz viļņa, kur viņš pilnībā akceptē to, ko tu ar viņu taisies darīt. Vienkārši paņemtu uz galdu un uzspiestu masku, viņš, protams, brēks, ārdīsies, viņam tas nepatiktu, jo kuram gan patiktu? Priekš kam, ja? Tādā veidā, tas viss ir jāasocijē individuāli, to noķer tā bērna uzticību, lai viņš paļautos uz to, ko es ar viņu darīšū.
>
> ---
>
> You find ways to motivate a child, like when he arrives to the operation with a cool shirt, you talk about what's on the shirt. Last week I had a kid with NHL shirt, I asked him about his favourite team and he told me all the hockey players he knows. Basically, you get him on the groove where he'd readily accept anything you'd do with him. If you'd simply put him on the operating table and stuck a mask on his face, obviously, he'd panic, toss around, he wouldn't like that, who would? What for.. right? That's why you need to create associations for each individual, you have to capture the child's trust, so that he would trust me with what I was going to do with him.

As per Mattingly's perspective, the doctor does create a narrative the patient can relate to and find compelling to go through with, thus, making him an active actor in his

treatment, rather than just a passive body that is acted upon (1998:92). On the other hand, it is primarily the doctor's agency and agenda that is being carried out and the rhetorically persuasive dramatization of the procedure serves to give the child the impression that it is something that he is willing to go through with as well. In a sense, the imaginative narrative framework constructs the illusion of the anesthesia and operation being something fun and harmless through the elaborate usage of cutural resources that are relatable for the child understands and presented in terms he perceives as something he would want.

All in all, the patient who is below the age of 14, for whom mostly this kind of approach is intended, is not given agency or choice in the matter of his or her treatment, as this role falls to their caregivers and doctors. In this kind of scenario rhetoric serves to maintain the asymmetrical relation between doctor and patient, but it does so in a very subtle and gentle way by using dramatization to reduce anxiety and ensure trust and compliance from a child patient. Furthermore, based on the explanations I heard in the multiple consultations and in interviews with doctors themsevles about the many possible consequences of a situation, where a patient starts to panic, fidget and toss about during the clinical procedure, it is clear that cooperation and compliance is necessary for the sake of the patient's own wellbeing. There are a variety of ways a patient can hurt him or herself if he or she becomes insubordinate, hence, while it may be an unpleasant experience, in some cases it is a necessary hardship to endure in order to resolve a medical condition and ensure a better quality of life afterwards. In conclusion, the dramatization of the process makes it more bearable overall.

3.1.2. 'Little Pill'

In regards to rhetorical tropes, while I did not observe as many as I hoped to, there was one very prevalent rhetorical phenomenon in everyday clinical practice. This is a very minute thing, but regadless it carries a certain effect in presenting information in a certain conotative shading. I am refering to the way doctors, all of whom I observed without exception, used deminutive when talking about medication, especially, about anti-anxiety and sedative drugs. Common expressions included variations of 'zālīte', 'maza zālīte', 'tabletīte' among others. Unfortunately, the demunitive forms of Latvian nouns do not have an equivalent in English, the best translation in this case would be to

add an adjective that gives the conotative effect, for example, a pill would become a ‘tiny pill’ or ‘little pill’ or something similar. Moving on, the effect of the demunitive is that the drug is rendered as more harmless than it actually is, the slight conotative shading serves to persuade the patient or caregiver to be more inclined towards agreeing to taking the medication, because a healthcare professional has presented it as nothing that special. Here I will demonstrate a typical scenario that plays out during the question phase of an anesthesiology consultation:

D: Kā jūs domājiet vai jūsu bērnam vajadzēs dot nomierinošo zalīti pirms procedūras, vai nē?

PC: Vajag.

D: Vajag. Bērns ir ļoti emocionāls?

PC: Jā, jā, jā, ļoti emocionāls, tas protams.

D: Es uzrakstīju jums, lai jūsu bērniņam iedod premedikāciju

PC: Nu jā

D: Tā nu tas būs, tā teikt, ehh...

PC: NU, tā nu jūs varētu viņu, jo savādāk sanāk, ka tās bēdas ir lielākas nekā viss tas process vai ne? ...tad vismaz ir miers.

D: Mhm.

D: Do you think your child will need a little sedative before the procedure, or not?

PC: Yes.

D: He’ll need it. Is the child very emotional?

PC: Yes, yes, yes, very emotional, of course, that.

D: I wrote down that your child be given a premedication.

PC: Well, yes.

D: So be it, so to say, ehh...

PC: WELL, you could do that, otherwise the fuss is bigger than the whole process, right? ... At least then there’s peace.

D: Mhm.

Whether the deminutive played a vital role in this exchange I cannot say for sure, but it does have a softening effect. The mother does express some doubt and she attempts to justify to herself that its for the best, clearly indicating that she is not entirely sure. The

doctor does react to this show of uncertainty and merely concurs, witholding further explanations in order not cause more anxiety for the mother, as he revealed after the consultation. After the consultation I also interviewed the mother and she confided that she was overall anxious about the whole operation and, in regards to the sedative, she said she was not entirely okay with having her child medicated to that degree, but that she trusted the doctor. Of course, considering that a patient is taking localized or full anesthesia, the use of a sedative would really be nothing at all in comparison. Regardless, it is interesting that the phenomenon is so pervasive. Doctors did not note in interviews that they had not noticed that they used demunitives and they did paid no special heed to this when speaking.

3.2. The Allergist Consultation

Unlike the anesthesiologist consultation, the allergologist consultation follows the pattern of a more conventional medical interaction. It has the typical division of phases which include: presentation of health-related complaint, assessment of medical history, description of symptoms, diagnosis, planning a course of treatment. The encounters would more or less follow this set of phases without much deviation. Of course, there is the difference between first time patients and ones that come repeatedly, as the former already have established more or less the diagnosis and treatment and they generally come to report how well or not is the treatment plan working.

Allergologist consultations are a good place to observe the co-construction of diagnosis and treatment plans. Hence, unlike the anesthesiology phase, negotiation and persuasion takes place in the diagnosis and treatment planning stages. In my opinion, based on what I observed and discussed with the allergologists, this is due to the nature of allergies and the process of pinpointing the exact allergens or conditions that cause an allergic reaction. Diagnosis allergies is a tricky process, as one has to take into consideration a huge variety of possible factors, such as, evironmental and seasonal triggers, nutritional and lifestyle aspects, psychosomatic causes, allergies of animals, activity-related triggers such as physical exhertion, etc. The diagnostic and treatment process entails a trial and error approach to rule out multiple possibilities in order to single out the main causes for the allergy and develop the most effective and appropriate treatment.

In this kind of setting, while there is an inherent asymmetry in the interaction given that the doctor possess superior medical expertise and undestanding of allergies, there is still the window of opportunity for the patient or their caregiver to present their own hypothetical diagnosis by contributing the side of knowledge that the doctor does not have – the social aspect and information about specific events where the allergy has flared up. Hence, a medical explanation and hypothetical diagnosis can be countered by the patient or caregiver by presenting information from their personal experience of the illness that does not go together with the doctor's proposed diagnosis. Essentially, it is a process where a proper diagnosis is not exactly impossible, but definitely more time consuming without the careful cooperation of both doctor and patient. It is a place where agency and patiency get exchanged during the interaction based on the narratives and explanations each participant provides. Of course, the rhetorical and persuasive aspect of presenting a particular possibility is also important to note in this context.

3.2.1. Rhetorics in Anethesiology Consultations: Disruption of Phases, Co-Construction of Diagnosis.

In this section I will present and discuss what goes on during the consultation interaction between the allergologist and a middle-aged mother and her two daughters, one of whom is the patient who suffers from a yet undiagnosed form of allergic reaction which causes inflammation in her airway tracts. What takes place is an exchange of conflicting perspectives on the current treatment plan, followed by a negotiation of hypothetical storyworlds, using Ainsworth's terms, of considering alternative causes and possible treatments. This is a follow-up visit to report the success of a treatment plan that was prescribed some months earlier, the mother reports that symptoms remain the same and that medication is not helping. In the following paragraphs I will present the interaction fragment by fragment, as it unfolds, giving an analysis of each separately.

The interaction begins with a report of the daughter's symptoms, which develops into, what Ochs and Capps described, a sort of exchange of narratives and counternarratives in order to establish a coherent and mutually acceptable understanding of the current inchoate state of affairs of the daughter's ineffective treatment. The letters A and C represent – allergologist and caregiver.

D: Lūdzu pastāstiet, kā izpaužas simptomi.

PC: Vienalga, nu, piemēram, sēžot... it kā nekas un pēkšņi uzpampst, smok nost. Man tas nepatīk...Nav normāli.

D: Vienkārši sēžot?

PC: Jā un ārā arī bijis... nu, no aukstuma nātrene.

D: Jums pilnīgi nemaz nesakrīt... arī tas, ka viņa sēž. Šodien mēs uztaisījām pārbaudi. Redziet, cik Jums labi rādītāji? Viņai ir ļoti labi rādītāji, bet, ja viņai ļoti grūti un smaktu, tad viņai nebūtu šitik labi rādītāji.

PC: Man arī nav.. erm, ira labi rādītāji, bet ir tā, ka man aiziet balss ciet un nevaru vispār ieelpot un izelpot, redzi, man arī IT KĀ labi rādītāji.

D: Mhm, tātad jāmeklē cita vaina.

D: Please tell how do the symptoms manifest?

PC: Whatever, well, for example, while sitting... supposedly nothing's going and then suddenly she gets all swollen up... starts suffocating. I don't like it... It's not normal.

D: While simply sitting?

PC: Yeah and outside there's also been... well, a rash from the cold.

D:It does not add up... also while she's sitting. We took tests today. Do you see how good your results are? She has very good results, but, if she were suffocating, then she wouldn't have results like this.

C: I also don't have.. err, I also have good results, but my voice goes too and I can't inhale or exhale at all, you see, I too, SUPPOSEDLY, have good results.

A: Mhm, so then we need to look for another cause.

Several things happen in this brief exchange. First of all, the conversation starts with a habitual narrative, characterizing symptoms, which turns into a story, when the mother adds in how she feels about what is happening. According to Nancy Ainsworth's perspective, the mother has already expressed her agency and claimed power through introducing aspects of the voice of the lifeworld, using Elliot G. Mishler's concept[3], the

[3] I did not discuss Eliot G. Mishler's theory (1984) in the theoretical section, however, I find her ideas of 'the voice of medicine' and 'the voice of the lifeworld', as useful concepts to describe the kind of persuasive resources both doctor and patient's caregiver draw persuasive resources from.

social and personal experience of illness. In essence, she expresses her agency by putting expressing her perspective and attempting to make the doctor take it into condsideration.

The doctor, however, is incredulous of the mother's narrative, as she puts forward her own counternarrative about taking tests and the good results her daughter showed. Using Carrithers' notion of cultural resource as persuasive material, here the doctor finds it hard to believe the mother's account, because as a doctor trained according to a Western biomedical understanding of health and medicine, she does not go against the empircally produced test results that are gained using scientifically proven medical methods. Furthermore, the doctor uses the voice of medicine (again Mishler), namely, the test results, as indisputable proof to persuade the mother of her point of view.

However, the mother does not yield to this stance, she counters using yet another counternarrative drawn from her lifeworld perspective, her personal experience of illness. In a way the mother defies the doctor's authority by showing that she is not all that trusting of medical tests, because she too has been given good results, but she has suffered from symptoms just the same. This is a very emotionally charged storyworld she uses to counter the doctor, as she emphasizes the word 'supposedly' when talking about her experience of 'good results' from tests. This marks the evaluative aspect that changes a report into a story, according to Ainsworth, as the mother expresses her own feelings of the significance of the event.

In the end of the exchange they reach a sort of stalemate. Nobody takes the position of the patient and nobody relinquishes the position of the *agent/persuader* – the mother does not back away from her stance and the doctor conceeds that another cause needs to be explored, not denying the accuracy of the test results. At this point both have reached the agreement to search for other solutions, however, the situation about the daughter's health remains inchoate. As I see it, the mother stood her ground despite the asymmetrical power relations and the doctor's argument, thus, she claimed and maintained power in this part of the interaction.

The power claim on part of the mother can be further supported by the fact that she caused a brief disruption in the natural flow of the consultation phases. Even though it is not helpful, in my opinion, to the diagnostic procedure, she did make her stance clear. This is followed up by the doctor trying to persuade her with a more elaborate biomedical explanation of how the airway tracts work, while at the same providing a hypothetical explanation of the symptoms:

> D: Ir ļoti daudzas citas vainas, kas norāda, kāpēc jums aiziet ciet. Tas nav apakšējie elpceļi. Tikpat labi augšējie elpceļi, kad jūs sakat, kad jums aiziet ciet aukstā laikā, tikpat labi ir balsene, kas aiziet ciet, bet tā nav apakša. Jums ir labi rādītāji. Elpceļi nesākas tikai no šejienes... Elpceļi sākas no deguna jau. Tātad, ja ir kaut kādas problēmas augšējos elpceļos, tad arī rāda, ka apakšējie... ja jūs esat tik ļoti, kā jūs tagad sakat, ja? Tad šiten te jābūt ļoti, ļoti sliktiem rādītājiem. Jums jābūt ļoti lieliem trokšņiem. Ja? Un ir citas vēl sūdzības klāt, tāpēc man ir jums šie te jautājumi, ja? Lai saprastu vai jums ir tā tikai astma vai kaut kas cits, kas traucē.

> D: There are many other ailments, that explain, why your voice goes. It's not the lower airway tracts. These could very well be the upper airway tracts, when you say your throat seizes up in cold weather, this could very well be the larynx, that seizes up, but not the lower tracts. You have good test result. The airway tracts do start just from here. Airway passages start already from the nose. Therefore, if there are some kind of problems in the upper airways, then it shows that the also the lower... if you are as, as you say you are, yes? Then there should be very, very bad resuults here. You'd have to have loud noises. Right? And there are other additional complaints, that's why we have thse question, alright? To understand whether you have asthma or something else, that's bothering you.

The doctor does two things simultaneously, on the hand, she is engaging in a cognitive reasoning process to formulate why the patient has the symptoms she has and why the previous treatment plan is not working. On the other hand, she is taking on the role of an educator to explain to the caregiver that her argument of having good results and still being sick, which, in a way, shows the mother's incredulence towards the doctor's expertise and authority, is not something mutually exclusive and, therefore, not a indicator that the test results and the doctor's position are wrong. Furthermore, the fact that the doctor reestablishes the purpose of the consultation is, in a way, a means to reclaim power within the interaction and remedy the disruption of normal procedure due to the mother's refusal to readily accept the doctor's explanation and authority. Paralells can be drawn with Paul ten Have's study that indicated that asymmetry is something constructed during the consultation and that the phase structure contributes

to it (1991:139), in this situation the transition of phases was disrupted by the mother's refusal to go along with what the doctor said.

Moving on, after the daughter's brief medical examination the two engage in a discussion of different hypothetical storyworlds. Basically, the initial exchange served to establish the mother's and doctor's stances on the current situation, this lead to following phase of redoing the diagnosis to attempt to find a better explanation and further plan of action. Here we can see the mother propose her own hypothetical storyworld, where she uses the voice of the lifeworld, her own personal experience of the allergy, basing her 'diagnosis' on the fact that she has observed similar symptoms that she has in her daughter as well:

D: Nav nekādu sliktu rādītāju, nav troksnīšu, tātad ir kaut kas cits, kas to visu ietekmē. Izstāstiet par to, kā jūs tiecāt, par to auksto gaisu.

PC: Mēs pampamstam, nē, nu man jau liekas, es diezgan droša, ka tas, visas šīs lietas, ir tāpēc ka... tas ir dēļ aukstuma, jo ziemā un mitrumā pampst. Redziet, man arī pampst, tāpec man liekas, ka... ķermeņa, ūdenī... strauja temperatūras maiņa pie vainas.

D: There are no bad test results, no noises, therefore, there must something else that is causing all of this. Tell what you were saying about the cold air.

PC: We get all swollen up, no, well I think, I'm pretty sure, that all of these things are because... because of the cold, because the swelling happens in the winter and when there's moisture. You see, I also get all swollen up, that's why I believe that... the body, in the water... rapid change of temperature is to blame.

The doctor ask the mother to present her view of the problem, to which the mother offers her own hypothetical storyworld of the cold, temperature change allergy that is coupled with habitual narrative of how symptoms are manifested. It is important that she insists that, in her opinion, this is the true cause of her daughter's allergy. Thus, it is not a mere report of systems, but an actual proposition of a diagnosis. She emphasizes this by saying that she is 'pretty sure' about her explanation, thus, showing her personal attitude that she is quite confident about her stance. Ainsworth claims that is the evaluative aspect of stories that make them different from mere reports, because this is what gives them their persuasive edge (1998:152). The persuasive element in her story is based on her strong confidence about cause-effect repeated observations and

correlation of symptoms between her and her daughter. She claims the initiative and power by having the doctor consider her possible explanation of events. The doctor is persuaded, as the explanation does hold facts worthy of further consideration, and proceeds to evaluate the hypothetical diagnosis by exploring details of her account:

D: Mhm. Ko jūs darat?

PC: Es neko... viņai, kad ir... es smērēju taukus uz sejas, nu, pret aukstumu, lai nav... Vistrakākais ir tad, kad lietus līst...

D: Ziemā, kad līst lietus vai vispār?

PC: Vispār, vasarā arī... redziet tas ir tās... straujās temperatūras maiņas dēļ, tad, kad nolīst sākās tāda tā kā dedzināšana. Viss ķermenis vienkārši deg.

D: Kā tā tūska izpaužas?

PC: Nu, pampast, redziet... man arī, tad, kad eju peldēties iet ciet kakls, tāda sajūta, ka viss iekšā.

D: Kur jūs peldāties?

PC: Karjers mums tāds, tur viscauru gadu... Sezonu neatklājam, sezonu nenoslēdzam. Nu viņu vairs tagad jau nelaižu peldēt.

D: Mhm, and what do you do?

PC: Me? Nothing... when she has it I smear fat on her face, to ward off the cold. It's the worst when it rains.

D: When it rains in winter or generally?

PC: Generally, in the summer too, it's because of the rapid temperature change. When it has rained, there's this kind of burning sensation. The body's all burning up.

D: How does the oedema manifest?

PC: Well, it gets swollen up. You see, when I go swimming... my throat also seizes up, there's the feeling that everything inside...

D: Where do you swim?

PC: We have a sort of quarry, there we swim throughout the year. No start of the season, no end. Well, I don't let her swim anymore.

The doctor does, however, upon examining in more detail the story, introduce another possible diagnosis by pointing out aspects that the mother might not have taken into consideration. Thus, the hypothetical storyworld of the pollen allegy is suggested for the mother's consideration:

D: Mhm, bet vai jūs neesat pieņēmuši, ka nav pie vainas aukstuma alerģija, bet gan ziedputekšņu... ja pa ūdens virsu peld, piemēram? Jo simptomi, ko jūs aprakstāt atbilst arī tādai varbūtībai. Ja nonāk saskarsmē ar tiem putekšņiem... Ziemā, jūs taču nepeldat?

PC: Nu ziemā jau arī peldam. Nezinu par putekšņiem, varbūt, neesam to pārbaudījuši. Taču mums pārbaudīja to, to mums šeit pat pārbaudija, ir atzīts, ka ir tā aukstuma nātrene.

D: Ir pārbaudīts? Labi.

D: Mhm, but have you considered that it is not due to a cold allergy, but due to pollen... if it is floating on the water's surface, for instance? Because the symptoms, that you describe also fit such a possibility. If one comes into contact with pollen... You don't swim in the winter, do you?

PC: Well, we swim in the winter, too. I don't know about pollen, maybe, we haven't checked that. We got checked though, we got checked right here, it's been diagnosed that it is a cold rash.

D: It's been checked? Ok.

The mother considers the pollen hypothetical storyworld, sees that it might be possible, but then emphasizes that the cold allergy storyworld is possible, as there has been a test to prove it. The doctor notes this and dismisses her proposition, as the medical test is a persuasive enough argument.

This exchange illustrates the sociocognitive nature of co-constructing a diagnosis by considering back and forth different hypothetical narratives and storyworlds. Each contributes by providing the knowledge the other lacks and, thus, collaboratively rule out false leads and work on the threads of information that lead towards a possible solution. It terms of agency and patiency, as well as power relations – the initial rocky start developed into a more collaborative framework where the *persuader/agent* and the *patient/the persuaded* roles get exchanged. Thus, a certain relative symmetry is reached where the doctor and patient's caregiver work in unison towards a common co-negotiated goal of finding the cause of the allergy. It is as Ainsworth writes,

> In the bases for claiming power in discourse, medical encounters will always be asymmetrical because physicians have both expert knowledge and socially legitimated authority. But in speech activities and self-definitions, participants

> in the encounter can approach or achieve symmetry. [...] The symmetry [...] lies in physicians' and patients' coconstruction of diagnoses and treatment plans, through their co-construction of narratives and stories about past, present, and future worlds (1998:170).

This interaction I captured demonstrates, as Carrithers and Cordella suggested, that it is possible to change the dynamic of power relations within the context of an unfolding interaction. This is achieved through persuasive means by drawing on arguments from each participants' own repertoire of knowledge – the patient's caregiver's knowledge and experience of the illness and the doctor's expertise and medical understanding of it. The combined knowledge serves to create coherence and moves away from the inchoate character of the allergy towards a concrete plan of how to remedy it.

4. CONCLUSIONS

The theoretical framework proposed by Micheal Carrithers and Marissa Cordella suggests that the reproduction of culture and power relations can be overcome or maintained within the context of an interaction. Carrithers proposes that culture is not determining, rather it serves as a resource that can be rhetorically employed by participants in an interaction to negotiate their positions of *agent* and *patient*, thus, affecting the dynamic of power relations step-by-step as the interaction as it unfolds. In doctor-patient communication the same stands true, as indicated by the ethnographic research by Paul ten Have and Nancy Ainsworth, the asymmetry of the doctor-patient interaction can be negotiated and, while some degree of asymmetry will always be present, there are ways to influence the way the interaction develops to attain some level of symmetry in terms of power relations.

In my research I studied the way rhetorical tropes and narratives for persuasion and negotiation of power relations. My findings indicate that the way rhetoric is employed differs according to the type of consultation and the individual style of each medical practioner. As I studied anethesiology and allergist consultations where the objectives and phases differ, it gave me the opportunity to do a contrastive analysis of the general patterns of rhetorical usage and the way it influences power dynamics between doctor and patient during the consultation.

In the allergist consultations I observed that, while generally patients in Latvia are passive and would rather prefer to let the doctor do the decisions for them, there are cases where patients take a more active role in the consultation. The case with the mother of two daughters and the allergist is one such example, where a degree of symmetry is achieved through the active participation of both doctor and the patient's caregiver. Each contribute by taking into consideration the information and suggestions of 'candidate diagnosis' proposed by each party. The contribution and collaboration stems from combining the medical and lifeworld aspects of disease and illness, the clinician's expertise and the patient's or caregiver's knowledge and experience of the social aspects of the condition. Power is claimed by presenting different stories that contain an evaluative element, that express the patient or caregiver's attitude about the

situation. Moreover, as Ainsworth claims, 'no more important claim to power could be imagined than that which aims to co-construct a diagnosis (entailing treatment) and at the same time define who we are and who we will be (1998:148). Storytelling in this context also serves a rhetorical function of persuasion, as the evaluative aspects of hypothetical storyworlds serve to convince participants of the interaction to take into consideration what is presented.

In the anesthesiology consultation I witnessed an elaborate means of maintaining power over the patient while persuading him or her in a subtle, gentle fashion through the use narrative dramatization and emplottment, using Mattingly's theoretical concepts. Essentially, the doctor presents a set of clinical procedures in the framework of a make-believe narrative, for instance, the child is told that the anesthesiology mask is that of a jet pilot, etc. This playful dramatization serves to reduce anxiety and ensure the patient's compliance. In terms of agency, it is an interesting phenomenon in the sense that the child is persuaded by the make-believe narrative that it is something he or she willingly would want to go through, while in reality it is the doctor who is the persuader and whose agenda is carried out. Nevertheless, this rhetoric strategy is very humane and practical because, while the child is not being told the truth, it is done in order to help him/her get through the procedure, which is often unavoidable, with less distress and in a more safer way.

Generally, while the two different consultations had their own unique ways of using rhetoric to control the unfolding of power relations, it is evident that rhetoric is central in clincal practice. As Carrithers claimed, rhetoric and persuasion entail moving away from the inchoate towards orderliness and coherence (2005:442). In the case of illness, which causes a disruption in the normal flow of everyday life, inchoate is the best term to describe the situation. It is within doctor-patient communication that this confusing situation gets worked out and transformed into a more coherent and understandable form. This is achieved through sets of interactions between the patient, caregiver and doctor. Who becomes the persuader or the persuaded, whose agenda gets carried out to what degree is determined within these interactions. While the relationship will always be asymmetrical, the doctor being in a more superior position, due to a variety of sociocultural and institutional factors, it is evident that these

structures are not determining, rather they serve as resources, among others, that the participants in the interaction can employ while engaging in a rhetorical negotiation of how to make sense and resolve the disruption caused by illness.

On a final note, though the work is about doctor and patient agency and power relations. It is evident throughout the analysis that the actual child's/patient's agency is mostly in the hands of the caregiver. In this work I took it for granted that the caregiver represents the child's interests, because with analytical framework I developed I required to analyse the conversation between doctor and patient/caregiver. In the majority of cases the child did not speak at all during the consultation. The premise that the caregiver more or less adequetly represents the child's interests is not always true, as my observations indicate that there are occasions where this might not be the case. An anesthesiologist reported a compelling example, where, as I see it, he defended a child's agency by not allowing his parents decide in the child's place to go through with cosmetic surgery, that the doctor saw as unnecessary. The anesthesiologist interweened and persuaded the parents to let the child reach the age of fourteen and decide on his own whether the surgery is required. Situations like these point out that the question of agency in the triangle of power relations between doctor, patient and caregiver is something that merits a future in-depth study of its own, taking into consideration developing a whole different theoretical framework and methodology.

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Attachments

Dokumentārā lapa

Maģistra darbs „ Retorika ārsta-pacienta komunikācijā” izstrādāts LU Humanitāro zinātņu fakultātē.

Ar savu parakstu apliecinu, ka pētījums veikts patstāvīgi, izmantoti tikai tajā norādītie informācijas avoti, un iesniegtā darba elektroniskā kopija atbilst izdrukai.

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