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Diagnosis as Cultural Practice

(Morton J. Poynter)

Chapter 5

Revisiting authority in physician–patient interaction

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As both physicians and social scientists have noted, the physician–patient relationship is marbled through with the exercise of authority. An orientation to authority begins when the patient, who has experienced some potential medical symptoms and perhaps formed some theory of their nature and etiology, makes an appointment and visits the doctor. At the moment when they present a medical problem, patients face the problem of justifying the medical visit and, in particular, of showing that their concerns are neither irrational nor motivated by external, instrumental considerations (Heritage and Robinson, forthcoming). During the history-taking phase of the visit, patients' reported symptoms are validated (or not) as medical 'signs' relevant to a diagnosis. And at the point of diagnosis, the patient's 'illness' ("the innately human experience of symptoms and suffering" (Kleinman 1988: 3)) becomes a medically validated 'disease' ("an alteration in biological structure or functioning" (Kleinman 1988: 5)). All these activities are impregnated with the exercise of authority, but its exercise arguably becomes

most explicit during the physician's rendering of a diagnosis and subsequent recommendations for treatment.

In his book *The Social Transformation of American Medicine* (1982), Paul Starr argues that medical authority involves each patient in what he calls "the surrender of private judgment" (p. 10). By that he means that when patients get a recommendation from their doctor, they end up abandoning whatever private beliefs, uncertainties, fears, and misgivings they may have about their medical condition, and accept the physician's diagnosis and treatment recommendation. This medical authority, Starr observes, has two main sources. First, there is the dependency of patients who are sick, demoralized, and fearful, and who are not capable of understanding or solving their health problems without expert assistance. The second derives from the cultural authority of science. Cultural authority, says Starr, involves the rights of certain individuals, groups or professions to describe the world: that is, to make definitive pronouncements about the nature of the world, or about specific objects or qualities to be found in the world. Physicians have been trained as scientists in regimes of seeing and recognizing complexes of signs (cf. Barnes 1982; Kuhn 1970, 1977) and have been so certified. Starr argues that medical authority doesn't simply derive from the fact that certain medical techniques work, but rather from the more general scientific basis of medical knowledge which empowers doctors to describe and define the nature of health and illness and the causes of both.

Doctors have not always possessed the kind of authority they wield today. As Edward Shorter (1985) observes, before the rise of scientific medicine in America starting around 1880, patients avoided doctors as far as possible and only went to see them under very severe circumstances. By the turn of the century, the improvement of medical technique resulted in improvements in diagnosis and prognosis and, some time before the development of significant drugs like antibiotics and the development of surgical techniques, the status of the profession rested primarily in its ability to diagnose rather than to treat disease (Shorter 1986). In the opinion of many commentators (Friedson 1986; Shorter 1985; Starr 1982), medical authority and status, powered by the emergence of new drugs, surgical techniques and other treatments, reached its zenith around 1960 – the 'golden age of doctoring' (McKinlay 1999) – and subsequently entered a long process of decline. While many factors have contributed to this process, two stand out. First is the rise in 'consumerist' attitudes among patients who are prepared to 'shop around' for doctors, and to evaluate and disagree with their medical conclusions by looking at the internet or in medical textbooks (cf. Roter and Hall 1992: Ch. 2). The second is the rise of managed care, which allows corporations to subject medical judgments to bureaucratic and financial evaluation, and involves sanctioning doctors for the use of inappropriate treatments (Light 2000).

In this chapter I will examine medical authority in relation to the process of diagnosis and treatment recommendation. There is broad agreement among medical sociologists and practitioners that diagnostic reasoning in medical settings is an activity based on special knowledge possessed and controlled by the profession of medicine. A number of authors also argue that the knowledge gap between the physician and the patient is so wide that diagnostic reasoning is inherently opaque to the layperson. As Parsons (1951) put it, "The physician is a technically competent person whose competence and specific measures cannot be competently judged by the layman. The latter must therefore take these judgments and measures 'on authority'." So then it is this point in the visit – where the physician counsels the patient and proposes treatment – that we arguably reach the point where the patients truly "surrender their private judgment," as Starr puts it. By the same token, it is this point where physicians most completely deploy their cultural authority to define the nature of the patient's problem. Most medical sociologists therefore suggest that the patient is at best a marginal participant in the diagnostic process, and that physicians are not obligated to present, to explain or justify their medical reasoning to patients or to persuade them of the rightness of their decisions. It is sufficient for them simply to pronounce a diagnostic judgment.

Our questions in this chapter are: How do physicians wield their cultural authority at this point? What sort of information do they give patients? On what sort of a basis do patients surrender their private judgment at this point in the interaction? And what are the dynamics of the physician's assertion of cultural authority in the interaction? To answer these questions, discussion will focus on primary care. Here, we are dealing only with moderate illnesses that are not normally life-threatening. The story is likely to be significantly different with more serious illnesses.

With respect to these moderate, primary care illnesses, preliminary evidence from studies of recordings of medical encounters suggests that patients do indeed abrogate their own judgments and more or less surrender with a blindfold on. Roter and Hall (1992) cite a number of studies showing that patients are badly informed about their medical conditions, that physicians tend to use too much medical jargon that patients do not understand, and that physicians underestimate the amount of information patients want about their diagnoses. Most of these studies are based on survey data, but they have been confirmed by studies that rely on recordings of physician–patient interaction which, given the deficiencies of memory, should be regarded as the 'gold standard' in these matters. One of these (Waitzkin 1985) based on 330 recordings, found that physicians spent about 9 percent of their time (on average 1 minute 20 seconds) giving information or explanations to patients about their condition. Notwithstanding the relatively little time they spent in these activities, the physicians believed that they had spent a good deal of

their time in giving information. When asked to estimate it, the average estimate was just under 9 minutes (an overestimate of nearly seven times!). Initially, then, it seems apparent that physicians imagine that they do a great deal of explaining, while patients are reluctant to initiate explanations by asking questions. This study also found that physicians significantly underestimated the patient's desire for information. Thus, in addition to their erroneous perception of the amounts of information they have given to patients, physicians also generally do not recognize the amount of information which patients actively desire.

What factors impacted this situation? There were two main sorts of factors focused on (i) patient characteristics and (ii) situational characteristics. With regard to patient characteristics, older patients tended to get more information than younger ones, women received more information than men, and middle class patients received more information than working class patients. In terms of situational characteristics, length of acquaintance with the physician was strongly associated with information giving and busy case loads were strongly associated with less information giving (Waitzkin 1985).

In what follows, I will explore the process of diagnosis and treatment recommendation as an interactional negotiation. I will do so, first, with the aid of three significant studies of the 'diagnostic moment' in the medical visit which give strong, though qualified, support for the idea that patients show strong recognition of medical authority during the process of diagnosis. Second, I will qualify these observations by reference to studies of diagnosis and treatment recommendations in patients with upper respiratory tract infections (URTIs), which are common medical conditions in which many patients may claim some expertise.

1. Three studies of the interactional management of diagnosis

1.1. *Patrick Byrne and Barrie Long: Doctors talking to patients (1976)*

I want to begin by considering a British study conducted about twenty-five years ago by Patrick Byrne and Barrie Long (1976). Byrne and Long's study was large scale (over 2000 medical visits were examined) and pioneering in that it focused on the need for patient-centered medicine (see Mead and Bower 2000 for a review of contemporary literature on this topic). The study focused on a range of physician behaviors across the medical visit, but in relation to the diagnostic phase Byrne and Long asked two questions:

- (1) Did the physician identify and explain the diagnosis and treatment?
- (2) Did the physician design these descriptions so as to invite the patient to ask questions or participate in a discussion or negotiation of the treatment?

Using these criteria, Byrne and Long formulated seven diagnostic styles, which they arrayed in terms of whether they were physician-centered (focusing on the physicians' knowledge and expertise) or patient-centered (attending more to the patients' interests and concerns).

Table 1. Diagnostic styles (Byrne and Long (1976))

1. The physician makes a decision about the patient and his treatment and then instructs the patient to see some service.	31%
2. The physician makes a decision and announces it.	36%
3. The physician sells his decision to the patient.	4%
4. The physician presents a tentative decision subject to change.	14%
5. The physician presents the problem, seeks suggestions, and makes decisions.	8%
6. The physician defines the limits and requests the patient to make a decision.	4%
7. The physician permits the patient to make his own decision.	1%

As Table 1 indicates, most of the cases fall into styles 1 and 2, which are the most doctor-centered styles. Below are some examples of these:

Style 1: [Diagnosis is not named, treatment is not explained]

Doc: Well now, take this along to the chemist. Take them three times daily after meals.
Bye bye.

Doc: I'll make an appointment for you to have an X-ray. Now don't worry. We'll be in touch.

Style 2: [Diagnosis is named, but not explained. Treatment is not explained, discussed, or negotiated]

Doc: Well now you seem to have nothing more than a bout of flu. Take this to the chemist on your way home. Go to bed for a few days and I'll look in from time to time.

Doc: This is an infection of the lung. I want you to go upstairs and have an X-ray now. When you've had that, come back here and I will detail some more treatment.

Style 4: [Diagnosis is presented and explained: treatment options are given in a more exploratory, tentative fashion]

Doc: Now then, you appear to be having some more trouble with that leg of yours. This is, I think, a consequence of the fact that you're still trying to work as you did ten years ago. Now you are fifty-five and you ought really to start taking

things a little easier. I think you ought to have a long rest. Now then, how do you think you can cope with that?

As will be clear from these examples, physician-centered styles of diagnosis are those that involve little or no explanation to patients, and that invite little or no participation from them. Patient-centered styles involve more of both. The two most physician-centered styles are by far the most common, amounting to a total of two thirds of all the diagnoses in Byrne and Long's 2000+ recordings. And, as Table 1 shows, in nearly a third of these, no diagnosis was given at all. This study strongly reinforces the general claim from within medical sociology that physicians tend to be highly authoritarian in their delivery of diagnoses and that they, in effect, compel patients to surrender their private judgment to the physician because they leave the patient little other choice.

1.2. *Christian Heath: Diagnosis in the general practice consultation (1992)*

This idea that diagnosis involves the exercise of authority is also addressed by the second study, Heath's investigation of how patients respond to medical diagnoses (Heath 1992). His central observation concerns the remarkable passivity of patients in the face of diagnoses by physicians. Most obviously, Heath notes that in a significant proportion of the videotapes he looked at, patients remained completely silent in the face of a diagnosis. Note the arrowed silence at line 2 in (1) below, which is a point at which the patient could have responded.

(1) [Heath 1992: 239]

- 1 Doc:→ Er:..... Yeas:: (0.3) this one's blocked (.) the other one's not.
 2 → (1.2)
 3 Doc: Well when would you like to have them done
 4 (.)
 6 Doc: Next week sometime:?
 7 Pat: Yers (.) yes please.

Patients also responded to diagnoses with a minimal form of acknowledgment token, a downward intoned "er", "uh", or "yeh".

(2) [Heath 1992: 240]

- 1 Doc: hhhh You've got erm: (0.8) bronchitis:.
 2 Pat: → °er:°
 3 → (4.5) ((Dr begins to write prescription))
 4 Doc: .hhh (0.3) I'll give you antibiotics: to take for a week. hhh
 5 (0.8)
 7 Doc: How long are you here for?

Heath notes that there are several other response types that are completely absent. Patients could, for example, respond with "oh," a form of acknowledgment that treats what they have just heard as new information (Heritage 1984). Another response could be with a 'newsmark' (Heath 1992), for example, "it is?" or "oh really," which show interest in the diagnosis and invite some expansion of its details by the physician. And, of course, there are explicit questions patients might ask in response to a newsworthy item: "What's that?", "What causes it?", "Is it contagious?", "Is it serious?", "How long will it last?" All of these response types are largely absent. These patients have just been given a diagnosis, but they don't even acknowledge it as information.

Why is this the case? Heath considers the bodily and other nonverbal behavior of the physician. For example, the physician could be writing notes or a prescription, and appear unavailable. This, however, was not the case. Physicians were normally gazing directly at the patient – something which ordinarily solicits response. Heath argues that patient passivity is directly related to the design of the diagnostic utterance – the feature stressed in the Byrne and Long study. For example, in (1) and (2) the diagnoses are simply delivered as authoritative assertions of fact. As expert opinions, authoritatively delivered, they do not offer a context that is ripe for subsequent enquiries. If we had to classify these designs in Byrne and Long's terms, we would probably suggest that they are 'style 2' diagnoses.

Heath confirmed this observation by looking at cases in which the diagnosis is offered in a less authoritative way as in (3):

(3) [Heath 1992: 247]

- 1 Doc:→ .hhh It's not a totally typical story of a
 2 → wear and tear arthritis, but I think that's:
 3 → what it's going to turn ou[t to be:....
 4 Pat: [(Well that (.) but that en right wouldn')
 wife and nurse
 5 says hhh[h
 6 Doc: [Oh well [I think we ought to get an X-ray as a check.
 7 Pat: [.hh heh Yers
 8 Doc: You've not had this done on that ankle before?
 9 Pat: No:.

Here the physician offers a tentative diagnosis that will require confirmation by X-ray, and the patient responds quite actively.

Heath also shows that similarly active responses also emerge when the physician's diagnosis is different from the patient's lay understanding of the problem. In (4), the patient has an eye problem that he thought was due to a vein: the phy-

sician determines that it's a muscle problem, and this engenders some discussion between physician and patient.

(4) [Heath 1992: 250]

- 1 Doc:→ It's not a vein: (.) it's a muscle in spas:[m.
 2 Pat: → [Is it?
 3 Doc: Yeah.
 4 Pat: → Oh:
 5 Doc: And I think what's cau[sing it to be in spasm
 6 Pat: → [I've had it for about
 7 → three or fou[r weeks, and n[ow (or something like that.)
 8 Doc: [Yeah [Yeah
 9 Doc: You've got a low grade inflammation of the eye:::
 10 (0.3) the front of the eye and this is probably making the spasm
 come.

A third environment in which patients offer elaborate responses to physician's evaluations emerges when these evaluations undermine the legitimacy of the patient's reasons for visiting the doctor. In (5) the patient who is in effect told he's well, counters with a report that his symptoms arise at night.

(5) [Heath 1992: 255]

- 1 Doc: Well yer ches:t is:: (.) absolutely cle:ar: today::,
 2 (1.0)
 3 Doc: which is helpful: (0.4) and your pulse is: (0.7) only eighty .thhhh
 (.) which is er:: (1.2) not so bad.
 5 (1.2)
 6 Pat: (Right it's::) there:: night time (uh) (.) it's:: 'ts not clear there, I've
 got er::: () (1.4) () (0.3) I've more
 7 or less gone to bed when it starts: on us:?
 8 (2.5)
 9 Pat: I wake all the way through the night without getting any sleep
 (un open)
 10 (0.5)
 11 Doc: Mm
 12 Pat: (I don't know what's fetchin it up) during the nights (.) but it
 comes in at the nights.

Even here the patient avoids an overt challenge to the status of the evaluation, but instead vigorously asserts that his, currently undetectable, symptoms emerge at night. Similar responses emerge when physicians offer diagnoses that appear to "question the severity of their symptoms and suffering" (Heath 1992: 255), though these rarely eventuate on overt disagreement or challenge.

To summarize, both the Byrne and Long and the Heath studies suggest that diagnosis is a prime site for the expression of medical authority. Byrne and Long

show that the majority of diagnoses are delivered in a highly authoritarian fashion, offering little explanation and seemingly designed to occlude patient participation. Heath shows that patients respond to these diagnoses very passively. Patients rarely ask questions about the diagnosis and almost never question it or challenge it. So they tend to remain outside of and uninvolved in diagnostic reasoning. Heath finds only two types of exceptions to this: (1) if physicians are more patient-centered, patients become more involved; (2) if the diagnostic process threatens the legitimacy of the patient's complaint.

1.3. Anssi Peräkylä: Authority and accountability (1998)

More recently a further perspective on medical authority and diagnosis has been offered by Anssi Peräkylä, a Finnish sociologist studying the physician-patient relationship. Peräkylä starts by establishing clearly that the simple unelaborated diagnostic statement is the basic or default kind of diagnostic statement that physicians most commonly make. Peräkylä calls these kinds of diagnoses "straight assertions." They are the most common kind of diagnosis in primary care and they are illustrated in (6):

(6) [Peräkylä 1998] "Straight factual assertion"

- 1 Doc: Here's (.) luckily the bone quite intact,

However, Peräkylä also notes two other ways in which physicians can frame their diagnoses. One involves reference to the experience of the physician in coming to a decision. This type involves the use of what linguists term 'evidentials' (Chafe and Nichols 1986). These are expressions where people make reference to what they are seeing, feeling, hearing, smelling or sensing. In this format, Peräkylä writes that evidential verbs "operate in a border area, as it were, between the speaker's inner world on the one hand, and the external, objective world on the other. Thus, they are verbs capable of expressing how the external world is revealed to the inner world of the speaker-observer." This type of diagnosis is illustrated by (7).

(7) [Peräkylä 1998] "Evidential formulation"

- 1 Doc: Now there *appears to be* an (1.0) infection at the contact point of
 the joint below it in the sac
 2 of mucus there in the hip

A third type of diagnostic format involves laying out some of the reasoning that stands behind the physician's judgment. Peräkylä calls this the "evidence formulating pattern," as illustrated by (8).

(8) [Peräkylä 1998] "Evidence formulating pattern"

- 1 Doc: As tapping on the vertebrae didn't cause any .pain
 2 and there aren't any actual reflection symptoms
 3 in your legs it corresponds with a muscle h (.hhh)
 4 complication so hhh it's only whether hhh (0.4) you
 5 have been exposed to a draught or has it otherwise=
 6 Pat: =Oh yes,
 7 Doc: .hh got irritated,

Although the straight factual assertion format is the most common, the other two formats are also quite common. The relative frequencies of these formats is found by Peräkylä is given in Table 2:

Table 2. Frequency of types of diagnostic turns (Peräkylä 1998)

Turn design	Frequency	Percentage
1. Plain assertion	31	44
2. Evidential	12	17
3. Evidence formulating	28	39
Total	71	100

How are we to explain this general pattern? Peräkylä argues that we have to start from a different place than the traditional discussions of medical authority that I have discussed so far. He argues that physicians' authority is not unbounded, but is balanced by their accountability. By accountability, Peräkylä means that physicians have some obligation to index the grounds on which their conclusions are formed. In practice, he suggests physicians' diagnoses incorporate a balance between the authority of their conclusions, and the social accountability of their judgments. This accountability of medical judgments is limited, Peräkylä argues, because laypersons cannot fully recognize the symptoms the physician is seeing, or make fully valid inferences about the causes of those symptoms: these things belong to the realm of expert knowledge. Nonetheless, Peräkylä finds that physicians are accountable to patients in the more limited sense of indicating to them the general basis of the judgements they are making.

Peräkylä argues that even the diagnoses that are formatted as straight factual assertions and look really quite authoritarian, can embody this balance between authority and accountability. He shows that when there is a close and relatively transparent relationship between the examination and the diagnosis that results from it, the diagnosis will be presented as straight factual assertion. For example, in (6) the physician's assertion "Here's (.) luckily the bone quite intact," is made while he is holding up an X-ray picture between himself and the patient. The pa-

tient can clearly see the evidence on which the diagnosis is based, though in keeping with his limited capacity to 'read' X-ray plates he only briefly glances at it.

In this case, there is close a relationship between the evidence and the diagnostic conclusion without any great leap of inference. Peräkylä calls this relationship between evidence and conclusion the 'inferential distance' between the two, and in the X-ray example case it is extremely short. In this case the authority of the physician's diagnosis is expressed in the *verbal design* of his diagnostic turn. The accountability of the diagnosis is managed through the *context* of his utterance, which conveys without stating so in so many words that the diagnosis is based in evidence that both parties have in front of them, though they have differential abilities to make use of it.

Let me repeat here that Peräkylä is not claiming that the patient has an exact understanding of the physician's diagnosis. Quite the contrary, the patient mainly does not understand them, but the patient does know what the physician looked at in arriving at the diagnosis: the patient knows that the diagnosis is based on something specific, even though he may not know exactly what its relevance is. In Peräkylä's words, the patient knows from what direction the evidence comes.

Peräkylä shows that in the vast majority of cases where the inferential distance between examination and diagnosis is short – for example, the physician looks in the patient's ear and then announces she has an infection – physicians tend to use the simple factual assertion format. And his argument is, as I have suggested, that this does not embody flat-out authoritarianism, but rather a particular balance between authority and accountability.

What are the contexts then in which physicians move away from the simple factual assertion to the more elaborated formats, using evidentials or evidence formulating? Let's start with the evidentials. Peräkylä argues that physicians use evidentials when the inferential distance between the examination and the diagnosis is greater. This greater distance can be the result of two factors, either separately or together. The first involves what Peräkylä calls temporal separation between the exam and the diagnosis. For example in (9), the physician conducted a physical examination of the patient, then he spent a while working on the computer preparing a referral for an X-ray, and at line 14, quite a while after the examination, he describes his diagnosis using an 'evidential formulation' – "there appears to be an infection ..."

(9) [Peräkylä 1998: Expansion of (7)]

((Before this extract, the physician conducted the physical examination, after which he worked on his computer, telling the patient that he was preparing a referral to the X-ray lab))

- 1 Doc: Has your hip ever been X-rayed before.
 2 (0.5) (Dr picks up some papers)
 3 Pat: hhhh erm::hhh (1,0) I don't really rememb-

- 4 I don't think it has.
 5 (0.8)
 6 Pat: I don't think it has.=hh My knee has been X-rayed
 7 as it #erm# yea:rs (0.2) .hh years
 8 ago as riding a bicycle was so painful
 9 that it couldn't put up (.) with it, .h but
 10 then nothing was found there.=As far as I remember there has never
 been an
 11 X-ray of my hip hh.
 12 (1.2)
 13 ?Pat: .mth
 14 Doc: Now there appears to be an (1.0) infection at the contact
 15 point of the joint below it in the sac of mucus
 16 there [in the hip.
 17 Pat: [Oh right .hh that's what I thought myself
 18 too that <it probably must be an infection>.
 19 [hhhhh
 20 Doc: [And, because you have had trouble this [long we will
 21 Pat: [hhhhh
 22 Doc: make sure and take an X-[ray.
 23 Pat: [Yes:.

Peräkylä argues that through this evidentialized turn design the physician verbally retrieves the earlier examination of the patient as a context for his diagnosis. In other words, the construction *there appears to be* reinvoles the examination where the physician got his evidence, and indicates that this event can be understood as the context for the diagnostic conclusion. The same is true for evidence formulating. Here evidence is explicitly retrieved. So when the diagnosis is temporally distant from the exam, physicians use the more expanded 'evidential' or 'evidence formulating' diagnostic designs.

The second aspect of greater inferential distance between exam and diagnosis involves what Peräkylä calls the 'opacity' of diagnostic reasoning. By the term 'opacity,' Peräkylä means to refer to cases where the patient knows what was examined, but does not know what it was being examined for. This is what happens in (10). Here the patient complained about a pain in her foot and physician has been looking at it.

(10) [Peräkylä 1998]

((The physician has just examined the patient's foot))

- 1 Doc: Okay:. .h fine do put on your,
 2 (.)
 3 Doc: the pulse [can be felt there in your foot so,
 4 Pat: [Thank you.
 5 Doc: .h there's no, in any case (.) no real circulation
 6 proble[m

- 7 Pat: [Yes I don't understand then
 8 [really .hh I was wondering whether (.) I should
 9 Doc: [is <involved>.

Peräkylä reports that the patient's foot looks quite normal and it's not clear what the examination was aimed at. At the end of it, the physician describes a result of the examination, stating that he can feel a pulse in her foot, and then concludes with a diagnostic evaluation, telling the patient that she doesn't have a circulation problem. In this way, he connects his diagnostic conclusion to the physical exam, whose point is now revealed. Once again, Peräkylä finds that this is a quite general pattern where the purpose of physical examinations is opaque to patients.

Another kind of relationship between evidence formulating diagnoses and their circumstances will be more predictable in light of Heath's findings. It occurs when the diagnosis is uncertain, or when the diagnosis is controversial. By controversial Peräkylä means the diagnosis runs against the patients' beliefs about what is wrong with them, most often when the patient believes that the diagnosis is more serious than the physician seems to think, or the diagnostic evaluation may seem to undermine the legitimacy of the patient's medical visit.

Peräkylä's study does two things. It revises our mind-set about the nature of authority. If we do not look at interactional data, it is all too easy to see authority as an all-or-nothing phenomenon. Peräkylä reminds us that accountability goes with authority – in the medical office just as much as the Oval Office. And he also shows us how subtle that accountability can be. It can simply be a matter of the context in which a diagnosis is offered. And that kind of subtle accountability may be just enough when the problem isn't that serious and does not (or should not) require a vast amount of discussion or joint decision-making.

Peräkylä also shows how physicians expand the verbal accountability of their diagnoses when the context cannot or will not do the job. He points out that physicians treat themselves as more accountable when their diagnoses are problematic, uncertain or disputed. Some researchers believe that physicians restrict the flow of information to patients as a means of bolstering their authority. But research by Howard Waitzkin (1985) suggested that when their diagnoses are tentative or under attack, physicians actually give more information to their patients. This finding is underlined by Peräkylä's study. Peräkylä shows that in these situations, physicians don't give orders or simply "assert their authority," rather they engage in persuasion: they treat their judgments as founded in an authority that is, after all, accountable.

2. How authoritative are physicians? A case study

All the papers described so far have deployed interactional data to give at least qualified support to the traditional sociological understanding of the relationship between diagnosis and medical authority. But more recent studies of medical visits involving relatively mild conditions, e.g., upper respiratory tract infections (URTIs) suggests some further adjustments to this picture.

A large body of research suggests that patients find ways to convey a demand for certain medications, particularly antibiotics, and that as a result the medical visit can take on the character of a tacit negotiation. The starting point for this research is that antibiotics are more commonly prescribed when patients want them and/or convey that they want them to the physician (Britten and Ukoumunne 1997; Cockburn and Pit 1997; Hamm, Hicks, and Bemben 1996; Himmel, Lippert-Urbanke, and Kochen 1997; Macfarlane, Holmes, Macfarlane, and Britten 1997; Schwartz, Freij, Ziai, and Sheridan 1997; Virji and Britten 1991). As Stivers and colleagues have shown, this desire is not always conveyed explicitly (Stivers 2002a, 2002b; Stivers, Mangione-Smith, Elliott, McDonald, and Heritage 2003). But, as Table 3 shows, when physicians perceive such a desire, they commonly adjust their diagnoses in the direction of bacterial illness and prescribe accordingly.

Table 3. Impact of perceived parental expectations on diagnosis and treatment of pediatric upper respiratory infections (Mangione-Smith, McGlynn, Elliott, Krogsstad, and Brook 1999)

	Physician believes parent expects ABX (%)	Physician believes parent does not expect ABX (%)
Otitis media Dx (all cases)	49	13 (p<.001)
Sinusitis Dx (all cases)	38	5 (p<.001)
ABX prescribed (viral cases)	62	7 (p<.001)

Recent research by Stivers (forthcoming a, b) confirms Heath's earlier findings that patients rarely question physicians' diagnoses. However, she also shows that they more frequently contest treatment recommendations, and that this is one of the factors involved in inappropriate antibiotics prescribing. In one of her examples, (11) below, it is clear from the way in which the physician formulates his diagnosis (lines 1–8) that he perceives that the patient would like an antibiotic for her child. And, shortly after he has stated that the condition is viral "so we can't make it go away any faster," the mother makes a guarded request for antibiotics at lines 14–15:

- (11) [Stivers 2000]
- 1 DOC:→ Well you know it's sort of one of those *good* news
 2 → *bad* news scenarios. On one han:d thuh *good* news is
 3 → that she [doesn't have any serious infection. I=
 4 GIR: [()].
 5 DOC: =mean her ears are fi:ne, so she can fly: an' .hh=
 6 MOM: =(an-)=
 7 DOC:→ =everything *else* looks okay. Thuh *bad* news is that
 8 → it's probably *viral* so we can't make it go *away* any faster,
 9 (.)
 10 MOM: Mokay.
 11 (0.4)
 12 MOM: .hh -h Now-
 13 GIR: ([])
 14 MOM:→ [should I- (0.4) just as uh preventative *thi:ng*,
 15 → should I give them some- antibiotics?, or: [(does that-)
 16 DOC: [It wouldn't
 17 do anything for thi[s.
 18 MOM: [No?=
 19 DOC: =An' if [anything it'd make: her diarrhea [worse=
 20 MOM: [Okay. [#huh huh#

While the physician succeeds in resisting the mother's pressure for antibiotics in this case, in others physicians reverse their diagnoses and/or prescribe inappropriately (Stivers 2002b, forthcoming a). In such cases, patients have exerted pressure for prescriptions and coerced physicians into prescribing against their better judgment. This is the reverse of the 'surrender of private judgment' with which we began, and represents, in effect, an abrogation of medical authority.

In recent work, Heritage and Stivers (1999) have suggested the use of 'online commentary' as a means of resisting patient pressure to prescribe. Because a good deal of patient pressure is exerted through the problem presentation stage of the visit (Stivers, Mangione-Smith, Elliott, McDonald, and Heritage 2003), physicians often perceive patient pressure early on. In such cases, online commentary, in which the physician describes the physical examination as it is happening 'online' can be a means of defeating patient expectations. In the following case, the physician describes what he is seeing, in the process indicating that the patient's signs are mild. While this may reassure the mother that her child is not very sick, it also builds a case against antibiotics prescribing and 'forecasts' (Maynard 1996) an eventual 'no antibiotics' treatment recommendation:

- (12) [Heritage and Stivers 1999]
- 1 Doc: Can you op'n your mouth for me agai:n,
 2 (0.3)
 3 Doc: °'ats i:t°

- 4 (0.7)
 5 Doc:→ °Little bit re:d (.) hm°
 6 (1.6) ((moving sounds))
 7 Doc: °°Alri::ght(h)°°
 8 (2.8) ((more moving sounds))
 ((32 lines omitted))
 9 Doc: Ari:ght Michael. Can I loo:k >in your< ears
 10 (0.3)
 11 Mom: °This o:n[e:°
 12 Doc: [ˈʌŋk you
 13 (0.9)
 14 Doc:→ 'ats fi:ne the other one?
 15 (4.5)
 16 Doc: ktch °okha::yh°
 17 (0.5)
 18 Doc:→ They're alri::ght(h). I mean there's a *just a li:(tt)le*
 19 → redness in his *throa:t* an:d and just a little pinkness ther:e
 20 → which (.) means he's got one of tho:se *co:lds* that make them
 21 → cou:gh a lot .hh Because his chest is pe:rfectly all ri:ght
 22 → he *ce:r*tainly doesn't need (.) penicillin
 23 Mom: N:o[:
 24 Doc: [°r anything like tha:t° .hhhh hh I think the *coughing* ...
 ((talk continues))

Here the online comments (lines 5 and 17) 'forecast' the diagnostic outcome, which explicitly retrieves them as part of the case against prescribing (lines 21–24). Here, we might say, Peräkylä's 'evidence formulating' starts earlier in the medical visit and is used ancillary to a 'no treatment' recommendation. Preliminary findings suggest that this kind of online evidence formulating can reduce inappropriate prescribing (Mangione-Smith, Stivers, Elliott, McDonald, and Heritage 2003).

3. Conclusion

What conclusions are to be drawn from this array of conversation analytic studies of medical practice? First, it is clear that the act of diagnosis remains a fulcrum in the exercise of medical authority. None of the studies reviewed here shows a significant incidence of explicit disagreement with medical diagnoses. This is so even though the medical conditions being addressed are the relatively minor staples of primary care medicine in which patients may have some experience and 'expertise,' and it may be surmised that in more serious, unusual or life-threatening conditions the conclusion holds with still greater force. The older Byrne and Long study shows physicians exercising this authority in a fashion which is quite

authoritarian, though this observation and those of Heath's later study need to be seasoned with Peräkylä's observations, which suggest more of a balance with social accountability than is traditionally observed in the sociological literature.

The studies of antibiotics prescribing qualify these observations significantly. They suggest that in cases of mild illness which patients have frequently experienced in the past, medical authority is compromised by a tacit bargaining process, in which the perception that patients may become dissatisfied with their medical care may outweigh the exercise of clinical judgment. Paradoxically, if the results of the 'online commentary' study are borne out by further research, physicians can redress the balance by a more fundamental exercise of the cultural authority of medicine: the capacity to 'name the world' which in this case takes the form of unchallengeable observations about patient signs and symptoms. Yet this too involves a revision of physician authority. 'Online commentary' is 'evidence formulating' and reveals a process of diagnostic reasoning to the patient, thus further redrawing the balance between authority and accountability a little further in the direction of accountability.

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Chapter 6

“I just wanna know *why*”: Patients' attempts and physicians' responses to premature solicitation of diagnostic information

Charlotte M. Jones and Wayne A. Beach

Picking up on the issue of authoritarianism raised by Heritage in the previous chapter, Jones and Beach examine how authoritarianism gets enacted throughout physician–patient encounters. A collection of instances are analyzed where patients solicit diagnostic information during initial moments and phases of medical interviews. In response, doctors treat such actions as premature and generally avoid addressing patients' concerns. The authors then examine instances where patients take the initiative, despite discouragement, to pursue diagnostically relevant responses. For the most part physicians continued to not respond willingly to patients' pursuits, revealing their dispreference for ongoing patient-initiated questions (and related actions). But the authors also describe interactional environments wherein patients shape their initiations in ways that doctors treat as acceptable. After exploring specific features of interactions resulting in more positive responses by physicians, it becomes clear that mutual involvement and decision-making can be enhanced through collaborative approaches to medical care.

During medical interviews patients seek assurance, solicit diagnostic information from physicians, and even proffer their own diagnosis of an illness. We examine a range of soliciting techniques employed by patients as they pursue understandings about their medical condition, and in response, how physicians treat such contributions with hesitation and indirectness. At times, physicians are also shown to disattend patient-initiated topics by moving back to biomedical agendas. Acting as though patients' contributions are untimely and/or altogether inappropriate, physicians appear to treat patients as resisting adherence to a biomedical model in which *physicians* address diagnoses, and only subsequent to data-gathering and physical examination. The result is a marked contrast in orientations to communication in medical interviews, where patients' lay concerns and diagnoses get raised but only minimally acknowledged by clinicians (Beach 1995, 2006; Beach and Mandelbaum 2005; Jones 2001; Lutfey and Maynard 1998; Peräkylä 1991).