Quality of *Educator Voice* in Clinics; Conversation Analyzes of Clinical Counseling in Shiraz, Iran.

**Abstract**

**Objective**: Doctor-patient communication includes different voices which has a function in clinical setting. An important voice in this setting is educator voice which promotes patients medical literacy. The goal of this study is to explore the quality of educator voice in 33 clinical consultation sessions is Shiraz, Iran.

**Method**: Method of analysis is Conversation Analysis (CA), where the conversations are interpreted as a *social actions* and *social events*. The quality of educator voice was analyzed based on these interpreted *actions* and *events.*

**Results**: Educator voice includes two general dimensions that are: *descriptive* and *prescriptive*. Our interpretation showed that the quality of educator voice includes; *superficial,**marginalizing patients, one dimensional approach, ignoring healthy lifestyle,* and *is being robotic*.

**Conclusion**: Based on our findings this type of interaction can be described as a weak educator voice. Due to its important, health policy makers should implement policies that can supervise the educator voice in order to enrich and raise its quality.

**Key words**: clinical consultation, educator voice, conversation analyses

**Introduction**

Educated Patient is defined as a person who has been trained about different aspects of therapeutic and health education plus clinical health promotion by a doctor (1). Patient health literacy plays an important role on his/her health status (2). In order to achieve this aim physician must recognize that this issue is a vital link for promoting health statues in society. Due to its importance, in contemporary health care, educating patients is defined as a right (3), as well as ethical (4). It has become one of the most important subjects in developed countries' health care system. Results of Visser et *al*., research showed that patient education is a general features of healthcare in the UK, Belgium, Germany, and The Netherlands (5). Moreover, this subject has become an important topic in academic debates (5).

Generally, patients acquire part of their health literacy in clinical consultation sessions. Dreeben-Irimia believes that the goals of clinical teaching and learning should be based on patient assessment, evaluation, diagnosis, prognosis, and individual needs and requirements related to intervention (6). Also Redman views that the main goals in patient education should heavily focus on direct application of physician-prescribed actions (7). Hence, Doctor-patient interaction plays a pivotal role in general promotion of health.

Hence, doctor-patient interaction is an important subject in medical research and sociology of medicine (8-10). Based on sociological theories there are numerous voices in every interaction (9-11). A physician's voice that focuses on the patient's education is called *educator voice* (9). According to Cordella, the primary purpose of educator voice is to help the patient understand and follow the appropriate treatment and management (9).

Even though there has been an ample amount of research on patient education, however, there has been little or no qualitative study on the subject of educator's voice. In Iran there has been no qualitative study on this subject and for this reason the present study was conducted. Due to the importance of educator voice in clinic, the main goal of this study was to explore the quality of educator voice in clinical consultations. Hence, this research seeks to respond to these questions:

1. How do doctors educate patients during consultation sessions?
2. How many different aspect of educator voice is used by doctors?
3. What is the educator voice main emphasis?

**Method and Context**

This study was conducted in the second largest medical training center of Shiraz, Iran. The main reason why the researchers' choses this center was that it has; internal, surgery, OB-GYM, and Dermatology clinics. Research data that were included were dialogs that took place between physician and patient in clinical setting between April 2014 till September 2014.

For data gathering, researchers explained the aims of this study to physicians in the clinics and those who verbally agreed where included. At least one physician form each clinic agreed to participate and the total number of physicians who agreed was 9. Prior to each consultation a verbal agreement was taken from both the physician and the patient. Each session was separately recorded and then transcribed. From 50 conversations 33 were selected to be analyzed. Inclusion criteria were diversity of disciplines, and being fruitful conversation. Based on saturation rule, we reached saturation (12, 13) after the 33rd consultation.

For data analysis method we used conversation analysis (CA). CA is a traditional methodology in sociology which was introduced by E Goffman (14) the in 70s. According to this, sociology is the science of natural observation (15-17) that can be analyzed. In this approach researcher evaluates the natural dialogue that occurs between two or more ordinary people. For CA data, we evaluated the conversation as a *social action* and *social events*. Therefore, we interpreted the educator voice from the conversations based on the two mentioned criteria*.* According to this approach, any statement that was exchanged between physician and patient was interpreted as a meaningful action between both parties. This research was conducted based on ethical codes defined by American Sociology Association (18). It also obtained the ethical approve from Shiraz University.

Validation of the study was observed in three ways. Members check as a tool of validation. For this reason the researcher's interpretations for some participants and verification were given back from theme. Also, trustworthiness was observed during the study.

**Results**

After evaluating the consultation sessions, it showed that educator voice has two characteristics which are *descriptive* and *prescriptive*.

*Descriptive voice*: In this voice a doctor explains the process of illness and specifically the process of diagnosis, treatment, tests, graphs, and etc.

Educator voice in consultation # 14 (patient with H-Pylori infection):

*D: Yeah, duodenal ulcer is not usually cancerous*

*P: Ok,*

*D: Typically it recovers faster*

*P: Oh, really!?*

*D: Yep, usually due to infections such as; H. pylori and peptic ulcer you don't have to do re-endoscopy.*

*P: Thanks*

*D: If you're other symptoms are gone.*

In this statement, physician is trying to convince the patient that his condition has improved by referencing from the paraclinical data. Also, he ensured the patient that he does not need re-endoscopy. Sometimes, physicians inform their patient about the illness process and its treatment. For example in consultation # 22 (patient with renal colic) the physician informed the patient in this way:

*D: There is some blood (U/A), but it's Ok, it seems that your kidneys are clean.*

*P: No, this is a previous (test), D:[this one is the latest], Yea, this is it.*

*D: Have you seen any stone pass through your urine, lately?*

*P: No.*

*C: This is also good news, probably it has passed.*

In this part, physician refers to the urine analysis test and says that the probable renal stone has passed. So, in this short conversation, physician explains the process of illness to the patient. In descriptive voice, also, sometime, physician talks about the prognosis of the illness. For example; a physician in consultation # 6 says "your kidneys are better, your anemia is Ok too, but your blood sugar is not under control". In this statement the physician seeks to present an overall explanation for the patient condition. Also the physician informs the patient that in this condition, her blood sugar needs more attention. So, descriptive voice is about *'what is present'*.

*Prescriptive* *voice*: Is about what the patient should be doing. This part of educator voice includes various issues such as; next referral, paraclinical tests, graphs, medication orders and self-care. This is the main part of educator's voice that deals with promoting health by prescribing medication as well as healthy behavior. Hence, this voice is trying to inform patients about '*what should be done'*. This includes various issues. However, the dominant issues are medication and further tests. For example in consultation # 9 (woman with acne) physician prescribes:

*D: These are your tests that you should do on the third and fifth day of your menstruation period. I have prescribed some medications, take a capsule every other day with lunch, if it dries your lips, use a chap stick, come back and see me in one month with your tests results.*

Another consultation # 16 (woman with advanced breast cancer) shows the dominance of paraclinical data and medication prescription:

*D: This is a sleeping pill, eat it before going to sleep, if you take it at the dinner table, you should immediately go to bed. I have also written a chest X ray, hold your breath then take the X ray, then you can come and see me anytime. Please take your documents; this is your appointment in three weeks from now.*

In this consultation final prescription was issued about the medication, X ray, and future appointment. So, in this voice, a physician prescribes the things that a patient should do.

**Characteristics of educator voice**

Despite the mentioned characteristics in consultations, when we looked at the *educator voice* from critical points of view, we detected several flaws in the consultations. By analysis of the transcripts we saw that these consultations had the below characteristics of educator voice.

***Superficiality***

*Educator voice* is simply superficial, because it does not emphasis on the important issues. Recognizing this is not that difficult, you can do it by simply evaluating the consultations content, in a way that, nothing is being thought in the consultation sessions. For example diabetic is a chronic disease that needs special education. In the consultation # 6 an illiterate old woman who had referred to endocrinologist, many issues was discussed in the consultation session by the physician about the history, medication and range of blood test, however, no training or education was provided. At the end of this consultation the physician changed her medication and prescribed a re-test for the blood sugar. As it was stated, the only thing that she learned during the consultation was that her blood sugar was very high by the physician referring to the result of FBS that was 303. The physician does not pay any attention to other aspects of educational needs of an illiterate and elderly woman such as; dieting or exercising.

***Marginalizing patients***

Consultations showed that, the educator voice is merely based on physician-centeredness. It means that it is the physician who determines the subject of education without including the patient. For example in consultation # 33 (woman with numbness in her shoulder), this patient was previously prescribed to do NCV test. According to her test result, her physician recommended surgical procedure. But then again, she refused to go through with the procedure due to fear, not having anyone to look after her and being doubtful about the diagnosis. As result she asked her doctor for an alternative procedure. However, since the physician's opinion was based on NCV result, he tried to ensure her that his recommendation was the best choice. Even though he realized that the patient had doubted him, but he insisted that the patient should obey him.

*D: Why don’t you want to undergo the operation?*

*P: Well, I think this may not require an operation, am I right?*

*D: According to this nerve strip (NCV), you should do it!*

*P: Yea, isn’t there anything else to do? Because….*

*D: You see, nothing is certain, nothing is certain; what I mean is that, with this nerve strip (NCV), you need to undergo operation for sure, and I'm sure we will be able to achieve good result, scientifically speaking ….*

*P: Yea!*

*D: ….A patient like you should undergo this operation. If you say no to it, or resist it.….*

*P: Ok then, I won’t do it…*

*D: ….Listen! Resistance means you are avoiding the operation, under any circumstances you should do this.*

In this consultation, due to dominance of physician voice, educator voice is asymmetrical. So, descriptive voice (refer to nerve strip) and prescription voice (refer to surgery procedure) are based on physician-centeredness without paying attention to patient's concerns. In this situation, slightest doubt in the patients mind can lead to failure of educator voice. The reality is that, this is deep rooted in marginalization of patient and his/her wisdom and knowledge by the educator voice.

Overall, when there is a lack of attention to patient concerns, not only the consultation would fail, but it also creates psychological pressure on the patient. In all 33 consultations, there was only one which was an exception. In that consultation the urologist provided adequate explanation to reduce psychological stress on the patient family member. In consultation # 23 patients' son tried to conceal his mother's illness (woman with kidney tumor).

***One dimensional approach***

Another critical characteristic of all consultations was that, they were one-dimensional. It means that each physician merely approached his/her specialty domain. For example; a surgeon only paid attention to the surgical procedure and this happened in all other fields of medicine. In this condition other disciplines are generally ignored, unless the patient complains.

For example; in consultation # 6 the patient has diabetes. In this case, physician does not pay any attention to the effects of high BS on other organs such as; heart, eyes and nerve system. Another example is consultation # 18 patient with spinal cord injury who was afflicted with a testicular and urinal infection. In this case patient's son talked about patient's digestive problem due to antibiotic consumption. Despite his great emphasis on this issue, the doctor does not pay any attention to his statements and ends the session.

*Patient's son (PS): Thank you! Aren't you going to prescribe any drugs?*

*D: No, there is no need for drugs at the moment, just use the previous drugs.*

*PS: Well, those drugs cause diarrhea!*

*D: So, if that is the case, stop taking them. I mean, stop taking Clindamycin.*

*PS: Isn’t there any alternative medicine? Something that can reduce his stomach problem; because when he defecates, it really hurts and it is annoying for him and people around him.*

*D: Ok, have a Good day!*

As you can see, the physician easily ignores the patient. Even though this is a multifactorial issue, but one reason could be the one dimensionality of the consultation. Here, the physician sees himself as someone who is only responsible for the patient urinary problem and nothing else. In addition, this question comes to mind, why was this medication prescribed and why was it discontinued?

***Ignoring healthy lifestyle***

Healthy lifestyle is one of the most important dimensions of educator voice which has to be thought by a physician. This includes; providing proper information on healthy behavior, diet, exercising, and hygiene. However, after evaluating the consultations it seems that healthy lifestyle was totally ignored and the doctor orders were simply limited to prescribing medication. Although in some sporadic cases this issues was touched upon by the physician. For example in consultation # 4 (patient with anal fisher), physician indicated that being overweight is the main cause of the problem, but her recommendation was limited to these statements:

*D: How much do you weight?*

*P: 73 Kg.*

*D: you are slightly overweight! [Yea] you're too young to be this heavy.*

*Patient's mother: He doesn't eat much but he gains weight.*

*D: He is not that active.*

In this conversation, the physician's statements were limited to her observation and did not provide any solution to rectify the problem based on promoting healthy lifestyle. In other consultations such as; diabetic, elderly patient, and obese patient, the healthy lifestyle recommendation was totally ignored.

***Being Robotic***

This theme means that essentially all consultations were based on parachlinical observations and only occasionally physical examination or active conversation took place. In this situation, patient felt that the consultation was meaningless. In a Robotic consultation there were some general or routine phrases that were used frequently such as; “Where are your echo test results?”, “Your tests are incomplete”, “As the ultrasonography test says”, “Have you brought your previous tests?”, “Your previous test results are better than these ones”, “You should do another test and come back in a month”, “I’ll prescribe a re-test”, “Repeat the test”, “Just do these tests”, “For the time being, get examined for these tests”, “Bring the results to me later”, “An endoscopy re-test might be needed”, “Let me check out your blood sugar too”, “I’ll add a mammography too”, “You should get scanned in two months' and so on.

These types of clinical approaches can be looked at from several aspects. When it is evaluated from educator voice it shows how robotic they are. In this condition, physician merely relays on the paraclinical data and ignores other aspect of consultation. Therefore, if a physician wants to simply relay on the praclinical data and ignores other aspects of consultation this question comes to mind, what happens if the paraclinical data is not accurate or misleading, then what will happen to educator voice?

**Discussion**

The result from this study shows that educator voice in the context of this study has not been effective. Additionally, in most cases this voice was inefficient and was not up to the task to fulfill its duties. Its characteristics were *superficiality,**marginalizing patients, one dimensional approach, ignoring healthy lifestyle,* and *being robotic*. Based on our observations it is obvious that these clinical consultations cannot function accordingly. Consequently, it is deviated from its original aims, especially in chronic illness where the physician has to approach the issue holistically. There is a flip side to this coin, this type of consultation can lead to distortion in a doctor patient interaction such as; miscommunication, misconception, disagreement and in some cases argument.

In all our observation we only came across one study that had explored this subject in this depth and method. Cordella study described the nature of *educator voice* with critical view in clinical counseling. She discussed the deficiency of educator voice in 7 consultations sessions whit the main questions of: "Are we to understand the absence of the educator voice from those consultations as depriving the seven patients of the opportunity to acquire a better understanding of their health condition? Will this limit their chances of looking after themselves adequately? Is the absence of patient education in almost one-third of consultations contradictory to the basic teaching principles of the institution where the study was conducted? If we accept that the silencing of the Educator voice may be a problem, then what is its cause, and how should it be interpreted?" (9). Our investigation confirms Cordella's findings. With regards to her last question, the cause can be explained in the below discussion.

Hence, here asymmetrical power relationship is one of the most important issues. Mhishler in her classic study showed that voice of medicine dominants the voice of lifeworld, where, the first one is technical and mechanical, but the second one is humanistic (19). In a recent study by Sadati et al., they showed that unequal relationship leads to domination and suppression of patient lifeworld, our result also confirms this (8). Also other studies have shown that paraclinical standard is one of the most important causes for patient dependency on clinics (20). The present findings also show that these paraclinical standards are the main obstacle in front of active consultation, and that is why we are confronted with robotic consultation.

A new interdisciplinary discourse which has recently entered medical research is called patient-centeredness. This discourse aims to reduce the unequal power relation equation. In this approach a physician is obligated to consider patient's worries and apprehensions. In this scenario he/she has to get the patient involved in the treatment. If this materializes, the major problem in this study can be solved.

Finally, educator voice has to provide a patient with adequate information in order for them to manage their medical problems. To reach a suitable educator voice several alternatives are proposed; academic institutions have to pay more attention to educator voice as an important part of any consultation, promoting awareness and educating the public about their right as a patient, promoting the overall health literacy of the society and at the end instigating the issue of patient centeredness discourse.

**Limitation:**

The most important limitation in our study was the way the conversations were recorded. Even though the researcher had tried his best not to interfere in the natural setting of the dialogs between the physician and the patient, in order to reduce the bias as much as possible, but the reality is that most likely the presence of the researcher might have had some influence on the quality of the consultation. Unfortunately, our methods were unethical.

**Conclusion**

Educator voice is an important part of any clinical consultations. Our result showed that educator voice in this context is; *superficial,**marginalizing patients, one dimensional approach, ignoring healthy lifestyle,* and *is being robotic*. These characteristic cannot meet the demands of today's patient needs and they are not in line with basic aims of clinical consultation. A clinical consultation has to be holistic and has to relay on understanding the realm of lifeworld.

**Conflict of interest:** not declared

**Acknowledgment**

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