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Conversation analysis: a new model of research in doctor-patient communication

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In his much cited 1983 review, David Pendleton¹ strongly criticized existing research on the process of medical consultation. What he meant by process research was research that focuses on what happens *during* the consultation. Pendleton argued that consultation process descriptions have been 'like the listing of ingredients in a cake without the analysis which shows how to put the ingredients together'. The research that has appeared since Pendleton's critical review indicates that the difficulties are far from overcome. Most of the analyses of doctors' and patients' activities in consultation have applied 'aggregation techniques'², which operate by coding and counting the frequency of a small number of behaviours such as 'information giving', 'social conversation', 'positive talk' or 'negative talk'³. This approach has drawn attention to various types of activity within the consultation and their possible association with the outcome, for example patient satisfaction. What it seriously lacks, however, is exactly the kind of insight that Pendleton called for 13 years ago—an analysis of 'consultation process in terms of social interaction'¹ and an ensuing understanding of the consultation as a *sequentially organized event*.

Around the time that Pendleton published his critical review, conversation analytical studies of a new kind began to appear. Reports from Heath^{4,5}, Frankl^{6,7} and West^{8,9} raised the hope that conversation analysis could meet exactly the challenge spelled out by Pendleton. (Refs 10-12 offer examples of later developments of conversation analytical studies on medical interaction.) In this paper, I will demonstrate the possibilities that conversation analysis opens up for research on doctor-patient communication.

CONVERSATION ANALYSIS AS A WAY OF DESCRIBING THE SEQUENTIAL ORGANIZATION OF INTERACTION

Through a detailed qualitative examination of tape recordings and transcripts of real-life interaction, conversation analysis (CA) reveals how day-to-day human activities are composed and organized¹⁴⁻¹⁷. The aim of such studies of interaction between client and professional is to describe the particular ways in which both parties

accomplish their tasks through the sequential organization of interaction¹⁸⁻²¹. In medical consultations, central tasks include elicitation of the patient's complaint, the history, the physical examination, diagnosis and advice (how these are delivered and received), and information about further examinations^{22,23}. All of them can be subjected to a detailed analysis. To demonstrate how conversation analysis can shed light on accomplishment of the physician's and the patient's tasks I present results from a study on medical consultations in Finnish primary health care. A central medical task that we have focused upon is the delivery of diagnostic information²⁴⁻²⁶.

THE DELIVERY OF DIAGNOSTIC INFORMATION

In our corpus of 65 videotaped primary health care consultations, we have identified two different ways in which doctors tell patients their diagnosis. Here I discuss the two types of utterance, focusing on the ways in which communication of the diagnosis involves a balancing act between authority and intersubjectivity—i.e. a balance between orientation to the doctor as a possessor of exclusive knowledge and orientation to the patient as an informed participant.

All the extracts in this paper are presented with a simplified transcription system (see Box 1). In the first example, the diagnosis is delivered through what we call a 'straight factual assertion'.

Box 1 Transcription symbols

The <u>pulse</u>	Underlining means emphasis
Dr: <u>pulse</u> [can be felt [Square brackets mean overlapping talk
P: [Thank you. (0.2)	Numbers in parentheses indicate silences measured in tenths of seconds
((The doctor is examining the X-ray))	Descriptions of non-verbal events are given in double parentheses
→	Single arrows mark diagnostic statements
⇒	Double arrows mark reports of observations

Extract 1

- 1 (The doctor looks into the patient's ear)
 2 Dr: > There's still an infection
 3 > in the auditory canal. I'll prescribe
 4 kind of drops for it

The doctor makes a statement in the classical format 'X is Y'. The utterance offers the diagnosis as a direct description of reality.

In the other type of diagnostic utterance, doctors describe specific observations and frame them as *evidence* for their diagnostic statements—the 'evidence formulating pattern', of which extract 2 offers an example:

Extract 2

(The doctor has just examined the patient's foot)

- 1 Dr: Okay. Fine do put on your,
 2 (0.2)
 3 Dr: => The pulse [can be felt
 |
 4 P: [Thank you.
 5 Dr: => there in your foot so,
 6 > there's no, in any case no real
 7 > circulation proble[m
 |
 8 P: [Yes I don't understand then
 9 [really I was wondering whether] I should
 |
 10 Dr: > [is involved.

The main difference between extracts 1 and 2 is that, in the latter, the doctor describes some of his observations (the pulse can be felt) before the delivery of the diagnostic statement and frames his observations as reasons for, or evidence of, the diagnostic conclusion. Thus, the doctor treats the patient as an *understanding recipient* of medical reasoning.

By contrast, when employing the 'straight factual assertion' format, doctors indicate that the diagnosis is unproblematic and must be taken for granted²⁷; they do nothing to make the medical reasoning transparent to the patient.

Thus, straight factual assertions seem to involve a strong orientation to the doctor's authority, whereas the evidence-formulating pattern seems to work towards establishing an intersubjective understanding of some aspects of the diagnostic process. However, a closer sequential analysis will show that there are elements of intersubjectivity and authority in both types of diagnostic utterance.

LOCAL CONTEXT OF THE DIAGNOSTIC STATEMENTS

'Straight factual assertions' are regularly used when the reasons or grounds for the diagnosis are obvious either on physical examination or from some medical document such as an X-ray.

In extract 3 the patient has hurt his finger when lifting a stone in a lake. Our extract is from the first follow-up visit after an X-ray was taken of the finger. The patient has brought the X-ray to the consultation. Before the diagnostic statement, the doctor examines it against the illuminated screen while the patient volunteers his own reflections on the circumstances of the accident.

Extract 3

- 1 (6.2) (Dr switches off the illuminated screen and returns to his seat. He holds the X-ray picture in his hand in front of him.)
 2 Dr: Luckily the bone is quite intact,
 3 P: Yeah,
 4 Dr: So within a week it should get better
 5 with that splint.

In line 2, when producing the diagnostic statement 'luckily the bone is quite intact', the doctor holds the X-ray in his hand, so that the picture is between himself and the patient. The diagnosis can be heard as a description of the X-ray. Thus, the *evidence of the diagnostic conclusion*—the X-ray picture—is prominently present in the activity context. The grounds of the diagnostic conclusion are, literally, visible to both participants. Equally importantly, however, the patient avoids any active use of the evidence: when the doctor examines the X-ray pictures against the illuminated screen the patient merely glances at the picture. In this way, the patient acknowledges the evidential source of the diagnosis but does not presume to examine or interpret that evidence.

The physical presence of evidence—either from medical documents or from physical examination—is a feature in all our cases of 'straight factual assertions'. Therefore, the doctors' use of such assertions in the delivery of the diagnosis does not involve a claim of unconditional authority at the cost of intersubjectivity. The doctors create a context where authority and intersubjectivity are blended.

In what context, then, is the evidence-formulating pattern used for delivery of the diagnosis? Two issues seem to be concerned here. One of them is the problematic stature of the diagnosis, as involving a choice between serious and non-serious possibilities. Doctors may display evidence in a context where they *rule out* more serious diagnostic possibilities, which the patients might have indicated that they were worried about (example 2).

Secondly, and perhaps more importantly, use of the evidence-formulating patterns is related to the non-transparent nature of the evidence—that is, to the inferential distance between the events seen and undergone by the patient on one hand, and the diagnostic conclusion on the other. In extract 3, illustrating straight factual assertion, the evidence was in a single X-ray picture. For

members of our culture, it is obvious that an X-ray shows whether a bone is broken or not.

By contrast, the patient in extract 2 has complained about an intense pain in her foot—pain that went away on its own but still worried her. During his examination (looking at and palpating the foot), the doctor has not reported any findings or observations. After the examination, the doctor tells the patient that ‘no real circulation problem is involved’. By formulating the evidence ‘the pulse can be felt’ the doctor demonstrates to the patient not only something he was doing (i.e. checking the pulse) but also that there *was* a positive finding that can be used to rule out a potentially worrying disease.

In sum, the evidence formulation bridges the potential inferential gap between the events during the examination and the diagnostic conclusion. Without this bridging device, it could have remained unclear for the patient which, if any, events or observations in the examination support the doctor’s diagnostic choice.

PATIENTS’ RESPONSES TO DIAGNOSTIC STATEMENTS

When diagnoses are delivered by straight factual assertions the patient’s response is typically slight²⁶. In extract 3 we see an example: after the diagnostic statement the patient produces a minimal ‘Yeah’. Through this token response he acknowledges the diagnosis and the doctor’s authority in diagnostic reasoning.

Diagnoses that employ the evidence-formulating pattern often elicit more elaborate responses, as in extract 4:

Extract 4

- 1 Dr: => As tapping on the vertebrae didn’t cause any
pain
2 => and there aren’t (yet) any actual reflection
symptoms
3 > in your legs it corresponds with a muscle
4 > complication so it’s only whether
5 you have been exposed to a draught
6 or has it otherwise
7 P: Oh yes,
8 Dr: got irritat[ed]
|
9 P: [It couldn’t be from somewhere inside
10 then as it is a burning feeling there so it couldn’t
11 be in the kidneys or somewhere (that pain)

In her response to the doctor’s diagnosis, the patient both formulates her own diagnostic suggestions and offers evidence to support them, thus treating herself as an independent agent in the realm of medical reasoning. However, through the use of a question format in her diagnostic suggestions, she displays an expectation that it is the doctor who will ultimately diagnose the trouble. Moreover, the evidence she produces in line 10 is of an

‘experiential’ nature: she describes a bodily sensation to which she and she only has access. Thus, the patient’s evidence is of a ‘subjective’ character, whereas the doctor’s is ‘objective’ (lines 1–3).

In sum, the evidence-formulating pattern differs from the straight factual assertion in making relevant the patient’s comment on the diagnosis; but, even in this further discussion, the doctor’s authority is preserved.

CONCLUSION

In this paper I have tried to show how conversation analysis offers a rigorous method of determining how the ‘ingredients of the cake’¹ come together in medical consultations. Thereby, it becomes possible to point out *different ways* of accomplishing given medical tasks. I have looked at two ways of delivering the diagnosis and shown how each has its typical environment of occurrence.

Nevertheless, there is always an element of choice: each doctor is free to decide whether or not, and in which ways, to describe the evidence for the diagnosis. The choice that is made has implications for the patient’s response. Conversation analysis can point out and clarify the parameters within which these choices are made.

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