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Expanded answers to bureaucratic questions: Negotiating access to public healthcare[1]

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This article analyzes expanded responses to statistical-epidemiological questions at a mental health outpatient service at a public hospital in Buenos Aires, Argentina. Bureaucratic questioning is a highly routine activity which supplies information to the biopolitical apparatus of the modern State. We understand that expanded answers are meaningful actions which not only serve individual, local tactics (such as raising personal concerns), but also index higher contextual levels. In this sense, resisting the constraints of a question may also imply resisting State-defined policies of biopolitical classification and exclusion. We examine, from a discursive interactional point of view, 41 admission interviews held at the outpatient mental health care service. We observe four types of expanded answers which: (a) display competence in bureaucratic discourse; (b) move from the sphere of the public to the private; (c) deal with potential face-threats; and (d) pre-empt rejection. Although the former is actually an optimized way of collaboration with the biopolitical order, the latter three types can be seen as actions of resistance to classification, not only symbolically but also in material terms: resisting statistical criteria of exclusion allows clients to negotiate access to mental healthcare.

En este artículo analizamos respuestas expandidas a preguntas estadístico-epidemiológicas en un hospital público de Buenos Aires, Argentina. Los cuestionarios burocráticos son una actividad rutinaria que alimenta el aparato biopolítico del Estado moderno. Consideramos que este tipo de respuesta es una acción significativa que no sólo responde a tácticas locales individuales (como presentar preocupaciones personales), sino que también indexicaliza niveles contextuales más altos. En ese sentido, responder resistiendo los condicionamientos impuestos por una pregunta puede también suponer una resistencia a las políticas estatales de clasificación y exclusión. Examinamos, desde una perspectiva discursiva interaccional, 41 entrevistas de admisión a los consultorios externos de salud mental. Observamos cuatro tipos de expansión, las cuales: muestran competencia en el discurso burocrático; se desplazan de la esfera pública a la privada; enfrentan amenazas potenciales a la autoimagen; buscan anticiparse al rechazo. Aunque el primero pueda verse como una forma óptima de colaboración, los otros tres tipos pueden verse como forma de resistencia a la clasificación, no sólo en términos simbólicos, sino también materiales:

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resistirse a los criterios estadísticos de exclusión le permite a los pacientes negociar el acceso a la salud mental. [Spanish]

KEYWORDS: Interaction, doctor-patient communication, response expansion, resistance, sociolinguistic scales

INTRODUCTION

Medical consultation usually includes, as shown in the analysis of primary care acute visits (Heritage and Maynard 2006), a more or less routine questionnaire addressing the patient's 'past medical conditions, the health status of parents and siblings, and psychosocial and lifestyle aspects of the patient's circumstances' (Stivers and Heritage 2001: 152). This is a key strategy designed to gather relevant clinical information during history taking. As it also conveys information about the physician's own beliefs, prejudices and attitudes (Heritage 2010), it is not a unilateral practice of collecting data but an exchange of information during which patients can adopt different positions and strategies.

One of these strategies is what Stivers and Heritage (2001) describe as answering 'more than the question' during comprehensive history taking. History-taking questions are designed as a 'checklist' that demands only minimal answers which would not move beyond the immediate agenda set by them (Stivers and Heritage 2001: 153; Raymond 2010). Patients' responses usually answer the question as put, as a simple request for unelaborated facts. Each short answer is usually taken as complete both by the patient and the doctor, both of whom collaborate in a recognizable routine activity. Therefore, there has to be a good reason for the patient to depart from the pattern of minimal responses, volunteering more information than required. Stivers and Heritage (2001) analyze these expansions as a way to incorporate patients' concerns without making them explicit. Nishizaka (2011) analyzes response expansion in routine prenatal checkups (instead of acute medical visits), finding that answering 'more than the question' is one of the few opportunities available to pregnant women to take the initiative in presenting their concerns at the consultation. Through different perspectives, response expansion in medical settings seems to be linked to some kind of empowerment or resistance – however limited it might be – regarding patients' asymmetrical position (see Gill 1998; Robinson and Heritage 2006; Stivers 2006; Stivers and Hayashi 2010; Heritage and Raymond 2012).

We can distinguish between optimized medical questions, typically designed by doctors to obtain a 'no problem' response during history taking (Boyd and Heritage 2006; Heritage 2010), and bureaucratic questions, which refer to an institutionally set agenda and which is, in a sense, ancillary to healthcare

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(Heritage and Sorjonen 1994; Heritage and Lindström 1998). Recent study of questioning and answering in medical settings, however, does not usually take into account the bureaucratic questionnaires which are routinely applied, especially at public hospitals: written, bureaucratic forms designed to gather statistical-epidemiological information. As research in this field has a predominantly conversation-analytical perspective, there is a restricted view of context which does not take into account institutional and political conditionings of the interaction (Heritage and Lindström 1998; Candlin and Candlin 2003; Iedema 2007; Bonnin 2013b). Therefore, the activity of gathering epidemiological-statistical information is usually seen as alien to the medical interaction proper, not only by analysts, but also by professionals themselves (cf. Excerpt 1).

In the case of public mental healthcare in Buenos Aires, clients must respond to an epidemiological-statistical form with information ranging from name and ID number to occupation and former treatments (Figure 1). Although this form is not attached to the patient's medical history but sent instead to the City Government Mental Health Office, it plays at least two important roles regarding interaction and access to mental health. On the one hand, it is statistical input for designing public health policies in Buenos Aires City. As such, it classifies individuals into social-demographic categories such as male, married, unemployed, schizophrenic, etc. (Bonnin 2013b). In this sense, printed forms are used from a biopolitical point of view, enhancing State governance through 'the mundane administration and surveillance of individual bodies and the social body' (Ong 2003: 91). The privileged agent of this governance is modern medicine, 'defining and promoting concepts, categories, and authoritative pronouncements on hygiene, health, sexuality, life, and death' (Ong 2003: 91). Official forms, statistical questionnaires, printed and written administrative documents become the key input in a State 'enterprise of production, reproduction and transformation of legitimate [social/epidemiological] problems and solutions [which produce] the creation and normalization of an order of social problems' (Pantaleón 2005: 90; my translation).

On the other hand, as these forms are filled by the professional who conducts the interview, they are the main topic of an interaction with an extremely restricted agenda, set by the form's checklist. Despite its function at the level of the State, in the local interaction, participants negotiate the activity they are engaged in and its expected outcome: being admitted to the mental health service as outpatients. In this sense, bureaucratic interaction may adopt a 'restrictive' or 'inclusive' character, following different eligibility criteria (Jean 2004; cf. *infra* D) which may result either in the inclusion or the exclusion of the client in the mental health outpatient service. As there is a limited number of consulting facilities and very restricted number of personnel to deal with the demand, 'they are not admission, but rejection interviews' ('*más que de admisión, son entrevistas de expulsión*'), as one psychiatrist once told me. Patients, on the other hand, are generally not aware of inclusion/exclusion criteria other than availability of 'slots' ('*cupos*') which are filled by order of

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FICHA EPIDEMIOLOGICA

HOSPITAL:	FECHA ADMISION:	HISTORIA CLINICA N°:
SEXO F M EDAD	NOMBRE Y APELLIDO:	

DOMICILIO	ESTADO CIVIL	TRATAMIENTOS ANTERIORES
☐ Capital	☐ Soltero	☐ Ambulatorio
☐ Conurbano	☐ Casado/en pareja	☐ Hospital de Día/Noche
☐ Interior	☐ Separado	☐ Internación
☐ Extranjero	☐ Viudo	☐ Urgencia
		☐ Ninguno

EDUCACION	CONDICION LABORAL	VIVIENDA
☐ Sin escolaridad	☐ Ocupado	☐ Casa propia
☐ Pre-escolar	☐ Desocupado	☐ Alquilada
☐ Primaria	☐ Subocupado	☐ Ocupada
☐ Secundaria	☐ Jubilado	☐ Hotel/Pensión
☐ Terciaria	☐ Estudiante	☐ Institución
☐ Universitaria	☐ Ama de casa	☐ Calle
☐ Incompleta ☐ Completa		

GRUPO CONVIVIENTE	COBERTURA DE SALUD	DERIVADO POR
☐ Solo	☐ Obra social	☐ Otro Servicio del hospital
☐ Padres	☐ Prepaga	☐ Otro Hospital
☐ Cónyuge/Pareja	☐ Ninguna	☐ Escuela
☐ Hijos	**TIPO DE CONSULTA**	☐ Sistema Judicial
☐ Parientes	☐ Espontánea	☐ Profesional Privado
☐ Amigos	☐ Derivación	☐ Familia/Amigos

MOTIVO DE CONSULTA	INDICACION TERAPEUTICA	DERIVACION EXTERNA
☐ Ansiedad	☐ Terapia Individual	☐ NO
☐ Depresión	☐ Terapia grupal	☐ SI
☐ Adicciones	☐ Terapia Familia/Pareja	
☐ Violencia	☐ Psicoprofilaxis	☐ Otro hospital GCBA
☐ Intento de Suicidio	☐ Psicopedagogia	☐ Hospital conurbano
☐ Prob. Familiares y/o Sociales	☐ Hospital Día/Noche	☐ Obra Social
☐ Problemas Psicosomáticos	☐ Internación	☐ Institucion Privada
☐ Prob. Aprendizaje y/o Conducta	☐ Tto. psiquiátrico y/o farmacológico	☐ Profesional Privado
☐ Otros problemas	☐ Otras	☐ Otros

DIAGNOSTICO

☐ CIE-10 ....

☐ DSM-IV ....

Figure 1: City Government Mental Health Office epidemiological-statistical form

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arrival. Thus, being rejected regardless of how long they have waited for their appointment may cause indignation: 'I've been here since five in the morning and now [mid-morning] they tell me I have to go to XX [public hospital in the Buenos Aires Province]' ('*Estoy acá desde las cinco de la mañana y recién ahora [media mañana] me dicen que tengo que ir a XX [hospital público de la provincia de Buenos Aires]*'). In other words: locally managed inclusion/exclusion is conditioned by structurally defined rationing of public healthcare.

If we adopt a scalar view on context (Blommaert 2007), we can observe how epidemiological-statistical questions and answers may index, simultaneously, both semiotic levels: the local, immediate situation of the interview, and the higher, State-administrated biopolitical order. Therefore, answering 'more than the question' may be an individual strategy for raising concerns (as seen by Stivers and Heritage 2001; Nishizaka 2011) but it also may embody a practice of resistance towards State-defined classifications and policies regarding mental suffering and healthcare.

This is the idea we will discuss in this article. We will analyze expanded responses to epidemiological-statistical questions in admission interviews to an outpatient mental healthcare service at a public hospital in Buenos Aires, Argentina. Firstly, we will describe the data and setting of our research. Secondly, we will distinguish four types of expanded answers as they serve strategically to:

a. display competence in bureaucratic discourse;
b. move from the sphere of the public to the private;
c. deal with potential face-threats; and
d. pre-empt rejection.

In the last section, we will discuss our results from the point of view of the potential political effects of local interaction.

DATA AND SETTING

The healthcare system in Argentina is organized in three sectors: public, private and mixed (Acuña and Chudnovsky 2002). The private sector includes about 10 percent of the population and is financed through a voluntary insurance scheme. The mixed sector, on the other hand, is financed through mandatory insurance schemes and managed by labor unions, which provide health insurance to 20.3 million users (53% of the total population). Finally, the public sector offers free healthcare to all inhabitants of the country, financed by the State. About 37 percent of the total population (16 million people), who are not included in the former two sectors, receive healthcare at public hospitals and primary healthcare centers (Abeledo 2010).

Patients who receive healthcare at public hospitals are usually not included in the formal sector of the economy or do not enjoy full citizenship. Despite the effort and professionalism of public healthcare providers, structural conditions are extremely poor and basic resources – from personnel to supplies – are

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scarce. Many political and academic activists believe that the lack of resources is part of a policy to dismantle the public health system, which is no longer considered a basic human right but now perceived as relief for the poor (Comes and Stolkiner 2005). Therefore, most people who go to public hospitals do not have access to any other kind of healthcare. We have even observed that healthcare providers at the hospital reject patients with medical insurance arguing that 'people who come here have nowhere else to go for healthcare' ('*las personas que vienen acá es porque no tienen ningún servicio para atenderse*'). In these conditions, the system is overwhelmed by a demand that cannot be adequately satisfied.

In order to manage the admission (and rejection) of patients to the outpatient mental healthcare service, a system of 'admission interviews' or 'first consultations' was implemented two years ago at the hospital where I am doing fieldwork. Once a week, candidates apply for an interview with two professionals who evaluate whether the interviewees meet the required criteria to be admitted as patients. These criteria, however variable, are usually linked to the available slots in the schedules of the different specialties (individual therapy, group therapy, addictions, etc.). Approximately fifteen people are interviewed every week, about ten of whom are admitted to the outpatient mental healthcare service. Thus, the patient's performance during the interview is extremely important, as it is his/her only chance to face institutional criteria and negotiate his/her admission.

I have ethnographically observed 72 admission interviews between 2011 and 2012, and tape recorded 82 of them in 2012 – 2013 with the informed consent of patients and professionals. Because many professionals left the service in 2013, and stylistic features are very important in our research, we will analyze here only the first 41 recorded interviews. The interviews were held at the outpatient mental healthcare service at a public hospital in Buenos Aires, Argentina. To ensure the confidentiality of data, I do not identify the hospital where the interviews took place. I have also replaced, when necessary, the names of patients, professionals and locations with randomly selected letters.

THE EPIDEMIOLOGICAL-STATISTICAL FORM AND THE ORGANIZATION OF THE INTERVIEW

Every interview is noticeably organized in three distinct parts explicitly designed to:

a. gather information to complete the epidemiological-statistical form provided by the City Government Mental Health Office;
b. inquire about the reasons why the patient requires mental healthcare and make a tentative diagnosis in order to later decide on which specialty the patient should be referred to; and

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c. gather personal information to make contact later and inform the patient regarding the appointment to begin treatment.

These three moments are usually treated as separated activities, as can be seen in the following excerpt (see the Appendix for transcription conventions):

Excerpt 1: Patient 7

1	*Professional:*	*bueno (0.5) mire (.) esta es una pequeña*
2		*↑entrevista*
3	*Patient:*	*sí=*
4	*Professional:*	*=de orientación (1.0) yo primero le voy a toma:r-*
5		*(.) le voy a hacer algunas preguntas que son para*
6		*la (2.0) estadística del hospital=*
7	*Patient:*	*=sí*
8	*Professional:*	*y después nos cuenta (.) qué lo trae por acá (0.3)*
9		*le parece?*
10	*Patient:*	*sí*
11	*Professional:*	*bueno (0.3) dígame su edad*

1	Professional:	well (0.5) look (.) this is a short
2		↑orientation
3	Patient:	yes=
4	Professional:	=interview (1.0) first I'm going to ta:ke-
5		(.) I'm going to ask some questions for
6		the (2.0) hospital statistics=
7	Patient:	=yes
8	Professional:	and then you tell us (.) what brings you here (0.3)
9		OK?
10	Patient:	yes
11	Professional:	well (0.3) tell me your age

The excerpt begins with a metapragmatic comment by the professional, who describes the general activity which will take place as 'a short orientation interview' (lines 1–4). Due to her position of power as an institutional representative, she is allowed to 'orchestrate' the interaction, determining 'when the other party or parties may speak and receive attention and what they may speak about' (Dingwall 1980: 156). Therefore, she anticipates the structure of the interview, differentiating bureaucratic questions – 'I'm going to ask some questions for the hospital statistics' (lines 5–6) – from clinical ones – 'then you tell us (.) what brings you here' (line 8). Line 11 introduces a *bueno*-prefaced move into the interview, with '*bueno*' being equivalent to 'okay' (cf. Beach 1993). This kind of move is usually repeated as a transition between the three stages we described earlier, in all cases projecting the beginning of the new activity.

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About 25 percent of the interview time is dedicated to the first of these parts, in which one of the psychotherapists (usually the more experienced one) introduces the successive items of the epidemiological-statistical form checklist, rephrasing them as questions. This rephrasing is orientated by the therapists' own 'best guesses' (Heritage 2010: 43) about which could be the most likely answer.

In what follows, we will focus on those answers which, contrary to those observed in previous excerpts, do not offer a short, concise and complete response but an elaborated one, answering 'more than the question' to these bureaucratic, epidemiological-statistical questions. We observed 56 sequences of expanded answers related to every item of the form, from name to health insurance. We can distinguish four basic types of expansion according to the action the patient takes:

a. displaying competence in bureaucratic discourse (10%);
b. moving from the sphere of the public to the private (41%);
c. dealing with potential face-threats (37%); and
d. pre-empting rejection (12%).[2]

a. Displaying bureaucratic competence

The first kind of expanded response to epidemiological-statistical questioning is, actually, an over-efficient type of straight answer: it is not designed to move away from the agenda set by the questions but, rather, to advance rapidly through the routine steps of bureaucratic questioning. Therefore, the answer to one item is expanded with information which responds to the usual follow-up question, which has not yet been asked, in a 'nonconforming, yet cooperative' kind of response (Lee 2011: 905). We have already analyzed this phenomenon as a potentially empowering voice adopted by patients in order to level the structurally asymmetrical roles of the doctor-patient situation (Bonnin 2014). Here are two typical examples:

Excerpt 2: Patient 33

1	*Professional:*	*está bien (0.3) e:h (.) tus estudios?*
2	*Patient:*	*secundario completo*
3	*Professional:*	*completo (0.3) [iniciaste-]*
4	*Patient:*	*[acá en Buenos Aires]*
5	*Professional:*	*algún estudio terciario?=*
6	*Patient:*	*=no (.) no (.) no porque me fui para XX*
7		*((provincia argentina))*

1	Professional:	OK (0.3) u:hm (.) your education?
2	Patient:	secondary, complete

3 Professional: complete (0.3) [did you star-]
4 Patient: [here in Buenos Aires]
5 Professional: any higher level studies?=
6 Patient: =no (.) no (.) no because I left to XX
7 ((Argentine Province))

Excerpt 3: Patient 5

1 Professional: bueno (.) casa propia (.) alquilada (.) ocu[pada?]
2 Patient: [casa]
3 propia (.) con mis padres
4 Professional: <con tus pa::dres> bien (0.5) obra social?
5 Patient: obra social (0.5) sí

1 Professional: well (.) your own house (.) rented (.) occu[pied?]
2 Patient: [my own]
3 house (.) with my parents
4 Professional: <with your pa::rents> good (0.5) medical insurance?
5 Patient: medical insurance (0.5) yes

Excerpt 2 addresses the issue of educational level, which is usually followed up by the specification of the level of completion (complete/ incomplete; cf. Figure 1). As the patient is acquainted with this kind of questionnaire, his response in line 2 includes not only the required 'degree of education' but also the level of completion. The therapist begins a question in line 3 about possible incomplete higher education. The patient regains the turn to add information about the place where he studied, a question which had not been asked but the speaker treats as likely. The professional, however, is seeking for a confirmation to the information given by the patient, who justifies why he did not start higher studies (an expansion typical of the third type we discuss here, to prevent social prejudices against under-education).

The answer of line 3, in Excerpt 3, is still more plainly over-efficient. As can be seen in Figure 1, the question on 'Dwelling' is followed by that of '*grupo conviviente*' ('cohabitants'). Although the therapist only asks for the first item in line 1, the patient answers both questions, even although the second one had not been uttered yet.

As a potentially empowering voice which displays competence in bureaucratic discourse, this kind of expansion also allows moving forward to the second stage of the interview (hence related to the second type of expansions we analyze here). However, it is not designed to avoid or circumvent classification but, rather, to advance willingly through it.

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b. Moving from the sphere of the public to the private

The transition from the stage of gathering epidemiological-statistical information to the account for the reasons of the visit has been described as a passage from the sphere of the 'public' to the 'private' in psychotherapeutic interviews (Bonnin 2013b). This move is usually proposed by therapists, who have previously 'orchestrated' and anticipated the structure of the interview (cf. Excerpt 1) but it also can be initiated by the patient. As the therapist's questions set an agenda which discourages moving away, the patients' preferred strategy is to expand the answer to some epidemiological-statistical question which can be related to those private, biographical reasons for the visit:

Excerpt 4: Patient 15

1	*Professional:*	*hiciste algún tratamiento anterior psiquiátrico*
2		*psicológico=*
3	*Patient:*	*=sí estaba haciendo y lo abandoné*
4	*Professional:*	*qué hacías?*
5	*Patient:*	*porque (.) pasa así (0.5) yo estaba: tan tan tan::*
6		*depresiva que me quise matar (1.0) [no tenía]*
7	*Professional:*	*[internada] o*
8		*tratamiento=?*
9	*Patient:*	*=sí (0.3) estuve interna:da y todo (.) con*
10		*trata[miento]*
11	*Professional:*	*[bueno] ahora después nos (.) nos contás bien*
12		*(0.5) eh::: llegaste a:::: qué nivel de[::*
13		*educación]*

1	Professional:	have you had any previous treatment psychiatric
2		psychological=
3	Patient:	=yes I have but I left it
4	Professional:	what were you doing?
5	Patient:	because (.) the thing is (.) I wa:s so so so::
6		depressive that I tried to kill myself (1) [I didn't have]
7	Professional:	[inpatient] or
8		outpatient=?
9	Patient:	=yes (0.3) I was an inpa:tient and everything (.) with
10		treat[ment]
11	Professional:	[well] you can tell us about it (.) later on
12		(0.5) uhm::: you reached:::: what level of[::
13		education]

In lines 1–2, the therapist asks a yes/no question about previous treatments together with an alternative question about psychiatric or psychological treatment. The answer, in line 3, is affirmative and offers the

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rudiment of a narrative about the patient abandoning treatment. The therapist does not acknowledge this small expansion but, rather, follows with a wh- question to differentiate between psychiatry and psychotherapy. The patient's response, in lines 5–6, answers 'more than the question' and addresses the non-required background of the previous treatment. By introducing her attempted suicide, the patient projects a move towards the sphere of the private, presenting her biography as the main topic of the conversation (Bonnin 2013b). However, the professional overlaps in line 7 to regain the turn and follow the written form – distinguishing between 'outpatient' and 'inpatient' treatment. As the patient insists on her narrative, expanding what began in line 3, the professional explicitly postpones the biographic story (line 11) and continues with the form.

Sometimes the strategy of moving towards the sphere of the private, and thus commencing the psychotherapeutic conversation proper (Bartesaghi 2009), is successful, as can be seen in the following example:

Excerpt 5: Patient 19

1 Professional: bien (.) con quién vivís? °contáme°
2 Patient: ahora estoy: con mi señora
3 Professional: Mm
4 Patient: mi señora que es (.) la que está: mal viste?
5 por los problemas que tuve de la adicción ↑mía
6 Professional: ahá >ahora ahora vamos< a::
7 Patient: °por eso ahora estoy-° se arregló todo! estoy
8 bie::n no estoy consumie::ndo (.) (>que es-<
9 vengo a hacer) tratamiento
10 Professional: °sí sí°
11 Patient: [(apar-)]
12 Professional: [bueno] contanos que: qué te trae por acá

1 Professional: OK (.) who do you live with? °tell me°
2 Patient: now I am: with my wife
3 Professional: hmm
4 Patient: my wife is the one who (.) the one who is: unhappy you know?
5 because of the problems I had with my ↑addiction
6 Professional: right >now we are going< to::
7 Patient: °that's why now I'm-° everything worked fine! I'm
8 fi::ne I'm not u::sing (.) (>which is-<
9 I come to have) treatment
10 Professional: °yes yes°
11 Patient: [(besid-)]
12 Professional: [well] tell us what: what brings you here

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In this example, the question about '*convivientes*' ('cohabitants') triggers a narrative through the adverb '*ahora*' ('now'), emphasized by the patient (line 2). This adverb suggests a story of breakup and reconciliation which is encouraged by the therapist in line 3 and expanded by the patient, who introduces his former drug addiction as the main reason for that breakup (line 4–5). The professional tries to regain the turn in line 6 by postponing the narrative, but the patient keeps elaborating his previous turn, presenting the reason for the consultation. The minimally displayed narrative is central to the presentation of these motives, because it leaves the addiction in the past and argues for a psychotherapeutic, non-drug-related treatment in the present. The professional, despite her attempt to follow the epidemiological-statistical form in line 6, agrees with the patient to move to the private sphere of therapy and confirms the transition with '*bueno*' (line 12).

c. Dealing with potential face-threats

Some expanded responses are designed to deal with potentially face-threatening inferences which could be triggered by the patient's straight answer. We will observe here two examples which involve different types of threats, either legal or moral:

Excerpt 6: Patient 18

1	*Professional:*	*tenés un número de documento?*
2	*Patient:*	*tengo carnet=*
3	*Professional:*	*=mm=*
4	*Patient:*	*porque: (.) está en trámite mi mi DNI*
5	*Professional:*	*(quedó) acá?*
6	*Patient:*	*adelante está*
		(...)
7	*Patient:*	*el DNI lo tengo pero::=*
8	*Professional:*	*ESTÁ BIEN (.) está bien=*
9	*Patient:*	*=lo tengo en trá[mite]*
10	*Professional:*	*[no te] preocupes=*

1	Professional:	do you have an ID number?
2	Patient:	I have a card=
3	Professional:	=hmm=
4	Patient:	because: (.) my my ID is in progress
5	Professional:	(did you leave it) here?
6	Patient:	it is in the front
		(...)
7	Patient:	I do have the ID but::=

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8	Professional:	OKAY (.) okay=
9	Patient:	=I've got it in pro[gress]
10	Professional:	[don't] worry=

This example features a Bolivian patient who lives in Argentina without legal citizenship or residency. As the 'illegal alien' figure entails a strong anti-immigrant prejudice, especially related to the use of public services,[3] the patient refuses to give a straight answer to the yes/no question of line 1. Instead, he offers an alternative response, 'I have a card' (line 2), on the nature of which he does not provide any information. As the professional offers an ambiguous 'mm' in line 3, the patient argues that his ID card is in process. This answer still does not respond to line 1 and can actually be seen as one of those lies which happen when addressing 'delicate subjects' in health communication (Vincent, Laforest and Bergeron 2007: 234), as it may lead to legal sanctions.[4] The weak argumentation, mainly based on repetition (lines 4, 7, 9) is interrupted by the therapist in line 8 and the issue of the ID card is dismissed in line 10.

Other expansions of this type are designed to face moral prejudices about unemployment, which assert that 'he who doesn't work, doesn't want to' (Buendía 2010: 35). This is the case in the following example:

Excerpt 7: Patient 19

1	*Professional:*	*tu situación actual: de trabajo? trabajá:s (.) °no*
2		*tra[bajá:s]°*
3	*Patient:*	*[ahora] no*
4	*Professional:*	*no=*
5	*Patient:*	*=ahora no*
6	*Professional:*	*por el tema de la pierna?*
7	*Patient:*	*por el tema de la pierna (.) por el tema de la*
8		*pierna*
9	*Professional:*	*ahá (.) pero estás de lice:ncia estás sin*
10		*tra[ba:jo]*
11	*Patient:*	*[>no no] no< me quedé sin laburo*
12	*Professional:*	*sin trabajo (.) °bien° (.) e:h la casa donde vivís*
13		*es pro:pia (.) alquila:da?*

1	Professional:	your current: job situation? you wo:rk (.) °you
2		don't [work]°
3	Patient:	[not at the moment] no
4	Professional:	no=
5	Patient:	=not at the moment

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6	Professional:	because of the leg problem?
7	Patient:	because of the leg problem (.) because of the leg
8		problem
9	Professional:	ok (.) but are you on a sick le:ave are you
10		un[employed]
11	Patient:	[>no no] no <I became unemployed ((untranslatable '*laburo*'))
12	Professional:	unemployed (.) °ok° (.) uh:m the house where you live
13		is it yo:urs (.) ren:ted?

The item in the epidemiological-statistical form is 'Job status' ('*Condición laboral*') and provides the following options: 'Employed', 'Unemployed', 'Underemployed', 'Retired', 'Student', 'Housewife'. The therapist begins with an open question about the patient's 'current job situation', which she immediately rephrases as an alternative one, between the options 'employed' and 'unemployed' (lines 1–2). The patient overlaps with emphasis in the adverb '*ahora*' ('at the moment'), following a similar strategy to that of Excerpt 5, line 2, in order to suggest a narrative of former employment interrupted by a complication. The therapist only recalls the negative answer in line 4, so the patient repairs by repeating the adverb (line 5). Facing this brief but eloquent expansion, the therapist inquires about the complication which led to the unemployment situation, making a 'best guess' based on the leg plaster the patient is wearing. As this reason does not necessarily lead to unemployment in formal work, the therapist asks in line 9 if the patient's condition is that of unemployment or if he is on medical leave. At this point, the patient states plainly his unemployment condition through an informal expression: '*me quedé sin laburo*' (line 11), which is formally repaired by the professional ('*sin trabajo*', line 12), who now continues with the rest of the form.

d. Pre-empting rejection

As mentioned above, the public healthcare system is overwhelmed by a demand that it cannot satisfy in its current structural condition. It is a perverse system in which the responsibility for actually deciding who will receive medical attention and who will not is placed on the healthcare providers (Jean 2004). Doctors, nurses and therapists are implicitly entitled with the power to deny people their legitimate right to healthcare on behalf of a deficient system. As one psychiatrist once told me bitterly, 'they are not admission, but rejection interviews' ('*más que de admisión, son entrevistas de expulsión*'). As there is a limited number of consulting facilities and very restricted personnel to deal with the demand, professionals use rejection criteria which are not explicit.[5] The two main rejection criteria which we have found are based on city of residence and medical insurance:

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Excerpt 8: Patient 2

1	*Professional:*	*((inaudible)) terapia (1.0) sí (.) obra social?*
2	*Patient:*	*y:: sería galeno*
3	*Professional:*	*galeno (1.0) R (.) escúcheme una cosa (.) esto lo*
4		*comentó? porque nosotros- el tema es así (0.3)*
5		*nosotros tenemos una demanda:*
6	*Patient:*	*grande (.) sí (.) ya sé me doy cuenta*
7		*((inaudible))*
8	*Professional:*	*claro eh: no- los que tienen obra social- las*
9		*personas que vienen acá es porque no tienen*
10		*ningún servicio para atenderse*
11	*Patient:*	*((inaudible))*
12	*Professional:*	*usted tiene galeno (0.3) yo le tengo que decir*
13		*que: tiene que ir a galeno*

1	Professional:	((inaudible)) therapy (1.0) yes (.) medical insurance?
2	Patient:	uhm:: it would be galeno
3	Professional:	galeno (1.0) R (.) listen (.) did you mention
4		this? because we- the thing is (0.3)
5		we have a demand:
6	Patient:	that is huge (.) yes (.) I know I realize
7		((inaudible))
8	Professional:	right uhm: don- those who have medical insuran-
9		people who come here have
10		nowhere else to go
11	Patient:	((inaudible))
12	Professional:	you do have galeno (0.3) I have to say:
13		go to galeno

In this example, when the patient admits he does have private medical insurance, called *Galeno*, the therapist rejects him as a patient on the basis that 'people who come here have nowhere else to go' ('*las personas que vienen acá es porque no tienen ningún servicio para atenderse*', lines 8–10). Many patients, however, have practical knowledge of these (unspoken) criteria because they regularly use public services and are thus able to pre-empt rejection and argue for admission.

Excerpt 9: Patient 16

1	*Professional:*	*(1.2) tiene alguna cobertura social?*
2	*Patient:*	*sí*
3	*Professional:*	*qué tiene?*
4	*Patient:*	*eh (0.3) yo (.) eh:::: yo trabajo de bombero para*
5		*la PFA (((Policía Federal Argentina)) y:: (1.0)*
6	*Professional:*	*para la policía?*
7	*Patient:*	*sí (0.5) soy bombero de acá de XX ((barrio))*

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8		*y trabajo acá en el hospital*
9	*Professional:*	*y qué obra social tiene?*
10	*Patient:*	*la de::::l churruca (3.0) lo que pasa es que yo*
11		*(vengo) acá porque si yo planteo los problemas que*
12		*tengo allá (.) ahí me retiran el arma y: y me*
13		*sacan: no me dejan trabajar más*

1	Professional:	(1.2) do you have any medical insurance?
2	Patient:	yes
3	Professional:	which one?
4	Patient:	uhm (0.3) I (.) uhm:::: I work as a fire-fighter for the
5		PFA ((Argentina Federal Police)) and:: (1.0)
6	Professional:	for the police?
7	Patient:	yes (0.5) I'm a fire-fighter here at XX ((neighbourhood))
8		and I work here at the hospital
9	Professional:	and which is your medical insurance?
10	Patient:	the:::: churruca one (3.0) the thing is I
11		(come) here because if I talk about my problems
12		there (.) they will take away my gun and: and get
13		rid of me: they won't let me work any more

In Excerpt 9, the item 'Medical insurance' (and its options, 'mixed', 'private', 'none') is presented as a yes/no question in line 1, and answered affirmatively in line 2. Although the therapist asks for further information, the patient begins an expansion in line 4 related to his employment as a fire-fighter for the police force. As the professional asks again, in line 9, about his medical insurance, the patient elaborates on the reasons why he does not want to use his medical insurance. This answer could have been considered as irrelevant to the question insofar as these reasons were not inquired about. However, the patient pre-empts rejection based on medical insurance, a practice we have just observed in Excerpt 8. As he is a police officer and has a drug addiction, he is afraid of losing his job if he uses the medical insurance provided by the police department. Therefore, in lines 10–13, he argues his reasons for seeking attention at a public hospital, in order to preserve his employment in the formal sector.

The other main reason for rejecting applicants is based on the city of address. As in the previous case, there is no explicit rule for this, but it may be based on declarations of Buenos Aires Governor, Mauricio Macri, who in 2007 said that Buenos Aires Hospitals should prioritize care for Buenos Aires citizens over people who come from neighboring cities.[6] Despite widespread negative response to this opinion, it remained as an implicit criterion among healthcare providers, and is a regular argument used to reject patients. As many patients have already been rejected for similar reasons, they may use expanded responses to pre-empt this kind of refusal of care:

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Excerpt 10: Patient 2

1	*Professional:*	*eh dígame le tengo que hacer ((inaudible)) capital*
2		*o provincia vive?*
3	*Patient:*	*no (.) vivo en provincia (.) en XX ((ciudad)) más*
4		*precisamente ahora estoy viviendo acá por esta*
5		*situación de esta mujer (.) que no no quiero ir*
6		*con mis padres pero (.) no- yo estuve en el: me*
7		*dijeron no hay cupo (0.3)*
8		*lo comenté acá desde el primer día*
9	*Professional:*	*sí (1.0) lo vamos a atender pero en realidad yo*
10		*contaba con que usted era de capital porque no-*
11		*si el((inaudible)) no tiene cupo nosotros no-*
12		*(0.5) sí (.) su estado civil?*

1	Professional:	uhm tell me I have to ask ((inaudible)) capital city
2		or province do you live?
3	Patient:	no (.) I live in the Province (.) in XX ((city))
4		right now I'm living here because of this
5		situation with this woman (.) I don't don't want
6		to go with my parents but (.) don- I've been at:
7		they told me there are no available slots (0.3)
8		I've been saying so since the first day
9	Professional:	yes (1.0) we will take you in but actually I
10		thought you were from the capital because we don-
11		if the ((inaudible)) there is no availability we don-
12		(0.5) yes (.) your marital status?

The item about city of residence is presented as an alternative question between the options which determine the admission or the rejection (i.e. 'Capital City' or 'Province', lines 1–2). The patient begins with a confused negative which he immediately repairs by answering that his address is in XX City, in Buenos Aires Province. The expansion is confused. In line 4, he states he is currently living in the Capital City, but immediately begins a narrative about a previous visit during which he was rejected (by saying 'there are no available slots', '*no hay cupo*', line 7). Then the patient argues for his honesty as a positive self-image feature: he has been saying 'since the first day' that he does not live in Buenos Aires. This implies that he has already been admitted from the first day (otherwise he would not have made it to the admission interview). This argument seems to be effective enough for the therapist, who admits the patient ('we will take you in', '*lo vamos a atender*') as an exception, pointing out that the available slots are intended only for those who live in the Capital City (lines 9–11).

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DISCUSSION: BUREAUCRACY AND ACCESS TO HEALTHCARE

The issue of doctor-initiated questions is a consolidated line of research in doctor-patient interaction studies. Most of these studies share two distinct features: (a) they analyze conversation in biomedical specialties; and (b) they focus on history-taking questions. Our article attempts a contribution to this line of research from a different, more critical point of view, regarding bureaucratic questions as a mechanism to manage inclusion in and exclusion from healthcare, and expanded answers as strategies: resisting statistical criteria of exclusion allows clients to negotiate access to mental healthcare. Therefore, (a) we examine interaction in psychotherapeutic settings; and (b) we focus on bureaucratic, epidemiological-statistical questions from a political point of view.

Both aspects are closely linked, precisely because psychotherapy looks for the patient's lifeworld experiences which are not usually seen as relevant to other clinical specialties (Mishler 1984; Waitzkin 1989). On the contrary, biomedical questions 'tend to ignore those aspects of patients' utterances that report on subjective experience, personal circumstances and social conditions' (Ten Have 2005 [1991]: 3). These are matters covered by the epidemiological-statistical form, which is not usually considered as a part of clinical interaction but, rather, as an independent bureaucratic activity. This activity, however, can be strategically used by patients and professionals alike.

In this article, we have focused exclusively on clients' expanded responses to bureaucratic questions and their use as a local strategy devised to obtain access to mental healthcare. The whole process entails tension: the right to mental healthcare can only be satisfied if the patient gives up his/her right to privacy, thus providing information on his/her relationships (marital status, convivial group), economic activities (occupation, social insurance), national/local identities, etc. This information is not intended to be used for treating the patient. Instead, the epidemiological-statistical form is stored separately from the patient's medical history and collected by the City Government Mental Health Office to develop statistics and, ultimately, design more restrictive and rejecting health policies.

Our results show different strategies for gaining access to healthcare through expanded answers to bureaucratic questions:

- Type (a) displays bureaucratic competence and thus cooperates in completing the epidemiological-statistical form as quickly and efficiently as possible. Not sensing any threats, not fearing rejection, expansions do not move away but forward in the institutionally defined agenda.
- Type (b) expansions, on the other hand, also move towards the private clinical interview proper, but not following the institutionally defined agenda. Rather, biographical narrative expansions attempt to force the

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move towards the private sphere, either successfully (as in Excerpt 5) or not (as in Excerpt 4).

- Type (d) responses are the most interesting, as they attempt to pre-empt rejection through expansion. Patients seem to have practical knowledge about (informal) eligibility policies and therefore devise interactional strategies to avoid them.
- Lastly, type (c) responses are a sort of borderline case which do not deal directly with access but with the categories implied in the epidemiological-statistical form. Excerpt 7 deals clearly with a face threat due to the patient's unemployment situation. Excerpt 6, on the other hand, is on the edge of type (d): the patient's expansion faces a prejudice which ultimately questions his right to obtain public healthcare in Argentina, even if this right is not at issue either in legal or interactional terms in the interview.

As these strategies imply patients' self-images and private information about them, one of the reviewers of the first draft of this article suggested that there may be a relationship between mental condition, diagnosis (self or other administrated) and response expansion type. This relationship, however, is not apparent, at least in the data analyzed herein. Patient 5 and Patient 33, who are included in the first type of answers, received radically different diagnoses: while the former was admitted to psychiatric treatment for psychosis, the latter was admitted as an outpatient for psychotherapy to deal with a small relationship crisis. Patients included in type (b) also differ: Patient 15 was diagnosed with severe depression, including previous attempted suicide, and therefore derived to psychiatry and psychotherapy. Patient 19, on the other hand, who was a former drug addict, was referred to group therapy. Patients included in type (c) expansions are equally heterogeneous: Patient 18 was diagnosed with psychosis (and was actually seeking to continue a former treatment, initiated in Bolivia) and Patient 19 with mild depression. As for type (d), Patient 2 received psychotherapy for his relationship issues with his family, while Patient 16 was admitted as an outpatient to receive a combined addictions treatment, both psychological and psychiatric.

One relevant feature of the patients we analyze here is that all of them – except for Patient 5 – have received previous treatments of one sort or another in other public institutions. We could, therefore, hypothesize that this experience is not only clinical but also bureaucratic. Previous contact with medical institutions, implicit or explicit eligibility policies and similar questionnaires probably helped to develop a repertoire of strategies for negotiating or gaining access to health care. Is this experience only a personal, individual one? Is there any sharing of this knowledge between patients – for instance in the waiting room or other public spaces of the hospital – or do individualistic strategies prevail in order to compete for a place in a resource-starved and bureaucratically-regulated system? These questions

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cannot be addressed in this article and will require further ethnographic contextualization.

NOTES

1. The author wants to thank both anonymous reviewers, whose thorough comments have improved the final version of this article. An earlier draft was ameliorated by Virginia Unamuno's critical reading.
2. Percentages are indicative of the quantitative relevance, but they have no theoretical value in our analysis insofar as our research has been qualitatively designed.
3. As public services are tax-funded, this prejudice asserts that immigrants enjoy public services without paying for them. On this argument, and other similar ones, cf. http://cuadernos.inadi.gob.ar/ (National Institute against Discrimination, Xenophobia and Racism). It should be noted that, at least theoretically, not being an Argentine citizen should not be an obstacle to access to public healthcare, which is said to be universal. This is the reason why this case does not fall into the next category, type (d) expansions, which attempt to prevent rejection.
4. The figure of 'ID card in process' was used, until five years ago, to designate the time elapsed between the end of the legal procedures to acquire an ID card and the analogical assignation of a number by the Ministry of Interior. Since 2009, the 'process' is digital and instantaneous: once the bureaucratic steps are completed, the ID number is immediately assigned. The patient here uses a figure which no longer exists, although he shows acquaintance with former procedures.
5. On the contrary, it is said to be free and universal; cf. the City Government Ministry of Health, http://www.buenosaires.gob.ar/salud
6. Cf. '*Hospitales: duro cruce entre el gobierno macrista y Scioli*', *Clarín* 23/12/2007. http://edant.clarin.com/diario/2007/12/23/laciudad/h-06215.htm

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APPENDIX: Transcription conventions (from Richards and Seedhouse 2005)

Symbol	Meaning
[	overlap onset
]	overlap termination
=	inserted at the end of one speaker's turn and at the beginning of the next speaker's adjacent turn, it indicates that there is no gap at all between the two turns
(3.2)	interval between utterances in seconds
(.)	a very short untimed pause
<u>word</u>	speaker emphasis
:::	lengthening of the preceding sound
-	abrupt cut-off
?	rising intonation
!	animated or emphatic tone
,	low-rising intonation, suggesting continuation
.	falling (final) intonation

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↑ ↓	marked shifts into higher or lower pitch, following the direction of the arrow
CAPITALS	especially loud sounds relative to surrounding talk
° °	utterances between degree signs are noticeably quieter than surrounding talk
°° °°	considerably quieter than surrounding talk
> <	talk produced more quickly than neighbouring talk
(( ))	comments on non-linguistic behavior
(guess)	indicates transcriber doubt about a word

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