Effects of Laughter in Medical Discourse

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Abstract

This study examines the ways in which laughter has affected the medical discourse at a dizziness outpatient clinic. The transcribed data gained from two consultation sessions of two participants projected the different features in the interaction with an expert physician. The results, based on the analyses using RIAS (Roter Interaction Analysis System) and Politeness Theory, suggest the important role of laughter for establishing the rapport, which may eventually enhance the quality of medical practice.

Keywords

laughter, medical discourse, rapport, RIAS, politeness theory

Introduction

As Cousins (1979) points out, some factors not directly related medicine including communication causing laughter may affect the medical or physiological effects on curing the clients/patients. Therefore, it should be vital to investigate the ways in which the medical professionals such as physicians in particular should interact with their clients/patients for establishing rapport with their clients/patients. This study aims to explore the optimal communication styles to enhance the quality of medical practice, by analyzing the medical discourse.

Methods

Data

The data was gathered from the first consultation sessions at the dizziness outpatient clinic. The director of this clinic is a physician with both practical and academic experiences for more than three decades and recognizes the importance and significance of communication with his clients/patients complaining dizziness, which may be affected by psychological factors (Nakamura, 2006). Two new clients/patients and the expert physician participated in this study, and the first sessions of consultation were recorded using video camera, and recorded data were transcribed word by word. Following analyses were utilized for the transcribed data.

Analyses

RIAS analysis

Roter Interaction Analysis System (RIAS, hereafter) was conducted as a functional analysis. RIAS (Roter and Larson, 2002) has two main categories – medical-service communication with 26 sub-categories and socio-affective communication with 15 sub-categories which includes 'laughs'. Each verbal and non-verbal behavior in an interaction was categorized according to RIAS in order to find out specific functions containing in medical discourse.

Politeness theory

Politeness theory established by Brown and Levinson (1983) was used for analyzing the qualitative features of RIAS categorized utterances. Centering the key notion of face, politeness theory provides politeness strategies consisting of 16 positive politeness strategies and 7 negative politeness strategies, all of which were validated in Japanese medical contexts (Yoshioka, 1998). Each politeness strategy exists for purpose of mitigating the face-threatening act fluctuated by the social distance, power relations, and the degree of imposition of the act, dynamically.

Results

Two cases of first consultation scenes generated the following results.

The first case was provided by a participant, who is 38 years old, female, teacher with no medical history and diagnosed as Meniere's disease. The duration of the consultation was seven minutes 44 seconds, the number of utterances was 158, and RIAS analysis indicated 34 utterances (21.5%) of socio-affective category and 124 utterances (78.5%) of medical-service category.

The second case was provided by a participant who is 49 years old, female, office worker with no medical history and diagnosed as benign paroxysmal positioning vertigo. The duration of consultation was nine minutes 28 seconds, the number of utterances was 253, and RIAS analysis showed 46 utterances (18.2%) of socio-emotional category and 207 utterances (81.7%) of medical-service category.

Discourse analysis using politeness theory of social distance, power relations and imposition generated the following result.

A scene from the first case
Laughter (Joking): Successful case
Doctor: Actually, the stress is a main cause of this problem.
Patient: [Nodding]
Doctor: I guess your boss (vice-principal) is a problem.
Patient: [Laughing]

A scene from the second case
Overlapping (Overlapping): Unsuccessful case
Patient: Does this cause dizziness?...
Doctor: (Overlapping) Did I say such a thing?
Patient: No you didn't. I am sorry.
Doctor: I did not, did I?

Laughter was induced in the first case as the response of the physician's joking, which may lead them to establishing rapport. On the other hand, the second case includes overlapping, which may lead to failing in establishing rapport.

Discussion
There are some contrasts of these two cases. The results using the RIAS analysis show that the successful case (the first case) had shorter session than the unsuccessful case (the second one); however, the successful case generates more utterances of socio-affective category. This finding suggests that successful discourse does not have to be a longer session but it should contain a larger portion of utterances belonging to socio-affective category. Therefore, the physician may well try to give socio-affective utterances when and where appropriate. Regarding the duration of consultation sessions, a longer one is not necessarily preferred. Discourse analysis of politeness strategies, on the other hand, suggests that joking as a physician's effort of making a closer social distance and lower degree of power with his patient/client should generate laughter, which is regarded effective in curing medical problem (Bennet, 2003) and establishing rapport. On the contrary, overlapping followed by confirming utterance which may function as 'disapprove' in RIAS analysis could be regarded as a negative role of mitigating a face-threatening act. In the same line of Chou et al. (2011), using multiple analyses (RIAS and politeness theory in this study) may enable to explore the optimal communication styles for enhance the quality of medical practice.

Acknowledgement

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