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Displays of authority in the clinical consultation: A linguistic ethnographic study of the electronic patient record

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ABSTRACT

The introduction of computers into general practice settings has profoundly changed the dynamics of the clinical consultation. Previous research exploring the impact of the computer (in what has been termed the 'triadic' consultation) has shown that computer use and communication between doctor and patient are intricately coordinated and inseparable. Swinglehurst et al. have recently been critical of the ongoing tendency within health communication research to focus on 'the computer' as a relatively simple 'black box', or as a material presence in the consultation. By re-focussing on the electronic patient record (EPR) and conceptualising this as a complex collection of silent but consequential voices, they have opened up new and more nuanced possibilities for analysis. This orientation makes visible a tension between the immediate contingencies of the interaction as it unfolds moment-by-moment and the more standardised, institutional demands which are embedded in the EPR ('dilemma of attention'). In this paper I extend this work, presenting an in-depth examination of how participants in the consultation *manage* this tension. I used linguistic ethnographic methods to study 54 video recorded consultations from a dataset collected between 2007 and 2008 in two UK general practices, combining microanalysis of the consultation with ethnographic attention to the wider organisational and institutional context. My analysis draws on the theoretical work of Erving Goffman and Mikhail Bakhtin, incorporating attention to the 'here and now' of the interaction as well as an appreciation of the 'distributed' nature of the EPR, its role in hosting and circulating new voices, and in mediating participants' talk and social practices. It reveals – in apparently fleeting moments of negotiation and contestation – the extent to which the EPR shapes the dynamic construction, display and circulation of authority in the contemporary consultation.
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1. Introduction

The introduction of computers into general practice has changed the dynamics of the clinical consultation, particularly through the widespread adoption of the electronic patient record (EPR) to support patient care. General practitioners spend about 40% of the consultation interacting with the computer (Kumarapeli and de Lusignan, 2013).

Like its predecessor, the paper medical record, the EPR is a place where patients' medical notes are recorded. Previous research has shown that paper medical records mediate social relationships and play an active, constitutive role in medical work, shaping consultations, organising and transforming professional conduct to some extent (Berg, 1996; Heath, 1982, 1984; Robinson, 1998). However there are important differences between paper and electronic records which may point to EPRs having greater potential to shape and transform. For example in EPRs diagnoses, procedures and results can be assigned unique codes which make them searchable for audit purposes; electronic templates (or forms) are used to structure the chronic disease consultation, offering limited fields for completion; reminders and prompts urge clinicians to take specific action at specific times; inbuilt calculators estimate medicines usage and disease risk. The EPR supports not only the management of individual patients (the 'primary use' of data) but also produces aggregated data on organisational performance, costs and other metrics ('secondary use') (Berg, 2001).

Researchers have coined the term 'triadic' consultation to capture the notion of the computer as an influential 'third party' in the consulting room (Booth et al., 2002; Chan et al., 2008; Margalit et al., 2006; Pearce, 2007; Pearce et al., 2009; Scott and Purves, 1996; Ventres et al., 2006). Most empirical studies which claim to investigate the impact of the computer on the consultation do so from a perspective that *separates out* the computer from the communication arising between clinician and patient. This is despite evidence from the early 1990s (when computer use was gathering momentum in UK general practice) that computer use

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and communicative conduct between doctor and patient are intricately coordinated (Greatbatch, 1992; Greatbatch et al., 1995, 1993). Greatbatch et al. challenged the assumptions underpinning much previous work in the field of human–computer interaction by showing that *apparently* 'single user' activities around a computer are often – on closer scrutiny – collaborative activities requiring an appreciation of the computer as being *embedded* within work practices (Greatbatch, 1992; Greatbatch et al., 1993). Recent research confirms the value of appreciating the EPR as *integral to* the practice of consulting, showing the extent to which it shapes, and is shaped by these practices (Pearce et al., 2012; Rhodes et al., 2008; Swinglehurst et al., 2012, 2011; Swinglehurst and Roberts, 2014).

With notable exceptions (Kumarapeli and de Lusignan, 2013; Pearce, 2007; Pearce et al., 2012, 2009, 2008; Rhodes et al., 2006) most research to date has focused on 'the computer' as a relatively simple 'black box', or as a material presence in the consultation. For the purposes of this paper, I use the term electronic patient record (EPR) to refer to the clinician's desktop computer (including monitor, mouse and keyboard for example) and the display of clinical information that is visible on the monitor. This brings together both the material dimension of the EPR, which holds consequences for the interaction as an embodied practice *and* the textual dimension of the EPR.

One enduring characteristic of the medical consultation which has fascinated social theorists, medical sociologists and analysts of health communication is how authority 'plays out' between clinician and patient. Authority has been defined as the legitimate exercise of power in an asymmetrical relationship, by those 'in authority' over those who are subjects of authority, either by virtue of specialised knowledge or by holding a particular political or social position (Anon, 2011). Early research on the asymmetrical nature of the clinical consultation tended to assume this asymmetry resulted from pre-existing institutional 'structures', *brought to* the consultation and leading to the subordination of the patient's perspective to the professional perspective (Freidson, 1970). Examples of such institutional structures might include a doctor's mandatory qualifications, professional registration and gatekeeping privileges. More recent research has shown that this asymmetry is not simply a *given* or a product of the clinician's abstract power but is *brought about* within the consultation and achieved interactionally to a greater or lesser extent (Ariss, 2009; Hak, 1994; Heritage, 2005; Maynard, 1991; ten Have, 1991). For example, a study of consultations involving 'frequently attending' patients has shown how doctors and patients display normative entitlements to knowledge (epistemic authority) which relate to their identities as 'patient' or 'doctor' (Ariss, 2009). These entitlements tend to be maintained, although participants can – and sometimes do – achieve more equal claims to authority through collaborative interactional strategies (Ariss, 2009).

In this paper I adopt a perspective that authority is both *brought to* the interaction (through institutionalised practices) and also *brought about* in the interaction (in its moment-by-moment unfolding between social actors) There exists a recursive relationship between the two, and it is in the ongoing productive relationship between the two that what is recognisable as legitimate authority may be shaped or redefined over time. Attention to the micro-detail of the interaction provides insights into how and to what extent authority is accomplished and reproduced.

Early interest in (and criticism of) the authoritarian 'paternalistic' nature of the medical consultation (Mishler, 1984) has shifted more recently towards an emphasis on concepts such as patient-centeredness, patient 'choice' and 'empowerment', shared decision-making, patient participation, the 'expert patient' and the 'activated, self-managing patient' (Collins et al., 2005; Edwards and Elwyn, 2009; Entwistle et al., 2004; Greene and Hibbard, 2011; Stewart, 2001; Towle et al., 2006). Arguably these descriptors do not represent well-defined social phenomena or theoretically coherent constructs. Rather they signify a shift in the underpinning ideology of health care away from one which assumes the unquestioned authority of the clinician towards one which espouses greater involvement of the patient.

The increasing use of the EPR in primary care – both in terms of geographical coverage (almost universal in the UK) and technical capability (what the EPR is used *for)* – has evolved in parallel with these developments and has largely been informed by a range of different (and potentially competing) ideologies. These include the evidence based medicine movement, clinical governance, rising managerialism and a general move towards valuing standardisation and eliminating what are perceived to be undesirable variations in care. Although there is enthusiastic optimism for the potential of EPRs to foster doctor–patient collaboration and patient activation within the consultation, there is as yet little evidence to support this (Saleem et al., 2013; White and Danis, 2013).

Authority, asymmetry and power are not inherently 'bad' things (Blommaert, 2005; Schei, 2006). Indeed some commentators argue that an undue emphasis on the 'autonomous' patient can lead to a situation of harmful indifference (Mol, 2008; Schei, 2006), suggesting that the structural and symbolic power wielded by doctors is legitimate, socially conferred and indispensible for help and healing to occur (Schei, 2006). However, the exercise of authority involves responsible moral work, and how authority is established in the consultation provides an interesting lens through which to examine the contribution of the EPR to contemporary consulting practices.

One researcher who recently explored this by analysing video-recorded consultations concluded that the computer demonstrates agency, vying for recognition as a source of authority in its own right, with a flexible set of alliances evolving among the three 'players' (actants) in the consultation, and authority shifting amongst them in "ever revolving circles" (Pearce, 2007; Pearce et al., 2008). In one of the few studies that has engaged with the EPR as text, Pearce has drawn attention to the way in which the EPR articulates several influences in the consultation (e.g. those of system designer, government agencies and commercial entities), concluding that the more active the mode of presence, the more patients and doctors have to adapt their communicative styles to accommodate it (Pearce et al., 2012). Pearce has identified a need for further research to examine in more detail how authority is created dynamically in the consultation (Pearce, 2007), and also highlights the potential value of combining screen capture with analysis of micro-interaction (Pearce et al., 2012). This paper develops and extends this work by using a novel methodological and conceptual approach (Swinglehurst, 2011; Swinglehurst et al., 2011) to illuminate how authority is constructed in the consultation, conceptualising the computer not as 'agent' or 'partner' in its own right (Pearce, 2007) but as a collection of multiple significant and consequential 'voices' – stratified, ordered and meaningful within a specific social, professional and institutional context. This orientation shifts the enquiry away from a sole focus on which party in the consultation is the source of authority, or where authority resides at any point in time and allows us to extend our analysis to the *practice* of authority building – the *doing* of authority within the consultation and its relationship with wider social and institutional contexts.

2. Methods and methodology

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