



A RIAS analysis of doctor-patient communication dynamics in the TV series “House M.D.”

Nguyen Huu Nhat Tan¹, Tran Thi Thao Phuong²

¹Master's student, English Language, University of Foreign Languages and International Studies,
Hue University

²Faculty of English, University of Foreign Languages and International Studies, Hue University

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ABSTRACT

This study provides the first quantitative analysis of doctor-patient communication in the acclaimed television series House M.D. Using the Roter Interaction Analysis System (RIAS), this study quantitatively examines House-patient communication in ten episodes of the TV series to measure three key structural indices: the Verbal Dominance Ratio (VDR), Content Balance Ratio (CBR), and Communication Control Ratio (CCR). The findings revealed a central paradox: while the VDR indicated surprising parity in speaking turns, in contrast to real-world clinical practice, the CBR showed that dialogue was overwhelmingly biomedical-dominant. Furthermore, a seemingly patient-controlled dynamic (CCR > 1.0) was found to be a statistical artifact, driven primarily by Dr. House's extensive information-giving rather than genuine patient initiative. We conclude that House M.D. presents a compelling but misleading model of communication, co-opting the form of patient participation to reinforce the physician's singular diagnostic authority.

1. INTRODUCTION

Language and communication have always played an essential role in enhancing the quality of medical encounters between doctors and patients (Vermeir et al., 2015; Shitu et al., 2018). In their synthetic literature reviews, both Vermeir et al. (2015) and Shitu et al. (2018) point out that effective medical exchanges between doctors and patients should be seriously considered to improve patients' health care outcomes. This creates a dynamic interplay between doctors and patients, as both play roles in the conversation. Hence, communicative patterns in medical exchanges between doctors and patients should be closely examined.

When it comes to media such as movies or TV series, McCombs and Shaw (1972) conclude that it has always influenced the shaping of public perceptions and understanding of issues in society. In particular, Gerbner et al. (2002) point out that TV dramas are an essential tool that offers viewers a shared experience and helps shape their expectations across various domains. In a study by Strauman & Goodier (2008), they state that medical dramas are a consistently popular genre that offers audiences portrayals of medical professionals. Even though these shows are often fictionalized, they have become significant for shaping the public's imagination and understanding of medicine and its roles. Among many TV series about the medical field, House M.D. stands out as an internationally well-known and long-running series. Not only does it catch viewers' attention with clever plots and odd cases, but it also shows doctor-patient communication as tense and, at times, manipulative (Henrysson, 2015). Consequently, this TV series is a suitable source for examining the communicative patterns in the medical field portrayed in the media.

Corresponding author: Tran Thi Thao Phuong;

E-mail address: ttphuong@hueuni.edu.vn

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In particular, this study aims to answer the following research question: How do the communication dynamics in Dr. Gregory House's medical consultations reflect verbal dominance, content balance, and communication control, as measured by the RIAS framework?

2. LITERATURE REVIEW

2.1 Physician Dominance in Medical Interactions

The medical consultation is traditionally considered an inherent imbalance of power and knowledge, resulting in the physician's dominance in the conversation (Waitzkin, 1985; Pilnick & Dingwall, 2011). According to these studies, this dynamic is rooted in the participants' roles, in which they are positioned as the help-seekers. At the same time, the physician holds epistemic authority over biomedical matters. In communication research, this asymmetry can be examined through the concept of verbal dominance.

Verbal dominance is most frequently operationalized as the quantitative share of talk. Studies consistently show that in typical medical encounters, physicians speak significantly more than patients, accounting for a larger proportion of words, utterances, and overall talk time (Roter et al., 2008; Graugaard et al., 2005; McCarthy et al., 2013). In several studies using the RIAS (Paasche-Orlow & Roter, 2003; Cooper et al., 2012), this disparity can be measured using metrics such as the Verbal Dominance Ratio (VDR). This metric compares the physician's speaking turns or utterance counts to the patient's. According to the studies mentioned, a higher ratio is interpreted as greater physician dominance, reflecting a more physician-centered interaction style in which the physician's voice and perspective occupy the majority of the conversational space.

2.2 Patient-centred care

In contrast to the doctor-dominated model of communication, patient-centred care (PCC) has been considered the gold standard for high-quality medical practice (Epstein, 2007). While definitions vary, PCC fundamentally represents a shift away from the traditional, biomedical model toward an approach that recognizes the patient's unique experience of illness, their values, needs, and preferences (Mead & Bower, 2000; Stewart, 1995). According to a widely accepted conceptual framework by Mead and Bower (2000), the five key dimensions of patient-centredness can be converted into specific observable behaviors in medical communicative terms. In their empirical literature, the mentioned patient-centred interactions include, for example, using open-ended questions to elicit the patient's perspective, active listening, and higher levels of socio-emotional or psychosocial talk.

Studies have consistently demonstrated that patient-centered care is associated with higher levels of patient satisfaction, better adherence to therapeutic regimens, improved emotional well-being, and, in some cases, better physiological health outcomes (Stewart et al., 2000; Street et al., 2009; Stewart & Ryan, 2024). Two factors can be used to measure PCC (Mead & Bower, 2000; Epstein & Street, 2011; Brown et al., 2024). The first one is behavioral markers of partnership-building (such as inviting questions, eliciting preferences, and interpreting patients' responses), and the second is socio-emotional talk (empathy, reassurance). The other one can be the structure of the visit's conversation (which can either focus on socioemotional or biomedical topics). Specifically, within RIAS-based works, patient-centredness can be measured using the formulas proposed by Ford et al. (1996), as mentioned in the Research Methodology chapter of this study.

2.3. Previous Studies

As a global television phenomenon, the series *House M.D.* has attracted considerable scholarly attention from a variety of aspects. The first aspect concerns the contrast between the abnormal portrayal of Dr. House and the traditional "doctor-hero" model. In the series, Dr. House is not portrayed as an idealized television doctor who concerns about the emotional and personal needs of the patient. While personally and interpersonally problematic, his biomedical effectiveness stands out in helping patients, and this is thought to be a direct counterpoint to the modern, patient-centred ideal (Strauman & Goodier, 2011; Bittner et al., 2013; Holtz, 2006). Other studies have examined Dr. House's communicative patterns through qualitative linguistic analysis. Specifically, as a standout trait of Dr. House, his impoliteness strategies have been reviewed by Kantara (2010) and Laitinen (2011). The results indicate that this impoliteness was used to assert Dr. House's expert power and control over interactions. In a related study, Henrysson (2015) qualitatively analyzed the use of speech functions (namely statements, questions, and commands) to demonstrate how doctors in the series dominate the interaction and exercise power over patients. These studies confirm that House's communication is strategically designed to be controlling, confrontational, and deeply asymmetrical.

While previous studies have provided rich interpretive insights into the show's messages and communication style, the field lacks quantitative measurements of the dialogue's structure using a validated

clinical communication framework. In particular, previous linguistic studies have been qualitative and interpretive, focusing on selected instances of impoliteness or specific speech acts. However, no known research has applied the Roter Interaction Analysis System (RIAS) to the House M.D. corpus. This study addresses this precise gap, employing the RIAS framework to conduct a quantitative analysis of key communicative patterns employed by Dr. Gregory House in the TV drama “House M.D.”.

3. METHOD

3.1. Research design

The primary quantitative component involves content analysis utilizing the Roter Interaction Analysis System (RIAS) framework. This is a widely used and well-validated scheme for quantifying medical dialogue (Roter & Larson, 2002). This method is built on the distinction between the task-focused and socio-emotional domains of medical exchanges (Bales, 1950; Roter & Larson, 2002). This focus allows researchers to simultaneously evaluate the efficiency of information exchange and the quality of the interpersonal relationship being built during a medical encounter. Despite critiques by Sandvik et al. (2002) (e.g., decontextualization, limited nonverbal focus), RIAS remains a gold standard for quantitatively assessing interaction patterns (Roter & Larson, 2002).

By applying RIAS, this research can objectively measure the distribution of different communication categories (socioemotional vs. task-focused), calculate frequencies of specific behaviors (e.g., negative socioemotional expressions), and gather the necessary data to compare communication styles (House’s style vs. RIAS benchmarks).

3.2. Corpus and sampling

The primary source for this research consists of 10 episodes of House M.D. spanning Seasons 1-6. Episodes were selected by purposive sampling to cover different seasons, patient profiles, and clinical settings. The target for analysis is consultation talks between Dr. Gregory House and a patient or a patient representative.

The selected episodes included: S01E06 (The Socratic Method); S01E11 (Detox); S02E01 (Acceptance); S02E19 (House vs. God); S03E12 (One Day, One Room); S03E15 (Half-Wit); S04E01 (Alone); S04E11 (Frozen); S05E09 (Last Resort); S06E05 (Instant Karma).

In total, there are 88 micro-encounters comprising of 1,368 utterances. Due to the purposive sampling, turn counts vary among episodes. The marked variability in turn counts across episodes is attributable to specific narrative structures and clinical contexts. For example, episodes like S03E12 - One Day, One Room and S04E11 - Frozen feature unique communicative demands. In “One Day, One Room”, the episode focuses on extended bedside counseling and philosophical debate regarding a rape victim, naturally inflating the verbal exchange. Similarly, “Frozen” necessitates high verbal volume because it is a telemedicine consultation. This requires Dr. House to verbally direct a mechanic to perform physical procedures, demanding dense instructional sequences that replace silent physical actions. Conversely, episodes with fewer counts are characterized by fewer micro-encounters. In these instances, the narrative prioritizes plot progression and external conflict over sustained diagnostic dialogue. This results in shorter and more functional exchanges.

The sampling process was operated in 2 steps. Firstly, the researcher watched the selected episodes to confirm the presence of at least one doctor-patient encounter. Second, within each episode, the consultation was categorised into “micro encounters”. A micro encounter is a consultation sequence with a clear opening and closing and at least one completed adjacency pair. Only conversations between Dr. House and the patient (or Dr. House and the patient’s companion) were retained. Communicative exchanges between doctors, doctor (other than Dr. House), and patient (and/or patient’s companion) were excluded

3.3 Coding framework and procedure

To quantify task-focused and socio-emotional communication in House-patient consultations, the Roter Interaction Analysis System (RIAS) was used as an utterance-level coding system. Before the coding process began, a codebook was developed based on the framework proposed by Hall, Roter, and Junghans (1995), including categories, definitions and corresponding examples (table 1 presents a condensed list for presentation only of the RIAS categories for doctors’ and patients’ communication). The coder conducted self-training and pilot coding to get the hang of the coding process before formal coding.

Transcripts of ten episodes were verified by rewatching to confirm speaker attribution, turn boundaries, and wording sufficient for RIAS coding. Bracketed scene directions were excluded; nonverbal tags served only as contextual cues.

Table 1. Condensed categories of the RIAS for doctors' and patients' communication

Functional Grouping	Role	Communication behavior	Examples
Data gathering	Doctor	Asks questions about issues of health behaviors, lifestyle, social context, psychosocial aspects, and feelings, etc. (Cavaco & Roter, 2010)	"Since when do you let patients participate in differentials?"
Patient education and counseling		Gives information, instructions, and explanations, answers patient questions.	"Your blood pressure is high today, 180/95"; "Put your hands on the bar, and your chin in here."
Partnership Building		Asks for understanding, makes interpretations, seeks the patient's ideas.	"What is your understanding of the reasons we did the MRI?"
Expressing and Responding to Emotions	Doctor and patient	Positive: Agrees, gives reassurance, calms. Negative: Disagrees, shows antagonism, confronts. Social chitchat: Greet, makes nonmedical statements.	"Yeah, all right, all right." "It was a dumb question." "Hello, Mr. Waller, nice to see you." "DON'T TOUCH ME!!"
Information Giving	Patient	Presents symptoms, provides information, and answers the doctor's questions	"My gut, I feel like I'm getting stabbed!"
Question Asking		Asks questions about treatment, health behaviors, lifestyle, etc.	"What's the treatment?"

The unit of analysis was the speaker turn; turns expressing multiple functions could receive multiple RIAS codes. For each turn, only House-patient and House-companion talk was included; doctor-doctor and interactions involving non-House physicians were excluded. In this analysis, utterances from patients and their companions (representatives) were aggregated into a single 'patient-side' category. This grouping is theoretically justified by the functional alignment between patients and their companions observed in medical communication research. Laidsaar-Powell et al. (2013) identify that companions predominantly serve as advocates or surrogates, providing essential "informational support" (including such categories like asking questions, clarifying history, and ensuring the patient understands medical instructions), thereby acting as an extension of the patient's agency. Consequently, companion's role is structurally similar to the patient's role and distinct from the physician's medical authority.

Coding was conducted in NVivo 20: speaker cases (House, patient, companion) were created, RIAS codes applied, and Matrix Coding Queries generated category frequencies by speaker group. Results were exported to spreadsheets for computation of the three RQ1 indices: verbal dominance, content balance, and communication control.

3.4. Measures

Three ratio indices from RIAS-coded counts were operationalized to quantify structural features of the consultations. These ratios were calculated at the episode level and then pooled (by token counts). Patient-side = patient and/or companion. Doctor-side = Dr. House only. Turns are uninterrupted speaker contributions. Multi-function turns count once.

3.4.1. Verbal Dominance Ratio (VDR)

$$VDR = \frac{\text{House turns}}{\text{Patient-side turns}}$$

Interpretation: $VDR > 1$ indicates that Dr. House speaks more often than the patient; $VDR < 1$ suggests the opposite.

3.4.2. Content Balance Ratio (CBR)

$$CBR = \frac{\text{House psychosocial/lifestyle information} + \text{House socio-emotional talk}}{\text{House biomedical information}}$$

Interpretation: $CBR < 1$ = biomedical-dominant content; $CBR \approx 1$ = balanced; $CBR > 1$ = psychosocial/socio-emotional tilt.

3.4.3. Communication-Control Ratio (CCR)

$$CCR = \frac{\text{Patient-controlled}}{\text{Doctor-controlled}} = \frac{\text{Patient-side questions} + \text{House information-giving} + \text{House counseling}}{\text{House questions} + \text{House procedural talk} + \text{Patient-side biomedical}}$$

Interpretation: CCR > 1 indicates greater patient-oriented initiative and uptake (more patient questions and doctor responses to the patient agenda); CCR < 1 indicates stronger doctor control through questioning and structuring.

3.5. Data analysis

Only House-patient/companion consultations were analysed within identified micro-encounters. After coding in NVivo, Matrix Coding Queries produced frequency tables of RIAS categories by speaker role and episode. Raw exports were preserved as read-only sheets; a separate analysis worksheet (Google Sheets) contained derived variables and transparent formulas. Indices followed the definitions in “Measures for RQ1”.

3.6. Inter-Rater Reliability

An independent coder recoded 1,150/1,290 utterances (89.1%), stratified across episodes. Reliability was evaluated using percent agreement and Cohen’s κ across three domains: Doctor task-focused (89.3%, 0.30), Doctor socio-emotional (93.3%, 0.28), and Patient communication (92.8%, 0.36). According to Landis & Koch (1977), κ values indicate “Fair” agreement; high agreement suggests limited miscoding. The discrepancy reflects the “kappa paradox” (Cicchetti & Feinstein, 1990; Feinstein & Cicchetti, 1990): low-prevalence codes inflate chance agreement and depress κ . Accordingly, both metrics are reported, and reliability is deemed adequate for the study.

4. FINDINGS

4.1. Verbal Dominance Ratio

As can be seen from table 2, overall verbal participation in House-patient medical encounters approaches parity with a pooled VDR of 0.937 and a mean VDR of 1.030. This result contrasts with medical consultations in the real world, as many other studies show that physicians are verbally dominant in actual medical exchanges. For example, a study by Roter et al. (2008) indicates that physician talk averages around 60% in primary care visits. This is consistent with other RIAS studies that show a conventional pattern in primary care and several specialty settings, set against RIAS benchmarks (Roter et al., 1997; Graugaard et al., 2005; Pires & Cavaco, 2014), in which physicians typically contribute a larger share of utterances. Furthermore, this pattern of physician dominance has proven remarkably consistent and stable across different cultural contexts.

Table 2. Verbal Dominance (VDR) and Content Balance (CBR) by episode

Episode	House turns	Patient-side turns	VDR	House’s RIAS assigned codes	House biomedical (% within the episode)	House psychosocial (% within the episode)	House socio-emotional (% within the episode)	CBR
S01E06	47	47	1.0	79	26 (32.9%)	3 (3.8%)	30 (38%)	1.27
S01E11	38	24	1.6	48	16 (33.3%)	3 (6.3%)	18 (37.5%)	1.31
S02E01	19	21	0.9	27	12 (44.4%)	0 (0.0%)	7 (25.9%)	0.58
S02E19	31	36	0.9	40	17 (42.5%)	1 (2.5%)	17 (42.5%)	1.06
S03E12	68	118	0.6	200	102 (51.0%)	0 (0.0%)	55 (27.5%)	0.54
S03E15	44	35	1.3	51	33 (64.7%)	0 (0.0%)	10 (19.6%)	0.30
S04E01	50	54	0.9	61	38 (62.3%)	5 (8.2%)	10 (16.4%)	0.39
S04E11	99	88	1.1	134	66 (49.3%)	1 (0.7%)	54 (40.3%)	0.83
S05E09	87	95	0.9	106	59 (55.7%)	0 (0.0%)	23 (21.7%)	0.39
S06E05	16	15	1.1	13	8 (61.5%)	0 (0.0%)	5 (38.5%)	0.63
Pooled	499	533		759	377	13	229	

However, the significant variability in VDR across the analyzed episodes (ranging from highly patient-dominant (0.60) to moderately doctor-dominant (1.60)) should be taken into account. This suggests that verbal dominance in the series functions as a flexible narrative tool rather than a fixed character trait. In real-world settings, a physician’s communication style, while adaptable, tends to exhibit consistency (as previously mentioned studies). However, House’s style shifts dramatically to serve the specific plot. In psychosocially dense episodes like S03E12 - “One Day, One Room”, when the narrative requires a deeper patient disclosure, it results in House speaking less than the patient. Conversely, in episodes revolving around a rapid diagnostic puzzle, such as S01E11 - “Detox”, the plot demands authoritative exposition from House, driving his verbal share higher. This variability indicates the constructed nature of the consultations, in which conversational dynamics are shaped by dramatic necessity rather than by the principles of patient-centered care.

This surprising balance, however, should not be misinterpreted as an indicator of patient-centeredness. The

concept of patient-centered care emphasizes not just the quantity of patient talk but the quality of the interaction, focusing on a partnership-building dynamic in which the patient's perspective is actively sought and valued (Mead & Bower, 2000). While increased patient talk is a feature of this model, its function is typically collaborative. In House's consultations, the purpose of the extended patient talk appears to be fundamentally different. The dialogue often resembles an interrogation, where House cedes the floor only to extract the necessary diagnostic clues from the patient's narrative. This aligns with findings that physician control is not solely measured by talk time, but by how talk is structured; for instance, a physician can maintain control while speaking less by using specific questioning strategies to guide the patient's responses (Mishler, 1984). Thus, the balanced VDR in House M.D. may represent a dramatized form of diagnostic data extraction rather than a genuine transfer of conversational power.

Ultimately, this analysis uncovers the "House paradox": the series constructs conversations that mimic a positive communication metric (balanced talk time), which, in empirical research, is linked to higher patient satisfaction and improved outcomes (Stewart et al., 2000; Roter et al., 1997). An audience may perceive these interactions as more engaging or even effective precisely because the patient is given so much space to speak. However, this quantitative balance masks a qualitative reality in which the patient's talk is strategically managed to serve the physician's singular intellectual goal. The show co-opts the form of patient participation without embracing its collaborative function, presenting a compelling but ultimately misleading model of physician-patient interaction.

4.2. Content Balance Ratio (CBR)

In contrast to the surprisingly balanced verbal dominance, results for the communicative content reveal a dynamic consistent with real-world clinical practice. Data from table 2 shows a pooled Content Balance Ratio (CBR) of 0.642, with 70% of episodes classified as biomedical-dominant. This indicates that Dr. House's consultations are overwhelmingly weighted toward biomedical topics. When compared with the widely documented pattern in physician-patient communication, this result is consistent and aligns precisely with the "narrowly biomedical" visit type (Roter et al., 1997), where problem-solving is driven by technical information exchange while psychosocial and emotional content remains limited. Later studies show similar results, with biomedical conversation accounting for the largest share of topics (Agha et al., 2009; Tai-Seale et al., 2007). This study's findings suggest that while the quantity of talk in House M.D. may be a dramatic construction, the substance of that talk reflects a reality of modern medicine, in which there is a tendency to prioritize the disease over the patient's life context.

This alignment has significant implications for the principles of patient-centered care (PCC). According to the benchmark proposed by Mead & Bower (2000), effective medical communication requires understanding patients' emotional state, life circumstances, and personal values. The purpose is to have a more effective diagnosis and treatment. As a result of effective patient-centered care, several studies have firmly established that incorporating psychosocial dialogue facilitates a stronger therapeutic alliance, enhances patient trust, and can lead to improved health outcomes (Street et al., 2009). Because the CBR favors the biomedical topic, this suggests that House's dialogue style might reduce patient satisfaction, as research has shown that patients in narrowly biomedical consultations report the lowest satisfaction levels with their care (Roter et al., 1997; Stewart et al., 2000).

However, the findings also reveal crucial exceptions that add a layer of sophistication to this analysis. The three episodes that were rated as balanced or psychosocially oriented (e.g., S01E06 - "The Socratic Method", S01E11 - "Detox" and S02E19 - "House vs. God") were not random deviations. In these instances, the narrative was constructed so that the patient's lifestyle, beliefs, or emotional state was not a peripheral context but a central clue to the vital diagnosis. This suggests that House's shift toward psychosocial inquiry is not driven by empathy but by pragmatic necessity. His focus broadens only when the patient's life becomes an unavoidable part of the biomedical problem.

In synthesis, the analysis of content balance provides a powerful counterpoint to the findings on verbal dominance. While the VDR presented a fictionalized egalitarianism, the CBR exposes a core realism. The show accurately captures a fundamental tension in medicine: the struggle to see the patient as a person rather than a collection of symptoms. By consistently centering biomedical dialogue, Dr. House's interactions exemplify the very communication patterns that the patient-centered movement has sought to reform for decades (Epstein, 2007). This makes the show a compelling, if cautionary, illustration of a system where the intellectual pursuit of a diagnosis can overshadow the humanistic practice of medicine.

Table 3. Communication Control (CCR) components and ratio by episode

Episode	Patient-controlled utterances			Doctor-controlled utterances			Patient-controlled total	Doctor-controlled total	CCR
	Patient questions	House information-giving	House counseling	Patient biomedical info	House questions	House structuring			
S01E06	9	23	10	12	8	30	42	50	0.84
S01E11	22	12	5	11	0	32	39	43	0.91
S02E01	16	9	3	6	2	23	28	31	0.90
S02E19	16	13	6	5	0	42	35	47	0.74
S03E12	5	93	16	35	8	39	114	82	1.39
S03E15	18	25	15	8	0	28	58	36	1.61
S04E01	32	36	8	5	3	23	76	31	2.45
S04E11	28	48	29	8	5	69	105	82	1.28
S05E09	19	45	22	18	6	38	86	62	1.39
S06E05	17	8	1	0	0	16	26	16	1.63
Pooled	182	312	115	108	32	340	609	480	

4.3. Communication Control Ratio (CCR)

A pooled Communication Control Ratio (CCR) of 1.27 indicates that communication control tilts toward the patient. On the surface, this result suggests that patients and their companions direct the conversational flow more than the physician, a dynamic that would be highly unusual in real-world practice. However, a deeper analysis of the operationalized metric reveals that this figure does not reflect genuine patient empowerment. As shown in table 3, the Patient-controlled utterances cluster includes “Patient questions”, “House information-giving”, and “House counseling”, and the latter two doctor-related items (51.23% and 18.88%, respectively) dominate in number compared with the remaining patient-related item (29.89%). This finding indicates that the “patient-controlled” numerator is primarily driven not by patient initiative, but by Dr. House’s own extensive information-giving and counseling.

This method of how Dr. House controls his medical exchanges contrasts with the mechanisms typically observed in clinical settings. Traditionally, physicians maintain control through structural means, such as agenda-setting and, most notably, their questioning patterns (Roter & Hall, 2006). By employing closed-ended questions, physicians can restrict patient responses to specific, biomedically relevant details, thereby orienting the conversation. This process has been described by Mishler (1984) as a struggle between the “voice of the lifeworld” (the patient’s narrative of their experience) and the “voice of medicine” (the physician’s framework of objective, technical inquiry). In most real-world encounters, even though studies suggest that consultations oriented to the lifeworld are often associated with better outcomes and more humane care (Barry et al., 2001), physicians usually steer the conversation firmly into the voice of medicine (Mishler, 1984; Roter et al., 1997). The findings for Dr. House show a similar outcome but through a different mechanism. The fact that “Patient biomedical information” (22.5%) accounts for a considerable share of the doctor-controlled side of the ratio indicates that, when patients do speak, they are primarily confined to the voice of medicine, providing data elicited by House. From this, Dr. House achieves not just through questioning but also by framing the entire encounter with his own authoritative narratives. Given Dr. House’s dominance in biomedical utterances (see Content Balance Ratio), this finding is consistent with van den Brink-Muinen et al.’s (2006) results, who found that patients were less often involved in decision making when treatments or diagnostic procedures were performed.

In synthesis, the data reveal a model of interaction where superficial metrics suggest patient control, while the underlying structure is profoundly physician-centric. House strategically cedes the conversational floor, allowing extended patient disclosure only to gather the raw data he requires. He then reclaims the floor to deliver his analysis, effectively dominating the encounter’s most critical phase: the interpretation and management of the illness. This reflects a dramatized, extreme form of “informational leadership”, in which the physician’s power is anchored not in a high volume of questions but in the capacity to frame reality through authoritative exposition. This makes for compelling television but offers a cautionary model of communication that runs counter to the collaborative and empowering ideals of contemporary medical practice.

5. CONCLUSION

In sum, applying RIAS to ten House-patient consultations shows that, although participation often appears balanced in shared talk time, interactional power remains physician-centred. The data indicate that House

routinely elicits patient talk to gather biomedical data, then reasserts interpretive authority to frame problems and drive management. The series constructs a communication model that mimics patient participation not for collaboration, but as a strategic tool for diagnostic data extraction, reinforcing the physician's singular intellectual authority. As a result, this produces encounters that are collaborative in form but not in function.

Beyond theoretical insights, these findings offer tangible implications for medical communication education. The observed findings serve as a critical pedagogical tool. It illustrates for trainees that "letting the patient speak" does not mean the medical exchange is patient-centered. Furthermore, educators can utilize these House M.D. profiles as negative case studies to demonstrate that high patient participation can be superficial if the physician retains strict control over the topic agenda, using closed questioning and authoritative information-giving. By analyzing these interactions, students can learn to distinguish between the quantity of patient talk and the quality of the therapeutic alliance, helping them avoid the "participatory illusion" where diagnostic efficiency is prioritized over the biopsychosocial integration required for effective practice.

While these findings from a fictional series cannot be generalized to clinical practice, they serve as a cautionary illustration for medical communication: quantitative metrics of patient-centeredness are meaningless without a qualitative analysis of their function.

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Giao tiếp bác sĩ-bệnh nhân trong loạt phim truyền hình y khoa “House M.D.”

Nguyễn Hữu Nhật Tân¹, Trần Thị Thảo Phương²

¹Học viên cao học, Ngôn ngữ Anh, Trường Đại học Ngoại ngữ, Đại học Huế

²Khoa tiếng Anh, Trường Đại học Ngoại ngữ, Đại học Huế

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Giao tiếp bác sĩ-bệnh nhân;

House M.D.;

Hệ thống Phân tích Tương tác Roter (RIAS);

Áp đảo bằng lời nói;

Kiểm soát giao tiếp.

Tác giả liên hệ:

Trần Thị Thảo Phương

Địa chỉ e-mail:

ttphuong@hueuni.edu.vn

TÓM TẮT

Nghiên cứu này trình bày phân tích định lượng về giao tiếp bác sĩ-bệnh nhân trong loạt phim truyền hình nổi tiếng “House M.D.”. Bằng cách sử dụng Hệ thống Phân tích Tương tác Roter (RIAS), nghiên cứu này khảo sát mười tập phim của loạt phim để đo lường ba chỉ số cấu trúc chính: Tỷ lệ Áp đảo bằng lời nói (VDR), Tỷ lệ Cân bằng Nội dung (CBR), và Tỷ lệ Kiểm soát Giao tiếp (CCR). Kết quả cho thấy một nghịch lý: dù VDR cho thấy sự cân bằng đáng ngạc nhiên về lượt lời, trái ngược với thực tế lâm sàng, CBR lại cho thấy đối thoại thiên về y sinh một cách áp đảo. Hơn nữa, một động thái tương tự do bệnh nhân kiểm soát (CCR > 1.0) thực chất là tạo tác thông kê, chủ yếu bắt nguồn từ việc Bác sĩ House cung cấp thông tin một cách sâu rộng thay vì từ sự chủ động thực sự của bệnh nhân. Chúng tôi kết luận rằng House M.D. đã trình bày một mô hình giao tiếp hấp dẫn nhưng dễ gây hiểu lầm, trong đó hình thức tham gia của bệnh nhân chỉ được vay mượn để củng cố quyền lực chẩn đoán duy nhất của người bác sĩ.