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Patient Participation in Decision Making Process in Primary Care

A conversation analytic study

ACADEMIC DISSERTATION
To be presented, with the permission of the board of the School of Humanities and Social Sciences of the University of Tampere, for public discussion in the Väinö Linna-Auditorium K104, Kalevantie 5, Tampere, on July 27th, 2011, at 12 o’clock.

UNIVERSITY OF TAMPERE
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ABSTRACT

This study examines how patients participate in the diagnostic and treatment decision making in Finnish primary care consultations for upper respiratory tract infection. The study focuses on doctor-patient interaction in three phases of a consultation: problem presentation, diagnosis delivery and treatment decision making and examines how these phases are linked to each other, forming a process of diagnostic and treatment decision making within the consultation.

The data of this study consist of ninety-eight video- and audio-recorded doctor-patient encounters that were collected in nine municipal health centres in different parts of Finland in 2005-2006. Eighty-six encounters were selected into the detailed analysis: forty-six child patient encounters and forty adult patient encounters. The method of the study is ethnomethodological conversation analysis. The results are presented in four empirical articles that are published/accepted to be published in peer-reviewed scientific journals.

The study examines how doctors and patients’ epistemic positions are interactionally constructed and oriented to in presenting and receiving a reason for the visit. Firstly, ‘front-grounded’ and ‘back-grounded’ candidate diagnoses were discerned from the ‘symptoms only’ –type of problem presentations. When a patient presents ‘symptoms only’, the doctors receive this type of symptom descriptions minimally, without contemplating the patient’s experience as such and the patient’s and the doctor’s epistemic positions are oriented to as conventional doctor-patient roles. When the patient presents a candidate diagnosis in her or his problem presentation, the doctors typically address it right then and there: the patient’s problem presentation guides the doctor’s responsive actions in terms of when and how the doctors take the patient’s epistemic position into account, and how the doctors orient to the patients’ rights to possess medical knowledge.

Further, the doctor’s diagnosis delivery serves as an interactionally responsive and thus relevant action with regard to the way in which the patient presented the
problem earlier in the visit. Therefore, the patient’s problem presentation and the doctor’s diagnosis delivery constitutes a request-grant–type of activity in the consultation. As doctors design their diagnosis deliveries to be responsive to the patient’s problem presentation, they treat themselves accountable for meeting the patient’s particular agenda in the consultation.

Moreover, the study shows how patients resist a diagnosis given by a doctor and how they re-invoke the reference between the problem presentation and diagnosis delivery in cases in which the doctor’s diagnosis does not fit the initial complaint. In resisting, patients resort not only to their experience-based views on their illness to which they are ‘entitled’ to, but also on medically informed knowledge on their previous diagnoses. This is evident when the patients re-invoke their own initial diagnostic expectations: the diagnosis is something on which the patient has a say not only in presenting the problem at the beginning of the encounter but also later on, upon hearing the doctor’s diagnosis.

The study also examines the ways in which the doctors and patients arrive at treatment decisions following a doctor’s ‘unilateral’ decision delivery. The term ‘unilateral’ refers to decision delivery formats within which the doctors suggest, recommend or conclude a treatment or some other further plan of action to the patient and which are given as initiative actions in the decision making phase, thus offering the decision as already-made. However, even in unilateral decision deliveries doctors typically accommodate the patient’s perspective to it: they make the medical rationale of the decision making available to the patient and/or refer to the patient’s possible diagnostic or treatment expectations in delivering the decision. This way, the doctor’s decision is not presented as the conclusion of his/her medical opinion only but also as a response to the patient’s expectation. The ways in which the patients receive these decision deliveries either maintain the orientation in the decision making in doctor-controlled agency, or shape the orientation toward a more shared practice. Firstly, by absent or minimal response to the decision delivery and aligning with the initiation of the next activity after the decision delivery, patients may orient to the conduct in unilateral decision making as adequate. In turn, in their extended responses the patients further their own perspectives in decision making by assessing the
decision positively, by evaluating the grounds on which the doctor’s decision is acceptable, or by resisting the decision. Again, in extending the sequence of decision delivery and reception, the patients orient to the decision as negotiable and shape the unilateral process of decision making into a shared one.

The results of the study are discussed in relation to concepts such as patient participation, concordance and shared decision making that are used in current health policy and research. The study also considers the viewpoints which empiric, conversation analytic research can bring to the theoretical discussion.
ACKNOWLEDGEMENTS

I am grateful to all who have helped, encouraged and guided me through this dissertation process. Here I can name only a few of them. First of all, thank you to those who made this dissertation possible: the doctors and patients who trusted me their consultations. I am also grateful to the nurses of the participating health centres for their help in recruiting the patients.

Thank you to Academy of Finland, Kone Foundation, Otto A. Malm’s Foundation and Emil Aaltonen’s Foundation for providing funding for this study.

The flaws of this study are entirely my own, yet I have a number of researchers who have inspired and taught me in these years. Johanna Ruusuvuori introduced me to “the antibiotic project” and conversation analysis in 2004 and stood by me in the ups and downs of this process. Johanna, I can not thank you enough! Anssi Peräkylä has been the most empathic leader in our project and provided an excellent work and learning environment for me. Thank you. Finally, Ilkka Arminen was the one who encouraged me to pursue a doctorate in the first place. Since then, his support and guidance have been solid.

I started my work in the Academy’s research project Interaction and outcome in social and health services. The project created the best possible environment for my development as a novice researcher. Thank you to the project members Sonja Backman, Leena Ehrling, Esa Lehtinen, Pirjo Lindfors, Tiina Mälkiä, Pirjo Nikander, Anssi Peräkylä, Johanna Ruusuvuori and Sanna Vehviläinen. After “the outcome project” my work continued in another Academy research project, Emotion, interaction and institutions. Thank you to Hanna Falk, Mikko Kahri, Anssi Peräkylä, Johanna Ruusuvuori and Liisa Voutilainen for the good conversations and critique in our meetings as well as lovely free time together.

I had a privilege to study at UCLA in 2007-2008. Under my advisor John Heritage’s supervision the analyses and the dissertation as a whole started to take
shape. Thank you John for giving your time and dedication to the early sketches of my analyses. I also thank Emanuel Schegloff, Steven Clayman and Charles Goodwin for their inspiring and eye-opening data sessions and lectures.

My fellow students and UCLA visitors taught me a great deal. It is impossible to name all important encounters in classes and conferences, but without a doubt Liisa Voutilainen, Mikko Kahri, Hanna Falk, Yujong Park and all members of the graduate seminar at the Department of Social Research, University of Tampere have had an influence on my thinking and most of all, motivation to work on this study.

I have received a lot of practical help with this study, too. Pirjo Lindfors, Aku Kallio, Riikka Homanen and Johanna Ruusuvuori helped me in data collection, and Aku Kallio did excellent work in transcribing the data. Yujong Park, Ieva Boyett, Sarah White and Antti Kallio helped me with the English language. Thank you!

The pre-examiners of this study, Anna-Maija Pirttilä-Backman and Esa Lehtinen gave me good and usable comments on the dissertation manuscript. Thank you very much. Thank you to Anna-Maija Pirttilä-Backman also for being my opponent in the public defense.

At the end of this process I got a lot of help and support from Anja-Riitta Lahikainen and as always, Johanna Ruusuvuori. They understood my life situation from half a word and made the final stages of this process happen swiftly. Thank you, my family and I really appreciate it!

Thank you to all my friends with their families for giving me joy and something else to think about during these years. A few Californians have a very special role in this dissertation process, as I wrote the whole thesis while living in Santa Monica. Donna, a landlady and a very good friend of mine, provided me with a peaceful place to work and write, not to mention refreshing swims and afternoon coffees. Vincent taught me life-work balance and disturbed it, thank you for that.
And Ieva, our deep conversations while hiking and watching for mountain lions and rattlesnakes were so needed!

My beloved parents Marianne and Asko Ijäs have taught me what I needed most in this process: hard work. Their love and support has been, and is, something indescribable. Also my sister Miia and brother Mika have always been there for me. Thank you.

Thanks to this dissertation, the dearest things one can ask have come into my life. During my first week at UCLA I met Antti who became my friend, dive buddy, back-packing companion and husband. I dedicate this dissertation to us and our baby who will be born very soon.

June 2011

Taru Ijäs-Kallio
LIST OF ORIGINAL ARTICLES


INTRODUCTION

This doctoral dissertation is a conversation analytic inquiry into the patient participation in the process of diagnostic and treatment decision making in Finnish primary care consultations for upper respiratory tract infection. The study encompasses the interaction between primary care physicians and their patients in the phases of problem presentation, diagnosis delivery and treatment decision making, and discusses the social grounds of patient participation in these core aspects of a medical visit.

In this introduction, I reflect on two types of patient participation. First, I consider patient participation as a concept of current health policy, i.e. as attempts to improve patients’ possibilities to get involved in treatment decisions and other processes that affect their health outcomes, and as a theoretical concept with which such attempts are measured and assessed in clinical discourse. Second, I consider patient participation as actual interaction in terms of how patients communicate with their doctors. This type of participation, in turn, I understand as an inherent aspect of any social conduct. Patients necessarily participate in their health care consultations, only the forms of their participation vary.

The nexus of the two types of patient participation is contemplated throughout this dissertation. In section 1 of this introduction, I consider the concept of patient participation and the models of doctor-patient relationship in medical consultations. Section 2 reviews some previous studies on doctor-patient communication and patient participation. In section 3, I present my research questions. Section 4 introduces the theoretical framework and the method of this study. Section 5 reports the main results of the four original articles included in this dissertation and discusses how diagnostic and treatment decision making evolve as a process in medical consultations. In section 6, I return to discuss patient participation in the interface of ‘theory’ and ‘practice’ in medical consultations. In this final section I also consider the limits of this study and present further research questions.
1. CONCEPT OF PATIENT PARTICIPATION

The primary medium for patient participation and decision making is social interaction. The science of medicine is practiced in terms of visual observation, microbiology, clinical chemistry and physiology, radiology, surgeries and other physical manipulations. Nevertheless, in clinical medicine the whole process of finding out the nature of the patient’s illness, injury or disability to the evaluation of the attempts of its healing or alleviation is accomplished in interaction, perhaps most crucially in talk-in-interaction between the doctor and the patient. So when we study patient participation and decision making in medicine and health care, we necessarily study social interaction.

Patient participation is a concept that emphasizes a particular aspect in medical interaction: the patient’s possibilities and means to get involved in and affect the consultation process, including treatment and other decisions. Patient participation stresses the importance of the patient’s input in health and illness management, besides that of the doctor’s. In brief, the concept of patient participation reflects on how the patients’ agency and control in doctor-patient encounters is understood and studied. (Collins, Britten, Ruusuvuori and Thompson 2007, Thompson 2007, Peräkylä and Ruusuvuori 2007, Entwistle and Watt 2006, Horne, Veinman, Barber, Elliot and Morgan 2005.)

1.1. Patient participation as health care policy

Contemporary patients in Western countries are more educated and informed than perhaps ever before in the history of modern medicine. This has reinforced the patients’ agency and empowerment in medical and health care. For instance, patients have an increasing access to medical information via the Internet. Patients’ previous knowledge on diagnoses and treatment options acquired beforehand effects the physician-patient relationship in the consultation and may bring problems to clinical communication in case the information received from various sources of the Internet is misleading or misinterpreted (Cline and Haynes...
Moreover, patients are often free to choose their doctors and switch them if they are dissatisfied with the provided care.

Health care policies, education and research that advocate patient participation have recognized the changing trend in the patients’ and providers’ attitudes and needs in health care. The concept of patient participation endorses a departure from the outdated doctor-centred health policy toward more patient participatory and patient-centred care (Roter and Hall 1992). Consequently, advocacy of patient participation is a major trend in medical education, research and health policies in Europe and throughout the Anglo-Saxon world (Horne et al. 2005, Entwistle 2000, Mead and Bower 2000, Elwyn et al. 1999a). Motivation for more patient participatory conduct in health care and medicine derives from various sources: political, medical and in general, humane points of view.

The political impact on the promotion of patient participation in health care has been particularly explicit in the UK where, since 1979, the neo-liberal administration have encouraged patients’ greater involvement and independency in medical decision making in favour of consumer-oriented health care (Thompson 2007). Patient participation and patient-centred decision making is still strongly favoured in Britain’s public health care system, National Health Service (NHS) (Horne et al. 2005). In the US, where health care is almost exclusively a market-based system that uses private health insurance (government-subsidized Medicare system for people over 65 and Medicaid for the children in the poorest families providing exceptions), patient participation is also promoted from a consumerist viewpoint (Roter and Hall 1992: 27-31). For instance, one of the hot topics debated in relation to the currently ongoing health care reform in the United States concerned the extent to which the public insurance replaces private insurers – which did not happen at all. However, both the advocates and opponents of the reform stress the patient-consumers’ freedom of choice with regard to their doctors and insurance providers.

In Finland, health care is provided as public, universal service but patients may choose to complement or replace their public services with private, although state-subsidized, health services. Consequently, the consumerist approach is
perhaps less overt. However, Toiviainen (2007) pointed out that more than half of the Finnish doctors report that they frequently encounter patients who explicate a wish to receive certain diagnostic tests, procedures or medicines in the consultation, and that such patient behaviour has increased in recent years. Interestingly, two out of five Finnish doctors perceive this as negative, whereas only one out of five doctors sees it as being positive patient behaviour (Toiviainen 2007: 78-79).

Emphasis on significance of patient participation in decision making is not only political or economical, but medical. Already in an early study on paediatric emergency room communication (Korsch and Negrete 1972) it was shown that the less mothers of ill children were satisfied with communications with their doctors, the less likely they adhered to the treatment plans given by their doctors. More recent studies show that quite often patients with prescribed, self-administered medications take lesser doses than what is prescribed to them, or leave the prescribed medicines not taken altogether (Haynes, Ackloo, Sahota, McDonald and Yao 2008). The studies indicate that the more patients are able to participate in their own treatment decisions, the more compliant their post-consultation behaviours are. Patients who have participated in decision making better adhere to the agreed treatment plans and actually take the medications as prescribed to them (Haynes et al. 2008, Krousel-Wood, Hyre, Muntner and Morinsky 2005, Winnick, Lucas, Hartman and Toll 2005). Therefore, patient participation in treatment decision making may well have important medical benefits in terms of treatment outcomes and effective, continuing care.

Finally, patient participation is supported by purely humane reasons. Patients are active agents in their own health and illness and thus the rights, responsibilities and decisions concerning these matters do not belong only to their doctors but to the patients themselves (cf. Mishler 1984: 187-196). From this point of view, patient participation must be an inherent, crucial part of health care (Weiss and Britten 2003, Guadagnoli and Ward 1998). Equal relationship between a doctor and patient and the doctors’ respect toward the patients’ rights to self-determination is noted in the ethical guidelines of the medical profession itself (Saarni 2005: 10-11). For instance, The Finnish Medical Association
acknowledges interaction as an important foundation for an equal, respectful doctor-patient relationship. Even though a doctor-patient encounter necessarily includes epistemic asymmetry between the parties, it still is and should be approached as an encounter between two equal human beings. Both parties should become understood and their viewpoints balanced in the encounter (ibid: 40-42, see also Laki potilaan asemasta ja oikeuksista 1992/785: §5, §6).

1.2. Models of patient participation and medical decision making

In sociology, one of the first theorizations of the doctor-patient relationship in the modern society was offered by Talcott Parsons. In his book ‘The Social System’ (1951), Parsons describes the doctor-patient relationship as fulfilling the socially expected doctor-patient roles, i.e. the doctor’s role as ‘professional’ and the patient’s role as ‘sick’. To Parsons, these roles have ‘latent functions with respect to the motivational balance of the social system’ (ibid: 476). The different, opposing social roles are purposeful as the doctor legitimizes the patient’s illness as well as determines when the patient is illness-free again. This way the doctor exempts the patient from his or her social obligations of work and home life and judges when these privileges of the sick role should end. In turn, as the patient enters the socially recognized and accepted ‘sick role’, she or he is entitled to be excused from these daily responsibilities, but is also obliged to seek treatment, obey the doctor’s orders and eventually resume to the usual activities. Illness is a disturbance in normal functioning of the individual both in terms of somatic disease as well as personal and social adjustments, whereas medicine is a mechanism within the modern social system for coping with such disturbances of its members (ibid: 431-432). The ‘professional role’ and the ‘sick role’ regulate and maintain the structure and order of the society as the roles are enacted within the social system of medicine which is, in turn, embedded in the larger social system of the modern society.

Another influential treatise on the doctor-patient relationship is offered by Eliot Freidson (1970). Freidson’s view, while also seeing a fundamental difference in rights and responsibilities of the doctors and patients, is more conflictive. As for
Parsons the doctors’ and patients’ different roles aimed at a well-functioning society and the doctors’ responsibility for the welfare of the patients as their first priority (Parsons 1951: 447), Freidson’s view on an asymmetric doctor-patient relationship points out the doctor’s and patient’s conflicting interests. He sees the ownership of medical knowledge determining the doctor-patient relationship: the patient is more an ‘object’ of health care rather than a ‘person’ (Freidson 1970: 139). Doctors, by being unwilling to share their knowledge with patients seek to maintain their professional role and high status in the society. The less knowledgeable the patients are the less likely they are to challenge the doctor’s authority. In Freidson’s view, doctors and patients are in competition over epistemic rights and responsibilities. In regulating the society in the competition over knowledge the doctors hold a crucial gatekeeper role (ibid: 141-143).

Both Parsons (1951) and Freidson (1970) described a doctor-patient relationship in terms of society’s structure, at a macro-sociological level. However, already in the days of Freidson’s (1970) influential study the view on different doctor-patient roles was contrasted with a notion on how professional roles are susceptible to change, especially in health care (Reeder 1972). Mere paternalism or professional (societal) dominance (Freidson 1970) is challenged by more patient-centred approaches which are illustrated in ‘micro-sociological’ models of doctor-patient relationship.

Roter and Hall (1992) offer a comprehensive view of different variations in the doctor-patient relationship. In terms of who holds control in medical consultation, they describe four distinctive prototypes of doctor-patient relationship: paternalism with high physician control and low patient control (cf. Parsons 1951, Freidson 1970), consumerism with low physician control and high patient control (cf. Reeder 1972), mutuality in which both parties have high control over how the consultation unfolds, and finally, a default doctor-patient relationship in which both parties hold low control in terms of being able to change the nature of their relationship (Roter and Hall 1992: 24).

The prototypes of doctor-patient relationship described by Roter and Hall (1992) have, to some extent, counterparts in the existing models of decision making in
medical consultations. Among the decision making models, *paternalism*, *professional-as-agent* –model, *shared decision making*, and *informed decision making* are perhaps the most prominent ones (Thompson 2007, Horne et al. 2005, Elwyn et al. 1999a, Charles, Gafni and Whelan 1999 and 1997). Thompson (2007) places these models into a ‘power continuum’ ranging from the patient’s exclusion from decision making (*paternalism*) to the patient’s full freedom of choice with regard to treatment options (*informed decision making*).

The paternalistic model of doctor-patient relationship (Roter and Hall 1992: 25-27) echoes Parsons’ (1951) and Freidson’s (1970) views by stressing the doctor’s authority and control over the patient. In the paternalistic approach to patient care the doctor is the one who, on the basis of his or her medical expertise, decides the treatment and what the patient ought to do, whereas the patient’s participation is limited to submitting to the doctor’s authority. In contrast, in the *professional-as-agent* -model the doctor is assumed to possess the technical and medical knowledge needed in decision making but also to incorporate the patient’s preferences into the process which is still, in the end, accomplished by the doctor. The model of *informed decision making* takes one step further in the power continuum. It sees decision making as a process in which the doctor provides all the necessary or relevant information and treatment options to the patient who, then, makes the final decision according to her or his own preferences. (Thompson 2007.)

The approach of *shared decision making or mutuality* in Roter and Hall’s (1992: 32-33) terms refers to a doctor-patient relationship in which both the doctor and the patient equally take steps to achieve a mutually agreed decision (Thompson 2007: 46-47, Charles, Whelan, Gafni, Willan, Farrell 2003, Charles et al. 1999 and 1997). In other words, the model of shared decision making balances between the extremities of doctor vs. patient controlling the decision making (Charles et al. 1997, Elwyn, Edwards and Kinnersley 1999a). The model does not abandon the doctor’s role in favour of the patient’s fully independent role in decision making, nor does it place the doctor as the ultimate authority. As Charles et al. (1997) put it, the model of shared decision making is an intermediate approach to decision making. It gives the patient some say with regard to treatment options without transferring the full responsibility to her or
him, and by the same token the doctor can move beyond the role of mere information provider or authoritarian decision maker (Elwyn et al. 1999a).

Charles et al. (1997) clarify the models for shared, informed and professional-as-agent decision making which, according to them, do not adequately describe the process of decision making apart from information sharing. On the basis of this critique, they construct a model for ideal shared decision-making in medical interaction which encompasses both of these features: information sharing and decision making. According to Charles et al. (1997), shared decision making firstly involves at least two participants, in most ‘simple’ cases a doctor and patient (as well as other professionals, family members etc.). Secondly, the doctor and patient should share information with one another and thirdly take steps to build consensus of the preferred treatment. As a fourth step they should agree on how the treatment will be implemented.

This model was soon revisited to better recognize the dynamic process of (shared) decision making (Charles et al. 1999). In the revisited model for shared decision making, all the steps or as Charles et al. call them, *analytic stages*: information exchange, deliberation, and deciding on treatment to implement are two-way processes. Firstly, both a doctor and patient have to share information on treatment options, side effects, patient’s preferences, values etc. Secondly, the deliberation process should be accomplished between the doctor and patient, not by the doctor alone (as in paternalistic model) or by the patient alone (as in informed or consumerist models). And thirdly, deciding on the treatment to implement is again a matter of the doctor-patient dyad, not relying on the doctor or the patient only (see also Elwyn, Edwards, Kinnersley and Grol 2000).

In sum, the model of shared decision making addresses the patient’s point of view along with that of the doctor’s and stresses the significance of both parties’ share in the decision making process as well as in its outcome (Charles et al. 2003, Charles at al. 1999). Besides the models of decision making process, the *outcome* of decision making is equally essential for understanding ‘patient participation’ in medical decision making. In this discussion, the concepts of patient’s *compliance, adherence* and *concordance* need to be introduced here.
Today, the concepts of patient compliance and adherence have, to some extent, been replaced by the concept of concordance (Cushing and Metcalfe 2007, Horne et al. 2005, Stevenson and Scambler 2005, Dickinson et al. 1999, cf. Segal 2007). ‘Compliance’ is defined as ‘the extent to which the patient’s behaviour matches the prescriber’s recommendations’ (Horne et al. 2005: 12). The term ‘adherence’ has a slight modification with regard to the patient’s agency as it refers to ‘the extent to which the patient’s behaviour matches agreed recommendations from the prescriber’ (ibid: 12). ‘Concordance’ in prescribing and taking medicines was first introduced in the UK. It is an attempt to overcome the problems of non-adherence and non-compliance that results in ineffective medical care and waste of resources due to inappropriate or inadequate prescribing and medicine-taking. The definition of concordance ranges from a reference to ‘a consultation process in which the patient and physician agree decisions that incorporate their respective views, to a wider concept that stretches from doctor-patient communication in the prescribing process to patient support in medicine taking’ (Horne et al. 2005: 12).

The concept of concordance resonates with the model of shared decision making (Bissell, May and Noyce 2004, Cox, Stevenson, Britten and Dundar 2004, Weiss and Britten 2003, Dickinson et al. 1999). In a concordant doctor-patient relationship the patient’s experiences and knowledge about her or his illness are valued as equal and important as the doctor’s biomedical knowledge on the illness management. Moreover, a concordant and thus shared decision making process incorporates both parties’ contributions. It stresses the decision making process as the doctor’s and the patient’s reciprocal, open contributions. Problems that may result in the patient’s non-adherence to treatment regimens, such as a doctor providing little information on medicines, not mentioning its side effects and not expressing her or his own views on medicines, should be overcome with open communication, providing information to the patient and exploring the patient’s views, beliefs and concerns related to the medicines (Cox et al. 2004, Weiss and Britten, for an opponent view, see Segal 2007). Also possible challenges the patient anticipates in following treatment plans should be addressed in the concordant decision making process, as well as the ways to help
the patient to deal with these challenges. This communicative process is not (ideally) a ‘tag-on’ practice addressed at the end of the consultation but a part of the consultation process as a whole (Cushing and Metcalfe 2007, Weiss and Britten 2003).

In sum, patient participation in medical communication in general and in decision making in particular includes various aspects (Peräkylä and Ruusuvuori 2007) and can be understood via various concepts (Thompson 2007). This poses also challenges for its promotion and evaluation. Next I turn to review some problems recognized with regard to terms such as ‘shared decision making’ and ‘concordance’ in medical interaction.

1.3. Challenges to patient participation in decision making

There are theoretical and practical challenges in how to understand and implement patient participation for instance as shared decision making or concordance in medical interaction in general and in decision making in particular. One question is to what extent the different models of doctor-patient relationship, including shared decision making, are put into practice in various clinical contexts. Previous research has shown that communicational accomplishment of decision making in health care consultations still often or even mostly implements the professional-centred approaches and that ‘shared decision making’ is not reality in doctor-patient encounters (Bissell et al. 2004, Rees Jones, Berney, Kelly, Doyal, Griffiths, Feder, Hillier, Rowlands and Curtis 2004, Stevenson, Barry, Britten, Barber and Bradley 2000). In a recent review study on the health care professionals’ perceptions of decision making, Gravel, Legare and Graham (2006) pointed out that in the doctors’ views, factors that complicate the implementation of shared decision making include lack of time, and lack of applicability due to patient characteristics or the clinical situation. On the other hand, the doctor’s own motivation to engage in shared decision making was seen as an important facilitator of it and the doctors were motivated to implement shared decision making because of its positive impact on the clinical process and the patient’s health outcomes (Gravel et al. 2006).
The concepts of shared decision making, concordance and patient participation in clinical communication pose also methodological challenges for research. As Charles et al. (1997) point out, the conceptual confusion involved in shared decision making makes it difficult to judge what such a process includes within it and, in turn, what kind of communicational conduct falls outside of it. Besides the conceptual confusion, empirical questions include how to measure patient-centred care or the level of patient participation in decision making (Epstein, Franks, Fiscella, Shields, Meldrum, Kravitz and Duberstein 2005, Butler, Kinnersley, Prout, Rollnick, Edwards and Elwyn 2001, Mead and Bower 2000), how to assess the process within which doctors and patients achieve the decision, and how shared it is in the end (Stevenson et al. 2000, cf. Silverman 1987: 40-41). It has also been suggested that the terms such as informed choice, shared (or joint) decision making and concordance would be difficult to operationalize for scientific purposes due to their multi-faceted nature (cf. Horne et al. 2005: 160).

Finally, it needs to be considered whether patient participation and shared decision making are applicable as universal solutions for any medical encounter. As Thompson (2007) points out, in line with Charles et al. (1997 and 1999), Roter and Hall (1992: 104) and Guadagnoli and Ward (1998), not all patients wish to participate in making medical decisions. There are various factors that effect the patient’s readiness or willingness to participate, such as the nature of her or his illness, the patient’s personal characteristics and the level of trust the patient has with her or his physician (Thompson 2007). On the other hand, it has been shown that the patients may have incorrect expectations on the nature and proper treatment of their illness which may, in turn, lead to inappropriate prescribing practices. In such cases, to what extent shared decision making could or should be implemented is perhaps a relevant question (Stivers, Mangione-Smith, Elliott, McDonald and Heritage 2003, Elwyn, Gwyn, Edwards and Groll 1999, Macfarlane, Holmes, Macfarlane and Britten 1997).

In sum, the theoretical and normative concept of patient participation, including the terms concordance and shared decision making, poses also challenges in terms of how to define, measure, assess or promote it. In the overwhelm with the
concepts, what truly constitutes patient participation, shared decision making or concordant doctor-patient relationship that is free of ‘doctor-centred decision making bias’ may become, or remain, problematic (Segal 2007). In the next section of this introduction, I review previous research on doctor-patient communication that has uncovered the empirical aspects of patient participation (or lack of it).
2. STUDYING DOCTOR-PATIENT COMMUNICATION

2.1. Different approaches in the research of doctor-patient communication

The doctor-patient relationship and medical communication have been objects of study for more than 30 years (Heritage and Maynard 2006b). In the following, I briefly review some of the most influential research approaches in the field. A prominent trend has been to code doctor-patient communication. Later on, qualitative studies (such as ethnographic observation, interviews and discourse analysis) have contributed to the knowledge of doctor-patient communication. These research approaches providing the context, I thereafter turn to review more in detail the recent conversation analytic studies on doctor-patient interaction. Note however that not all the studies reviewed here claim that they would study ‘patient participation’ as such. Yet, as they offer relevant information on the doctor-patient relationship and the doctors’ and patients’ communicational conduct in the medical consultation, and have been influential both in the academic research and medical training, I consider them here.

2.1.1. Coding methods

In the early days of the study of doctor-patient communication, a coding system developed by Robert Bales (1950) was used. Originally, the Balesian coding scheme called interaction process analysis (IPA) was developed to categorize task-oriented behaviours in small groups (not in doctor-patient encounters particularly), enabling the researcher to classify group members’ behaviours either to task-oriented or socio-emotional behaviours. The Balesian coding system was used by Korsch et al. in their groundbreaking studies of communication between doctors and mothers in paediatric emergency room encounters (see e.g. Korsch and Negrete 1972). They studied mothers’ satisfaction and compliance to medical advice, and compared these dependable variables to interaction in the consultation. Among their significant findings were the notion that the mothers desired more information than what they
actually received from the doctors, but still did not ask a lot of questions. They also pointed out that the less the mothers were satisfied with the amount of information received from the doctors, the less they adhered to the doctors’ orders. Korsch and her associates were one of the groundbreakers who showed the importance of communication in terms of the outcome of medical consultation, and that doctor-patient communication is a possible, yet complex, object of empirically reliable research.

The Balesian coding scheme and its categories were still very general, giving a far from complete view on the components of actual doctor-patient communication (Heritage and Maynard 2006a: 3, Ong et al. 1995). The general categories of IPA are not particularly informative in terms of doctor-patient communication. For instance, in Korsch and Negrete’s (1972) research nearly 45% of the physicians’ remarks in total fell under the category ‘gives information’. In their seminal study, Byrne and Long (1984/1976) went further in detail and offered another coding system for the doctors’ talk to patients. They created over 60 categories of interaction to code doctors’ talk, for example by discerning different question types that the doctors use. On the basis of substantial data (over 1500 consultations), Byrne and Long dissected the medical visit into six distinct phases with particular doctor behaviours in each phase. These phases include 1) the doctor establishing a relationship with the patient, 2) the doctor (attempting to) discover the reason for the patient’s visit, 3) the doctor conducting verbal and/or physical examination of the patient 4) the doctor (or rarely the patient) considering the patient’s condition, 5) the doctor (and again rarely the patient) detailing the treatment or further investigation and finally, 6) the doctor terminating the consultation (ibid: 19). This distinction between the phases of consultation still informs the studies of doctor-patient communication in terms of how doctors’ and patients’ communications are understood in the context of each activity phase (Heritage and Maynard 2006a: 13-15).

Another important contribution to the understanding of the doctor-patient relationship and communication provided by Byrne and Long (1984/1976) was the concept of doctor vs. patient-centred talk. They concerned how a doctor may conduct each phase of the visit in either way; a doctor’s way of communicating
may derive from strictly medical knowledge, or he or she may attend more to the patient’s experiences. For instance in the diagnostic phase, as a doctor simply announces the name of the illness and then proceeds directly to its treatment, he or she engages in the doctor-centred conduct. Alternatively, the doctor may ask the patient’s opinion concerning the diagnosis and seek the patient’s acceptance or opinion becoming more important and relevant in the diagnostic phase. This is one way to accomplish the patient-centred style of communication (Byrne and Long 1984/1976).

More recently, *Roter interaction analysis system* (RIAS) developed by Debra Roter and her associates has contributed to the classification of doctor-patient communication (see e.g. Roter and Larson 2002). As Ong et al. (1995) point out, Bales’ (1950) interaction process analysis captures more instrumental or task focused talk than ‘patient-centered’ or socio-emotional talk between a doctor and patient. In contrary, RIAS is able to capture more ‘affective’ or care oriented talk than the IPA system (Korsch and Negrete 1972), or Byrne and Long’s (1984/1976) system that focused on doctors’ talk exclusively. RIAS includes 39 categories for doctor-patient communication; 15 categories for socio-emotional talk and 24 categories for task-related talk that offer tools for classification of action and behaviour in medical visits.

However, RIAS has been criticised for the same reason as the other coding methods; for its inability to capture what kind of influence doctors’ and patients’ behaviours have to each other and thus, how any coding system looses the understanding of the context and meaning of the doctors’ and patients’ talk (Ruusuvuori 2000: 23). This dynamics of the doctor-patient communication is what qualitative research aims to capture.

2.1.2. Qualitative studies

In his influential and much cited study *Discourse of Medicine*, Elliot Mishler (1984) presents a thoughtful critique toward coding methods and the picture of the doctor-patient interaction that result from using these methods (Mishler
directs this critique also toward conversation analysis. I will return to this critique in section 2.2). He suggests that the coding methods take the doctor’s point of view or as Mishler calls it, the *voice of medicine*, for granted. This is because within these methods, a researcher looks at the doctors’ actions only and strips the context of talk out of its interpretation (which is the case especially with the coding methods). Thereby, such research treats the doctor as the only causative agent in the consultation. According to Mishler, the bias between the doctors’ and the patients’ views is embedded in the very methods, analysis and interpretations of research. Therefore, the research itself operates within the voice of medicine that focuses only on technical and biomedical management of illness. The patient’s voice, i.e. the *voice of life-world* that places the illness experiences into the context of everyday functioning, emotion and social relations, is left untouched (ibid: 56-57).

Mishler (1984) proposes an alternative method to analyse communication between doctors and patients. He introduces a method of transcription, analysis and interpretation of doctor-patient communication that points out and lifts the patient’s ‘voice of life-world’ into the centre of the analysis. Mishler shows how the voice of life-world interrupts the ‘unremarkable discourse’ that is controlled by the voice of medicine. By concentrating on the constant struggle between the two voices, Mishler sophisticatedly shows how doctors tend to ‘correct’ the attention of conversation from the patient’s voice of life-world back to the voice of medicine (ibid: 95-97). According to Mishler, this is the very mechanism through which the patient’s life-world experiences are suppressed in the clinical discourse. On the other hand, Mishler suggests that a more ‘humane’ discourse is possible (ibid: 137-140). He analyses a rare case of a doctor-patient encounter in which the doctor is attentive to the patient’s life-world, and in which the orientation to the patient’s life-world matters informs good parts of clinical discourse. Therefore, as Mishler argues, in order to accomplish medical tasks in consultation, the patient’s life-world matters need not to be suppressed by limiting the discourse to the bio-medical matters only. Attending to the life-world does not exclude effective medical discourse (Mishler 1984: 191-196).
Two ‘voices’ were identified also by Philip Strong in his ethnographic study *Ceremonial Order of the Clinic* (1979) (although Strong does not use the term ‘voice’). Strong’s study encompasses the doctors’ and parents’ (mainly mothers) ceremonial (ritual) behaviours in doctor-parent interaction in paediatric encounters. With the method of ethnographic observation, Strong (1979) provides insights into the moral work which is inherent in medicine on one hand and in good parenting (or better, mothering) on the other hand. He shows that the two distinct moral expectations are repeatedly oriented to in these encounters; the doctor is expected to act, and acts, as an ultimate medical authority and as a professional, whereas the mother’s ability and willingness to care and nurture her child is unquestioned.

More recent discourse analytic studies have drawn from these studies and complemented the picture of doctor-patient communication. For instance, taking Mishler’s (1984) idea of the patient’s voice of lifeworld and the doctor’s voice of biomedicine as a point of departure Barry et al. (2001) detail this notion further. They compiled patients’ and doctors’ interviews and transcribed consultations to formulate four distinct communication patterns which the doctors and the patients used in consultations. They found a communication pattern in which both the doctor and the patient focus on 1) strictly medical matters, usually in acute physical problems. Another pole was found in communication pattern in which both parties attended to 2) mutual lifeworld matters. In this communication pattern the patient was recognized as a unique human being. This approach could be adapted in psychological but also in physical problems. The poorest communicational conduct was found from patterns categorized as 3) lifeworld ignored 4) lifeworld blocked. In these two communication patterns various lifeworld matters were brought up by the patient, but ignored or blocked by the doctor. Barry et al. (2001) suggest that if doctors could be ‘sensitised’ to perceive and manage their patients’ lifeworld matters, better and more patient-centred care could be provided.

In sum, qualitative research has shown that doctor-patient communication may take various forms, the doctors are not the only causative agents in clinical discourse, and that communication and patient participation is often complicated
by the doctors’ and patients’ differing viewpoints, priorities and ‘voices’. Next I turn to review a distinctive method for doctor-patient communication among the qualitative methods; conversation analysis. As conversation analytic studies do not rely on a researcher’s reconstructions of meaning and interaction but on strict empirical observation, these studies have revealed various interactional practices in and through which ‘patient participation’ is accomplished in medical consultations.

2.2. Conversation analytic studies of doctor-patient communication

One of the major contributions to the knowledge of doctor-patient communication offered by conversation analytic studies have been the notion of the consultation process being a dynamic series of co-constructed, concerted activities contributed to by both, the doctor and the patient (Heritage and Maynard 2006a, Peräkylä, Eskola and Sorjonen 2001, Drew, Chatwin and Collins 2001, Peräkylä 1997). This view has implications also for how we understand ‘patient participation’ in medical interaction (Peräkylä and Ruusuvuori 2007). Prior to reviewing any particular study, I describe the conversation analytic approach to doctor-patient interaction in light of the critique Mishler (1984) presented toward it.

Previous research and literature have repeatedly noted the asymmetry between doctor-patient roles and how this emerges in their communications (Byrne and Long 1984/1976, Roter and Hall 1992, Mishler 1984, Beckman and Frankel 1984). As briefly noted earlier, Mishler (1984) criticised the studies of doctor-patient communication by blaming them on forgetting the larger context of meaning in clinical discourse; how distinct meanings of illness are embedded and manifested in the voices of medicine and that of life-world. By detailing only the observable practices of talk, such as those of turn-taking (Sacks, Schegloff and Jefferson 1974), the inquiry looses the patient’s point of view, i.e. her or his life-world experience, and sees the conversational conduct as undisrupted, unitary flow of turns and sequences (Mishler 1984: 104-105). According to Mishler, conversation analytic study (as well as the coding
methods) normalizes the voice of medicine that suppresses the voice of life-world, and thus loses a large part of what constitutes the illness experience from the patient’s point of view. This is illustrated with Mishler’s well-known example of a doctor’s and patient’s talk concerning the patient’s drinking habits. The following extract is taken from Mishler 1984, page 134:

174 D ......................... How long
175 have you been drinking that heavily?

[  
176 P ....................... Since
177 I’ve been married.

[  
178 D ........... How long is that?
179 P (giggle..) Four
180 years.

In his transcript notation, Mishler draws to some extent from conversation analytic conventions, but adds elements that help the researcher (and the reader) to pay attention to the ways in which the doctors and patients ‘switch’ between the voices of medicine and of life-world in their discourse, and how the two voices are in constant struggle. Concerning the above exchange Mishler (1984) notes:

‘--- in the medical interview, an appropriate answer is one that refers to objective physical signs or indicators of the problem. If an answer is not objective in these terms, the physician will ask the question again. Thus, to the physician’s question ‘How long have you been drinking that heavily?’ (174), the patient responds, after a pause, ‘Since I’ve been married.’ The inadequacy and perhaps inappropriateness, from the physician’s biomedical perspective, of this response is made clear by the physician who immediately restates his question, ‘How long is that?’ (Ibid: 114).

In other words, the voices of medicine and of life-world are in dialectic struggle in the medical interview. The bracket between lines 175 and 176 marks the
location where the voice of medicine is interrupted by the voice of life-world as the patient contextualizes her heavy drinking to a significant life event, marriage. However, the doctor does not pay attention to the connection between drinking and marriage, but interrupts the voice of life-world by resuming the discourse back to the voice of medicine (the shift is indicated by the bracket between lines 177 and 178), i.e. the exact, measurable span of time.

Mishler’s analysis is insightful in its capability of directing the analytic attention toward the different voices, and how they interact in shaping and organizing the development of form and content of the medical interview (Mishler 1984: 105). However, from conversation analytic point of view, the patient is allowed to bring her turn to its completion before the doctor takes the turn (instead of the doctor interrupting her), as it apparent in the transcript (l. 177-178). And in terms of attending to the content of medical interview, the doctor does not merely restate his question as it was presented in lines 174-175, but reformulates it in the context of the patient’s preceding turn. ‘How long is that’ addresses the length of the patient’s marriage but, indeed, represents the question in light of the just introduced topic of the patient’s life event.

In the following, I review some conversation analytic studies on doctor-patient encounters in terms of how doctors and patients accomplish the various tasks of the medical consultation in their interaction. Moreover, as a response to Mishler’s (1984) critique I consider these studies in terms of how they are capable of grasping the ‘deeper’ levels of meaning, social relations and moral work in medical discourse, and importantly, how these aspects as well as the roles of doctor-patient relationship are managed in the details of turns and sequences of the doctors’ and the patients’ talk and other interactional conduct.

2.2.1. Interaction in the different phases of medical consultation

As Byrne and Long (1984/1976, 19) noted, a medical consultation includes distinct activity phases in which doctor-patient communication has different characteristics. Conversation analytic (CA) studies corroborate this view and
have yet furthered the knowledge of the practices of interaction in and through which the distinctiveness of each phase of consultation is accomplished. For instance, CA studies have detailed the doctors’ practices of eliciting patients present problems (Robinson 2006), giving and receiving a reason for the visit (Heritage and Robinson 2006, Ruusuvuori 2000), asking and answering history taking questions (Boyd and Heritage 2006, Stivers and Heritage 2001), delivery and reception of diagnosis (Maynard 2003, 1992 and 1991, Peräkylä 2002 and 1998, Heath 1992) and achieving a treatment decision (Stivers 2005a, 2005b and 2002b, Lindfors 2005). As these studies have looked at the doctor-patient interaction in detail, they have given us a more comprehensive view on both the doctors’ and patients’ actions and orientations in each activity phase in the consultation, and revealed also the patients’ ways to participate in and affect the course of the ongoing action.

Ruusuvuori (2005a and 2000) showed how patients, in and through their ways of giving reason for the visit, may control the course of action in a consultation in its opening phase. For instance, by presenting the reason for the visit in a narrative form the patient reserves an extended space to describe the problem as well as the patient’s own agency in managing with it. Within the ongoing patients’ narratives, the doctors’ remarks and comments can be treated (by the patient) as belonging to the story-in-progress, not interrupting the patient’s telling as such. Moreover, within the narrative the patient can establish a more personal viewpoint to her or his sick role and in this way, manage the implicit moral work of being trouble-resistant, yet responsible person who looks after herself but not for problems (Ruusuvuori 2000: 150-152, Halkowski 2006). This notion is quite in contrast with the interpretation of how ‘the doctor discovers the reason for the patient’s attendance’ (emphasis mine) (Byrne and Long 1984/1976: 22-23).

Even though the problem presentation phase is undeniably the patient’s chance to speak her or his mind, it is not the only place for the patient to direct the course of action in the visit. In the history taking phase that typically follows the problem presentation and is explicitly controlled by the doctor asking questions, the patients have means to overcome their acquiescent role of mere answering
the doctor’s questions. Even though the question-answer –structure, through which the history taking phase is carried out, constrains the patient in terms of what sort of next actions are available for her or him (Schegloff 1972 and 2007: 14-16, cf. Mishler 1984), this structure does not determine entirely the patient’s possibilities to affect the course of consultation. To begin with, questions in general embody features such as topic and action agendas, presuppositions and preferences concerning the forthcoming answer (Heritage 2002: 62, Heritage 2010, Sacks 1987). Doctors unavoidably embody these features in designing their questions and select between the different possibilities for agenda setting, presupposition and preference (Heritage 2002 and 2010). Even though their questions are often designed to prefer the patient’s alignment, the patients can departure from the agenda or presupposition embedded in the question by their own initiative actions (Boyd and Heritage 2006).

One such practice is studied by Stivers and Heritage (2001). They show that by answering ‘more than the question’, i.e. volunteering more information than what was asked for patients may implement specific projects in their responses. They may address difficulties in answering, add details to the answer, pre-empt negative inferences the doctor might do on the basis of her answer (cf. Gill, Pomerantz and Denvir 2010) or engage in telling a narrative. Within these practices the patient is able to invoke the life-world matters that are of concern to her, and may thus direct the attention to these matters. As Stivers and Heritage (2001) point out, the expansions which the patient produces to the answer also exert pressure to the doctor to respond. This is markedly evident after the patient’s narrative which, unlike expanded answers, clearly departures from and is independent of the rather restrictive context of question-answer –structure of the history taking phase in which it occurs (cf. Ruusuvuori 2000: 80-82).

Besides history taking, diagnosis delivery is seen as a phase in which the doctor’s medical expertise, authority and conversational control is brought to the fore in consultation whereas the patient’s participation is of lesser role (Byrne and Long 1984/1976). Heath (1992) shows how doctors and patients may both preserve the doctors’ medical authority in this activity. First of all, patients may remain silent altogether after the doctor has delivered the diagnosis (or other
kind of medical assessment). In this way, the patient enables the doctor to move abruptly on from the diagnosis delivery to the management of the problem. On the other hand, patients may make this possible also with a minimal response token, that is often downward-intoned, retro-active yeh or er with which the patient passes the turn quickly back to the doctor who, then, continues the consultation as she or he wishes. Such a conduct, according to Heath (1992), results in very little diagnostic information provided to the patient. In other words, even though there would be a place for the patient to reply to the diagnosis, the turn may not be taken or is passed back to the doctor. This way, the patients themselves may contribute to their minimal involvement in the activity.

On the other hand, doctors themselves may undermine the patient’s participation in the diagnosis delivery by attaching a treatment recommendation directly to the delivery of a diagnostic statement (Heath 1992). If the patient replies to the joint action of diagnostic informing and giving a treatment recommendation it is frequently the recommendation, not diagnostic informing, which is addressed in the reply. Moreover, the doctors may discourage the patient’s response by excluding a silence after giving the diagnostic statement, for example when they indicate with intonation that the diagnostic informing is not complete. Or, the doctor may direct her or his gaze and bodily orientation elsewhere than toward the patient and thereby imply that the patient’s response is not relevant or expected (see Goodwin 1981). And last, a diagnosis that is delivered as a factual, monolithic assertion does not particularly encourage the patient to contemplate it (Heath 1992).

Peräkylä (1998) furthered Heath’s (1992) analysis by showing that in delivering the diagnosis, the doctors maintain their medical authority but also treat themselves accountable for explicating their diagnostic reasoning to the patient. Peräkylä (1998) found that doctors frequently make their diagnostic reasoning somewhat transparent to the patient. This observation suggests that the doctors treat themselves being accountable for providing the patient with the evidential basis of the diagnosis, and that they treat the patients capable of understanding their medical reasoning. However, there is variation in the extent to which the
doctors rely on their authority vs. accountability (or balance in between) in delivering a diagnosis. Firstly, a doctor’s plain assertion may merely name the patient’s disease or condition as in the utterance *the bone is intact*. However, Peräkylä (1998) found that this kind of diagnostic statements are often positioned in a way that allows the patient to observe the evidence for the diagnostic statement, as right after the physical examination, for instance. Secondly, in delivering the diagnosis the doctor may incorporate inexplicit evidence to it, as in saying *there appears to be infection*. And thirdly, the doctor may explicate the evidence of his or her diagnostic conclusion by stating *the pulse can be felt there so there is no circulation problem*. These two latter formats of diagnosis delivery are regularly used by doctors when the diagnosis is temporally detached from its relevant environment, e.g. physical examination. In these cases, the doctors explain the diagnosis more than in the first case and thereby, again, they treat themselves accountable for providing the patient with the evidential basis of the diagnosis.

Yet another context for verbalising the evidential basis found by Peräkylä (1998) is the opacity of examination. For instance, when the examination phase has included a number of actions and it is not clear which of these provide the evidence for the diagnosis, the doctors may contemplate it more. The third environment for providing diagnostic evidence is a possibly challenged medical expertise. When the diagnosis is uncertain, the doctors use more complex turn designs rather than plain assertions. This is the case also when the doctor’s and patient’s views on the diagnosis differ. In sum, Peräkylä’s (1998) study shows that the doctors do not present diagnostic statement from the mere position of an unconditional, unquestioned medical authority. Again, this observation is quite different than the one made by Byrne and Long (1984/1976) who noted that often the doctors did not explicate the diagnosis to the patient at all. Peräkylä (1998) suggests that the finding of the doctors’ accountability reflect more profound, societal change in the doctor-patient relationship that has taken place from early 1970s to 1990s.

Even though a patient’s typical way to receive the diagnosis is a minimal or even absent response, in some cases the patients respond to the doctor’s diagnosis
delivery and thus participate in the diagnostic phase more extensively. Both Heath (1992) and Peräkylä (2002) have detailed the interactional environments of the patients’ extended responses to a diagnosis delivery. For instance, Heath (1992) showed how doctors may design diagnosis in a question form with which they explicitly encourage the patient to respond. Also when the doctor communicates uncertainty or tentativeness of diagnosis, the patient is more prone to respond. Importantly though, patients may respond extensively when the diagnosis is delivered as a plain fact. As Heath (1992) found, a systematic environment for this is incongruence between the doctor’s and patient’s views. The doctor may contrast her or his diagnostic statement with the patient’s understanding of the medical problem. In such a case, the doctor may encourage or elicit the patient to respond and secure the patient’s understanding or commitment to the doctor’s professional (vs. the patient’s lay) understanding of the medical problem.

Peräkylä (2002) showed that patients are more prone to produce an extended response after a diagnosis delivery when the doctor had referred to the evidential basis of diagnosis (Peräkylä 2002 and 1998, cf. Heritage 2005). Peräkylä (2002) discerned the patients’ extended responses to include straight agreements, symptom descriptions, rejections of the diagnosis and actions related to the interpretation of diagnostic evidence. The latter three of these response types convey some sort of disagreement with the doctor’s diagnosis. The primary form to convey disagreement is the patient’s symptom description. In describing her symptoms upon hearing the diagnosis, the patient’s resistance is however implied, and challenges the doctor’s diagnosis only indirectly as the patient explicates symptom experiences that are discrepant with the diagnosis. The patient’s agency is claimed in the realm of her experiences, not in the discussion of the correctness of diagnosis per se. Sometimes, however, the patients challenge the diagnosis given by the doctor more overtly, either by rejecting it or proposing an alternative. Nevertheless, Peräkylä (2002) found that even within these practices the patients oriented to the doctor’s ultimate authority in diagnostic reasoning and medical expertise. The patients systematically withdraw from referring to, contesting or otherwise talking about the very evidence upon which the diagnosis is based (see also Peräkylä 2006).
Maynard (2003, 1992 and 1991) and Maynard and Frankel (2006) have depicted practices of interaction with which the doctor’s communicational conduct in diagnosis delivery can be seen as ‘patient-participatory’. One such practice is a *perspective display series* (Maynard 1992 and 1991). Perspective display series refers to a practice of interaction within which the doctor incorporates the patient’s perspective into the delivery and design of the diagnostic news before delivering the diagnosis as such. In other words, in deploying this practice in conversation, the doctor invites the patient to express his or her perspective on the forthcoming diagnosis. This can be done for example by initiating the diagnostic phase with a question “*what is your idea about what’s causing your symptoms?*” Maynard found perspective display series as a useful practice specifically when delivering serious diagnoses, such as developmental disturbances or cancer (Maynard 1992 and 1991).

In sum, like history taking (or examination phase which I have not reviewed extensively here), the diagnostic phase is most typically controlled by the doctor who is the news teller, i.e. the one who explicates the medical reasoning, and so oriented to by the patient. In various instances, and for various reasons, doctors however do deploy methods of interaction with which they share the reasoning process with the patient (Peräkylä 1998) and incorporate the patient’s point of view into the delivery of diagnostic news (Maynard 1992 and 1991).

This is perhaps even more so in the phase of treatment decision making, an activity phase that typically follows the diagnosis delivery. By examining paediatric consultations in the US, Stivers (2006, 2005b) showed how doctors and parents repeatedly orient to the parent’s right and responsibility to accept the treatment decision given by the doctor. This expectation of the parent’s participation, however minimal, in decision making sequence prevails even though the initial decision delivery would not particularly invite the parent’s participation. The expectation of the parent’s response becomes evident when the parent does not accept the decision or recommendation immediately. In such instances, the doctor engages herself in more work pursuing the parent’s acceptance of the treatment recommendation. Therefore, Stivers (2006, 2005b)
suggests that as the parent’s response is evidently ‘due’ after the treatment decision delivery, the whole concept of patient (or parent) participation in treatment decision making should be seen in a broader scope; in light of the doctors’ and patients’ orientations to the patient’s or parent’s rights (and responsibilities) in accepting the treatment decision, however minimally.

Even though the patient’s or parent’s acceptance is rather systematically expected after the doctor’s treatment recommendation (Stivers 2006 and 2005b), the way in which the doctors design their actions in treatment decision making has also further consequences for the patients’ participation (Stivers 2002b). In Britain, Collins (2005) and Collins et al. (2005) studied decision making in primary care encounters with diabetes and specialist oncology encounters with ear, nose and throat cancer. They found that the practitioners’ approaches to decision making range in a spectrum from ‘unilateral’ to ‘bilateral’ communication patterns in the trajectory of decision making, and they compared bilateral vs. unilateral conduct in each phase of decision making trajectory. This trajectory consists of 1) the opening of the decision making sequence, 2) presentation and evaluation of test results or diagnosis, 3) introduction of the decision point (how the decision is initially referenced), 4) discussion of option(s) and 5) conclusion of the decision making phase.

Collins (2005: 263-282) and Collins et al. (2005) show how the opening of the bilateral decision making elicits the patient’s point of view on the management of illness, whereas with unilateral opening this remains unelicited. Further, in presenting test results on which the following decision will be based on, bilateral conduct places the results to the patient’s unique life situation, whereas unilateral conduct presents the results as medical facts in general. Thirdly, when practitioners introduce the decision point, they can refer to the shared status of decision for instance by referring to it as ‘we’ve got choices…’, whereas in unilateral conduct, the doctor evokes an unequivocal situation of something that ‘needs’ to be done. Fourthly, in discussing treatment options, a doctor who resorts to a bilateral communication pattern, counterbalances the medical options and the patient’s perspective. This is in contrast with unilateral conduct that focuses on the medical options only, which subsequently leaves little room for
negotiation and patient’s perspective. Finally, in concluding the decision making phase in diabetes consultation, the bilateral approach terminates the phase gradually, by inviting the patient to contemplate and choose between the treatment options. In unilateral conduct, the doctor addresses the necessary measures she or he needs to take, and does not leave room for the patient to display her or his perspective.

Collins et al. (2005) also present observations on patient participation with regard to the practitioners’ actions. They suggest that when practitioners focus on the medical facts in general, the patients’ responsive actions display their understanding accordingly, i.e. ‘in general’. This ‘blocks out’ their individual preferences and experiences. This notion is in contrast with observations made on bilateral decision making. As bilateral conduct elicits the patient’s point of view and accommodates the patient’s experience, the patients indeed express their individual perspectives in response. However, in overall Collins et al. (2005) observed that the patients’ participation in decision making was limited. They said very little in the first place, and when they did, it did not seem to have a remarkable influence on the treatment decisions. Nevertheless, as bilateral decision making pattern created a context in which the patient’s view was particularly invited, it is suggested that a bilateral approach could account for more extensive patient’s input in decision making (Collins et al. 2005, Collins 2005: 284-294).

In Finland, Lindfors (2005) studied treatment decision making in homoeopathic consultations and compared the decision making practices found in this context with those in general practice consultations (see also Ruusuvuori 2005a). The study shows that even though the holistic approach to patient care is a key idea in homoeopathic care (Lindfors 2005: 33-34), decision making in majority of the homoeopathic consultations was conducted in practitioner-centred way, i.e. a homoeopath simply announcing what she or he has decided to do (ibid: 118). This type of unilateral decision making takes place after a comprehensive interview of the patient is completed by the homoeopath, and consists of a sequence in which the homoeopath 1) opens the decision making phase, 2) announces the decision, that is followed by 3) the patient’s minimal reception
40

token, after which the homoeopath 4) closes the decision making sequence and
initiates a new topic (ibid: 119). These features characterize unilateral decision
making also in general practice consultations (ibid: 154).

In contrast, in ‘bilateral’ or patient-participatory decision making patterns the
homoeopath may introduce various treatment options to the patient, ask the
patient’s opinion or perspective concerning a treatment, or engage in a dialogue
with the patient whether the patient’s symptoms would be compatible with the
proposed treatment options. In all three forms of participatory decision making,
the homoeopath’s communication patterns open up possibilities for the patient to
express his or her perspective and understand on what grounds certain treatments
are recommended (Lindfors 2005: 156-201). Participatory decision making in
general practice consultations was done in the first two ways; either by
introducing several treatment options to the patient or by asking the patient’s
opinion on certain treatment (ibid: 201). When the practitioners both in
homoeopathic and in general practice consultations engaged in participatory
decision making, their patients responded more extensively. This observation
aligns with Collins’ et al. (2005) observations on patients’ responsive actions in
unilateral vs. bilateral decision making sequences in medical consultations.

2.2.2. Interaction and the overall structure of medical consultation

Besides detailing interaction and patient participation in the specific phases of
medical consultation, some conversation analytic studies have paid attention to
the patient’s participation in and influence on the consultation process as a whole
(Stivers 2007, Robinson 2003, ten Have 1991, Silverman 1987). For instance,
Lindfors (2005) observed that participatory decision making is not that
‘straightforward’ and placed in any particular phase of consultation (typically
after the interview) than what unilateral decision making is. Instead,
participatory decision making evolves in the process of consultation, in a series
of sequences as the consultation unfolds (Lindfors 2005: 156-157). This
indicates that an orientation toward particular tasks of the consultation (such as
achieving a treatment decision) informs the practitioners’ and patients’ conduct in various phases of it.

Such orientation is visible also in other clinical tasks than decision making. In presenting the problem, the patient has a sequentially provided place to control the consultation and affect the course of action in the consultation (Ruusuvuori 2000, Peräkylä and Ruusuvuori 2007). However, patients do not just answer the doctor’s opening question, but present a problem ‘in its own right’, and subsequently, the doctors and patients do not orient only to the immediate interactional context of the problem presentation but to a larger activity structure which serves as a basis for coherence for the whole consultation (Ruusuvuori 2000: 271). Further evidence for this has been offered by Stivers (2002a; 2007) who showed how two forms of problem presentation, i.e. ‘symptoms only’ vs. ‘candidate diagnosis’, inform the course of a paediatric consultation. The parent’s presentation of symptoms only makes relevant the doctor’s investigation and evaluation of the child’s condition, whereas when the parent presents a candidate diagnosis, she or he is seen as taking a certain stance toward the child’s condition as being medically problematic and, importantly, treatable. Doctors, in turn, are systematically responsive to such orientation. They indeed perceive the parent as seeking confirmation for the candidate diagnosis and consequently, deliver the diagnosis accordingly, i.e. in confirmatory or disconfirmatory manner with regard to the parent’s problem presentation (Stivers 2002a, see also Heritage and Stivers 1999).

These observations indicate that the patient’s problem presentation informs the whole consultation process. In a way, it sets an agenda for it. Robinson (2003) argues that when a patient presents a new medical problem in a primary care visit, he or she and the doctor mutually enter into an interactional project, a certain structure of interaction within which activities unfold in an accountable way. In other words, the interactional project, even though it contains multiple activities and activity phases, is in itself a coherent package of social action. The establishment of a new medical problem makes relevant an interactional project that works toward treatment of the problem. Even though earlier literature shows that primary care encounter typically follows some routine structure (as defined
by Byrne and Long 1976, for instance), in terms of interaction it must be evidenced that participants actually orient to their current activities progressing toward, and being in service of particular next activities, and that each activity is produced in reference to the project as a whole. Robinson considers patients’ often claimed passivity in medical consultations in terms of orienting to this project of consultation. For instance, by ‘withholding’ a response to the diagnosis the patient orients to the treatment negotiation as due after the diagnosis delivery. In other words, a patient’s response after a diagnosis delivery does not become conditionally relevant (Schegloff 1968), and therefore there is project-based ‘pressure’ against its production (Robinson 2003).

Next I review some previous studies on communication in the consultations for upper respiratory tract infection that is also the focus category in the present study.

2.3. The case of upper respiratory tract infection

Previous literature on doctor-patient communication has pointed out the two distinct, yet interrelating ‘standpoints’ from which doctors and patients communicate. Perhaps most clearly Mishler (1984) has established an understanding of the division between the dominance of the doctors’ biomedical ‘voice’ that focuses only on technical and medical management of the illness, and the patients’ tendency to place their illness experiences into the life-world context in which the technical management of the illness is far less relevant than its influence on the patient’s everyday matters. However, it seems that in case of upper respiratory tract infection the ‘voices’ get intertwined. The studies that I now turn to review show that it is not rare that the doctors give up their strictly biomedical rationale in face of ‘parental pressure’ for antibiotic prescribing, for instance (Stivers 2007).

Mainous, Zoorob, Oler and Haynes (1997) surveyed 961 adult patients in metropolitan areas of Kentucky and Louisiana, US, to explore the patients’ beliefs concerning when and what kind of medical help they would seek for
upper respiratory tract infection. They found that 72% of patients would seek medical help after five days after the onset of illness (sore throat, cough, discoloured nasal discharge) and 61% of patients believed that under these circumstances antibiotic treatment would be effective. Regardless of the patients’ socio-economic background the strongest predictor of the belief in the effectiveness of antibiotics was the usual use of antibiotics for upper respiratory tract infection. Especially the meaning of discoloured nasal discharge was not clear for the patients; 79% said they believe that antibiotics are effective when there is discoloured discharge. The study suggests that patients lack an understanding of the normal presentation of upper respiratory tract infection, even though they make conclusions between its symptoms and an appropriate treatment. Macfarlane, Holmes, Macfarlane and Britten (1997) came up with similar results in a British study, concluding that patients often think antibiotics are the answer for a respiratory tract infection, and that these expectations have a significant effect on the physicians’ prescribing behaviours (see also Braithwaite and Pechere 1996).

Further, it has been shown that the patients’ expectations toward prescribed medicines as an outcome of the visit effect physicians’ prescribing behaviours. In a British questionnaire study conducted by Britten and Ukoumunne (1997) it was shown that the doctors’ perceptions of the patients’ expectations toward prescription were the strongest predictor of the decision to prescribe (on the other hand, 25% of the patients who had hoped for the prescription did not receive it). However, in a fifth of the consultations in which a prescription was written it was not strictly indicated on purely medical grounds. The study suggests that the patients’ expectations may lead to inappropriate prescribing.

A similar trend has been shown in studies that focus on prescribing in cases of upper respiratory tract infection. With US data on paediatric visits, Stivers, Mangione-Smith, Elliott, McDonald and Heritage (2003) showed that physicians are more likely to prescribe antibiotics if they perceive or believe a parent to expect it. They also showed that ‘parental pressure’ for prescribing is not limited to overt, verbal requests, but include ‘indirect’ communication practices such as presenting a candidate diagnosis (treatable with antibiotics) in the beginning of
the visit, or resisting a viral diagnosis given by a doctor later on in the visit. When parents presented a candidate diagnosis, odds that the doctor perceived the parent to expect an antibiotic prescription increased five times; and three times in cases of the parent’s resistance toward viral diagnosis. The study suggests that doctors form their perceptions of the parents’ expectations from less direct communications than overt requests of medicines.

However, Stivers et al. (2003) found incongruence in the parents’ expectations and in the physicians’ perceptions. There were no associations between the parents’ candidate diagnosing or viral-diagnosis resistance in the visit and their expectations toward receiving an antibiotic prescription reported prior to the visit. On one hand, parents may not report their antibiotic expectations fully. On the other hand, parents’ communication patterns (candidate diagnosis and resistance toward viral diagnosis) of which physicians interpret as pressure toward certain prescribing behaviours may indicate various other psycho-social and moral factors: presenting oneself as a competent parent, communicating concerns of the possibility of the child’s more serious illness, or seeking reassurance for the legitimacy of the possibly premature visit (Stivers et al. 2003). Also, variation has been found in the parent’s cultural background in terms of expecting antibiotics. In a study conducted in Los Angeles County, Latino and Asian parents reported antibiotic expectation 17% more likely than non-Hispanic white parents. Discrepancy in culturally bound communication patterns between the doctors and parents may occur, and the doctors may not be able to address these differences adequately (Mangione-Smith, Elliott, Stivers, McDonald, Heritage and McGlynn 2004, cf. Goossens, Ferech, Vander Stichele and Elseviers 2005).

In sum, in-visit communication patterns play a crucial part in shaping the doctors’ perceptions of the parents’ expectations and on the other hand, parents’ resistance toward treatment plans and recommendations. In a series of conversation analytic studies Stivers (2005a, 2005b, 2002a and 2002b) detailed the interaction practices in and through which these perceptions and expectations are brought to the fore in interaction in paediatric encounters. For instance, Stivers (2005a) showed how the doctor’s treatment decision delivery format is
linked to the parent’s treatment resistance; when the doctors formulate a treatment recommendation for some treatment regimen, whether antibiotic or not, they are less likely to encounter parent resistance than the doctors who formulate treatment recommendations against some (usually antibiotic) treatment. Nevertheless, recommending the practitioners to always formulate treatment decisions for, instead of against, some treatment is not sustainable. Stivers (2005a) notes that in some contexts, such as when the parent had presented a candidate diagnosis (which would be treatable with antibiotics), the doctor accounting for not prescribing is interactionally responsive behaviour, and thus relevant. Nevertheless, in Stivers’ data (substantive corpus of 570 paediatric consultations) it was shown that the doctors secured the parent’s alignment with the treatment recommendation by giving some positively formulated recommendation for a treatment at first, followed by a recommendation against a particular treatment only thereafter (see also Mangione-Smith, Elliott, Stivers, McDonald and Heritage 2006).

In another study Stivers (2005b) showed how both the doctors and parents orient to the necessity to reach accord in treatment decision concerning the child’s upper respiratory tract infection. Through 1) acceptance, 2) withholding of acceptance or 3) active resistance, the parents have resources to negotiate on the treatment decision toward the direction of their own treatment preferences. Therefore, Stivers (2005b) concludes that contrary to the assumption of shared decision making model, i.e. that patients or parents must be invited to participate by the doctor in order to involve them into the decision making process, the parents actually impact treatment decisions in any case even though the doctors would not have overtly invited them to do so. As the parent’s acceptance of treatment recommendation emerges as a rather systematic norm which both parties orient to (see also Stivers 2006), withholding the acceptance or active resistance are methods with which the parents may communicate their desire for certain treatment outcomes, and which the doctors may perceive as pressure toward certain, perhaps inappropriate prescribing behaviours (see also Stivers 2002b, 2007).
The challenge for clinical communication posed by the patients’ and parents’ beliefs and expectations concerning diagnosis and appropriate treatment of upper respiratory tract infection raise questions of the relevance of the existing models of medical decision making in this illness category (cf. Stivers 2006 and 2005b). Elwyn, Gwyn, Edwards and Grol (1999b) conducted a detailed discourse analytical study of two paediatric consultations with upper respiratory tract infection in which the parent’s and the doctor’s views concerning the diagnosis and treatment differed. They noted that strong parental views, deriving from previously experienced similar illnesses and prescriptions received earlier (cf. Mainous et al. 1997), were expressed by the parent both overtly and covertly. In turn, the doctor argued for the normality of the child’s current illness and emphasized the ineffectiveness of antibiotic treatment in a viral condition. Consequently, the competencies of shared decision making were not exhibited. These included: establishing a context in which patients’ views about treatment options are valued and necessary, eliciting patients’ preferences, transferring technical information to the patient on treatment options, risks and benefits in an unbiased way, physician helping the patient to weigh risks vs. benefits of treatment options, and physician sharing his or her treatment recommendation with the patient and/or affirming the patient’s treatment preference (Towle and Godolphin 1999). Therefore, Elwyn et al. (1999b) suggest that the model of shared decision making should be developed further to better address the described situation of discrepant physician-parent views.

However, Butler, Kinnersley, Prout Rollnick, Edwards and Elwyn (2001) consider models of paternalistic decision making, informed decision making and shared decision making in the case of respiratory tract infection and despite the controversies pointed out elsewhere (Elwyn et al. 1999b, Gwyn and Elwyn 1999), they propose the model of shared decision making as the best available, although possibly time-consuming model for clinical communication also in this illness category (see also Rollnick, Seale, Rees, Butler, Kinnersley and Anderson 2001, cf. Stivers 2005b). Butler et al. (2001) suggest that the time invested in shared decision making would decrease future medical visits, the level of public health problems caused by antibiotic resistant bacteria as well as the wasted resources in health care. Also, engaging in the model of shared decision making
in clinical communication could enhance more profound physician-patient understanding and relationship as the patient’s ideas, fears and expectations would be met on a fundamental level, not on a symbolic level of providing an antibiotic prescription as a quick fix, or leaving the patient with ‘empty hands’.

These questions are equally relevant in Finnish primary care. A recent Finnish-Dutch questionnaire study (Tähtinen, Boonacker, Rovers, Schilder, Huovinen, Liuksla, Ruuskanen and Ruohola 2009) on parents’ experiences and attitudes toward the management of acute otitis media (AOM) shows that there is a relation between parental expectations, national AOM treatment guidelines and doctors’ prescribing practices. More often than Dutch parents, Finnish parents think of antibiotics as being necessary for the treatment of AOM, and the antibiotics are indeed prescribed more frequently in Finland than in the Netherlands. However, it is also noteworthy that Finnish guidelines for treating AOM have differed from those in the Netherlands. In Finland, antibiotic treatment has been recommended whereas in the Netherlands watchful waiting prior to antibiotic treatment is preferred. In January 2010, the Finnish treatment guidelines were revised. Finnish medical association Duodecim now recommends to wait for 2-3 days and treat the child with pain-relievers in the early stages of illness and to re-evaluate the necessity of the antibiotic treatment only later (www.kaypahoito.fi, Tähtinen et al. 2009).

2.4. Summary: patient participation in medical interaction and the standpoint of the present study

As we have seen in this review, interaction point of view may not comply with a single model of medical communication (whether being shared, informed, paternalistic, etc.), but recognizes various components of communication that make the difference in terms of patient participation. Peräkylä and Ruusuvuori (2007) propose a more context-sensitive model to study patient participation in health care encounters. They distinguish five key components of patient participation as it emerges in clinical discourse. These are 1) patient’s contribution to the direction of action, 2) the patient’s influence in the definition
of the consultation’s agenda, 3) patient’s share in the medical reasoning process, 4) the patient’s influence in the decision making, and 5) emotional reciprocity in the doctor-patient relationship. The patient’s contribution to the direction of action emerge in any phase of consultation for instance as initiative actions such as the patient giving a reason for the visit or proposing explanations for illness condition (Gill 1998, Gill and Maynard 2006, Gill et al. 2010). The patient contributes to the direction of action also in and through responsive actions, such as receiving a diagnosis (see e.g. Peräkylä 2002) and answering history taking questions (see e.g. Heritage and Stivers 1999). Within these actions the patient is able to maintain, adjust or alter the ongoing course of action, i.e. participate in the co-construction of consultation (cf. Heritage and Maynard 2006a).

The second component of patient participation according to Peräkylä and Ruusuvuori (2007) is the patient’s influence in the definition of the consultation’s agenda. In an acute primary care visit the key is the patient’s problem or concern and how ‘well’ he or she manages to present it (Ruusuvuori 2000). Another aspect of this component is how well the health care professional meets this agenda and whether he or she acts responsively upon the consultation (cf. Robinson 2003, Stivers 2002a). The third component is the patient’s share in the medical reasoning process; how and to what extent the patient conveys his or her knowledge on the ailment and how and to what extent the doctor provides the patient with access to information on diagnosis (Peräkylä 1998), prognosis and treatment options (Lindfors 2005). The fourth component of patient participation is the patient’s influence in the decision making. This is again accomplished through the patient’s initiations such as proposing or requesting a treatment (Robinson 2001) and in responsive actions such as the patient displaying a certain stance toward the doctor’s proposal (Stivers 2005a and 2005b). Finally, the fifth component of patient participation is emotional reciprocity of the doctor-patient relationship, i.e. what are the patient’s opportunities for expressions of emotion in the consultation and how the professional responds to these displays (Ruusuvuori 2007 and 2005b, cf. Voutilainen, Peräkylä and Ruusuvuori 2010).
The components of patient participation overlap in interaction in the consultation and are manifested in various levels of doctor-patient interaction: over the course of the consultation as well as in the sequences of interaction in particular phases of it. Interaction studies have shown how doctor-patient communication is a dynamic process in which the participants’ concerted actions, instead of one party’s actions only, have an influence on the direction of action as well as meaning-making in medical consultations (Peräkylä and Ruusuvuori 2007, Heritage and Maynard 2006a, Drew 2001, Drew, Chatwin and Collins 2001, Peräkylä 1997).

The review of communication in consultations for upper respiratory tract infection showed that this illness category offers a peculiar locale for the study of patient participation in terms of the patients’ contribution to the direction of action, their influence in the definition of the consultation’s agenda, and their share in the medical reasoning process and decision making (Peräkylä and Ruusuvuori 2007).

The present study continues the line of conversation analytic studies of medical interaction. The analytic focus of the study is on the doctors’ and the patients’/parents’ interactional conduct in establishing a mutual understanding on the patient’s concern, in delivering and receiving the diagnosis, and in treatment decision making in consultations for upper respiratory tract infection. Through the analysis of these phases of a primary care consultation, I consider the diagnostic and treatment decision making and a patient’s participation in them as a process that evolves within the consultation. On the basis of the empirical analysis, this study considers also more abstract concepts and models of clinical interaction, such as ‘patient participation’ and ‘concordance’. The next section summarizes my research questions.
3. RESEARCH QUESTIONS

This study examines *how patients participate in the diagnostic and treatment decision making process* in Finnish primary care consultations for upper respiratory tract infection. The research questions are:

1. How an understanding of the patient’s concern is established in the beginning of the visit as the patient/parent presents the reason for the visit and the doctor receives it?
2. How a diagnosis is delivered by the doctors and received by the patients/parents; what orientations they adopt toward diagnostic reasoning and what interaction practices they use to display these orientations?
3. How patients/parents participate in treatment decision making; what orientations they adopt in this process and how patients/parents and doctors thereafter arrive at the decision?

On the basis of these empirical questions, the study considers:

4. What implications the doctors’ and patients'/parents’ face-to-face interaction in the process of diagnostic and treatment decision making have to the discussion on patient participation and medical decision making in general?
In this section I reflect on interaction as a site for social action and order and consider how it can be reliably studied not only in doctor-patient interaction in particular, but in any context in general. I start with a review of ethnomethodology (Garfinkel 2006 and 1984/1967, Heritage 1996/1984), an underlying sociological framework inspiring the method of conversation analysis (Sacks, Schegloff and Jefferson 1974, Garfinkel and Sacks 1970, Sacks 1992a and b). After introducing some basic organizations of interaction as they are studied conversation analytically, I discuss one particular branch of CA: studies of institutional interaction (Arminen 2005a, Drew and Heritage 1992, Schegloff 1992, Heritage and Clayman frth). Finally, I describe the data of this study and its collection process.

4.1. Ethno-methods

Ethnomethodology could be described as ‘sociology of common sense’ (Heritage 1996/1984). As its founder Garfinkel puts it, ‘ethnomethodological studies analyse everyday activities as members’ methods for making those same activities visibly-rational-and-reportable-for-all-practical-purposes, i.e. ‘accountable’, as organizations of commonplace everyday activities’ (Garfinkel 1984/1967: vii). This is to say that ethnomethodology approaches the human sociality by looking at what people actually do, how they do it and what their doings tell about their everyday reasoning and interpretations of whatever social situations they are engaged in. The study of these details can give us an understanding of the ways humans do things (Sacks 1984a), hence the name ‘ethno-methods’. In more general terms, ethnomethodological sociology considers how any such common sense world is possible (Garfinkel 1984/1967: 36).

Even though the ‘familiar common sense world of everyday life is a matter of abiding interest’ in social sciences (ibid: 36), Garfinkel’s thinking was
revolutionary in sociology at the time it was introduced. The dominating social theory had understood social action as shaped, regulated and being explainable by social norms which people are first socialized in and then adhere to. Social norms and social structure were seen as external ‘facts’ according which a society, i.e. social order and action are organized (Parsons 1951). In this view, situated social action is the mere ‘effect’ of the structure (as criticized by Goffman 1983), caused or conditioned by the structure of society.

The notion of social norms is an essential part of ethnomethodology, too. However, Garfinkel was not satisfied with the Parsonian theory of norms informing social action as it could not explain deviations from the norms in any way but blaming an inadequate socialization. Also, it could not explain change in a social order. If everyone acts according to the existing norms and therefore maintains the prevailing social order, how can a society ever change as it obviously does? And perhaps most importantly, Parsonian sociology could not offer a norm for any and every social circumstance or situation that can arise. In other words, getting socialized into any social condition is just not possible; there can not be an unlimited number of external social norms. Therefore, an (imaginary) person who would act according to a set of adapted, external social norms would be a ‘judgemental dope’ (Garfinkel 1984/1967: 68). However, as we act as members of our societies, institutions, peer groups, families etc. we are not judgemental dopes, but capable to interpret the ever-unfolding and changing social situations which we are involved in, act reasonably and interpret others’ actions as reasonable even in situations we have not been before (cf. Sacks 1992b: 367-369). This is possible because the social norms are not external facts, but resources for action, interpretation and sense making in social action (Garfinkel 1984/1967: 35-75, Heritage 1996/1984: 108-136, Schegloff 1995).

In a way, Garfinkel changed the direction of explanation in sociology’s action-structure dilemma the other way round. Ethnomethodological understanding of the social norms as means for interpretation and construction of social action and order produce the structure, not vice versa (Heritage 1996/1984: 113). In everyday circumstances, this was exemplified by Garfinkel in his ‘social experiments’. He encouraged his students to break the conventional norms of
every day encounters, such as in responding to greetings. When a student was greeted (by an innocent family member, for instance) as ‘how are you’, he or she responded, as encouraged by Garfinkel, ‘what do you mean, do you mean my physical or emotional state...’ etc. By noticing how the first greeters reacted (usually with anger and irritated frustration) Garfinkel illustrated that the members of any everyday situation, like reciprocal greetings between two people, expect each other to share and act within the same ‘natural attitude’ or ‘natural facts of life’, and that these expectations are profoundly moral and normative, ‘sanctionable’ matters in social action and interaction (Garfinkel 1984/1967: 42-44; Heritage 1996/1984: 83-107).

The ethnomethodological view to social action and social order points out that the ‘members’, i.e. parties of any social situation establish, maintain and alter their social relationships and social order within the concerted actions in interaction. Therefore, one can not explain or understand communication or other social conduct by looking at one party’s actions only or by interpreting the social conduct as products or effects of ‘structure’ (Goffman 1983). Instead, what constitutes action and social order is members’ ‘doubly contextual’ actions (such as utterances, sounds, gestures, even silences) in interaction. These actions are both context-shaped and context-renewing (Heritage 1996/1984: 119-123). This means that, firstly, in her or his current action, a party to a conversation orients to and displays her or his understanding of the immediately preceding action(s). The current action is indexical, i.e. it is understood in relation to its context. Secondly, the current action in interaction is context-renewing; it, in turn, provides a framework, i.e. renewed or altered context, for any subsequent action (Sacks et al. 1974, Heritage 1996/1984: 237). In this dynamic process of sense-making and mutual understanding social orders are built, maintained and altered (Garfinkel 1984/1967, Arminen 2005a: 11). The primary locus, or machinery, for its accomplishment is social interaction (Sacks 1984a, see also Garfinkel 2006: 179-182), and talk-in-interaction in particular (Schegloff 1987).

Next I reflect on a specific method for the study of talk-in-interaction: Conversation analysis.
4.2. Conversation analysis

The method of this study is conversation analysis (CA) (Scheglof 2007, Heritage 1996/1984, Sacks 1992a and b, Sacks, Schegloff and Jefferson 1974, Garfinkel and Sacks 1970). CA is a method to study social action ethnomethodologically, as accomplished in the members’ practices of talk-in-interaction (Garfinkel and Sacks 1970, Schegloff 1987). CA was developed primarily by the seminal works of Harvey Sacks, Emanuel Schegloff and Gail Jefferson in the University of California starting from early 1960s (Sacks 1992a and 1992b, Sacks et al. 1974, Schegloff and Sacks 1973, Schegloff 1968). CA offers an apparatus to reliably, empirically, repeatedly and systematically observe the ‘ethno-methods’; how natural interaction unfolds and constitutes social action, order and structure. The underlying principles of CA are: 1) the understanding of interaction as structurally organized entity in which 2) the members orient to the situated context of their interaction, and therefore 3) the conversation analytic study can not ignore any detail of interaction as unorganized or irrelevant a priori (Heritage 1996/1984: 236).

CA uncovers the members’ methods of mutual sense-making and producing sensible actions in interaction as it visibly and hearably, i.e. observably unfolds to and is established by its members (Sacks 1984a: 21). CA studies structures of social action in terms of how people accomplish activities in and through talk, activities such as story-telling (Jefferson 1978) reporting of extraordinary events (Jefferson 2004), or requesting (Schegloff 1990). Moreover, CA is able to reveal the underlying social and moral ‘order’ to which speakers and hearers orient to and which they maintain in their interaction: balancing the delicacy of possibly ‘face-threatening’ actions such as requesting (see e.g. Robinson 2001, Schegloff 1990), maintaining and establishing epistemic rights and responsibilities in a relationship (Heritage and Raymond 2005), presenting oneself as a reasonable person (Jefferson 2004, Sacks 1984b), etc. CA examines how these orders are collaboratively produced and managed in talk and other interactional conduct (Sacks et al. 1974, Goodwin 1981, Heath 1984).
By the same token, CA does not study ‘versions’ of the social reality: cultural artefacts and representations, pre-determined or intuitive categories the researcher has composed, single utterances extracted from their interactional environment, or the ethnographer’s field notes (see e.g. Hutchby and Wooffit 1998: 17). Therefore, the absolute prerequisite for a conversation analytic study is the utilization of naturally occurring data (Sacks 1984a: 26, 1992a: 28). Development of the devices with which natural talk could be captured for research purposes was crucial for the development of CA (Sacks 1984a: 26). The very first studies were done with audio-recorded (telephone) conversations which still are an important and developing locus of conversation analytic research (Arminen 2005b, Raudaskoski 2009). In addition, video-recordings, whenever possible, provide an access to members’ non-verbal methods of interaction that are of equal importance in naturally occurring talk-in-interaction (see e.g. Goodwin 1979). However, talk as such is not the only object of conversation analytic research. Conversation analytic studies address also other mediums of interaction in and through which human sociality is enacted (Schegloff 2006, see also Ruusuvuori and Peräkylä 2009, Schegloff 1984, Goodwin 2000 and 1981, Rossano frth).

In sum, CA approaches conversation as a series, i.e. sequence of social actions. Each turn at talk, gesture or even ‘notably absent’ action (Schegloff 2007: 19, Sacks 1992b, 35-36) such as a non-existent answer after a question performs certain action within some larger activity. A turn at talk (i.e. an action in interaction) does not necessarily render the turn’s literal meaning or its syntactical form (see e.g. Sacks 1992b: 367-375) and therefore, it is impossible to understand if extracted from its interactional context. Still, the members are able to make sense of these actions and collaborate in their interactional environments in a meaningful, sensible way. The key for mutual understanding and reasonable social action, as well as a reasonable analysis of it, resides in sequencing of actions (Schegloff 2007, Sacks et al. 1974, Schegloff and Sacks 1973). Parties to conversation do not interpret or produce utterances or other actions as separate units outside the context in which they occur, neither does a conversation analyst. Instead, the members deploy (and a conversation analyst...
examines) systematic organizations of (talk-in-)interaction in interpreting and producing larger social activities and social order (Schegloff 2007: 2). Next I contemplate some of the basic organizations of interaction that provide a basis for the members’ actions and interpretations as well as the analysis of them.

**Sequence organization.** Sequence organization is the key for all interaction (Schegloff 2007, Schegloff and Sacks 1973; Schegloff 1968; Sacks 1992a: 3-11). Sequences form out from at least two adjacent utterances (or gestures, sounds, etc.) that are produced by two members of interaction. These utterances form, then, an adjacency pair (Sacks 1992b: 521-541, Sacks et al. 1974). The adjacent pair of utterances has a first pair part (FPP) and a second pair part (SPP); the latter is made relevant and projected by the former, and therefore, the latter offers an interpretation of the former (Sacks et al. 1974).

The base sequence organization of two adjacent turns can naturally be expanded (see e.g. Sacks 1992b: 354-359). Firstly, a practice of pre-sequence (Schegloff 2007: 28-57, Schegloff 1988, Schegloff 1980) can be deployed to foreshadow the base sequence yet to come, for example in summons (Schegloff 2007: 48-53). For instance, ‘Daniel’ is a first pair part in itself with which a speaker initiates an activity, i.e. invites or alerts the other party that more interaction is about to evolve – at least preferably. Then, as Daniel produces ‘what’ he provides a second pair part for the first pair part as he recognizes and acknowledges that he has been summoned. At the same time, his ‘what’ works as a ‘go-ahead’ for the first speaker to move on to the actual business (Schegloff 2007: 44). Secondly, the sequence can be expanded with insert expansion(s) (Schegloff 2007: 97-114). For example in requests for information: ‘Did you show the apartment’/’Which apartment’/’B4’/’Yes I did’. With the insert expansion the addressee of the question initiates a new sequence within the ongoing sequence to postpone the production of the projected second pair part for the main sequence; in this case, an answer (Sacks 1992a: 55). Thirdly, sequences can be expanded with post expansions (Schegloff 2007: 115-168). For example as follow-ups for question-answer –sequences: ‘Did you show the apartment’/’Yes I did’/’And?’/’I think they take it’.
Turn-taking. A sequence forms out of at least two adjacent turns. How turns at talk are allocated as such, is a matter of another basic organization in interaction; organization of turn-taking (Sacks 1992a: 523-534, Sacks et al. 1974). Even though in natural conversation turn length or content or speakership allocation are not fixed, overwhelmingly parties to conversation manage to avoid overlapping talk, transfer between turns and speakers without notable gaps in talk, and repair errors in turn-taking, such as when two parties start speaking at the same time. In their seminal paper, Sacks et al. (1974) point out two components of turn-taking system: turn-constructional unit (TCU) and turn-allocation which speakers rely on in natural conversation. What type of TCU is underway, for instance lexical (‘and?’) or clausal (‘I think they take it’) (see also Schegloff 1996) is projectable in terms of how the turn will be completed; until it is completed, its speaker is ‘entitled’ to hold the turn. When a TCU arrives at the first possible completion a transition relevance place (TRP) opens up. At TRP, the next turn is allocated either by the current speaker selecting the next one or by potential next speakers’ self-selection (cf. Stivers and Rossano 2010).

Turn-taking organization for every day talk (as well as its modifications, see e.g. Atkinson and Drew 1979) controls the understanding the utterances get and is thus methodologically consequential (Sacks et al. 1974) in the sequence. Upon the production of the next turn the speaker, either being selected by the current speaker or by self-selecting her or himself, displays her or his understanding of the prior turn.

Organization of preference. A closely related organization of talk-in-interaction with regard to the organizations of sequence and turn-taking is the organization of preference (Schegloff 2007: 58-96, Sacks 1987, Pomerantz 1984). Preference organization refers to the ways in which a certain array of SPPs become relevant and are oriented to as expected after a given FPP; as a question makes relevant an answer, a proposal its acceptance or rejection, etc. However, typically only some next actions are preferred over the others. For instance, acceptance of an invitation is preferred, whereas its rejection is dispreferred. Disagreement with a self-deprecation is preferred over agreement (Pomerantz 1984). Typically, a preferred responsive turn is produced immediately whereas dispreferred responses are often produced with hesitations and delays (Pomerantz 1984). For
instance, after preparing salt-cured salmon, a man asks his wife ‘is it too salty’. After a notable pause in talk, i.e. notably absent (preferred) response, the wife says ‘no it’s not’. In his next turn, the husband explicates his interpretation of the wife’s turn ‘that means yes it is’. Dispreferred actions threat the interlocutors’ social relationship, as when the wife ‘blames’ her husband’s salmon being not quite perfect. Thus, these actions typically get accounted for (‘no it’s not too salty, it’s just saltier than last time…’) (Pomerantz 1984, Sacks 1992a: 72-80). Preference organization does not regard responsive actions only; FPPs may project, i.e. prefer certain array of SPPs (Schegloff 2007: 81-96, Sacks 1987, Boyd and Heritage 2006), or be dispreferred (such as requests, see e.g. Robinson 2001).

In the above, I briefly reviewed some basic organizations of conversation through which any instance of interaction is organized by its members: the organizations of sequencing, turn-taking and preference are further considered as they become evident in the doctors’ and patients’/parents’ talk and other activities in my own data. Next I turn to consider a subset of conversation analysis: studies of institutional interaction (Drew and Heritage 1992; Arminen 2005a). Interaction for instance in professional or cultural institutions is, first and foremost, organized in and through the very same underlying organizations of interaction as every-day conversation is (Drew and Heritage 1992; Schegloff 1992a). However, when interacting in institutional contexts the participants may orient to specific sets of norms and conventions of conversation that are perhaps applicable to that particular context only.

4.2.1. Institutional interaction

The above introduced organizations of interaction: sequencing of actions, turn-taking, preference and other prevalent methods (such as organization of repair, see Schegloff, Jefferson and Sacks 1977) of talk-in-interaction enable the members of any given social situation to establish, interpret, alter and restore social actions and social order and importantly, the members’ mutual understanding of these ongoing actions. In deploying these methods the
members display their orientations to their interactional environments, context or ‘social structure’ (Schegloff 1992 and 1991, Zimmerman and Boden 1991) in terms of 1) how they understand and interpret the other members’ previous actions and 2) how they use their own current actions as a slot to either maintain, alter or adjust the context of the interactional environment. Now this becomes particularly interesting, and perhaps difficult, when we study phenomena that are called ‘occasions of institutional interaction’ (Schegloff 1992).

Studies on institutional interaction have shown how the prevalent methods of ordinary conversation, such as turn-taking (Sacks et al. 1974) or activities such as ‘troubles-telling’ (Jefferson 1988) are employed and altered in institutional interaction. Ground-braking studies have been conducted for instance on adaptations of turn-taking organization in a courtroom (Atkinson and Drew 1979) and in news interviews (Heritage and Greatbatch 1991), and on the intersection of the orientations to troubles-telling in everyday talk vs. in service encounters (Jefferson and Lee 1992).

Drawing from our everyday knowledge, we behave differently when we attend to academic seminars, visit a doctor or are being interviewed for a job. However, interaction even in institutional settings is not reinforced by external norms (although violations against established conventions may well have costly or legal sanctions) nor is our interaction enforced by its structural context. Again, it is the participants’ orientations to the norms and their interpretations of other parties’ actions that maintain – or alter – the institution as it emerges (Arminen 2005a: 19). According to John Heritage’s famous formulation, institutions are talked into being (Heritage 1996/1984: 290). A doctor’s office does not force us to behave any differently than how we behave in a family dinner. It is our own orientation, actions and concerted actions with our fellow interlocutors that make it a doctor’s office. Necessarily, there is no strict line between institutional vs. everyday interaction. As an example, consider the following exchange from a primary care visit:

Extract 1: Consultation 8
Doc  [ .h]hh (..) joo, (..) .h mitäs  
     yes  what  
[ .h]hh (..) right, (..) .h how is  

kuuluuh,  
hear  
it goingh,  

(0.4)  

Pat  .hhh no (..) kiitos muuten kuuluu  
     PRT thank+you otherwise hear  
    .hhh well (..) thanks otherwise it’s  

oikeen hyvää mutta (0.9) nyt on niinku  
really good but  now is like  
going very well but (0.9) now I’ve had  

(.) tänä talvena tuntunu et on ollu  
this winter feel that is been  
like (..) this winter I’ve felt that I’ve  

(0.3) semmone flunssa et ei o ollu  
that+kind+of cold that no is been  
had (0.3) a kind of flu that  

niinku mone’ vuoteen=mul oli kauheen  
like many years I+with was terrible  
I haven’t had for many years=I had  

( .) paha poskiontelo’ ja korvatulehdus  
bad sinusitis and ear+infection  
terribly (..) bad sinus and ear infections  

tossa ja mä sön lääkekuurin (.). hh se  
there and I ate course+of+medicine+GEN it  
and I was on medication (.). hh I finished  

loppu ↑viikko sitte?, (..) mt. nyt must  
ended week ago now I  
it a ↑week ago?, (.). tch now I feel
What is it that would make this exchange particularly institutional interaction instead of being an ordinary opening sequence in the conversation between any acquaintances? There is nothing in the doctor’s greeting in lines 1-2 that would make it particularly ‘a doctor’s talk to his patient’. The doctor’s turn is a conventional greeting *how is it going* and so received by the patient. As the patient answers ‘*well thanks otherwise it’s going very well*…, she interprets and acknowledges the doctor’s previous turn indeed as a greeting. But she also goes ahead and does something else. Instead of greeting the doctor back in the same way (what she probably could have done if the lines 1-2 would belong to a friend who she meets at a café), she keeps the turn to herself and instead of merely answering the question, she presents a detailed description of her recent and current medical problems (Ruusuvuori 2000). In other words, the patient orients to the present interactional environment as a doctor’s office, not a café. She displays her understanding that it is relevant to present specific medical problems here and now, that she is entitled to complain about her medical problems in detail instead of greeting the doctor back, her interlocutor is a person who is obliged to and to whom it is relevant to listen to such complaints, etc.

However, as we see further in this exchange, the interactional environment
changes in and through the members actions. In line 15, the doctor receives the description of the patient’s medical problems with a simple *yeah*. In everyday conversation a minimal response *yeah* without further, more personal attentiveness to the interlocutor’s just presented problems would be heard as being ‘rude’. Here, with *yeah* the doctor acknowledges the patient’s complaint as heard (Sorjonen 2001: 280) but does not display himself as engaging in more personal view with the patient (Ruusuvuori 2000: 228-230, Ruusuvuori 2007, Ruusuvuori and Lindfors 2009). However, the doctor does not show that the complaint would trigger him to start a medical examination, either verbal or physical, or anything alike that would make it particularly ‘a doctor’s *yeah* to a patient’. Instead, he uses the slot of his current action to change the orientation altogether as he asks *how’s the baby doing*. Again, this simple, friendly, conventional every day inquiry could be directed to anyone who has had a baby recently, it is not a way to greet a sinus patient in particular. In her preceding turn, the patient directed the conversation toward her sinus and ear problems, but with his current action the doctor *alters* the context of talk from institutional and medical business back to everyday matters.

These observations indicate that interaction in medical (and any other institutional) context can unfold non-formally, i.e. the members are not restricted to act and talk in some pre-determined way (Drew and Heritage 1992: 27-29). As recalled from the ethnomethodological understanding of social norms, institutional norms do not determine or force the members’ behaviours to be of particular kind. Vice versa, the members use norms to interpret each others’ actions and they evoke the norms constitutively, in producing their own actions. This is exactly what makes our inquiry into *institutional* interaction possibly challenging (Schegloff 1992 and 1991, cf. Arminen 2005a: 35-37). As conversation analysts, how do we judge what features in interaction amount to institutional vs. every day talk? First, I review some conversation analytic findings that may help the studies of institutional interaction.

Drew and Heritage (1992) outline some features of interaction that may indicate the members’ orientations being directed toward institutional context rather than
every day conversation. Firstly, these include the members’ *lexical choices* (ibid: 29-32). In institutional interaction, speakers may choose institution-specific ‘technical’ or ‘professional’ terms instead of ‘lay’ terms. In the above example, the patient evokes diagnostic categories of ear and sinus infections, thus presenting them as more relevant and specific in this context than complaining just ‘pain’ or ‘thing’ or ‘stuff’. Another feature of institutional interaction specified by Drew and Heritage (1992: 32-36) is *turn design*, including both selection of action and details of verbal construction of this action. Going back to the above example again, the action the patient selects to accomplish is a specific presentation of a medical problem; she tells the reason for her visit rather than just ‘how is it going’ with her (Ruusuvuori 2000). Moreover, she constructs this action first by acknowledging the doctor’s greeting, then by producing a narrative where the gist is her recent problems (Ruusuvuori 2000: 115-155) and finally by presenting her current symptom (Robinson and Heritage 2005). A third feature of institutional interaction according to Drew and Heritage (1992: 37-42) is (possible) adaptations of *sequence organization*. In this example, the patient interprets the doctor’s question as a greeting but also as a possibility for her to begin the medical business. She does this by adapting the conventional, reciprocal ‘how are you – fine thanks, how are you – fine’ – sequence, that is prevalent in the openings of everyday and telephone conversations (Schegloff 1986). By utilizing her second position in this sequence, she is able to present a medical concern and start the medical business instead of just completing a pair of greetings (Ruusuvuori 2000).

The notion of the adaptation of sequence organization echoes the patient’s overall understanding of her current context, the medical consultation, as being a goal-oriented encounter with some kind of *overall structural organization*, which is the fourth aspect distinguishing institutional interaction from every day talk (Drew and Heritage 1992: 43-45). Everyday interactions do not usually have a particular structured order (although the openings and closings of telephone conversations are exceptions; see e.g. Schegloff 1986) as institutional conversations more or less do. The overall organization of institutional talk derives from its task-oriented nature (Whalen and Zimmerman 1987, Zimmerman 1992). For instance, the patient’s turn in the above example
indicates that there is a particular focus of action, i.e. she is not meeting the
doctor and presenting her problem to him just by chance or to hang out. There is
indeed a reason, a goal according to which she produces her action as she does;
to ask, and ultimately receive some medical service (Ruusuvuori 2000).

The last, fifth aspect of institutional talk is the members’ *social relations and
social epistemology* in, for instance, requesting and providing institutional
services (Drew and Heritage 1992: 45-53). This is evident as on one hand, the
patient presents herself as having the knowledge of her diagnosis and treatment
decision made recently. On the other hand, she is cautious in claiming that this
diagnosis and treatment decision is what she is assuming also this time -
although the implication is made. Instead, she tells that she *feels* similar
symptoms in her ear than during the recently diagnosed ear infection. With this
turn design, the patient balances between explicating ‘lay’ and ‘medical
knowledge’ and in the end, leaves it to the doctor to evaluate and resolve the
puzzle. In other words, the patient orients to the epistemic asymmetry between
herself and the doctor; she does not claim a confident diagnosis, as it is the
doctor’s task to do.

Next I make a few remarks on a medical institution: how it provides a context
for interaction carried out within it and what CA study takes into account in
considering talk in a doctor’s office.

4.2.2. Medical consultation as a context for interaction

Conversation analytic studies of doctor-patient communication as a form of
institutional interaction consider the context as a production of its members’
context is established, manipulated and maintained in and through its members’
actions, the extent to which the members orient to it as relevant (Schegloff 1992
and 1991, Arminen 2005a: 32-35). Institutional context of talk can be seen as a
‘structure’ of society that includes socio-economic, age, gender, professional and
other (structural) differences that may or may not inform the interaction the
members are engaged in (Schegloff 1991). Nevertheless, the parties of a medical visit are without a doubt doctors and patients and by definition represent professional and other structural differences. However, conversation analysts explain and understand the relation between a ‘larger’ (or external) social structure on one hand, and locally situated interaction on the other hand by detailing how interaction constitutes ‘structure’, not vice versa (Heritage 1996/1984: 281, ten Have 1991). Therefore, a conversation analytic research considers social structure or institutional context only in terms of its relevance to the members in any given instance of interaction, and in terms of its procedural consequentiality for the interaction the members are engaged in, i.e. how the context ‘shapes’ the talk produced within it – or does not (Schegloff 1991).

However, the problem of institutional vs. interactional contexts does not have to be irresolvable. As Heritage and Maynard (2006a) regard turn design as one level of analysis in medical interaction (others being overall organization and sequence organization), they note that the details of the design and composition of a turn, for instance, becomes sensible both in its interactional context; for example as an action initiating a diagnostic information giving-reception – sequence, and in its larger social or institutional context; for example when the doctor balances between her or his medical authority and accountability in delivering the diagnosis (Peräkylä 1998, Heritage and Maynard 2006a: 14-19).

This being said, the present study of diagnostic and treatment decision making encompasses all levels of interaction analysis: its overall structural organization, sequence organization and turn design. In terms of institutional context of primary care, the present study concerns the doctors’ and patients’ roles and identities as they are displayed in these activities; for example how they orient to each others’ epistemic positions in treatment decision making. And finally, this dissertation aims to give empirical substance to the theoretical concepts such as ‘patient participation’ or ‘shared decision making’ by discussing them in relation to how empirical findings from actual doctor-patient interaction can contribute to their definitions and uses in research and medical training. To me, this is one form of dialogue, hopefully constructive, between institutional and interactional contexts.
4.3. Data

The data of this study include 98 doctor-patient encounters in Finnish primary care. Each visit is made because of the symptoms of upper respiratory tract infection: cold, sniffles, sore throat, ear pain, cough, sinus congestion, tight chests, etc. The motivation for the data collection in a standard setting arose directly from the previous research that have shown that in this illness category the patients and parents may have quite pre-determined expectations on the nature of their or their child’s illness, i.e. diagnosis and its appropriate treatment, ant the consequentiality of these expectations to the management of the consultation (Stivers 2007, Stivers et al. 2003, Elwyn et al. 1999b, Macfarlane et al. 1997). Therefore, it seemed that this illness category could offer fruitful data to study patients’ participation in diagnostic reasoning and treatment decision making. Thus, the data corpus that was collected is not, by any standards, ‘unmotivational’. As many studies of institutional interaction, this study sets out to concern whether or how some institutional setting or social structure such as professional-lay person -division, affects the interactional conduct (whether this holds true or not) (Schegloff 1992a and 1991, Zimmerman and Boden 1991: 13).

The previous conversation analytic studies concerning decision making regarding upper respiratory tract infections have been done in a paediatric setting (Stivers 2007, Stivers et al. 2003). When adult patients have been involved in the study, the data have been analysed with other methods than conversation analysis (Elwyn et al. 1999b). Thus, the present data provides access also to the adult patients’ communication practices in this particular illness group. Therefore, this dissertation contributes to the cumulative knowledge on communication patterns that have been shown, with substantial data providing evidence, to be rather persistent in a paediatric setting in the US. Here we have collected data from Finnish primary care and from adult patients, and are able to consider whether and how the interaction practices are similar or different than in the settings already studied. Such cumulative nature of CA findings enables us to consider what actually is institutional and particularly context-specific in the
participants’ interactional conduct, or whether the communication patterns are more generally prevailing practices of interaction, not reducible to appear in one context only (cf. Drew 2002).

Thirdly, upon the analysis (even more than before it) I discovered that the standardized data setting became resourceful to discern the different patterns of diagnosis and treatment delivery. As in every consultation the patients’ symptoms and the doctors’ examination procedures are similar, these data provided access to consider ‘different ways of doing one thing’ in medical consultations.

The data, video- and audio-recorded primary care consultations, were collected in nine (9) municipal health centres in different parts of Finland in the years 2005-6. Besides the author, Dr. Johanna Ruusuvuori, Dr. Pirjo Lindfors, PhD candidate Riikka Homanen and M.Soc.Sc Aku Kallio contributed to the data collection. Altogether, we collected a corpus of ninety (90) consultations including ninety-eight (98) patients and eleven (11) doctors in total. The uneven consultation/patient - ratio is caused by six consultations that involved more than one patient, e.g. a parent and a child or siblings. The consultations with more than one patient are counted as including two or three doctor-patient dyads.

From these ninety-eight doctor-patient encounters i.e. dyads I selected eighty-six (86) encounters into the detailed analysis: forty-six (46) child patient encounters and forty (40) adult patient encounters. Twelve (12) encounters were left out of the study for a set of reasons: the consultation was not captured on tape as a whole but parts of it were missing, the patient’s problem turned out to be something else than an upper respiratory tract infection, or the consultation was a pre-scheduled follow-up visit involving an evaluation of a previously diagnosed medical problem instead of being an acute visit with a new medical concern (such as a follow-up visit after a child’s ear infection). The length of the consultations varies from approximately five to twenty minutes. Child patient consultations were usually, but not systematically, longer than adult patient consultations. Throughout this dissertation, I refer to these data as child or adult patient visits, the reason being that each consultation is a primary care visit. In
Finland, a *paediatric* visit refers to the medical speciality of paediatrics provided in secondary care.

This study is approved by the Ethical Board of Pirkanmaa Health Care District, Finland (project number R04143). Adhering to the ethical guidelines of a study involving human subjects, the patients were personally recruited to the study by asking their permissions for the video-recordings. Each patient was informed about the purpose of the study and how the video-recordings and their transcripts will be used and stored. The patients were given a possibility to revoke their permissions for any, even unspecified reason later on. The research team’s contact information was provided for each participant in case they had any inquiries concerning the study or their participation in it. Moreover, each patient was given a possibility to admit her or his consultation to use for research purposes and academic teaching or for the former purpose only. Regarding the child patient consultations, the permission for video-recording was asked from the child, given that he or she was old enough to understand the conditions of his or her participation. Each patient and parent gave their permissions in a written form. The doctors were also recruited on a volunteer-basis (instead of an employer deciding on their behalf, for instance). Prior to deciding to participate, the doctors were informed about the study, data collection and storage. Each doctor gave her or his permission for video-recording in a written form. All information letters and permission forms that were given to and filled out by the participants are found in Appendix I.

In most consultations, the doctor switched on and off the video camera that was assembled in the corner of the consultation room. In a few cases where the doctor preferred the member of our research team to take care of the actual recording, the recording was started and ended before and after the actual visit. The researchers were not present in the consultation room as the consultation was on its way.

After each consultation, the patient/parent filled out a short questionnaire on their satisfaction regarding communication in the visit. These questionnaires
were not used in the present study, but are stored in the department of Social Research, University of Tampere for further research purposes.

The video-recorded data were transcribed with conventions originally developed by Gail Jefferson (Jefferson 1984). The transcription symbols used in this study are listed and explained in Appendix II. To secure the anonymity of the participating doctors and patients, all names of people, places and other details giving information of the individuals involved in this study have been changed. The data were transcribed by M.Soc.Sc Aku Kallio and the author. The transcripts provide as detailed as possible access to the interaction as it unfolds in the consultations but still, only to a relevant extent – capturing *everything* in interaction to its written representation would be impossible. However detailed the transcriptions are, the original video-recordings remain the primary data.

All analyses reported in the four articles of this dissertation are based on the original video-recorded data supported by their original language transcripts. Due to the journals’ rather economic word count limits for article manuscripts, the data extracts in the articles that were written in English are presented only as English translations. To provide the reader of this dissertation with a more comprehensive view to the original data, appendix III presents the data extracts as original transcriptions, their word-by-word translations and as-accurate-as-possible translations to ‘spoken’ English (as presented in the articles). In the next section I summarize the results of the study.
5. RESULTS

This dissertation includes four empirical articles: 1) *Mitä potilas voi tietää? Potilaan tiedollisiin oikeuksiin orientoituminen lääkärin vastaanotolla* [What a patient may know? Orienting to the patients’ epistemic rights in primary care] (Ijäs and Ruusvuori 2007), 2) *Patient involvement in problem presentation and diagnosis delivery in primary care* (Ijäs-Kallio, Ruusuvuori and Peräkylä 2010), 3) *Patient resistance toward diagnosis in primary care: implications for concordance* (Ijäs-Kallio, Ruusuvuori and Peräkylä 2010) and 4) *Unilateral decision making and patient participation in primary care* (Ijäs-Kallio, Ruusuvuori and Peräkylä, forthcoming). Each article focuses on a certain phenomenon in doctor-patient communication and can be read as an independent study. However, all analyses are based on the same data and the examined phenomena concern the different aspects of the same general topic, i.e. the grounds for patient participation in medical decision making in primary care consultations. Therefore, together the articles build a bigger picture on social constituents of diagnostic and treatment decision making and give a broader view to the topic than what a single article could provide.

The articles consider the medical decision making as evolving in the consultation process. The first article focuses on to the opening phase of a primary care encounter and looks how doctors orient to patient’s diagnostic suggestions compared to the patients’ presentations of ‘symptoms only’ in the beginning of the consultation. The two subsequent articles examine interaction in the phase of diagnosis delivery and reception and point out how communication in the opening phase of the encounter informs the interactional conduct also in this later phase. The last article examines the interactional conduct of treatment decision making following the diagnostic phase.
5.1. Mitä potilas voi tietää? Potilaan tiedollisiin oikeuksiin orientoituminen lääkärin vastaanotolla [What a patient may know? Orienting to the patients’ epistemic rights in primary care]

This article analyses how doctors and patients’ epistemic positions are interactionally constructed and oriented to in presenting and receiving a reason for the visit. The analysis discerns ‘front-grounded’ and ‘back-grounded’ candidate diagnoses from the ‘symptoms only’ –type of problem presentations and shows that the patient’s problem presentation guides the doctor’s responsive actions in terms of when and how the doctors take the patient’s epistemic position into account, and how the doctors orient to the patients’ rights to possess medical knowledge.

When a patient presents ‘symptoms only’, the patient’s and the doctor’s epistemic positions are oriented to as conventional doctor-patient roles: the patient describes her or his subjective experiences of symptoms. Typically, the doctors receive this type of symptom descriptions minimally, without contemplating the patient’s experience as such. This is in contrast with candidate diagnosis –type of problem presentations. When the patient presents a candidate diagnosis in her or his problem presentation, the doctor typically addresses it right then and there, in receiving it (Stivers 2002a).

This article shows that the doctors address the patient’s problem presentation immediately in cases where the patient presents a candidate diagnosis as the primary element of the problem presentation; either as the first part of it, i.e. as a gloss (Jefferson 1985) after which the patient presents evidence for it (symptoms), or as the patient presents the candidate diagnosis by explicating the evidence for it at first and concluding the candidate diagnosis thereafter. In both selections of turn design, the candidate diagnosis is offered as the main reason for the visit. Typically, the doctors immediately address such problem presentations by evaluating the relevance of the evidence that is given to the candidate diagnosis, or by assessing the possibility or probability of the
diagnosis itself. In turn, in cases where the patient presents her or his problem by only implying a candidate diagnosis, for instance by giving it as background information for the current symptoms, the doctors tend not to address these problem presentations in their immediately following turns of talk.

So it seems that when the patient presents the candidate diagnosis as a ‘central element’ of her or his problem presentation, the parties’ epistemic positions are brought up in the conversation in a particular way that does not happen following a ‘symptoms only’-presentation. As the patient had thus adopted an active epistemic position in the consultation by expressing her or himself as possessing medical knowledge, i.e. suggesting some diagnosis in the consultation to begin with, the doctors extend the problem presentation phase by addressing this knowledge and the patient’s role in claiming it before initiating the next phase.

5.2. Patient involvement in problem presentation and diagnosis delivery in primary care

This article continues the line of analysis that was launched in the first article. In this article, I argue that the doctor’s diagnosis delivery serves as a response to the patient’s problem presentation. Although the diagnosis delivery and its reception forms an activity in its own right, the diagnosis serves also as an interactionally responsive and thus relevant action with regard to the way in which the patient presented the problem earlier in the visit. In other words, the patient’s problem presentation and the doctor’s diagnosis delivery constitutes a request-grant –type of activity in the consultation. This article shows how systematically doctors orient to this ‘activity type’ (cf. Levinson 1992) in these data, and describes the methods of interaction how such a reference between the two distinct phases of the consultation is displayed.

The argument presented in this article is that as the doctors design their diagnosis deliveries to be responsive to the patient’s problem presentation, they do not rely only onto their medical authority (Heath 1992) or even accountability (Peräkylä
1998) in explicating their medical reasoning to the patient, but orient to and treat themselves accountable for meeting the patient’s particular agenda in the consultation. With the help of data extracts, the article demonstrates the communicational linkage between the two temporally distinct activities of consultation, problem presentation and diagnosis delivery. Moreover, the link between the two phases is illustrated by showing how systematically doctors refer to the different types of problem presentation later on in the consultation, as they deliver diagnosis.

The analysis includes all consultations in the data corpus; 40 doctor-adult patient encounters and 46 doctor-parent encounters, 86 consultations in total. As a point of departure, four types of the patient’s/parent’s problem presentations were discerned in the analysis: 1) symptoms only, 2) candidate diagnosis, 3) diagnosis implicative symptom description and 4) candidate diagnosis as background information (cf. Stivers 2002a). (For background knowledge on patients’ candidate explanations, see ten Have 2001, Gill 1998.) The distribution of these problem presentation types in the data is presented in table 1:

<table>
<thead>
<tr>
<th>Problem Presentation Type</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms only</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>Candidate diagnosis</td>
<td>25</td>
<td>29</td>
</tr>
<tr>
<td>Diagnosis implicative symptom description</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Candidate diagnosis as background information</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>86</td>
<td>100</td>
</tr>
</tbody>
</table>

n=86 consultations

The first two types of the patient’s problem presentation, *symptoms only* and *candidate diagnosis*, are the most distinct and frequent forms of telling the reason for the visit (Stivers 2002a). Symptoms only is a ‘default’ way to present...

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1 The distribution of the problem presentation types is somewhat different in this article than in the article that reported the first analysis. In the first article I differentiate only three ways of problem presentation: 1) symptoms only, 2) candidate diagnosis, and 3) candidate diagnosis as background information and say that the ‘symptoms only’-type of problem presentation occurs in 45 consultations (52% of the data corpus). Later on, as the analysis was developed further I named one more category for the patients’ problem presentations: diagnosis implicative symptom descriptions. These were mainly counted as ‘symptoms only’ in the first article.
a problem in a medical visit (Heritage and Robinson 2006, Stivers 2002a, Ruusuvuori 2000), most typically used by the patients also in these data. The doctors receive this type of problem presentation and initiate the next activity after it without addressing any particularities in the patient’s just preceding problem presentation. This way, the doctor’s selection of action following the symptoms only –type of problem presentation is to initiate a rather independent medical reasoning process, which is of course made relevant by the patient’s medical complaint but still follows the doctor’s line of reasoning. As the names of the categories indicate, *diagnosis implicative symptom description* and *candidate diagnosis as background information* convey some sort of diagnostic references in the patient’s problem presentation. However, in these types of problem presentation the patient does not offer the candidate diagnosis as the primary reason for the visit, and the doctors tend not to address these problem presentation types in their immediately following turns of talk (Ijäs and Ruusuvuori 2007). The differences in the communicational conduct in the phase of presenting and receiving the medical problem are illustrated in table 2:

<table>
<thead>
<tr>
<th>Table 2: Doctors’ next actions after a problem presentation</th>
<th>No reference</th>
<th>Reference</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms only</td>
<td>24</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Candidate diagnosis</td>
<td>4</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>Diagnosis implicative symptom description</td>
<td>7</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>Candidate diagnosis as background information</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

n=86 consultations

The difference in the doctors’ orientations to the patients’ problem presentation types are not on display only in the immediate environment of the problem presentation, but also later on in the phase of diagnosis delivery. These data show that the doctors’ modify their diagnosis delivery formats rather systematically according to the way in which the patient presented the problem in the beginning of the consultation. When the patient presents symptoms only, the doctor delivers the diagnosis as an explication of her of his own diagnostic rationale, without a reference to the particularities in the patient’s problem
presentation. Again, this is in contrast with the doctors’ conduct following the candidate diagnosis –type of problem presentations. In these consultations, the doctors deliver the diagnosis not as an explication of their medical reasoning only, but formulate the diagnosis as a confirmation (and naturally, in some cases as a disconfirmation) of the patient’s diagnostic assumption. Interestingly, the doctors address also the latter two types of problem presentation; diagnosis implicative symptom description and candidate diagnosis as background information in delivering the diagnosis in the same way as they address the candidate diagnoses that were presented as the primary reasons for the visit. Table 3 illustrates how systematically the doctor’s diagnosis delivery formats differ with regard to the patient’s problem presentation in these data:

<table>
<thead>
<tr>
<th>Table 3: Doctors’ actions in the diagnostic phase</th>
<th>No reference</th>
<th>Reference</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms only</td>
<td>24</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Candidate diagnosis</td>
<td>3</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Diagnosis implicative symptom description</td>
<td>2</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>Candidate diagnosis as background information</td>
<td>1</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

n=86 consultations

In sum, variation in the doctors’ orientations to the two main types of problem presentation, symptoms only and (explicit) candidate diagnosis is most evident in three loci of the consultation: 1) in receiving the candidate diagnosis –type of problem presentation, the doctors comment some aspect of it. 2) In initiating the next activity after the problem presentation (typically a verbal or physical examination), the doctors display their actions being connected to the problem presentation. And 3) in the diagnostic phase, the doctors design the diagnosis delivery as confirmation (or disconfirmation) of the patient’s candidate diagnosis. These aspects are in contrast to the symptoms only –type of problem presentation that the doctors 1) receive without addressing any particular part of it and after which 2) the doctors initiate the examination phase without a reference to the problem presentation. Finally, 3) the diagnosis is delivered as being based onto the doctor’s own medical reasoning only.
The observation that the patient’s selection of action in problem presentation is consequential for the course of action in these three stages of the consultation has implications for how we understand the concept of ‘patient participation’ in primary care consultations. Even though the patient’s explicit participation would not become relevant in the currently ongoing action of diagnosis delivery as is shown by Heath (1992) and Peräkylä (1998), the patient’s point of view is nevertheless involved in the design of it. In these data, the doctors do not only engage in delivering an objective conclusion of their medical investigation (Heath 1992: 238), or even provide the patient with access to the medical reasoning process only (Peräkylä 1998). In addition to these characteristics of the diagnosis delivery, in these data it becomes evident that the doctors orient to responding to the patient’s specific ‘agenda’ that was established in the problem presentation earlier in the consultation.

This finding is the reason why I have titled the article as ‘patient involvement’ rather than ‘patient participation’. The incorporation of the patient’s point of view to the way in which the doctor delivers the diagnosis can be seen as one form of patient participation, i.e. patient’s contribution to the agenda setting and action in the medical consultation (Peräkylä and Ruusuvuori 2007), even though the patient would not participate explicitly in the diagnostic phase other than by producing a minimal response if a response at all. Nevertheless, the patient’s perspective is involved into the design of the turn within which the doctor delivers the diagnosis.

Next I turn to review the analysis of quite rare instances of interaction in the data; the patients’ resisting responses to the doctors’ diagnostic statements. In resisting a diagnostic statement either the diagnosis itself, the doctor’s explication of its grounds or aetiology, or the doctors’ online commentaries (Heritage and Stivers 1999) with which they convey diagnostic information, patients themselves may re-evoke the connection between their problem presentation and the subsequent diagnostic statement. This implies that the problem presentation carries diagnostic expectations the patients hold their doctors accountable for meeting.
5.3. Patient resistance toward diagnosis in primary care: Implications for concordance

The article ‘Patient resistance toward diagnosis in primary care: implications for concordance’ considers the ‘other side of the same coin’ that was analysed in the article reviewed above (section 5.1.2.). This article describes how patients resist a diagnosis given by a doctor and how they re-invoke the reference between the problem presentation and diagnosis delivery in cases in which the doctor’s diagnosis does not fit the patient’s initial complaint. In other words, this article considers the consultations in which the request-grant –type of activity turns out to be request-rejection –type of activity, and how the doctors and patients deal with such incongruence in their views. A doctor may well be responsive to the patient’s candidate diagnosis, but she or he has to deal with the issue of discrepancy in case the patient’s view proves uncertain or incorrect. In the data corpus of 86 consultations, there were 10 consultations in which the doctor’s and the patient’s views differ. From these 10 consultations I found 16 sequences of conversation where the discrepancy was communicated explicitly. These 16 sequences form the data of the analysis.

The patients initiate their resistance displays through two distinct turn formats: by misaligning with the ongoing diagnostic information giving – reception -sequence or by aligning with it. In the article, misalignment within the sequence means the patients’ choices to do something else than what was projected in the doctor’s preceding turn (diagnostic information giving). This turn format is perhaps more overtly resistant. However, the analysis shows that the patient may align with the ongoing sequence by acknowledging the doctor’s just preceding diagnostic statement as information, and proceed to an overt resistance display thereafter (for further discussion on misalignment in doctor-patient interaction, see Drew 2006).
The patient’s resisting turn, initiated either by misalignment or alignment with the doctor’s preceding diagnostic statement launches a new sequence of information telling; it is a new first pair part (Sacks et al. 1974). By initiating a new information giving sequence the patient’s resistance emerges as a cooperative action seeking to further the participants’ shared understanding of the patient’s condition, rather than as a flat rejection of the diagnosis (Peräkylä 2002). However, through these actions the patients are able to call into question the doctor’s diagnostic information. The epistemic resources within which the patient is able to contest the diagnostic information that was given in the doctor’s preceding statement include: 1) the patients’ present symptoms, 2) their past experiences on symptoms, 3) information they have received in the previous medical visits, and 4) their own diagnostic expectations.

The first two resources of resistance are resources of knowledge only the patients have access to; in relying to these resources the patients give subjective accounts of their illness experience. In contrast, when the patients rely on information they have received in the previous medical visits with similar illnesses, they in a way ‘borrow’ from another medical authority. Doing so, the patients are able to contest the present doctor’s view not only with their subjective knowledge, but with their medical knowledge. Finally, the patients’ initial problem presentations that were presented in the beginning of the visit may include candidate diagnoses encoding the patients’ own diagnostic expectations. These expectations can be re-invoked as an epistemic resource to resist the doctor’s diagnosis in a later phase of the consultation.

These findings corroborate the previous studies on patients’ and doctors’ discrepant views on diagnosis. Heath (1992) showed how a patient may respond to the diagnosis first with an agreement that, however, foreshadows an account that attempts to counter the doctor’s opinion of the condition. With these accounts, the patient suggests that the problem is not only more severe but something else than what the doctor proposes. This way, the patient encourages the doctor to reconsider the condition but also reinforces the threatened legitimacy of the visit (Heath 1992, Heritage 2009). By providing unmentioned
symptoms or asserting the severity of the symptoms or their concerns, the patient’s account attempts to (re)assert the reason for seeking medical help.

Heath (1992) notes however that actual disagreement between a doctor and a patient is extremely rare. The patients carefully preserve the difference between their own and the doctor’s medical opinion. This is in line with Peräkylä’s (2002) findings that patients may resist a diagnosis by offering additional or alternative information but do not contest the very evidence which the doctor presents for the diagnosis (see also Raevaara 2000: 173-174). Also Stivers (2007: 77-104, 2005b) has shown that by inquiring about the child’s symptoms or asking about other possible diagnoses after a diagnosis delivery, the parents display their reluctance to accept the diagnosis that indicates a non-antibiotic treatment decision. These studies indicate that the patients resist the doctors’ diagnostic views by relying on their subjective experiences on the symptoms. Even though they bring these symptoms forward to contest the doctor’s diagnosis, they preserve the doctor’s medical authority and do not contest the clinical evidence on which the doctors based the diagnosis (Peräkylä 2002). Stivers (2007: 103-104) argues that questioning is a way to contend with the doctor’s diagnosis as the diagnosis delivery does not make the parent’s response conditionally relevant as such (Schegloff 1968, see also Heath 1992, Peräkylä 1998, Gill 1998, Gill and Maynard 2006, Gill, Pomerantz and Denvir 2010).

This article supports these earlier findings. It shows that the patients have both a sequential place as well as epistemic resources to further their own views against that of the doctor’s. However, this article also shows that the patients resort not only to their experience-based views on their illness to which they are ‘entitled’ to (see e.g. Gill et al. 2010), but also on medically informed knowledge on their previous diagnoses. In Mishler’s (1984) terms, the ‘voice of lifeworld’ and the ‘voice of medicine’ get intertwined in the patients’ resistance displays, that include besides questions, also other types of turns within which the patients and parents give contrary information to the doctor’s diagnostic statement. This is perhaps most evident when the patients re-invoking their own initial diagnostic expectations, regarding it as strong enough to compete with the doctor’s diagnostic statement. This suggests that patients, to an extent, orient to the
doctor’s diagnosis as ‘negotiable’. The diagnosis is something on which the patient has a say not only in presenting the problem at the beginning of the encounter but also later on, upon hearing the doctor’s diagnosis. By responding to the patient’s initiation of information giving sequence and by giving grounds to her or his own view on the diagnosis also the doctors, to an extent again, orient to the diagnosis as a negotiable matter.

These findings are discussed in relation to the term ‘concordance’ that refers to a model of doctor-patient relationship in which the doctor’s medical as well as the patient’s experience-based life-world knowledge on the illness are considered as equally important. In a concordant doctor-patient relationship the parties engage in mutual information giving and shared decision making on the treatment of the patient (Weiss and Britten 2003, Bissell, May and Noyce 2004, cf. Mishler 1984). While the term concordance has mostly been used in reference to prescribing and taking medication (Horne et al. 2005, Stevenson, Cox, Britten and Dundar 2004, Weiss and Britten 2003), in this article it is extended to encompass the process in which the doctor and the patient reach an agreement upon the diagnosis. The article suggests that in order to achieve a concordant view on the treatment decision, the doctors and patients take steps to achieve agreement on the nature of the medical problem in itself (diagnosis) before seeking a solution to it (treatment decision).

In the article I argue that the negotiation on the diagnosis is one interactional constituent of concordance as ‘an agreement reached after negotiation between a patient and a healthcare professional that respects the beliefs and wishes of the patient in determining whether, when, and how medicines are to be taken’ (Dickinson et al. 1999). This article shows what kind of actions in doctor-patient interaction work as efforts to reach shared understanding and agreement on the proper diagnosis and subsequently, treatment for the patient. The patients have means to participate explicitly in this negotiation. This article offers one viewpoint to concordance in action; what sort of actions amount to efforts toward shared understanding and agreement on the proper diagnosis and treatment for the patient, and how the patients’ views are brought to the fore as equally valid as the doctor’s opinion as a medical expert.
5.4. Unilateral decision making and patient participation in primary care

The fourth article ‘Unilateral’ decision making and patient participation in primary care’ examines the ways in which the doctors and patients/parents arrive at treatment decisions and how the patients participate in the process.

In initiating the decision making ‘unilaterally’ (Collins 2005, Collins et al. 2005), the doctors explicate what they have already decided concerning the treatment or other next action. Contrary to the unilateral conduct, ‘bilateral’ (Collins 2005, Collins et al. 2005), ‘patient-centred’ (Roter and Hall 1992: 90) or ‘participatory’ (Lindfors 2005: 170-181) approach to the decision making incorporates the patient’s perspective or contributions to the initiation of the activity.

In these data, I found 26 unilateral primary decision deliveries in the adult patient consultations plus 27 unilateral primary decision deliveries in the child patient consultations, 53 unilateral decision deliveries in total. The article Unilateral’ decision making and patient participation in primary care’ examines patient participation in decision making following the doctors’ ‘unilateral’ decision deliveries. The term ‘unilateral’ refers to decision delivery formats within which the doctors suggest, recommend or conclude a treatment or some other further plan of action to the patient, and which are given as initiative actions in the decision making phase, thus offering the decision as ‘already-made’.

The article shows that ‘unilateral’ decision making may be collaboratively maintained in consultations and that patients have means for challenging it. Even

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2 Concerning ‘patient-involving’ decision making, in these data I found 13 decision making sequences in the adult patient consultations and 12 decision making sequences in the child patient consultations, 25 decision making sequences in total, in which the doctor initiates the decision making in a way that invites an explicit contribution from the patient. Further, in 8 consultations the patient is the one who initiates the decision making. The analysis of these data are to be presented in future research.
though the initiative turn in a unilateral decision making sequence is an explication of what the doctor has already decided, the doctors in these data typically accommodate the patient’s perspective, to an extent, to the initial decision delivery. This is evident as they explicate the grounds of the decision to the patient. Firstly, the doctors may refer to the diagnosis as a basis for the decision and thus make the medical rationale of the decision making available to the patient (cf. Peräkylä 1998). Secondly, the doctors may refer to the patient’s particular diagnostic and/or treatment expectations in delivering the decision or its grounds. This way, even though the doctor delivers the decision unilaterally, i.e. as what she or he has decided to do, the decision is not presented as the conclusion of the doctors’ medical opinion only but also as a response to the patient’s expectation that was either perceived (by the doctor) or explicated (by the patient) in the consultation (Stivers 2005a). However, in the latter practice of decision delivery the patient’s perspective becomes more deep-seated in the activity.

The ways in which the patients receive such unilateral decision deliveries either maintain the orientation in the decision making in doctor-controlled agency, or shape the orientation toward a more shared practice. Firstly, by remaining silent after the decision delivery and aligning with the initiation of the next activity after the decision delivery the patients may orient to the conduct in unilateral decision making as adequate. Also their minimal responses such as yeah or okay mark the decision as acknowledged but do not bring their own perspectives to the fore in any particular way.

Secondly, the patients may respond to the unilateral decision delivery with an extended response. In their extended responses the patients further their own perspectives in decision making 1) by assessing the decision positively, 2) by evaluating the grounds on which the doctor’s decision is acceptable, or 3) by resisting the decision. As the patients thus extend the sequence of decision delivery and reception they orient to the decision as negotiable and shape the unilateral process of decision making into a shared one. Moreover, within their extended responses the patients explicate their diagnostic and/or treatment expectations regardless whether the doctor did so in the preceding decision
delivery. Thus, they claim access to the diagnostic reasoning behind the doctor’s treatment decision. This way, the patients’ display their epistemic rights to assess and direct the decision making in the course of consultation even though it was not particularly projected in the doctor’s initial decision delivery (cf. Heritage and Raymond 2005, Stivers 2005b, Stivers 2006).

These observations suggest that fundamentally, unilateral decision making is a co-constructed activity in the doctor-patient encounter and prone to change in the participants’ orientations to their situated contexts of interaction. This article shows that the patient’s expectations (either perceived or explicated) concerning the diagnosis or treatment provide one such context to which the parties of decision making, even in ‘unilateral’ decision making, orient to. Therefore, I suggest that the unilateral decision delivery does not as such restrict the patient’s possibilities to participate. On the other hand, within their minimal responses, even silences, the patient may orient to the unilateral decision making as a sufficient conduct.

The findings of this article are discussed in relation to the previous research on unilateral vs. bilateral treatment decision making (Collins 2005, Collins et al. 2005) and the patients’ responses to their doctors’ decision deliveries (Stivers 2005b and 2006). This analysis shows that the unilateral decision delivery does not as such restrict the patient’s possibility to express their subjective views (as suggested in Collins et al., 2005) (parallel discussion on opening questions is offered in Ruusuvuori 2000). On the other hand, the patients do not necessarily respond to the decision delivery at all, their absent responses not halting the progression of the consultation (as suggested by Stivers 2005b, 2006). Whether the patient responds is a matter of the parties’ situated orientations to the context of their interaction. For instance, in these data we saw that when the doctor or the patient is already orienting (for instance with gaze and postural orientation, see Goodwin 1981: 96, Heath 1984, Ruusuvuori 2001) to the next relevant activity following the decision delivery instead of the patient’s response, the patient may produce no response at all (cf. Heath 1992, Robinson 2003). This finding is at variance with Stivers (2005b, 2006) findings of the parents systematically and normatively responding to the decision delivery. Importantly
though, the patients may respond, also extensively, even though the doctor would already orient to the next activity following the decision delivery. This suggests that the doctor’s unilateral decision delivery and her or his orientation to something else than the patient’s possible response do not necessarily restrict the patient’s participation (however, it may reduce patient participation; this notion requires further research). In these data I have observed that the patients produce both minimal and extended responses after unilateral decision delivery and thus orient to their rights to assess and direct the decision making process, even if the doctor did not project it in the initial action of the sequence.

5.5. Summary: The process of diagnostic and treatment decision making in doctor-patient interaction in primary care

As a summary on the interaction in the diagnostic phase in Finnish primary care consultations for upper respiratory tract infection, I argue that the diagnosis serves as a ‘second pair part’, i.e. as a response to the patient’s problem presentation. The doctors and the patients orient to this projection or expectation in their interactions in the diagnostic phase, the doctors by modifying their diagnosis delivery formats to ‘fit’ the patient’s problem presentation, and the patients in resisting a diagnosis that does not ‘fit’ their initial complaints. This gives evidence that the diagnostic decision making is a co-constructed activity within the consultation; it is a matter of negotiation that involves both parties’ views. Diagnosis is a medical fact, but how this fact is talked about and negotiated in doctor-patient interaction is a context-sensitive activity in the consultation, the context being the parties’ situated orientations to the mutually constructured agenda of the consultation.

Heritage and Sorjonen (1994) define an activity as ‘the work that is achieved across a sequence or series of sequences as a unit or course of action, meaning by this a relatively sustained topically coherent and/or goal-coherent course of action’. The analyses reported in these two articles indicate that the activity of diagnosis delivery and reception is relevantly and accountably tied also to the participants’ understanding of and their orientation to the overall organization of
their situated interaction, in Robinson’s (2003) terms the large-scale structure or project of doctor-patient interaction. I argue that the link between the problem presentation and the diagnosis delivery is a display of the participants’ understanding of the goal of their interaction in the consultation. This observation from Finnish primary care is very much the same than what Stivers’ (2002a) observed from paediatric consultations in the US. The way in which the patient/parent presents the problem, i.e. her or his selection between symptoms only vs. candidate diagnosis informs the course of consultation as a whole as both (all) participants orient to it in a way that is consequential for the later management of the consultation. This does not apply to the paediatric context only, but also to the primary care consultations in general, at least in the illness category of upper respiratory tract infections.

This is to say that the ‘request-grant’ –type of activity is accomplished in the progression of the consultation’s interactional project (Robinson 2003), through the participants’ understandings of their activities’ role in the overall organization of the consultation (Ruusuvuori 2000: 271). The patient’s candidate diagnosis is a diagnostic suggestion that is quite systematically referred to, i.e. confirmed or disconfirmed by the doctor after a series of sequences of talk in consultations. Thus, interaction and the mutual understanding that is established in the prior phases of the consultation create a context for the subsequent actions not only in the immediate sequence of conversation, but in the larger activity which the ongoing sequence (and the sequences of sequences) accomplishes, and in the whole consultation within which the actions and activities progressively unfold.

Charles et al. (1997) point out the difficulty of ‘measuring’ the extent in which the patient participates in the decision making process in a medical consultation (see also Butler et al. 2001, Epstein et al. 2005). They propose that if a patient simply agrees with the treatment decision suggested by a physician, we can not say that the patient would have participated in the decision making process as such. In other words, Charles et al. (1997) suggest that to accommodate the patient’s participation into the decision making process the verbal exchange needs to be more extensive. By observing that the parents normatively respond
to the doctors’ treatment recommendations and thereby display their rights to accept or reject the doctor’s decision, Stivers (2005b, 2006) suggests in contrast with Charles et al. (1997) that the concept of patient participation could thus be understood in broader terms. As the parents and the doctors systematically orient to the parent’s response as being due after the decision delivery and as the parent’s absent acceptance complicates the progression of the consultation, the parents actually do participate in decision making in the consultation (Stivers 2005b, 2006).

The findings of the present study corroborate but also, to some extent, contradict with both Charles et al. (1997) and Stivers’ (2006) views on patient participation. Firstly, with their minimal responses, not to mention ‘no responses’ to the unilateral decision deliveries the patients maintain the orientation in the decision making as unilateral. However, the patients themselves may show that more extensive exchanges may not be necessary. On the other hand, the patients have means to participate in the process even though it would not have been particularly projected in the doctor’s decision delivery. This suggests that patient participation does not necessarily call for the doctor’s particular efforts to invite the patient into the decision making, as also Stivers (2006) suggests. However, the patient’s response may not become relevant at all (cf. Stivers 2005 and 2006).

The article ‘Unilateral decision making and patient participation in primary care’ describes the conversational structures within which treatment decisions are achieved in these data. These structures include a) the doctor’s treatment decision deliveries that receive no response from the patient (which is not, strictly speaking, a sequence at all), b) decision deliveries – minimal responses, c) decision deliveries and extended responses that include receptions of the decision complemented with expansions that convey either positive assessments or resistance, or initiations of insert expansions within which they judge the grounds on which the initial decision is acceptable.

The variation in the conversational conduct in decision making sequences found in these data indicate that there is no one form of decision making or even two
(unilateral vs. shared) but many, and that in interactional accomplishment of unilateral vs. shared decision making the parties’ epistemic positions, rights and orientations shape the conversational conduct in the ongoing sequence of decision making (cf. Heritage and Raymond 2005). Again, I argue that treatment decision making, even though being a distinct activity phase in the consultation, is embedded in and derives from the preceding activities and mutually established orientations that constitute the participants’ general sense of the context that they are dealing with (Robinson 2003, Heritage and Maynard 2006a: 11). This is evident in the ways in which the doctor accommodates the patient’s diagnostic and/or treatment expectations to the decision delivery or how the patients themselves do so.

Treatment decision making resides in the very nexus of patient participation as a theoretical concept vs. in naturally occurring interaction. The observations that I have made concerning the unilateral decision making which is often considered as a doctor-centred, outdated way of decision making that should be avoided, suggest that on occasion, unilateral decision making may be sufficient also from the patient’s point of view and further, that patients have means for challenging it. These complexities are discussed in the next and final section of this introduction.
6. DISCUSSION

This study was a conversation analytical inquiry into ‘patient participation’ in decision making in primary care. In adopting this method, certain requirements for research follow. Firstly, the study must be first and foremost empirically-driven and inductive. CA does not set out to test pre-existing social theories; vice versa, upon the accumulation of the systematic empirical findings of the orderliness of human interaction discovered in CA, CA itself works as a distinct social theory (Heritage 2008). Secondly, a researcher does not place pre-existing categories or attributes to the ‘objects’ of the study to guide the observations thereby made, nor they guide the interpretations or explanations of whatever phenomena are to be found. A turn at talk is not uttered because its speaker is ‘male’, ‘white’, ‘middle-aged’ or ‘a physician’. As Schegloff (1992) puts it, a student of naturally occurring interaction can not take such social organizations or even ethnographic facts for granted in observing and explaining phenomena in interaction. In any instance of interaction, the members produce these social structures and attribute them to each other or do not do so; the variety of possible attributes may or may not be relevant for their ongoing action. With these notions in mind, I will now turn to reconsider the models of ‘patient participation’ in light of the empirical findings of this study.

6.1. Theories and practices of patient participation in decision making

Roter and Hall (1992) propose that ‘patient-centered exchanges maximize a collaboration between both doctors and patients, while, one might suggest, doctor-centered exchanges maximize the physician’s input and minimize the value of patient input’ (ibid: 89). They also give examples on each conduct in decision making:

‘You have an upper respiratory tract infection. More likely than not it will clear itself up in three or four days. I can give a prescription that may well clear it faster. What do you think? (patient-centered)’ (ibid: 90).
‘Take this to the drug store and come back in a week if it is not better. (physician-centered)’ (ibid: 90).

Roter and Hall also note that ‘social, non-medical conversation in consultation cannot be clearly viewed in terms of either patient-centered or doctor-centered talk’ (ibid: 90). The studies of medical communication, as those reviewed in this introduction, have pointed out how the tasks of medical consultation can be done in doctor-centred, unilateral, one-sided manner, within the voice of medicine. Or, on the other hand, how the tasks can be accomplished in a patient-participatory, bilateral, patient-centred or shared manner. The distinction between the doctor’s vs. patient’s perspective can be seen also in the communication patterns studied in this dissertation. However, in these data the selection between the varying degrees of doctor vs. patient-centred approach in the accomplishment of the diagnostic and treatment decision making, at least regarding this illness category is not exclusively a matter of the doctor’s selection of different styles of communication. The doctors’ and patients’ conduct in decision making varies with regard to their orientations to the overall structure or ‘task’ of their encounter (or project, cf. Robinson 2003). The patient’s perspective, established in a problem presentation for instance, plays a crucial part in forming this orientation. To challenge Roter and Hall’s (1992: 90) distinction between patient vs. doctor-centred talk I argue that besides non-medical talk, medical talk itself may not necessarily be a matter of being either ‘doctor’ vs. ‘patient-centred’.

The main finding reported in the article ‘Patient involvement in problem presentation and diagnosis delivery in primary care’ is that in initiating the next action following the problem presentation and in delivering the diagnosis later on, the doctors’ systematically modify their actions with regard to the way in which the patient presented the reason for the visit. More specifically, they modify their actions to be responsive to the patient’s problem presentation. In turn, what is observed in the article ‘Patient resistance toward diagnosis in primary care: Implications for concordance’ is that the patients have means to re-invoke their initial problem presentations and diagnostic expectations as resistance in case the doctor’s diagnostic statement, however responsive, does
not fit those. Moreover, in the article ‘Unilateral decision making and patient participation in primary care’ it was shown how the doctors may accommodate the patient’s perspective into the otherwise unilateral treatment decision delivery and how again the patients themselves may further their perspectives to the diagnostic and treatment decision making regardless whether the doctor did so in the preceding turn.

Even though the patient’s actual, verbal participation is not necessarily on the fore in the diagnostic phase, the patient’s perspective established in the problem presentation is still carried along in the activity. This notion supports the idea that the diagnostic phase follows the logic of a service encounter in which the patient’s request is met in the doctor’s responsive action with regard to the patient’s complaint, instead of being a display or account of the doctor’s medical reasoning process only (cf. Ruusuvuori 2000: 100-103, Zimmerman 1992, Whalen and Zimmerman 1987). The same goes for treatment decision making. The doctors at least in these data typically orient to the patient’s perspective even in delivering a unilateral treatment decision, at least by making the grounds of the decision available to the patient or by accommodating the patient’s specific diagnostic or treatment expectations to the decision delivery, as they also do (to an extent) in initiating the process of shared decision making. These observations show that the doctors’ and patients’ perspectives are both incorporated into the accomplishment of the activities of diagnostic and treatment decision making. To what extent their perspectives come to the fore, is a matter of the parties’ situated orientations to the overall structure of the consultation and its tasks or goals, and their understandings of their epistemic positions and rights in its fulfilment.

The present study has contributed to the knowledge of the social and interactional grounds of the diagnostic and treatment decision making in Finnish primary care, and uncovered the links between the distinct phases of the primary care consultation that precede the actual decision making. Each article has addressed some aspect of patient participation in these activities and given empirical substance to the normative concepts of ‘patient involvement’, ‘concordance’ and ‘unilateral’ (vs. ‘shared’) decision making. However, keeping
the inductive nature of the conversation analytic study in mind, instead of judging whether these normative models of communication inform doctor-patient interaction or not in these data, this study has looked at these phenomena from a profoundly different angle: by observing what actually happens in interaction in these encounters and what constitutes patient participation in action in the activities of diagnostic and treatment decision making.

In this study, the patient’s influence to the course of action(s) in the consultation (Peräkylä and Ruusuvuori 2007) was observed in the ways in which the patient’s choice between the types of problem presentation guided the doctor’s ways of responding to it. Importantly, this influence is not restricted to the phase of problem presentation only; the doctors’ conduct in the diagnostic phase is responsive to the patient’s initial problem presentation. This way, the patient’s perspective is carried along in the diagnostic phase which itself rarely makes relevant an explicit or extended contribution from the patient. This indicates that in evaluating ‘patient participation’ in medical consultations, research and practitioners would benefit from paying attention also to the patient’s ‘indirect’ contributions to it. So far, the main focus has been on how the patient participates explicitly, for instance by asking questions, requesting or volunteering information (which are without a doubt important and relevant topics, see e.g. Cegala and Post 2009, Robinson 2001). This research has helped to observe how the patient’s perspective may be incorporated into the activities in which the patient may not participate explicitly or extensively, such as delivering diagnosis or making treatment decisions. Such ‘patient involvement’ is systematically brought to the fore in the data analyzed, and can thus be seen as one form of ‘patient participation’ in medical communication.

The term concordance, as recalled from section 1 of this introduction, promotes a particular kind of patient participation in the consultation; the explication and incorporation of the patient’s knowledge, values, preferences, beliefs etc. to the decision making which, in turn, evolves as a process in the consultation perhaps more than in a particular phase of it. Concordance stresses the importance of incorporating the patient’s knowledge and expertise to the medical decision making and thus, gives perhaps more weigh on the patients’ epistemic
participation in it, such as their own experiences and opinions (Weiss and Britten 2003, Horne et al. 2005, Cox et al. 2004: 144). However, there is little evidence for the actual accomplishment of concordant decision making in interaction (Bissel et al. 2004, Cox et al. 2004: 144-148, Elwyn, Edwards and Britten 2003). Moreover, as concordance is regarded as a shift from compliance to concordance (Weiss and Britten 2003) as an attempt to overcome, perhaps paradoxically, the problem of non-compliance, it has been criticised as being more a representation than a revolution in health policies (Segal 2007).

One problem Segal (2007) attributes to the model of concordance is its emphasis on the doctors and the patients as equals. Segal writes: ‘Faced with a person --- who insists on antibiotics for a diagnosed viral infection --- the physician’s job is to be a partner in conversation yes, but not, disingenuously, to be an equal partner. The physician’s job is to be a persuasive expert.’ In this study I have considered concordance, strangely enough, in cases of incongruence between the doctors’ and the patients’ views (cf. Stevenson and Scambler 2005). Despite the controversies in the development of the concept of concordance, I have found it useful as it pays attention to the practices in which doctors and actually bring their views to the fore, at least somewhat equally, and thus negotiate on the diagnosis and treatment. However, the article in which I present this analysis (‘Patient resistance…’) shows that concordance, if understood as seeing the patient’s beliefs and expectations as important and relevant in decision making as those of the doctor’s may not lead to a rational medical decision. Perhaps more it secures a conflict-free doctor-patient relationship.

The concept of concordance can be further discussed in relation to the analyses on unilateral (Ijäs-Kallio et al. submitted a) and shared decision making (Ijäs-Kallio et al. submitted b). The practices of decision delivery in which the doctors accommodate the patients’ perspectives as well as when the patients further these perspectives in their responsive turns, can perhaps be seen as constituents of concordance. For instance, a patient assessing the decision from his or her perspective can be seen as ‘an agreement reached after negotiation between a patient and a healthcare professional that respects the beliefs and wishes of the patient in determining whether, when, and how medicines are to be taken’
(Dickinson et al. 1999). Further, as the patients evaluate the grounds on which the doctor’s decision is acceptable by introducing new information they do initiate a negotiation and contribute to the possibility of making ‘choices that are as well informed as possible about diagnosis and treatment’ (ibid). In the analysis of unilateral decision delivery and reception, I observed that the patients may pursue ‘concordance’ in decision making despite their doctors’ more unilateral approach.

In existing literature, it is frequently brought up that interaction in clinical encounters rarely implements the models of ‘patient-centred medicine’, ‘shared decision making’ or ‘concordance’ (Cox et al. 2004: 145-148, Bissell et al. 2004, Stevenson et al. 2000, Elwyn et al. 1999b). It is also noted that patient participation and shared decision making particularly in the case of upper respiratory tract infection may become problematic as in this illness category the normative models of preferable ways of decision making may lead to medically inappropriate treatment outcomes, i.e. antibiotic prescribing in viral conditions (Segal 2007, Stivers 2007, Elwyn et al. 1999b). Are the models of patient participation thus not suitable if the patient does not, paradoxically, submit to the doctor’s opinion as Segal (2007) points out in criticising the concept of concordance? Should the models of patient participation, concordance or shared decision making be applied only with some patients or in some illness categories? On what grounds the practitioner should or could make the selection whether or not to apply the models in the face-to-face encounter with the patient?

To me, these questions reflect a more profound methodological issue: direction of inquiry and explanation that is from ‘top to down’. By this I mean the attempts to deploy the models of patient participation as overarching norms that should, or in some cases, should not guide interaction in the clinic. Conversation analytic study and ethnomethodology in general avoids this problem by reversing the direction of inquiry and explanation. In the study of naturally occurring interaction (of which a medical encounter in the end is – apart from any ideals), the role that is given to the normative models in the research is different. As the study starts with unmotivated observations from the data
Shared decision making is an example. In the article ‘*Unilateral decision making…*’ we saw that the patient’s extensive response following a unilateral decision delivery turn the activity of decision making into a shared practice. From this empirical observation, methodological consequences follow. That is, we can not determine decision making being doctor-centred or patient-centred by looking at the doctor’s conduct only. The activity of decision making is co-constructed in the doctor’s and the patient’s concerted actions in interaction. This means that the patient’s role in the decision making in primary care consultations (for upper respiratory tract infection) is not only a subordinate one, i.e. a position of an information provider (in problem presentation) or information receiver (in diagnosis delivery and treatment decision making). In the co-constructed activity of decision making that accommodates, to varying
degrees for sure, the patient’s perspective (in terms of the doctor’s orientation to the patient’s epistemic position) is not solely a matter of asymmetry between the roles and tasks of the doctor and the patient. Interaction in medical consultation as in any instance of interaction is doubly contextual. A current action, for instance an initiation of the decision making phase, is indexical and so understood in relation to its context. Secondly, it provides a framework for subsequent actions. This applies to the doctors’ diagnosis and treatment deliveries as well as the responses by the patients.

According to Charles et al. (1999) (and many others), recognition of the model of the ‘analytical stages’ of shared decision making can raise physicians’ awareness on the multifaceted nature of decision making. Secondly, with the help of the normative model, a physician can discuss the different possible approaches in decision making (paternalism, shared and informed) with the patient to find out about the patient’s individual preferences in decision making. Also, as the doctors recognize the stages of decision making, they may switch the form of communication (from paternalistic to shared, informed to shared etc.) according to patient preferences as the encounter unfolds (Charles et al. 1999). I do not deny this possibility. The models of shared decision making or other forms of patient participation are good tools to raise awareness on communication in health care encounters. Still, from actual interaction point of view, the doctor’s and the patient’s focus is first and foremost in their here-and-now encounter as it unfolds, not in the models of how it should or could unfold.

Next I turn to consider the limits of this study and the several further research questions which thereby rise.

6.2. Limits of this study and further research questions

Even though I have presented some critical views with regard to how the normative models of communication, such as ‘patient participation’ and ‘shared decision making’ work in practice, my intention is not to propose the replacement of these models but their reflexive, context-sensitive use. For
instance, the illness context studied here, acute upper respiratory tract infection, differs dramatically from chronic conditions that create very different kinds of contexts for decision making and patient participation in health care consultations.

Therefore, this study meets its limits and raises several further research questions at various points. One is the patients’ readiness and willingness to participate as their knowledge on illnesses accumulates over time, as is evident particularly with chronic diseases. Most existing interaction research concerns the communication on acute problems, and less detailed interaction research has been done on actual interaction in routine check-up consultations between doctors and patients with chronic diseases (However, see Collins 2005). Since chronic health problems affect a significant part of the population and require long-time (sometimes life-long) management in which the patient’s empowerment on psycho-social level as well as her or his commitment in somatic illness management is crucial (Kantola 2009), the insufficient research on actual provider-client communication related to these conditions is a major draw-back in our knowledge. Also longitudinal studies on the patients’ ways to participate in illness management in the different stages of the disease would be particularly interesting and informative for the development of ‘the best practices’ in the management of a long-term client-practitioner relationship in chronic diseases.

Second, the primary care context with acute conditions would benefit from combining interaction analysis on the decision making process in the consultation compared with post-consultation surveys on the outcomes such as patient satisfaction, medicine taking and recurrent visits. This would produce resources for the discussion on to what extent patient participatory conduct in decision making with acute conditions should be particularly encouraged, what kind of patient participation leads to profitable outcomes, and what other aspects in consultation, not necessarily directly related to the decision making per se, have an influence on favourable post-consultation behaviours (see e.g. Robinson and Heritage 2006). One such study on this illness condition is possible thanks to the additional data that were collected in this project but were not used in my
own study. After each consultation that was video-recorded for this study, a parent or patient returned to the member of our research team to fill out a short questionnaire on her or his satisfaction with the just preceding consultation. Now that the detailed interaction analysis on the decision making practices in these consultations is done, we could compare the patients’ post-consultation views as they reported them in the questionnaire to their in-consultation communications with their doctors.

Thirdly, longitudinal studies on communication patterns in decision making and other clinical tasks would give information on whether and how physician-patient relationship and patients’ ways and willingness to participate in decision making and other clinical communications has changed in the society in general. This would be a useful resource for training of future doctors, as well as for continuing education of already practicing physicians. For instance, in the Department of Social Research at the University of Tampere there are sets of valuable existing databases. These corpora include 250 primary care consultations from early 90s, 50 consultations from mid-90s and the present data; 98 consultations from the years 2005-6.

Moreover, there are possibilities for conversation analytic studies addressing further the intersection of the models and practices of patient participation in medical interaction. For instance, systematic international comparative studies would give resources to consider the extent to which the patients wish to participate and whether the models of decision making are universally usable for communication regardless how health care is organized institutionally and culturally. Besides giving sociological knowledge on the cultural and national differences in medical communication, the study would have implications for international health and education policies. For instance, the European Union allows its member countries to organize their social policy and health care as they wish, whereas the EU citizens, health care professionals included, are in principle free to work in any member country. Knowledge on possible institutional and cultural differences in communicating could help newcomers to meet the needs of their new work environments. Training implications are also apparent as EU countries are underway of standardizing their higher, including
medical, education. One reform aims to qualify and allow health care professionals to work in any country after getting trained wherever in the EU.

Another research question concerning the intersection of the models and practices of patient participation is that to what extent the training in communication skills has an influence on clinical practices. In this study, I have argued that the interactional conduct in diagnostic and treatment decision making is grounded on the mutual understanding that has been established in the preceding actions and phases of the consultation. In other words, the parties’ orientations to their situated contexts of interaction inform the ways in which they go about in treatment decision making. In turn, an intervention study including naturally occurring data before and after training (for example on the characters of and the competencies in shared decision making) would give evidence on the applicability of the normative models of decision making in the actual clinical conduct.

Policy changes raise potential research questions, too. For instance, the Finnish Parliament has accepted a law reform that enables registered nurses to prescribe and renew prescriptions to illness conditions such as diabetes, some throat infections, asthma and hypertension (concerning the preparation of this law, see http://www.stm.fi/vireilla/lainsaadantohankkeet/sosiaali_ja_terveydenhuolto/am_mattihenkilosto). The authorization concerns only those nurses who work permanently in municipal health centres and who have acquired continuing education. The final authorization to prescribe medicines would be obtained from each health centres’ chief physician. Among the goals of the law reform, one is to reduce the patients’ routine visits to the doctor and thus allocate the doctors’ work force to the management of more complicated illness conditions instead. Also, a goal of the reform is to get rid of an already existing, yet unrecorded practice of nurses handing out doctors’ pre-signed prescriptions to patients, the doctors actually not seeing these patients at all. In the UK, Ireland and Sweden registered nurses have prescribed certain array of medicines for certain illnesses for years and the reported experiences have been good.
Some instances, such as Nuorten Lääkärien Yhdistys (Association for Young Doctors), resist the mandate (http://www.nly.fi/kannanotot-ja-suositukset/cat_view/11-kannanotot-ja-suositukset/12-nlyn-hallituksen-lausunnnot-ja-kannanotot). The opposing argument states that each illness condition to which registered nurses could prescribe medication requires a proper diagnostic procedure and in the end, only a trained doctor has the resources to do this. Nuorten Lääkärien Yhdistys specifically demurs at the inclusion of any antibiotic medication to the array of medicines the nurses could independently prescribe, the reason being the global increase in the development of the antibiotic-resistant bacteria and its relation to the extensive use of antibiotics (see e.g. Goossens et al. 2005), and the possibly severe consequences of the unrecognized complications of improperly diagnosed infections.

Nevertheless, the proposed law came into force on September 1st 2010. Continuing education of nurses is currently underway. Nurse-patient interaction in diagnostic and treatment decision making compared to doctor-patient communication and its influence on the patient’s satisfaction, health outcomes and illness management are relevant and important topics for future research.
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ANTIBIOOTILÄÄKITYKSESTÄ NEUVOTTELEMINEN LÄÄKÄRIN VASTAANOTOLLAA

Amerikkalaisissa tutkimuksissa on havaittu, että lääkärien oletukset potilaan ( tai potilaan vanhempien) odotuksista selittäävät antibioottien kirjoittamista jo kahden vuosiksi pidetyn bakteeritulehduksen olemassaolosta. Tutkimusten perusteella on oletettava, että antibioottimääräysten epääminen on lääkärille vuorovaikutukseksi ongelmallista. Toisaalta on tapauksia, joissa potilas kielletään antibioottista, vaikka selkeä indikaatio sen hyödyllisyydestä olisi olemassa, mikä myös voi aiheuttaa ongelmia hoitosuosituksen neuvoteluissa.

Vastaanottokeskusteluun analysoidaan esimerkiksi, miten mahdollinen antibioottilääkitys otetaan huomioon ja miten potentiaalinen potilaan tarkastus ja hoitosuunnitelma tutkimusohjelmasta käydään ja päätetään vastaanottolla. Tämän perusteella tuotetaan tietoa Suomessa käytössä olevista hoitosuositusten kertomisen tavoista ja siitä, miten hoitosuositusten kertomisen tavoittaminen tapa on yhteydessä niiden ymmärtämiseen ja hyväksymiseen. Tutkimuksen tulokset avulla pyritään parantamaan vastaanottovuorovaikutuksen laatua ja helpottamaan potilastyötä.


Tutkimus tehdään tutkimuksen käsittelyään luottamuksellisesti ja nimettöminä. Tutkimus suorittaa tutkimukseen osallistuvien potilaiden informoinnissa, pystytävät suostumuksen tutkimukseen sekä toteuttavat potilaskysyyn vastaanoton jälkeen. Lääkäreilta tutkimukseen osallistuminen edellyttää lupaa heidän omien vastaanottojensa videoimiseen (käytännössä esim. kahden päivystysvuoron videointi tuottaa yleensä riittävän määrän vastaanottoja).

Korvaakseen osallistumisestaan lääkärillä saavat 100 euron lahjakortin Duodecimin julkaismumyyntiin.

Annamme mielellämme lisätietoja tutkimuksesta.

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Sosiologian ja sosiaalipsykologian laitos, 33014 Tampereen yliopisto
Hyvää potilas,

Pyydämme Teitä osallistumaan tutkimukseen, jossa selvitetään lääkärin ja potilaan välisen vuorovaikutuksen tuloksellisuutta. Pirkanmaan sairaanhoitoopin eettinen toimikunta on antanut tutkimuksesta myönteisen lausunnon. Kerättyä tutkimusaineistoa käytetään tieteellisessä tutkimuksessa, jonka avulla pyritään parantamaan vastaanott ovuroivaikutuksen laatua potilasystävälliseen suuntaan.

Olette saapuneet vastaanotolle ylähengitystie- tai korvatulehdusoireiden takia. Vastaanott ovuroivaikutuksen videoinnin sekä vastaanoton jälkeen tehtävän lyhyen kyselyn avulla tutkimme, miten vuorovaikutus hoitavan lääkärin kanssa sujuu, ja miten tyvyvän olette vuorovaikutuksen sujumiseen.

Tutkimuksessa toivotaan teidän täyttävän suppean kyselylomakkeen vastaanoton jälkeen, sekä pyydätään lupaanne videonauhoittaa vastaanottokäynti. Tutkijat eivät ole itse läsnä vastaanottotilanteessa.

Aineistoa (videonauhoitoksia ja kyselylomakkeita) käsitellään seuraavasti:
1. Aineiston salassapito turvataan niin, että aineistoa käsittelevät allekirjoittavat vaitiolositoumuksen.
2. Aineisto muokataan muotoon, jossa potilaan nimeä, asuin- ja työpaikkaa ja ammattia koskevat tiedot eivät käy ilmi.
3. Tutkimusta raportoitaessa kaikki tunnistamisen mahdollistavat tiedot muutetaan.
4. Tutkimuksessa kerättyä aineistoa käytetään yllämainitun tutkimuksen päätytyyvä vain tieteellisessä tutkimuksessa
5. Aineistoa säilytetään tieteellistä tutkimusta varten 25 vuotta tutkimuksen päättymisen jälkeen.
6. Potilaan erillisellä luvalla aineistoa voidaan käyttää lääkärivakuutuksessa sekä yliopistolisessa opetuksessa.

Teillä on oikeus missä vaiheessa tahansa kieltäytyä tutkimuksesta, syytä siihen ilmoittamatta. Kieltäytymisnen ei vaikuta mahdollisesti myöhemmin tarvitsemaanne hoitoon.

Mikäli Teillä on kysyttävää tai haluatte lisätietoja, vastaamme mielellämme.

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Hyvä potilas ja potilaan vanhemmat,

Pyydämme Teitä ja lastanne osallistumaan tutkimukseen, jossa selvitetään lääkärin ja potilaan välisen vuorovaikutuksen tuloksellisuutta. Pirkanmaan sairaanhoitopiirin eettinen toimikunta on antanut tutkimuksesta myönteisen lausunnon. Kerättyä tutkimusaineistoa käytetään tieteellisessä tutkimuksessa, jonka avulla pyritään parantamaan vastaanottuvuorovaikutuksen laatua potilasystävälliseen suuntaan.

Olette saapuneet vastaanotolle terveyskeskuksen lapsenne (6kk – 10v) ylähengitystietoihin tai korvatulehdusoireiden takia. Vastaanottuvuorovaikutuksen videoinnin sekä vastaanoton jälkeen tehtävän lyhyen kyselyn avulla tutkimme, miten vuorovaikutus hoitavan lääkärin kanssa sujuu, ja miten tyytyväinen olette vuorovaikutuksen sujumiseen.

Tutkimuksessa toivotaan teidän täyttävän suppean kyselylomakkeen vastaanoton jälkeen, sekä pyydetään lapsenne videonauhoittaa lapsen vastaanottokäynti. Tutkijat eivät ole itse läsänä vastaanottotilanteessa.

Aineistoa (videonauhoituksia ja kyselylomakkeita) käsitellään seuraavasti:  
1. Aineiston salassapito turvataan niin, että aineistoa käsittelevät allekirjoittavat vaitiolositoimeksuksen.  
2. Aineisto muokataan muotoon, jossa potilaan tai hänen vanhempiensa nimeä, asuin- ja työpaikkaa ja ammattia koskevat tiedot eivät käy ilmi.  
3. Tutkimusta raportoitaessa kaikki tunnistamisen mahdollistavat tiedot muutetaan.  
4. Tutkimuksessa kerättyä aineistoa käytetään yllämainitun tutkimuksen päättyttyä vain tieteellisessä tutkimuksessa.  
5. Aineistoa säilytetään tieteilistä tutkimusta varten 25 vuotta tutkimuksen päätymisen jälkeen.  
6. Potilaan vanhempien erillisellä luvalla aineistoa voidaan käyttää lääkärikoulutuksessa sekä yliopistollisessa opetuksessa.

Teillä on oikeus missä vaiheessa tahansa kiellettyä tutkimuksesta, syytä siihen ilmoittamatta. Kiellettyymisenne ei vaikuta mahdollisesti myöhemmin tarvitsemamaan tai lapsenne tarvitsemaan hoitoon.

Niiltä lapsilta, jotka kykenevät ymmärtämään tutkimuksen merkityksen, pyydetään myös suostumusta tutkimukseen. Lapsen vastustautaessa tutkimusta noudatamme hänen mielipidettään.

Mikäli Teillä on kysytävää tai haluatte lisätietoja, vastaamme mielellämme.

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Toimipaikka: Sosiologian ja sosiaalipsykologian laitos, 33014 Tampereen yliopisto
Olen saanut sekä kirjallista että suullista tietoa vastaanottovuorovaikutusta ja sen tuloksellisuutta selvittävästä tutkimuksesta ja mahdollisuuden esittää siitä tutkijoille kysymyksiä.

Olen saanut tiedon, että aineistoa (videonauhoitukseja ja vastaanottoja koskevia lääkemääritystietoja) käsitellään seuraavasti:
1. Aineiston salassapito turvataan niin, että aineistoa käsittelevät allekirjoittavat vahvistettavat salassapitotarkastuksen.
2. Aineisto muokataan muotoon, jossa nimeäni, SV-numeroani ja toimipaikkaani koskevat tiedot eivät käy ilmi.
3. Tutkimusta raportoitaessa kaikki tunnistamisen mahdollistavat tiedot muutetaan.
4. Tutkimuksessa kerättyä aineistoa käytetään yllämainitetun tutkimuksen päättyttyä vain tieteellisessä tutkimuksessa
5. Aineistoa säilytetään tieteellistä tutkimusta varten 25 vuotta tutkimuksen päätymisen jälkeen
6. Erillisellä luvallani (ks. alla) aineistoa voidaan käyttää lääkärikoulutuksessa sekä yliopistollisessa opetuksessa.

Ymmärrän, että tutkimukseen osallistuminen on vapaaehtoista ja että minulla on oikeus kielletä sitä milloin tahansa syytä ilmoittamatta ja pyytää, että mahdollisesti jo nauhoitettu aineisto tuhotaan.

Paikka ja pvm_____________ ____.200_ Paikka ja pvm_____________ ____.200_

Suostumus osallistumaan tutkimukseen:

lääkärin allekirjoitus

nimenselvennyys

SV-numero

toimipaikka

Suostumus vastaanottaja:

nimenselvennyys

Suostun siihen, että videoaineistoa voidaan hyödyntää lääkärikoulutuksessa ja yliopistollisessa opetuksessa:

lääkärin allekirjoitus
VASTAANOTTOVUOROVAIKUTUSTA SELVITTÄVÄ TUTKIMUS

Olen saanut sekä kirjallista että suullista tietoa vastaanottovuorovaikutusta ja sen tuloksellisuutta selvittävästä tutkimuksesta ja mahdollisuuden esittää siitä tutkijoille kysymyksiä.

Olen saanut tiedon, että aineistoa (videonauhoitoksia ja kyselylomakkeita) käsitellään seuraavasti:
1. Aineiston salassapito turvataan niin, että aineistoa käsittelevät allekirjoittavat vaidolositoumukseen.
2. Aineisto muokataan muotoon, jossa nimeäni, asuin- ja työpaikkaani ja ammattiosi koskevat tiedot eivät käy ilmi.
3. Tutkimusta raportoitassa kaikki tunnistamisen mahdollistavat tiedot muutetaan.
4. Tutkimuksessa kerättyä aineistoa käytetään yllämainitun tutkimuksen päätyttyä vain tieteellisessä tutkimuksessa.
5. Aineistoa säilytetään tieteellistä tutkimusta varten 25 vuotta tutkimuksen päättymisen jälkeen.

Ymmärrän, että tutkimukseen osallistuminen on vapaaehtoista ja että minulla on oikeus kielletytyä siitä milloin tahansa syytä ilmoittamatta ja pyytää, että mahdollisesti jo nauhoitettu aineisto tuhotaan.

Paikka ja pvm____________ ___.___.200_ Paikka ja pvm___________.___.200_

Suostun osallistumaan tutkimukseen: Suostumukseen vastaanottaja:

potilaan allekirjoitus

nimenselvennys

osoite

Suostun siihen, että videoaineistoa voidaan hyödyntää lääkärikoulutuksessa ja yliopistollisessa opetuksessa:

potilaan allekirjoitus
SUOSTUMUS

ETL-koodi R04143

VASTAANOTTOVUOROVAIKUTUSTA SELVITTÄVÄ TUTKIMUS

Olen saanut sekä kirjallista että suullista tietoa vastaanottovuorovaikutusta ja sen tulosellisuutta selvittävästä tutkimuksesta ja mahdollisuuden esittää siitä tutkijoille kysymyksiä.

Olen saanut tiedon, että aineistoa (videonauhoituksia ja kyselylomakkeita) käsitellään seuraavasti:
1. Aineiston salassapito turvataan niin, että aineistoa käsittelevät allekirjoittavat vaitiositoimikunnan.
2. Aineisto muokataan muotoon, jossa nimeäni, lapseni nimeä, asuin- ja työpaikkaani ja ammattiani koskevat tiedot eivät käy ilmi.
3. Tutkimusta raportoittaessa kaikki tunnistamisen mahdollistavat tiedot muutetaan.
4. Tutkimuksessa kerättyä aineistoa käytetään yllämainitun tutkimuksen päätyttyä vain tieteellisessä tutkimuksessa
5. Aineistoa sääliytetään tieteellistä tutkimusta varten 25 vuotta tutkimuksen päättymisen jälkeen.

Ymmärrän, että tutkimukseen osallistumisen on vapaaehtoista ja että minulla on oikeus kieltäytyä siitä milloin tahansa syytä ilmoittamatta ja pyytää, että mahdollisesti jo nauhoitettu aineisto tuhotaan.

Paikka ja pvm _____________ ___.200__ Paikka ja pvm _____________ ___.200__
Suostun osallistumaan tutkimukseen: Suostumukseen vastaanottaja:

______________________________ __________________
potilaan vanhemman allekirjoitus

______________________________ __________________
nimenselvennys

______________________________ __________________
lapsen nimi

______________________________ __________________
osoite

Suostun siitä, että videoaineistoa voidaan hyödyntää lääkärikoulutuksessa ja yliopistollisessa opetuksessa:

______________________________ __________________
potilaan vanhemman allekirjoitus
APPENDIX II: TRANSCRIPT NOTATION

word. period marks lowering pitch (turn-ending)
word, comma marks level pitch (turn-ending)
word? question mark marks rising pitch (turn-ending)
<word> talk produced on slower pace than surrounding talk
>word< talk produced faster than surrounding talk
↑word word/sound uttered with higher pitch
↓word word/sound uttered with lower pitch
°word° talk/sound produced in silent voice
.word word/sound uttered while breathing in
[word onset of overlapping talk
word] offset of overlapping talk
#word# talk/sound produced with creaky voice
=word utterance started immediately after preceding one ends
WORD capital letters mark talk/sound uttered in high volume
word underlying marks stressed words/sounds
wo:::rd semi-colons mark prolongation of words/sounds
word< word/sound cut-off or ended abruptly
fworf£ smiley voice
wo(h)rd talk/sounds uttered with laughter
(word) word/sound unclear for transcriber (the best guess in brackets)
(0.5) pause in talk in seconds and tenths of seconds
(.) micro-pause (less than 0.2 seconds)
.hhh inhale
hhh exhale
((note)) transcribers notes, e.g. gestures ((nods))

PRT particle (discourse particles that do not translate, such as niin, and in some contexts kyllä, no and joo/juu)
+ combines the English words that are needed to translate one
Finnish word

- marks the Finnish compound noun

-PAS passive

+COND conditional

Ø-person sentence includes a verb that conjugates in a third person form but does not include the subject

+also conveys the meaning of Finnish suffix –kin

+Q verb in question form (Finnish suffix –ko, -kö)

+of-course conveys the meaning of Finnish suffix –hän, -han

+in, +from, etc English preposition that is needed to translate the word
APPENDIX III: FULL DATA EXTRACTS

The original data extracts are provided here with 2-line translations. The first line shows the original Finnish transcript, the second one their word-by-word translations (in *italics*), and the third line represents the data as presented in the articles 2-5 (in *bold font*).

PATIENT INVOLVEMENT IN PROBLEM PRESENTATION AND DIAGNOSIS DELIVERY IN PRIMARY CARE

Excerpt 1

Problem presentation (Consultation 57)

01 D niin (.)) niin kertokaapa nyt,
    PRT PRT tell+you now
    yeah (.)) so tell me,
02 (0.8)
03 P se on tämä: (.) rinta kippee tämä (.)
    it is this chest painful this
    it's thi:s (.)) pain in the chest
04 [näi.
    that+like
    over (.)) [here.
05 D [mm::?,
06 (1.2)
07 P ja (0.8) s- (.)) on (.)) on (.)
    and is is
    and (0.8) I- (.)) am (.)) am (.)) I
08 ei o nii hyvä olo ollu että hh. (0.3)
    not has like+that good feeling been that
    haven't been feeling too good soh
09 miä kävin eilen ni: (.)) venneenki: (nostamas)
    I went yesterday PRT rowing-boat+also (lift)
    h (0.3) yesterday I went to: (.)
10 mut ei (.)) k' hiki kyl ihan virtanaan "tul"o.
    but no sweat PRT quite flowing came
    (lift) a rowboat but no (.)
11 indeed< I was sweating all "over".
12 (0.4)
Diagnostic phase (Consultation 57)

01 D nii sehän on se lääkekuuri nyt
PRT it+of-course is it course-of-medicine now
so you’re now still on

02 meneillään edelleenki
göing-on still+also
that medi[cation aren’t you]

03 P [o:n. vielä on]
is still is
[ ye:s. a week ]

04 vii[kko.]
week
sti[ll.]

05 D [ kyl]lä (0.2) joo.
PRT yes
[yes] (0.2) yes.

05 (0.4)

06 D .hh

07 (1.1) ((Patient gets dressed))

08 P .hh oon minä sitä syöny.
have I that eaten
.hh I’ve been taking those.

09 (2.4) ((Patient gets dressed))

10 D istukaa vaan siihen.
sit+down just there
please go ahead and sit down.

11 .hhh (. ) tuota:
that
.hh ( . ) erm:

12 (0.6)

13 D [siel]lä:
there
[ther]e:

14 P [æhh.]
[ehh.] ((sits down))

15 D (. ) on niinkun

are like that

(. ) are like signs that there

16 merkkejä että poskionteloisakin on

signs that sinuses + in + also is

is infection in the si[nuses ]

17 P                               [ hhh. ]

18 D tu[lehdus]tah.

infection

tooh.

Excerpt 2

Problem presentation (Consultation 87)

01 D mikä <on,> hhh (0.2) asia?

what is thing

<what’s> hhh (0.2) going on?

((mutual gaze))

02 P no toi, (. ) kurkku kipee? (0.2)

PRT that throat painful

well that, (. ) sore throat?

03 sitten #tota, (. ) nieleminen aina

then that swallowing always

(0.2) then #erm, (. ) it’s painful

04 sattuu ja,# (0.2) en pystyny

aches and I + not could + not

to swallow and,# (0.2) I can’t

05 kunnolla syömäään.

properly eat

eat properly.

06 (0.2) ((Doctor takes notes, nods))

07 P hyvin pientä?

very little

very little?

08 (0.4) ((Doctor writes))

09 D joo-o?

yes

yea-h?

10 P ja sit on ollu kuumetta tossa

and then is been fever there

and then I’ve had fever in the

11 aikasempina päivinä ja, (0.2)

earlier days and
past few days and, (0.2)

12 päättä särkeny?
   head ached
   a headache.

13 (1.2) ((Doctor nods, takes notes
   and moves gaze to Patient))

14 D mitä vielä.
   what still
   what else. ((mutual gaze))

15 P en mä muista oliks siin muuta.
   I+not I remember was+Q there else
   I don’t remember if there was

16 anything else.

17 (0.2)

18 D .hhh (0.4) kuinka monta päivää
   how many days
   .hhh (0.4) for how many days

19 sitä kurkkukipua on ollu.
   that throat+ache is been
   you’ve had a sore throat.

Diagnostic phase (Consultation 87)

01 (1.2) ((Doctor palpates
   Patient’s lymph nodes))

02 D <joo-o?>
   yes
   <yea-ah?>
   ((Doctor moves away from Patient))

03 ↑noh, (1.0)
   PRT
   ↑well, h (1.0) ((mutual gaze))

04 .tch (.) tää on, (0.4) virustauti
   this is         viral+illness
   .tch (.) this is, (0.4) a viral

05 tai ↑bakteeritauti. (0.2) .hh ja
   or bacterial+illness and
   illness or a bacterial illness.

06 jos tää on virustauti, (0.5) niin,
   if this is viral+illness PRT
   (0.2) and if this is a viral

07 (0.2) meil ei oo siihen mitään,
   us+with no is it+for any
   illness, (0.5) then we don’t have
Problem presentation (Consultation 10)

01 D  joo::?, (0.3) mikäs (.). mikäs sul³la³, yes what what you+with yea::h?, (0.3) what’s (.). what’s

02  “up³, ((Doc sits down))

03  (0.3) ((mutual gaze))

04 P  no ↑mää luumlen että poskiontelontulehdus ku mul on FRT I think that sinus-infection because I+with have well ↑I think I’ve got sinus

05  täälä painetta ja iha’ vihreää on toi (.). here pressure and quite green is that infection because I have pressure

06  here and phlegm is all green

07  (.). ((pat. points to cheekbones))

08 P  räkä ja se el kulje niinku helposti phlegm and it not move that+like easily and it doesn’t run easily

09  sie[lä että] there that the[re so,]

10 D  [tääni vä]hän honot³t[aa³]. voice little odd [³your vo]ice is a bit

11  [³odd³. £ ]
12 P [vähähönottaa joo] 
little odd yes

[fa bit]

13 od[df] yeah

14 D [.h et siis semmone] 
that I+mean that+like
.[.h so that kind of]

15 ääni et sointi [et kylälä sul saattais olla, 
voice the sound [that you] 
that PRT you+with may+COND be sound that sound

16 P [mm:, ]

17 D may have it indeed, ((turns toward a computer))

Diagnostic phase (Consultation 10)

01 D katotaas tää terveempi poski ekaks,
look+let+us this healthier cheek first
let’s look at the healthier

02 side at first,

03 (1.5) ((Doc examines))

04 D täällä ei ole tautia =vähän toi limakalvo
here no is illness little that mucus-membrane
there’s no illness here=the

05 on paksuuntunu .hh
is thick+got
membrane is just a bit thicker

06 mä kokeilen tätä puolta käytän samaa geeliä ↑uudelleee.
I try+I this side use+I same gel again
.hh (.) I’ll try it from this

07 side then I use the same gel

08 ↑again.

09 (2.8) ((Doc examines))

10 D täällä on tau:ti.
here Is illness
there is an illness he:re.

11 (2.5) ((Doc examines))

12 P siltä puolelta se on kipeempiki.
that+from side it is painful+more+also
it hurts more on that side too.

13 (0.9) ((sinus exam ends))
Excerpt 4

Problem presentation (Consultation 17) ((D = doctor, F = father))

01 D no ni[:h] mitäs Taavilla.,
  PRT PRT what with+((name))
  okay[:h] wh[at’s with Taavi.,

02 F [täti ( ) ]
  aunt
  [lady ( )] ((talks to the child))

03 F Taavil on ollu nyt viikon verrä< (0.5) .hh kova nuhah?
  Taavi+with has had now week ((“about”)) hard cold
  Taavi has had a *sniffles?< (0.5)

04 .hh for a week now?

05 (0.2)

06 j[a, ]
  and
  a[nd, ]

07 D [joo?] 
  yes
  [yes?]

08 F tota nii nii, (0.6) .hh nyt o’ pari yä- nii yötä
  that PRT PRT now is couple night PRT nights
erm, (0.6) .hh now it’s been

09 menny tai alkuyö-
  nii yötä menny tota
  went or early-night PRT nights went that
  hutaes
  screaming+while
  a couple of ni< erm nighths or

10 early< erm nights he’s been

11 =heti ku’ hä pistää päään makuulleen nii
  immediately when he puts head lay+down PRT
crying =right after he lies

12 down and puts his _head on the

13 sit al*kaa huto.
  then starts scream
  pillow he sta*rts crying*

14 D ju:st.
  exactly
  ri:ght.

15 F =.hh nii mää tiiä et vo[is ] korvis olla <jottai>.
  PRT I know that can+COND ears+in be something
  =.hh so I don’t know if he could
have something in his <ears.>

D nii:. no [ihan,]
PRT PRT quite
nii:. well [quite,]

[.hh ]

(.)

pääteilty =oks hää <yskiny> kovin tai, well concluded has+Q he coughed lot or
we[ll ] (. ) judged=has he been

[Tmmh. ]

coughing> a lot or,

Diagnostic phase (Consultation 17)

((doctor examines))

[no se on kyl<
PRT it is PRT
[well it’s indeed<

ääghh

(.)

tää on tuleh*tunu*. this is infected
this is infec*ted*. 

D nii se on sem[monen ryppyn[< ja punanen,
PRT it is that+like wrinkled and red
nii it’s li[ke

[mh

wrinkle[d< and red, ((examines))

[joo. yes
[yes. ((ear exam ends))

et se e< ei kyl, (0.4) sillai kauheesti et
that it no no PRT like+that terribly that
so that i< it’s not (0.4) like

siel ei hirveesti sitä märkää oo mut
there no terribly that discharge is but
there isn’t terribly lot of

certainly exactly then when he goes
discharge but indeed when

makuul[le ni
lay down PRT
[he< ] lies do[wn the

14 F [nii.] PRT
[aivan., exactly
[yeah.] [exactly.,

15 D se paine tulee #siält nih,# it pressure comes there+from PRT the pressure comes #from there

16 soh,#

Excerpt 5

Problem presentation (Consultation 83) ((D = doctor, M = mother))

01 D .hhh joo (. ) mitäs maij°alla°, yes what ((name))+with
.hhh yes (. ) what’s with Maija°,

02 (0.7)

03 M maijal on kor°va kipee°. Maija+with has ear painful Maija’s having an ear ache°.

04 (0.3)

05 D mm.

06 (0.8) ((D reaches the ear exam device from the desk))

07 D onks ollu kaua?, have+Q been long-time+for has she had it for a long time?,

08 M no nyt illalla #se rupees valittamaan° sitä et se o°, PRT now in+the+evening it started complain it that it is well now in the evening #she

09 started to complain about it#

10 °so it’s°,

11 (0.3)

12 M sil on ollu pit°kää° (.), ’nuhaa ja ys°kää°. it has had long-time+for sniffles and cough she’s have (.) ’sniffles and

13 cough for °longer time°.
Diagnostic phase (Consultation 83)

01 (9.0) ((Doc examines))

02 D #tää on ihan reilusti tulehtu#nu tää kor°va°, this is quite generously infected this ear

03 it's really heavily infec#ted

04 that °ear, °

05 (.).

06 D näyttä toine, show other

show me the other one,

07 (0.5) ((child turns))

08 D se: #on ihan punane# ja pullot°taa°. it is quite red and swollen

09 it’s: #really red and swol°len°.

08 (0.5) ((Doc exams the other ear))

09 M joo sitä se valittaakív °just°. yes that it complains+also exactly

yeah that one she complains

10 °about°.

11 D #joo.°

12 (0.7)

11 D #joo.°

12 (0.7)

13 D tää korva ei oo niin pahan näkönen, this ear no is that+like bad looking

14 (1.6) ((ear exam ends))

this one doesn’t look too bad,

Excerpt 6

Problem presentation (Consultation 62)

01 D no minkäslaista asiaa sinulla oli, 
PRT what+kind+of thing you+with had

02 (0.7) well what brings you here,
03 P no minulla on kyllä pitkittyny yskä että minä oon nyt
PRT I+with is PRT prolonged cough that I have now
well I have a prolonged cough

04 viime yön oikeastaan yskiny ihan koko yön,
last night actually coughed quite all night
so that last night I did nothing

05 but coughing all the time

06 nyt en oo nukkunun paljo ollenkaan et se o semmosen
now not+I have slept lot at+all that it is like
actually I haven’t slept almost

07 at all so that it’s been over a

08 releun viikon,
over week
week now,

09 (0.4)

10 D mm↓↓↓?

11 (.)

12 P on ollu.
has been
like that.

13 (1.2)

14 D mit[e se]
how it
ho[w did it]

15 P [ja: ]
and
[a:nd ]

16 (.)

17 D nii?
PRT
yeah?

18 (0.2)

19 P nii että mulla on astma on ja (0.5) sillä lail et
PRT that I+with have asthma is and that+like kind that
so that I’ve got asthma and (0.5)

20 se sitte heti kyllä vaikuttaa että on nii pa-
it then immediately PRT effects that has so/PRT
so it effects right away that I

21 (.) ollu niitä poskiontelon tulehukuja ja,
been those sinus-infections and
have lo- (.) I’ve had sinus
I’ve got here also (0.3) feeling

tähän oikee puoli että täältä ei oikeastaan lähe mittää. this right side that here+from not actually leave anything

that at least this right side is

like totally congested.

( .)

D  mm?:?,

(0.7)

D  .hh tuota mites tää alko et alkoks se yskäl that how this started that started+Q it cough+with .hh ( .) erm how did it begin did

nuhali oliko sul niinku #ää ( .) kurkku kipee ensi?, 
sniffles+with had+Q you+with that+like throat painful at+first
it start with cough sniffles or

did you have like #e# (. ) throat

did you have like #e# ( .) throat

Diagnostic phase (Consultation 62)

(0.3) ((stethoscope exam ends))

02 D  joo::?, ( .) .hh et tietysti nuo nyt #ö-# yes that of+course those now yea::h?, ( .) .hh so that of

(0.3) noi oireet ja (. ) ja sitte tuo ultraääni #i-# those symptoms and and then that ultra-sound course those #e-# (0.3) those

(0.5) löydös ja tietysti että limaa on finding and of+course that phlegm is symptoms and ( .) and then the

ultra sound #e-# (0.5) finding

nielussa ni sopis siihen että siellä tosiaan throat+in PRT fit+COND there that there indeed and of course the phlegm in your

throat would indeed fit to the

poskiontelontulehdus on, sinusitis is
PATIENT RESISTANCE TOWARD DIAGNOSIS IN PRIMARY CARE: IMPLICATIONS FOR CONCORDANCE

Extract 1 (Consultation 12)

01 Doc °>jooh< pistä päälle°=noi keuhkot on #ihan:# noi
   yes put+you on those lungs are quite
   like-
   °>yeah< put the shirt on°=the lungs are #qui:te# by

02 kuunnellen puhtaat elikkä,
   listening+by clean in+other+words
   listening they are clear so,
   (.)

04 Pat [KRH] ((coughs))

05 Doc [enem]män se olis tual poskionteois siältä
   se valu
   more it be+COND there sinuses+in there+from
   it drips
   [it’d] be more in the sinuses it’s dripping from
   there

06 ja sä, (0.4) vedät sitä alaspäin sitte.
   and you pull+you it downwards then
   and you, (0.4) get it down on your throat then.

07 (.)

08 Pat joo:-o?
   yes
   yea:h? ((mutual gaze))

09 Doc <pistä paintaa päälle vaan.>
   put+you shirt on just
   <go ahead put your shirt on then.>

10 Pat khhhhh (0.2) hhhhhhhh ((starts getting dressed))

11 Doc mä paan antipiootin sulle, (0.3) ei auta mitää,
   I put antibiotic you+for no help anything
   I’ll put you on antibiotics, (0.3) that’s what one

12 has to do,
Extract 2, represented as Extract 6 (Consultation 68)

01 Doc antibioticinha tuo vaatis koska korva on tulehtunu
antibiotics+of-course that require+COND because ear is infected
it would require antibiotics because the ear is infected

02 ja se voi olla että se on jääny (. ) muhimaan siit
and it might be that it has left lingering that+from
and it might be that it’s been (. ) lingering there since

03 edellisestäkin?, (0.2) infektio[stakin,
previous+also infection+also
the previous?, (0.2) infec[tion,

04 Mom [ne katto sillon korvat
they looked then ears
[they did examine her ears

04 ainaki ja sano että ei oo.,
at-least and said that not is
then and said that she doesn’t have it.,

06 Doc joo sillon (0.2) ku [kävitte,
yes then when visited+you
yeah when (0.2) you [visited,

((talk about the previous visit continues))

Extract 3, represented as Extract 7b (Consultation 8)

01 Doc [ elikä se paine siälä sitte vaihtelee
in-other-words it pressure there then changes
but that [so ]the pressure inside the ear changes then but

02 ite siel korvas ei oo tulehdusta ky[llä?,
itself there ear+in not has infection actually/PRT
the ear itself is not infected ac[tually?,

03 Pat [ joo.]
yes
[ yeah. ]

04 (0.4)

05 Pat se o’ just ku se on iha saman tuntune ku tääl
it is exactly as it is quite same feeling as here
was
it’s just because it feels exactly the same as it

05 silllon ku se alko se tulehdus, (0.4)
then when it started it infection did here when the infection started, (0.4)

I [got it in the sinus]es first but when I finally visited a doctor when I realized it won’t

(se parane ni nyt se on menny jo korvaan asti?) it heal PRT now it has gone already ear in to heal so now it has gone to the ear already?

(1.1) ((mutual gaze))

(joo:?, (0.3) kai se (0.5) viksumpi o panna piäni yes probably it wiser is put little yeah:? , (0.3) I guess (0.5) it’s wisest to put you on some antibiotics and [ see ] how it startles course-of-antibiotics and look how it works,)

Extract 4 (Consultation 21)

((Doc examines patient’s sinus[uses] with ultra sound))

(ei siält kyl nyt ↑tuu semmost merkki et siäl, no there+from PRT now come that+like sign that this doesn’t now ↑give the kind of sign that there’d be,)

(. ) ((exam continues))

(kui se noi kauheen kipee o. how it that terribly painful is how come it hurts so much.)

*niī-ih?,*

(0.5)

(ei kai se tual ot"sas vois ollah, no probably it there forehead+in can+COND be)
it couldn’t be in my forehead could it,

Extract 5 (Consultation 82)

01 Doc et koska noit nivelkipuja on ni se on parempi sitête
that because those joint-pain is PRT it is better then
so because you have that joint pain it’s better

02 otaa ne tuulehdusnäytteet#. (.) mut et
muuten ni
take 0-person those infection-samples but that
otherwise PRT
to #take the blood sample#. (.) but otherwise the

03 vaikutelma on ihan se et sul on virustauti
impression is quite it that you+with is viral-illness
impression is quite that you have a viral illness (.)

04 .hh joka parane joka parane kyllä itekseensä
which cures which cures PRT on+its+own
.hh that will indeed cure on its own #as long as you

05 #kun vaan malttaa pikkasen levätä ja,#
as just keeps 0-person little rest and
just keep resting a bit and,#

06 (1.3)

07 silole[e].
that+like
li[ke [that].

08 Pat [mut kyl tää siis kyl tää huomattavasti
kovempi on
but PRT this then PRT this notably
harder is
[but this is indeed I mean this is indeed notably

09 mitäh mul on ollu siis sano[taan
what I+with has been I+mean say+let+us
worse than what I’ve had like let’s [say

10 Doc [mm::.

11 (0.4)

12 Pat kahteen kolmeenkymmeen' vuoteen et,
two(twenty) thirty+for years+in that
for twenty thirty years so,

13 Doc mm::.

Extract 7a (Consultation 8)
Doc [ .h]hh ( .) joo, ( .) .h mitäs kuuluuh, yes what hear
[ .h]hh ( .) right, ( .) .h how’s it going,
(0.4)

Pat .hhh no ( .) kiitos muuten kuuluu oikeen hyvää
mutta
(0.9)
PRT thanks otherwise hear really good but
.hhh well ( .) thanks otherwise it’s going very well
but

nyt on niinku ( .) tänä talvena tuntunu et ollu
now is PRT this winter felt that has been
(0.9) now I’ve had like ( .) this winter I’ve felt
that

(0.3) semmone flunssa et ei o ollu
that+kind+of flu that not has been
niinku monee' vuoteen=mul oli
that+like many+for years I+with had
I’ve had (0.3) a kind of flu that I haven’t had for
many

kauheen ( .) paha poskiontelo' ja korvatulehdus tossa
ja mä
terribly bad sinus and ear-infection there
and I
years=I had terribly ( .) bad sinus and ear infections

söin lääkekuurin ( .) .hh se loppu ↑viikko sitte?,
ate course-of-medicine it ended week ago
and I was on medication ( .) .hh I finished it a ↑week

nyt must tuntuu et mul oireilee toinen korva
joka
now I feel that I+with symptom+have other ear
which
ago?, ( .) .tch now I feel that I have symptoms in the

piti olla sillon kunnos°sa°, was-supposed-to be then condition+in
other ear that was supposed to be fine back °then°,

Extract 8a (Consultation 76)

Doc .hh ( .) osaatko kuvata tarkemmin miten koskee
can+your+Q describe precisely+more how aches
.hh ( .) can you describe it more precisely how

(0.3)
04  Pat  #n-# (.) no tuntuu että (0.9) no tuntuu siltä kun
PRT feels that PRT feels that+like
when
#w-# (.) well it feels like (0.9) well it feels like
05  mul oli kur#kunpääntulehdus toss[a#
I+with had laryngitis there
when I had laryngitis the [re#
06  Doc                         [nii,
PRT
[yeah,
07  (.)
08  Pat kesällä ni tuntuu ihan samal°ta°. (0.8) ni
in-the-summer PRT feels quite same PRT I
in the summer so it feels exactly the sa°me°. (0.8)
09  #ajattelin et mul on taas kurkunpän#°t[ulehus°.
thought+I that I+with is again laryngitis
so I #thought that I have laryngitis° a[gain°.

Extract 8b (Consultation 76)

01  Doc  .hhh tuota: (.) #ö-# (.) niinkun ei näytä
that PRT no show
.hhh erm: (.) #e-# (.) so it doesn’t look like a
02  bakteeritulehdukse[lta vaa]n virustulehdukselta
bacterial-infection just viral-infection
bacterial infec[tion but a] viral one but
03  Mom                         [ nii:, ]
PRT
04  Doc  mut [se ] kannattaa varmistaa sil
but it worth+to confirm that+with
nielunäyt[teellä.
throat-sample
[it’s] worth to check it with the throat cul[ture.
05  Mom                         [nii.³
PRT
06  (.)
07  Doc  se asia.
that(the) thing
this situation.

³ In this data extract, I have chosen not to translate the mother’s (or the doctor’s) nii-particles. The reason for this is that the nii-particles are central in the analysis of how the mother and the doctor convey disagreement with regard to the diagnosis and treatment recommendation (Sorjonen 2001).
08 (0.6)
09 Mom .thh no sillön edelliskerralla sillä oli just silleen
PRT then last-time that+with was exactly that+like
.thh well the last time she had it exactly like such a
10 #että tuota# .hh se ei näkyny (. ) mut[ta sit]ten tota::
that that it no showed but then that way #that erm# .hh it didn’t show (. ) b[ut the]n erm::
11 Doc [ mm. ]
12 ( . )
13 Mom .hh ne- (. ) kuitenki kirjotettiin et- (. )#n# se:
those however write+PAS that it
antibioottikuuri
course-of-antibiotics
.hh tho- ( . ) anyhow she was prescribed th- (. )#n# the:
14 .h (. ) ja (. ) sitten tuota: .hh (1.2) katottiin< (. )
and then that looked+PAS antibiotics .h (. ) and (. ) then erm: .hh (1.2) we waited<
15 >kohan me myös seuraavaan #päivään (. ) s- se vielä#
Q+also we also next+till day+till it still (. ) perhaps until the next #day too (. ) s- still#
16 ( . )
17 Doc mm[: . ]
18 Mom [ ja] sitten [hajet#tiin v[asta se ja (. ) ote]ttii
and then fetched+PAS only it and took+PAS
[and] only then we fill[ed it in and (. ) to]ok it
19 Doc [ joo:. (. ) joo. ]
yes yes
[ yeah:. (. ) yes. ]
20 Mom että ei heti.#
that no immediately
so that not right away.#
21 ( . )
22 Doc joo minusta se kannattaa sillä viljellyllä nyt
yes me+from it worth+to that+with culture+with now
yeah I think it’s worth to make sure with that
23 varmi[staa] et siitähän sen näkee sitte.
confirm that that+from it see+0-person then
cultu[re now] so that’s where you’ll see it then.
24 Mom [ nii. ]
25  (0.4)
26  Mom .thh (.) et ku sillä oli se kurkunpää vaan that because that+with was it larynx only
tu[lehtunu.]
infected
.thh (.) because it was just her larynx
27  that was infected.
28  Doc [joo. n]ii
   yes PRT
   [yeah. nii]
29  että ei muuten mut nyt ku se näyttää olevan siellä that no otherwise but now because it seems be+to there so otherwise not but now that it seems to be there in
(. ) sanoit et samalta tuntuu mut siellä nielurisan said+you that same feels but there palatine-tonsil the (.) you said it feels the same but there in the
30  reunassa näyttää se pahin (.) vasem#malla olevan nyt se# edge+in show it worst left+on be+to now it edge of the palatine tonsil it seems to be the worst (. )
31  pahin punotus tällä hetkellä. (0.9) .hhhh niin (. ) worst redness this moment+at PRT on the #left side the# worst redness at the moment. (0.9)
32  menisit nyt laboratorioo ja huomenna se soitto go+you+COND now laboratory+to and tomorrow that(the) call .hhhh so (. ) now you’d go to the lab and make the call
33  koska se [viljel]y kestää se' ver#ran aikaa#. because that(the) culture lasts that much time tomorrow since that [cultur]e takes that #much time.#
34  Mom [ joo. ]
   yes [ yeah. ]
Excerpt 1 (Consultation 80)

01 Pat [se]mmonen huimauslääke ja like+that dizziness-medicine and [one] for dizziness and.
02 (0.3)
03 Doc mm::,
04 Pat nyt se huimauskin on taas ollu semmesta pahaa now it dizziness has again been like+that bad now that dizziness has also
05 laatua nyt on käveleminen on vaikeita ja quality now is walking is difficult and been of the worse kind now walking is difficult and.
06 (0.3) ((Doc gazes at computer))
07 (0.8) ((Doc gazes at computer, Pat gets dressed))
08 Doc °hjoo:* yes
°hyea:h°
09 (0.7)
10 joo ku TEIL ON NOIN MONTA SAIRAUTTA yes because you+with have that many illnesses yes since YOU HAVE SO MANY
11 NI LAITETAAN SITTE' TOI TOTA (0.7) PRT put+PAS then that that ILLNESSES LET'S PUT YOU ON
12 .hh ANTIBIOOTTIKUURI nytte, course-of-antibiotics now THE ERM (0.7) .hh ANTIBIOTICS
13 now, ((gazes at computer))
14 (3.4) ((Doc gazes at computer, Pat gets dressed))
15 Doc onks mitää LÄÄKE#lergioita,# have+Q any medicine-allergies do you have any MEDICINE
AL#lergies,#

(0.4) ((Doc gazes at computer, Pat gets dressed))

Pat no en oo huomannu.

PRT not+I have noticed
well I haven’t noticed.

(0.4) ((Doc continues writing))

Excerpt 2 (Consultation 25)

((Father and doctor talk about children’s recurrent illnesses in nurseries))

01 Doc kosk kaikishan niissä kyllä on ku ne because all+in+of-course those+in PRT It is as those since in every nursery they

02 taudit kiertää.,
ilnesses circulate

03 have these as these infections

04 circulate.,

(0.5) ((Doc turns toward computer))

05 Doc mä paan kuitenki silmätippaa., (0.4) .mt I put+I however eye-drop
I prescribe eye drops anyhow.,

(.){(Doc gazes at computer)}

06 antibioottitippaa., (0.6) fuse<traalikkia>,
antibiotic-drop ((name))
.tch antibiotic drops.,

07 fuse<tralic,.>

08 (0.6) ((Doc gazes at computer))

09 fuse<tralic,.>

10 (0.7) ((Doc gazes at computer and writes))

11 Dad mites ny sitte muu peröhe°.
how now then other family

12 how about the rest of the

family °now°.

13 (0.5)

14 Doc tota, (.2) tästätuubista (.) jos muut saa
that+this+from tube+from if others get

15 ern, (0.2) this tube (.) if
tän nii tästä riittää kaikille.
this PRT this+from enough+be all+for
the others get it this tube
16 will be enough for all.
17 Dad joo.
yes yeah.

Excerpt 3 (Consultation 97a)

01 Doc [.hh nyt tota (0.3) eemelin suhteen
now that ((name)) regard+with
[.hh now erm (0.3) with Emil
02 ni mun mielest tää tilanne vaikuttaa
PRT my think this situation seem
the situation seems to be
03 varsin rauhalliselt k[uitenki nyt, (.)
quite calm however now
quite calm any[now now, (.)
04 Mom [joo,
yes
05 Doc nuo korvat on  terveet nielu on ihan vähän
those ears are healthy throat is quite little
the ears are healthy throat
06 is a little bit
07 ärtyny mut ei sillä lailla et mä (.).
eritated but not that+way+in that
irritated but not in such way
08 that I (.) would think that
09 epäälin sin et siel ois vältä[mättä
I suspect+I+COND that there be+COND necessarily
there’d ne[cessarily be any
10 Mom [joo,
yes
11 Doc mitään bakteeri-infek#tiota nytte#
any bacterial-infection now
bacterial infec#tion now#
12 .h[hh ja (.)
and
. hh and (.)
13 Mom [°joo.°
yes
[°yes. °
Doc: tää kokonaisvointi on hyvä et no keuhko
this overall-being is good that those lungs
his overall health is good the

breathing and heart sounds

Doc: ja sydänäänet on hyvät ja vatsa on
and heart-sounds are good and stomach is
were good his stomach

Mom: joo.
yes

Doc: pehmee ja sillee.
soft and that+like
is soft and so on.

Mom: joo.
yes

Doc: [.hhh eli (.) ] mä (0.5) kuitenki ajattelisin
in-other-words I however think+I+COND
[jh] [.hhh so (.) ] I (0.5) would still

Doc: et hänel on mahollisesti joku virusinfektio
that him+with is possibly some viral-infection
think that he possibly has some

viral infection which (.) is now

Doc: joka (.) on vaan nyt vähän (.).
which is only now little
just a bit (.)

Pro: jatkun[u] sitte siitä
continued then there+from
prolonged then

Mom: [sitkeempi,
persistent+more
more persistent,

Mom: [.]

Mom: [.]

Doc: [n[i]i.
PRT
yeah.

Doc: [n[i]i sitte että .hh >että tota: (.) et maa
PRT then that that that that I
[yeah then so .hh >so that:.]

Doc: en laittas mitään antibioottia (.).
not+I put+I+COND any antibiotic
I wouldn’t prescribe any antibiotics

Doc: [.]
and on other hand,
31 Mom [joo, yes [yes,
32 Doc [en (. ) toisaalta ottais myöskään not+I on-the-other-hand take+I+COND also+neither [I wouldn’t (. ) take any tests
33 mitään näytteit nyt et (. ) [m- katottas viel any samples now that look+PAS+COND still either now that (. ) [w- we’d
34 Mom [nii. PRT [right.
35 watch it still #over the
36 Doc täs #tä' vi[iko'lopun yl[i.# ja, there+from weekend over and wee[kend.# and, ((glances at Mom))
37 Mom [joo, [joo ihan, yes yes quite
[yes, yes quite,
38 (. )
39 Doc ja aina saa tietystikki #ottaa sit and always get of-course take+0-person then and of course you can always
40 uudelleen yhteyt#°tä. again contact #contact us# ag°ain.°
41 (. )
42 Mom >jo{o.< (. ) .hjoo yes yes >ye{ah.< (. ) .hyeah

Excerpt 4 (Consultation 67)

01 D .hh (. ) tota (0.8) tässä mun that here my .hh (. ) erm (0.8) ((examines x-ray image))
02 mielestä ei semmosta selvää opinion no that+like clear I think there’s no like clear
03 keuhkokuumevarjostumaa oo mut pneumonia+shadow is+not but pneumatic signs but there
kyllä siellä (kuvio lisää) mut
yes there  pattern more but
is some (changes) though but

et (.). hh huomenna sitte
that tomorrow then
erm (.). hh tomorrow a

röntgenlääkäri kattoo tänä'
radiologist looks this
radiologist will check it

"vielä".
still
"still".

(.)

M nii::?,
PRT
yea::h?,

(.)

D mut et kyl mä sen antibiootin
but that yes I that antibiotic
but erm indeed I’d start the

alot"tasin".  
start+I+COND
antibio"tics". ((glances at child))

(0.2) ((mutual gaze between M&D))

M kivaa mieluusti että vähän
fun preferably that little
that’s nice by all means so

sitte (.). jos helpottaa
then if eases
it a little (.). if it helps

tä[ta (.). olotil:aa ni]
this condition PRT
he[r (.). condition so]

D [ nii:, (.). nii:],
PRT  PRT
[ yeah:, (.). yeah:],

(.)

M [ .nii, ]
PRT
[.yeah,]

D [että se] ei o ihan (.). ihan
that it no is quite quite
[so that] it’s not (.). quite

normaali toi röntgenlöydös
normal that x-ray+finding
completely normal that ↑finding,

Excerpt 5 (Consultation 12)

01 Doc [enem]män se olis tual poskionteois siältä se more it be+COND there sinuses+in there+from it [it’d] be more in the sinuses

02 valuu ja sä, (0.4) vedät sitä alaspäin sitte. drips and you pull it downwards then it’s dripping from there and

03 you, (0.4) get it down to

04 your throat then.

05 (.) ((mutual gaze))

06 Pat joo:-o?
yes yea-h? ((mutual gaze))

07 Doc <pistä paitaa päälle vaan.> put+you shirt on just <go ahead put your shirt on

08 then.> ((sits down, turns toward computer))

09 Pat khhhhh (0.2) hhhhhhhh ((starts getting dressed))

10 Doc mä paan antipiootin sulle, (0.3) I put+I antibiotic you+for I put you on antibiotics,

11 (0.3) ((Doc gazes at computer))

12 ei auta mitää,
no help anything that’s what one has to do,
((Doc gazes at computer and writes, Pat gets dressed))

13 Pat noh (.) sen mä just aattelin et kyllä PRT it(+is) I exactly thought+I that yes well h (.) that’s exactly what

14 I thought that it’s probably

15 se varmaan sen, (.) [sen se it supposedly that(it) what, (.)[what it requires

16 Doc °joo.° yes °yeah.° ((gazes at computer))
17 Pat vaatii ja kun- (0.2) kunnon ropit
that it requires and real drugs
and rea- (0.2) real stuff for it

18 jotta se ei tähän kuin (.). kun (0.4) hhh
since it no this+for as when
so this isn’t than (.). since

19 nämäh (0.2) h (.). finreksit, (0.5)
these ((name))
(0.4) hhh these h (0.2) h (.)

20 auta mitää.,
help anything
Finrexins (0.5) are of no help.,
((gets dressed))

21 Doc =jätä, (0.4) jätä välilin.,
leave leave between+in
=leave, (0.4) leave those.,

Excerpt 6 (Consultation 48)

01 Doc et kyl siäl tauti on hh.
that PRT there illness is
so indeed you have the

02 illness there hh.

03 (1.4) ((Doc sits down))

04 Pat että ihan samat oireet on ku' tos'sa°
that quite same symptoms are than that
yeah I have the exact same

05 symptoms than °there°

06 (0.6) ((Doc gazes at computer))

07 Doc onks sul sitä locacort:eenia jäljellä,
have+Q you+with that ((name)) left
yes. (0.3) do you have that

08 Locacorten left still,

09 Pat ei ol yhtään.
no have at-all
no I don’t.

10 (1.0) ((Doc starts writing))

11 Doc joo; (.). mä paan antibiootin sulle ↑kuitenkin
yes I put+I antibiotic you+for however
yeah; (.). I prescribe
antibiotics for you 

mä paan doksisykliinin ((name)) .hh
I put Doxycycline ((name)) .hh

(Doc gazes at computer and writes))

Pat

et epilsepsialääkkeenä mul on trileptal
that epilepsy-medicine me+with is ((name))
so for my epilepsy I have

Trileptal so that this, (1.2)

et täst (1.2) ei el [mitään,
that this+from no is any
hasn’t [any,

Doc

[e:i,
no

[no,

(0.3)

Pat

ongelmia [niitten suhteen,]
problems those regard+with
problems [regarding them,,

Doc

[ei ku mä (.).] ekkaan sen [viälä]
no as I check+I it still
[n:ø,

check it [still.]

Pat

[.hhjø]o
yes

[.hyeah]
06 Mom
just.

exactly

right.

07 (0.2) ((Doc gazes at computer))

08 Doc
mä paan pikkusen yskänlääkettä ettei

I put+I little cough-medicine not+that

I prescribe a little bit cough

09 tartte röyhkiä niin pal°joo°.

need+to cough PRT lot

medicine for her so she doesn’t

10 have to cough so °much°.

((gazes at computer, starts writing))

11 Mom hh ventolinea kirjotti virtanen aamulla,

((name of medicine)) wrote ((name)) in-the-morning

Dr. Virtanen prescribed Ventoline

12 in the morning, (.) for the

13 (. ) pienelle, (0.4) °pi[enemmälle.°

little+for little+more+for

little., (0.4) °li[ttle one. °

14 Doc                  [<aha.>

PRT

[<u-huh.>]

15 Mom mitäs sanot oisko tähän< (.) jotain eri,

what say+you be+COND+Q this+for something different

what do you say would it be

16 something< (.) something (0.2)

17 (0.2) .hh ↑eri,

different .hh ↑different for this,

18 Doc =no mä panisin kokillaanaa sen takia et

PRT I put+I+COND ((name)) it(+is) because that

=well I’d put Cocillan

19 because Cocillan takes the unnecessary

20 se kokilla [(se turhaa räyskytstä vie pois

it ((name)) it unnecessary coughing take away

coughing away ((turns to Mom))

21 Mom =jo[o.

yes =ye[s.

22 Doc [ja sit ku se ei räyskytä niin paljo

niin and then when it not coughing like+that lot

so/PRT

[and when she doesn’t cough
it not is that painful
that much it’s not that painful. ((looks at Mom))

Doc
ventolinehan <avaa röörejä.>
((name)) + of-course open tubes
Ventoline <opens the airways.> ((looks at Mom))

Mom =joo. (. ) niin on[ki ( )
yes PRT is + also
=yes. (. ) that’s r[ight ( )

Doc [ja kokillaana taas vie sitä
and ((name)) again takes that
[and Cocillan

räyskytystä pois.
coughing away
again takes the coughing away.
((turns toward computer))

Excerpt 8 (Consultation 16)

01 (7.5) ((Doc examines Pat’s sinuses with ultra sound))

02 Doc ei täääl kyl tuu niinku,<
no here PRT come PRT
this doesn’t give PRT

03 (1.0) ((Doc examines))

04 .mt (. ) inahdustakaa.
sound (+ neither/ not-even/ any)
.tch (. ) any sign.

05 (16) ((Doc examines))

06 Doc .mt .hh (1.2) tost saa pyyhkii
töhnät pois.,
there can wipe +0- person dirt away
.tch .hh (1.2) there you go

07 wipe your face,

08 (5.2) ((Doc gives a tissue to Mom,
mom wipes the child’s face))

09 Mom ( ) ( ) ((whispers to the child))

10 Doc .hh >mut< tehdääs nyt nii et mää kirjotan sen
but let’s proceed in such a way now that I write the x-ray-referral so,.

(0.8) ((Doc turns toward Mom))

Doc .mt .hhh

Mom voisko sen samalla, (0.4) vai kannattaak' could it at the same time,

(0.4) or is it worth to look

Mom nii,.

Doc keuhkokuvan,
you mean chest x-ray,

Mom nii,.
PRT yes,.

Doc no kyllähän ne siin samal menee et sitä
that as-(few)-as tries like as much as possible

((14 lines omitted, Doc explains on what grounds the chest x-ray can be taken))

Doc et ku se tietyst se lämpö on ny niinku
that as it of-course that fever has now PRT risen
noussu,.
so of course now that the fever has gone up,
Mom: joo.
yes
|yes.

Doc: nii (.) katotaan se s(amal "sitte".)
PRT look+PAS it at-the-same-time then
so (.) let's take it at

[the same time "then".]

Mom: [ nii:,. ]
PRT [ yea::h,. ]

kyllä mä mieluusti nyt sii[he ]
PRT I willingly now it+for
I'd indeed like to get [a course]

Doc: [.joo.,]
yes
[.yeah., ]

Mom: jonku ✽kuurin haluaas(h)in£.
some course want+I+COND
of medication for it (h) now£.

Doc: ↑mm:. 

Excerpt 9 (Consultation 61)

Doc: ei täältä kyllä mitää hälyttävää kuulu.
no here+from PRT anything alarming hear
indeed I don’t hear anything

Doc: alarming.

(1.6) ((Doc puts a stethoscope away))

Doc: et se on varmaan toi korvapistos tulee
that it is supposedly that ear-stinging comes
so it’s likely that the ear

sieltä kurkustah,
there+from throat
pain comes from the throat,

(.)

Doc: ja tulehdus on siellä kurkunpäässä
and infection is there larynx+in
and the infection is in the

(.)

Doc: mhm.

Doc: (.)

Doc: ja tulehdus on siellä kurkunpäässä
and infection is there larynx+in
and the infection is in the
äänihuulitasolla että (.).
hhh ei kantsi
throat in vocal cords so that
we won’t benefit from
muuta ku jatketaan sairaslommaa tää
other than continue+PAS sick-leave this
anything else than extending
loppuviikko ja yrität levätä.
rest-of-the-week and try+you rest
your sick leave for the rest of
the week and you trying to get
some rest. ((Doc glances at Pat,
Pat nods slightly))
(1.0) ((Doc looks down at her notes,
Pat looks at Doc))
Pat mm. ((looks toward Doc))
ja: (.). jos nyt uudelleen noo- (.).
and if now again rises+0-person
now if you get high fever
kuumetetus niin varmaan sitten pi*stäää (.).
fever PRT supposedly then have+to
(..) fever again then we probably
need *to°, (0.2)
Pat .H[Hhh
Doc [mietiä uuelleen tilann[etta ja, ]
think+0-person again situation and
[think it over aga[in and,] ((gazes at notes))
Pat [onks ] täälä normaali
is+Q this normal
[is this]
sun mielest niinku sellai et kestää
you+from opinion PRT that+like that last
normal in your opinion that it
näin pi[tkää.
this+like long-time+for
lasts such a long t[ime. ((gazes at Doc))
Doc [voi se kesi*stäää°.
can it last
[it can last
for a long °time°. ((nods))
(1.1) ((Doc looks down at notes,
Pat looks toward Doc))
29 Pat  et ei tää nyt johdu niinku siitä et
that no this now caused+by PRT that+from that
so th[at it’s not now because of
[[(Doc turns her gaze toward Pat)]

30 jostain syystä nytten niinku se (0.2)
some reason+for now PRT that/the the for some reason now the

31 perussairaus ( [ )
chronic-disease
(0.2) chronic disease ( [ )
((Doc turns back toward the notes))

32 Doc  [#joo:?,# hh.
yes
[##ye:s?## hh.

33 (1.3) ((Doc looks down, Pat toward Doc))

34 Doc  mt. tietysti voihan se ärsytättä
of-course can+of-course it irritate vocal-cord-
äänihuuli*tasoa.
level .tch of course it can irritate

35 vocal °cords°.

36 (.) ((mutual gaze))

37 Pat  nii:?,
PRT
ri:ght?

38 (0.6)

39 Doc  °mm.° (.) .hh et (2.2) tietysti voi tää (.)
that of-course can this
°mm.° (.) .hh that, (2.2) of course

40 voihä täs sillä tavalla tehä että
Jos ei
we could (.we could do in a way

41 that if it doesn’t sta:rt to,

42 nyt rupee: tässä (0.5) mikäs tänään eletään
now start+0-person here what today live
(0.5) what day is it today

43 <#tii::s#[tai]ta? ]
tuesday
<#Tue::s#[day? ]

44 Pat  [khhö. kh.]

45 (.) .hhh krh. kh. ((coughs))

46 Doc  et jos sitä torstaina tuntuu tosi huonolta
that if that thursday+on feel+0-person really bad
so if you feel really bad still

vielä ni käävist uuestaan verikokkeessa (.)
still PRT visit+you+COND again blood-test+in
on Thursday then you’d go to get

a blood sample again (.). hh blood

dh kokeissa et katottais se
tests+in that look+PAS+COND that (the)
sample so we’d check the full
täydellinen veren*kuva*.
complete(perfect) blood-picture(image)
blood *work*.

(0.3)

Pat mm:?,
ORIGINAL ARTICLES