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Asymmetrical Roles and Conflicting Expectations in Institutional Talk: An Analysis of Verbal Autopsy

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ABSTRACT

This study addresses the research gap in doctor-death informant interactions within verbal autopsy (VA) contexts, examining these interactions as unequal encounters through institutional interaction research. The study aims to analyse the content, structure, and function of question-and-answer exchanges in VA interviews, explore conflicting frames, and identify opposing discursive strategies. It connects microanalysis to the broader sociocultural context, viewing VA as a regulatory practice reflecting local health unit procedures. Data were collected from 64 death informants and two rural municipal health physicians in Northern Leyte, Philippines. Interviews were conducted using WHO's Standardised Verbal Autopsy guide, and the interactions were transcribed and analysed for topic, question type, question-answer sequence, and alignment with institutional roles. The study reveals that doctors, as institutional authorities, control the interaction, with informants recognising this asymmetry through honorifics and apologies. Conflicting frames of expectations between doctors' objective questioning and informants' subjective responses lead to interactional struggles. These struggles are exacerbated by the informants' emotional instability, potentially compromising the reliability of death reports. The overwhelming VA process challenges doctors' decision-making capabilities, leading to the imposition of institutional authority. The study highlights the need for VA training that considers the psycho-socio-cultural contexts of informants to improve the quality of health information systems. Understanding interactional barriers and implementing research-based communication strategies can enhance doctor-informant relationships and institutional protocols. Policymakers might better address the need for context-sensitive VA training. Future research could explore variations in death reporting across different regions and the psychological experiences of doctors and informants.

Keywords: asymmetry of roles; frames of expectation; institutional talk; verbal autopsy

INTRODUCTION

Research into talk within institutional environments such as courtroom interactions, medical consultations, news interviews, and mediation has generated significant cross-disciplinary interest. This is due to its potential to reveal how institutions are “talked into being” (Heritage, 1984, p. 290), demonstrate the interface of power and conversation analysis (CA) (Ekström & Stevanovic, 2023), highlight how institutions impose limits on people's actions (Alasuutari, 2023), outline the competencies required for professional conduct (Hassan et al., 2021), and provide advice to individuals and organisations on managing practical problems for smooth and effective practice (O’Reilly et al., 2020; Ten Have, 2002). Fairclough (1995) describes an institution as a unique speech community with specific speech events characterised by settings, participants, and norms (p. 38). Institutional interaction is seen as more restricted than casual conversations because certain conversational elements are excluded (Ten Have, 2002).

Research on institutional interaction provides a foundational understanding of the dynamics present in the doctor-informant talk. It highlights that such talk is "goal-oriented, subject to specific constraints, and linked to inferential frameworks unique to institutional contexts" (Drew & Heritage, 1992; Ten Have, 2002, p. 5). Participants had to follow strict procedural and discipline-specific guidelines to avoid miscommunication (Hamzah & Wong, 2018). They inherently adopt an "overall instrumental orientation," leading to unequal discourse rights and obligations (Ten Have, 2002, p. 5). Boxer (2002) notes that public sector encounters create two opposing roles, the institutional representative and the client, often resulting in frustration due to power imbalances (Alasuutari, 2023). Civic discourse demonstrates how institutional procedures enforce a rigid turn-taking sequence, thereby stifling citizen participation (Farkas, 2012). In public forums, an "instrumentalised discourse" is employed, where public participation is restricted by boundaries set by city officials. This limitation pertains to whether questions or suggestions can be accepted, heard, or recommended for action (Hodge, 2005, p. 173). In leader-follower interactions, leaders may exert authority over followers without challenge. However, tension arises when this authority is contested, including when a client refutes a leader's assertion (Chan et al., 2019, p. 9). Tension in institutional encounters can lead to escalation. Klein (2018) reports a police encounter incited by anger, resulting in an arrest and, tragically, the citizen's death. The root cause was identified as institutional flaws, including inadequate mental health training among jailers. These studies illustrate interactional struggles, which provide the backdrop for investigating tension in the doctor-informant talk.

In medical contexts, the relationship between practitioners and patients is often problematic. Patients may perceive the language used by practitioners as impersonal, seeing themselves as "objects," which can lead to their explanations being overlooked during medical visits (Maynard & Heritage, 2005, p. 432). Patients expect doctors to acknowledge their explanations, even if premature (Maynard & Heritage, 2005, p. 432). Similarly, the nurse-patient relationship is fraught with differing perspectives. Nurses view patients as part of routine work, focusing on safe and effective care delivery, while patients see this approach as impersonal and lacking in genuine care (McLean et al., 2016). These findings informed our decision to adopt a critical perspective on conversations as a form of social action in VA. These interactions occur at the local health level and are part of the broader national health information system, making them a suitable subject for investigation.

As a method, the VA determines probable causes of death by conducting interviews with family members or caregivers regarding the symptoms and events leading up to the death (World Health Organisation, 2024). Studies on verbal autopsy have highlighted its utility in generating cause-of-death data in settings lacking robust civil registration and vital statistics systems. For instance, Bailo et al. (2022) discussed its applicability in specific healthcare contexts, emphasising that verbal autopsy could soon become a highly valuable tool for understanding natural or accidental deaths and forensic investigations. Mahesh et al. (2022) provided a systematic review validating verbal autopsy methods, which aids the formulation of guidelines for VA validation procedures. Additionally, Billah et al. (2024) provided policy recommendations that call for suitable interventions aimed at strengthening the health system through their study of the causes of under-five mortality in urban slums in Bangladesh. While these studies have been conducted for system and policy improvements, such VA studies are limited to improving the scope, applicability, and validity of questions to consider in VA, and they fail to explore how understanding the frames of VA may affect the overall quality of the details of death. It must be noted that VA is a type of institutional talk similar to other settings where context creates power

imbalances between healthcare professionals and death informants. Ignoring the different orientations in VA means missing potential interactional struggles. Surek-Clark (2020) points out that fieldworkers act as interpreters and cultural mediators, facing linguistic and cultural challenges during verbal autopsies. Yet, these studies often overlook death informants' perspectives. Studying VA interactions enriches research by questioning the nature of institutional discourse in these settings. Although VA is known for its power disparities, research on interactional challenges remains scarce. The study investigated VA interactions as unequal encounters, guided by a combination of theoretical frameworks that consider both the local context of ongoing utterances and the broader institutional frameworks (Drew & Heritage, 1992; Ten Have, 2002). It aims to (1) analyse the topic, question type, question sequence, and alignment of doctor-informant roles to the institutional context in VA interviews in order to reveal their asymmetrical roles, (2) explore the conflicting frames, and (3) identify opposing discursive strategies. By connecting microanalysis to the larger sociocultural context, the study views VA as a regulatory practice reflecting local health unit procedures. The findings aim to assist healthcare organisations and similar institutions in enhancing stakeholder interaction skills, institutional protocols, and actors' roles and expectations.

THEORETICAL FRAMEWORK

This research employs Todd's frame conflict analysis (Prego-Vazquez, 2007; Todd, 1983) as its overarching framework. The choice is driven by the asymmetrical roles of participants in VA interactions. Frame conflict analysis effectively elucidates this asymmetry, as it highlights the opposing frames represented by the two parties within the context of an institutional interrogation. In addition, it also utilises a combination of four other frameworks. In unison, these frameworks enable a thorough examination of the depersonalised authority of doctors versus the personalised subservience of informants, providing a nuanced understanding of the unequal power relations in death-reporting interviews. Haworth (2006) provides a framework for analysing the structure of interviews in VA, while Morales-Lopes et al.'s (2005) categories of discursive strategies depict the opposing strategies of doctors and informants. Canagarajah's (1993) and Mahon and McPherson's (2014) critical approach to ethnography offers a deeper understanding of the power structures and social contexts influencing these interactions. Finally, Tracy and Robles' (2009) perspectives on questioning and institutional practices complete our theoretical and analytical tools, establishing that the unequal encounter and conflicting frames in institutional interaction are constructed and represented in questioning.

FRAME CONFLICT ANALYSIS

Frame conflict analysis is applied to identify traces of tension and interactional struggles in VA. Frame refers to people's "definitions of a situation" (Goffman, 1974; Gordon, 2015 p. 324). Gordon (2015) retraces the concept of the frame to Bateson's essay in 1972 on zoo monkeys' capability to shift from an aggressive act of nipping to a similar act within a 'play frame,' elaborated by Goffman in his Frame Analysis in 1974. Informed by CDA, the concept of frame conflict was introduced by Todd (1983) as cited in Prego-Vazquez (2007) as a "basis for explaining how differences between the value systems and knowledge schemas of institutions and the lay world represent a cause for misunderstanding" (p. 299). Frame conflict analysis best examines linguistic strategies utilised by interactants, especially in institutional encounters (Prego-Vazquez, 2007).

INTERVIEW ANALYSIS

The analysis of verbal autopsy in this study draws on principles of conversation analysis (CA), focusing specifically on the sequential organisation of talk rather than the formal analysis typical of the CA tradition. In response to the first research question, the analysis of the verbal autopsy as a clinical encounter utilised Haworth's (2006) interview analysis, focusing on the following: 1) topic, 2) question type, 3) question-answer sequence, and 4) alignment to or identification with institutional roles. Since verbal autopsy is hardly explored in the medical field, this analysis is significant as it aims to describe its main features and establish it as a form of institutional talk. Exploring the features of VA as part of the analysis answers questions about the unexplored nature of VA as an institutional talk.

PERSONALISING AND DEPERSONALISING STRATEGIES

In analysing the linguistic strategies employed by the participants in this study, the categorisation of linguistic strategies found in the data is based on the study of Morales-Lopes et al. (2005). It divides the strategies into two discursive strategies: (1) personalising strategies and (2) depersonalising strategies. The former emphasises personal experiences and subjective viewpoints, while the latter focuses on presenting information in an objective manner. In their study, these two discursive strategies emerge within the conflicting relations between the institution and the individuals caused by their "differing interpretive frames" (p. 248). Hence, in this study, the projected conflict that arises between the institution (represented by the municipal doctor) and the death informants is categorised by the same discursive strategies used by Morales-Lopes et al. (2005) since VA emphasises face-to-face interaction characterised by similar asymmetrical and conflicting relations between participants contained within the same institutional setting.

CRITICAL APPROACH TO ETHNOGRAPHY

The analysis of social actors in this study is also underpinned by Canagarajah's (1993) critical approach to ethnography, which goes beyond its descriptive direction. Critical ethnography guides research into people's everyday experiences while being sensitive to issues of power and equity. This study also utilises Mahon and McPherson's (2014) extended definition of critical ethnography, which refers to the use of power in social interactions and the structures in which these interactions take place. The employment of critical ethnography provides a detailed account of practice and explores how differing degrees of power and privilege influence participants' work lives. Like Mahon and McPherson's (2014) argument, the use of critical ethnography in this study aims to shed light on the two participant roles: (1) as doctor-interrogator and (2) as death informant. Our analysis of interviews may reveal 1) the extent or limitation of their resources, which can enable or constrain their roles, 2) how they employ discursive strategies to counter constraints, and 3) how the institutional representatives employ measures to maintain their institutional control.

QUESTIONING AND INSTITUTIONAL PRACTICES

Institutional interactions often involve unequal encounters and conflicting frames, primarily constructed through questioning, which is deemed a central communicative practice (Tracy & Robles, 2009). These interactions follow a predetermined agenda such as delivering a sentence, making a diagnosis, or closing a deal, which must be achieved for the conversation to conclude.

Questioning facilitates the negotiation of goals and reflects institutional values and identities. Tracy and Robles (2009) identified questions as multifunctional: they ascertain the truth, elicit realities, and challenge norms. Their review of questioning across seven institutions, namely, medicine, policing, court sessions, education, research interviews, therapy, and mediated political discourse, has enhanced their understanding of unequal encounters. They noted a lack of research on doctor-death informant talk, highlighting the significance of this study in contributing to the limited literature on death reporting.

METHODS

PARTICIPANTS AND SETTING

A country's strong record of vital statistics provides a demography of death and its causes, pinpoints health inequalities, and evaluates outcomes of health programs (World Health Organisation, 2010). It also helps policymakers achieve targeted outcomes. However, while deaths in developed countries occur in hospital beds (Kawashima, 2018) and records of death details are readily provided, in many rural areas of poorer countries, deaths occur away from health facilities, so that a verbal autopsy (VA), is held to be "the only practical option" (World Health Organisation, 2010).

The peripheral positions of local health units compared to city health units in the Philippines make them interesting sites of struggle as the former are on the outskirts of urbanised environments with poor access to delivery of goods and services. Hence, for this present study, we recruited two rural municipal health physicians and sixty-four (64) death informants from two of the rural municipalities of Northern Leyte, Philippines, which have a total combined population of 90,147 (Cities and Municipalities Competitive Index, 2024). The participants spoke in Waray, using a few borrowed English words for medical terms during the talk. The two doctors were the assigned doctors in the two municipalities at the time of data gathering. Only cases of deaths which transpired outside the hospitals were included in the study. Such cases would then require an interview of a death informant in order for the doctor to get the details of the death. Of the 64 death informants, who were between the ages of 40 and 60, 90% were women. They were relatives of deceased individuals who passed away outside of hospital settings during the five-month data collection period.

INSTRUMENT

The study centres on verbal autopsy data gathered through interviews with family members of the deceased, conducted by municipal doctors using WHO's Standardised Verbal Autopsy guide. This guide includes questions designed to identify causes of death by collecting information on symptoms, medical history, and circumstances surrounding the death. It begins with preliminary questions about the deceased's identity and demographics, ensuring that the informant is qualified to provide accurate information. If necessary, doctors can request a more suitable informant. The medical history section addresses chronic illnesses, past treatments, and symptoms before death while also exploring the circumstances and location of death. Questions about injuries or external causes are included, along with a narrative section for personal accounts of events leading to death. Doctors use both structured and follow-up questions, with the flexibility to ask additional questions as needed.

PROCEDURES

DATA COLLECTION

The interviews with informed consent from the participants were conducted within five months. Prior to this, the town mayor's approval for the data collection was sought. The first author conducted pre-interview briefings with the death informants to explain the purpose of the data collection and the recording of their interaction with the municipal health physician. Also, personal interviews with the physicians and field notes were used as supplemental data in analysing the recorded VAs. The first author also volunteered to be part of the municipal health staff to immerse herself in the day-to-day activities of the municipal health centre during the duration of the study in order to contextualise our analysis within the institutional and sociocultural contexts of death reporting in the local health units. The recorded VAs were transcribed and translated by two English teachers who are Waray speakers. The authors then checked these to ensure the accuracy of the transcription.

DATA ANALYSIS

The verbal autopsies recorded were transcribed following Coates' (2003) codes. Since the local language was used in verbal autopsies, translation of the exchanges was provided. As mentioned earlier in the study, the analysis of the talk was informed by Conversational Analysis but was only limited to the sequential organisation of the talk. Hence, the unit of analysis was per turn taken. The transcription codes were placed in the segmented turn-taking sequence.

Haworth's (2006) interview analysis was used as the analytical framework in analysing the 1) topic, 2) question type, 3) question-answer sequence, and 4) alignment to institutional roles of the doctor-informant talk. The concept of frame conflict by Prego-Vazquez (2007) was used as a "basis to explain how differences between the value systems and the knowledge schemas of institutions and the lay world represent a cause for misunderstanding" (p. 299). In analysing the contrasting strategies utilised by the participants, we used Morales-Lopez et al.'s (2005) two discursive strategies: (1) personalising strategies and (2) depersonalising strategies. In order to ensure validity and reliability in analysing the data, two experts were commissioned to verify the codes assigned to the differing frame conflicts and the opposing linguistic strategies used by the two parties. Differences in assigning codes between the two experts and the first author were discussed until a 100 per cent agreement was reached.

RESULTS

ASYMMETRICAL ROLES REVEALED IN THE ANALYSES OF TOPIC, QUESTION TYPE, QUESTION SEQUENCE, AND ALIGNMENT OF DOCTOR-INFORMANT ROLES TO THE INSTITUTIONAL CONTEXT

In this section, we explore who controls the topic, what kind of questions doctors dominantly use, what question-sequence the doctor-informant talk follows, and whether there was an alignment of roles to the institutional context in order to uncover whether asymmetrical roles that cause tensions occur in VA.

Topic in doctor-informant talk

The doctor has full control of the topic during the interaction. Upon establishing the purpose of the client, the Doctor, being the solely recognised institutional authority, interviews while the death informant responds to questions that the Doctor asks.

A typical doctor-death informant talk starts with an information-seeking question, as shown below:

D= Doctor ; DI = Death Informant

1. D: WHEN did he die?
2. DI: yesterday=
3. D: =what TIME?
4. DI: at eleven o'clock=
5. D: MORNING?
6. DI: yes/

In this series of exchanges, D is determined to establish the details of death before the person's death. As seen in the turn-taking exchange, D initiates the interrogation using the Wh-questions. D emphasises "WHEN" in line 1, "*WHAT TIME*" in line 3, and "*MORNING"*, asking DI if the death occurred in the morning in line 5. In all instances of the Doctor's interrogation, the informant fails to provide precise details, so the Doctor keeps on asking follow-up confirmation-seeking questions.

Question types in doctor-informant talk

(1) Information-seeking question

An information-seeking question is structured as Wh-questions. This type asks for specific details of death, particularly exact names, dates, frequency, duration, dimensions, and amount, among others. The accepted responses are treated as pertinent data.

Examples of these are as follows:

1) HOW MANY years did he stay bed-ridden?
2) HOW MANY days had he been coughing?

Information-seeking questions serve as core questions of the verbal autopsy conducted by the Doctor since responses to this type of question become the basis for the Doctor to determine the cause of death.

(2) Confirmation-seeking question

Structured as a yes/no question, this question type provides the informant with the convenience of opting between two response choices. For example:

1) Did he have a FEVER?
2) Is he BED-RIDDEN?

This question type reveals the doctor-participant's speculative direction and provides the Doctor the impetus to sort out for the informant two possibilities to choose from, thereby achieving the objectivity and precision of responses the Doctor intends to maintain.

(3) Explanation-seeking question
Explanation-seeking, which demands a more elaborative rendition of the details prior to the death, is structured as the "Why" or "How" questions. Examples from our dataset are as follows:

1) HOW did you make her eat?
2) HOW did you KNOW that she was feeling pain in the stomach/ when she couldn't talk?

Responses to this question type help the Doctor patch the missing pieces to complete the hazy reportage. These questions reflect how the Doctor does the work of revising earlier informative-seeking and confirmation-seeking questions to explanation-seeking questions to elicit accounts of reality.

(4) Accusatory question
Accusatory question is the least used question-type used by the doctor. Some examples are as follows:

1) How could you afford to see her in her worst condition?
2) Why did you not take her to the hospital/ when you knew she couldn't get up anymore?

This question type goes beyond mere explanation and leans toward its underlying accusative tone. Here, the asymmetry of speaking rights is exposed when the legitimate authority of the Doctor is fully enacted. The questions accentuate a threatening stance that purposively puts the informant on the spot.

Question-answer sequence in doctor-informant talk

Typically, the Doctor ushers the informant inside the Doctor's clinic as the Doctor's way of initiating the talk. When an informant arrives next in line, the Doctor becomes particularly anxious about the long line of patients waiting outside. Hence, when an informant is ushered in, the Doctor skips the reply to the informant's greeting. In response, the Doctor might say, *"Have a seat"*. Such an expression typically initiates the talk, which becomes the Doctor's way of greeting.

The Doctor also opts for a more straightforward information-seeking question such as *"How are you related to the deceased?" or "When did the person die*?" This type of opening question acts as a gatekeeping measure so that when the informant fails to prove their legitimacy as an informant, the interview is aborted. When this is established, the interrogation begins.

Similar to the opening, the closing is usually never formally performed. Take, for instance, the following closing exchange:

53. D: TAKE this to the LCR/ you GO BACK to LCR to—
54. DI: [But the embalmer hasn't signed=]
55. D: = Ah, is there no SIGNATURE? ok, have it signed first/
56. DI: Thank you, Doc/

In most cases, D indicates the cause of death and affixes his signature. When this is done, D hands the document to the DI and says, "*Okay*", and starts to call the next client in line. In this case, the closing is not formally performed but understood.

Alignment of roles

In all instances of the talk, the death informant has recognised the institutional authority the Doctor holds. The honorific "Doc" *(clipped form for* Doctor*)* was most commonly used by the informant when addressing the Doctor.

1) When I checked on her the next morning, Doc, she was gone/
2) She is hypertensive; Doc/

Also, expressions of apology such as *"sorry, Doc" are* used when they fail to meet the expectations of the Doctor. An expression of gratitude such as *"thank you"* is used to recognise the Doctor's assistance as he fulfils his institutional role as the authority in death reporting protocols.

In this section, it is clear that the topic, the questions that the doctors ask, and the question-sequence of the talk are clearly controlled by the doctor-interrogator. As a gatekeeper, the doctor decides if the interrogation is ended or extended. When the doctor shows discontent in the responses, the death informant readily expresses apologies for appeasement and tries to provide more information in the hope of gaining the doctor's approval. Hence, the asymmetry of roles is consistently apparent, revealing power imbalance and tension during VA interaction (Ekström & Stevanovic, 2023). This finding corroborates Drew and Heritage's (1992) and Ten Have's (2002) findings that institutional talk is restrictive and imposing.

CONFLICTING FRAMES OF EXPECTATIONS IN THE DOCTOR-INFORMANT TALK

In the following analysis, the contradictory frames of the two parties become evident. The Doctor expected straightforward reportage, but the informant failed to do so—giving the Doctor the exact opposite. Our analysis of the doctor-informant talk revealed four categories of conflicting frames of expectations, as discussed below.

(1) Clear versus vague responses

The Doctor's expectations for a clear description of occurrence conflict with the informant's vague descriptions. Take, for example, the following extract:

16. D: What's the INTERVAL of the baby's breastfeeding time?
17. DI: about 4 hours, if— then he gets weak/
18. D: Except during breastfeeding, does he NOT move often?
19. DI: he moves/ but when he turns on one side, he only, sort of, like— 'you know, like that'/

20. D: =WHAT DO YOU MEAN by that, you know, like that? <a bit irritated> Now, you better explain clearly what you REALLY MEAN by 'you know, like that'?/
21. DI: he turns on one side, you know when babies are still incapable of— like they are limited to just lying on their back/ but he would… he would—he would lean on one side=

In this extract, D targets factual information such as number, frequency, and other details. The female informant, in line 17, is questioned again for further details, but she fails to provide an accurate term that describes the baby's movements. D retorts her frustration and utilises her legitimated authority to demand from the informant a more accurate use of words. In line 20, tension arises as D shows exasperation. This is felt in a raised tone with the words, "*WHAT DO YOU MEAN by that 'you know, like that'?"*. Here, the doctor is losing patience. The death informant, feeling the doctor's frustration, tries to rehash the response and, in the middle of the utterance, continues to reword it and commits many repetitions. The asymmetry of roles is continually felt as the informant hopes to seek the approval of the doctor.

(2) Precise versus imprecise responses
The Doctor's concept of informative data continually conflicts with the informant's frame. Take, for example, the turn-taking exchange below:

3. D: [HOW MUCH blood was expelled?]
4. DI: A lot, Ma'am/
5. D: =one, one—HALF a pail? ONE pail?}
6. DI: I don't know/ because he had washed it away with water/
7. D: approximately how much? HOW MANY litres, perhaps?
8. DI: There was so much blood, Ma'am, because —
9. D: [More than TWO litres?]
10. DI: Because when we came, he was already so pale/
11. D: Was he already PALE?/Was there a profusion of blood coming out?
12. DI: The blood was even coming out of his nose/

In this instance, D is able to utilise six confirmation-seeking questions since the informant is unable to provide precision. In the attempt of the Doctor to extract the accuracy of data, two of D's turns—as can be seen in lines 5 and 11—come in a series of questions. Here, the informant's concept of a massive amount of blood conflicts with the doctor's demand for exploitation, qualified in terms of a concrete measure. As the informant provides an imprecise response, the doctor insists on a specific detail by providing two possibilities to choose from. However, even when D utilises a confirmation-seeking question to give the informant two options, the DI refuses to consider and hesitates to do an estimated measure, showing the resigned uncertainty of the dead informant.

(3) Direct versus indirect responses
Informants were often preoccupied with providing the Doctor with subjective details, and they failed to answer the question directly. In this exchange, D asks whether the person gets her daily maintenance medicine or not. However, DI does not answer this question directly. The informant

first highlights her feelings of frustration, then reveals that the person refuses even to see her Doctor for a year:

25. D: Didn't she have her MAINTENANCE?
26. DI: OH, DOC/ that was what her doctor was furious about /because she only visits the clinic when her condition gets worse/Would you believe she didn't see her doctor for over a year?
27. D: =For HOW LONG?
28. DI: one year/

Here, D accepts the response given, and he is forced to deduce from it. In a strict sense, the question is not directly answered, and D relies on the available response provided by DI.

(4) Short factual response versus lengthy narratives
Informants provided lengthy narratives instead of short responses. In this instance of talk, the confirmation-seeking question asks for a "yes" or "no" response and yet the informant provides a lengthy response. On the second turn, D acquiesces while DI takes the floor.

23 D: Was she brought to the hospital?
24 DI: No Doc/ because on Thursday of that week /we brought her to the District hospital/ and they told us:/ 'You take her to St. Paul's hospital since she got confined there earlier/
25 D: ah—
26 DI: They wouldn't accept her / because they thought it would be better to take her to a bigger hospital like St Paul's/

The differing frames of expectations between the Doctor and the death informants confirm the different orientations of the two parties in question, as established by Todd (1983) and Prego-Vazquez (2007). On the one hand, the Doctor embodies a medical perspective framed by objectivity. Verbal autopsy is found to be communicatively structured, utilising the clinical framework. On the other hand, the death informants are orientated to subjectivity at all times. Their facts are narratives wrapped in reveries and memories that sometimes fail them, and their responses are imbued with personal meanings, which clash with the Doctor's objective frame. These conflicting frames cause interactional struggles between the two parties.

PERSONALISING VERSUS DEPERSONALISING STRATEGIES IN THE DOCTOR-INFORMANT TALK

In order to consistently highlight the differing frames of expectations of the two parties, the analysis of the doctor-informant talk in this section is discussed to reveal the contrasting strategies used by both the Doctor and death informants. The first section tackles the personalising strategies utilised by the informants. In our analysis, the informants recognise that the Doctor, as an institutional authority, has the right to accept or reject any or all of their qualifications as informants. Since gatekeeping affects requests for death certification services, these depersonalising strategies were used to seek gatekeeping approval from the Doctor in order to be provided with the service an informant requested.

(1) Use of honorifics and apologies to compensate for unsubstantiated information
Apologies and honorifics show the informant's affiliative and harmonious efforts in the institutional interaction, as shown below:

(1) Thank you, Doc.
(2) Sorry, Doc.

(2) Use of a monologic structure to qualify the informant's narrative
The use of a monologic format in the informant's narrative provides a more personal appeal to the interviewee:

19. D: Did she NOT complain?
20. DI: No, because we would talk to her/ 'Grandma, do you feel any pain?' She wouldn't say anything/ she'd just stare at us/Then Tay Leo, our stepdad/ we called him/ 'Tay Leo, take a look at her.' / and he said, Maybe it's her old age'/, but she didn't have a fever, cough or colds of some sort/

In line 20, DI provides a detailed reconstruction of the events that occurred prior to the death, with the exact words uttered and acted out. This manner is an attempt of DI to relive the specific activity that is being described.

(3) Use of clauses that help meet gatekeeping expectations
Doctors always set gatekeeping rules by validating informants' legitimacy. The Doctor's basis of qualifying is by testing the informant's capacity to supply details. As shown below, DI is burdened to meet the gatekeeping demands of D, most especially because DI is relatively not in constant contact with the person during his last days as she does not live with the person.

8. D: Does this (person) live with you?
9. DI: No, he's with my sister/
10. D: = But YOU DO KNOW the details of your father's death/
11. DI: Yes/ he happened to—His case, Ma'am, is that/ he died while he was sitting down/ and when my sister went inside, she thought he was just dozing off with his mouth open/ he was roused, but he was no longer woke up/ he was having lung complications/ so he was taking his medication and he was— well, but it sort of came back so he was coughing again/ that was all/ no other illness that I know/

The informant readily supplies all the information she knows with clauses that detail the specific events without waiting for the Doctor's specific questions. The statement in line 11, such as "*that was all, no other illness that I know of*", reveals how the informant tries to establish credibility as an informant. In line 9, DI admits that she does not live with the patient, but the Doctor's confirmation question in line 10 reveals a gatekeeping measure that the Doctor expects of the informant to qualify, as shown in words, "*but you KNOW what happened to him.*"

(4) Use of approximative expressions to accommodate the Doctor's demand
Informants do not often value the precision of details and factuality of data. The use of approximative expressions acts as a depersonalising strategy. Take, for instance, the following responses:

1) More likely that even a month, I bet, more or less/
2) perhaps she tripped, probably because they say it was cardiac/

While there is uncertainty in all of these responses, they are used to compensate for the lack of precision that is expected of the Doctor. These responses reveal how informants recognise such shortcomings brought about by the lack of preciseness of details so that these responses form approximation in order to fulfil institutional alignment. In the examples, the approximation is supported by *"probably, even a month, I bet*", "*perhaps*" and "*I heard.*"

This section tackles the Doctor's depersonalising strategies. In response to the death informant's subjective and often emotional nature, the Doctor utilises depersonalising strategies in order to keep an objective reporting of the details of death.

(5) Use of short structured questions that maintain a distancing effect
The Doctor's questions are generally short in terms of structure, typical of a doctor-patient clinical encounter, as shown below:

13. D: hypertensive?
14. DI: It would decrease a bit, but sometimes he's got a high temperature—}
15. D: No check-up?
16. DI: Yes, he wasn't even able to finish the schist medication, which started in Nov 2016/
17. D: WHY?
18. DI: We forgot his card dosage, but he was still agile. He was even clearing up the yard/

In this interrogation, D formulates the questions with a limited number of words compared to the much longer responses of the informant, which creates a distancing effect that keeps the Doctor from making too much engagement in the conversation. The effect is a structured questioning that reveals an institution-oriented approach for the sake of attaining efficiency.

(6) Use of confirmation-seeking questions in the negative form to test speculations
In order to mitigate the imprecise responses of death informants, doctors use confirmation-seeking questions structured in the negative form to confirm some speculations. Sample questions are as follows:

1) WASN'T there any MEDICINE?
2) WASN'T there any improvement?

With these questions, the gatekeeper Doctor brings in the presupposition that the possible cause of death could be aggravated by lapses on the part of the caregiving family.

(7) Use of agentless constructions
The Doctor's use of confirmation questions is most often structured in passive construction, such as in the following questions:

1) Wasn't she BROUGHT to the hospital?
2) Was he admitted to the hospital?

Here, the confirmation-seeking questions form an agentless construction, which reveals how the Doctor gives more weight to the act rather than to the agent. They are used to maintain an objectified interrogation.

(8) Use of spatial deixis to mark detachment
As can be seen in the exchange, the Doctor utilises the spatial deictic expression "this" or the deictic "that" to refer to the dead person:

1) D: WASN'T this (person) brought to the hospital?
2) D: Is this (person) HYPERTENSIVE?

The use of spatial deixis as a linguistic strategy becomes aligned with the Doctor's medicalised objective orientation by referring to the dead as 'this' instead of using a personal pronoun. Our analysis has uncovered that, indeed, the informants' personalising strategies frequently clashed with the Doctor's depersonalising approaches during interrogations, which is consistent with the observations of Morales-Lopes et al. (2005). Tension arises due to their indirectness and vague information about death, which burdens the Doctor. The Doctor's insistence on objectivity highlights why interrogation and gatekeeping become meticulous processes. As service-seeking clients, informants necessitate the Doctor's attention (Boxer, 2002), but this requires enforcing strict institutional controls to ensure reliable data and efficient service. Linguistic strategies like short-structured questions, speculative inquiries, agentless verbs, and spatial deixis help depersonalise and speed up the interrogation, heightening tension.

DISCUSSION

This study has explored the asymmetrical role relations in doctor-death informant communication, which results in conflicting or differing frames. Our painstaking analysis leads us to the following summary of findings. Firstly, in an asymmetry of roles, particularly the doctor-death informant talk, the Doctor, as an institutional authority, almost always controls the interaction, and the death informant recognises this asymmetry. The recognition of doctors' institutional authority by informants, as evidenced by their use of honorifics and apologies, aligns with previous research on power dynamics in institutional talk (Alasuutari, 2023; Ekström & Stevanovic, 2023; Prego-Vazquez, 2007).

Second, the conflicting frames of expectations of both interlocutors reveal two opposing positions that clash with each other: 1) the doctor's objective frame of questioning and 2) the death informant's subjective frame of responding. These frames result in interactional struggles, which are scarcely mitigated by their contrasting linguistic strategies. The informant's subjective responses reveal their unstable recollection of details due to their fragile emotionality. This

subjective approach indirectly leads to an impending danger of producing an unreliable death report and invariably impacts mortality data in the larger health data system in the country. However, there is a need to recognise that the Doctor's interrogation can be threatening to the dead informants' emotional well-being (King et al., 2016). Since tension in encounters can instigate escalation (Klein, 2018), measures to de-escalate the depersonalising strategies of the Doctor should be considered. Opportunities for improving the doctor-informant relationship may be missed if essential skills are lacking (Davis, 2010).

The third point highlights how the overwhelming verbal autopsy process and the subjective nature of death informants challenge the decision-making capability of the municipal health doctor. As a result, the doctor experiences significant frustration. This explains the imposition of institutional authority to ensure objectivity in extracting accurate death details. Fourth, our study enriches the understanding of institutional discourse by examining the complex interplay of power and language in VA interactions. The integration of various theoretical frameworks provides a comprehensive analysis of these encounters, offering valuable insights for discourse analysis and interactional research. More specifically, Todd (1983) as cited in (Prego-Vazquez (2007) frame conflict framework has been shown to be a strong framework for identifying asymmetrical roles within VA discourses. Morales-Lopes et al.'s (2005) discursive strategies equally succeeded in highlighting these conflicting frames.

CONCLUSION

This research distinguishes itself from conventional methods of evaluating medical practices by employing a microanalysis of institutional dialogue to elucidate the verbal exchanges and interactional frameworks that constitute institutional practices. It uncovers numerous underlying processes involved in the roles of doctors and informants, focusing on the less-explored area of doctor-death informant interactions. By analysing 64 recorded interviews between municipal health doctors and death informants, we examined the content, structure, and function of their question-and-answer interactions during VA interviews, highlighting conflicting perspectives and opposing discursive strategies. Our analysis is linked to the broader sociocultural context, viewing VA as a setting where conversation functions as a regulatory practice, reflecting the procedures within a local health unit. An institution-oriented approach to interrogation is a repetitive struggle for the death-informants who come as fragile and mourning family members who have not wholly processed the remorse experience.

The broader implications of our study suggest that policy-making should address the need for VA training that considers the psycho-socio-cultural contexts of informants to uphold quality health information systems. Additionally, exploring the institutional context of doctor-informant dialogue is essential as it hints at issues with information-giving protocols. Healthcare professionals can benefit from understanding interactional barriers and implementing research-based strategies for effective communication. Our study has limitations that future research could address. First, since data were collected from two municipalities in one country, future studies could explore other regions to understand variations in death reporting using VA. Interactional research may assess the ways in which different doctors conduct VA differently across settings. Second, the psychological experiences of doctors and informants were not included, which could inform emotional and cognitive processes. This opens avenues for research into customised wellness programs. Third, demographic data about physicians, such as years of VA experience,

were not gathered. Future research might correlate physicians' experience with their style of information extraction. Additionally, research might better assess the language of death reporting across diverse communities and consider cultural variability and demographic factors in developing models for healthcare compliance. Interdisciplinary research efforts might help overcome barriers to effective healthcare management and communication.

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