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Introduction: Analyzing interaction between doctors and patients in primary care encounters

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In 1976, Patrick Byrne and Barrie Long published a path-breaking study of the doctor–patient relationship. Based on some 2,500 tape-recorded primary care encounters, *Doctors Talking to Patients* anatomized the medical visit into a series of stages, and developed an elaborate characterization of doctor behaviors in each of them. Drawing on Michael Balint's (1957) proposal that the primary care visit has therapeutic value in its own right, Byrne and Long focused on the ways in which its therapeutic possibilities were attenuated by the prevalence of doctor-centered behaviors in the encounters they studied. The study was also conceived as an intervention: physicians were invited to use its coding framework to evaluate their own conduct, and to modify it in a more patient-centered direction. Not surprisingly, given these goals, *Doctors Talking to Patients* was itself somewhat doctor-centered. The authors had little to say about patients' contributions to the encounter or the sociocultural context of social interaction in primary care.

In the present volume we revisit Byrne and Long's project of anatomizing the primary care visit, doing so from a primarily sociological and interactional perspective. We begin from the standpoint that physician and patient – with various levels of mutual understanding, conflict, cooperation, authority, and subordination – jointly construct the medical visit as a real-time interactional product. Within this orientation, we consider some of the social, moral, and technical dilemmas that physicians and patients face in primary care, and the resources that they deploy in solving them. Our objective is to open the study of doctor–patient relations to a wide range of social and interactional considerations.

We begin this Introduction with a sketch of recent approaches to the analysis of the physician–patient relationship, before going on to describe the methodological underpinnings of our research. The objective is to set out the conceptual context of the studies making up this volume, and to consider what they might contribute both to the social scientific investigation of primary care and, in keeping with Byrne and Long's original objective, to its practice.

Studies of doctor–patient interaction: a brief overview

Sociological concern with the doctor–patient relationship received its classic formulation in a chapter of Parsons' (1951) theoretical work, *The Social System*. Working within the functionalist perspective that he did much to develop, Parsons conceptualized the institution of medicine as a social system's mechanism for assisting those who fall ill and returning them to their regular contributory capacities. Rather abstract and generalized, the role-based model that Parsons formulated did not generate much empirical investigation. Instead, starting in the 1960s, research on doctor–patient interaction has increased greatly according to two main approaches: process analysis, and the microanalysis of discourse (Charon et al. 1994).

Process analysis

Process analysis was introduced into medicine in a series of path-breaking studies by Barbara Korsch and associates on interaction in a pediatric emergency room (Francis et al. 1969; Korsch et al. 1968; Freemon et al. 1971; Korsch and Negrete 1972). Using the "interaction process analysis" coding scheme which had been developed by Robert Bales (1950), these studies demonstrated that mothers, desiring more information than they actually obtained from the physicians, were reticent about asking questions, disappointed at the amount of information they received, and frequently (one-fourth of the subjects) did not mention their most important concern to the physician. These observations were linked to adherence: patients whose needs for information were least satisfied were also least cooperative with treatment recommendations and also less satisfied with the outcome of the visit. Such findings made a powerful case for the study of physician–patient interaction, because they showed

that systematic study in the field is achievable, and that the results can be significant for patient health outcomes.

As noted, the original Korsch studies quantified interaction using Bales' interaction process analysis, which had been developed for classifying role behavior in task-oriented small groups in terms of a contrast between task-oriented behaviors and socio-emotional categories. The Bales scheme had real strengths, including the attempt to be exhaustive and to facilitate administration so that a trained Bales researcher can code interaction in real time, without the need even of a tape recorder. As an approach to doctor–patient interaction, however, the scheme also had significant drawbacks. Its categories are exceedingly general, yielding a picture of the physician–patient encounter that is fuzzy at best. Nor were they adapted to the specificities of doctor–patient communication and the phases of the medical encounter.

Subsequently, coding schemes have undergone progressive refinements over the years to address these problems, becoming adjusted to dyadic interaction and to the specific content of physician–patient interactions (for overviews, see Inui et al. 1982; Wassermann and Inui 1983; Inui and Carter 1985; Roter et al. 1988; Roter and McNeilis 2003). By far the most influential is that developed by Roter and colleagues. The current Roter interaction analysis system (RIAS) contains 39 categories, broadly subdivided into socio-emotional (15 categories) and task-focused (24 categories) (Roter 2004). Like the Bales system, RIAS (Roter and Larson 2001, 2002) is designed to implement an exhaustive classification of the events of the medical visit, while using categories that are compatible with the three-function model of the medical visit described by Cohen-Cole and Bird (Cohen-Cole 1991; Cohen-Cole and Bird 1991).

The RIAS framework has opened up the physician–patient relationship to a significant degree, accommodating a wide range of contents and circumstances beyond primary care, including oncology, obstetrics and gynecology, end-of-life discussions, well-baby care, and specific diagnostic categories such as asthma, hypertension, and diabetes (Roter and Larson 2002). Related studies showed that eliciting the patient's view of the illness increased recall, understanding, and commitment to following a physician's advice (see Stewart [1995] and Brown et al. [2003] for overviews of outcomes related to physician–patient interaction). Shown by comparative studies to

be superior to other coding systems (Inui et al. [1982]; see also Thompson [2001] for a broad overview of systems), it has revealed important differences in how men and women (both physicians and patients) interact in the medical visit and how these interaction patterns are related to physician and patient satisfaction (Hall et al. 1994a, 1994b; Roter and Hall 1992). It has formed the basis for a valuable empirical specification of the main styles of primary care visits (Roter et al. 1997), and it has been used in nearly a hundred empirical investigations of a wide variety of medical contexts (Roter and Larson 2002).

Although the Roter system has served as the backbone for the study of the physician–patient relationship over the past twenty years, it is not without controversy. Criticisms of the RIAS system have focused on the very features that have contributed to its success – its capacity to deliver an exhaustive and quantified overview of the medical encounter. Critics of the RIAS system argue that its categories fail to address issues of content, context, and meaning in medical interaction, sacrificing these for an overview across medical encounters in which the interactivity – the capacity for one party to influence the behavior of another, or to adjust behavior in response to another – becomes invisible (Charon et al. 1994; Mishler 1984; Stiles 1989). Many of these criticisms have been developed from the microanalysis perspective, to which we now turn.

Microanalysis

At the opposite pole of the analytic continuum lie studies that focus on the microanalysis of medical discourse. Originating within anthropology and sociology, these studies deploy an essentially ethnographic and interpretive methodology to disclose the background orientations, individual experiences, sensibilities, understandings, and objectives that inhabit the medical visit. In sociology, microanalytic studies have a heritage that includes the "Chicago School" of ethnography and Hughes' (1963) work on occupations and professions. Hughes was among those in sociology to note the professionalization of work and occupations, but because of this focus, shared by Freidson (Hughes' student) and others, an astute observation by Fox (1989:38) still holds true: "Sociologists have

written more about health professionals – especially about physicians – than they have about patients."

We would add that, besides patients themselves, the physician–patient *relationship* is also much neglected. In recent years, ethnographers have included discourse analysis as part of their investigation of doctoring, investigating patients' experiences, sensibilities, understandings, and objectives to suggest that patients' subjectivity resides, like an iceberg, mainly below the surface of talk. It is maintained in this submerged condition by a combination of patient diffidence and self-censorship (Strong 1979), and practitioner disattention and obfuscation. Practitioner suppression of patient experience, investigators argue, is due to status and authority as built from educational, socioeconomic, ethnic, gender, and other differences between patients and physicians (Atkinson 1995; Clair and Allman 1993; Davis 1963; Fisher 1984; Todd 1989; Zola 1964, 1973). Ethnographic research in this vein is consistent with the perspective of social constructionism (Brown 1995; Miller and Holstein 1993; Spector and Kitsuse 1977). Where process techniques like those of Roter concentrate on what is present in medical conversations, the microanalytic approach, in highlighting absences in the dialogue, imparts a strongly critical edge to appraisals of medical practice.

Elliot Mishler's (1984) *The Discourse of Medicine* is a most compelling implementation of microanalysis. Mainly focusing on the medical history, Mishler observes that physician and patient often pursue distinct, and sometimes conflicting, agendas in the medical visit: the doctor's medical agenda focuses on biomedical evaluation and treatment, and the patient's "lifeworld" agenda concentrates on personal fears, anxieties, and other everyday lifeworld circumstances. Implementing the medical agenda, physicians recurrently suppress the patient's concerns, even though they can be important resources for understanding medical problems.

In the context of history-taking, the basic mechanism of this suppression is the simple three-part sequence of actions through which history-taking is recurrently transacted:

Doctor:	Symptom question
Patient:	Response
Doctor:	Evaluation or acknowledgment (e.g., "OK") and/or Next question

Mishler observes that this interaction sequence, while ordinary and unremarkable, is in fact a mechanism by which the physician controls three important matters: initiation of particular topics, extent of their development, and the degree to which patients can respond. Although a patient may "leak" lifeworld concerns into the interview by offering "surplus information" in response to medically focused questions, regularly physicians' subsequent questions avoid taking up the moral, social, and existential issues the patient raises in favor of a narrowly focused medical agenda (Mishler 1984:85).

Mishler's observations were expanded in Howard Waitzkin's *The Politics of Medical Encounters*, where he (1991:231–2) argues that the underlying, and largely unrecognized, structure of medical discourse militates against the expression of personal troubles including "difficulties with work, economic insecurity, family life and gender roles, the process of aging, the patterning of substance use and other 'vices,' and resources to deal with emotional stress." Instead, the medical management of patients' contextually generated problems focuses on technical solutions, reinforces ideologically dominant outlooks and prohibitions, and contributes to social control by reinforcing the patient's accommodation to the social contexts from which illness arises. Waitzkin observes that these dysfunctional features of the medical visit emerged in 70 per cent of the 336 cases he examines. Similar findings are reported in microanalytic studies involving women's reproductive choices (Fisher 1986; Todd 1989; see also Fisher and Todd 1993), which also address a variety of other aspects of the medical visit.

Taking stock

It is now time to take stock of these two traditions of interaction research: the Bales-based RIAS coding model and the microanalytic approach. In principle, the strengths and weaknesses of the two approaches are complementary, and combining them should result in a greatly enhanced view of the medical encounter (Roter and Frankel 1992; Waitzkin 1990). In practice, this has not come about (Roter and McNeilis 2003). Process approaches have resulted in findings about the medical encounter that are systematic and replicable. The most robust findings have centered on relationships between

interaction variables and patient and provider characteristics, and to a lesser extent with patient satisfaction and adherence outcomes. Process approaches have not developed associations between interaction variables and medical decision-making (surely one of the core areas of medical practice), nor in relation to patients' treatment preferences or physicians' perceptions of those preferences.

Such deficiencies are probably associated with the kinds of coding categories used in process analysis. In the effort to generalize across practice contexts, coding categories are pitched at a very general level. This is a well-rehearsed criticism of process analysis (see Mishler 1984; Inui and Carter 1985; Tuckett et al. 1985; Tuckett and Williams 1984; Pendleton 1983), and it is associated with two related problems. The first is that, in the course of coding, the *content* of the medical encounter is largely washed out. What the physician and patient were talking about is lost, often irretrievably, when the original tapes are destroyed and the coded material effectively becomes "the data" (Mishler 1984; Charon et al. 1994). A second problem is that coding expunges the *context* of utterances and actions – their location in a phased activity within the encounter such as history-taking or counseling, and their placement in a specific and autochthonously intelligible sequence and course of action. It is precisely these aspects of context that give utterances and actions the meaning they have.

On the other side of the ledger, microanalytic approaches have retained crucial elements of medical sense-making and interpretation, but issues remain. One of these is how to integrate ethnographic inquiry (interviews and observations) with the study of interaction and language use (Maynard 2003: Chapter 3). Even when that integration is successful, many small-scale quasi-ethnographic studies of discourse have not been able to establish a non-interpretive evidential base for associations between meaningful communicative practices on the one hand, and medical outcomes on the other.

Of course, many studies in this tradition, including those in this book, analyze generic practices of talk-in-interaction, and thereby are able to make recommendations about specific practices for enhancing the medical interview. In delivering diagnostic news, for instance, it is demonstrable from interactional evidence that,

and how, physicians can enhance the understanding and acceptance of patients or other recipients. Or in making treatment recommendations, it is also clear that proposing particular therapies in one fashion rather than another can decrease the likelihood of patient resistance. Each of our chapters, on the basis of the conversation-analytic methodology employed, has implications for medical practice, whether it is how to open the interview, take an effective and sensitive history, conduct the physical exam, explain illness and convey diagnostic news, make treatment recommendations and prescribe medicine, deal with lifestyle matters, or close the encounter.

Nonetheless to extract robust outcome-based conclusions about how physicians (or patients) should conduct themselves in specific moments in the flow of the medical encounter, it is important to find a meeting point between the two methodologies of coding and microanalysis (Roter 2000; Roter and Frankel 1992; Roter and McNeilis 2003). In other words, beyond the intrinsic worth of analytical framework responsive to very granular, individual moments in the physician–patient encounter, we need one that simultaneously supports coding at a broader level of granularity sufficient to reach beyond individual cases to generate findings at a statistical evidential standard. For example, qualitative studies of pediatric interactions involving patients who present with upper respiratory tract infections (Stivers 2002b, 2005a, 2005b, this volume; Heritage and Stivers 1999) have resulted in quantitative studies that show how these various conversational actions are associated with the perception of demand for antibiotics and inappropriate prescribing (Stivers et al. 2003) and parent resistance to treatment recommendations. These studies identify communicative resources that physicians can deploy to resist these negative outcomes (Mangione-Smith et al. 2003, 2004). In addition to their generic implications for medical practice, accordingly, the chapters of this book offer a framework for granular *and* quantitative, outcome-oriented analyses. In the remainder of this Introduction, we provide an overview of the theory of interaction and its methodology as they provide for clinical implications of our individual chapters, and as they allow for connections between microanalysis and coding operations for overall assessment of medical communication.

Conversation analysis as an approach to medical communication

In this section, we will first give a brief preview of the orientation of conversation analysis (henceforth CA) to social interaction in general. Second, we will sketch several levels of application of CA to the medical interview, and address the relationship of qualitative and quantitative analysis. Finally we will give a thematic overview of the contents of this book.

(1) Conversation analysis: a brief introduction

Conversation analysis emerged as a field in the 1970s from pioneering research by Harvey Sacks, Emanuel Schegloff, Gail Jefferson, and others. Initially focused on ordinary conversations between relatives, friends and acquaintances, and (later) on interactions in more formal or institutional settings such as medical clinics, the field coalesced around a set of fundamental theoretical assumptions: (1) social interaction is an autonomously organized domain – an "interaction order" (Goffman 1983) – that exists independently of particular motivational, psychological, or demographic (race, class, gender, ethnic) characteristics of participants; (2) gestures, utterances, turns of talk, and their subcomponents perform recognizable actions that are both context-shaped and context-renewing; (3) these first two properties inhere in the very minutiae of interaction, which means that no order of detail in conversation is to be dismissed a priori as disorderly, accidental, or irrelevant to participants' concerted endeavors; (4) appreciating the sequential organization of conversation could mean an important methodological advance in the analysis of everyday talk that would make that analysis both "reliable" and "valid" in the terms of normal social science.

(1) The bedrock upon which conversation analysis stands is sequencing, which was explored in early papers on turn-taking (Sacks et al. 1974) and the organization of adjacency pairs – turns of talk like questions and answers that are two utterances long and have other regular characteristics (Schegloff and Sacks 1973). To start analysis with a focus on turn-taking and adjacency pairs translates in the medical context into a concern with everything from

"how are you" questions and their replies, to history-taking questions and answers, to diagnostic announcements and their receipts, to treatment proposals and their acceptance or rejection, to many other kinds of sequences (as the chapters in this volume show). The analysis of turn-taking and adjacency pairs permits the appreciation of how parties to conversation make it possible to coordinate understanding and joint actions at all, whatever the sociodemographic backgrounds or psychological dispositions of these parties may be. This approach is taken, for example, in studies of interruptions by men and women in conversation and medical interviews (Kollock et al. 1985; West and Zimmerman 1983; Zimmerman and West 1975; West 1984).

(2) Spoken utterances (as well as nonvocal gestures and other embodied behavior) accomplish activities. In one of his early lectures, Sacks proposed that the most banal and familiar conversational utterances are social objects that *do* actions and activities without necessarily formulating them as such. He noted that with "This is Mr. Smith," a call recipient at a suicide prevention center can unofficially ask a caller to identify himself and to do so with the same mode of address (Sacks 1992a:3). With "I was trying you all day and the line was busy for, like, hours," a caller can "fish" for information as to her caller's whereabouts by giving her own version of things, which invites the recipient to tell hers (Pomerantz 1980). Conversation analysis represents the attempt to describe and analyze a host of ordinary activities – informing, describing, criticizing, insulting, complaining, giving advice, requesting, apologizing, joking, greeting, and many more. These activities are rarely announced in so many words. Nor does the syntactic structure of an utterance often convey its force as an action. For example, we use question forms to align with a speaker's talk ("Oh, isn't he dreadful?"), we use declarative forms to make requests ("It's cold in here."), and we use imperatives to invite ("Come in."). The production and understanding of an utterance as an action derives from *features of the social context*, most especially an utterance's place in an organized sequence of talk. Sequencing is what conversation analysts regard as an utterance's fundamental context.

Any participant's communicative action is doubly contextual. First, the action is *context-shaped*. Its contribution to an ongoing activity derives in part from the immediately preceding utterance or