A Discourse Analysis of Transactional Patterns in Two Health Facilities in Nyanza, Kenya

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Abstract

Receptionists who work in government health facilities in Kenya are part of large state funded ministry, the Ministry of Medical Services. Their counterparts who work in private hospitals fall under the hospital management, the human resource department. Private hospitals in Kenya are represented by the Kenya healthcare federation. Their (receptionists) duties include registering patients, arranging appointments for them and checking them for consultations as well as administration of the ordering and collection of repeat prescriptions. This paper therefore analsysed transactional patterns used by receptionists and patients in their enactment of their different roles and identities. The data analysis is based on Goffman's (2002) roles and identities and Kaspar's (2000) power models. The study uses both primary and secondary sources that involve audio data recorded at the one government health facility and one private health facility, and extensive library research. Purposive sampling is used to sample the two health facilities in Nyanza. Data from naturally occurring conversations among the receptionists and the patients is analysed using the qualitative research design. It is therefore proposed that the findings from this study be used in receptionist training programmes to raise awareness of patterns of discourse behaviour at the front desk discourse with a view to improving both the professional experience of receptionists and the quality of service which patients at government health facilities and private health facilities receive. Quality customer service is equivalent of vision 2030's social pillar, which rests on the premise that investment in human capital is paramount for economic development.

Key words: Transaction, receptionists, patients, roles and identity, power

1.0 Introduction

This is a study of interaction between receptionists and patients at the front desk of government health facilities and private hospitals in Kisumu, Kenya. Unlike medical personnel, whose work to patients involve combination of discursive, physical and technical examination, hospital receptionists accomplish their work with patients exclusively through spoken and written means. The focus of this study is therefore exclusively on spoken discourse. Using a tape recorder at one government health facility and one private hospital in Kisumu, Kenya, the researcher comparatively explore the verbal structure of frontline interface between patients and receptionists, describing recurrent transactional patterns and variations in their enactment in the two health facilities in Kenya.

The study also examines roles and identities which are constructed by receptionists and patients as they pursue their discourse goals in the two hospitals. Lastly this paper seeks to consider how knowledge on front line interface discourse patterns can be used in receptionists training. Merritt (1976) as reported in Hewitt (2006) describes an episode between a receptionist and a patient at the front desk of a general hospital as a form of service encounter. He talks of an instance of face-to-face interaction between a server who is officially posted in some service area and a customer who is present in that service area and, the interaction being oriented to the satisfaction of the customer who is present in that service area. He further states, that, the interaction being oriented is to the satisfaction of the customer's presumed desire for some service and the server's obligation to provide that service.

Therefore both the transactional and interactional functions of service encounters, respectively expressing content and social relations and personal attitude have been the subject of detailed critical attention (Brown and Yule 1993). The interest of this study in service encounters in public and private hospitals in Kenya was stimulated by the work of Mc Carthy (2000), who looks at the co-occurrence of transactional and relational talk in client encounters with hairdressers and instructors and vision 2030 on service delivery which is a long term development plan in Kenya.

Another study by Hewitt (2001) investigates encounters between bus drivers and passengers. She found that while bus drivers and passengers collaborated in the pursuit of transactional goals, the driver's dual role as both provider of the service and the gatekeeper or controller of passenger access influenced the relational structure of the talk. The gatekeeping role of the bus driver therefore is similar to that of receptionists in mainly stationary environments. Therefore, there being a substantial body of work not only on service encounters but also on both gatekeeping and power relations in institutional discourse, this study comparatively explores this discourse further in one level five general hospital and one private hospital in Kisumu, Kenya. The goal of easy access to medical services has become an important one for the ministry of Medical Services throughout Kenya and is one of the millennium development goals and is in line with vision 2030, which is a national long-term development blue-print that aims to transform Kenya into a newly industrialising, middle income country providing a high quality of life to all its citizens by 2030 in a clean and secure environment. Receptionists are very vital to the process of facilitating access for patients who need medical attention hence achieving quality life envisioned in vision 2030.

The vision 2030 comprises three key components which include the economic, social, and political pillars. This study will be based on the social pillar which aims at investing in the people of Kenya, in order to improve the quality of life for all Kenyans by targeting a cross-section of human and social welfare projects and programmes specifically education, and training, health, environment, housing and urbanization, gender, children and social development ,and youth and sports. Under health, vision 2030 has a flagship of projects which include human resource strategy and training. Therefore this study of receptionists and patients is anchored in the vision 2030 specifically on training of receptionists and the expectations of patients in both government health facilities and private hospitals. In addition the study strives to achieve better, fairer access to services and to improve communications and break down barriers.

Despite the recognition of the importance of receptionists in Kenya, especially in the delivery of primary health care, their training has been neglected in government hospitals. Their training normally include introduction to telephone skills, health and safety, and customer care. Therefore, many level 5 government health facilities receptionists receive no formal training and this is also the case in private hospitals where medical receptionists have no formal training in customer care but are given in house training by the human resource department. However compared to government hospitals, private hospitals are well structured at the front desk. This is at variance with service charters of government hospitals which strive to provide innovative human resource services for specialized quality healthcare. Kenya's vision 2030 intends to correct this inconsistency. In addition the findings of this study will be used in receptionist training programmes which is in line with government hospitals' charters and vision 2030.

2.0 The Healthcare

The encounters between receptionists and patients who are considered in this study took place in one government health facility and one private health facility, which are part of the healthcare system in Kenya.

In a 1999 paper, Hyden and Mishter (1999:185) commented that "the health field has become a contested space where alternative conceptions of illness and treatment compete with the dominant tradition of scientific medicine" The dominant tradition is captured by Parsons' (1952) view that there is an unwritten contract between physician and patient: the physician's technical expertise entitles them to the institutionally ratified role of healer while the patient has an accepted sick role, whose characteristics include exemption from normal social responsibility and the obligation to seek technically competent help in order to achieve the goal of recovery. While the most notable features of the medical role are objectivity, effective neutrality and technical competence, those of the sick role are helpless dependence, emotional involvement and technical incompetence.

According to Lawton (2003) there has been a shift of a patient being a dependent outsider towards an increase in lay involvement in medical decision-making and an acknowledgement of the value of the individual's subjective experience of illness. In this interpretation, the sick role has been superseded by the health role in which the individual assumes responsibility for health maintenance through appropriate lifestyle choices, thereby further reducing the centrality of the physician.

In addition, there has been an increasing influence of corporate managers on medical agendas, for example through media campaigns. They are required to work in bureaucratically organized institutions under a new cadre of managers. In Kenya, Kenyatta National Hospital- a government institution is currently managed by a non-medical chief executive officer (Richard Lesiyampe) which was not previously the case (Ndavi, 2009).

In Kenya, the trend towards increased lay involvement was reflected by the introduction in 2009 of the patient's charter (Ministry of Medical servicers strategic plan, 2008 – 2012), a document which was designed to redress the clinical balance in favour of patients and involve them in medical decision making at all levels. The trend towards centralized corporate management has also been reflected in changes to the administrative structure of the ministry of Medical Services. Historically, Kenya has had a centralized approach to health care systems decision making (MOH 2012). Centralized functions at the headquarter level in the ministry of Health (MOH) include policy formulation, coordinating activities of government and non-governmental organizations, managing implementation of policy changes regarding government services such as user charges, and monitoring and evaluating the impact of policy changes (MOH, 2012)

3.0 Conceptual Framework

3 1 Institutional discourse

This investigation on interaction between receptionists and patients is based on institutional discourse. These models are *Roles and Identities* by Goffman (2002) and *Power* (Kaspar 2000). According to Heritage (1992) institutional discourse includes analysis of both communication practices within institutions and of talk at the interface of institutional and lay worlds. This study is a contribution to the latter category. The study draws attention to the main areas of interest for receptionists – patient discourse.

3.2 Roles and Identities

Goffman (2002) has made an influential contribution to the understanding of the roles and positions which are taken in talk. He covers three concepts: participation, footings and frames. The term participation captures the idea of the set of roles open to speakers and hearers. A set of positions which individuals within perceptional range of an utterance may talk in relation to what is said. Roles are developed as speakers assume footings, according to Goffman (2002). According to him, the alignments we take up to ourselves and the others present as expected in the way we manage the production or reception of the utterance. In doing this, speakers recreate frames, the organisational and interactional principles by which situations are defined and sustained as experiences. Aspects of Goffman's model has been used in studies of institutional talk and therefore this study utilized the theory in order to bring out the roles and identities of both receptionists and patients in two health facilities in Nyanza, Kenya. The study analysed entitlements and responsibilities associated with transactional frames between receptionists and patients. Failure to align to a frame either by a receptionist or a patient in order to sustain the appropriate footing will be noticeable and negotiation will take place.

3.3 Power

Kaspar (2000) suggests that the relationship between communicative action and social power is evident in institutional discourse.

He adds that discourses of both receptionists and patients regulate access to roles statutes and authority structures they realize in those context and sites. According to Kaspar (2000), power is realised through four inter-related components:-

1. Differentiated pre-inscribed participant's roles and identities.
2. Structurally asymmetrical distribution of turn types
3. Asymmetrical relationship between participants in terms of speaker rights and obligations
4. The discursive resources and identities available to participants to accomplish specific actions are either weakened or strengthened in relation to their current institutional identities.

Kaspar (2000) differentiates power to and power over. He says that power to is the realisation of personal or collective goals. In the negative sense, it is hindering of other individual's achievement of goals for the sake of hindering. Power over, on the other hand according to Kaspar, is the relational facet of power, one person has power over another person when the two stand in a relationship of dominance and submission. This study therefore analysed the gatekeeping role of receptionists in health facilities in Kenya and how it affects the transactional patterns enacted by receptionists and patients. Their power over patients when they go to seek treatment in these hospitals was analysed.

4.0 Methodology

To achieve the objective of this paper satisfactorily, it was essential to obtain examples of naturally occurring interaction from the front desks discourse of the two health facilities in Nyanza, Kenya. By naturally, the study refers to talk which is not the product of experimental conditions but would occur in some form regardless of the presence of a researcher or recording equipment.

The qualitative researcher's approach to triangulation, the comparison of results from two or more sources whether data, method, analyst – participant (Denzin 1978), dictates the sampling strategy which is adopted. The study therefore sought data from a range of health facilities with different demographic profiles, making the sampling purposive with regard to number and type as well as setting. On the assumption that it is necessary for the researcher to report plenty of instances (Silverman 2000), the study recorded a minimum of 40 episodes of interactions from each health facility respectively, which gave a total of at least 80. Milroy (2002) posit that linguistic samples are usually too small to ensure that the set of persons selected is representative of the population as a whole, in the sense that findings can be extrapolated from the sample to the population within measurable and statistically specifiable confidence limits. Researchers are in agreement that participant selection process should remain open in a qualitative study as long as possible so that after initial accounts are gathered and analysed, additional participants can be added who can fill gaps in the initial description or can expand or even challenge it (Dornyei,2007). Therefore this study used iteration and saturation when selecting the patients in the two health facilities in Nyanza, Kenya.

The researcher selected patients until that point when additional data by the patients did not seem to develop the concepts any further but simply repeated what previous patients had already revealed. In other words, saturation is that point when the researcher becomes empirically confident that he/she has all the data needed to answer the research questions (Dornyei, 2007).

5.0 Discussion

5.1 Transactional patterns

Patients' task of engaging in interaction with receptionists can be achieved through a number of transactional stages. The researcher found that there are three types of activity carried out by patients at the reception when they attend the health facilities: *requesting*, *claiming* and *reviewing*. When *making appointments*, *collecting prescription* and *registration encounters*, patients are *requesting services*. In *problem solving ones* they are both *requesting* and *reviewing* services, and when *checking in* or *collecting prescription*, they are *claiming services* which have already been arranged. All these activity types have a maximum of four stages which include *service orientation*, *information check*, *confirmation* and *resolution*. The researcher also found that because of the possibility of non verbal communication in the two health facilities under study, and the use of existing documentation by the receptionists, there is not always verbal enactment of all the four stages.

For example, during the activity of *checking in*, if the receptionist is already aware of a patient's name or sees it written in the appointment schedule, the *service orientation stage* may be left out, while the *information check* may be ellipted entirely when patients provide all the necessary information as part of the service orientation. *Information check* also applies during prescription collection because receptionists are required to confirm the bio data of patients before issuing prescriptions. This was very common at the health facility B during the study.

The researcher built up each stage up through the use of distinctive exchange patterns. Table 1 indicates that the stages are constructed from two part exchanges. In the *service orientation* and *resolution* stages the receptionist initiates the interaction and the patient responds whereas in the *information check* and *confirmation* stages either receptionist or the patient may initiate the interaction.

Table 1: Stages with sequences

Stages	Speaker	Action
Service orientation	receptionist	signal availability
	patient	bid for service
Information check	receptionist/patient	seek information
	patient/receptionist	provide/not provide info
Confirmation	receptionist/patient	seek confirmation
	patient/receptionist	confirm/not confirm
Resolution	receptionist	inform/instruct
	patient	accept/reject

For service orientation, the moves involve signals and bids for services. Information check and confirmation, requests or elicitations followed respectively by provision or non provision and confirmation or non confirmation of the information. For resolution, there is informing or instructing about services followed by either acceptance or rejection. The researcher found that sometimes there are a few variations to these patterns. On some occasion the first move of a stage is ignored by hearer, leading to omission of the second pair part of interaction. In both health facilities A and B it was found that all encounters begin with service orientation, the point at which the agenda is set by the patient, and continue with one or more additional stages. The pattern for *check in* and *prescription collection* encounters is shown below with optional stages in brackets.

Procedure for checking in and prescription

Service orientation
(Information check)
(Confirmation)
Resolution

At the health facility B the researcher found that in *check in* encounters, *service orientation* is followed by *information check* at the reception. However at health facility A, *check ins* have only two stages which include *service orientation* and *resolution*. At the facility B, the remainder stages that include *confirmation* and *resolution* follow. During prescription collection, which was only noted at the health facility B, *information check* follows *service orientation* in well over 50% of encounters between receptionists and the patients at the reception. The researcher also noted that patients from outside who have medical covers, prescription collections move straight from *service orientation* to *resolution*.

Hasan (1978) and Ventola (1987) observe that the ordering of stages in appointment making encounters as well as the whole range of problem solving encounters is complex, variable and recursive, as is typical in service encounters. They add that confirmation is more likely to follow service orientation during appointment making and that there are large numbers of information checks in both these encounter types. Both also have an interim resolution stage in which a proposed appointment time or problem solution is given and provisionally accepted or rejected. Further information checking and confirmation then typically follows before the final resolution stage which like in checking in and prescription collection marks the close of almost all encounters. The typical procedure is as follows:

Procedure for appointment making and problem solving

Service orientation
(Confirmation)
Information check
Resolution
Information check
(Confirmation)
Resolution

How all this can work in a health facility is shown in Table 2, in a turn by turn analysis of an appointment making encounter at health facility B (Facility B, Tape 2, episode 10, F/26-40/lm/om)

Table 2: Structure of appointment making encounter

(R = receptionist RB1; P = patient PB10)

Stage		Action	R/P	Text
Service orientation	1	Signal availability	R	Good afternoon
	2	Bid for service	P	I wanted to make an appointment with a resident gynecologist?
Resolution 1	3	Inform	R	Let me confirm .
	4	Inform	R	O:h (.) just a moment (.) the doctor will be available at three o'clock=
	5	Accept	P	=ok . I'll be there
	6	inform	R	With doctor Ogutu
Information check	7	Seek information	R	(1)When were you born?
	8	Provide information	P	Ok . (er) .five two eighty one
	9	Seek information	R	(2) and you are?
	10	Provide information	P	I'm er . Jackson Otieno
Resolution 2	11	Instruct	R	(4) very fine (.) sign here . you will see the nurse over there before you see the doctor
	12	accept	P	//thank you // yes

In this example, service orientation is accomplished through one two part exchange, each conversation of which consists of only one speech act, that is, a greeting first and then a question (1 and 2). It is followed by a resolution stage (3), in which the receptionist confirms whether the doctor is available which she finally affirms in stage (4). The informing move is achieved through one speech act, 'the doctor will be available at three o'clock=' but is preceded by two meta discursive utterances, the discourse marker 'oh', which affirms the availability of the doctor, and the fixed expression 'just a moment', a mitigated form of the imperative 'wait a moment', which holds up the discourse and closes down the preceding topic (see Heritage 1984). The patient's acceptance (5) also consists of two separate acts, the affirmation 'ok' and the assertion 'I'll be there', and is followed by an informing move (6), in which the receptionist completes the offer.

The information check follows which includes two questions, one a conventionally direct question (7) and the other in the form of an incomplete statement (9), and two answers, the first including two parts, the affirmation 'ok' and the numerical statement of the date (8), and the second a single statement (10). After a four minute delay, during which the receptionist is entering the bio data in the computer, the closing resolution stage (11 and 12) is introduced by the discourse marker 'very fine', which marks the end of one discourse stage and the beginning of another. The resolution stage and the encounter are completed by an instruction from the receptionist which is accepted by the patient. These encounters between a receptionist and a patient as illustrated above in health facility B, is in line with roles and identities proposed by Goffman (2002) where participants enact their different roles and identities based on participant behaviour and activity type.

Both the receptionist and the patient have assumed different footings based on the alignments taken in the different stages of conversational sequences (see 1.10.2). In addition, although all transactional talk between receptionists and patients is accounted for by the stages described above in health facility B, the researcher observed that the ordering and length of the exchange and sequences, through which the four stages are in turn constructed, is influenced both by participant behaviour and activity type (c.f Goffman , 2002).

6.0 Conclusion

A number of observations can be drawn about the discourse patterns described by the researcher in this paper. It has been noted that the transactional structures at the reception desk of the two health facilities are similar to Mitchell's (1957) predictable stages, Ventola's (1987) recursion and Hewitt's (2006) transactional structures between bus drivers and passengers. Therefore these patterns are meant to meet the patients' needs of accessing health services at the health facilities and the receptionists who wish to have health problems resolved.

References

Brown.G and G.Yule. (1983).*Discourse analysis*.Cambridge: Cambridge University Press.

Dezin, N. (1978). *The research act: A theoretical introduction to sociological methods*. New   York: McGraw-Hill

Dornyei, Z. (2007).*Research methods in applied linguistics*.Oxford: Oxford University Press.

Goffman, E. (2002).*Frame analysis: An essay on the organization of experience*. Boston: Northeastern University Press

Heritage, J. and S. Sefi. (1992). Dilemmas of advice: Aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. In Drew, P. and J. Heritage (eds):331-358

Hewitt, H. (2001).*Encounters between bus drivers and passengers*.Cambridge: Cambridge University Press.

Hewitt, H. (2006).*Receptionists strategies.Cambridge*: Cambridge University Press.

Hyden, L-C and E.Mishler. (1999).Language and medicine. *Annual Review of Applied Linguistics* 19:174- 192

Kaspar, G. (2000).Data collection in pragmatic research. In Spencer-Oatey H. (ed):316-341

Lawton, J. (2003).Lay experiences of health and illness. *Sociology of Health and Illness* 25:23-40

Ministry of Health, 1999.The first national health sector strategic plan of Kenya.Nairobi, Kenya: Government printer

Ministry of Health, 2005.The second national health sector strategic plan of Kenya. Nairobi, Kenya: Government printer

Ministry of Medical Services, 2008.The first national medical sector plan of Kenya.Nairobi, Kenya: Government printer.

Ministry of Medical Services and Ministry of Public Health and Sanitation, 2012. Kenya health policy. Nairobi, Kenya: Government printer.

Ministry of Medical Services and Ministry of Public Health and Sanitation, 2012. Kenya health sector strategic and investment plan. Nairobi, Kenya: Government printer.

McCarthy, M. (2000). Mutually captive audiences: Small talk and the gener of close-contact service encounters. In Coupland, J. (ed):84-109)

Merritt, C. (1976) .On questions following questions in service encounters. *Language in society* 5:315-357

Milroy, L. (2002). *Observing and analyzing natural language*. London: Oxford University Press.

Ndavi, P.M. et al (2009).*Decentralizing Kenya's health management*. Nairobi: University of Nairobi Publishers.

Onyango, R.O. (Forthcoming) .*Frontline interface: A study of interaction between receptionists and patients in government and private health facilities in Nyanza, Kenya.* Unpublished PhD thesis, Maseno University.

Parsons, T. (1952).*The social system*. London: Routledge and Kegan Paul

Silverman, D. (2001).*Interpretating qualitative data: Methods for analyzing talk text and interaction*.2nd   Ed London: Sage.

Ventola, E. (1990).Linguistic difficulties in institutional discourse. In Halliday, M.A.K., Gibbons, J. and H.Nicholas (eds):493-508