On the interactive constitution of medical encounters

Paul ten Have©

Abstract

The paper offers a concise introduction tot the conversation-analytic study of medical encounters. The basic perspective is that medical personnel and patients constitute the encounter together as being a medical one. The paper discusses some of the major findings from the CA literature in this area, detailing some generic resources and their local applications as used by the parties involved. Fragments from one consultation, recorded in the Netherlands in the late 1970s, are quoted for illustrative purposes.

Résumé

Cet article propose une brève introduction aux études émanant de l'analyse conversationnelle sur les consultations médicales. La perspective adoptée considère que le personnel et les patients constituent ensemble la rencontre comme une interaction médicale. L'article discute les résultats principaux issus de la littérature en analyse conversationnelle dans ce domaine et détaille quelques-unes des ressources génériques utilisées par les participants ainsi que la manière dont ils les exploitent localement. Une illustration de ces résultats se fonde sur des extraits tirés d'une consultation particulière, enregistrée aux Pays-Bas.

Introduction

Over the last 40 years or so, CA has discovered and formulated a range of more or less generic 'formats' which members of society have available to organize their interactions. While being generic, they can and are continuously adapted to the local occasions of their use. Participants may differ in their format preferences and negotiate the organization of their encounter in more or less open ways. Format preferences often become institutionalized, involving change over time and differences between various styles and cultures. These formats can be related to diverse tasks and objectives. The tasks tend to be asymmetrically distributed in terms of initiatives and responsibilities, while the objectives may be complementary, but at times divergent.

CA stresses that such formats have the character of sequential structures that evolve over time. As one, speaker, for instance, initiates a greeting, other participants in the event are expected to greet in return, so that they produce a 'greeting sequence' together. In similar ways, interactants produce question-answer sequences, story-telling sequences, etc. of varying complexities. Each 'production' of talk-in-interaction is a collaborative one. Any next action can be related to the previous one, and produces a local context for the next.

As a background to their local decisions, participants rely in part on sets of notions which they presume to be shared among them regarding the various categories to which they belong and

the various predicates associated with them. Predominant among the possibly relevant categories for the encounters to be discussed are the complementary ones of, on the one hand, *physician,* and, on the other, *patient*. This is an examples of what Harvey Sacks (1972: 37-39) has called the category collection K, 'a collection constructed by reference to special distributions of knowledge existing about how to deal with some trouble', where 'collection K is composed of two classes (professional, laymen)'. In other words, physicians and patients assume that they have different 'rights' and 'duties' regarding specific types of knowledge. Physicians should have a stock of general medical knowledge of a 'technical' kind and the ability to apply this knowledge to the case at hand, while patients are supposed to have only a 'lay' version of medical knowledge, but quite an extensive and specific knowledge of their own life experiences. Concepts of differential knowledge and knowledge rights play a role in the overall structure of the encounters as well as in the details of the actually realized formats. On occasion, more general categories of, for example, age and gender, or parent and child, may also come into play.

The overall structure of medical consultations

Most medical consultations seem to be organized along the lines of a fairly stereotypical overall sequential structure, with many type- or case-dependent variations (cf. Byrne & Long, 1976; Heritage & Maynard, 2006: 14; Ten Have, 1989: 118). After some preliminaries, the first item on the agenda will be the reason for the visit, expressed and explicated by the patient in first visits and sometimes by the professional on returns. Some sort of 'examination' is often next, whether as a verbal questioning or a physical one, or a combination of these. The results can be given as a (provisional) diagnosis, followed by a treatment advise, further testing, or a referral. Within this overall schema, a variety of interactional formats can be used. Patients can express their concerns as a list of symptoms or as a story, for instance, while questioning and explanations may be formats used by the professionals to do their work.

The special contribution of CA research consists not primarily of structural overviews like the ones just given, but in explicating the actively and collaboratively achieved character of those structures in their local details[1]. Due to the restricted size of the present paper this point can only be illustrated incidentally; more wide-ranging illustrations can be found in the literature cited and elsewhere.

Preliminary sequences

The first few sequences of medical encounters mostly resemble those in other agent-client meetings, including greetings, invitations to come in or sit down, and identifications if needed. In this way, the physician acts as the host of the encounter as well as the one who is to provide a personal service. He sets the scene for the to be enacted service encounter. In first visits, the physician often invites the patient to voice the reason for the consultation, although he or she can also start as soon as the doctor seems 'ready to receive' (cf. Heath, 1981, 1984, 1986). In return visits or chronic conditions, the physician often refers to the previously discussed problem or condition as a known-in-common ground for what is to follow. Depending on the format of the invitation chosen, or its absence, the patient will design his or her formulation of

---

[1]Heritage and Maynard (2006) offer an extensive explication of such studies in relation to other kinds of approaches to doctor-patient interactions.

current concerns as a second, responsive action, or and a first, initiating one. Therefore the manner in which the physician opens the floor for the patient has an impact on the subsequent reporting by the patient (Robinson, 2006). In my Dutch data, *vertel het es* (roughly: tell is now) is a common opening format; for English 'what can I do for you today?' or 'what brings you in today?' is often mentioned as a common format (Heath, 1981). In these opening sequences, then, physician and patient take their positions, mutually adapting their actions and their reception of the actions of the other to the circumstances of the encounter as these become available step-by-step.

Patient's problem presentations

The primary formulation by the patient (or a care-giver) of the reason for the consultation is a crucial moment in the interaction: the basis for what is to follow. It is the major moment in the encounter in which the patient is 'free' to bring in his or her own concerns in his or her own words. The physician's invitation marks its beginning, while his or her first question or comment initiates its provisional end, after which the possibilities for the patient to speak are mostly in second, reactive position[2].

It is quite clear from the dense formulations used that many patients have prepared these presentations carefully before coming in, and struggle to bring then out as planned during their actual voicing. Sometimes they are very short, just mentioning the major topic without further elaboration, while in other cases they have the format of a list of symptoms or a summary tale. In this way, patients set the agenda for the consultation, offering the topics on which they want to be questioned. But at the same time, they account for the visit, for the claim on the physician's time and attention. In other words, the first formulation combines a topic-initiating move with a legitimizing one (Heritage & Robinson, 2006; Ten Have, 1987; also Halkowski, 2006).

Heritage and Robinson (2006: 74-83) account for some of the design features of problem presentations in terms of what they call, referring to Jefferson (1988), 'troubles resistance'. That is the observed tendency of people when talking about a problem they have to strike a balance between on the one hand what is indeed troubling them and on the other their 'normality' in being able or at least willing to cope with it on their own. One aspect of problem presentations which is said to show such a 'resistance' is their overall 'factual' orientation, and another is the frequent reference to lay ways of coping used before consulting a professional, including a 'wait-and-see' strategy and the application of home medicines. References to such previous actions are also often voiced later in the consultation, demonstrating that the legitimacy of the visit continues to be a preoccupation of the patient. Physicians, on the other hand, may endorse the decision to consult explicitly, and they do so implicitly when they reach a serious diagnosis and offer a treatment.

Some of these features can be seen in the first illustrative extract[3]:

---

[2]Cf. examples in Ten Have (1991): 142-5

[3]The fragments are quoted in a rough English translation; the full transcript in Dutch with line-by-line English glosses, is available at: http://www.paultenhave.nl/JansmaFull.htm.

Extract (1) ((Patient has earlier seen another physician in the same practice))

| | | |
|---|---|---|
| 17 | D | that has been quite a history with you in uh January huh |
| 19 | P | yes |
| 21 | D | and that has then that has been (.) going alright since then? |
| 22 | P | yes |
| 23 | | ((46: interrupting telephone call)) |
| 24 | P | (it's the case that) for a few months I have been having (.) a cold |
| 25 | | and then it's over again and then it's gone again |
| 26 | D | yes |
| 27 | P | and sunday I got suddenly uh (.) a real headache |
| 28 | D | yes |
| 29 | P | (I had to all-) on on this side altogether |
| 30 | D | yes |
| 31 | P | and sunday night I got uh pain in my chest here |
| 32 | D | with coughing or something or |

In line 17, the physician refers to an earlier event about which he is apparently aware through the patient's record. After a positively formulated general question regarding the time since then and now, there is an interrupting telephone call, which the doctor answers rather quickly. When it is finished, the patient starts his presentation (24). This is a clearly structured concise story in three parts: first a middle-long timed background complaint, an intermittent cold (24-5), then a concretely timed headache (27, 29), and finely an even more concretely timed chest pain (31). In so structuring his tale, the patient indicates that on the one hand he for some time already suffered from a general complaint, for which he did *not* consult, while now he had a sudden aggravation, for which he decided to do so, implicitly suggesting at the same time that the earlier and the present symptoms might be related. In 32 the physician starts questioning, which is the topic of the next section.

Questionings[4]

During a patient's presentation, or after its marked ending, the physician will mostly 'take back' the initiative by asking questions on the patient's observations and experiences: pains, failures, bodily changes, etc. Questioning can take many forms, which include but are not limited to grammatical questions. Physicians often use statements about the patient's observations or experiences, with or without a rising intonation. I will therefore discuss questioning in functional rather than structural terms. Furthermore, questioning will be considered as an embedded interactional activity.

Very often questioning initiatives will be tied back to what went before, but later questions may be on the surface unrelated, probably stemming from a checklist for a differential diagnosis. Even such seemingly unrelated question will quite frequently be started with 'and' (or other connectives), which has been called 'and-prefacing' (Heritage & Sorjonen, 1994).

---

[4]For brevity's sake, I focus on the kind of questioning that immediately follows a problem presentation in acute visits. There are other contexts in which physicians systematically question patients, such as 'comprehensive history taking' (cf. Stivers & Heritage, 2001; Boyd & Heritage, 2006), which have partly different properties and a different function.

This seems to suggest that there is indeed an underlying logic connecting the questions, although it may not be obvious to the patient.

Whatever the connections and the format, a physician's questioning initiative opens up a pre-structured 'answer space' for the patient. Patients can use that space in different ways, just limiting themselves to a direct answer, or adding additional components in an 'answer elaboration'. In multi-unit answers there is quite often a subtle 'shifting away' from the question as the elaboration continues. The first item may be a direct answer, the second a more reflective and subtle reaction, followed by components that express the emotional meanings of the experiences being spoken about. In this way patients can use their answer space to do more than was required, adding items relevant to the agenda as supplements to their initial problem presentation (cf. Stivers & Heritage, 2001 for similar phenomena during history taking).

Physicians may react to such elaborations in a permissive way, with an acknowledgement token at various points in the expansion. But they can also come in with an 'okay' receipt, as soon as a minimal answer is produced, and in so doing cutting off or ignoring any elaborations (c.f. Frankel, 1984). Such early, continuation discouraging acknowledgements would then function to interrupt 'the voice of the life-world' (Mishler, 1984). This negative evaluation of doctors' practices is part of a larger one regarding series of medically-oriented factual questions which would limit the contributions of patients to what is technically required (Frankel, 1990, West, 1984; but see Ten Have, 1991). However one may judge these various alternatives, it is clear that patients and physicians can and do negotiate how answer spaces are to be used.

Some of these issues can be seen in the following extract, continuing from extract (1):

Extract (2)

```
32   D   with coughing or something or whatever=
33   P   =well no coughing I cannot do at all no longer
34   D   m hm
36   P   it is more uh (.) well now is it all the way from (.) here down
37       my back all the way to uh to under my shoulder and then this side
38       all the way
39   D   yes
40   P   because I can not uh breath as I would do otherwise
41   D   no
42   P   then I get a stitch that is uh
43   D   and where do you work
```

In line 32 the physician suggests an additional symptom to the list provided by the patient in his presentation. The patient denies it, but he does so in a way that has been shown to be typical for 'dispreferred' reactions[5]. The negation is prefaced by a hesitation marker and followed by an account (33), which leads to further elaborations (36-8, 40, 42). At first the physician

---

[5]In CA, the notion of 'preference' does not refer to personal preferences but to structural ones. In the case at hand the physician's suggestion makes a confirmation the 'easiest' next action (cf. Sacks, 1987), but the patients has to go against it.

acknowledges these elaborations (34, 39, 41), but then he comes in with a completely unrelated question, switching from symptoms to life conditions, but prefaced with 'and' (43).

After this there are some exchanges on whether the patient can still work, to which he adds a description of un unsuccessful application of a home medicine for muscle pain, followed by more descriptions of his symptoms, partly acknowledged by the physician, and some requests for elaboration. Then the physician comes in again as follows:

Extract (3)

72   D hmhm (.) which bar do you work in? which bar do you
        work in?
73   P  Paradiso on the Market
74   D oh (.) 'h if you could take this off

After a minimal acknowledgment of the preceding item, the physician switches again to work (72), but in a medically rather less relevant way, taking the patient off his complaining track. He marks the answer as informative (oh), and invites the patient to prepare for a physical examination (74).

Physical examinations

When a physical examination or test is judged to be necessary, the interactional setting changes completely. While in the previous phases the patient as a person was the source of knowledge, now the physician turns to the patient's body in order to check or specify any diagnostic ideas voiced by the patient or inferred from the reported symptoms. In other words, the physical examination offers an objectifying opportunity after a reliance on the subjective reports from the patient. For the analysis of this phase of medical encounters, video becomes essential, as is clear from the work of Christian Heath in this area (Heath, 1986: 99-127; 1988, 1989, 2006; see also Frankel, 1983).

As can be seen in a range of details of the ways in which physicians and patients handle physical examinations, both parties take great care to avoid embarrassments. In a way they both 'enact' a split between the to be examined body as an *object* and the patient as a *subject*. Physicians will avoid looking at the patient when he or she undresses of dresses again after the examination, while during the examination focussing on the relevant area of the body. Patients, on the other hand, will then look a bit aside, at middle distance, as if not at all concerned. They make their body, or a part of it, available for the examination, but do not actively participate in it. It is, then, 'an activity which is guided by medical practice and convention rather than momentary and shifting requirements of fully fledged interaction with a co-participant' (Heath, 2006: 194). The physical is the most asymmetrically enacted phase of the encounter and a mutually constituted 'time out' from active verbal interaction..

Physical examinations are, in fact, mostly accomplished in silence, with only restricted instructions from the doctor, as in 'inhale deeply'. At times the physician may utter some comments on his or her findings, an 'online commentary', which in anticipating a diagnosis seems to serve a specific strategical purpose. namely to 'prepare' the patient for a diagnosis which runs counter to his or her expectations (Heritage & Stivers, 1999). Patients may provide

additional comments or descriptions, invited or not, and in particular kinds of examinations report on their experiences, such as pain in particular places or positions (Heath 1989, 2006).

The following extract does illustrate some of these possibilities.

Extract (4) [during a chest examination]

```
90  P  bu- but it's really stiches you know?
91  A  yes=
92  P  =when you you have to really uh when you sit in a chair then you
93     really have to (sit) in a specific way- you cannot take any position
94     [with sleeping it's exactly the same=
95  A  ['hh  bec-
96  A  =because I don't hear anything (.) in your lungs (.) on the inside
97     there's nothing (.) and uh you don't cough either
98      (.)
99   P  yes from time to time bu-
```

While the physician examines the patient's chest, the latter adds some unsolicited characterizations of his pains (line 90), and of the way these pains restrict his possibilities to sit in a chair or lay in bed comfortably (92-4). The physician confirms the first item (91), but at a possible completion point starts a remark which he interrupts (95) as the patient continues (94). At the next completion point, he does voice his remark in the clear, noting some negative observations from his examination (96-7). This illustrates the notion of 'online commentary' and it prepares the patient for a negative conclusion regarding one aspect of his complaints, a 'cold'. At the same time, it marks the end of (at least a part of) the examination.

Diagnosis

In one way or another the previously discussed phases will lead up to a moment when the physician reports his or her conclusions in the form of diagnostic statements and/or treatment proposals, recommendations for further tests, or a referral to another professional. For reasons of space I will restrict my treatment here to diagnostic statements and their reception, followed in the next section by a consideration of phases in which a treatment is proposed.

Diagnostic conclusions can be brought forward in various ways. Anssi Peräkylä (1998, 2006) has distinguished three types: 'plain assertions' (it is X), 'diagnoses indexing inexplicit references to the evidence' (it seems to be X), and 'explicating the evidence of the diagnostic conclusion' (because of P and Q it must be X). These types differ in their implications regarding the physicians' 'authority' and how they present themselves as more or less 'accountable', as well as willing to grant their patients with abilities to understand the diagnostic process. However, even in the apparently most 'authoritarian' format, 'plain assertions', they do place their diagnostic conclusions just after the examination or other evidence, and in that way make 'visible' how they arrived at it. Peräkylä suggests that a 'plain assertion' format, placed adjacent to the examination or other evidence, is a kind of default option for presenting the diagnosis. Other formats seem to be chosen under circumstances when the default is less adequate, for instance when other topics are raised between the examination and the diagnosis, when the specific aspect of the examination that grounds the diagnosis is not clear to the patient, or when the diagnosis is uncertain or disputed. In those

cases physicians seem to take extra measures to strike a balance between their authority and their accountability *vis à vis* their patient.

In line with earlier observations by Heath (1992), Peräkylä (2006) finds that in most cases patients react to diagnostic statements minimally or not at all. In the fewer cases in which they do produce a more extensive reaction, however, these tend to follow statements in which the physician has, in a way, opened up the discussion by providing explicit references to the evidence, the third option above. When they react, however, patients do so cautiously, referring to their lay experiences rather than professional observations. So patients also work to strike a balance between their own knowledgeability and their respect for the doctor's authority in medical matters.

Here's an extract with the diagnosis from the consultation we have been considering before.

Extract (5) [after the examination]

```
126  D  I do think that after all uh that that it's something in your muscles
127  D  [that what you have there that pain
128  P  [(strange)
129  D  'hh that it's a kind of uh muscular pain
130     (.)
131  P  [it's really under my shoulder (he[re) so her[e
132  D  ['hh                            [yes:      [yes
133  P   and here [(straight befo[re it)
134  D          [on your     [on your side yes yes because its all
135  D   it feels all and it sounds all normal 'hh
136  D   that breathing
137  P   well I'm happy with that
```

Earlier in the consultation, the patient had reported that he had used a home medicine for muscular troubles which did not help to alleviate the pain (data not quoted). So in line 126-9 the physician returns to a diagnosis that the patient had discarded, to which the patient reacts with a muttered surprise marker (127). The tentative way in which the physician brings forward his diagnosis (126, 129), as well as the repeated 'empirical' account, (134-6), are in line with Peräkylä's findings, noted above, that physicians depart from the default format of straightforward asserting in cases where the patient has suggested a diagnosis before, which the doctor is now rejecting. This is also in line with the 'online commentary' discussed in the previous section. Note that the patient, after having added some more descriptions (131, 133), which are confirmed by the doctor (132) accepts the diagnosis with appreciation (137).

Treatment

After the diagnosis, the time frame referred to tends to shift from looking backward, speaking about what went before and up to the present, to the future. When the character of the past has been established, if only provisionally, it's time to look ahead: what is to be done. The possibilities include: 1) wait-and-see: doing nothing for the moment and observe how the ailment will develop in the near future, 2) further tests, examinations, etc., possibly to be referred to others, 3) a treatment proposal, such as a medication or an intervention by the

physician him- or herself, or 4) a referral to a specialist, who is to apply special knowledge and/or technology.

For reasons of space I will only discuss options 3) and 1) here. Option 3 proceeding to an immediate treatment can be seen as the default. It is what patients generally expect and what rounds off the case, at least provisionally, in the same session in which it was raised. It can be formulated as the obvious thing to do (I will give you Y), or as a proposal (I propose that you take Y). But in any case it can be demonstrated that, in contrast to a diagnosis, here an explicit *acceptance* by the patient is due. When it is not forthcoming it tends to be invited, and its absence may be seen as passive resistance (Stivers 2006).

In our exemplary consultation it is the default format 3) that is used:

Extract (6) [consecutive with the previous extract]

```
138  D   and well what I would like to propose to you is to take a
139        sedative? to counter the pain?
140  P   hmhm
141  D   so you in any case you let's say can do everything
142        with it
143  P   hmhm
144  D    and you should not take it for more than a week
145  P   hahhm
146  D   and then we will consider how it is after that
147  P   yes
148  D    and the moment you are still not satis[fied
149  P                                          [it is uh
150        during the night it is at its worst huh
          [10 lines of further complaint descriptions omitted]
162  D   but do you think it's a good proposal to do it like that?
163  P   yes of course as long as I'm rid of it
          [followed by additional instructions from the physician]
```

Here the physician formulates his advise explicitly as a proposal, thereby opening up a treatment negotiation (Ten Have, 1995, see also Stivers, 2006). The patient reacts minimally to the physician's explications (140, 143, 145, 147), starting further complaint descriptions in overlap with the physician's 'still not satisfied' (148-9). After more descriptions, the doctor explicitly request the patient's acceptance (162), which he gets immediately (163).

Now let us take a look at what I termed option 1) above. In terms of the organisation of the treatment phase, and of the encounter as a whole, this option tends to be the most problematic. For many patients, the fact that they initiated the consultation means that the time to wait-and-see has been passed; they already did that. Research by Tanya Stivers on pediatric encounters (2005, 2006) shows that many parents bring in their children with relatively minor respiratory problems expecting and wanting an antibiotics treatment. When they are told that such a treatment doesn't make sense with a viral infection, the interaction can become quite tense. Many of them do insist that something has te be done and for them antibiotics is the obvious solution. And when parents do not explicitly resist, but just 'fail to accept', physicians take this as resisting and wanting antibiotics.

Leave-taking

With an acceptance of the treatment, the consultation is not automatically over. There can be further arrangements to be made, instructions to be given, or pending issues to be dealt with, In the consultation from which I have discussed a few extracts, for instance, we see that from the formal acceptance in line 163 until it's actual end, physician and patient discuss a number of related issues, including further instructions and the air-conditioning at the patient's work setting, until the encounter ends at transcript line 286. Nowadays such an extension of the consultation may have become quite rare as physicians are confronted with quite severe time constraints. Closing off the encounter may therefore require some pressure from the doctor and more or less tense negotiations between physician and patient (cf. Heath, 1986: 128-52, West, 2006)

Practical implications

I have reported above in summary fashion some of the major findings of conversation analytic research on the social organisation of physician-patient interaction. This organisation is both local and interactionally achieved. This means that actually observed interactions show variations at all points, products of a continuous mutual adaptation to each other's actions by both physician and patient. At the same time, the observed interactions show persistent patterns, based on routines, conventions and interactional 'logics'. This Janus-faced character of medical interaction, both patterned and regular as well as locally achieved, has various practical implications, of which I will discuss just a few in an exemplary fashion. Both parties might profit from designing their actions with an eye on such implications.

As a first example let us consider the overall structure of consultations, which suggests that there is a logical setting for the various actions of the two parties. After the preliminaries, patients are, in the case of first visits, to present their reasons for it, both to start off the proceedings and to account for the claim on the physicians time and attention. These reasons may be quite complex. For the patient this creates a serious design problem: how to use the 'free space' of the initial presentation in such a way that the physician gets a clear picture of what is involved. When the patient has more than one concern, for instance, it seems wise to announce this right from the start. For the physician, on the other hand, it might be profitable to postpone the questioning until a reasonably complete overview has been presented.

A related issue arises from the patient's 'account problem'. It can be observed that many patients keep adding unsolicited complaint descriptions at various moments later in the consultation, even after their acceptance of diagnosis and treatment. This can be seen as an effort to be informative, to help the physician to do his or her work, but quite often an aspect of continuous accounting seems to be discernable. Explicitly accepting the account, stressing the reasonableness of the initiative to consult, and in so doing validating the patient's decision, may help to discourage further accounting activities. In an implicit way, various aspects of the doctor's actions of course do validate the visit, but an explicit acceptation may be more effective.

For many kinds of actions, speakers have a choice among alternatives which may have different interactional effects. We encountered this, for example, in the findings by Anssi Peräkylä that the way in which a physician announces a diagnosis has a strong impact on how the patient will

react to it, in a limited or in a more elaborate way. The latter may have further consequences for the patient's acceptance of treatment.

Another example can be found in Tanya Stivers' investigations in acute pediatric care, focussed on interactional aspects that might lead to an medically unjustified treatment of viral infections with antibiotics. In one of her papers (2005), she identified two formats physicians use to recommend non-antibiotic treatment: recommendations *for* a particular treatment (e.g., 'I'm gonna give her some cough medicine.') and recommendations *against* a particular treatment (e.g., 'She doesn't need any antibiotics.'). The first type turned out to be less likely to engender parent resistance to a non-antibiotic treatment, than the second type. Physicians who provide a specific positive treatment recommendation followed by a negative recommendation are most likely to attain parent alignment and acceptance when recommending a non-antibiotic treatment for a viral upper respiratory illness.

Relatedly, and in more general terms, it may be suggested to reflect on the 'results' of a consultation, in relation to what patients can be taken to want or expect. It has been noted that most patients tend to use a descriptive format to bring forward their complaints, while in those cases where a request is formulated, this is often done in rather general terms like 'would you please look at X'. When we look at the uptake by physicians, however, we saw that, after investigating the case, they tend to do two different although connected things as a response: they formulate a diagnosis and they offer a treatment proposal. These two actions are accountably interconnected, as well as related to the investigation: the diagnosis is announced in a way that connects it as a result to the examination, as we saw in Anssi Peräkylä's observations; and the proposed treatment is mostly explicitly based on the diagnosis. Patients can be seen to have a double-faced concern: 'what is it?' and 'what can be done about it?', so physicians are under pressure to provide an answer to both parts. The fact that the two are most often implied rather than voiced explicitly can intensify a problematic situation if the physician is not able or willing to answer positively to one or both parts. When a clear diagnosis is not achievable within the consultation itself, further investigations or a referral may be offered. But when no sensible treatment is available, the physician is empty-handed, so to speak: he or she has nothing to 'offer' in order achieve an acceptance and proceed to closing the encounter. Handing over a recipe for some medication works pragmatically as a closing invitation, as it makes an acceptance materially relevant. It makes sense, both sequentially and in terms of communicative efficiency, to hand over some other kind of written instruction, a diet for instance, or and instruction sheet for exercises, when medication is not relevant medically.

In sum, understanding the sequential logic which is operative in consultations, based on conversation-analytic findings can be useful to formulate quite specific practical recommendations to physicians in order to optimize consultations, both interactionally and medically.

"The routine as achievement"

I have borrowed the title of this pre-final section, 'the routine as achievement', from a 1986 paper by Emanuel Schegloff, the major living conversation analyst. In that paper, he discusses the ways in which people start conversations on the telephone. For most people in western societies, making and receiving a telephone call is a routine activity. But at the same time each call is a unique event, which is produced as such by the parties in interaction with each other.

Schegloff formulates what he calls a 'canonical model of telephone call openings', which consists of a logical series of steps leading to the introduction of a first topic. He notes, however, that in none of the many cases on which he has based this model, is it completely realised. One part of this model is, for instance, a 'how-are-you sequence', which offers the possibility to treat general topics of well-being before the specific 'reason for the call' is mentioned. Whether such a sequence occurs at all, and if so how it is initiated and dealt with, differs of course enormously. In short, the routine is always a locally achieved one.

My sketch, given in the preceding sections, of the overall flow of medical consultations should be understood in a similar way. For physicians, consultations are a routine and while this is not the case to the same extent for patients, adults tend to have at least some experience with being the patient in a consultation. That the routine has to be learned can be observed in consultations with a child (cf. Ten Have, 1998). This suggests that both participants in the encounter, physician and patient, have an overall image of the purpose of the encounter and of the ways in which this purpose can be achieved. This offers a kind of template for the actual enactment of the consultation in which their actions offer a display of how they take it that the template has to be used 'this time'. In a subsequent consultation on the same ailment, for instance, the problem presentation can be limited to an update.

In short, the sketch that I have offered should not be taken as a description of a 'structure', as a kind of fixed list of obligatory parts, but rather as a template that can be used as a resource for the participants in order to shape the encounter in a series of logical steps, adapted to the job they have to do. It is, in other words, not so much an analyst's construct as well as an analysis of the participants' structuring resource, visible in the observed sequence of their enactments.

Conclusion

I have, in broad outline, sketched the major interactional patterns that can be observed in medical consultations, taking acute primary care as the paradigm case. And I have noted again and again that which participants use such patterns in particular ways, adapting to circumstances, the medical condition and each other. A number of special topics had to be left aside, including the role of documents (earlier the record card, now the computer), general check-ups, and the presence of 'third persons' such as mothers consulting for their children. A bibliography of ethnomethodological and conversation analytic studies in medicine and related fields is available on the internet at http://www.paultenhave.nl/medbib.htm The thrust of these studies, as is the case for the text above, is to stress the flexible, locally adapting use of generic interactional practices.

References

Boyd, Elizabeth, John Heritage (2006) 'Taking the history: questioning during comprehensive history taking'. In: John Heritage, Douglas W. Maynard, eds. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press: 151-84

Byrne, P.S., B.E.L. Long (1976) *Doctors talking to patients: a study of the verbal behaviour of general practitioners consulting in their surgeries*. London: H.M.S.O.

Frankel, Richard M. (1983) 'The laying on of hands: Aspects of the organization of gaze, touch, and talk in a medical encounter'. In: S. Fisher, A. Dundas Todd, eds. (1983) *The Social Organization of Doctor-Patient Communication*. Washington, D.C.: Center for Applied Linguistics.: 19-54

Frankel, Richard M. (1984) 'From sentence to sequence: Understanding the medical encounter through micro-interactional analysis', *Discourse Processes* 7: 135-70

Frankel, Richard (1990) 'Talking in interviews: a dispreference for patient-initiated questions in physician-patient encounters'. In: George Psathas, ed. *Interactional Competence*. Washington: University Press of America: 231-62

Halkowski, Tim (2006) 'Realizing the illness: patients' narratives of symptom discovery'. In: John Heritage, Douglas W. Maynard, eds. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press: 86-114

Have, Paul ten, (1987) *Sequenties en formuleringen; aspecten van de interactionele organisatie van huisartsspreekuurgesprekken* [Sequences and formulations: aspects of the interactional organization of general practice consultations]. Dordrecht: Foris

Have, Paul ten, (1989) 'The consultation as a genre'. In: B. Torode, ed. *Text and Talk as Social Practice*. Dordrecht/Providence, R.I.: Foris Publications: 115-35

Have, Paul ten (1991) 'Talk and institution: a reconsideration of the 'asymmetry' of doctor-patient interaction'. In: Deirdre Boden & Don H. Zimmerman, eds. *Talk and social structure: studies in ethnomethodology and conversation analysis*. Cambridge: Polity Press: 138-63

Have, Paul ten (1995) 'Disposal negotiations in general practice consultations'. In: A. Firth, ed. *The discourse of negotiation: studies of language in the workplace*. Oxford: Pergamon: 319-44

Have, Paul ten (1998) 'Formatting The Consultation: Communication Formats And Constituted Identities'. Unpublished paper, available at: http://www.paultenhave.nl/Format.htm

Heath, Christian (1981) 'The opening sequence in doctor-patient interaction'. In: Paul Atkinson & Christian Heath, eds. *Medical Work: Realities and Routines*. Farnborough: Gower: 71-90

Heath, Christian (1984) 'Talk and recipiency: sequential organization in speech and body movement'. In: Atkinson, J. Maxwell, John Heritage, eds. *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press: 247-65

Heath, Christian (1986) *Body Movement and Speech in Medical Interaction.* Cambridge: Cambridge University Press

Heath, Christian (1988) 'Embarrassment and interactional organization'. In: Paul Drew, Anthony Wootton, eds., *Erving Goffman: exploring the interaction order*. Cambridge: Polity Press: 136-60

Heath, Christian (1989) 'Pain talk: the expression of suffering in the medical consultation', *Social Psychology Quarterly* 52: 113-25

Heath, Christian (1992) 'The delivery and reception of diagnosis in the general practice consultation'. In: Paul Drew, John Heritage, eds. *Talk at Work*. Cambridge: Cambridge University Press: 235-67

Heath, Christian (2006) 'Body work: the collaborative production of the clinical object'. In: John Heritage, Douglas W. Maynard, eds. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press: 185-213

Heritage, John, Jeffrey Robinson (2006) 'Accounting for the visit: giving reasons for seeking medical care'. In: John Heritage, Douglas W. Maynard, eds. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press: 48-85

Heritage, John, Douglas W. Maynard (2006) 'Introduction: analyzing interaction between doctors and patients in primary care encounters'. In: John Heritage, Douglas W. Maynard, eds. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press: 1-21

Heritage, John, Marja-leena Sorjonen (1994) 'Constituting and maintaining activities across sequences: *And*-prefacing as a feature of questioning design', *Language in Society* 23: 1-29

Heritage, John, Tanya Stivers (1999) 'Online commentary in acute medical visits: A method of shaping patient expectations', *Social Science and Medicine* 49(11): 1501-17

Jefferson, Gail (1988) 'On the sequential organization of troubles talk in ordinary conversation'. *Social Problems* 35: 418-41

Mishler, Elliot.G. (1984) *The Discourse of Medicine: Dialectics of Interviews*. Norwood, N.J.: Ablex

Peräkylä, Anssi (1998) 'Authority and accountability: the delivery of diagnosis in primary health care', *Social Psychology Quarterly* 61: 301-20

Peräkylä, Anssi (2006) 'Communicating and responding to diagnosis'. In: John Heritage, Douglas W. Maynard, eds. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press: 214-47

Robinson, Jeffrey (2006) 'Soliciting patients' presenting concerns'. In: John Heritage, Douglas W. Maynard, eds. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press: 22-47

Sacks, Harvey (1972) 'An initial investigation of the usability of conversational data for doing sociology'. In: David Sudnow, ed. *Studies in social interaction*. New York: Free Press: 31-74

Sacks, Harvey (1987) 'On the preferences for agreement and contiguity in sequences in conversation'. In: Graham Button, J.R.E. Lee, eds., *Talk and social organisation*. Clevedon: Multilingual Matters: 54-69

Schegloff, Emanuel A. (1986) 'The routine as achievement', *Human Studies* 9: 111-51

Stivers, Tanya (2005) 'Non-antibiotic treatment recommendations: delivery formats and implications for parent resistance', *Social Science & Medicine* 60: 949–64

Stivers, Tanya (2006) 'Treatment decisions: negotiations between doctors and patients in acute care encounters'. In: John Heritage, Douglas W. Maynard, eds. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press: 279-312

Stivers, Tanya, John Heritage (2001) 'Breaking the sequential mold: Answering 'more than the question' during comprehensive history taking', *Text* 21: 151-85

West, Candace (1984) *Routine Complications: Trouble with Talk between Doctors and Patients*. Bloomington: Indiana University Press

West, Candace (2006) 'Co-ordinating closings in medical interviews: producing continuity of care'. In: John Heritage, Douglas W. Maynard, eds. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients*. Cambridge: Cambridge University Press: 379-415