Communication in medical care: Interaction between primary care physicians and patients

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Communication in Medical Care provides an analysis of doctor-patient interactions while specifically focusing on the “co-constructive” contributions of both doctor and patient. Greater understanding of these essentially social interactions, as well as more effective medical treatment, is an obvious goal of the research. The book consists of fourteen chapters with each chapter dealing with a unique phase of the doctor-patient interaction and satisfyingly arranged to generally match the real-life sequence of such interactions.

The editors give an introduction in chapter one, including a brief overview of previous research into doctor-patient interaction. This overview details the evolution of medical communication research from a largely functionalist method, which was rather abstract and general, to two other approaches: process analysis or microanalysis of discourse. Process analysis seeks to describe interactions in a chronological process through the assignment of role behavior to one of several categories available in the model’s coding scheme. Microanalysis utilizes an interpretative methodology that attempts to address a variety of contextual concerns including participant background, sensibilities, and experiences in an effort to arrive at an actual-meaning analysis of the interaction.

While proponents of the two approaches have each pointed out the weaknesses of the other’s approach, this book suggests that they are not mutually exclusive but rather complementary. Thus, the authors set out to employ a method referred to as conversation analysis, one that integrates both quantitative and qualitative elements into the research design. Some readers may not be familiar with conversation analysis, and the particular approach to this method utilized by the authors of this book is distinctive enough that I will note its major features below.

In utilizing conversation analysis as a framework for carrying out their research and analysis, the authors are guided by a number of theoretical practices and principles. (1) Interactions should be organized into sequences generally characterized as turn-taking or adjacency pairs. (2) Spoken,
as well as unspoken, utterances accomplish interactional activities. Therefore, each utterance (or non-utterance) of any given adjacency pair must be evaluated for intent. Further, each member of an adjacency pair is doubly contextual—parameters for an utterance’s contribution to the ongoing activity is provided by preceding utterances while itself providing the parameters for some next action in a sequence. (3) No aspects of an interaction are to be regarded as disorderly or insignificant noise. This requires recognition of and interpretation of various expressions of all kinds including silences, overlapping talk, breathing, etc. (4) Speakers utilize the hearer’s following turn as a way of evaluating the alignment of understanding between the participants. If a speaker judges that the hearer has not understood what the speaker intended to convey, they will utilize their next turn to correct the misunderstanding. Thus, the analyst has a built-in method for identifying the norms of communicative behavior and the means utilized for ensuring that mutual understanding is achieved.

The resulting methodology organizes interactions in a systematic manner generating quantifiable data and repeatable research operations. Pragmatic concerns may also be addressed as close attention is paid to evaluating intent and meaning. But all the while, the analyst is guided by the overall regularity of the interaction in addressing “deviant” turn-taking analysis.

Chapter two, “Soliciting patients’ presenting concerns,” begins the investigation of the medical visit. Jeffrey D. Robinson reveals that physicians typically format their questions in such a way as to be relevant to the type of concern for which the patient presents. Question format essentially indexes the patient concerns as new, follow-up, or chronic/routine. Patients intuitively recognize the appropriateness of this indexing, with implications regarding the patient’s overall level of comfort, confidence and satisfaction with the interaction.

John Heritage and Jeffrey D. Robinson, in their chapter “Accounting for the visit: giving reasons for seeking medical care,” suggest that patients frequently display “troubles resistance” resulting in a perceived need to provide justification for the visit. Patients use a variety of means in seeking justification, including self-diagnosis, invoking third parties in the decision to seek medical advice, and making troubles resistance claims, which seek to prove that the patient has spent time or effort coping with the concern on their own and have sought medical advice as a last resort. Doctors are encouraged to be aware of the patient’s need for justifying the visit and respond appropriately, as ineffective interaction may result in de-legitimatizing the visit from the patient’s perspective.

Chapter four, “Realizing the illness: patients’ narratives of symptom discovery,” is authored by Timothy Halkowski, who notes that patients frequently provide the circumstances surrounding the discovery of their medical problem. The patient’s narrative typically seeks to convey adequate concern for their general health, but without obsessive attention to their bodies.

Virginia Teas Gill and Douglas W. Maynard, in “Explaining illness: patients’ proposals and physicians’ responses,” address the challenge patients face in offering their own suggestions regarding their health concerns and strategies doctors employ to acknowledge these suggestions. Patients’ explanations may be either overt or tacit and appear to be designed to respect the collection-of-information phase of the interview, avoiding the demand for an assessment before all the data have been collected. Doctors are called upon to confirm or disconfirm patient
explanations, doing so in a variety of ways, each of which have implications to the ongoing interaction.

The next chapter, “Taking the history: questioning during comprehensive history-taking,” is authored by Elizabeth Boyd and John Heritage. They show that the history-taking phase of the doctor-patient interaction remains characteristically co-constructive in nature, in spite of the control exerted by the doctor over this interview phase.

Chapter seven deals with how the patient presents the body as a site for clinical study. Christian Heath, in “Body work: the collaborative production of the clinical object,” observes how both patient and doctor adopt a middle-distance orientation during the examination, enabling the doctor to perform otherwise intrusive actions.

“Communicating and responding to diagnosis,” by Anssi Peräkylä, demonstrates that doctors orient their telling of diagnosis to the visibility and intelligibility (for the patient) of the evidential basis of the diagnosis. Patients, in turn, respond to diagnoses with no more than acknowledgement tokens in most cases. However, extended responses are most often given following diagnoses accompanied by explicated evidence. Furthermore, the data support the doctor’s authority as a fundamental element in doctor-patient interactions and patients’ acceptance of diagnoses.

Douglas W. Maynard and Richard M. Frankel write, in “On diagnostic rationality: bad news, good news, and the symptom residue,” that doctors follow a generic “news delivery” sequence, adapted to the clinical setting. Bad news presents the possibility of strong emotion and the loss of rational dialogue. Therefore, bad news is delivered in a somewhat guarded manner. Doctor and patient work together to maintain order and objectivity. Good news delivery is typically upbeat and rational. However, good news often brings with it the lack of an explanation of symptoms and can therefore move the interaction in the direction of irrationality. Patients may seek to justify their visit, and doctors may reinitiate their investigation into the patient condition.

Chapter ten, “Treatment decisions: negotiations between doctors and parents in acute care encounters” by Tanya Stivers, suggests that parents arrive at the medical care encounter already implicated in the child’s treatment phase. Treatment recommendations are most likely to be resisted by parents when they are seen as against a particular treatment, e.g., when the doctor advocates for no antibiotics to be given in the treatment. Doctors can minimize resistance by offering treatment recommendations that are positive rather than negative as well as including a concrete next action step.

David Greatbatch’s chapter, “Prescriptions and prescribing: coordinating talk- and text-based activities,” describes the physician’s use of the computer in preparing prescriptions during the doctor-patient interaction. Use of the computer necessarily disrupts the flow of dialogue, enabling the doctor to focus on inputting the information correctly. Doctors typically relate the details of the prescription to the patient either as they are typing those specific details in or just before doing so, while the cursor is located in the relevant field. Meanwhile, patients are reluctant to interject during times of quiet or when it appears the doctor is in the middle of typing. Rather, patients look for cues, such as a pause in the doctor’s typing, to raise a concern or ask a question.
In “Lifestyle discussions in medical interviews,” authors Marja-Leena Sorjonen, Liisa Raevaara, Markku Haakana, Tuukka Tammi, and Anssi Peräkylä look at how lifestyle issues such as smoking and diet are addressed in Finnish medical care consultations. When questioned regarding habits, patients generally orient around a non-problematic assessment. Initial responses are typically general, which elicit follow-up questions from the doctor seeking specification. In most cases, doctors close these discussions in a non-evaluative manner. Lifestyle questions are more likely to imply a problematic orientation when posed immediately following a medical problem formulation. In these cases, doctors regularly are seen to give advice regarding the lifestyle issue.

Chapter thirteen, “Coordinating closings in primary care visits: producing continuity of care” by Candace West, shows that closings are usually initiated by the making of arrangements, either for a follow-up visit or for some course of action. Invitations for other concerns not yet addressed may also be given, to which patients are often initially hesitant to accept. Serious or major health concerns are only rarely introduced by patients during closing procedures. Throughout the closing are actions that work towards maintenance of a standing relationship, even when the visit marks the closure of a specific concern-generated affiliation.

Chapter fourteen, “Misalignments in ‘after-hours’ calls to a British GP’s practice: a study in telephone medicine,” addresses supposed differences in the opinions of callers and doctors regarding the seriousness of a medical condition. Author Paul Drew notes that doctors generally decide early in the call, following just the caller’s initial report of the patient’s condition, whether or not to pay a home visit. Only rarely does the doctor’s further diagnostic questioning have bearing on the decision to “see” the patient. Callers’ descriptions tend towards the dramatic and the seriousness of the patient’s condition, while doctors’ design of investigation reveals an orientation to an assessment of routine and non-urgent.

*Communication in Medical Care* presents an interesting look at the social interactions between doctors and patients. The arrangement of the chapters, organizing them according to their position in sequence of occurrence, enhances the readability and overall enjoyment of the book. That medical encounters share many similar features of other routine social interactions is evident from the conclusions offered by the authors. In this, we find a useful addition to studies of discourse and pragmatics in linguistics.

The focus of the book is, however, clearly sociological in nature. Conclusions tend toward observations of human behavior rather than language use, with language utilized as just one source among several of evidence of behavior. The methodology also appears to rely too heavily on subjective evaluation and too little on pure linguistic data, according to my tastes. Indeed, conversation analysis seeks to integrate social context into the interpretation of communicative events to a greater extent than other discourse analysis models such as *rhetorical structure theory* or *corpus based analysis*. One should also keep in mind that conversation analysis is distinct from text analysis, which typically involves just one speaker. Nevertheless, some field linguists will likely find a number of useful elements to include in their own research, and sociolinguists particularly will be intrigued by the language use of doctors and patients.