
SRIKANT SARANGI

Experts on Experts: Sustaining ‘Communities of Interest’ in Professional Discourse Studies

1. Introduction

Building upon and expanding on a number of earlier publications (Sarangi 1998, 2002, 2005, 2007, 2010; Sarangi/Candlin 2011, Sarangi et al. 2003), this chapter is primarily a practising discourse analyst’s reflections on ‘interpretive repertoires’ surrounding interprofessional collaborative research, with particular reference to the domain of healthcare. In a classic study of scientists’ discourse, Gilbert and Mulkay (1984) draw attention to scientists’ use of two distinct ‘interpretive repertoires’: while the ‘empiricist repertoire’ exemplifies impersonal accounts of scientific discovery and the rules and procedures governing the production of factual knowledge, the ‘contingent repertoire’ appeals to personal motives, biases and intuitions. It is the simultaneity of these two repertoires that gives rise to ‘interpretive variability’. This distinction between empiricist and contingent repertoires easily maps onto the objective-subjective dialectics and also applies to discourse analysts’ accounts of data-based findings. The situation becomes complex when a discourse analyst’s account is subjected to further interpretation by professional practitioners on a collaborative footing.
For many of us, collaborating and partnershiping across disciplinary and professional boundaries is assumed not only to be desirable and value-added, but also as being a smooth operation without visible challenges. Indeed one’s experience of collaboration can be productive, but at times one is confronted with interpretive dilemmas. My own collaboration with professional practitioners in the field of genetics and genetic counselling over the past two decades has yielded many fruits but not without interpretive challenges that underpin the long-term marriage. The aim here is not to offer an evaluative assessment of collaborative research or to set out criteria and principles that one should follow. Instead I wish to argue that collaborative interpretive practices provide a useful platform for inevitably reflecting upon one’s own assumptions, especially in the context of language/discourse-oriented qualitative inquiry.

Collaboration takes many forms: with colleagues from different academic disciplines, with professional practitioners, with clients and service users, and with managers and policy makers. Collaboration with colleagues representing different disciplines can be as demanding as collaboration with professional practitioners at practical, epistemological and ontological levels (see Sarangi 2002 on a distinction between interdisciplinary and interprofessional collaboration, each posing different challenges for the communication/discourse researcher). The holy grail of interdisciplinary and interprofessional research – what I characterise here as experts on experts – is the subject of the present chapter.

I first briefly visit existing notions – communities of practice, communities of discourse (or discourse communities) and communities of interpretation (or interpretive communities) – and propose the notion of ‘communities of interest’ which characterises the lasting interprofessional collaboration of the kind I am engaged in. I then outline the key features of professional practice in relation to clients as well as interprofessional communication. I single out the notion of categorisation as ‘biased’ interpretation and apply this to selected data to make the point about ‘analyst’s paradox’ (Sarangi 2002, 2007) embedded within interpretive operations. The ‘interpretive variability’ across the professional practitioner and the discourse analyst is cast as a tension between ‘scientific-technical-
specific knowledge’ (knowing that) and ‘discourse-analytical-specific knowledge’ (knowing how).

2. Communities of practice/discourse/interpretation and communities of interest

The notion of ‘community’ has received critical attention within sociological and anthropological literature. Gusfield (1975) distinguishes between two meanings of community – locational/geographical vs. relational – and it is the relational dimension of community that concerns us. The relational dimension, however, should not be taken to mean primordial attachment or loyalty in an absolute sense. Following the seminal work of Lave and Wenger (1991), a community of practice is characterised by the following features: mutual engagement, a joint enterprise and a shared repertoire (Wenger 1998: 73). These features go beyond mere social categorisation, interpersonal relationship and geographical proximity. A key point is that a community of practice “does not entail homogeneity” (Wenger 1998: 75). Instead it affords diversity and partiality, similarities and differences, self and other competencies. In a nutshell, communities of practice are sustained via intelligible ‘interpretive variability’.

Of the three definitional features of communities of practice, the affordance of a shared repertoire is relevant here. This idea coincides with Wuthnow’s (1989) notion of community of discourse, which can also be traced to the sociolinguistic notion of ‘speech community’ (Gumperz 1968). Other scholars such as Swales (1990) and Porter (1992) have talked about the notion of discourse communities. Swales (1990) characterises discourse communities as socio-rhetorical networks with access to participatory mechanisms such as specific genres and communicative acts through which certain goals and purposes can be achieved. Porter (1992: 106) defines discourse communities as:
a local and temporary constraining system, defined by a body of texts (or more generally, practices) that are unified by a common focus. A discourse community is a textual system with stated and unstated conventions, a vital history, mechanisms for wielding power, institutional hierarchies, vested interests, and so on.

At one level, notions such as community of practice and discourse community are conceived of as organic systems involving dynamic inter-relationships with their environments. At another level, these notions remain abstract and normative and thus prove difficult to operationalise at an analytic level.

Shared practices – inclusive of the discursive, communicative dimension – no doubt exist, but intra-community tensions also emerge. The classic example here is Stanley Fish’s (1980) notion of ‘interpretive communities’ (see also Bleich 1978 on ‘communities of interpretation’), exemplified by different interpretations of the utterance “Is there a text in this class?”. While one colleague interprets the question with the answer “Yes, it’s the Norton Anthology of Literature”, Fish would prefer to interpret the question as it was originally intended – whether a literary text can be autonomous from its contexts and readers. Can Fish and his colleague claim membership in the same interpretive community despite their differences in interpretation? As Schauber and Spolsky (1986: 146) observe:

If, on the one hand, every variation in interpretive perspective or strategy indicates a new community, then the notion of community loses its force. If, on the other hand, major variations in perspective do not mark community boundaries, then again the notion has little use.

The community of discourse scholars – whether seen as communities of practice or discourse communities or interpretive communities – is divided on professed lines, resembling tribal warfare, each safeguarding their own territories. In systemic thinking, such demarcations can be seen as sub-systems with overlapping stakes and interests, rendering any neat classification of sub-communities nearly impossible.

Here I would like to introduce the notion of ‘communities of interest’ which acknowledges differences in ontologies and
epistemologies across given communities of practice/discourse/interpretation, but privileges the mutual interest in the phenomena under study. This is parallel to the broader notion of ‘interest groups’ who organise themselves, with shared attitudes, to mobilise political action and are motivated by a purpose. The phenomenon of ‘special interest groups’ in academic disciplines and conferences also serves as a good example.

‘Communities of interest’ concern scenarios in which one crosses different communities of discourse/interpretive practice – where one may share ‘interests’ but not ‘practices’, ‘discourses’ and ‘interpretations’. Consider, for example, multiprofessional teams in the healthcare setting who work towards a shared interest in the patient’s wellbeing, independent of their belonging to different communities of discourse/interpretive practice as manifest in different explanatory frameworks and in differential uses of acronyms/jargons. Mary Douglas’ (1985: 95) definition of community foregrounds ‘commitment’: “The full sense of the term community is a committed group in which individuals derive their life support and which bounds their commitments”. Likewise, the notion of commitment assumes utmost significance in communities of interest. One not only derives support from source but is also bound by a goal in the future. Differences in empiricist and contingent discourse/interpretive practices do not stand as a barrier to shared membership in communities of interest.

When a particular tribe of discourse analysts studies another profession (e.g. a community of healthcare practitioners) tensions can arise during the research process, especially in relation to how data is to be interpreted and findings are to be disseminated. Categorisation of observable phenomena, or more generally the sense of meaning-making, is likely to be marked by discretions and differential inferences, leading to formulation of subjective reporting/judgements.

3. Expertise, guilty knowledge and professional practice
Notions of profession and practice are nuanced in the literature. The same is true of notions like expertise, knowledge and authority (Walton 1997). Practice, according to Bourdieu (1977), always implies a cognitive operation including perception. For him, practice is socially and discursively constructed, and is always culturally relative (both in terms of ethno-linguistic cultures and institutional ones). Whatever the manifestations of practice, or to use Bourdieu’s pet notion of ‘habitus’, these are always historically determined and durable, although allowing for flexibility, contingency and improvisation. Over time, practice assumes theoretical significance (cf. contemporary interest in practice theory).

According to Hughes (1975: 249, cited in Walmsley et al. 1993: 9-10): “Professions profess. They profess to know better than others the nature of certain matters, and to know better than their clients what ails them or their affairs”’. This ‘knowing better’ is premised on theoretical knowledge as well as experience, which jointly affords authority. To this mix one can add knowledge of technology, knowledge of institutional orders, and more importantly, communicative knowledge. ‘Knowing better’ goes beyond the professional-client divide to capture the interprofessional division of expert labour. Again, in the context of multiprofessional teams, one specialist may know better than his/her counterpart about specific phenomena.

‘Knowing better’ can sometimes be equated with ‘guilty knowledge’. Hughes (1993: 22-23) observes:

The prototype of all guilty knowledge is, however, a different, potentially shocking way of looking at things. Every occupation must look relatively at some order of events, objects or ideas. These things must be classified, seen in comparative light; their behaviour must be analysed and, if possible, predicted. A suitable technical knowledge must be developed in which one may talk to one’s colleagues about them. This technical, therefore relative, attitude must be adopted toward the very people whom one serves; no profession can operate without license to talk in shocking terms behind the backs of its clients.
For Kenneth Burke (1966), ‘knowing better’ may amount to experts operating with a ‘terministic screen’ or on the basis of ‘trained incapacities’:

Any definition of man in terms of specialised scientific nomenclatures would necessarily be ‘over-socialised’, or ‘over-biologised’, or ‘over-psychologised’, or ‘over-physicised’, or ‘over-poeticised’, and so on, depending upon which specialised terministic screen was being stretched to cover not just its own special field but a more comprehensive area. (Burke 1966: 52)

We may add to this list over-linguisticised, over-discoursised and over-communicationised etc. Moreover, within these so-called disciplines, further sub-specialised terministic screens are noticeable. This tendency simultaneously leads to over- and under-interpretation of observed phenomena. For Burke (1965: 49), “every way of seeing is also a way of not seeing”. With reference to the world of painting and art criticism, John Berger (2008: 1) writes:

We only see what we look at. To look is an act of choice. As a result of this act, what we see is brought within our reach – though not necessarily within arm’s reach.

Goodwin (1994) foregrounds the discursive practices underpinning what he calls ‘professional vision’. Like Hughes, he draws particular attention to discursive practices of coding, highlighting and articulating material representations. Expert knowledge and professional experience both shape and are manifest in professional vision. However, from the Burkean perspective, professional vision can be seen as professional myopia – the act of seeing is also an act of not seeing. Here is an example, taken from Flint (1995: D8, cited in Walton 1997: 10):

Biology students once learned that a sperm swims toward the passive egg of the female, pounds on the walls and breaks down the damsel’s defenses. Conception was not so much a union as a vanquishing. Today’s researchers see it differently. The egg, they say, sends out messages to guide the sperm, participating actively in the process, until sperm and egg find each other and merge.
Yet because scientists came to the lab with preconceived labels for the microscopic players – sperm as aggressive male, egg as passive female – it has taken a long time for them to see what was really going on.

Two points emerge from the above example: professional vision is constituted in the act of ‘biased’ interpretation of phenomena and that professional interpretive repertoires, whether empiricist or contingent (Gilbert/Mulkay 1984), change over time, i.e. a kind of ‘professional correctness’ reigns periodically. As Kuhn (1962) points out, epochal changes occur even in the domain of ‘normal science’ to make it possible to codify phenomena with a degree of consensus.

4. Categorisation of professional practice and interpretive cleavages

Description is the basis of categorisation, which is central to both the natural sciences and the human/social sciences. According to Dunn (1978), while within the natural sciences descriptions take the form of statements and assertions which can withstand inter-observer reliability, within the human and social sciences ‘reporting’ is the preferred form of description which may have no corresponding inter-observer reliability.

One of the challenges is that if language and discourse is context-specific, who owns the description and interpretation of context? In other words, whose categorisation of observed phenomena should prevail: the discourse analyst’s or the professional practitioner’s, both in the historical sense of professionalism and in the contingent sense of the specific encounter? In relation to psychotherapy, what might appear as ordinary conversation to the outsider discourse analyst may be invested with psychotherapeutic meaning-potential. As O’Hanlon and Wilk (1987: 177) note:

A ‘fly on the wall’ who did not know we were doing psychotherapy would not necessarily suspect that that was what we were doing; he would see and hear
only an ordinary conversation. What defines the conversation as psychotherapy is simply our goal in conducting the conversation.

By extension, what might seem a mere repetition to the naked eye of the discourse analyst can be descriptively discriminated as echoing vs. mirroring depending on who repeats what and for what purpose, i.e., the communicative potential of repetition as a discourse device can be optimally interpreted in relation to the ensuing therapeutic intervention (Ferrara 1994).

The act of categorisation is intimately tied up with forms of knowing and seeing. In the tradition of philosophy of science, Hanson (1958) distinguishes between ‘seeing as’ and ‘seeing that’: “it is a matter of logic, not merely a matter of fact, that seeing as and seeing that are indispensable to what is called in science, seeing or observing” (1958: 86). As Hanson (1958: 10-24) remarks:

Seeing that threads knowledge into our seeing; it saves us from re-identifying everything that meets our eye; it allows physicists to observe new data as physicists, and not as cameras […] Observation in physics is not an encounter with unfamiliar and unconnected flashes, sounds, bumps, but rather a calculated meeting with these as flashes, sounds and bumps of a particular kind.

This is echoed in Garfinkel’s (1967: 78) formulation of what Mannheim originally conceptualised as the ‘documentary method of interpretation’:

The method consists of treating an actual appearance as ‘the document of’, as ‘pointing to’, as ‘standing on behalf of’ a presupposed underlying pattern. Not only is the underlying pattern derived from its individual documentary evidences, but the individual documentary evidences, in their turn, are interpreted on the basis of ‘what is known’ about the underlying pattern. Each is used to elaborate the other.

The act of categorisation, when it leans heavily on ‘seeing that’, becomes indistinguishable from recontextualisation in many institutional/professional spheres (Sarangi 1998).

In my previous work (Sarangi 2002, 2007) I have suggested that attention to the notion of ‘analyst’s paradox’ – the activity of
obtaining members’ insights to inform analytic practice, including collaborative interpretation – is a way of approximating ‘ecological validity’ (Cicourel 2007). This is more the case when our analytic gaze is method-centred (resembling communities of practice) rather than problem-centred (resembling communities of interest). An extension of Kaplan’s (1964) generic concept of ‘the law of the instrument’ is discernible in ‘Maslow’s hammer’: “It is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail” (Maslow 1966: 15). Collaborative interpretation, involving the discourse analyst and the professional practitioner, is a useful safeguard against Maslow’s ‘law of the hammer’. I agree with Clarke (2005: 189) when he says:

Interpretation of professional behaviour, and especially any attempt to evaluate professional practice, can only sensibly proceed with some input from the professionals. This is not to say that a professional’s account of their practice must be taken at face value […] but an attempt to make sense of practice without some input from professionals is unlikely to be productive.

This plea is recognisable as the process of triangulation, which also goes under the label ‘respondent validation’, while acknowledging the limitations of post-hoc accounts of action (Schön 1983). Such processes of triangulation need to be matched by inter-analytic reliability whenever possible. Following Dunn (1978), this is a case of managing ‘descriptive discretion’ which underpins different, and even competing, interpretive practices:

The prevalence of descriptive discretion is not in itself epistemologically alarming, though it does weaken the prospects of any very crisply incremental development of the social sciences. In itself it comes no closer to imperilling the reality of human performance than variations in the taste of landscape artists come to altering the physical properties of mountains. To make it epistemologically alarming and not merely methodologically troublesome, it would be necessary for it to extend to the assertion and negation of the same description (identically interpreted) of the same phenomena by two different competent, sincere and attentive observers. (1978: 155-156)

The analyst’s paradox is a continuum: it is at its most extreme when interpreting different professional and organisational practices such as
the backstage activities, e.g., case records, peer-centred talk/text as in case presentations, case conferences, source texts, guidance notes etc. This is where collaborative interpretation by both professional practitioners and by discourse analysts belonging to a ‘community of interest’ may be an important means for minimising the analyst’s paradox.

Sarangi et al. (2003) report in a discursive vein an attempt to minimise the analyst’s paradox, which was achieved through recategorisation of the genetic counselling data corpus. For instance, what was first regarded as ‘therapeutic frame’ by discourse analysts gave way to ‘reflective frame’ preferred by the professional practitioners – the latter category being devoid of any negative connotation in the context of genetic counselling practice. Another analytical category – ‘normalisation of experience’ – was substituted by ‘psychosocial coping’, with the substituted category allowing for a deeper appreciation of subtle sub-categories that were hidden under the more generic label of ‘normalisation’.

5. Knowing better: scientific-technical-specific knowledge (knowing that) and discourse-analytical-specific knowledge (knowing how)

The distinction between ‘knowing that’ and ‘knowing how’ owes to Ryle (1949), which are also characterised as declarative knowledge and procedural knowledge, respectively. This distinction would apply to both genetics and genetic counselling as a discipline and as a professional practice as it would to discourse and communication studies as a discipline and as a professional practice, albeit with a range of variations. In a sense ‘knowing that’ aligns with our earlier discussion of ‘seeing that’ (Hanson 1958). For present purposes, I limit myself to characterising the position of the professional practitioner as representing ‘scientific-technical-specific knowledge’
(knowing that) and the discourse analyst as embodying ‘discourse-analytical-specific knowledge’ (knowing how).

Now I turn to some empirical data from genetic counselling. It concerns a situation where the parents wish to test their child for a genetic condition called polycystic kidney disease (PKD). The manifest symptoms are high blood pressure and urinary infection. My data is drawn from a joint clinic session involving the parents (PF and PM), the children (CF and CM), the genetic counsellor (G1), the kidney specialist (K1) and the genetic specialist nurse (N2) (see Appendix for transcription conventions). There is a division of labour between the two experts, G1 and K1 – in relation to what might be inheritance related and what might be dysfunctional about the kidney itself. As we will see, both experts display scientific-technical-specific knowledge (knowing that) of different kinds.

The selected data extracts were first analysed by SS and the written analytic commentaries then received feedback from the professional practitioner (AC). The opening data extract is contextualised by SS as follows, which receives a challenge from AC:

SS: “It is worth noting that in conventional medicine, tests and test results are aimed at uncertainty reduction and for confirmation of diagnosis – as a precursor to medical intervention. In the context of genetics, only a few diagnostic tests are currently available. The other types of tests – carrier testing and predictive testing – not only involve cumbersome and costly procedure but could fail to provide definitive results.”

AC: “This does not sound correct at all – I’m puzzled... the test is likely to be the same as far as the lab and the clinician are concerned (in the mechanics of doing it) and whether it is diagnostic, predictive, carrier etc will depend upon the context.”

SS: “In what follows I focus on a particular genetic condition called polycystic kidney disease (PKD), normally associated with an enlarged kidney, which can present cysts at a later stage.”

AC: “The first sentence about large kidneys later showing cysts is what K was hoping to show in the children’s PKD clinic but that study never got done. So while it may be that young children who are going to develop PKD have slightly larger kidneys, we don’t know that. It’d be much more reasonable to say something about those with a PKD mutation develop cysts that become
apparent on ultrasound scan over the course of 30+ years (becoming detectable at some stage from fetal life to >30 years old)."

Two relevant topics – testing (general vs. genetic) and the disease condition – are foregrounded by SS. Although the descriptions offered by SS may be sufficient for a discourse analytic audience, AC not only draws attention to the misconceptions inherent in SS’s framing of both the topics but also suggests remedial action. AC’s observations manifest a combination of theoretical, scientific knowledge and professional experience – which is not inhabited by SS. AC’s comments above concern misunderstandings on SS’s part about the nature of the disease condition as well as the scope of genetic testing and the professional practice underpinning testing, diagnosis and prognosis. These comments, I suggest, belong to the domain of scientific-technical-specific knowledge, with AC claiming expert authority. Under the circumstances, the discourse analyst has to concede to the other-expertise as a way of making their interpretation credible. Following Ryle (1949), this is evidence of ‘knowing that’ which is mainly non-negotiable.

In what follows, the genetic counselling data extracts are accompanied by written correspondence between SS and AC. In Data Extract 1, the kidney specialist (K1) is explaining the advantages and disadvantages of testing the child for PKD.

DATA EXTRACT 1

01 K1 but um (.) perhaps if I mention some of the (.) um (0.5) advantages of (0.5) knowing if the children have got it [PKD] for instance (0.5) obviously if you did know they’ve got it you’d make sure that if there was any (0.5) special (0.5) follow up or treatment that they ought to have [(0.5.)]

02 PM [mm]

03 K1 [then] you’d be able to make sure they’ve got it (0.5) but in fact =

04 PF [mm]

05 K1 = there is no treatment that (0.5) um (0.5) significantly alters the course of this condition (0.5) apart from treating blood pressure if it’s high (.) and treating infections if they occur [(1.0)]

06 PF [*mm*]

07 K1 (*it’s possible*) in future we [might]

08 PM [yeah]
09 K1 (.) have something different but that’s all we can (.) recommend at the moment (0.5) and we could of course check the blood pressure and make sure urine infections are treated (0.5) even if people didn’t have the scans to test for this condition so (0.5) you know if you wanted (.) the two smaller children could have um (.) an annual check up in our clinic just for (.) blood pressure and (0.5) uh and that’s the main thing we’d do (0.5) um (.) even if they hadn’t had the scans to [say]

10 PM [yeah]

11 K1 they’ve got the cysts (0.5) ((sound of door)) um (1.0) so um (.) w- we (1.0) we’re not pressing you at all (0.5) for them to have tests (0.5) um (.) >>*you know*<< specially in your in your family as (0.5) it sounds like it’s quite a mild problem

12 PM yeah

13 K1 um (0.5) if of course they (.) they developed a problem that needed to be investigated we’d say (0.5) should we investigate it in its own right (1.0) uh (0.5) the disadvantages of (.) children having tests (0.5) um (0.5) might be that (0.5) if the child was found to have a problem (0.5) they might be treated differently they might be treated as (0.5) sickly or (.) weakly (0.5) u::m (.) and um (.) it might cause extra anxieties either to yourselves or or to the child (0.5) [uh]

14 PF [mm]

15 K1 and then (.) when they’re they’re older (0.5) it might interfere with (.) certain careers they might want to (.) follow like um the armed forces might (0.5) not be willing to take them or um sometimes with insurances (0.5) um (0.5) they either give you a loaded premium or they won’t insure you (.) if you have certain conditions (.) so there are drawbacks [to]

16 PM [mm]

17 K1 having them tested young (1.0) u:m (1.0) I don’t know whether you’ve (.) thought at all about whether the children should have tests

18 PF *mm*

19 PM (haven’t spoken ^^^)

20 K1 not really no no I mean it’s not a pressing issue at all (0.5) um (.) then of course there is the question of whether the children should have the opportunity to decide for themselves (.) [and]

21 PM [yeah]

22 K1 of course if you’ve already done it (0.5) then they don’t have that (0.5) opportunity to decide for themselves (0.5) but it is worth thinking as they get to teenage (.) um that it’s probably fair that they should at least have the knowledge that this problem is going on in the family because if they don’t have knowledge (0.5) they don’t have any (.) choices (0.5) and uh (1.0) again they themselves can ask either for more information (0.5) (okay) from yourselves or (.) or from ourselves whichever is easy (but quite often) the GP (.) and (.) they can (0.5) consider whether they want to be tested (.) um (1.0)
in their own time and (0.5) they need to know about the advantages and disadvantages obviously (.) but in addition they need to be able to (0.5) um (.) take on board the fact that it is a genetic condition and therefore they might want to (0.5) take that into account when they’re planning their own families

What follows is the correspondence between SS and AC, selectively, based on SS’s analytic commentary on the above data extract.

SS: “K1 provides the information about the pros and cons of childhood testing in the form of a list structure. The list begins with the positive aspects (01-09), perhaps to align with and consolidate upon what parents might already know and expect, e.g., possible treatment scenarios following a diagnosis. However, this is immediately disclaimed – keeping with the professional stance against childhood genetic testing – although concession is made about possible future intervention.”

AC: “Top page 11, sentence 2 (However, this is immediately disclaimed – keeping with the professional stance against childhood testing). I disagree with this on two counts: (i) the “we’re not pressing you” statement is an attempt to retain equipoise, NOT to persuade one way or the other. The next statement (about weak family history) is getting at something else – the family history is strong (no doubt about it) but the pattern of disease is less severe than usual SO (i) the risk of severe disease in the child is less, even if they inherit the PKD, and (ii) this may have implications for which particular gene locus is involved (PKD1 or PKD2).

SS: “As we can see, the list of disadvantages outweighs the advantages with K1 deferring to the child the key decision making role, which amounts to delaying the parental decision about testing. A regular check-up of blood pressure and infections, rather than a genetic test, is proffered as a justifiable solution.”

AC: “At end of that same para, you interpret K1 as recommending that the child should not be tested until older. Maybe it came out that way but it was not her intent. K1 was trying to be ‘balanced’ – countering the list of reasons for testing that were given earlier. She is bearing in mind the very real limitations of testing (the difficulty of doing a linkage study in this family, the often inconclusive results from scans in childhood). She asks the parents if they have decided whether or not to request testing now and reassures them that there is no need to make a rushed decision. The limitations of testing provide part of the background – you can hardly recommend testing as the preferred option when you know that you are unlikely to be able to deliver clear results. I take this whole performance as an attempt to remain neutral,
Parental decision about testing the child is neither endorsed nor objected to as part of being professionally neutral in the face of uncertainty of test results. Through his comments AC is appealing to the broader family context, including the entire consultation. As a discourse analyst, SS’s interpretation attributes to K1 a preference for non-testing which may be contextually myopic and therefore misleading in terms of intentionality underpinning routine professional practice. For AC, the preference for non-testing does not count as neutral and this amounts to a divided sense of expert judgements (unlike division of expert labour between K1 and G1). As far as SS is concerned, there are no discursive cues in the local interactional environment to support a more neutral reading of K1’s communicative behavior. It is worth noting that if K1, instead of G1, were to comment in this instance, she may or may not align herself with G1’s interpretation. The ‘knowing how’ stance of a discourse analyst may seem constrained in a situation where the intentions behind communicative behaviour are not explicitly cued.

With regard to ‘knowing that’ and ‘knowing how’, what is manifest in talk and what might be the intention underpinning professional practice may constitute ‘interpretive variability’. The disagreement is heightened further in this particular situation as professional neutrality remains a central tenet of genetic counselling practice. The exact communicative dimensions of neutrality may not be so easily understood or shared both within the genetic counselling profession and across disciplinary/professional boundaries.

Let us consider a further extract from the same counselling session where the parent articulates her sense of guilt about testing the child – as a precondition for proceeding with her future pregnancy.

DATA EXTRACT 2

01 PF yeah I think I just wanted um (.) a bit more knowledge about what could happen because (.) like you said I could go through life and have (.) no problems at all in (.) but I d- (2.0) uh I didn’t know whether (.) would it be
selfish of me to have more children and pass it on to them then they’d have to (.): deal with what [(0.5) you] know I di- =
02 N2 [mm yeah]
03 PF = you know that I’d have to pass on all what I know about all this [(.] like mammy’s had to tell me (.) what she knows about it
04 N2 [yeah]
05 K1 I mean do you understand what are (.) the worst [possible things]
06 PF [yeah yeah]
07 K1 that can happen so (.) [you know (^^^^) at the best end of the situation]
08 PF [but when you look at it like that you think well (.) yeah that’s it yes] (gap)
09 G1 yeah I suppose the chance of of a young baby (0.5) uh (0.5) inheriting the PKD and being ill from it as a young child (.) is is not zero but is really rather small [(1.0)]
10 PF [yeah]
11 G1 so the vast majority of people with PKD wouldn’t (.) get health problems from it (.) in pregnancy (.) I mean s- in infancy or [(.] childhood really (1.0) s- much more likely =
12 PF [yeah]
13 G1 if it were to be a problem for another child [(1.0) to to] yes I mean =
14 PF [it would be like the same age as I am or whatever is it]
15 G1 not to show itself until adult life (.) as as a problem [(1.0)] =
16 PF [yeah]
17 G1 but occasionally it will (1.0) in younger but it would be very unusual (.) not (.). I’ve not got a percentage in my head for [that ((K1)]

The following is the correspondence between SS and AC, selectively, based on SS’s analytic commentary on the above data extract.

SS: “The implicitly positive endorsement for a future pregnancy is facilitated by discounting the chance of a young baby inheriting PKD. This no doubt contributes to an understanding and assessment of causal responsibility. The knowledge that a genetic test procedure involves more than simple blood extraction from herself and that an elaborate testing protocol involving other family members can still deliver an inconclusive result contribute towards PF’s decision not to go ahead with the test, which is evidenced at the close of the encounter.”

“This then forms a robust basis for safeguarding the child’s autonomy and their best interests.”

AC: “So I have reservations about that sentence, which represents the professionals as always wanting to defer testing. Well – not in this disease.
And I think your interpretation of the data has been distorted a bit to let you say what you want to say.”

“I hope I am not being too unfair – you will probably find lots of counter arguments – but I think you should revisit your data analysis sections. It will not alter what you say about the theoretical aspects and would actually make the paper much more interesting as exemplifying the attempt of two professionals to work for neutrality (an active non-directiveness, trying to ensure that parents get what they want – once they have understood the situation they are in).”

The divided expert accounts here directly bear on data analytic claims, especially the language of interpretation. AC’s objection alludes to the negative casting of the genetic counsellor who potentially comes across as being indifferent in deferring childhood testing as opposed to displaying a form of ‘active non-directiveness’. Such differential characterisation of professional practice – directiveness vs. indifference vs. active non-directiveness – is not benign and has consequences not only for the individual professional involved but also for the profession as a whole. The genetic counselling profession is premised on an ethos of non-directiveness (parallel to the principle of neutrality in mediation), so its discursive manifestation needs to be carefully categorised and safeguarded. While this professional commitment to non-directiveness (knowing that) is easy to uphold, the difficulties lie in identifying corresponding discursive evidence (knowing how).

Let us return to the earlier distinction between ‘seeing as’ and ‘seeing that’. Both SS and AC are engaged in ‘seeing that’ which underpins ‘interpretative variability’. Drawing on Goffman’s (1974) notion of ‘frame’ to refer to ‘schemata of interpretation to locate, perceive, identify and label’ phenomena, here we have a case of both over- and under-interpretation of discourse data vis-à-vis participants’ intentionality. The risks associated with non-negotiation of interpretations can be high on both sides: the professional practitioners adopting a sceptical stance to discourse analytic findings; and the discourse analyst having very little impact in trying to inform and change professional practice.
6. Conclusion

This chapter has primarily been about the bounds of interpretation – across different domains of expertise and authority in the healthcare setting. Expert interpretive authority may be claimed as the basis of knowledge (knowing that) and/or experience (knowing how). Discourse analysts are more likely to appeal to what is evidenced in the data – directly or indirectly – in the spirit of Lockean empiricism, ‘light arising from the nature of things themselves’. Discourse analytic interpretation is therefore indeterminate, especially in relation to intentionality underpinning participants’ communicative behaviour. Such indeterminate accounts may be seen as unsatisfactory, but any ‘definitive versions’ are likely to be equally unsatisfactory ‘because they imply unjustifiably that the analyst can reconcile his version of events with all the multiple and divergent versions generated by the actors themselves’ (Gilbert/Mulkay 1984: 2). The interpretive framework adopted by the discourse analyst is always underpinned by presuppositions and prior experiences. As Chisholm (1966: 56) suggests:

*Experience, in one or another of its various sources, is said to be the source of our knowledge; every valid claim to knowledge, it is supposed, will satisfy certain *empirical* criteria; and these criteria, it is then concluded, may be used to determine the extent of our knowledge. Empiricism thus begins paradoxically with a general premise.* [Emphasis in original]

In spite of the indeterminacy of interpretive frameworks in discourse analytic research, one feels compelled to make their interpretation count. Translational research, i.e., translating research findings into practice, is becoming the order of the day. In this context we need to ask: Can discourse analytic findings impact upon the culture of everyday professional practice? What are the challenges associated with interpretation of data as well as interpretation of findings? The nuances surrounding the different interpretive stances have been the focus of my reflections in this chapter. I feel open dialogues between experts belonging to a community of interest, albeit hailing from
different communities of practice/discourse/interpretation, are a necessary – but not sufficient – condition for triangulating interpretive preferences, and consequently enhancing translationality of discourse analytic findings.

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Appendix: Transcription conventions

G1 genetic counsellor
K1 kidney specialist
N genetic nurse
PF/PM parent female/parent male
CF/CM child female/child male
(.)(...) (...) micropause/pauses up to one second/pause exceeding one second
((gap)) an interval of longer length between speaker turns and an approximation of length in seconds
*word* decreased volume
>> << accelerated pace
underlining increase emphasis as in stress
question mark [?] rising intonation
- cut-off of prior word or sound
[text in square brackets] overlapping speech
((text in double round brackets)) description or anonymised information
(text in round brackets) transcriber’s guess
(^^^^^^) untranscribable
= a continuous utterance and is used when a speaker’s lengthy utterance is broken up arbitrarily for purposes of presentation.