

Beyond ‘doctor and patient’: developments in the study of healthcare interactions

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Introduction

Over the last three decades, conversation analytic (CA) studies have illuminated some of the fundamental organisational features and interactional processes in a broad array of medical encounters. Investigations of interactions between physicians and patients have been a cornerstone of this field since the early 1980s. However, conversation analysts have also moved beyond the dyadic doctor-patient encounter to consider interactions between a wider range of healthcare professionals and their clients, and between a variety of healthcare professionals themselves.

Practical motivations spurred some of the earliest CA research on encounters between doctors and patients. Beginning in the late 1970s, a few conversation analysts began videotaping primary care consultations. Among these was Richard Frankel who, as a faculty member in a department of medicine, had a practical interest in improving communication and was exploring how videotapes could be used for physician training. Frankel recognised that CA could be an especially useful tool for understanding the dynamics of medical encounters, given that so much of medical practice consists of real-time conversations between doctors and patients. Recordings of these conversations and detailed written transcripts provide direct and repeated access to the practices the participants use to accomplish actions and activities during medical encounters. This access allows for the systematic study of medical interactions and detailed specification of recurrent interactional processes (Frankel 1983, see also Frankel and Beckman 1982).

The concrete findings CA generates can be used to help doctors (and patients) become more aware of and sensitive to their actions, which ultimately stands to improve health and healthcare. Frankel (1990), along with other pioneers in the field – including Christian Heath, Candace West, and Paul ten Have – took a firm stand that any recommendations for improving communication between doctors and patients must be grounded in the details of actual interaction. As West argues, ‘...it is only through systematic empirical study of the minutiae of doctor-patient interaction that we can learn what constitutes the alleged communication “gap” between doctors and patients, and how it might be transformed’ (West 1983: 103).

The contribution of this work has not been restricted to issues relating to medical communication skills. Through systematic study of the details of medical encounters, conversation analysts have been mining a rich sociological seam for 30 years. Their work shares with other types of observational research in the sociology of medicine (*e.g.* ethnographic studies such as Emerson 1970, Silverman 1987, Byrne and Long 1976, and Strong 1979) a concern to witness and document naturally-occurring social interactions in medical settings. Like ethnomethodological investigations of medicine (Sudnow 1967) and of allied medical fields

such as psychiatry and psychotherapy (Coulter 1973, Turner 1972, Wootton 1977, Garfinkel 1967), CA investigations focus on the generation of social order, particularly how participants organise their work routines and engage in (and display) sense-making practices in real time. The CA approach reveals how, turn by turn in conversation, participants produce the social organisation of different types of medical encounters – with their attendant tasks and projects, asymmetries of authority and expertise, and particular interactional dilemmas. This approach enables empirically-grounded, concrete specifications of *what* is done in medical interactions and *how* this is achieved (Halkowski and Gill, forthcoming), findings that can be shown to others and verified by reference to the data (Sacks 1984).

Of particular significance for medical sociology is CA's ability to reveal and unpack the fundamentally collaborative and contingent nature of medical encounters (Maynard and Heritage 2005, Heritage and Maynard 2006a). This is achieved, in part, through its distinctive methodological commitments and concerns. In particular, CA notes that in all interaction, people are ongoingly attentive to the talk and visible conduct of their co-participants. Indeed, they rely on each other to make sense of emergent conduct by virtue of what has happened immediately before; that is, in the light of the sequential context. Because they routinely do so, a speaker can position an utterance in a particular location to give it a particular sense as an action without spelling it out in so many words. A related aspect of the collaborative nature of interaction is that actions are typically accomplished via sequences, where one participant initiates a sequence (*e.g.* asks a question, makes an offer, presents a proposal), making it relevant for the recipient to produce the second part (*e.g.* to answer the question, accept or decline the offer, agree or disagree with the proposal) (Schegloff and Sacks 1973). Whatever is produced after the sequence initiation is likely to be understood as responsive to it, unless marked otherwise. The production of action (the 'what is being done here') is also a contingent matter: in a responsive turn of talk, a recipient might or might not exhibit a particular understanding of a speaker's utterance, and in the ensuing talk, the original speaker might or might not correct this displayed understanding (Schegloff and Sacks 1973). As in ordinary conversation, social actions in medical settings are jointly accomplished over time, as the interaction unfolds (Heritage and Maynard 2006a).

These methodological commitments and concerns have important implications for the investigation of medical encounters and what can be discovered about them. Here we will mention just two of these implications. First, rather than treating aspects of social context (*e.g.* doctors' and patients' respective social statuses, power, knowledge asymmetries, etc.) as exogenous factors that affect participants' behaviour in predictable ways during medical consultations, conversation analysts begin with sequences of talk themselves and show how the participants build consultations with them – *i.e.* how they employ sequences in interactional practices and thereby carry out particular tasks, establish and maintain boundaries of expertise, display knowledge asymmetries, and the like. This approach enables a concrete understanding of how the social reality of medical encounters is accomplished in real time, and how interactional dilemmas (and their solutions) emerge.

A second and related implication is that CA investigations of medical encounters focus as much on *patients'* behaviour as doctors' behaviour. As Heritage and Maynard (2006b: 19) assert, 'It is by acting together that doctor and patient assemble each particular visit with its interactional textures, perceived features, and outcomes'. This approach has generated some significant findings about the nature of patients' participation and agency in medical encounters, findings that would not necessarily be predicted or uncovered if one starts with the assumption that, for example, patients' status precludes the exertion of agency (see Collins *et al.* 2007).

CA research on doctor-patient interaction: key issues

The major themes of the last 30 years of conversation analytic work on medical encounters have, then, emerged from the organisation of the encounters themselves, the tasks that participants accomplish, and the specific interactional issues and dilemmas to which the participants orient. For example, primary care medical consultations (especially acute-care visits, but also some non-acute visits) are typically organised around the twin goals of diagnosing the patient's medical problem and recommending treatment. To do this, the doctor and patient (1) come together and establish a relationship (*opening*), (2) the patient expresses the reason for the visit (*presenting complaint*), (3) the doctor examines the patient (*examination*), (4) the doctor produces an evaluation of the patient's condition (*diagnosis*), (5) the doctor proposes treatment for the condition (*treatment*), and (6) the doctor and patient terminate the visit (*closing*) (Heritage and Maynard 2006b: 14–15, see also Byrne and Long 1976, ten Have 1989, Robinson 2003).

The issues and dilemmas that emerge within these encounters reflect these activities. For example¹: patients face the issues of how to put their concerns on the floor (Robinson and Heritage 2005); how to show themselves to be properly oriented to their bodies (Halkowski 2006, Heritage and Robinson 2006, Heath 2002); how to direct the doctor's attention toward and away from certain diagnostic possibilities (Gill and Maynard 2006, Gill *et al.* forthcoming, Stivers 2002b); and how to deal with diagnoses and treatment recommendations that may or may not correspond to their own views and preferences (Heath 1992, Stivers 2002a, 2006, Peräkylä 2002).

From the point of view of doctors, issues include eliciting all of a patient's concerns (Heritage *et al.* 2007, Robinson 2001) and designing solicitations that are fitted to the concerns that patients are likely to have (Heath 1981, Robinson 2006); preparing patients for no-problem diagnoses (Heritage and Stivers 1999) as well as difficult diagnostic news (Maynard 2003, Maynard and Frankel 2006); and securing patient agreement in regard to diagnoses (Peräkylä 2006) and treatment recommendations (Stivers 2006, Roberts 1999).

In other genres of medical encounters – *e.g.* those outside doctor-patient interaction – the major tasks may be quite different. Visits may be therapeutic in nature (*e.g.* engaging in physical therapy), administrative (*e.g.* admitting a patient to the hospital), related to instruction (*e.g.* instructing a resident during a surgery), etc. This, in turn, engenders different sets of interactional issues and dilemmas, as we will discuss below.

Beyond the doctor-patient consultation

Over the past ten to fifteen years, we have witnessed an increase in the number of conversation analytic studies that consider settings and activities beyond the doctor-patient consultation. For example, recent studies have explored ante-natal screening and examinations (Büscher and Jensen 2007, Nishisaka 2007, Pilnick 2004), AIDS/HIV counselling (Peräkylä 1995, Silverman 1997), anaesthesia (Hindmarsh and Pilnick 2002), child counselling (Hutchby 2007), health visiting (Heritage and Sefi 1992), dentistry (Anderson 1989, Hindmarsh in press), emergency calls (Whalen *et al.* 1988, Whalen 1995), homeopathy (Ruusuvuori 2005), medical and child helplines (Greatbatch *et al.* 2005, Pooler forthcoming, Potter and Hepburn 2003), pharmacy (Pilnick 1998), physiotherapy (Parry 2004, Martin 2005), psychiatry and psychotherapy (McCabe *et al.* 2002, Antaki *et al.* 2005, Peräkylä *et al.* 2008, Speer and Parsons 2006) and surgery (Koschmann *et al.* 2007, Sanchez Svensson *et al.* 2007, Mondada 2007). Furthermore, there are a range of recent studies relevant to

medical sociology that stand outside formal healthcare settings, such as research concerning Alcoholics Anonymous (Arminen 1998) and the family (Beach 1996). Also of note are a set of studies that consider the bodily and vocal skills and competencies of people with communication disorders of various kinds (Goodwin 2003, Wilkinson *et al.* 2007, Beeke *et al.* 2007, Finlay *et al.* 2008, Maynard 2005). In doing so they detail the communicational competence rather than incompetence of people who have difficulties in speech and communication and, as such, have important contributions to make to speech therapy, as well as our understanding of forms of (dis)ability.

It is not simply the breadth of recent conversation analytic work on health and illness that is of value here (although that indeed is of value). More importantly, the consideration of these diverse settings and activities introduces new issues, and allows for the specification of existing issues, of sociological interest that cannot be captured in the study of doctor-patient interactions alone. This range is considerable and we cannot hope to do it justice. However, it may be worth highlighting three particular issues in order to illustrate some of the contributions that these developments are making. These concern: (i) different dilemmas that arise in practitioner-patient interaction beyond encounters between doctors and patients; (ii) interaction between healthcare practitioners, and (iii) how new technologies feature in the course of healthcare delivery. As will become apparent, these three issues have particular relevance for the present collection of studies.

Practical problems in practitioner-patient interaction

The consideration of a wider range of sites for healthcare introduces novel forms of activity and even types of patient. For instance, whereas doctor-patient consultations (especially acute-care consultations) are fundamentally concerned with issues of diagnosis and the discussion of treatment plans, other sites of practitioner-patient encounter relate more centrally to treatment delivery. Examples of such 'hands-on' treatment-based interactions include the work of physiotherapists, dentists, speech therapists and podiatrists. The very involvement of practitioners in physically treating patients raises some distinctive challenges and issues in the interaction. For example, in encounters in physiotherapy and speech therapy, one issue that emerges relates to a patient's performance during therapy sessions. When the patients display forms of physical or verbal 'incompetence' or 'trouble', then this requires correction and management. In their domestic interactions, lapses in competence by the patients tend to be explicitly noted and corrected by partners or relatives. However, studies of institutional encounters (Parry 2004, Lindsay and Wilkinson 1999) find that therapists are less likely to make explicit reference to troubles. Thus, within practitioner-patient encounters, incompetence is produced and oriented to as a sensitive issue. This sensitivity is grounded in the fact that one possible reason for incompetence is a potential lack of effort on the part of the patient, whilst another is the failure (or lack of progress) of the therapy itself. So these findings highlight the ways in which the particular institutional character of the encounter is accomplished in (and through) the forms of talk that feature within the setting.

In other settings, the combination of the tasks that must be performed in the encounter and the specific cohort of patients with whom practitioners interact, produces interactional dilemmas not typically found in doctor-patient encounters – especially those occurring in acute-care visits in primary care settings. For instance, hospital pharmacists in Britain are bound by a code of ethics to ensure that patients know the proper dosage instructions for their medications. However, patients who have chronic illnesses, and their caregivers, may already be well familiar with matters of dosage and administration. When pharmacists interact with these patients and their caregivers, they face the dilemma of how to adhere to

ethical codes without treating the recipients as less knowledgeable than they actually are (Pilnick 1998). The move to consider a wider range of healthcare interactions provides opportunities to explore such dilemmas and their interactional solutions, ones which are relatively uncommon in certain types of doctor-patient encounters. Thus, they provide more opportunities to consider how these circumstances are handled as a matter of routine.

These studies also demonstrate the ways in which 'blanket' recommendations for practice struggle in the face of local contingencies. Different types of healthcare place distinct demands on practitioners and patients and there may be different agendas and asymmetries at work. As Peräkylä *et al.* (2007: 140) note with regard to standardised recommendations for patient involvement, 'The relevancy of [different] forms of participation ultimately arises from the overall goal of the encounter, as well as from the theory of healing that guides the interaction'. Indeed, even within a single setting for healthcare delivery, policies and recommendations can raise challenges to practitioners who are dealing with patients with various levels of knowledge, expertise and commitment. To fully understand the impact of these recommendations, therefore, requires analysis of the ways in which they are deployed and treated in a range of practical circumstances of use (see also Collins *et al.* 2007). Moreover, it is valuable to ground the development of policies and recommendations in a solid understanding of actual practice.

Interaction between healthcare practitioners

While much work on communication in healthcare has been concerned with encounters between medical professionals and patients, one strand in the emerging body of conversation analytic work on healthcare considers forms of communication that arise in real time, between members of healthcare teams – in meetings (*e.g.* Housley 2003) or in the very course of treatment (Hindmarsh and Pilnick 2002, Mondada 2007, Sanchez Svensson *et al.* 2007). These investigations, and others, address Atkinson's concern that there is 'far too little research on how medical practitioners from different specialities cooperate or compete in the management of particular conditions' (Atkinson 1995: 34).

Perhaps the most significant body of work on interactions between practitioners concerns an issue of long-standing interest in medical sociology, namely medical (and professional) socialisation and training. A particular dilemma for practitioners in these cases relates to the ways in which medical practice is bound up with medical education. As Bosk (1979: 3) suggests, the superordinate must allow room for the trainee to make what he calls 'the honest errors of the inexperienced' in order to avoid damaging the confidence and the learning experience of the trainee. At the same time supervisors must ensure the quality of the patient's treatment. These can be conflicting concerns.

Some of the most complex and delicate analytic work in this area relates to one of the most complex and delicate medical specialities, surgery. For example, studies by Koschmann and colleagues (2007 and forthcoming) explore the artful practices in and through which surgeons provide instruction while operating. In particular, they consider how surgeons render visible specific features of the anatomy, and stages of the procedure, in the very course of those procedures. These studies are notable as they demand especially close attention to the bodily and material resources brought to bear in the interactional organisation of instruction. As a result, these studies often involve multiple cameras, multiple microphones and live audio-visual mixing in order to capture the action in sufficient detail to support the analysis. Importantly, the studies demonstrate how the surgeon's talk is only understandable (for participant or analyst) by virtue of its association with gestures and visible conduct and the wider 'material' context(s) in which it is produced and seen.

Issues concerning the relationships between medical practice and medical training are further complicated in other settings, for instance general hospital medicine (*e.g.* Pomerantz and Ende 1997, Pomerantz *et al.* 1995). Whereas in many surgical procedures the patient is often (although not always) fully anaesthetised, in general medicine, the patient is fully conscious and aware of the interaction between participants. All parties to the encounter manage the interactional and practical tensions that can arise in balancing teaching and learning with communication with the patient. For instance, Pomerantz and colleagues delineate the practices through which supervisors maintain the junior doctor's role as the primary caregiver while still monitoring their work and advising on the case in hand.

Interaction between healthcare practitioners (and indeed between experts and novices) also introduces more complex and variable forms of participation than are exhibited within general practice doctor-patient encounters. Rather than a straightforward interaction between practitioner and patient, many of these settings involve multiple parties to healthcare encounters with variable occupational concerns, specialties and interests. This can have implications for the very ways in which treatment is organised and delivered. Furthermore, it can have an impact upon the quality of communication with patients, as other activities such as training conversations, instructions or even decisions, are managed 'front stage' and are thus hearable (and visible) to the patient.

New technologies and healthcare interaction

Some of the most important developments in healthcare in the past few decades have related to the use of new technologies. Take for example, ultrasound scanners in ante-natal screening, systems to support laparoscopic surgery, telecare monitoring systems, and of course the various scripts and forms, whether on paper or computer, that underpin so many features of healthcare service and delivery today. Given the relevance of technology in modern healthcare, there are numerous recent studies that consider the ways in which anything from inhalers to electronic patient records are changing the organisation and delivery of care (for a review see Heath *et al.* 2003). Most relevant to this collection are a number of studies that consider how participants use technologies in the course of encounters relevant to health and illness. In each case the focus is not on what the technologies are designed to achieve, but rather with how they are put to work, how they feature, and how are they oriented to in sequences of interaction.

One example is the use of expert systems to support medical helplines. In a study of NHS Direct, Greatbatch *et al.* (2005) noted that their clinical assessment system (CAS) was designed to standardise and control interaction between the callers and the nurse call-takers. However, in interactions that emerge in delivering the service, participants work with – and around – features of the technology in artful and unexpected ways. Instead of the system enforcing standardisation, the nurses can be seen to prioritise their own knowledge and expertise and to 'adapt, tailor, qualify and supplement' advice and information for the specifics of the caller's problem' (Greatbatch 2005: 825). The use of the system and the management of the conversation by the nurses are delicately interwoven. This raises fundamental questions about attempts to manage or control healthcare interactions, the tension between abstract procedures and local contingencies, the distributions of expertise between new technologies and professionals and indeed the very nature or purpose of medical helplines.

In these and other ways practitioners need to 'manage' new technologies in the course of communication with patients. The technologies can introduce practical problems for practitioners in ensuring the 'flow' of conversation (Greatbatch *et al.* 1995) and they can also introduce distinctive dilemmas for practitioners in discussing medical issues and con-

cerns. Take, for example, the use of screening technologies in ante-natal care. These new technologies do not lead to definitive diagnoses of potential fetal abnormalities, but rather generate 'risk figures'. Communicating the meaning of these risk figures, such that prospective parents can make informed decisions, is a complex interactional matter (Pilnick 2004). The decisions asked of prospective parents require some understanding of the technology and the associated figures that it generates. So the introduction of the technology poses challenges to practitioners aiming to follow recommendations of shared decision making and the like, as they must not only communicate the figures but the reliability of the tests and technologies involved and their relevance for the pregnancy. These and other studies of healthcare technologies in interaction, therefore, can inform technological developments and indeed training programmes, by emphasising the communicational contexts in which technologies feature, rather than solely their technical operation and functionality.

Introducing the collection

The chapters that we have selected for this book build on the established tradition of applying CA to medical interaction, and many draw heavily on the key themes and findings that we have summarised above. Critically, they advance this work by unpacking some of the distinctive practical problems or institutional dilemmas that arise in different healthcare settings. The authors of these chapters also reflect upon the practical relevance of their work, and the ways in which the understandings they present may be used to address these dilemmas. As the title of the collection suggests, the themes of policy, participation and new technologies are at the forefront of the analyses presented here, just as they are at the forefront of many recent developments in healthcare.

The first chapter in this collection is a groundbreaking study of the solicitation of donated human tissue over the telephone, unpacking how call centre personnel work to solicit donations from the family of the deceased person. Weathersbee and Maynard's analysis shows how solicitation is carried out cautiously, incrementally and tacitly, reflecting both its interactional status as a dispreferred action and its wider delicacy. Their analysis is located within a wider policy context, as they highlight the shortage of donated tissues in the US and a drive to increase donation rates. In this context, the authors show how configurations in the wording of solicitations may operate interactionally but unintentionally to impact on the act of donation, in some cases encouraging it and in others acting to discourage. Solicitation is carried out tacitly, such that callers avoid overtly requesting donations, and instead 'mask' their requests as other actions such as 'ostensible offers', or 'notifications' that the decedent has the potential to donate tissue. However, whilst this orients to the very real sensitivity and delicacy of the situation, it also presents an early opportunity for the call recipient to decline, and Weathersbee and Maynard note that call makers never aggressively strive to convert refusals into consents. It has been argued that donation rates vary as a result of the logistical efforts of procurement organisations, but the analysis presented here shows how examination of actual interaction is critical for understanding this, since aspects of this interaction may exert a very real effect on outcomes. In other words, when policy initiatives do not come to fruition in the way that has been hoped, the authors show how it may be necessary to trace this process back to the fine details of how the involved parties talk to one another. As such, the chapter presents the first step in a crucial programme of research in organ and tissue donation, which until now has focused on who asks for donations or in what context they ask (face to face, over the phone) rather than how they ask.

The relationship between policy and interaction is also a key theme of our second chapter, by Butler, Danby, Emmison and Thorpe. At the same time, the authors address a classic and recurrent theme in the sociology of health and illness: the asymmetrical distribution of knowledge between medical professionals and the lay public. However, here it is applied to a very modern context – calls to a Child Health telephone line. As the authors note, the rising costs of face-to-face primary care have resulted in an increasing provision of broadly defined health services being devolved to telephone contact. The operation of such helplines generally involves clear policies and guidelines regarding appropriate call handling. Such guidelines may relate to professional boundaries and the institutional role of the call taker (for example nurses may not be permitted to diagnose), but they may also relate to the use of a particular paper or computer-based protocol to be followed. The Child Health Line under investigation is intended to offer support and information on children's behaviour, health and development, with guidelines that nurses should not provide specific 'medical advice'. However, callers regularly request medical advice, and assume that the nurses answering their call will be able to offer it. Such an assumption is understandable given the name of the service and a common sense understanding of the term 'health'. The guidelines thus result in multiple constraints, and obvious tensions, to be managed by the call-takers. The authors examine how these nurses manage the apparent paradox of responding to callers' needs by delivering what may be interpreted as medical advice, whilst formally and accountably abiding by service guidelines not to do so. Given the ambiguity and overlap between 'medical' and 'child development' issues, and what counts as advice as opposed to information, it would be virtually impossible for nurses to adhere strictly to the guidelines. The analysis illustrates how they use these ambiguities as a resource, in order to respond to callers' concerns. In this way the chapter shows how institutional guidelines and policies are 'talked into being' in the course of interaction with clients.

Our third chapter also situates itself within a policy context, but this time addresses policies specifically designed to encourage patient participation in healthcare. Talk about the meanings and rationale of procedures and proposals has been identified as a key issue in patient-centred care, shared decision making and patient education (Collins 2005) and is encouraged by official guidelines (*e.g.* NHS 2003). In her chapter, Parry offers an empirical examination of talk about reasons and rationale in healthcare consultations, by focusing on physiotherapists' accounts for the treatment actions they propose, instigate and conduct. Previous work in primary care (*e.g.* Peräkylä 1998, 2006) shows that accounts related to diagnosis do particular kinds of interactional work above and beyond the 'face value' explanations they provide. Critically, in making their reasoning apparent to patients, doctors balance their authority with accountability, and treat patients as individuals who are both interested in and capable of understanding. Accounts tend to occur in circumstances of overt or incipient patient resistance, where proposals run counter to patient expectations, and where the reasoning underlying actions is not obvious. Parry's work builds on this by extending it to a different clinical setting, and by examining accounts for treatment-related actions as opposed to diagnosis. Physiotherapy is a valuable setting for this kind of research because it generally requires visible and effortful co-operation on the part of the patient during treatment, and as such necessitates a particular focus on co-operation, persuasion and motivation. Whilst accounts in this setting are also found in circumstances where patients and therapists do not agree about the best way forward, where patients express concern over physical functions, or there is opacity about the rationale for a treatment proposal, Parry also finds new circumstances which have not been previously documented in the literature. Accounts are associated with removal or adjustment of

patients' clothing, and in this sense can be seen to relate to wider issues regarding the body, dignity, and the appropriateness of requests. They are also provided when treatment actions are designed to remediate some locally evident physical failure, and in this context help to build a sense that the problem that has manifested is a solvable matter that can be addressed in partnership. This latter category of accounts is used to persuade, influence and motivate patients, and as such has important implications for practice.

Participation may also come to be treated as a moral matter in healthcare. Obesity has been described as 'the modern epidemic' (WHO 2000) and is a key priority for governments and healthcare systems worldwide. However, there has been a lack of sociological work examining the way in which the condition is managed in the course of weight-loss consultations. This is of particular significance, given that the first line of treatment for obesity is behavioural intervention, achieved through advice giving on diet, exercise and lifestyle. The categorisation of obesity as a lifestyle issue positions the obese individual as normatively responsible for onset of obesity and as responsible to contribute to its management. The chapter by Webb in this volume addresses this gap in the literature through detailed analysis of consultations in two UK NHS obesity clinics. The focus of the analysis presented here is on opening questions, and the way in which patients' answers to these orient to moral issues of responsibility, and perform moral work. Webb shows how, when patients produce their answers to opening questions, they typically imply either 'success' or 'lack of success' in their weight loss programme. Whilst doing this, they construct their personal agency in different ways. Patients enhance their agency when reporting behaviours that would imply success, such as weight loss, continued exercise etc. By contrast, patients whose responses imply lack of success tend to minimise their agency, emphasising instead the role of external or unavoidable factors. As Webb concludes, these different types of response have resonance with the perceived responsibilities of obese patienthood, and highlight the particular moral responsibilities to which patients orient. Like many of the other chapters in this volume, the findings have important implications for healthcare practice, in this case by demonstrating how patients handle the tensions between moral and institutional agendas.

The next chapter considers participation in a more established doctor-patient context, but is distinctive in that it involves more than two participants. Clemente examines how older paediatric patients manage assistance from their parents in chronic pain consultations. In the context of answering questions from clinicians about symptoms, the chapter lays out child-initiated strategies that preclude, solicit or limit parental assistance in situations where the child is having difficulties providing an answer. The wider literature on doctor-patient interaction illustrates that providing clinicians with symptom information is not always an easy task – for example, patients must judge what is relevant and what counts as 'medical' (Heritage and Robinson 2006). This is complicated further in the setting Clemente considers, because in cases of recurrent non-malignant pain there is often a long and complex medical history. Careful analysis shows how information provision is a collaborative process supported in this context by the clinicians' strong commitment to child-centredness. The end result is that children are able to solicit and draw on parental assistance without losing interactional control, or the opportunity to present their own symptom accounts. Ultimately, the success of the children's strategies depends on the fact that they invite specific types of parental support whilst excluding other forms of parental participation. For example, parents' contributions may be framed as temporally limited or as responsive to the child, thereby underlining the role of the child as the primary informant. Through this combination of invitation and exclusion, children manage to assert agency and control. Children's limited participation has been identified as potentially problematic across a range

of medical settings, and Clemente concludes by suggesting that clinicians can promote children's participation by being sensitive to the strategies they employ. This chapter makes an important contribution to the wider study of paediatric medicine by illustrating the importance of studying it as a triadic rather than dyadic process. Focusing on doctor-child or doctor-parent communication alone would fail to uncover the delicate inter-relationship between the contributions of all three parties (see Stivers and Majid 2007).

Sanchez-Svensson, Heath, and Luff also consider multi-party encounters, but in a rather different context, where various members of a surgical team manage training episodes within the course of surgical procedures. Indeed, a longstanding interest in the sociology of health and illness has been the way in which healthcare expertise, practice and clinical mentality are established both through formal training and social interaction with peers (*e.g.* Becker *et al.* 1961). Less attention has been paid to the way in which forms of training and instruction are managed in moments of social interaction. The authors address this issue by examining the ways in which surgeons, alongside other members of the surgical team, carry out activities of demonstration and instruction. It is widely recognised that surgery requires a mixture of intellectual, technical and manual skills, and as the authors note, these skills can only be acquired through an opportunity to observe and discuss them *in situ*. Trainees must not only see what is happening, but also know how to make sense of it, and learn how to apply that knowledge contingently. Using video data, Sanchez-Svensson *et al.* carefully analyse how it is that surgeons make particular phenomena and procedures accessible and intelligible to trainees. What the authors describe as 'momentary revelations of the surgical field' provide the resources for trainees to follow, understand and where appropriate contribute to the production of a complex medical procedure. The intricacy of the tasks at hand make training a particularly complex process in this environment, and this complexity is added to by the fact that throughout the activities of training, the integrity of medical practice must be preserved. The analysis also reveals how instruction and training in this context rely upon the abilities of other professionals who are present, such as nurses and anaesthetists. They must anticipate and remain sensitive to episodes of teaching, to enable these to be interwoven with the surgical task at hand. The findings here have implications for the study of 'situated learning' across healthcare and beyond.

The theme of participation continues into the next chapter, but is explored from a rather different perspective. This chapter also introduces our final theme, that of technology. The need for increased patient participation during interaction with nurses has been foregrounded in a range of recent UK 'best practice' documents (*e.g.* Royal College of Nursing 2003). Jones's analysis focuses on one particular area of nurse-patient communication, the admissions interview. Specifically, it focuses on the use of the technology of the paper-based admissions document that nurses complete during the interview, and examines how the use of this document affects the interaction that takes place between nurse and patient. The analysis shows how the topics that are discussed, and the way in which they are discussed, are often closely related to the layout of the paper document. Whilst this may be logical in an administrative sense, the juxtaposition of topics on the assessment form (where, for example, the topic 'sleeping' is adjacent to that of 'dying') may make little common sense to patients who are attempting to orient to the discussion as a coherent interactional sequence. If patients' health needs and experiences are discussed as a series of apparently unrelated topic areas, this conflicts both with the ways in which people normally experience illness and the ways in which they normally interact. The end result is that patients' participation is limited both because only one specific and delimited topic is considered relevant at any one time, and because the ordinarily 'messy' talk which is produced by patients must

be made to fit into the appropriate topic-limited and space-limited section of the document. These findings are interesting, given that some nurses have resisted the introduction of more traditionally defined technology in the form of electronic patient records, for fear they restrict the patient's voice (Rhodes *et al.* 2006). However, as Jones points out, in order to address these issues and enhance possibilities for patient participation, we must guard against focusing on the templates or technologies, whether they be paper or electronic in form, and examine instead the way in which they are used in practice. Jones concludes by noting that 'best practice' guidelines should be grounded in a better understanding of the interactional dynamics of nurse/patient interaction and the contextual influences of specific nursing tasks.

Our final contribution to this volume continues the theme of the impact of healthcare technologies on medical interaction. However, this chapter examines medical interaction of a rather different kind from the other contributions to this volume: the interaction between doctors' reports of medical treatments, the individuals or systems that formalise them into reports, and the resulting documentation. As Jones's chapter in this volume highlights, medical records of one form or another play a central role in many aspects of healthcare, but little research exists on their creation. Using data from a study of healthcare documentation production, David, Garcia, Rawls and Chand examine the process of medical record creation through the use of speech recognition technology (SRT) and subsequent editing by medical transcriptionists (MTs). Their analysis shows that the work of MTs combines both skilled worksite practices (for example understanding what the normal range of values might be for a particular laboratory investigation) as well as an orientation towards the socially ordered properties of dictated speech. This latter orientation includes an understanding of the way in which spoken language is different from written language, for example the ways in which speakers produce self-corrections, or use voice inflections to indicate punctuation. Medical transcription, then, involves essential knowledge work based on social practices, and since SRTs cannot do this, there are limitations to their use and dangers of over-reliance on them. Through their single case analysis, David and colleagues show how MTs have the ability to create an 'intendedly unified object', and also to recognise and rectify many of the errors that SRT can introduce. The chapter is a timely reminder of the fact that, while new technology often holds the promise of improving healthcare, its application will not automatically result in doing so. As the authors identify, medical records, in common with other forms of socially constructed information, have essential social properties and so need to be considered within the context of their construction and use.

As a collection, the chapters contained in this book address the three themes of policy, participation and new technologies announced in the title, in the ways that we have described above. Taken together, what they also demonstrate is the breadth of medical interaction in which these issues come to the fore. They underline the utility of taking a conversation analytic approach to studying communication in healthcare settings, showing that the smallest details of the way in which the participants talk to one another can have sizeable impacts on the eventual outcomes. The study of doctor-patient interaction has been a cornerstone of the study of healthcare interaction, and CA researchers in this area of the field continue to generate important insights. However, healthcare today is more diverse than ever, and this encompasses not just the range of personnel who deliver care, but the settings in which they do so, the tools and techniques which they employ, the tasks they accomplish, and the dilemmas they confront. CA researchers have already begun to address this diversity, and we mean to add to this endeavour by bringing together the chapters in this collection.

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Note

- 1 This is an illustrative, and by no means complete, accounting of some issues and dilemmas that emerge in doctor-patient consultations and of the CA publications that explore them. Paul ten Have maintains an online bibliography of CA publications on medical encounters, an excellent resource to discover the range of studies in the field. See <http://www2.fmg.uva.nl/emca/medbib.htm>

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