ISR Italian Sociological Review
University of Verona, Italy
ISSN 2239-8589 | Editor in Chief Paola Di Nicola
Managing Editor Debora Viviani

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How to cite
Cersosimo, G. (2019). Interaction and Symbolism in Health Care Systems. [Italian Sociological Review, 9 (2), 305-315]
Retrieved from [http://dx.doi.org/10.13136/isr.v9i2.282]

[DOI: 10.13136/isr.v9i2.282]

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3. Article accepted for publication
Date: November 2018

Interaction and Symbolism in Health Care Systems

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Abstract

The purpose of this paper is to verify how and how much, interaction and symbolisms give sense and meaning to conversations and contribute to interpreting relations between patients and health professionals. They also express cultural biases, verbal and non-verbal skills, attitudes, behaviours and lifestyles. If interpreted correctly, interaction and symbolisms can optimise care relationships. Thus, symbols will be treated as factors that can help understand interaction in health care as well as its dynamics, often unintentional and predictable, that are culturally mediated. In this instance, we need to underline the growing importance of sociocultural changes in health care, (both their direct and indirect effects), as symbolic functional forms of knowledge and health literacy as well as their ability to explain systematic, though variable, relations between social statuses and healthy interaction. This paper aims to present Symbolic Interactionism as a theoretical perspective for multiple method designs with the aim of expanding the dialogue about new methodologies to manage health literacy. In other words, Symbolic Interactionism can serve as a theoretical perspective for conceptually clear and soundly implemented multiple method research, that will expand the understanding of a human's behaviour regarding their health and their own health literacy.

Keywords: Symbolic Interactionism, relationship, healthy interaction.

1. Introduction. Symbolic Interactionism and study of health care

It should be noted that Symbolic Interactionism has been applied to empirical research in health care. Literature on Symbolic Interactionism includes empirical cases that are mentioned in this paper since they have

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introduced and modified research methodology on health care following this kind of approach.

The first study was carried out on elderly patients in a nursing environment. Jaber Gubrium (1980) focused on the strategic interaction amongst clinical staff and patients. He used interaction as a method, highlighting 'strategic interaction' as the process of planned actions favourable to both professionals and patients leading to a higher degree of collaboration and inclusion.

The second study was carried out on emergency care. Wayne Mellinger (1994) pointed at doctor-nurse communication as a key element to patients' survival when using First Aid. Communication is characterised by a process of doctors and nurses' giving and receiving information to collaborate and decide what action to take. This process can be compared with negotiations since the meaning is defined before action takes place (Mellinger, 1994).

The emerging model sets a *turn-by-turn* interaction and the creation of meaning results from progressive negotiations among health care professionals. In this sense, Mellinger's analysis (quote) echoes Blumer's assumptions on meaning and interaction. However, Mellinger went beyond simply assuming the specific role of interpretation, meant to simplify what in practice is a complex dynamic process of creation and action of meaning and follows Anselm Strauss's (1978, 1933) idea of negotiated order. The interaction among individuals gives meaning according to specific situations and it takes place in participants' minds (Blumer, 1969) in a continuous process of cognitive evolution that translates in meanings, thereby facilitating communication.

Carol Heimer and Lisa Staffen (1998) also argued in their study on neonatal intensive care, that clinical professionals induced parents' willingness and capacity to optimise their children's health. Lutfey found that 'patient adherence and provider roles […] evolve in tandem' (2005: 444), as clinicians not only selectively provided patients and caregivers with the opportunities and tools to be more involved in medical care, but also shaped the circumstances under which such involvement could take place more or less successfully. The interaction concept thus maintains that providers not only induce certain kinds of patient behaviour, but also contribute to develop behavioural skills appropriate to new lifestyles when a disease is diagnosed and then treated.

Some years after Kotarba (2014) showed the interactionism's overall holistic approach to interfacing with the everyday life world in the evaluation of an NIH-funded, translational medical research program. The qualitative component has provided interactionist-inspired insights into translational research, such as examining cultural change in medical research in terms of

changes in the form and content of formal and informal discourse among scientists; delineating the impact of significant symbols. Another study used the interactionist model to analyze a new relationship between doctor and patient. Over the last years communication between physician and patients has become more and more complex. The patient-doctor relation has been transformed into part of a network of relations in which every contact is characterized by deep and continuous social and technological changes. This study showed a new way of communication between doctors and patients, that restructured and redefined old and new issues on health and disease and a new forms of the interaction (Cersosimo, 2017). Pennanen (2018) described and understood empowerment in the social interaction in hospital administrative group meetings, based on observation and analysis of seven administrative group meetings in a Finnish hospital. The findings show that responsibility is constructed by creating co-responsibility, taking individual responsibility, and constructing non-responsibility. Action and role and task responsibilities emerged as forms from the interaction. To support employee involvement in responsibility processes, they must also be provided with sufficient resources to deal with that responsibility and to manage its different dimensions. These insights can be utilized to improve health administrative groups.

The weight of this evidence triggered multiple efforts for clarifying how much symbolic interaction is now useful and appropriate in health care systems. These efforts were largely focused at a micro-level on patient-doctor-health professional interaction, but also at a macro-level, by posing two main questions: a) how do macro-level phenomenas occur and influence daily life activities? b) how does interaction in micro-systems increase and unlock processes in daily life on a large scale?

The observation has gone deeper considering the axioms of Symbolic Interactionism that give both the theoretical insights and the empirical attention to better understand doctors' behaviour (being the administrators of that system meant to provide care), relations in organisations, patients' feedback and disease management, shifting the management theory towards a perspective focused on knowledge and interaction among doctors, health professionals and patients.

2. Theoretical framework of the observations

The theoretical frame of these observations plunges its roots into Symbolic Interactionism and role theory (Blumer, 1969).

Meaning is derived from social interaction and it is the result of an interpretative process which pushes the individual towards an inner conversation: during this communication he '…*selects, checks, suspends, regroups and transforms the meanings in the light of the situation in which he is placed and the direction of his action*' (Blumer, 1969: 5).

This kind of interpretation is not the result of predefined meanings but derives from a creative process in which the meaning is often revised.

We analysed the actions of individuals who, being part of an interpretative process (Blumer, 1969), in the light of roles and sub-roles (Emanuel, Bennett, Richardon, 2007), acquired and experienced a disease. Moreover, this methodology derived meaning from verbal exchange and actions while actors, by turn, had specific roles. The analytical framework employed here relies on the fact that roles result from mental processes that would be otherwise difficult, even impossible, to be derived in unreal conditions.

However, nowadays, there are symbols in health care systems that help patients understand who they are talking to – a doctor, a nurse or an associated health worker – also thanks to the symbolic function of scrubs, different colours, white overalls or coloured uniforms. For a long time health literacy has been a hot topic among patients, since it helps us to understand which actions can prevent severe illnesses or complications that over time translate into chronic diseases and have social and financial costs on the National Health System expenditure.

Symbolic Interactionism sets a theoretical basis to better understand how organisations and individuals can influence the results of treatments through interaction and symbols charged with meaning and sense.

Our presence at the Hospital Ruggi Di Dio and D'Aragona of Salerno was discreet but constant, and positively welcomed by doctors, students and patients since we were not there as researchers, that could have caused unnecessary disruption) altered the sense and meaning of research by creating a sort of dramatisation, but as professors from the faculty of medicine. We were at the hospital for teaching and research activities, sometimes even as patients waiting for a visit, or as indirect observers of a situation where we were present as part of the study.

These observations are the result of a participated privileged presence in health care facilities which lasted for eight years. In particular, we observed the utility of roles and the interactionist methodology in clinics where diagnoses and therapies are issued. This implied using perhaps the most difficult, but less invasive, instrument at researchers' disposal for privacy protection, i.e. the diary on which we noted situations, episodes, sentences, emblematic symbols, relations, before and after talking with doctors, interns and students.

However, here we are not exploring methods and results as these are worthy of a deeper study and which will be published soon. This article aims to present those considerations deriving from research into Symbolic Interactionism which are useful for; developing new models and healthy behaviours, good compliance with treatments and optimised resourcing in terms of time and costs.

3. Meaning of the research observations

Keeping in mind these premises on Symbolic Interactionism (Blumer, 1969), diseases can be treated from a new – interactionist – perspective where daily life is populated by individuals interacting in relations and, in our case, where doctors' implicit roles emerge, in influencing patients and relatives' daily life as well as their care system management.

How does a doctors' role emerge? Let's try to explain it through three axioms, i.e. symbol, meaning and interaction/interpretation. A 'symbol' can be the prescription of a drug, the illustration of an education plan of a new lifestyle (depliants or gadgets), or the presence of a more or less invasive technology with which the diagnosis is done or a surgery is carried out.

When diagnosing a disease, doctors emerge as leaders, by using symbols embedded in health policies, in public health and in their renown ability to act legitimately with intervention, prescription, and diagnosis. There is no patient, met in any waiting room, ward or specialised clinic, who does not describe the doctor as the person able to diagnose a disease, prescribe in a resolutive way a therapy, perform a surgery, describe how to take a drug or indicate how to stick to a regime. In other terms, patients legitimate the power attributed to doctors through symbols – from drugs to new technology, and invasive to mini-invasive practices.

The meaning highlights our social inheritance in treating doctors as superior beings rather than ordinary people. In other terms, after meeting the doctor, the trend is to pathologise the person who receives the diagnosis or to self-pathologise, fascinated by medicalisation. This superior role assigned to doctors in society is strengthened and legitimated by overalls and scrubs as well as the presence of medical and laparoscopic ecographic devices and the setting where the interaction occurs. The meaning of a doctor is deeply embedded in our mind through symbols, but also in relation to their omnipresence, from birth to death, as reported '… we come to life and we die in doctors' hands'.

The interaction defines the doctor's role according to the context in which all stakeholders operate when shaping symbols and meanings. The

axiom of interpretation requires that medical meaning, as defined by interaction, is reformulated progressively while individuals interact, being inspired by their own values, norms, ideas and experience.

In other words, what seems common sense, according to which individuals follow rules, norms and absolute roles, has instead been an individual trait, being temporarily redefined when people meet.

Symbols help interpretation explain how to recognise the doctor's role and how doctors take leading roles. Patients following medical prescriptions, a new dietary lifestyle or being instructed on how to take care of themselves when being released or during follow-ups (tertiary prevention) mark the success of an interactive relationship where symbols are useful to recognise roles and functions.

This translates into a reduction of costs engendered by inappropriate service supply. Symbols and meanings help decipher roles while individuals perform their actions.

Symbols, meanings and interaction/interpretation can clarify some health topics since language (defined as 'by naming something, we classify our knowledge', Strauss (1959)) can be considered as an equal representation of our thoughts, values and norms. The interaction shows how a series of words that could mislead patients (irritable bowel syndrome, functional disease, borderline arterial hypertension) can be reformulated through symbols in order to give a piece of information, instil empathy and self-determination when choosing the best lifestyles to protect one's health.

Health care can be intelligible and interesting for patients and relatives only if they can see how to reduce costs and supplements, transforming themselves into an active part of a process meant to appropriately manage their health. Thus, interpretating highlights of symbolic interaction, could have a different meaning once patients interpreted the interaction and applied it to their own reference framework.

Interaction and symbols offer a consistent framework to understand the impact of important changes, the complex dynamics of medical interaction, and the relationships between health care and broader social relationships. They allow seizing what is a resource in medical encounters; behaviours or features which benefit patients and how they can vary in time and situations.

At present, we observe on the one side patients' excessive initiatives in self-medication, self-surveillance and self-management and on the other side the specific features satisfying doctor-patient interactions, such as:

- Knowledge of medical issues and terms linked to the understanding of scientific knowledge and health culture (in other words; that feature allowing doctors not to be interrupted when visiting);

- The skills to communicate health-related information to providers in a medically intelligible and efficient manner (time saving);
- Knowledge of what information is relevant to health care personnel;
- An enterprising disposition and a proactive stance towards health, both of which presuppose a sense of mastery and self efficacy;
- The ability to take an instrumental attitude towards one's body;
- An orientation towards the future and its control through calculation and action;
- A sensitivity to interpersonal dynamics and the ability to adapt one's interactional style.

In short, it is about health literacy, as defined by Marcia Ratzer and Scott Parker 'the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions' (Ratzan, Parker, 2000: VI). Ten years after the health literacy has been defined '…. *health literacy includes a variety of skills—reading and writing certainly, but also a facility with numbers and calculations (numeracy) and the ability to understand spoken health information and to describe one's health needs. In addition, health literacy is dynamic and essentially resides at the intersection of patient abilities and the demands of the particular situation'* (Weser, Rudd, DeJong, 2010: 590).

As such, health literacy is crucial in interactions in order to ensure the correct functioning of the healthcare environment. Indeed when health literacy is insufficient, it can contribute to social disparities in care quality as well as to wasteful inappropriate health services.

Other features that impact on interaction with health professionals include self-efficacy, mastery, control, and self-esteem (e.g., Bandura, 1997, 2004), all referring to a 'core belief that one has the power to produce desired changes by one's actions' (Bandura, 2004: 144).

Health literacy and selectivity add another element to the discussion since they indicate the ways, be they direct or indirect/symbolic or functional, in which these resources contribute to the rationalisation of health systems with a series of interaction and actions, a greater sharing of information, answers to doubts and questions that could improve communication, treatment compliance and care. In this case, interaction and symbols act like knowledge capital (Bourdieu, 1977), to which a distinction and positive approval is given, and re-compensated as such. This double nature of interaction, both functional and symbolic, offers a conceptual processing of existing notions on health literacy.

In other terms, interaction in health care is based on a deep analysis of verbal and symbolic conversations since most health operators and patients

exchange information, talk to each other starting from their social worlds and symbolic systems through which they interpret their lives.

These analyses reveal the general structure, actors' activities, the different sequences of clinical context and important features in the order of interaction and strategies where the encounters occur.

However, it is necessary to highlight that to some extent the order in interaction is unique, less flexible and more assertive than in daily life (Charmaz, Belgrave, 2013). In other terms, in doctor-patient interaction 'asymmetry is interactively achieved' (Maynard, 1991: 449), so interaction is the very means by which participants enact patterns of authority, distinctions of class, discursive formation, and other institutional features that form their social surroundings (Maynard, 1991).

The focus here is on the outcomes of interactions that can't be assumed by the structural position of participants. Power and asymmetry in health care become real through the interaction of social actors with their different and diversified roles. The conceptual instruments used to understand disparities between patients and health professionals should consider a certain degree of variability in relation to social positions and interaction dynamics in health systems, which are the expression of a hierarchical and asymmetric order of interaction.

It should be noted that during interaction, the different social actors have interactive manners derived from their symbolic universes. It should also be considered that, when observing situations, doctors, interns, students and patients behaved differently on the basis of age and experience. Older doctors tended to act in a more paternalistic way and patients had a more reverential attitude towards them.

This was not the same for interns who tended to prefer pro-active patients, and students who tended to discuss more on appropriate sharing and division of work and on responsibility among colleagues and patients.

The meaning of 'taking care' with reference to the context in which doctors are educated or are studying has different nuances because it can correspond to applied methods and means for treating the disease or to promote health with new forms of relationships.

Older doctors consider treatment as a synonym for therapy whereas younger doctors tend to include the concepts of prevention, literacy and information sharing. Health care therefore means taking care of people in a holistic manner.

Younger doctors recall Pericle's Greece where Socrates took distance from Hypocrites. Indeed, being humouristic in saying 'I know that I know nothing', he taught to live better and to heal ones' souls since soul and body are the same thing. He suggested that an individual can take care of his/her

body only if he/she understands that sharing and handling the process of diagnosing, therapy and treatment are key to a better health care.

Patients too, who are generally reverential, non-autonomous and passive, proved to be aware – especially when they had already experienced care services – of which kind of behaviour could facilitate the interaction translating into benefits in care services.

At present, patients seem to have learnt to recognise those promoting agencies and institutional bodies who stand as warrants of care and self-prevention. The sick learnt that taking care of themselves means being able to take decisions. To do so, they need knowledge and information about health and disease in order to judge, decide, and act for their own care. This echoes Heidegger's concept of Existence.

The individual put at the very heart of the decision, has first instinctive knowledge of protecting and promoting health. He understands the concept and only then, pondering, he acquires an ontologic knowledge, i.e. the structures of existence giving sense to the space-time configuration where he lives and experiences his/her daily life.

The question is the co-existence of those who take care of someone and those who need care for a certain problem. Heidegger (1970) states that we should take care of things, but we should *have* care of people. In other words, individuals should mutually support each other in order to create an outright collectivity.

This semantic explanation mentioned above, shifts from a reflexive to a transitive approach, and maintains that having care means participating to care itself. As a consequence, social and political health engagement should be modulated accordingly. Thus, health professionals can adapt their way of interacting in order to better meet patients' needs and inclinations.

This requires shared symbolisms and meanings in daily life towards a full integration of patients and care professionals in a conjunct framework where they are even more compatible.

4. Conclusions

If Symbolic Interactionism, a theoretical perspective based on Blumer's work, examines how people receive or give meaning to their social experiences, in relation to health and illness, it also focuses on the individual interpretation of health. In doing so, there is greater insight into personal health behaviour. This study on hospital patients revealed that behaviour is often a response or a reaction to other individuals or to physical settings. Thus, the individual's behaviour at the hospital is a response to the context

(rules, regulations, expectations) rather than to one's personality. Symbolic interactionists believe that health, illness and cultural setting are inseparable. Besides, medical knowledge is also socially constructed and so it is subjective and fallible.

Thus, studying health treatments through Symbolic Interactionism would allow a deeper analysis of strategic interactions among all stakeholders. Symbolic Interactionism allows timely literacy so that service quality is higher, unnecessary hospitalisation is limited and requests are better distributed across territorial health services.

The application of Symbolic Interactionism as a research methodology in health systems can trigger deep considerations into how to optimise appropriate hospitalisation and reduce disparities in health care services.

The interaction and knowledge processing through symbols offers a methodology that links meaning, interaction and roles' interpretation while actors play their temporary roles. This highlights the impact that each individual – doctors/health professionals/families/staff/clinicians/and managers – has on the care experience, on people, on himself/herself and on the health professional.

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