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Communicating and responding to diagnosis

Anssi Peräkylä

Introduction

In the literature on medical consultations, there are two strikingly different ways of thinking about the relation between doctors and patients. One emphasizes the doctor's authority, while the other, often programmatically, emphasizes the patient's knowledgeability and his or her participation in the diagnostic procedure and the decisions about the treatment. Writers who have emphasized the doctor's authority include, most notably, Talcott Parsons (1951), Eliot Freidson (1970b), and Andrew Abbott (1988). They point out that doctors possess technical and scientific knowledges that enable them to diagnose illnesses, and society has warranted them with the license to decide about medication and sick leave, and to perform surgical and other therapeutic procedures. The patient does not have such knowledge and licenses. Therefore, the relation between the doctor and the patient is necessarily characterized by the doctor's authority. However, there are other writers – for example, in medical anthropology (Stimson and Webb 1975; Kleinman 1980; Helman 1992) and on fields of research closely related to medical practice (e.g.; Pendleton 1983; Tuckett et al. 1985; Lipkin et al. 1995), who maintain that the patient, as well as the doctor, has ideas about the nature, the origin and the possible remedies of the patient's ailment. The consultation could and should be an encounter between two differently but equally resourceful agents where they negotiate diagnosis and treatment. In an ideal case, the parties' views will merge.

These two ways of understanding the doctor–patient relations appear as quite incompatible. Yet, at least for me, they both have

some intuitive appeal. When I am a patient, I think that a good doctor is one that I can trust by virtue of the doctor's special knowledge and expertise. However, I also expect that a good doctor does not deal with me as if I knew or understood nothing about my illness, but instead respects my views about my ailment and guides me to an understanding of its diagnosis. Thus, to put it in terms coined by Billig and his colleagues (1988), the doctor's authority and the patient's knowledgeability in the medical consultation are in a "dilemmatic" relation: in spite of their incompatibility, both ideas seem to have some truth in them. Billig argues that many modern professions are characterized by similar kinds of "ideological dilemmas." These dilemmas cannot be resolved by the participants trying to subscribe exclusively to one or the other set of conflicting ideas, but instead by balancing them in their everyday practice.

In this chapter, I will examine the interactions between doctors and patients during a specific phase of medical consultation: at the delivery and reception of diagnosis. Through the examination of these interactions, I will show how doctors and patients simultaneously orient to the doctor's authority and still maintain a degree of mutual intelligibility of the diagnostic procedure. In other words, I will show how the participants in medical consultations find ways of accommodating the doctor's authority with his accountability and the patient's knowledgeability. The first half of the chapter deals with the doctor's utterances in which he or she tells the patient the diagnosis. The latter half focuses on the patients' responses. Before presenting the empirical results, however, I will briefly summarize some earlier research and give details of the data.

Earlier research on diagnosis

The delivery of diagnosis in primary care was first examined by Byrne and Long (1976) in their classic study of doctor–patient interaction in Britain in the early 1970s. According to their account, the doctors regularly adopt a highly authoritarian footing when telling (or, rather, failing to tell) patients about their disease. Most consultations, according to Byrne and Long, contain no real delivery of diagnostic information "of more than two seconds' duration" (1976:50). Doctors very seldom engage in activities such as "selling"

their decisions to the patient. Thus the picture painted by Byrne and Long emphasized the doctor's authority and was very close to what one would expect on the basis of the theoretical writings of Parsons (1951), Freidson (1970b), and Abbott (1988): doctors interacted with patients in a way that implicated that diagnostic reasoning was their exclusive property.

More recently, Christian Heath (1992) found that in British general practice patients typically fail to respond with much more than minimal acknowledgment tokens to their doctors' diagnostic statements. He concludes:

> By withholding response to the medical assessment . . . patients relinquish or subordinate their knowledge and opinion concerning the illness . . . and render the co-participant's version as the objective, scientific, and factual assessment of the condition. (1992:264)

In emphasizing the knowledge gap between doctor and patient, Heath's interaction analysis also emphasizes the doctor's authority.

My analysis is grounded in the earlier analyses presented by Byrne and Long (1976) and Heath (1992); see also Heritage (2005). I add a new layer to the analytical depiction of the delivery of diagnosis: intertwined with the "authoritarian" elements, there are also features of interaction in the diagnostic sequences that maintain the doctor's accountability for the evidential basis of the diagnosis, and thereby preserve a degree of mutual intelligibility of the diagnostic process.

Data for the study

With a Finnish research team,[1] we video-recorded and transcribed more than 100 medical consultations. Four health centres were included in the data collection, and 14 doctors participated in the study. Each recorded consultation involved a different patient. Patients were not preselected according to their type of complaint or any other criteria.

[1] The team was led by Marja-Leena Sorjonen and myself, other members being Markku Haakana, Liisa Raevaara, Johanna Ruusuvuori, Tuukka Tammi, and Timo Vottonen.

From the recordings, I collected all diagnostic statements (n = 71). In them, the doctor named the patient's illness or asserted that the patient did not have a named illness.[2] The main analytical task was qualitative – it entailed developing a typology of the doctors' different practices of telling the patient the diagnosis, and of the patients' different practices of responding to the diagnosis. The qualitative analysis also involved an effort to describe the conditions, consequences and interrelations of these practices of the doctors and the patients. I also used quantitative analysis to assess the robustness of the qualitative conclusions.

The interactions presented here took place in primary health care environments. Interaction may be different in other medical contexts, such as specialized or hospital medicine.

How the doctors tell the patient about the diagnosis

As in any human interaction, the delivery of diagnosis can be performed in a number of ways. For example, the doctors have to choose which words they use and at which point of the consultation they deliver the diagnosis (cf. Drew and Heritage 1992). In this half of the chapter, I will focus on one central consideration of doctors when making these choices. (This consideration is not necessarily a conscious one, but by analysing tape-recorded data we can see that it is there.) It has to do with the ways in which the evidential grounds of the diagnosis are available for the patients to observe and to understand. I will argue that the doctors adapt their ways of delivering the diagnosis to the availability of evidence. Thereby, they maintain the mutual intelligibility of the diagnostic procedure. Through these actions, they indicate their accountability, vis-à-vis the patient, for the evidential basis of the diagnosis.

[2] Such statements were included only where the doctor named the illness for the first time, either after the examination of the patient or after the patient had rejected an earlier diagnosis. In other words, cases in which the doctors merely repeated diagnostic statements were not included in the analysis. I also excluded preliminary diagnostic statements: those in which the doctor reported diagnostic reflections during an ongoing examination, before the final diagnostic statement. It should also be noticed that, in professional medical discourse, "giving a diagnosis" is understood exclusively in terms of asserting the existence of a disease. By including the assertions of nonexistence of named diseases, I have adopted a broader definition of diagnosis.

Three types of diagnostic utterance

When doctors name a patient's disease, they can establish the relation between the diagnosis provided and the evidence used in medical reasoning in three different ways. In one type of diagnostic utterance, the doctor merely asserts the character of the condition without bringing out the reasoning on which the diagnosis is based. The second type of diagnostic utterance is designed so as to index a reference to an inferential process, but without explicating any details of that process. In the third type, the core diagnostic utterance is either preceded or followed by utterances with which the doctor, as an additional activity, details some features of the evidence on which his or her diagnostic conclusion is based. Below, I provide examples of each type of diagnostic utterance.[3]

Plain assertions. The following three extracts are examples of diagnostic utterances in which the doctor merely asserts the patient's disease.

(1) (Dgn 96 46B1)
Dr.: There's still an infection in the auditory canal

(2) (Dgn 20 11B1)
Dr.: Here's (.) luckily the bone quite intact,

(3) (Dgn 85 47A1)
Dr.: That's already proper bronchitis.

These utterances are presented as direct descriptions of reality. The doctors speak in a way that implicates their claim to knowledge as an unproblematic, taken-for-granted matter (see Pomerantz 1984b:609). This type of diagnostic utterance contains no verbal description of the reasons or the grounds for the diagnosis.

Diagnoses indexing inexplicit references to the evidence. Another type of diagnostic utterance in our data involves an inexplicit reference to the process by which the diagnosis was made. This reference is most often established by using verbs which formulate the diagnostic conclusion as based on sensory perception and inferences based on that. Extracts (4)–(6) are examples of this type of utterance.

[3] The original Finnish transcripts and word-by-word translations are available from the author.

(4) (Dgn 24 11B3)
Dr.: -> Now there appears to be an (1.0) infection at the contact point of the joint below it in the sac of mucus there in the hip.

(5) (Dgn 37 39B3)
Dr.: >Things like that but< no (0.5) bacterial infection
-> seems to be there.

(6) (Dgn 1 5A2)
Dr.: -> Otherwise the prostate feels really perfectly normal<

Instead of portraying their diagnoses as direct descriptions of reality, here the doctors point to the source of the diagnosis. By employing "evidential" verbs (Chafe and Nichols 1986) "to appear," "to seem," and "to feel," they allude to the sensory evidence on which their conclusions are based. Some of these evidential verbs indicate the general *type* of observation: "feels" in excerpt (6) indexes the observations made by the doctor during rectal examination; and "seems" in (5) indexes the observations made by the doctor while looking into the patient's throat. In (4), however, the construction "appears to be" does not single out any particular type of observation but indexes the doctor's more general observations. In sum, all the verbal constructions in extracts (4)–(6) index a reference to an observational and inferential process, marking the diagnosis as a conclusion that arises from the information that has been made available to the doctor. They do not, however, specify the details of this evidence. Simultaneously these constructions mark the diagnostic statement as tentative: extracts (4)–(6) do not claim the same level of certainty as do the plain assertions shown earlier.[4]

Explicating the evidence of the diagnostic conclusion. In the third type of diagnostic utterance, the doctors describe specific observations as evidence for their diagnostic statements. In some cases, the observations are formulated before the diagnosis; in others, the diagnosis is given first and the evidence formulated only after that. Extracts (7) and (8) are examples of the first type.[5]

[4] Uncertainty of diagnosis is discussed further below.
[5] For the other type, see extract (12).

(7) (Dgn 66 14A3; simplified)
((The doctor has just examined the patient's foot))

```
1  Dr.:      Okay:. .h fine do put on your,
2            (.)
3  Dr.:  =>  the pulse [can be felt there in your foot so,
4    P:                [↑Thank you.
5          ->  .h there's no, in any case (.) no real circulation problem
                . . .
8  Dr.:  ->  is <involved>.
```

(8) (Dgn 26–21A1)

```
1    Dr.:        (But but) I really can feel these with my fingers
2                here it is you see [(   ) this way, a very tight=
3      P:                           [Yes,
4    Dr.:        =muscle fiber,
5                (1.0)
6      P:        Yes a little th[ere<
7    Dr.:                       [IT GOes here from the top but
8                it probably gives it (.) a bit further down then,
9                (1.0)
10                  [((Dr. withdraws her hands from P's back))
11   Dr.:   =>   As [tapping on the vertebrae didn't cause any ↑pain
12          =>   and there aren't (yet) any actual reflection symptoms
13           ->  in your legs it suggests a muscle h (h.hhhh)
14           ->  complication so hhh it's [only whether hhh (0.4) you
15                                        [((Dr. lands on her chair.))
16               have been exposed to a draft or has it otherwise=
17               or has it otherwise=
17     P:        =Right,
18   Dr.:        .Hh got irritated,
```

Both extracts above contain a core diagnostic utterance in which the patient's problem is described by using a medical category (single arrows ->). These cases, however, differ from the others primarily because, in these, the doctor specifies some of his or her observations that form the basis of the diagnosis (double arrows =>). Thus, in extract (7), the doctor says, before delivering his diagnostic statement, that "the pulse can be felt there in your foot" (line 3). And in extract (8) the doctor reports two different observations: first, in line 11 (concerning the vertebrae), and second, in lines 12 and 13 (concerning the reflection symptoms). Using varying discourse

Table 8.1 *Frequency of types of diagnostic turns*

Turn design	Frequency	Percentage
Plain assertion	31	44
Evidence indexing	12	17
Explication of evidence	28	39
Total	71	100

markers, the doctors present their descriptions as reasons for, or evidence of, their diagnostic conclusions.

By explicating the evidence, the doctors make a part of their medical reasoning available to the patients, thus constructing them as *understanding recipients* of that reasoning.[6,7]

In numerical terms, plain assertions were the most frequent type of diagnostic turns in our database, representing well above 40 percent of the diagnostic utterances (see Table 8.1). Turns in which evidence was explicated were also quite frequent, whereas turns indexing inexplicit references to the inferential process were produced least often.

When we consider the verbal form of diagnostic turns, plain assertions seem to conform to the ideas that emphasize the authoritative relation between the doctor and the patient. The fact that diagnosis is delivered in the plain assertion format in not much less than half of the cases could be viewed as indicating the doctor's authority in relation to the patient, at least in these cases: these doctors seem to rest on their authority, without needing to resort to presentation of evidence in order to make the patients accept their diagnoses (see Freidson 1970b:120–1). In what follows, however, I argue that this is not the case. The doctors give plain assertions in activity contexts where the evidence is concretely present; thereby the evidential

[6] In research independent of that reported on in this chapter, Maynard (1991d) identified a similar practice in delivering diagnostic news in a developmental disabilities clinic and in HIV-testing clinics. In those contexts, however, "citing of evidence" often accomplished the entire delivery of the diagnostic news: it was left to the patient to infer the conclusion. Heritage and Stivers (1999), on the other hand, described a practice in which the doctor describes the physical examination as it is happening "online." Through this practice, doctors can, for example, resist patient pressure to prescribe medications inappropriately.

[7] This, of course, does not necessarily mean that the evidence presented by the doctor to the patient is always the evidence used by the doctor in his or her own reasoning.

grounds of the diagnosis are available for the patients to observe and to understand, and a degree of mutual intelligibility of the diagnostic procedure is maintained. In these actions, the doctors show their accountability for the evidential basis of the diagnosis.

Presence of evidence in plain assertions

When the diagnosis is given in the plain assertion format, the diagnostic statements are regularly positioned so as to allow for the observability of the evidential basis of the diagnosis. By giving the diagnosis at the completion of an examination or immediately thereafter, doctors establish an observable and inferable link between the examination, which the patient participates in or witnesses, and the doctor's diagnostic statement. For example, the doctor may look into the patient's ear, and immediately after doing so may assert that there is an infection in the ear; or he or she may examine a medical document (such as an X-ray) and state the diagnosis directly thereafter. By positioning the diagnostic statement next to the examination, the doctor minimizes what could be called the *inferential distance* between the diagnosis and its grounds: the activity context provides for the observability and the intelligibility of the evidence. In other words, even when giving their diagnoses in the plain assertion format, the doctors couch their actions in such a way that allows the patient to "keep on track" regarding the course of the diagnostic reasoning.

In (9), the patient has a damaged finger. This is his second visit for this complaint; an X-ray was taken between the two visits. (In lines 2–4, the patient talks about the circumstances of the accident.)

(9) (Expansion of [2])

1		(5.5) ((The doctor is examining the X-ray picture against the illuminated screen))
2	P:	It's probably a bit the water as well because,
3		hhh .hhh (0.5) as on the ground you couldn't but roll
4		it but, ,hh there you could lift it a bit.
5		(6.2) ((Dr. switches off the illuminated screen and returns to his seat. He holds up the X-ray picture between himself and the patient.))
6	Dr.:	Here's (.) luckily the bone quite intact,
7	P:	Yeah,
8	Dr.:	So within a week it should get better ↑with that splint.

When producing his diagnostic statement in line 6, the doctor holds the X-ray in his hand so that it is between himself and the patient. In this context, the referent of the pronoun *here* (line 6) is clear: "here" refers to the X-ray. Therefore the diagnostic statement is hearable as a characterization of the X-ray. Thus the evidence of the diagnostic conclusion – the X-ray picture – is observably present in the activity context.

In the above excerpt, the observably present evidence took the form of a medical document. After a physical examination as well, however, doctors can assert the diagnosis without referring verbally to any evidence. In these cases, too, the positioning of diagnostic statements is critical: because no actions intervene between the examination and the diagnosis, the physical examination is understood as providing the basis for the diagnosis. (For the generic ways in which previous actions form a backdrop for interpreting subsequent actions, see Heritage [1984:254–60]; Schegloff and Sacks [1973:295–8]).

Extract (10) is an example of this situation. The patient has complained about a persistent cold.

(10) (Expansion of [3])
((Dr. has listened to the patient's chest))

1	Dr.:		Let's listen from the back.
2			(0.3)
3	P:		.nff
4		=>	(9.0) ((P breathes in and out, Dr. listens.))
5	Dr.:	->	That's already proper bronchitis.
6	P:		Is it [hh
7	Dr.:		[It is.

Because the doctor utters his diagnostic statement immediately after a single, recognizable act of examination, it becomes apparent that he gathered the information for the diagnosis through this examination. The inferential distance is short because the link between the examination and the diagnosis is transparently accountable for the patient.

Yet the fact that the grounds of the diagnosis are observable and intelligible does not mean that the patient perceives, interprets, or uses the evidence in the same fashion as the doctor. In extract (9), when the doctor examined the X-rays against the illuminated screen

(line 1), the patient turned around and glanced briefly at the picture, which was behind him; when the doctor continued the examination (lines 2–4), the patient initiated talk that was not related to the X-ray; and when the doctor held the picture in his hand (line 6), the patient made no effort to look at it more closely. In (10), the patient was unable to observe the parts of her body that the doctor was observing, and the doctor did not describe what he actually perceived during the examination. Thus the participants do not coordinate their actions so as to make the evidence available for the *use* of the patients. The doctors, however, design their actions so as to preserve the observability and intelligibility of the bodily or documentary direction from which the evidence comes.

In summary, when doctors deliver diagnoses using the plain assertion format, they design and locate their diagnostic statements in a way that preserves a specific balance between the doctor's authority on one hand, and the patient's access to the diagnostic procedure on the other. By locating their plain assertions immediately next to relevant and recognizable examinations (as they always do), the doctors make the evidential basis of the diagnosis as transparently present. They design their actions with respect to their accountability for the evidential basis of the diagnosis. Yet, because the patients do not directly topicalize the evidence that is accessible, they orient themselves to the evidence as available to and grounded in expert knowledge and in the cultural authority (Starr 1982) of medicine.

In my database, this pattern – whereby a diagnosis, designed as plain assertion, follows immediately after a relevant, recognizable examination – is the most common format for delivering a diagnosis. Let us consider it as the default pattern of the delivery of diagnosis: "default" not only because it is most common, but also because it is the simplest and most straightforward way to deliver the diagnosis. In this pattern, the direction where the evidence for the diagnosis comes from is made observable for the patient, but the evidence is not verbally addressed, not put into words.

Departures from the default pattern

In some cases, the doctors depart from the default pattern. They move away from the tacit and incarnate accountability (Garfinkel 1967; Heritage 1984a) of diagnosis, and they refer to or discuss the

evidence of the diagnosis. That move is made regularly in response to two kinds of contingencies related to the context in which the diagnosis is delivered. First, in some contexts the inferential distance between examination and diagnosis is long, either because the diagnostic statement is detached from the examination or the examination is relatively opaque. In such circumstances, the connection between the examination and its conclusion is jeopardized, and the doctors regularly adopt turn designs other than plain assertions. In this way, they re-establish the observability of the evidence.

In another kind of context, observability per se is not at issue, but rather the routine assumptions concerning the doctor's expertise are challenged, either because the diagnosis is uncertain or because there are manifestly discrepant views concerning it. The doctors manage these situations by using diagnostic turn designs other than plain assertion.

Problems arising from extended inferential distance

Detachment of examination and diagnosis. Temporal separation of examination and diagnosis is often accompanied with modification in the shape of the diagnostic utterance. When other events take place between the examination and the delivery of the diagnosis, the observability of the evidential grounds for the diagnosis is less apparent than when the diagnosis follows immediately after examination. In these circumstances, the doctors often take special measures to make the grounds of the diagnosis observable, referring inexplicitly to these grounds in their diagnostic utterance or by explicating them. In (11), for example, the patient is an elderly lady undergoing a regular checkup, who has reported difficulties in her bowel movements. The doctor examined her stomach by palpation; thereafter, on her own initiative, she examined the patient's breasts. During the breast examination, the doctor recommends that the patient regularly examine her own breasts.

(11) (Dgn U24 41A3)

1	Dr.:	. . . it's the best of °all° examinations
2		what #you#,
3		(0.6)
4	Dr.:	what you do yourself and then if you would ↑find something
5		from here then you could,

6 (1.1)
7 Dr.: come here and show it >but this is< ↑very smooth the breast
8 gland tis[sue.]
9 P: [° #Y] eah#° I have had in my breasts a very
10 VERy bad milk infection.
11 (1.3)
12 Dr.: How many children you #ha#ve,
13 P: I have one ↑chi°ld° and °I ha-° I [ha- I'm a bit > like a <
14 Dr.: [( )
15 P: risk #mo#th↓er: #ha-# °.hhhh° had difficult de[liver]ies
16 Dr.: [Yeah,]
17 P: or °(l[ike)°,]
18 Dr.: [>F:ine<] now you can pull,
19 (1.2)
20 Dr.: <do↓wn>?
21 (0.7)
((11 lines of discussion on children omitted.))
33 P: . . . God's blessing in that
34 iss(h)ue [t(h)oo (he]h) if you were not able to deliver them
35 [$Yeah:$,]
36 $then you get other ones$,
37 (2.2) ((P is dressing, Dr. takes away paper that covered the examination table))
38 P?: °Hmm°
39 (11.0) ((P dresses and sits down; Dr. takes the paper to trash container and washes her hands.))
40 Dr.: –> ((While returning to her seat:)) Nothing malignant
41 >really< (°.hhh°) #and no#
42 nothing ex[tra] can be felt as being there, (.) n[either the]re
43 P: [hh] [.nfff]
44 Dr.: in your bowels nor there in your <↓brea[°sts°>.]
45 P: [Yeah:]:

Towards the end of the breast examination, in line 12, the doctor asks about the patient's children. In lines 18 and 20, she instructs the patient to rearrange her dress, thereby indicating the completion of the examination. In lines 25–36, more talk about children and grandchildren ensues. While the patient is dressing, the doctor removes the paper cover from the examination table and takes it to the trash container. Thus, when the doctor gives her diagnostic statement in lines 40–44, other activities (discussion of family, patient dressing, and doctor arranging the examination table) have been inserted between the examination and the diagnosis. Moreover,

Table 8.2 *Turn design and positioning of the diagnostic utterance*

	Positioning relative to examination		
Turn design	Adjacent	Detached	Total
Plain assertion	31	0	31
Evidence indexing	6	6	12
Explication of evidence	20	8	28
Total	57	14	71

Chi-square = 15.9515 $p < .001$

the breast examination took place between the examination of the patient's bowels and the diagnosis.

Thus, when the doctor initiates her diagnostic statement in line 40, she is speaking in an environment that is sequentially detached from the relevant events and objects that could serve as grounds for the diagnosis. Unlike the cases in which the doctors used "plain assertions," the basis of the diagnosis is no longer prominent here. In this context, the doctor chooses to refer indirectly to the inferential process by using the construction "nothing extra can be felt as being there." Through this turn design, which suggests that what she says is based on the sensory data that she has gathered, the doctor *retrieves the examination of the patient* as a context for her talk (see Drew and Heritage 1992:18–19). In other words, the construction "can be felt" reinvokes the palpation of the patient's body as the basis for the diagnostic conclusion.

Quantitative analysis confirms the relation between turn design and the positioning of the diagnostic utterance in relation to the examination of the patient or relevant documents (see Table 8.2).

The plain assertion design is used exclusively in cases where the diagnostic statement follows immediately after the examination.[8] There are not many cases where the diagnosis is detached from the relevant examination, but when the diagnosis is delivered in such circumstances the doctors systematically choose more complex turn designs. By thus reinvoking the examination, they re-establish

[8] The results are not derived from a random sample, and the chi-square is used in this and the following tables only heuristically, to show the magnitude of the patterns discussed.

the mutual intelligibility of the evidential basis of the diagnosis. Thereby, they orient to their accountability, vis-à-vis the patient, for the evidential basis of the diagnosis. If the doctors did not reinvoke the examination, they would be heard as taking a more authoritarian stance than they actually take.

Opacity of examination. Another context where the balance between authority and accountability is achieved by modifying diagnostic turn design is one where the relevant events in the examination are opaque. For example, the examination of the patient may include a number of different actions, and it may be unclear to the patient which of these, if any, provide evidence for the doctor's diagnosis. By explicating some features of the evidence, the doctor may make the grounds of the diagnosis observable for the patient.

The plain assertion design is used, first and foremost, in cases where the relevant events in examination are transparent to a lay participant. After an opaque examination, on the other hand, the doctors are most likely to choose the design of the diagnostic turn in which they explicate the evidence (for a more detailed discussion, see Peräkylä 1998:311–12). If the examination is not transparent, the doctors, rather than "resting on the authority of their professional status" (Freidson 1970b:120), are likely to explicate the evidence for the patient.

In summary, in some cases the inferential distance between examination and diagnosis is long, either because the examination is opaque from the lay perspective or because it is temporally detached from the diagnosis. In these two types of case, the observability of the evidence is jeopardized; the doctors, as we saw, rather than trading on their authority alone, designed their diagnostic utterances so that these utterances inexplicitly incorporated references to the evidence for the diagnostic conclusion or explicated that evidence.

Problems arising from challenges to medical expertise

In the cases I will now discuss, observability per se is not at stake. Rather, in these cases the doctor's expertise becomes problematic because of uncertainty or disagreement. In such circumstances, a display of evidence is a way to retain a claim to knowledge.

Uncertainty of diagnosis. One type of context in which the doctor's expertise is potentially undermined involves uncertainty of diagnosis. In most cases involving uncertainty the doctors use turn

designs other than plain assertion. Through these designs they can indicate their reasons for the proposed diagnosis. Thereby, the doctors orient themselves, in a special way, to their accountability for the evidential basis of an uncertain diagnosis. If the doctor does not know definitely what the patient's disorder is, he or she treats it as relevant to indicate verbally to the patient the basis of what he or she does know. Accountability and authority are closely intertwined here. Uncertainty undermines the doctor's authority as an expert; thus, when delivering an uncertain diagnosis, the doctor cannot rest on authority alone. By displaying evidence, the doctor earns his or her claim to knowledge. (For a more detailed discussion on uncertainty of diagnosis, see Peräkylä 1998:312–14.)

Discrepant views concerning the diagnosis. The doctor's authority is also potentially undermined in a diagnostic sequence where a discrepancy between the patient's and the doctor's views is manifest. In such circumstances, the doctors most often select a diagnostic turn design that involves explication of evidence.

Doctors often resort to explication of evidence when the delivery of the diagnosis involves explicit disconfirmation of candidate explanations expressed by the patient during the examination (see Gill 1998a; Gill and Maynard this volume; Raevaara 1996a), or when the doctor reasserts or corrects a diagnosis which he or she previously spelled out but which thereafter was questioned by the patient. Typically (but not exclusively) the discrepancy between the patient's and the doctor's views concerns the seriousness of the ailment: the doctor's diagnosis is less serious than the one proposed by the patient (cf. Heritage and Robinson's and Halkowski's discussions on "doctorability" in this volume).[9]

In the following extract, the doctor explicitly disconfirms the diagnostic suggestion offered by the patient. The patient suffered from intense pain in her leg and was making a follow-up visit after a sick leave. Early in the medical interview, the patient suggested that the pain in her thigh might have been caused by exertion or by "something either coming or going" in the thigh. The doctor

[9] Because the overwhelming majority of the consultations in our data set involve ordinary health problems rather than serious conditions or life-threatening situations, the management of serious diagnoses cannot be addressed properly here. See Lutfey and Maynard (1998) and Maynard and Frankel (this volume) for relevant discussions.

treats this comment as if the patient was referring to "thrombosis," a suggestion that the doctor explicitly disconfirms in her diagnostic utterance toward the end of the consultation:

(12) (Dgn 3 1B2)

1	Dr.:		Well (.) we'll have to follow up how this thigh of
2			yours, (0.6) .hh begins to respond and, (0.8) it has
3			indeed now clearly improved from °what
4			it is [and,°
5	P:		[It has at least in terms of pain th[e:n.
6	Dr.:		[Yeah:.
7			(0.4)
8	Dr.:		Yes:. .h >Did you have laboratory tests< now: sti[ll
9	P:		[NO:.
			((10 lines omitted))
20	Dr.:		Yes:.
21			(2.0)
22	Dr.:	->	.hh Well (0.8) I haven:'t (0.2) I I (1.0) haven't
23		->	(0.3) considered it as a (0.2) thrombosis.
24	P:		Mm hm,
25	Dr.:	=>	I think it isn't, (0.5) it would have,=if there would
26		=>	have been a beginning of a thrombosis then it would
27		=>	have been much more pain↑ful.
28	P:		Yes right.
29	Dr.:		So certainly there are the VARICOSE veins.
30			(0.8)
31	P:		Somethi- yeah I can feel the very lumps there
32			in a certain position ((continues))

The disconfirmation takes place for the first time in lines 22–23. Then, in line 25, after an acknowledgment by the patient, the doctor "elaborates" her view (cf. Maynard 1997). She first renews the disconfirmation and, thereafter, she explicates evidence that supports her conclusion. She explains what the symptoms for thrombosis would have been. The patient's agreeing receipt (line 28) is followed immediately by the doctor's substitute diagnosis in line 29. This, however, is presented as one that does not exhaustively explain the patient's problems. The patient aligns with the doctor's suggestion and herself refers to evidence for that (lines 31–32).

In extract (12), the discrepancy between the patient's candidate explanation and the doctor's rejection constitutes the controversial character of the diagnosis. In some other cases, the discrepancy arises

at a later stage, through the patient's response to the doctor's initial diagnosis. In such cases, the doctor may resort to explication of evidence in pursuing the diagnosis.

In (13), for example, the patient has come to see the doctor because of a persistent cough. She has made an earlier visit because of the same complaint, but in spite of the medication the cough has not been cured. The doctor orders new examinations (chest X-ray and blood tests) for the patient. At the beginning of the extract below, the participants have already been finalizing the arrangements for the examinations and a new appointment. While the doctor is dealing with a paper, the patient asks a question concerning pneumonia vaccination in lines 1–3.

(13) (Dgn133 27A1)

1	P:	How is it there, is it possible for me to have the,
2		the erm:: eh- which vaccinations are there, (.) >the
3		pneumonia vaccination<,
4	Dr.:	Yes, but it cannot be given to you now as you have
5		this,(.) this disease?, kind of (.) [on, [so
6		[be- [Yes,
7	Dr.:	this mu[st be cured] before, .hh[hh
8	P:	[So later it,] [Quite right,
9	Dr.:	before we can give [( ),
10	P:	[Yes yes,
11	Dr.:	Krhm krhm .hh
12	P:	Was it pneumonia then really [as,
13	Dr.:	[Well it has been pneumonia
14		because, #m:# there is, (0.8) #erm::# in the, (0.5) X-ray
15		of lungs it could be seen< seen and ↑the
16		se[dimentation rate was also so hig]h that, .hh that<
17	P:	[Yes right,]
18	Dr.:	really it is °but now for some,° (0.2) some reason it
19		has not got cured I'll eh- (.) I'll prescribe
20		for you still another medication ((continues))

The doctor tells the patient that she cannot be vaccinated before her current disease has been cured (lines 4–5, 7, and 9). It is notable that the doctor refers to the disease with the expression "this disease," thus not specifying the diagnosis but treating it as a known-in-common object. Thereafter, the patient inquires about the diagnosis in line 12. The question implies that the patient's disease has been considered as pneumonia; but on the other hand the question

Table 8.3 *Turn design and controversiality of diagnosis*

	Controversiality of diagnosis		
Turn design	Noncontroversial	Controversial	Total
Plain assertion	29	2	31
Evidence indexing	10	2	12
Explication of evidence	11	17	28
Total	50	21	71

Chi-square = 21.9525 $p < .001$

also incorporates a degree of doubt concerning this diagnosis. In line 13, the doctor reasserts the diagnosis of pneumonia initially made during an earlier visit. The reassertion is supported by the explication of the evidence in lines 13–16. In the final part of the doctor's diagnostic utterance (lines 18–19) it also transpires that the pneumonia has not been cured yet.

In the two cases discussed above, the doctors resorted to explication of the evidence when discrepant views concerning the diagnosis had been made manifest in the interaction. Discrepancy, like uncertainty, potentially undermines the doctor's expert role. The doctors responded by explaining the evidence; they pursued the diagnosis by accounting for it. Thus, when delivering a diagnosis in a context of discrepant views, they considered themselves as accountable for the grounds of their diagnostic statements. They justified their diagnostic conclusions by giving explicit reasons for those conclusions.

Quantitative analysis supports the qualitative results described above. All the diagnostic statements were coded in terms of their controversiality; the results are shown in Table 8.3.

When the diagnosis is controversial, the doctors seldom choose the plain assertion or the turn design in which they refer indirectly to the evidence. Instead they choose explication of the evidence.

Yet we could not observe open manifestations of the controversial status of the diagnosis in every case in which the doctor explicated the evidence for the diagnosis. In more than one third of these cases, the diagnosis was not presented overtly as involving a controversy between the patient's and the doctor's views. In some of these cases, however, a more subtle misalignment was observable between the doctor's and the patient's position: the doctor's diagnosis was

hearable as suggesting that no major problem existed, whereas the patient had presented the condition as a serious trouble. Extract (8), for example, contains no open discrepancy between the participants' views. Throughout the description of the problem, however, the patient portrays the pain in the back as exceptionally intense and puzzling for her. She does not present any candidate explanations (see Gill and Maynard this volume) before the doctor gives the diagnosis, but the doctor's explication of evidence nevertheless may be a response to the patient's unarticulated worry. By explicating the evidence (which takes the form of symptoms that are not present), she demonstrates the grounds for excluding some other, more severe (but unnamed) diagnostic possibilities.

Telling the diagnosis: a summary

In the empirical analyses presented thus far, we have seen that doctors in Finnish primary care adapt their diagnostic utterances to considerations that concern the visibility and the intelligibility (for the patient) of the evidential basis of the diagnosis. In their actions, they orient to their accountability, vis-à-vis the patient, for the evidential basis of the diagnosis. In the "default pattern," the doctor does not verbally refer to evidence, but locates the diagnostic utterance immediately after a transparent examination, thereby making it possible for the patient to see the link between the examination and the diagnosis. I have also argued that there are four kinds of circumstances where the doctors resort to implicit references to evidence or outright explication of evidence. This happens when the diagnostic utterance is temporally detached from the relevant examinations, when the examination is opaque for the patient, when there is uncertainty, or where there are discrepant views concerning the diagnosis. In other words, in those circumstances the doctors take extra measures to secure the visibility and the intelligibility of the evidence.

The patients' responses to the doctors' diagnostic utterances

In the remaining parts of this chapter, I will explore the ways in which the patients' responses to the doctors' diagnostic statements incorporate the patients' claim of knowledgeability concerning the

diagnostic reasoning, and an expectation of the doctors' ultimate authority. My main focus will be on cases in which the patients respond more than minimally to the diagnoses, and it is in these extended responses that the patients display their knowledgeability. The patients talk more than minimally after about one third of diagnostic statements. First, I will show that the extended responses occur most likely after diagnostic statements in which the doctor displays his or her own diagnostic reasoning through the design of the diagnostic utterance. Thereafter, I will explore some types of extended responses, showing how the participants cooperatively maintain a balance between an orientation to the patient's knowledgeability concerning the diagnosis and an orientation to the doctor's authority.

When do the patients talk after hearing the diagnosis?

The patients' ways of receiving the doctors' diagnostic statements can be divided into three broad classes: silence, minimal acknowledgment tokens such as "yeah," "yes," and "ahem,"[10] and extended responses. Some of the minimal acknowledgment tokens are designed to encourage further elaboration of the diagnostic statement or its implications in terms of treatment, while others do not overtly have such characteristics. Silences may also operate as elicitation of elaboration (cf. Maynard 1997). Further research is evidently needed regarding the work that the minimal responses and silences do after the diagnostic statements (see Robinson [2003] for a discussion on "progressivity" between the diagnostic sequence and the talk about diagnosis).

The third class of responses includes all responses where the patients do something more than just minimally acknowledge the diagnosis, e.g., cases where they (for example) show that the diagnosis is unexpected from their point of view, or verbally indicate agreement or disagreement, or describe symptoms that may be discrepant with the diagnosis. These responses entail that the progression of talk from diagnosis to other business (usually treatment) be postponed, at least for the time that the patient produces his or her

[10] These are English representations of Finnish response tokens used in the consultations. The original Finnish tokens include, e.g., "Joo.," "Juu.," "Nii.," "Jaa::," "Mm:," and "Aha," (cf. Sorjonen 1997, 2001).

Table 8.4 *Controversiality of diagnosis and the patient's response*

	Patient's response		
Controversiality of diagnosis	None or minimal	Extended	Total
No explicit controversy	37	13	50
Explicit controversy	11	10	21
Total	48	23	71

Pearson chi 2 (1) = 3.1561 $p = .076$

response. Moreover, the extended responses often incorporate the patient's claim to knowledge concerning the diagnosis.

In our sample of 71 diagnostic statements, these three types of responses are almost evenly distributed: no response was given by the patient in 23 cases, minimal acknowledgment in 25 cases, and an extended response in 23 cases. Thus, the Finnish patients actively took part in the diagnostic sequence in almost one third of cases. At least one extended response was produced in consultations of all except two doctors.

What, then, encourages the patients to talk, and thereby to adopt the role of a knowledgeable agent? According to Heath (1992:246–60), active patient responses typically follow diagnoses that are formatted as questions, presented as uncertain, or show implicitly or explicitly that the doctor's view of the condition differs from what the patient expected. In the Finnish data, there were no diagnoses formulated as questions. However, there were diagnoses that were presented as uncertain and those that showed discrepancy between the doctor's view and the patient's expectations. These features of diagnostic utterances are associated with the type of patient response that also occurred in the Finnish data; see Tables 8.4 and 8.5.

Table 8.4 indicates the relation between conflict in diagnosis and the patient's response. As in Table 8.3 shown at an earlier part of this chapter, the diagnosis here was also regarded as one involving conflict when the delivery of the diagnosis involves explicit rejection or correction of diagnostic suggestions expressed by the patient during the examination, or when the doctor reasserts or corrects a diagnosis which he or she previously spelled out but which thereafter was questioned by the patient. In our data, the relative proportion of extended responses is bigger after diagnoses that involve conflict.

Table 8.5 *Certainty of diagnosis and the patient's response*

	Patient's response		
Controversiality of diagnosis	None or minimal	Extended	Total
Uncertain	16	12	28
Certain	32	11	43
Total	48	23	71

Pearson chi 2 (1) = 2.3109 $p = .128$

Table 8.6 *Diagnostic turn design and the patient's response*

	Patient's response		
Diagnostic turn design	None or minimal	Extended	Total
Explication of evidence	12	16	28
Evidence indexing	9	3	12
Plain assertion	27	4	31
Total	48	23	71

Pearson chi 2 (2) = 13.5079 $p = .001$

However, this association is not statistically significant. Even weaker is the association between uncertainty in diagnosis and the patient's extended response seen in Table 8.5.

There was, however, a much stronger, statistically significant association ($p = .001$) between the type of the patient's response on one hand, and the design of the doctor's diagnostic utterance on the other. It was the way that the diagnostic utterance displayed evidence of the diagnostic conclusion that was associated with the type of response. Most of the extended responses occurred after diagnostic turns where the doctor verbally explicated the evidence for the diagnostic conclusion. The two other diagnostic turn designs (turns indexing inexplicit references to evidence and plain assertions with no reference to evidence) attracted far fewer extended responses. In particular, plain assertions were very infrequently followed by extended responses (see Table 8.6).

The explication of evidence makes it much more likely that the patient will produce an extended response to diagnosis than the two

other diagnostic turn designs. Thus, it appears that by explicating the evidence for the diagnostic conclusion, the doctor proposes a particular relation between the patient and himself or herself – one where the patient's reflections of the diagnosis are relevant and welcome.

It was shown in an earlier part of this chapter that uncertainty and conflict are in turn associated with the diagnostic turn design; the explication of evidence in diagnosis is more likely when the diagnosis involves uncertainty or conflict. In other words, explication of evidence is a practice that the doctors often resort to when the diagnosis is uncertain or involves conflict.[11] Thus, it appears that the diagnostic interaction can take two different trajectories that are separated from early on. In one type of case, the doctor produces the diagnosis in "plain assertion" format, and the patient remains passive while receiving it. In the other type of case, the delivery of diagnosis is made complicated by the inferential distance between the examination and the diagnosis, or by challenges to medical authority (uncertainty or discrepancy of views). In these circumstances, the doctors often resort to implicit references to, or explication of, the evidential basis of the diagnosis; and in particular if the doctor has explicated the evidence, the patient is then in his or her turn likely to respond to the diagnosis by producing his or her own talk. The doctor's choice of design of the diagnostic utterance is in a pivotal position here: retrospectively, the diagnostic utterance constructs the preceding activity (usually the medical interview and the examination) as routine or as potentially having involved some problematic aspects in it and, prospectively, it shapes the field or relevancies for the patient's recipient action.[12]

Quantitative analysis of interaction remains, however, necessarily quite far from the actual dynamics of the momentarily unfolding actions of the people who are interacting (Schegloff 1993). In the

[11] An elaboration of the four variables involved shows that, if "uncertainty" and "conflict" are controlled, the association between the form of reference to evidence and the patient's response remains strong when the diagnosis involves neither uncertainty nor conflict, whereas it is much weaker (but does not disappear altogether) when one of these or both are involved.

[12] I want to point out that this involves an active choice by the doctor: he or she *can* construct a case routine (by merely asserting the diagnosis) even if the patient has displayed problems in it; or, alternatively, he or she can treat a case as problematic (by, for example, explicating the evidence) even if there has not been any overt and explicit indications of problems in it; see extracts (8) and (15).

final part of the chapter, we will return to qualitative case-by-case analysis. We will focus on cases where the patients present themselves as knowledgeable agents. Two types of case will be considered: those where the patient explicitly agrees with the doctor's diagnosis, and others where the patient resists it.

Patient displaying agreement

In some cases, the patients say that they agree with the diagnosis that the doctor has proffered. Extract (14) below is an example of this kind of situation. During the physical examination, the patient proffered two candidate explanations for her presenting problem (pain in the hip): cancer and infection (data not shown). In his diagnostic utterance (taking place after the exam and some paperwork and involving an indexed reference to the inferential process), the doctor does not comment upon the patient's candidate explanations. However, his conclusion corresponds to one of the patient's earlier explanations:

(14) (Dgn 24 11B3)

```
1  Dr.:    Now there appears to be an (1,0) infection at the contact point
2          of the joint below it in the sac of mucus there [in the hip.    ]
3  P:   ->                                                 [Yes right. .hh]
4  P:   -> that's what I (think/thought) myself too that <it probably
5       -> must be an infection>. [.hhhh
6  Dr.:                          [And, because you have had
7  P:      trouble this [long we will make sure and take an X-[ray.    ]
8  P:                   [hhhhh                                [Yes:. ]
```

In lines 3–5, partially overlapping with the completion of the doctor's diagnostic statement, the patient responds with an acknowledgment and then expands her turn by saying, "Yes right. .hh that's what I (think/thought)[13] myself too that <it probably must be an infection>." By reporting her agreement, the patient treats herself as an agent capable of diagnostic reasoning. But at the same time, however, both participants also treat the domain of medical reasoning as something that ultimately belongs to the doctor. This is observable in a number of features.

[13] In the video recording, the tense of the verb "think" is ambiguous. If the patient is heard to speak in past tense, her utterance is also hearable as one that retrieves her earlier candidate explanation (Raevaara 2000).

First, the patient designs her agreement as arising from a distinct personal *perspective*. Through the turn beginning "that's what I (think/thought) myself too" she frames her agreement as a report of her own thoughts, not of "objective" realities (cf. Heath 1992; Maynard 1991c). Second, the patient formulates the diagnosis using probabilistic and non-specific terms ("it probably must be an infection"), thus portraying her conception of the illness as much more general than that of the doctor, who had given a detailed specification concerning the site of the infection (in lines 1–2). And third, it is also noticeable that by moving on to the next phase of the consultation (announcement of future action) immediately after the patient's turn, the doctor does not topicalize or otherwise take note of the patient's report of her thoughts. Through the continuation marker "And" at the beginning of his turn in line 6, the doctor frames his talk about the further examinations as a continuation of the diagnostic statement (lines 1–2) – thus "sequentially deleting" the patient's comment. Through this non-attention, the doctor constructs his own diagnostic reasoning and that of the patient as two separate processes (Raevaara 2000).

In sum, therefore, in extract (14) the patient presented herself as a knowledgeable agent in diagnostic reasoning by expressing an explicit agreement with the doctor's diagnosis. This agency had both self-imposed and externally imposed limits: the patient presented her diagnostic thinking as markedly subjective and approximate, and the doctor treated the patient's statement as not a relevant target for further talk. Hence, along with allowing for the patient's agency, the participants collaboratively treated the details of the process of medical reasoning as something belonging exclusively to the doctor's domain.

Patients resisting the doctors' diagnosis

Consider again extract (15) below, which was shown earlier as extract (8). Before the delivery of the diagnostic statement, the doctor has undertaken a long physical examination of the patient, who has complained about a sudden pain in her back. In lines 1–8, the doctor reports some of her observations while palpating the patient's back. She then withdraws from the patient (line 10) and, while returning to her seat, she tells the patient her diagnostic conclusion.

In her diagnostic utterance, the doctor first explicates the evidence for the diagnosis (lines 11–13), thereafter delivering the diagnosis proper (lines 13–14). Immediately after the diagnosis, she then moves on to speculate about the possible cause of the ailment (lines 14–16, 18). As it was pointed out above, this case does not involve any overt disagreement between the patient and the doctor before the delivery of the diagnosis; but by explicating the evidence for the non-serious diagnostic conclusion, the doctor seems to be attending to the fact that the patient has described the problem as particularly worrisome and puzzling.

(15) (Expansion of [8])

```
1   Dr.:    (But but) I really can feel these with my fingers
2           here it is you see [( ) this way, a very tight=
3     P:                       [Yes,
4   Dr.:    =muscle fiber,
5           (1.0)
6     P:    . Yes a little th[ere<
7   Dr.:                      [IT GOes here from the top but
8           it probably gives it (.) a bit further down then,
9           (1.0)
10                [((Dr. withdraws her hands from P's back))
11  Dr.:    As [tapping on the vertebrae didn't cause any ↑pain
12          and there aren't (yet) any actual reflection symptoms
13          in your legs it suggests a muscle h (.hhhh)
14          complication so hhh it's [only whether hhh (0.4) you
15                                   [((Dr. lands on her chair.))
16          have been exposed to a draft or has it otherwise=
17    P:    =Right,
18  Dr.:    .Hh got irrita[ted,
19    P:                  [It couldn't be from somewhere inside then
20          as ↑ it is a burning feeling there so it couldn't be
21          in the kidneys or somewhere (that p[ain,)
22  Dr.:                                       [Have you
23          had any tr- (0.2) trouble with urinating.=
24          =a pa- need to urinate more frequently or
25          any pains when you urinate,
```

The patient's first response to the doctor's diagnostic statement occurs in line 17. Through her "Right," the patient receives the prior turn (concerning the possible origins of the ailment) as informative and as something that makes sense and/or can be agreed with (cf. Heritage and Sefi 1992; Sorjonen 1997). The next time the patient speaks is in line 19, slightly overlapping with the completion of the doctor's reflections about the origin of the complication. The patient's comments at lines 19–21 take up and question the doctor's diagnostic conclusion. Her utterance is constructed as a multi-unit turn.

First, in line 19, she offers (in the form of a question) a characterization of the location of the trouble that is marked as contrastive to what the doctor has said. Toward the end of her turn she specifies this location, again in the form of a Yes/No question. In between these two proposals, she proffers evidence: "as it is a burning feeling." Thus, this patient not only provides a symptom description that is presented as discrepant with the doctor's diagnosis (which she does in line 20), but she also formulates her own diagnostic proposal concerning what these symptoms possibly could be a sign of (lines 19 and 21).

However, while talking about the diagnosis (and thus displaying her knowledgeability concerning it), the patient also orients to the doctor's ultimate authority in the medical domain. Through the use of a question format in her diagnostic suggestions (lines 19–21), and through the question design that is built to accommodate a rejection of her suggestion (cf. Stivers 2000), the patient displays a commitment that the doctor's view is correct and it is the doctor who will ultimately diagnose the trouble. The way in which she formulates her diagnostic proposals concerning the location of the ailment is nontechnical and approximate ("from somewhere inside then" and "in the kidneys or somewhere"). Moreover, the evidence that the patient produces in line 20 is of "experiential" nature: by saying *as* "it is a burning feeling" the patient describes a bodily sensation to which she only has access (cf. Peräkylä and Silverman 1991). This subjective evidence is in contrast with the objective evidence produced by the doctor in lines 11–13 (cf. Maynard 1991c:479).

In spite of their cautious and subjective character, the patient's diagnostic reflections are taken up by the doctor, who withholds the move to discussion about treatment which otherwise would have been projectable here (Byrne and Long 1976; Heath 1992; Robinson 2003). Instead, in lines 22–25, she resumes a verbal examination. The new examination (focusing on possible troubles with urinating) can be seen as motivated by the patient's suggestion that the trouble might reside in the kidneys. The doctor's questions follow

immediately after the patient's query and, hence, they are offered as preliminary to answering the patient's question. In resuming the examination, the doctor acknowledges the patient's response as a legitimate basis for reconsidering the diagnosis.

Extract (16) below is another example of the patient's explicit resistance to the diagnosis. In this case, the patient has come for a health check. The extract is from the beginning of the consultation. The doctor is examining papers that may have come from a nurse who has seen the patient before the doctor.

(16) (Dgn 29–21A2)

Dr.: So there's a hearing defect at some point hhhh
(0.3) ((Dr. goes through the papers))
Dr.: ((Focusing her gaze on a paper:)) or well that
doesn't actually look quite like a hearing defect that,
(0.5) ((Dr. gazes at the paper))
P: Mm::[::
Dr.: [cu:rve as there's such an even decline in the
<other ear.>
(0.8) ((Dr. gazes at the paper.))
P: Well in a way probably a defect but it is
one tha : : : :t erm (0.4) has (.) came up already
a long time ago an:d (2.0) I don't know then whether it
is : : from work of is i:t (.) from an illness
but (I don't),
(0.2)
B[ecause >you know I have< worked on a paper machine.
Dr.: [Nyeah,
Dr.: Ye:[:s,
P: [In a paper factory,
(0.5)
Dr.: Ex[actly,]
P: [So in] that sense: (0.2) it may also be from
that.
(0.3)
Dr.: .mhh
(0.5)
P: Or not from that.
Dr.: Or not from that.
(0.3)
Dr.: When was it that this was first taken
notice of do you have any: recolle[ction: of r- that,]
P: [hh mmmm hhhhhhh] Might
have been s: : :a:y ten year[s ago. hhhh]h
Dr.: ['rs ago]
Dr.: Yeah,=
P: =Something was then: : (.) when the first curves
were taken then it was found that there is something
((continues))

At line 1, the doctor identifies a probable diagnosis (a hearing defect) that is likely found in the records. Subsequently, while looking at the fresh hearing test result, she corrects herself (lines 3–4) and describes the evidence that she sees in the curve (lines 7–8). Via the correction, the diagnosis becomes problematic (for the author of the records, "hearing defect" has been a plausible diagnosis, but the doctor disagrees), and the description of evidence is alive to this problem. In his response to the diagnosis, the patient at first disagrees with the doctor's corrected diagnosis by insisting on the initial one: "Well in a way probably a defect" (line 10). He then proceeds to an elaborated account concerning the history and the background of the defect (lines 10–27). After the patient's account, the doctor takes up his contrastive diagnostic proposal in her follow-up question that seeks more information about the history of the trouble and the medical attention it has previously received (beginning from lines 30–31; continuation not shown).

It is obvious that by insisting on a diagnosis that has been rejected by the doctor, the patient assumes a role in which he is capable of diagnostic thinking. However, the way in which he does his disagreement also betrays a constant orientation to the doctor's ultimate authority in this sphere. Three features of the lengthy diagnostic segment are particularly significant. First, it is noticeable that the patient's disagreement is done "in the auspices of" the doctor's initial diagnostic statement. It was the doctor who first said that there is a hearing defect, and thus the patient insists on a diagnosis that *the doctor* has first suggested, not a diagnosis that he himself would have independently arrived at.[14] Second, in his account following the formulation of the disagreement, the patient draws attention

[14] It is quite possible, if not likely, that the reference to a "hearing defect" is in the papers that the doctor has read, as a result of the patient having told the nurse about it before the consultation. Even if that is the case, the doctor nevertheless herself spells out this diagnosis, and in the current interaction the patient insists on a diagnosis that has once been spelled out by the doctor.

not only to his own understandings, but also to the expertise of other medical professionals. In lines 11–12, he tells the doctor that the alleged defect came up long time ago. By using a Finnish word ("*ilmeni*") here, the patient alludes that the defect was identified *by somebody else than himself*, thus alluding to medical professionals that have been involved.[15] And third, when the patient moves on to speculate about the origin of the alleged defect, he suggests that it is caused by him having worked on a paper machine (lines 16–23). The doctor withholds uptake (see especially lines 24–26) – and in the face of that the patient explicitly backs down from his theory (line 27), thereby receiving marked acknowledgment from the doctor, who in line 28 repeats the patient's utterance whereby he backed down. By withholding uptake, the doctor couches the patient to offer backdown, with the result that the doctor does not need to "officially" assert that the patient is wrong.

Thus, in (16), in assuming the role of an knowledgeable agent in the domain of diagnostic reasoning, the patient simultaneously acknowledged the doctor's (and the medical profession's) authority in this area. The agency that he assumed was accountably produced by himself as agency operating in a world that is ultimately defined and guarded by the profession.

Responses to diagnosis: a summary

In the latter half of this chapter, I have explored the patients' extended responses to the doctors' diagnostic statements. I started with quantitative analysis which showed that the Finnish primary health care patients respond with more than acknowledgment tokens after about one third of doctors' diagnostic statements. Comparable exact numbers of patient responses have not been provided in earlier research, but the thrust of Heath's (1992) influential

[15] The doctor hears the patient's talk this way, which is indicated by her choosing the passive form in her follow-up question in lines 30–31. She doesn't ask when the patient has taken notice of the problem but, rather, when the problem "was first taken notice of," thus implicating other persons' possible involvement. And finally, in an expansion to his answer, by referring to the time "when the first curves were taken" (lines 36–37), the patient unequivocally indicates the involvement of medical professionals (and medical technology) in the identification of the "defect."

discussion suggests that the British patients in 1980s may have been more passive than the Finnish patients in the 1990s.

In the quantitative part of this study, we also found that the extended responses are most likely to occur after diagnostic statements in which the doctors explicate the evidence for the diagnostic conclusion. This observation has direct practical implications. It suggests that if (in a particular consultation) the doctor considers the patient's participation in discussion about diagnosis welcome, one thing that a doctor can do to foster such participation is to indicate to the patient some of the evidential grounds of the diagnosis.

The fact that the patients are passive after diagnosis in two-thirds of cases may be an indication of their submission in the face of medical authority, as Heath (1992) suggested. On the other hand, two other things may also be involved here. One is the patients' possible orientation to a generic "new delivery sequence" (Maynard 1997), where an extended response is not required from the recipient, and the other is the patients' possible orientation to the "progressivity" of the consultation (Robinson 2003). By remaining passive the patients can simply show their recipiency, and/or they can indicate their expectation that discussion on treatment or other future action will ensue. But my primary interests here were the one third of the cases where the patients responded actively and thereby halted the progression of the consultation towards "post-diagnosis" phases. I noted (again, essentially in line with Heath's earlier observations) that the patients design these responses in a cautious manner, consistently displaying an orientation to the difference between their own and the doctors' ways of reasoning. The primary way for the patients to express their reservations toward the diagnosis is to offer additional observations discrepant with the diagnosis. These additional observations come from outside the realm of the physical examination or the examination of documents; they are not observations of the things that the doctor has been examining, but they are about something that the patient has direct access to (bodily sensations or reports from everyday life). If the doctors present their observations as evidence to support the diagnosis, the patients in most cases systematically refrain from any discussion concerning these observations, let alone question the inferential procedures from the observations to the diagnostic conclusion.

The extracts of extended responses that we have examined suggest that primary care patients can, and in a number of cases do, assume a degree of agency and knowledgeability in relation to their diagnoses. They have available ways for displaying agreement and disagreement with the diagnosis. But their agency and knowledgeability are intertwined and also overshadowed by the patients' and the doctors' orientation to the doctor's authority in the domain of medical reasoning. This dual orientation is perhaps most strikingly encapsulated in those cases where the patient responds to a diagnostic utterance where the doctor has explicated the evidence for his or her conclusion (and that is where most of the active responses occur). The explication of evidence "opens up" patients to talk after the diagnosis. But in their talk that follows the diagnosis, the patients systematically avoid addressing the very evidence that the doctors explicated.

Conclusion

In the beginning of this chapter, I pointed out the dilemma between the expectations concerning the doctor's authority and the patient's knowledgeability in medical consultations. The dilemma first came up through literature on medical consultations: some texts emphasize the authoritarian aspects of the relation, while others describe it as a dialogue between two differently but equally resourceful agents. The dilemma, found in texts, motivated the empirical study of diagnostic sequences which was reported in this chapter.

Throughout the chapter, I have explored different facets of this dilemma in the context of the delivery and the reception of the doctors' diagnostic utterances. Again and again we have seen how the "symmetric" or "dialogical" qualities of interaction – the ways in which the doctors systematically orient to their accountability for the evidential basis of the diagnosis and the ways in which the patients adopt an active, knowledgeable position in responding to the diagnostic statements – are intertwined and also overshadowed with the participants' orientation to the doctor's ultimate authority in the domain of medical reasoning (cf. Heritage 2005).

The upshot of these observations for medical practice is twofold. *First*, I want to suggest – in line with Atkinson (1982) and Silverman (1987) – that those versions of "patient centeredness" which

assume that the patient's knowledge and experience can or should provide a frame of reference for the consultation, as an alternative to, or as an equal partner of, the doctor's expert knowledge, are out of touch with the interactional reality of medical consultation. The doctor's authority seems to be a constitutive feature of medical interaction. As far as I can see, deleting the doctor's authority would entail that the interaction would not any more be medical at all; and I see no reason to advocate that. But *secondly*, I also want to point out that the doctor's authority does not exclude the building of genuine doctor–patient partnership (cf. Roter and Hall 1992; Maynard 1991c). At least in the diagnostic sequences that I have considered in this chapter, the participants regularly find ways of accommodating the doctor's authority with his accountability and the patient's knowledgeability. In the diagnostic sequences, the doctors and the patients seem to be oriented to the maintenance of the mutual intelligibility of the evidential basis of the diagnosis. Even when the patients produce extended responses, they may be more concerned with intelligibility and evidence rather than challenging the doctors' authority, because these actions are produced and received, by both participants, in ways that systematically sustain the doctor's authority. Paradoxically, therefore, I would like to suggest that the doctor's authority is so deeply rooted in the details of medical interaction that it allows for the possibility of the doctors explaining their ways of reasoning to the patient, and the patients expressing their own ideas, possibly even more than they do today, without the doctor's authority being called into question.