

Patient's voices in the medical world:  
An exploration of accounts of noncompliance<sup>1</sup>

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Many scholars of language are drawn to the profound linguistic issues one finds in the study of medical discourse. Some of these researchers focus their efforts primarily on furthering our understanding of some aspects of discourse, such as frame-shifting (Tannen and Wallat 1982), questions (Ainsworth-Vaughn 1998), or giving of recommendations (Roberts 1999); others (Frankel 1994; Frankel and Beckman 1995) direct their work to the health care providers and consumers—the physicians and patients who talk to each other in doctors' offices and hospitals, far from university seminar rooms. Still others try to live in both worlds, shuttling between medical conferences and linguistics conferences and working hard to translate one set of disciplinary assumptions and frameworks into another.

Beginning with my study of conversation and Alzheimer's disease in the 1980s (Hamilton 1994a, 1994b, 1996), I have straddled both worlds: I have been involved in a variety of interdisciplinary projects examining aphasia (Hamilton 1994c); mental health delivery systems (e.g., the National Institute of Mental Health's "Healthy People 2000" initiative); genetic counseling (Benkendorf et al. 2001); physician-nurse communication (Larson et al. 1998); and Internet health support groups (Hamilton 1998). In 1999 I began to explore physician-patient communication as a linguistics consultant to a health care education project being conducted by a major health care communications company in the northeastern United States.

In this essay I discuss one facet of the project: patient compliance<sup>2</sup> in chronic or life-threatening illnesses, with a focus on diabetes. Specifically, I investigate verbal accounts offered by eighteen patients to excuse or justify noncompliant actions as related to the diabetes management plans recommended by their physicians. Based on analyses of the accounts' discourse structure, as well as personal attribute statements made within the accounts, I argue that these accounts contain information about the patients' lifeworld circumstances that is critical to the health of these patients and yet only rarely comes to light in interactions with their physicians. I close with specific recommendations on how to increase the exploration of such information in the patients' visits to their doctors.

Before I examine patient accounts, however, I step back for a moment to provide relevant background information in several areas. First I present the health care problem that motivated the analysis; second, I discuss relevant frameworks within the area of medical discourse analysis that guided my eventual focus on accounts and briefly describe the interactions I examine in this essay; third, I provide insights into the challenges of compliance related to diabetes.

### **The Health Care Problem**

Why might it make sense for a linguist to study compliance in diabetes or other chronic illnesses? What makes me think that an investigation of the language used by patients and their physicians could have anything to do with compliance and health? To commit to such a project, I had to assume two things: Physicians have the best interests of their patients in mind and at heart, and patients *do* want to comply because they understand the link between such compliance and better health.

If these assumptions are correct, the following fact is startling and cries out for action: According to the U.S. Health Care Financing Administration, 50–60 percent of medical costs paid by insurers can be traced to only 3–5 percent of all patients in the United States.<sup>3</sup> Although some of these patients face high medical costs related to unpredictable and largely unavoidable circumstances such as serious accidents and cancer, most of these patients have serious chronic conditions such as high blood pressure, congestive heart failure, and diabetes that can be managed to minimize serious long-term complications. For example, uncontrolled diabetes—cases in which patients do not, will not, or cannot comply with what their physicians think will help them live healthier lives—is the leading cause of kidney failure, lower extremity amputation, and new cases of blindness in adults. Thus, there is strong evidence that noncompliant actions by patients are leading them into worse and worse health accompanied by higher and higher costs, pain, and suffering. In fact, the American Diabetes Association reports that total direct and indirect costs related to diabetes in the United States in 1997 were approximately \$98 billion.

### **How Might Linguistics Help?**

Research into physician-patient interactions undertaken by language scholars over the past twenty-five years or so has focused a good deal on the pervasive and readily apparent asymmetries displayed and (re)created within such interactions. When the discourse of physician-patient interactions is contrasted with everyday conversations, it is clear that institutional discourse is shaped by the specialized education, training, and experience of the physician, as well as the institutional work that needs to be accomplished in such interactions. Technical vocabularies and presuppositions that are based on expected professional knowledge combine with expertly managed control of the interactional agenda as effected by asking

questions, initiating topics, and deferring or ignoring topics introduced by patients. Not only are patients not usually privy to the specialized knowledge of the physician, they usually have less experience with the goal-oriented interactional agendas and discourse structures that are typical of physician-patient encounters. In a seminal article, ten Have (1991) made the point that such asymmetry, although prevalent, actually is constructed every time patients and their physicians get together. Patients must collude with physicians as the discourse unfolds if the asymmetries are to be upheld. This fact encourages us not only to look to language and the emergent discourse for clues to how this asymmetry is accomplished but also to think seriously about ways in which the discourse might change to allow patient voices to be heard more frequently within the medical encounter.

Alongside this thread of discussion runs another, somewhat connected, thread having to do with the patient lifeworld or patient perspective. Mishler's (1984) foundational work in this area identified the "voice of the lifeworld" and the "voice of medicine," whose collision can be used to describe some problematic interactions between physicians and their patients. For example, whereas a physician may understand a disease in terms of objective blood counts and cultures, a patient with that disease may understand it primarily in terms of its impact on his or her life's activities—such as being too tired to go to work or socialize with friends. In her examination of claims to power in medical encounters, Ainsworth-Vaughn (1998) argues that glimpses into the patient's lifeworld can be offered through personal experience narratives told by the patient as part of the physician-patient interaction. These narratives can be integral parts of the diagnostic process for physicians who allow them to be told and understand them to contain important insights regarding patient symptoms and experiences of the disease.

Shifting slightly from sharing aspects of the patient's lifeworld to the patient's perspective, Maynard (1991) characterizes the "perspective display series" that some physicians use strategically to encourage patients (or parents of patients) to display their understanding of their medical problem before the physician discusses his or her own diagnosis of the problem. The fact that the patient's perspective is "on the table" allows the physician to tailor delivery of the diagnostic news, emphasizing points of agreement between perspectives and carefully discussing points of difference. My own ongoing work within genetic counseling and hormone replacement therapy in menopause has highlighted the importance of such exploration of individual patients' perspectives as health care professionals and patients weigh potential risks and benefits of medical decisions in areas where recommendations are made against a backdrop of medical uncertainty.

All of this work revolving around the role of patients' voices as related to the accomplishment of various kinds of medical work made me wonder about the possible connection between patients' voices and the problem of patient noncompliance. I began to think that some clues to this connection very likely were waiting

to be found deep within patients' and physicians' talk, so I gathered the project videotapes and transcriptions and embarked on my search for these clues. An examination of the project data set took me on a videotape-aided journey into physicians' offices in three locations: a group practice specializing in diabetes treatment in a small city in the northeastern United States; a family practice affiliated with a county hospital in a second small city in the northeastern United States; and an inner-city primary care practice in a large midwestern city. I watched and listened to twenty-four diabetic patients in routine check-ups with their physicians, aided by videotapes of open-ended interviews that were held with each patient immediately following the check-up. Videotapes of interviews with each of the six participating physicians regarding twenty-three of the twenty-four patients provided insight into the health care professional's perspective on these particular physician-patient interactions, as well as on diabetes issues in general.

I was immediately struck by the patients' account-giving within the larger discussion of noncompliance within their post-interviews. The insights into the patients' personal circumstances surrounding specific issues of noncompliance were obvious. I returned to the physician-patient videotapes to look for this type of information and found almost nothing. I had discovered my clue; a fuller investigation of patient accounts seemed to be a fruitful way to proceed.

### **Compliance Challenges in Diabetes**

Before we examine the patients' talk about compliance, we must understand the many challenges these patients and their physicians face. To manage their diabetes effectively, patients typically must control or lose body weight; exercise regularly; take prescribed medications in the correct dosages at the prescribed times of day; monitor blood glucose (sugar) levels in the morning and evening; have regular examinations by a variety of medical specialists, including ophthalmologists and podiatrists, in an attempt to diagnose and treat physical changes caused by diabetes; and watch the kinds and amounts of food they eat, taking care not to eat foods that can raise their blood sugar levels. These foods include potatoes, rice, and pasta in addition to the more obvious candies and desserts that contain sugar. The patient speaking in excerpt 1 offers some insight into the often overwhelming nature of this compliance.

#### *Excerpt 1*

It's a strain on your lifestyle.

I'll put it that way.

If you're cooking at home,

how you got to cook your food

and then you take your medicine

and then you got to keep checking your sugar  
 and you're ripping and running,  
 you're going to work.  
 You got all the stuff to do  
 and it just seems like it's a hassle to life, you know.  
 There's just so much to do.

Most of these compliance areas are integrally connected to how patients live their lives, helping to make diabetes one of the most “psychologically and behaviorally demanding of the chronic medical illnesses” (Ciechanowski et al. 2001: 29). Anderson (1985) reports that 95 percent of diabetes management is conducted by the patient.

Many physicians understand how difficult it is for patients to be consistently compliant. One physician in our study expressed it as follows:

*Excerpt 2*

Well, I think it's a tough disease to work with in many of these people, because a lot of, you know, many of these people are Type-2 diabetics who are overweight,  
 who basically need lifestyle changes in order to control it,  
 and that's a difficult -  
 Anytime you're asking anyone to do . . . that they have to do something, you know, other than take pills,  
 then it becomes very difficult.

The compliance difficulties patients experience represent immense challenges to their physicians. Our taped physician-patient interactions were filled with frustration—first as patients admitted to not adhering to aspects of their treatment plan and then as their physicians tried to get them to change. Over and over in our post-interviews, physicians mentioned the strategies they use in an attempt to encourage patient compliance. Many rely on education, calmly reciting relevant facts and figures. Some add affect to the facts, sounding more like salespersons than physicians. Others fall into yelling and nagging; they admit that they feel like mothers trying to get their children to behave. Still others resort to instilling fear in their patients—highlighting the kidney failure, blindness, or amputation that may await the patients if they do not change their ways. As a last resort, some physicians try

intimidation tactics, telling their patients that they will have to go elsewhere for treatment if they do not become more compliant. Out of desperation, many physicians report that they find themselves switching strategies from visit to visit or even over the course of a single visit in the hope that another approach might be more successful with a particular patient. Clearly the combination of low levels of compliance and high levels of interpersonal frustration points to a significant problem that cries out for solution. I propose that part of this solution may be found in patients' own accounts of their noncompliant behaviors.

### Accounts

An individual with diabetes has a multi-faceted treatment plan with which he or she must comply to remain relatively healthy. The vast majority of this compliance takes place in the lifeworld of the patient, with compliance decisions being made virtually each and every hour of each and every day. *Should I have syrup on my pancakes at breakfast? Should I take the cookie being offered to me at the office? Should I have an extra helping of rice at dinner? Do I have the time to go to the gym after work? Do I have the energy to get on my treadmill during the baby's nap?* One patient put it this way: "Diabetes never takes a vacation."

In stark contrast to this big, real-life world of patient compliance, the physician has a very limited view of this context for compliance when he or she is sitting with the patient within the four walls of his or her office. The typical individual with diabetes visits his or her physician every three months or so; between these visits life goes on, full of temptations. The patient makes decisions to comply or not multiple times each day—for a quarter of a year.

How can a physician gain crucial insight into the patient's lifeworld—and the patient's decisions relating to compliance—in the intervening months between doctor's visits? For help I turned to work by sociologists Scott and Lyman (1968: 46) on "accounts," which they define in the following way:

An account is a linguistic device employed whenever an action is subjected to valuative inquiry. Such devices are a crucial element in the social order since they prevent conflicts from arising by verbally bridging the gap between action and expectation . . . . By an account, then, we mean a statement made by a social actor to explain unanticipated or untoward behavior.

### *Accounts as Evidence*

Such verbal bridges between a patient's noncompliant actions and the patient's self-expectations (or, alternatively, recognition of others' expectations of him or her) can provide windows on individual struggles with compliance, on the individual circumstances of living with diabetes that are so critical to a physician's understanding of his or her patient. According to Scott and Lyman,

accounts can be of two basic types: excuses, when one admits the act in question is bad, wrong, or inappropriate but denies full responsibility; and justifications, when one accepts responsibility for the act in question but denies the pejorative quality associated with it.

Of the twenty-four patients in this study, eighteen gave accounts in their post-interviews for some type of noncompliant action. Of those eighteen, fifteen were accounting for noncompliant actions related to food.<sup>4</sup> Fourteen of these fifteen accounts were excuses, as illustrated in excerpt 3.

*Excerpt 3*

Oh you don't stay on your diet in Las Vegas.

We went to buffets,

which is the worst thing in the world to do for a person that overeats.

They got lots of delicious desserts right on the counter there,

where you can walk by and pick up anything you want, any amount you want. It's impossible.. [laughter]

I'm a chocolate lover..

It's impossible to walk by.

In this account, the speaker implies that her actions at Las Vegas buffets were wrong but sends a strong message that she cannot be held fully responsible for her eating behavior. The words she chooses in the design of this account indicate no possibility of compliance in these circumstances: “You don't stay on your diet in Las Vegas” and “It's impossible to walk by.”

*Account Components*

Recall that Scott and Lyman (1968: 46) characterize accounts as “verbally bridging the gap between action and expectation.” I now turn to an examination of each of these basic notions—addressing first expectation and then action.

*Expectation*

In the accounts examined in this study, patients talk about these expectations in terms of knowledge—knowledge about expected actions regarding the fundamental compliance areas of diet, exercise, and medication. In excerpts 4 and 5, speakers refer to such knowledge by stating “I know” followed by a negated action (“I'm not doing everything right”; “I just can't rest until I have it”), shedding light on what the speaker expects to be the “right” course of action: being able to do everything right or to “rest” (not act) in the face of an “awful urge” (see Tannen 1979 on the relationship between negation and expectation).

*Excerpt 4*

I know I'm not doing everything right.

I like my sweets.

I just love my sweets.

They shouldn't have given me this.

They should have given me something else.

Some other disease.

Not this one, you know?

Because I love my sweets.

And I do eat them now and then.

*Excerpt 5*

Once in a while I get this awful urge

and I just can't rest [laughs] until I have it.

And when I have it I kind of feel bad

because I know it's wrong . . . .

I feel guilty after I eat it.

But before, it's just like something I can't..live without.

If I don't have it, I don't know what's going to happen.

And well, after I eat it, I do feel guilty.

When we look at every instance of such knowledge statements by patients in their accounts of noncompliance, it is striking that not one patient produces one utterance that refers to *lack* of knowledge (such as "I just didn't know that I wasn't supposed to . . .") as a way of denying full responsibility for the resultant non-compliant action. Indeed, these patients seem to know very well how to manage their disease and what the expectations of them are in this regard, and they readily admit this knowledge to their interviewers (e.g., "I know I'm not doing everything right"; "I know it's wrong"; "I know I just can't do it [eat cookies]").

This impression is supported by explicit comments made by patients in other parts of our interviews with them following their visits with the doctor. Many patients spoke of intense frustration surrounding issues of compliance. They know what they need to do, but they struggle with other parts of the compliance

puzzle. One patient told us, “Oh I know it, and he [the physician] doesn’t have to explain it to me. I know it already.” Another said, “There’s nothing to tell. I know the situation. I know what it is. I know what I have to do.”

These statements provide strong evidence that attempts by physicians to encourage patient compliance through education often are less than effective. Many office visits include choral recitations of facts or pedantic series of questions and answers; in these parts of the visit, both parties seem to be operating on autopilot. Patients appear to have dutifully learned *what* they need to do to comply but not *how* to do it.

### *Action*

I turn now to a discussion of action; I argue that careful consideration of the issues related to diabetes compliance compels us to deconstruct the notion before we can move ahead. Noncompliance related to food and diabetes is related to (at least) two different types of action: procurement and consumption. Although it seems clear that only the act of actually consuming the food (not merely procuring it) constitutes noncompliance, how the food became available is relevant to the evaluation the noncompliant action receives when it is “subjected to valuative inquiry,” in Scott and Lyman’s (1968) terms. For example, in one of our interactions, a patient admitted to her physician that she ate some glazed doughnuts late one evening; the physician’s next move was to ask how the doughnuts came to be in the house in the first place. The subsequent discovery that the patient had actually gone out to the store and bought this “forbidden” food resulted in the physician judging the patient more harshly than he would have if someone else had brought them into the home.

As illustrated in Figure 8.1, a fuller understanding of the first action (procurement) must include information about the intended consumer of the food. In learning how a particular “forbidden” food became available to the patient, we note four possibilities: The patient procured the food for himself or herself; the patient procured the food for someone else; someone else procured the food for the patient; or someone else procured the food for someone else (and the patient just happened to be near it). I return to these distinctions in the discussion of discourse patterns below.

When we look at every action statement uttered in patient accounts of non-compliance, again it is striking (as it was with the knowledge utterances) that the speakers are so straightforward in admitting their noncompliant actions. We hear patients saying, “I do indulge,” “I’ll have a piece of cake,” “I’ll have dessert,” “I go get something to eat like candy,” and “I go overboard.” Not one hedge or downgrading adverb is found in any of these utterances (e.g., “I might eat a little bit.”).

Thus, the question remains: If patients have the relevant knowledge to comply, why don’t they?

*Action 1: PROCUREMENT*

Who procured "forbidden" food?

Patient

Other(s)

Who was the intended consumer?

Patient

Other(s)

*Action 2: CONSUMPTION*

Did the patient consume the food?

(No matter who procured it or who the intended consumer was)

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**Figure 8.1.** Two types of action related to noncompliance

*Bridging Expectations and Actions*

In an attempt to answer this question, I now look to insights provided by patients as they try to account for the mismatch between their knowledge of expectations and their actions, which they consistently and straightforwardly acknowledge. As noted above, eighteen of the twenty-four patients in this study gave accounts in our post-interviews for some type of noncompliant action. Of these eighteen, fifteen patients gave accounts for food-related actions. In what follows, I first address one marked type of utterance in these verbal bridges—what I call “personal attribute statements”—and then I discuss the two structural patterns in these accounts.

*Personal Attribute Statements*

As I began my examination of the accounts, I was immediately struck by the frequent mention of personal attributes by these patients. Closer examination of the accounts revealed that nine of the fifteen patients included at least one such statement in their accounts (for a total of fourteen). A quick glance at representative utterances should confirm the fact that these are not just any personal attributes (such as eye color or height) but exactly those that are directly incompatible with the kinds of compliance that go along with diabetes: “I’m a chocolate lover;” “I’m an emotional eater;” “I’m a big pasta eater;” “I’m bad around candy;” and “I love sweets. I always have. I love sweets.”

Why would so many patients incorporate personal attribute statements into their accounts? For a possible explanation, I return to Scott and Lyman (1968).

Recall that fourteen of the fifteen accounts are excuses rather than justifications and that, in designing an account as an excuse, the speaker admits that the act in question is “bad, wrong, or inappropriate” but denies full responsibility for it. Scott and Lyman (1968: 49) mention that one typical way speakers can mitigate or relieve responsibility for their actions is to appeal to biological drive. They elaborate as follows:

Precisely because the body and its biological behavior are always present but not always accounted for in science or society, invocation of the body and its processes is available as an excuse. The body and its inner workings enjoy something of a status of the sociological stranger as conceived by Simmel, namely, that they are ever with us but mysterious. Hence, biological drives may be credited with influencing or causing at least some of the behavior for which actors wish to relieve themselves of full responsibility.

It seems likely, therefore, that these personal attributes play a strategic role in the verbal bridge between noncompliant actions and expectations. That is, when the speaker states in a straightforward way that he or she performed a non-compliant act in spite of the fact that he or she knew better, inclusion of a relevant personal attribute can excuse that behavior by removing some of the speaker’s agency (as if to imply, “I’m just that way. What can I do about it?”).

### *Account Structure*

To explore more fully the function of these mentions of personal attributes within patient accounts of noncompliance, I move now from an investigation of the individual clauses that constitute the accounts to an examination of accounts as whole texts. In this way, we can come to understand how patients portray how they came to perform noncompliant acts.

Two major structural patterns emerged in this analysis. Both patterns start and end the same way. In both patterns, the knowledge component remains relatively stable across tokens, as is expected from our earlier discussion of patient knowledge; that is, most patients in this study seem to (think they) know what they need to do to be compliant. Likewise, in both patterns, the account contains evidence that the patient carried out the action of consuming the “forbidden” food. What differentiates the two patterns is the constitution of the verbal bridge that connects these two components of knowledge and action.

To understand these differences, we need first to expand on the foregoing discussion about patient compliance. I have noted that one condition for such compliance is sufficient relevant knowledge about recommended diet, exercise, and medication. I also have noted, however, that in many cases knowledge is not

enough. Fully informed patients still perform noncompliant actions. Motivation must be added to this knowledge. Patients must feel motivated to comply with the many difficult choices they must make in a life with diabetes. This motivation can be found in a variety of different sources—some extrinsic and others intrinsic to the individual. For example, some individuals tell us in their post-interviews that they are motivated by fear of kidney failure or amputation—common medical problems that accompany uncontrolled diabetes. Other individuals find motivation in their grandchildren.

Just as with knowledge, however, sometimes a person's motivation is not strong enough to ensure constant compliance. Patients are confronted with many roadblocks along the way that wear down their motivation. These barriers must be identified to be overcome. Examples of roadblocks mentioned in the patient post-interviews include unsupportive family members, friends, or co-workers who may tempt the patient to ignore his or her dietary restrictions; a hectic business travel schedule; or even a patient's own sense of self—as reflected, for example, in the foregoing personal attribute statements. The balance between a given patient's motivations and his or her roadblocks is delicate; for a patient to remain compliant, his or her motivations must be stronger than the roadblocks. In situations where the roadblocks overpower the motivations, the patient may be on the path to noncompliance.

With this understanding of motivation and roadblock added to the notions of knowledge and two action types, we can resume our characterization of the differences between the two account patterns. Pattern 1, as illustrated in Figure 8.2, is what I call the “give in and go get” account. This type of account begins with the identification of (or allusion to) a tension between a motivation and a roadblock, with the roadblock temporarily defeating the motivation. This unstable situation leads the patient to carry out the first action, procurement, which makes the “forbidden” food available to him or her. The patient then performs the second action, consumption.

Excerpt 6 illustrates an account of this type. Note that the roadblock in this account is characterized as a personal attribute (“I crave the sweets”). According to the account-giver, her (unspecified) motivation to comply usually keeps the

1. KNOWLEDGE
2. MOTIVATION<->ROADBLOCK tension
3. Action 1 (PROCUREMENT) by patient
4. Action 2 (CONSUMPTION) by patient

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**Figure 8.2.** Patient accounts of noncompliance: Pattern 1 (“give in and go get”)

roadblock in check. Here, however, the roadblock overcomes the motivation, and the patient goes to “get something to eat like candy.”

*Excerpt 6*

Even though I stay away from them pretty much,

**I crave the sweets.**

And every once in a while

**I go get something to eat like candy or something like that.**

But then I know for the next couple of days

I’ve got to really watch it and stuff like that.

The performance of the second action, consumption, is left unstated, although it is clear from the stated consequences (“for the next couple of days I’ve got to really watch it”) that the action was indeed carried out.

Pattern 2, as illustrated in Figure 8.3, is what I call the “see and succumb” account. In this type of account, the “forbidden” food becomes available to the patient; that is, the patient has not procured it himself or herself. The availability of the food, then, is the destabilizing force as related to the tension between motivation and roadblock. Just as in pattern 1 above, the roadblock in pattern 2 temporarily overcomes the motivation, leading the patient to perform the second action, consumption.

Excerpt 7 illustrates an account of this type. In this situation, the speaker’s children bring the “forbidden” food into his house in the form of candy collected door-to-door on Halloween.<sup>5</sup> The availability of the candy, then, destabilizes the precarious balance between the speaker’s (unspecified) motivation to comply and his roadblocks to compliance, expressed (as in excerpt 6) as a personal attribute (“I’m an old Reese’s Peanut Butter Cup freak”).

1. KNOWLEDGE
2. Action 1 (PROCUREMENT) by other
3. MOTIVATION<->ROADBLOCK tension
4. Action 2 (CONSUMPTION) by patient

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**Figure 8.3.** Patient accounts of noncompliance: Pattern (“see and succumb”)

*Excerpt 7*

Let's see, the other night was what.

It was Sunday night.

**The kids came home with big shopping bags full of -  
I'm an old Reese's Peanut Butter Cup freak.**

I used to..and all my kids,

I have three of them.

Before I had diabetes,

my two oldest ones,

I'd take them out,

I'd say

“You both owe me at least two Reese's.

Keep going until you get two Reese's

and the rest of it's yours.”

That was kind of like a family joke.

So now it's just carried on with my stepson.

So, of course he..the first one he gets,

he's ready to win.

He's like “Here, Dad!”

“Hmmm.

I shouldn't,

but I guess I will.”

So I.. I have a weakness there.

As in pattern 1, the roadblock temporarily overcomes the motivation, leading the patient to eat the candy. As in excerpt 6, the consumption action in excerpt 7 is not explicitly stated, although it can be confidently inferred through the speaker's reported conversational exchange with his stepson (“He's like, ‘Here, Dad!’ ‘Hmmm. I shouldn't, but I guess I will.’”).

### Bringing Accounts into the Doctor's Office

Close examination of the language in and of the accounts has revealed just a hint of the array of varying circumstances that can lead a patient to perform non-compliant actions in the face of knowledge and motivations that would indicate otherwise. Patients themselves know that their individual sets of circumstances are different from other patients and call out for individual attention from their doctors, as seen in excerpts 8 and 9.

#### *Excerpt 8*

I don't want to be treated like all the other patients.

I want to be treated as an individual.

I have to be treated as me.

#### *Excerpt 9*

Sure, we all want to do it,

but I'm Terry.

You got to say,

“Well, okay, you're a little chubby.

Take five steps instead of ten.”

Do you know what I mean?

He's [the physician] got to use his common sense for the person he's handling is what I believe.

These individual differences underlying noncompliant actions challenge physicians to (re)consider the strategies they employ to encourage patients to make choices that will lead to better health. In conversations with patients, one size does *not* fit all. Most doctors understand this point, but they often slip into what look like autopilot monologues regarding complications of uncontrolled diabetes or quick verbal slaps on the wrist, with no exploration of the reasons for patient noncompliance.

One of the greatest dangers of this kind of untailed talk on the part of physicians may be that it (unintentionally) blocks out the vast majority of information contained in accounts such as those discussed in this essay. One of the best ways to expand the domain of the physician-patient talk—to get it to include life outside of the physician's office—is for physicians to encourage accounting by their patients. In some cases, this strategy may lead to more thorough understanding of an unsupportive family or a heavy business travel schedule that

makes compliance difficult. In these cases, some creative solutions may be custom-designed to fit the problem. In other cases, the accounts might identify a personal attribute of the patient that is directly at odds with compliant actions. In such cases, practical solutions may be more difficult to come by, and the physician may need to help the patient “try on” a new identity (in the sense of Bruner 1990: 54) that is more compatible with compliant behavior.

To illustrate the interactional effect of physicians’ moves on the patient discourse, I briefly refer now to three different physician-patient scenarios from our study. In each case, the issue of patient noncompliance came up within the first minute or so of the visit. That is where the similarity ends, however. I look at each in turn and focus on what the physician does immediately following the patient’s admission of noncompliance.

In excerpt 10, the patient has had problems complying with her treatment because of a death in her family.

*Excerpt 10*

Patient: Everything was irregular. My whole life was upside down. I wasn’t eating properly. I wasn’t watching what I was eating.

Physician: We’ve got to make progress on this, because we can’t leave it the way it was. You can’t tolerate that. It’s totally out of whack. We’ve got to get things back under control.

In excerpt 10, the physician’s utterances immediately following the confession of noncompliance by the patient address the present situation (“It’s totally out of whack”) as well as the future (“We’ve got to make progress on this,” “We’ve got to get things back under control”). Note that the physician makes no move that allows exploration of the circumstances surrounding the noncompliance.

In excerpt 11, the patient has had trouble complying because of stress at work.

*Excerpt 11*

Physician: You haven’t been losing lots of weight, I see.

Patient: No, I’m about the same.

Physician: Okay. How has your vision been? No double vision?

Following the inferrable admission of noncompliance by the patient (“No, I’m about the same”) in response to the physician’s observation that the patient has not lost any weight, the physician quickly acknowledges her statement and then abruptly

ly changes the topic. As in excerpt 10, no move by the physician allows exploration of the circumstances underlying the patient's difficulty with compliance.

In excerpt 12, the patient was having problems complying because she was ambivalent about starting a medication that might have problematic gastrointestinal side effects.

*Excerpt 12*

Patient: Well, I haven't done anything that I said I was going to do.

Physician: Were you worried about side effects?

Here the physician immediately responds to the patient's statement of noncompliance with a question about the past. Although this question is a yes-no question rather than a more open-ended "wh-" question—such as "Why not?" or "What happened to stop you?"—the fact that the physician gave the patient a possible reason for not having complied with her treatment plan opens the door to a discussion of other reasons the patient might have had (e.g., "No, I wasn't, but . . .").

If physicians wish to increase patient compliance with their recommendations and are convinced of the potential value of patient accounts in shedding light on individual circumstances surrounding noncompliance, it seems obvious that their contributions to the discourse of the physician-patient interaction must encourage the giving of such accounts. Neither the future orientation of excerpt 10 nor the abrupt topic change of excerpt 11 will facilitate the type of exploration of the circumstances leading to noncompliance that is necessary for a change in action that leads to a change in health. The discourse of excerpt 12, with its opening to the past, offers a step in the right direction.

### **Conclusion**

Patient noncompliance in diabetes is rampant and presents a great challenge to patients as well as to their physicians. Frustration on all sides is highly evident in physician-patient interactions as well as in post-interviews with physicians and patients in our study. Strategies that physicians are using—from reciting facts and figures to instilling fear in the patient—usually are ineffective. And we've seen why. Patients tell us that they already know the facts but that this knowledge is not always enough to keep them toeing the line of compliance.

Our investigation of the language and structural patterns of accounts given by patients in our post-interviews has provided us with rich information that was unavailable to the physicians during their interactions with these patients. As patients construct verbal bridges between the expectations and knowledge they possess and the actions they clearly acknowledge are noncompliant, they provide the analyst with crucial details about themselves and their life circumstances that

seem to stand in the way—at least some of the time—of healthy lifestyle choices. By teaching physicians about the vital connection between the discursive choices they make and the subsequent moves available to their patients, we can help physicians make changes that encourage patient account-giving in their offices.

As interesting and convincing as this line of argument may be to us as linguists, I have learned through my work with physicians that the decisive test is whether these language changes ultimately result in concrete, specific changes in patient outcomes. That is, will these changes in discourse actually lead patients to better compliance that will then lead to better health? The next phase of our study is designed to address these real-life concerns. Until those results are in, I remain optimistic that those of us investigating the language of health care encounters can help physicians and patients as they struggle turn-by-turn to understand not only the physical symptoms but the sometimes more elusive reasons behind the choices made by patients as they strive for the best health they can have.

#### NOTES

1. I am indebted to Deborah Tannen for her many insightful comments and suggestions on an earlier draft of this chapter.
2. Some scholars and practitioners avoid the use of the term “compliance” (and, therefore, “non-compliance”) because they think it conjures up an image of passive patients who have nothing to say about their own treatment plans and whose sole job it is to carry out their doctors’ orders. In its place, their term of choice is “adherence.” Despite these very important concerns, I have decided to use the terms “compliance” and “noncompliance” throughout this essay because they are the terms used by the physicians and the patients in this study. My use of these terms is not meant to imply anything about a given patient’s level of self-advocacy or the level of collaboration between patient and physician in devising the patient’s treatment plan.
3. According to the cover story in the March 5, 2001, issue of the *Washington Post* Health section.
4. Of the other three accounts, one each was related to blood glucose testing, exercise, and foot care.
5. In the United States it is customary for children to dress up in costumes and go door-to-door to collect candy on Halloween (October 31).

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