Editorial of Special Section:

Sharing knowledge and shaping identities in health care interactions

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In the present issue of Patient Education and Counseling we publish a Special Section, which we have called "Sharing knowledge and shaping identities in health care interactions". The studies in this special section focus on communication practices that health professionals (HPs) and patients use to share information in different healthcare settings, and on how these practices embody different notions of professional and patient identity. By examining audio and video recordings of psychotherapeutic, medical and counselling interactions, the papers illustrate how, in the exchange of information around health, different notions of who the HP and the patient are to one another come into play. For example, different ways of providing diagnostic information, making treatment recommendations, or giving health advice can propose that the patient is more or less independent, knowledgeable, or capable of autonomous choice. These embedded identity proposals can be resisted by patients and negotiated within the interaction. The studies analyse how HPs and patients cooperate in the accomplishment of the tasks of hand, as well as what happens when their agendas diverge.

A peculiarity of the papers in this Special Section is that in the majority of cases they examine interactions between more than two participants. These include interactions between HPs, patients or clients and accompanying family members

[1,2], therapeutic community meetings [3], patient discussion groups led by nurses [4], and patients' meetings with teams of HPs [1,5]. Widening the focus from the doctor- patient dyad to multi-party interactions adds new dimensions to the understanding of knowledge exchange in health care and brings out the complex matrix of knowledge-related identities in these contexts.

All the papers use Conversation Analysis (CA), an approach that focuses on language use in social interaction [6]. Previous studies using CA have shown that in everyday conversation participants carefully calibrate their communication in ways that are sensitive to each other's degree of knowledge, by presenting it as an opinion or a fact, as something that the other does not know or should have known, and so on [7-10]. CA research on healthcare interaction has highlighted the asymmetries of knowledge that often characterise communication between patients and HPs [11-13]. A previous special section of Patient Education and Counseling [14] explored communication difficulties in circumstances where professionals refer to, employ or take for granted knowledge to which the patients may not have access. In an earlier contribution to this journal, Raymond explores a similar problem in paediatric genetic consultations and showed that parents' participation can be hampered when they do not understand or make sense of the knowledge that HPs are trying to convey [15]. In all these cases, difficulties arise because a knowledge gap between health professionals and patients has not been understood or properly addressed.

This Special Section takes this line of inquiry forward by exploring a tension that seems inherent in many types of healthcare interaction. The current emphasis on patient empowerment and autonomy implies that HPs are expected to act, at least in part, as facilitators and enable patients to make independent informed decisions; in some services (e.g. in the mental health sector), this translates into the expectation that

patients are enabled to find solutions to their own problems. At the same time, HPs are expected to act as experts and deliver services according to institutional standards. This can translate into a recurrent dilemma between enabling patient autonomy and 'getting the job done'.

Many of the communicative practices examined in the papers represent solutions or compromises to the general problem of balancing different professional identities (facilitator vs. expert) and corresponding tasks. For example, by using questions that solicit patients and clients to share personal information and demonstrate knowledge about their own condition, HPs enact the identity of facilitator, encouraging patients and clients to take an active role in the interaction. In their responses, patients and clients can modulate the extent to which they to take on this role and therefore of their collaboration with the HPs' projects; HPs might then shift to a more expert role as the interaction unfolds.

In settings where the provision of care is mainly administered through talk, as in psychotherapeutic or educational interventions, professionals heavily depend on patients and clients to supply the verbal materials (e.g. problem descriptions, stories, etc.) on which they will subsequently work on. If this redresses to some extent the traditional asymmetry of knowledge and power between HPs and patients, HPs often retain a significant level of control over what patients and clients can relevantly say and when they can say it. As several of the papers in the Special Section show, HPs have means to pursue their agendas, either by persevering in their requests for information [3] or by manoeuvring out of patients' and clients' demands to receive guidance and advice [16,4]. These papers also show that HPs' actions following on patients' and client' responses are equally (if not more) crucial than their initial questions in establishing the degree of autonomy and agency that is accorded to

patients and clients, and ultimately the nature of the relationship between all the parties involved.

Some of the papers in the Special Section examine cases in which, on the other hand, the provision of care is based on highly technical medical knowledge and HPs rely on clinical reports and technical evaluations to support a decision making process that is largely in their hands [2,5]. We see two very different types of communication being enacted here. In one study [2], the medical reasoning upon which the decision rests is made available to the patient by voicing the steps and evidentiary bases for the doctor's recommendations. These practices, which have a strong educational component, seem designed to achieve clarity and to foster patient understanding. In the other study [5], there is a team of professionals with different specialties who interact amongst them, in the presence of the patient, to reach an agreed upon definition of the problem and consequent treatment. Here we see that the HPs dim down the clarity of their talk for the patient, and the latter are minimally involved; patients' limited contributions, however, show attempts to overcome those communication barriers and capture the gist of what is going on. The practices analysed in these two papers illustrate different approaches to patients' engagement, and the work that is necessary in order to unpack the complexity of the medical workings for the patient.

A brief synthesis of the individual papers in the Special Section will describe how the key themes sketched above unfold in each of them.

O'Reilly, Lester and Muskett [1] examine initial child mental health assessments, in which professionals meet children and their families for the first time and establish whether the children require specialist mental health assistance. The study investigates moments in which HPs ask questions that fall in the children's

domain of knowledge, i.e. about their feelings and sensations or about past experiences and events. These questions enact the presupposition that the children are knowledgeable about themselves and are able to share that knowledge with the HPs. The analysis, however, reveals the fragility of this interactional arrangement; as the interactions proceed, HPs and parents can override the children's responses by contesting the validity of their knowledge about themselves. Children, on their part, can avoid answering the HPs' questions by disclaiming knowledge about themselves (e.g. by saying that they 'do not remember'), or can provide only minimal responses, resisting the role of 'experts about themselves' The study shows that the way in which HPs ask questions and receive children's response can affect the extent to which they will be able to evaluate children's mental health conditions from their own words.

In Pino's study of therapeutic communities for adults with drug abuse and mental health problems [3], the patients are similarly solicited to share personal information; differently from the O'Reilly et al.'s paper, however, here clients interact with HPs on a daily basis for an extended period of time, and they therefore have a long-lasting therapeutic relationship with them. This provides HPs with a communicative resource that the author calls Knowledge Display, namely the practice of exhibiting previous knowledge about clients to pursue provision of personal information in circumstances where the clients exhibit reluctance to do so. Pino's study complements O'Reilly' et al.'s study in exploring the delicate balance - and in some cases the friction - between respecting the clients' primary right to voice their own experiences and influencing the ways in which they report those experiences.

Fasulo, Zinken and Zinken [4] explore interactional uses of the question 'What about X' by patients with type 2 diabetes in group sessions with nurses. The sessions are aimed to support patients in their transition to insulin injections. It is argued that

patients use 'What about X' questions for soliciting nurses to impart longer explanations or more direct instructions than the adoption of empowerment-inspired communication techniques would favour. As in other papers, we see HPs and patients negotiating the use of limited resources; on the one hand, the nurses only have two meetings to help patients develop the knowledge and the confidence to make independent decisions on their diet and life-style; the patients, on the other hand, have the same amount of time to gather as much information as possible and ask questions. 'What about X' questions can sometime represent a solution for such interactionally complex situations, as they allow to seek information while leaving ample margins to the respondents in establishing the nature and extension of the information that they deem appropriate to deliver.

Moore [16] examines a call to a telephone helpline that provides information on mental health to the general public The ethos of the organization emphasises client empowerment, which "requires the institutional representative to prioritize the abilities of the caller in addressing their situation or needs, even when callers seek guidance or advice from the institution". One consequence is that, when callers solicit advice, the helpline operators can withhold its provision to abide by the service policy. In the phone call examined by Moore, the caller describes the problems she has with her abusive husband. This presents the helpline operator with the practical dilemma of how to address the client's problem without giving advice. The operator manages this dilemma by describing a possible course of action (calling a domestic violence helpline) as something that the caller may have already thought about prior to the call. Moore' study thus shows a case where a 'canonical' distribution of professional-client identities and associated prerogatives is reversed, with the HP

visibly avoiding acting as an 'expert' who is entitled to tell the client what she should do.

Fatigante et al. [2] examine an experienced oncologist's communication practices for delivering diagnoses and recommending treatment to breast cancer patients and their companions. They focus on how the oncologist presents the treatment recommendation as a 'logical consequence' of the available diagnostic information (i.e., the treatment is framed as the only or the most reasonably recommendable option on the basis of the available diagnostic information on the type of cancer affecting the patient). The authors show that this is a fairly straightforward process in circumstances where 'certain' diagnostic information is available on the type of cancer. Notably, in circumstances where 'certain' information is not available (usually because laboratory tests are still in progress), the oncologist does not stop short of providing a recommendation; instead he illustrates a possible recommendation and he formulates it as a logical consequence of the most likely diagnostic outcome of the tests in progress. This study discusses the implications of these practices against the background of the current emphasis on patient involvement in shared decision making; by presenting the recommendation as a logical consequence of the diagnosis the oncologist appears to encourage patient acceptance of what is deemed to be the best available treatment option and to effectively bypass patient involvement in discussing the pros and cons associated with alternative treatment options.

Finally, Galatolo and Margutti [5] analyse visits in which orthopaedic patients (most of whom have undergone surgery after severe upper limbs injuries) meet the team of specialists who are going to decide whether they are going to receive a functional or an aesthetic prosthesis. The team includes technicians and different

medical practitioners; they see the patient together for the first time, and during the visit they have to perform history taking, bodily examination, and the examination of the patients' records. What is prominent in these team visits is more the professional identity of the different specialists involved than the inclusion of the patients and their perspectives, and we are shown that patients' attempts to participate in the highly technical exchanges taking place within the team are not always successful. However, the authors also illustrate a more positive episode of patient' participation, and propose that HPs could make more efforts in this direction despite the complexity and the time limitations of this type of medical encounter.

Collectively, the studies in the Special Section update the current knowledge on interaction around healthcare provision and pose new questions to practitioners and researchers alike. For example, to borrow Moore's words, can empowerment be "interactionally but not objectively achieved"? Does "giving information" always enable choice? Can presuming patient knowledge or competence be sometimes an imposing if not aggressive communication strategy? Problems with transforming general guidelines or norms into actual conversational practices are recurrently identified in all professional sectors [17], and the papers illustrate a range of circumstances where implementing some principles in interaction (e.g. empowerment) can generate consequences that are not always in line with the principles themselves.

A general take home message is the importance of incorporating opportunities for observing real-world interactions within professional training and development, and for practitioners to "reflexively engage with their communication" [2]. This means that practitioners, be they doctors, nurses or therapists, can be also empowered to a fuller understanding of their own communicative choices and the effects these may have on how they deliver care.

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