

Control in the Medical Consultation



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Practices of Giving and Receiving the Reason
for the Visit in Primary Health Care

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ABSTRACT

CONTROL IN THE MEDICAL CONSULTATION: PRACTICES OF GIVING AND RECEIVING THE REASON FOR THE VISIT IN PRIMARY HEALTH CARE.

Johanna Ruusuvuori

This conversation analytic study examines doctor-patient interaction in Finnish primary care consultations. Using data from 100 video-recorded medical encounters with 14 different doctors, it describes in detail the structure of interaction in the phase of problem presentation. The focus of the analysis is on the doctors' and the patients' activities in giving and receiving the reason for the visit.

The results of the analysis draw attention to the widely maintained notion that medical consultation is a potential location of conflict and misunderstanding. It seems that although patients and doctors may at times have separate views on the definition of the ongoing action, they both have available resources for negotiating these definitions while interacting with each other. Instead of approaching the worlds of doctors and patients as separate, this study focuses on the process of interaction during which these worlds meet, and to the possibilities of negotiation and cooperation between them.

The results of the study both compensate and correct previous studies on control in medical consultation. On the one hand, they provide additional evidence to the prevailing idea of doctors having the ultimate control over the agenda of the consultation. On the other hand, they show how doctors' means of control are more manifold or even contrastive to those introduced in earlier studies. Further, the study introduces resources for control that patients have at their disposal and maps the opportunities they have for using them while presenting their problem to the doctor.

The study offers a detailed account on the ways in which the participants activities are informed by 1) the overall activity structure of the whole consultation as a request-response sequence, and 2) the moral task of justifying one's need for medical help. It also discusses and compares these Finnish results with observations made in American and British medical consultations on the one hand, and in other institutional situations on the other. The study, thus, opens up numerous possibilities for future comparisons in study of institutional interaction.

1. INTRODUCTION

This is a study of social interaction, specifically face-to-face interaction in a particular institutional situation, that of the medical consultation. It is limited to certain processes of talk-in-interaction which occur during a specific phase of the consultation, i.e., while giving and receiving the reason for the visit. In the study I will describe and analyze the ways in which patients tell the doctor about their problems, the ways in which doctors receive the patients' descriptions of their problems, and the ways in which each participant, in carrying out these activities, manages the course of consultation from their part: I will describe the process in which the consultation unfolds in interaction between the patient and the doctor. Throughout the study I will pay specific attention to the practices of talk and non-verbal action in and through which the participants control the course of consultation. In the analysis I will also touch upon the moral implications invested in the participants' turns of talk. The following introduction tries to account for the choices I have made in selecting specifically these aspects of the medical consultation as the objects of my study.

To begin with, I will briefly locate my approach within the fields of study of social interaction (1.1.) and research on doctor-patient interaction (1.2.). Next, I will describe the specific ways in which this study wishes to complement the existing body of research on doctor-patient interaction (1.3). Thereafter, I will describe the approach chosen for the study in more detail (1.4.), the focus and the aims of the study (1.5), the data and the method (1.6), and the structure of the study (1.7).

1.1. Social interaction as a primary focus of social psychological research

In social psychology, social interaction has mainly been studied with the help of variable-based theoretical models and experimental research designs aiming at achieving quantifiable information on the dynamics of interaction (Bull and Rogers 1989; Hopper 1989; Edwards 1997). One of the most influential researchers within this approach was Robert Bales¹.

¹ However, instead of designing strictly experimental settings and hypotheses, Bales used observation of a group of individuals in situations resembling naturally occurring ones as the basis for his considerations.

Study of action categories

In the 50's Bales developed a scheme for analyzing interaction processes in groups. Bales' analysis at that time concentrated around the division of labor which developed between the group-members in the experimental situations observed. He distinguished two aspects according to which group-members differ: instrumental and expressive² and assigned six action-based categories to describe each dimension. In this system, each act by the participants could be coded into one category of a twelve-step scale. Bales assumed that each action represents the meaning given to it by the one acting³. Thus, he presumed that the meaning of an action is constructed while the action is produced (Peräkylä submitted); he did not focus on how these actions were interpreted by the recipients.

Bales' scheme represents a widespread model of theorizing on interaction, which Edwards (1997, 90) calls the 'communication model' of interaction. Its starting point is that a situation where people interact consists of several individuals whose minds bear a distinctive content and who set out to influence one another. Within this approach, talk is perceived as a means of expressing the speaker's intentions, as a medium for exchanging ("pre-planned") thoughts between speaker and hearer. Human interaction is thus understood as transfer or flow of information between individuals (Wasserman and Inui 1983).

Later studies have identified different levels of communication within this transfer of information. Bateson (1987, e.g. 155-156) has distinguished between the 'content' and 'relationship' levels of communication. The content level refers to denotative information, whereas the relationship level contains information on affects and relationships between the interactants. The latter refers to a sort of meta-communication which may occur both verbally and non-verbally. This view thus takes into consideration the possibility that not only what is said, but also how it is said may be important in 'decoding the message', whereas in Bales' system each statement (unit of analysis) can be assigned to one category only⁴.

² Bensing, (1992) among others, has later termed these aspects as instrumental and affective.

³ This stance equals the one adopted by speech-act theorists, such as Austin (1962) and Searle (1969). See Schegloff (1992d) on a critique of the speech-act theory.

⁴ Harré et.al. (1985) also refer to 'practical' and 'expressive orders' as two concurrent modes of a single action.

Stiles' model (Stiles et al. 1979; Stiles and Putnam 1992; Putnam and Stiles 1993) for analyzing dyadic communication recognized the possibility that the meaning (or intent) of a statement (or a grammatically defined utterance) may be different from its grammatical form. For example, an utterance such as "Would you come in please" is formally a question, but has the intent of an invitation. However, Stiles' method does not allow for an investigation of non-verbal cues (Wasserman and Inui 1983). Furthermore, in common with the other methods within this approach, it assumes that the meaning of an action is inherent in its production, an action is depicted as a representation of the actor's mental intention.

This study will adopt a different stance, that of conversation analysis. Instead of individual actors and their individual acts, the focus of study will lie on the actual sequential process in which the participants' turns of talk follow one another. The meaning of their actions is perceived to be constituted in and through the continuum of these actions, in talk-in-interaction. Each action is seen as orienting to the relevances set in the previous action, and in its turn, respectively setting new relevances for the following action. Instead of trying to gain an exhaustive description of the situation by quantitatively describing the communicative styles of each interactant, the focus will lie on specific ways in which the interaction in question is organized. The locus of analysis is transferred from the individuals and their actions to the actual processes in and through which interaction occurs. Unavoidably, this approach results in a narrowing of the perspective: it becomes laborious to study whole conversations, and the focus of analysis has to be restricted to specified sequences of action in conversation.

Characteristics of the interactants and interaction

Some experimentally oriented researchers of social interaction have concentrated on studying specific features of talk, such as interruptions or non-verbal cues. In these studies the research setting is constructed through drawing upon some pre-defined characteristics of the participants. Specific features of interaction, such as interrupting or speech-dysfluencies, may be assessed with regard to specific group characteristics such as sex or institutional position, or perceived personality characteristics such as dominant vs. submissive. Thus aspects of interaction are related to features external to the actual talk-in-interaction (Bull and Rogers 1989, 3). As in Bales' tradition, the goal is to quantify the features in question in order to

make possible a statistical analysis. This line of study has produced results suggesting, for instance, that dominance correlates positively with the interruption-rate, whereas sex does not (Roger 1989), or that the participants of a conversation may accommodate themselves to one another's speech-styles (Giles et al. 1991).

Macroscopic structures and interaction

With regard to the role given to the social structure external to the situation in analyzing interaction, a quantitative analysis of this type resembles branches of discourse analysis where researchers examine the integration of specific macro-aspects in the interaction studied (although in discourse analysis, single conversations rather than statistical analyses of them are in the focus of interest) (cf. Engeström 1999, 49-58). For example, Waitzkin (1991) studies doctor-patient interaction from the point of view that doctors, in avoiding and discouraging talk about patients' life-world issues, reproduce the ideological status quo of the society (by reconstructing social problems as individual medical ones). Fisher and Groce (1990), on the other hand, point out how the prevailing reality of genders is sustained in the medical interview.

In this study the focus of interest lies not on the participants as representatives of specific pre-allocated categories, nor on representations of existing properties of social structure in interaction, but on the participants' actions in and through which they constitute the conversation as it occurs in the situation. The object of study is conversation per se, the talk and non-verbal actions of the participants as they unfold in conversation. Features of context external to the situation studied will be taken into consideration only if they are oriented to as relevant by the participants themselves. Thus, an observation such as the number of interruptions per situation and participant cannot a priori be considered as a relevant observation as such. Instead, in order to consider an interruption as a meaningful act, it should be oriented to as such by the participants themselves. (cf. Schegloff 1993).

Versions of mind and reality in interaction

A similar stance towards the study of interaction is taken in discursive social psychology represented by Edwards, Potter and Wetherell, among others⁵

⁵ Discursive psychology as a discourse analytic approach is often distinguished from critical discourse analysis, which is concerned with deconstruction of macro-level (ideological) discourses (Nikander 1995; Widdicomb and Wooffit 1995; Wetherell 1997).

(e.g. Potter and Wetherell 1987; Edwards 1997). Their focus is on studying how talk and text are constructed to perform social actions (Potter 1998). The line separating discursive psychology and conversation analysis is thin. One crude distinction would be the more inclusive view of discursive psychology on suitable data. In discursive psychology, also texts and interviews are regarded as valid data, whereas conversation analysis studies naturally occurring face-to-face conversation. Furthermore, discursive psychologists are specifically interested in studying the ways in which social psychological phenomena, such as cognition and emotion, are displayed and managed in interaction (e.g. Potter 1998). This is not the primary focus of interest in conversation analysis, though such phenomena may be studied with CA as well. Discursive psychologists preserve an open interest in ‘the versions of mind and reality’, whereas in this study, the focus is on finding and analyzing structures of social action which are used and managed in talk-in-interaction⁶.

The conversation analytic approach to the study of social interaction will be introduced in more detail in section 1.4. Next, I will briefly describe the ways in which approaches other than CA have been applied to the study of doctor-patient interaction. I will start by reviewing some major theoretical considerations on the doctor-patient relationship.

1.2. Doctor-patient interaction as a topic of study

Social scientific perspectives on doctor-patient interaction

The study of doctor-patient interaction in medical consultation was perhaps for the first time established as a topic of social scientific study by Talcott Parsons in his book "The Social System" (1951). In this study Parsons introduced his conception of the institutional roles of the doctor and the patient, using doctor-patient interaction as an example of the way in which the social system functions in general. In his view, illness was seen as dysfunctional for the society, and medical practice as an institution with the function of remedying this situation of imbalance. (Parsons 1951, 428-433). He perceived the division of labor between the doctor and the patient as being based on specialization of technical competence. In Parsons' view, doctors possess a high level of technical competencies which the patient is dependent on. This is the basis on which, on questions of illness, patients surrender

⁶ For a more detailed discussion on differences between discourse analysis and conversation analysis, see Potter (1996), Schegloff (1997b), Wetherell (1997), Potter (1998).

their private judgment to the doctor (cf. Lukes 1978, 639) and respect the doctors' medical authority.

In the 70's Freidson (among others) criticized this view maintaining that the reason why patients trust decisions concerning their illness to doctors is not the doctors' medical, scientific authority, but their professional authority. This authority is based on the doctors having a monopoly over various techniques of healing (for example, only doctors are allowed to prescribe medicine, etc.), and on the doctors' position as gate-keepers to several social benefits, such as sick-leaves, statements about the patient's health, etc. (Freidson 1970, 105-126).

Towards applied research on doctor-patient interaction

Since Parsons, several theoretically derived or historically specified 'models of doctor-patient relationship' (Szasz and Hollander 1956; Roter and Hall 1992, 21-38) or 'bedside manners' (Shorter 1986) have been introduced. Unlike the more macroscopic speculations by Parsons and Freidson, these models concentrate on medical interaction per se. Their aim is not to contemplate the relationship between agency and structure, to propose a grand theory on social structure or on professional dominance, but rather to describe and assess the development and the present state of the medical services specifically. In these models, the relation between the doctor and the patient has been perceived as more or less asymmetric: the proportion of the patients' autonomy and the doctors' authority varies.

Szasz and Hollander (1956) distinguished between three basic models, each of which would be applicable to a different type of illness. Thus, a model where the patient is a passive object of the doctors' activities could be applied in serious cases where the patient is, for instance, in coma. A model where the doctor guides the patient and the patient cooperates would be suitable for acute situations, for example a sinus infection which can be cured with medication. A model of mutual participation would be applicable in cases where the patient's illness is chronic, such as diabetes, which makes it necessary for him to help himself. Szasz and Hollander maintain that the last one is, in an evolutionary sense, more highly developed than the two others, as it requires more complex social and psychological organization from the participants. However, they also suggest that as different models are applicable to illnesses of different degree of severity, the models also help to

delineate areas across which it is meaningless to make comparisons. Thus the models are not arranged in an explicit order of preference.

Roter & Hall (1992, 28) name four different types of doctor-patient relationships: paternalism, consumerism, mutuality, and default. Paternalism stands for a situation where the physician is dominant and the patient is passive. Consumerism refers to an opposite situation where the patient as a consumer of medical services has the right to decide what to buy, and the doctor as the provider of the service has no particular authority. Mutuality is described as a more moderate alternative than paternalism and consumerism. In this model a reasonable sharing of decision-making responsibilities is suggested, drawing upon the division of labor of the participants. The default model is the opposite of mutuality, and refers to a hypothetical situation where neither of the participants assumes responsibility for making decisions. Unlike Szasz & Hollender's, Roter & Hall's typology treats the different models as interchangeable, and explicitly prefers the mutuality model over the prevailing paternalistic one.

Shorter (1986) approaches the doctor-patient relationship from a historical perspective where he distinguishes three periods of American medicine and discusses the development of the doctor-patient relationship throughout these periods. He points out how, since 1950's, a sort of deterioration has occurred in the paternalist model of doctor-patient interaction, while consumerism, on the one hand, and distrust in doctors on the other, have been rising tendencies. Shorter links this development with the tremendous growth of drug-therapies (such as antibiotics), on the one hand, which has boosted consumerism as a rising demand for cure, and with the longer and increasingly technically oriented medical training on the other, impairing the doctors' abilities to relate to their patients. (see also Starr 1982; Silverman 1987).

A concurrent development starting in the 50's has been observed in the models of doctor-patient relationship depicted in medical textbooks. The preferred model develops from a disease-centered approach where the patient was considered only a carrier of the disease towards an approach where the patient is perceived as a whole person and should be treated as such. (Arney and Bergen 1984).

The prevalence of the paternalist model continues to be discussed in social scientific texts on medical care (e.g. Cant and Calnan 1992; Wiles and Higgins 1996; Lupton 1997). Considering the rise of the consumerist trend⁷ and the growing emphasis on the importance of treating patients as persons, this has been regarded as a situation which leaves room for development. For example, Roter and Hall (1992) explicitly set out to transform the dissatisfying situation where the disease-centered approach dominates in health care, while the patient as a person, and his experience of the illness are left aside. They distinguish seven communication-transforming principles which would bring out a change for the positive in doctor-patient interaction. Similar recommendations and considerations on 'positive developments' have been taken up in studies representing more qualitative approaches.

In many of these studies, what are presented as 'the patient's needs' or preferable models of doctor-patient interaction are described on a rather abstract level. For example, recommendations such as "communication should serve the patient's need to tell the story of his or her illness and the doctor's need to hear it" (Roter and Hall 1992, 5) give little information on how such a goal could be achieved in practice. Further, these recommendations are often based on interviews with the participants outside the actual medical consultation. Thus they cannot capture the logic of the actual interaction in situ. For instance, in order to specify what actions constitute an act of 'listening to the patient' from the patient's point of view, we would need to specify what activities are responded to by the patients as 'practices of listening' vs. as 'practices of not-listening'. Still further, in studying the interaction in question we should perhaps consider whether the 'patient's need to tell the story of his or her illness' varies with different types of consultations, and in different phases or moments during the consultation. It seems possible (even likely) that there are situation-specific features which inform the conduct of the participants. Some of these features may be inherent in the organization of face-to-face interaction, whereas some may be connected with the specific institutional environment of doctor-patient interaction. Thus, in order to find out how practices of 'good consultation' can be realized in and through talk-in-interaction it may be helpful to know more about the logic of medical interaction, about the way in which doctors'

⁷ With the new patients' rights legislation (785/1992, 333/1998) this line of thought has been established also in Finland, where the major part of health care is funded by the state and municipalities.

and patients' activities are connected with each other. This study aims at providing a description of this logic as regards one particular phase of the medical consultation. Before analyzing more closely the aspects further indicating the necessity of such an account I will briefly review some major empirical approaches on the study of doctor-patient interaction.

1.2.1. Empirical study on doctor-patient interaction

In empirically oriented study on the doctor-patient interaction, communication is widely recognized as the principal medium or ingredient of medical care. A considerable part of the study has centered on verbal communication, but non-verbal interaction has also received attention (see e.g. Heath 1986; Bensing et al. 1995). Both in studies approaching the doctor-patient interaction from the point of view of doctors' work, and in investigations of patient satisfaction, it is repeatedly pointed out that successful communication is essential for achieving good results in medical care (e.g. Pendleton 1983; Virtanen 1991; Ong et al. 1995).

Study on beliefs and perceptions on doctor-patient interaction

A substantial part of the study under the heading 'research on doctor-patient interaction' has concentrated on studying the patients' and doctors' perceptions on the elements of 'good communication'. Numerous studies on the ingredients of patient satisfaction belong to this line of inquiry. The data are gathered with questionnaires and interviews taking place after the actual interaction in focus (e.g. Stewart 1984; Roter et al. 1987; Virtanen 1991). Yet another branch of study often perceived as investigating 'doctor-patient interaction' examines the doctors' and patients' different understandings and beliefs concerning illness, their differing conceptual models of the origins and consequences of illness (Kleinman 1988; Punamäki and Kokko 1995). Also within this line of study, interviews occurring outside the actual medical consultation are widely used as data. Although often classified as 'study of doctor-patient interaction', neither of these approaches actually has 'interaction', nor the situation where the doctor and the patient communicate, as the main object of study.

Study on the process of doctor-patient interaction

This study is part of a third line of study which analyzes the dynamics of the actual interaction between the doctor and the patient during medical

consultation. Within this approach the data usually consists of tape and/or video recordings of ‘naturally occurring’ medical consultations. However, the methods of analysis within this approach, as well as the theoretical stances taken, may differ considerably.

Roughly, two approaches drawing upon differing methods of analysis can be distinguished: A) those where the data is immediately coded into pre-defined categories which are then statistically analyzed and often related with socio-demographic characteristics of the participants (e.g. Stewart and Roter 1989; Roter and Hall 1992), and B) those where the data is not coded but qualitatively analyzed from the recordings or from transcripts of the recordings (e.g. Fisher and Todd 1983; Mishler 1984; Waitzkin 1991).

A) Study of action categories in doctor-patient interaction

Various systems of interaction analysis⁸ belong to the first line of study. Korsch & Negrete’s study on doctor-patient communication, where they used Bales’ Interaction Process Analysis (IPA) in combination with evaluations of patient satisfaction was among the first ones to concentrate on analyzing medical interaction in detail. Among other things they concluded that specific modes of communication by the doctors (such as showing positive affect to the patient) correlate with patient satisfaction and compliance. (Korsch and Negrete 1972; see also Stewart 1984). Bales’ model of analysis was later developed by Roter to fit specifically the study of medical interaction.

In Roter’s Interactional Analysis System (RIAS) the number of action categories is expanded from 12 to 16, and the institutional roles of the doctor and the patient are built into the coding scheme (so that there are eight categories for each) (Ong et al. 1995). With this and similar systems, it is possible to perform statistical operations in order to find out, for instance, the frequency with which each participant performs the actions belonging to each category, or the proportions of each type of action in the whole encounter. The results consist of correlations between different variables: for example, female doctors have been found to make more positive statements, ask more questions, and make more back-channel responses (Roter and Hall 1992).

⁸ For a more extensive introduction to the systems of interaction analysis on doctor-patient interaction, see Wasserman and Inui (1983); Ong et al. (1995). For a review of systems which relate the communication process to satisfaction outcomes, see Bensing (1992).

As with the traditional approaches to the study of social interaction in general (see section 1.1.), what is common to these analysis systems is that they focus more on the persons acting, and on the frequency of different types of actions, than on the actual processes and structures of interaction. They provide valuable information on the frequency of different actions, and the correlation between them, but yet they leave questions to be asked on the structure of (doctor-patient) interaction and on its character as a meaningful encounter (cf. Mishler 1984, 61; Waitzkin 1991, 50-53). For instance, in assigning single actions to categories, the relationship of different (consequent) actions is broken: the context formed by the preceding activities and serving as the framework for interpretation for the following actions receives no attention. Consequently, such approaches do not produce information on the actual process of interaction, on the 'logic' with which actions and sequences of actions follow one another in this process (cf. Stiles and Putnam 1989, 222).

B) Study of the logic of the interaction process

The second, more qualitatively oriented line of study examines the actual practices of communication in more detail. In these studies, the focus of analysis shifts from counting frequencies of distinct acts to studying processes and structures of interaction. Byrne & Long's seminal study (1984(1976)) on doctor's patterns of behavior in medical consultation already took a step towards this direction. They were among the first to pay attention to the medical consultation as a structured continuum of events, describing the ways in which consultation is opened and in which it progresses to diagnosis and further. Thus, although they concentrated solely on describing the doctors' activities within each phase of the medical consultation, they took the local context into consideration when assigning meaning to the actions in question.

The structure of interaction in doctor-patient communication was adopted as the object of study in the beginning of 1980's. The focus switched from analyzing distinctive acts by individual actors to distinguishing and examining recurrent structures of interaction. Among others, Mishler, in his 'Discourse of medicine' (1984), studied the structure of interaction in medical consultation, concluding that it is constructed as a pattern of three subsequent turns of talk: doctor's question - patient's answer - and doctor's acknowledgment. Mishler observed that this 'normative' structure of consultation restricts the scope of actions available for the participants. A slightly different approach is the discourse analytic line of study mentioned in

section 1.1. in which existing macro-level social structures, such as gender (e.g. Fisher and Groce 1990) or individualistic ideology (e.g. Waitzkin 1991) are seen as integrated in micro-level interaction, and interaction is analyzed with regard to these macroscopic social structures.

Since then, studies analyzing doctor-patient interaction with a focus on the interaction process and its recurring structural features have multiplied (see e.g. Cicourel 1983; Fisher and Todd 1983; West 1984; Silverman 1987; Heath 1988; Frankel 1990; Maynard 1991b; ten Have 1991; Clark and Mishler 1992; Coupland et al. 1994; Heritage frth).

In Finland, the latter approach in studying doctor-patient interaction has been established only recently. A research project "Doctor-patient interaction in general practice consultations" has produced several studies examining the processes of medical interaction in Finnish medical consultations (Peräkylä 1997; 1998a; 1998b; Peräkylä and Sorjonen 1997; Haakana 1999; Raevaara frth; Sorjonen et al. frth). The present study is also part of this project. Engeström et. al (1989; Engeström 1999) have analyzed doctor-patient interaction in the framework of developmental work research (see Engeström and Engeström 1986) using partly video-recordings, partly interviews as their data. Otherwise, focus on the process of interaction in studying medical consultations is so far scarce in Finland.

Many of the studies mentioned have served as a motivation for this study. In the following section I will introduce four different aspects with regard to which this study wishes to add to the previous understandings on the nature of doctor-patient interaction. The aspects are: 1) views on patient participation, 2) defining the patient's needs, 3) concern on the location of activities in the overall structural organization of the consultation, and 4) pre-dispositions concerning the conflict-oriented nature of doctor-patient interaction.

1.3. Motivation for the study

The idea that patients should be seen as active agents when studying doctor-patient interaction is widely supported in the field (Mishler 1984; Fisher and Groce 1990; Fisher 1991; Clark and Mishler 1992). This study also starts out from this idea.

However, in actual empirical research attention is often only paid to the doctors' activities. Even when suggestions are made concerning the nature of the patients' projects or best interests, their actual activities in the situation are often treated as a material which the doctors shape to fit with their professional (control) purposes. Less attention is paid to the underlying potential of the patients to carry out their own projects, and further, to control the course of conversation. In this study, my intention is to take this possibility into consideration. I will describe and analyze proceedings of both participants, making no premature assumptions on the ways in which control over the course of the consultation is distributed between them.

Secondly, explicit or implicit assessments of the patients' best interests are often based on views originating outside the actual situation of doctor-patient interaction. Many researchers have observed that what is described as 'the patient's best interest' is drawn from existing theoretical views on the nature of the doctor-patient interaction (Meehan 1981; Gerhardt 1989, 226; Silverman 1993; ten Have 1995). Many otherwise elegant studies on interaction in medical consultations maintain tacit presuppositions on the goals and needs of the patients, without reflecting the relation between these theoretical considerations and the actual activities of the participants in the situation.

For example, the idea according to which patients should not be interrupted and maximum space should be offered for them for telling about their problems (e.g. Beckman and Frankel 1984; Roter and Hall 1992) is based on the assumption that patients themselves would prefer to give long descriptions of their illness to the doctor (also Davis 1988; Heritage 1984). However, there is scarce empirical evidence (that would be based on patients' actual activities when presenting their problems) to support this idea.

Furthermore, the observation that the patients' life-world issues are often ignored in favor of a more 'disease-centered' approach to the patient's problem (e.g. Mishler 1984; Waitzkin 1991; Clark and Mishler 1992) suggests that patients would actually prefer to tell the doctor about their domestic or other social problems. However, this suggestion may be problematic, as it seems equally possible that patients as well as doctors in primary health care orient to medical consultations mainly as service

encounters, as situations which they have sought in order to attain medical help for their problems, not to receive sympathy and affiliation (cf. Silverman 1987, 25; Lupton 1997, 493). In this study I will set out to describe and analyze the participants' own orientations to the tasks at hand, assuming these orientations to be observable in the details of their talk.

Another notion emerging from considerations according to which talk on life-world issues is discouraged in medical consultation is that life-world issues are also often delicate issues (such as marital problems or alcohol abuse, for instance), and there is evidence that these are not preferably introduced as the first topic in conversation (be it ordinary or institutional) (e.g. Linell and Bredmar 1996). This would indicate that there are bound to be both more and less optimal locations within medical encounters to bring up life-world issues. Thus, even though it were in the patients' best interest to encourage them to talk on life-world issues, the beginning of the consultation is not necessarily the best place to do this.

Consequently, one crucial issue to consider when contemplating 'the patients' best interest' in medical consultation would be the manner in which topics unfold 'naturally' in conversation. If one accepts the idea that to a large extent, medical consultations involve talk about the trouble or problem at hand, and that such talk is a principal means for finding out what is wrong with the patient, then one should also take into consideration that there are rules and orders inherent in the ways in which people talk with each other. In the first place, such orders make possible the processing of topics in medical consultation, but they may also complicate it. In this study, I will study the participants' activities in medical consultation taking into account the ways in which their talk is organized with regard to structures inherent in ordinary conversation.

The third point which has gained little attention in previous studies on doctor-patient consultation is the intertwining of the overall structural organization of the medical consultation with the status of the practices or activities performed. A common focus for studies on doctor-patient interaction is the distribution of a specific activity between the participants throughout the whole consultation. For example, the observation that doctors ask the most questions whereas patients ask only a few (West 1983, Frankel, 1990) has been considered to depict the subordinate position of the patient in

consultation. However, the specific goals and activities attached to each phase⁹ of medical consultation may also work to limit the patients' question-asking. It seems possible that asking questions when discussing the patient's treatment, compared to asking them when describing the reason for the visit, would have quite a different status on the patient's agenda¹⁰. When presenting the problem the patient is the participant with knowledge, whereas when discussing treatment, asking questions from the doctor could clarify many contingent possibilities to the patient.

Further, the three-part structure of medical consultation introduced by Mishler, where the doctor asks a question, the patient answers and the doctor acknowledges the answer, has often been described as the institutionalized structure of turn-taking of the whole consultation, although actually it may be more fit to describe just a specific phase of the consultation, namely verbal examination. For example the phase where the diagnosis is given seems to be organized as a sequence of information delivery where instead of a question-answer-receipt structure the phase consists of the delivery of diagnosis by the doctor followed by silence, receipt or response by the patient (Heath 1992; Peräkylä 1998b).

It seems that the examination of separate types of action, such as interrupting and questioning, or telling a story, detached from their actual placement in the overall structural organization of the consultation may produce a very different understanding of their functions than when studying them in their specific local contexts. The goals of the participants and the practices they engage in to achieve these goals may vary in different phases of the consultation. Thus the constituents of 'what is best for the patient' may also change when shifting from one activity to another.

In this study, I will examine the patients' activities as part of the specific phase in which they present their problem to the doctor. In the analysis, I will take into consideration the ways in which the location and function of this

⁹ With 'phase of consultation' I refer to specific sequences of activity found to follow one another, often in a particular order, in medical consultation (Byrne and Long 1984 (1976)). (See chapter 2).

¹⁰ In a comparative pilot-study on patients' questions it was found that both in Finland and in the US, by far the most questions by the patients are made when discussing treatment or other future action related to the medical business at hand (Heritage et al. prep).

particular phase in the overall structural organization of the encounter may bear on the interpretations of the practices analyzed.

The fourth issue to be considered is that doctor-patient interaction has often been viewed as a location of conflict and misunderstanding (e.g. Fisher 1983; Beckman and Frankel 1984; Mishler 1984; West 1984; Davis 1988). This conflict has often been perceived as emerging from the asymmetry of the preallocated institutional positions of the participants: the worlds of doctors and patients have been considered as separate by definition: due to their specific perspectives they have different concerns and different understandings of the nature of the problem. Even if valid, a suggestion of this sort leaves open the question of how and where in consultation such conflict emerges. Further, it leaves open the question of what in the ways in which misunderstandings emerge in consultation is specifically institutional, specifically characteristic to the medical aspect of interaction. In this study, I will show how, on the level of sharing an understanding on 'what we are doing', on the level of constructing a shared understanding on the nature of the ongoing activity (as giving and receiving the reason for the visit, for example), the participants also have a common ground (cf. Garfinkel 1984, 35-75). I will study in detail a specific phase in the medical consultation, from the viewpoint that the participants' practices constitute the ongoing activity. Such a detailed description hopefully allows us to locate possible points of conflict in this interaction, and consequently, to distinguish whether there is something particularly institutional going on at these points.

1.4. Conversation analysis

The analytical starting points mentioned in the previous section: regarding as relevant the activities of every participant of an interaction, searching for the participants' own orientations to the tasks at hand, perceiving ordinary conversation as the basic form of social interaction, paying attention to the placement of actions in the overall structural organization of the event in focus, and preferring a method of analysis which proceeds from empirical observations towards generalizations, are all principles central to conversation analytic (CA) research. In the following I will introduce the basic assumptions of CA in more detail. More extensive introductions to the method are available in e.g. Levinson (1983); Atkinson and Heritage (1984); Heritage (1984).

At the roots of conversation analysis is the idea of social interaction as an independent locus of order (Sacks 1972a; Sacks et al. 1974; Goffman 1983). In CA interaction is considered as a distinctive social institution with a distinct order, the interaction order. This order is understood to inform interaction in any face-to-face encounter. In institutional contexts it serves as a basis for specific institutional variations (such as the distinctive turn-taking organizations of court-room interaction or news interviews, for instance). (Drew and Heritage 1992; Peräkylä 1997).

Within this order, interaction is organized in structures by which participants to an interaction co-ordinate their activities in 'doing what they are doing and getting it done' (Schegloff 1992b, xvii). These institutionalized structures of social action are the object of study in CA. They address, for example, the ways in which participants organize their turns of talk so that only one person talks at a time, the ways in which talk is structured in sequences so that a question is followed by an answer or a greeting by a greeting, the ways in which intersubjective understanding may be guaranteed, and the ways in which alignment may be achieved.

These structures are perceived as normative in the sense that they are used as resources in organizing and understanding talk-in-interaction. Garfinkel's influence on these considerations is evident. According to Garfinkel's view, in everyday interaction norms are activated as resources for both interpretation, i.e., as resources for understanding the meaning of any action, and controlling an action. As in a game of chess, rules governing the actions are seen as constitutive: if the rules were not followed, the game would not be chess but something else. Breaking the rules of a game leads to efforts by co-interactants to sanction actions of this kind, or to understand them, for instance by framing them as acts of a different activity, such as joking. (Garfinkel 1984, 35-75; Heritage 1984, 83; also Jimerson 1999). Thus, departures from the normative order of conversation would similarly be notified as exceptions, or as implications that the current orientation may have to be reconsidered.

Another fundamental assumption is that every act in interaction takes into account the context (Schegloff 1992a; Heritage 1995; 1997; 1998). What is often meant by context is the larger social context, or the setting in which the

interaction takes place. In CA analysis, the larger social context is only taken into account so far as it is made relevant by the participants themselves in and through their turns of talk-in-interaction. The focus of interest is on the ways in which the participants themselves attend to the situation under scrutiny (Duranti and Goodwin 1992, 4; Schegloff 1992a). Thus, in medical consultation, for instance, by regularly describing their conduct as 'responsible and troubles-resistant' when presenting their problem to the doctor, patients treat such moral inferences as relevant for problem presentation, in this way evoking the larger moral context attached to seeking the patient role (cf. Heritage frth; chapter 4, this study). Again, by regularly designing their diagnostic statements as tentative, patients make relevant the doctor's position as the medical authority in the situation (Gill 1995; Raevaara frth).

In conversation analysis context and meaning are closely linked to the idea of sequence. Sequences of actions are considered to form the most proximate context of any single act, a primary context informing the actions of the participants. In this sequential context, every action is 'doubly contextual': the meaning of an action is shaped by sequences of preceding actions, and the context is then reshaped by the action itself. In this sense, social context is produced in interaction, in and through the talk of the participants involved (Heritage 1997; 1998).

Heritage (1997) summarizes this CA theory on the participants' orientations to interaction as follows:

1. In constructing their talk, participants address themselves to preceding (most often immediately preceding) talk.
2. In doing an action they project (empirically) and require (normatively) that the next action should be done by the next participant
3. In their next action participants show an understanding of a prior action, and these understandings are then either confirmed or rendered objects of repair in the third turn of the sequence.

Within this normative framework, the participants are able to maintain a shared understanding of the object of talk and the situation going on. The question is not about sharing an opinion, but about sharing a common focus

of attention (Peräkylä 1992). This intersubjective understanding is then constantly sustained and updated in and through every subsequent action.

The third assumption of CA is that no detail is irrelevant to the analysis. By using naturally occurring conversation as data the analyst is able to avoid premature interpretations of the participants' actions and also to return to the data whenever a potential problem arises. Methods such as coding interaction directly from the tape (e.g. Roter and Hall 1992) may obscure significant nuances in the participants' talk. It may be hazardous to presuppose that every relevant aspect of interaction could be noticed on the first hearing (Sacks 1992, Vol.1, 28). In trying to pinpoint the participants' own orientations naturally occurring data is a valuable resource.

Results obtained in conversation analysis are cumulative. In the actual analysis, the data structures distinguished in earlier studies form a basis on which to ground later analyses. In the following section I will briefly introduce some basic structures of ordinary conversation which will be used as resources for analysis in this study.

1.4.1. Some basic structures of ordinary conversation

In their seminal study, Sacks, Schegloff and Jefferson (1974) introduced a set of rules according to which conversationalists organize their turns of talk in conversation. Drawing upon an extensive analysis of naturally occurring conversation they found that in any conversation (whether face-to-face or telephone), overwhelmingly, only one speaker speaks at a time, speaker change recurs, transitions between turns are finely coordinated, and overlapping talk is avoided. (These are just a few of the basic regularities).

The basic analytic units used by Sacks, Schegloff and Jefferson in discovering this turn-taking organization were based on the logic with which turns are organized by the participants of conversation. The units are: turn-constructional unit (TCU), and transition-relevance place (TRP). One turn-constructional-unit, or TCU, consists of a sequence of talk which is grammatically and pragmatically complete and is produced as one entity (Sacks et al. 1974; Ford and Thompson 1996; Schegloff 1996b). After a complete TCU a speaker change becomes relevant unless the current speaker uses specific devices (such as rushing rapidly to the next TCU) to keep the

turn to her/himself (Sacks et al. 1974). TCUs are not equivalent to grammatical sentences but may be sentential, lexical, phrasal or clausal as they unfold in interaction. The following invented example illustrates these types of TCUs:

A: He'll be here at ten to one.	sentential
B: When?	lexical
A: At ten to one.	phrasal
A: If he's on time.	clausal

The possible completion of a TCU is perceived as a possible moment for speaker change by the participants in a conversation (Sacks et al. 1974; Ford and Thompson 1996; Schegloff 1996b). The first possible completion of a TCU constitutes an initial transition relevance place (TRP). At such a possible completion:

- a) If the next speaker has been assigned by the current speaker, the next speaker has a right and an obligation to take the turn.
 - b) If the next speaker has not been selected, the first starter acquires rights to the next turn.
 - c) If the next speaker has not been selected, unless someone else self-selects, the current speaker may, but need not, continue.
- If the current speaker has self-selected, the rule-set is applied in the next transition relevance place, and recursively thereafter. (Sacks et al. 1974, 704).

The participants in a conversation constantly monitor the unfolding of this organization and orient to it as a resource for their action. Overwhelmingly, they locate the beginning of their turn at the possible completion of the previous speaker's TCU, and if there is overlapping talk, it is usually very minimal and occurs within the transition space (Jefferson 1983).

In doctor-patient interaction only two participants are usually present, which means that at possible completion points there is only one other participant to take the turn. The organization of turn-taking will be used as a major resource for analysis in this study.

In addition to turn-taking organization, participants orient to specific organizations of sequences. A basic unit for a large part of talk-in-interaction is the adjacency pair. The basic adjacency pair is

- a) composed of two turns
 - b) by different speakers
 - c) adjacently placed
 - d) ordered as first-pair parts (such as questions) and second-pair parts (such as answers), and
 - e) pair-type related, i.e., a specific first-pair part makes relevant a particular second-pair part, so that a question may not be answered by an agreement etc.
- (Heritage 1984, 246; Schegloff 1995, 4)

Again, this adjacency-pair structure is normative. A question does not force its recipient to answer, although not answering would appear as an accountable act: it would be treated as something which can and perhaps should be explained¹¹. Furthermore, in interaction there would be innumerable ways to go round this accountability - in the case of a question, for instance, by posing a counter-question etc.

Sequences may be expanded within and around the adjacency pairs (Schegloff 1995). In this study, the adjacency-pair structure will be the starting point in examining the sequence starting with the doctor's opening question. At the beginning of the consultation the doctor usually asks an opening question, in response to which the patient makes his initial complaint. The doctor then indicates that she considers the description to be sufficient and moves on to the verbal examination, or asks the patient to specify his problem (Byrne and Long 1984 (1976)). Thus, the beginning of the consultation is understood as a sequentially organized event. Sequential organization will be an important resource in analyzing what relevancies the turns of talk by the doctors and the patients set for the following actions by the other participant.

Other central 'structures of social action' include, for example, repair organization and preference organization. Repair organization is a structure which inherently works to guarantee a shared understanding on the focus of interest in interaction. It will not be described in detail here, as it will not be in focus in this study. Extensive descriptions of repair organization are found in (Schegloff et al. 1977; Schegloff 1986; 1992c; 1997a).

¹¹ On accountability of actions, see Heritage (1984, 135-178; 1988)

Preference organization (see e.g. Pomerantz 1984a) has to do with the type-relatedness of the turns in adjacency pairs. Specific first-pair parts prefer specific second-pair parts while dispreferring others. Thus, for example, a preferred second-pair part for an invitation would be acceptance, whereas rejecting an invitation would be dispreferred. This preference does not refer to any motivational disposition of the participants, but is normative in the same sense as the interaction order in general. Dispreferred actions are usually marked by specific techniques such as mitigation, elaboration and delay. Thus, for example, a long gap following a question may implicate some problem with the answer. Preference organization will be applied in the analyses in chapter 3.

There is yet another order intertwined with the organization of talk-in-interaction. Goodwin has located specific ways in which gaze-directions are co-ordinated with regard to talk in ordinary conversation (Goodwin 1981; Kendon 1990). This organization functions mainly in securing a framework in which interactants are engaged in conversation with each other. The maintenance of such an engagement framework in giving and receiving the reason for the visit will be examined in chapter 7.

All these specific structures are basic for the conversationalists. They are invariant to the parties, they can be used and are attended to in any conversation. On the other hand, they are selectively and locally influenced by social aspects of context. (Sacks et al. 1974). In this study I will investigate how these structures inform the activities of the participants when they start the medical business in doctor-patient interaction.

1.4.2. Institutional interaction

In studying institutional interaction with a CA approach, it is supposed that ordinary conversation is the predominant mode of interaction, the basic type with which interaction in institutional situations should be compared (see also Schegloff 1987a; Drew and Heritage 1992; Heritage 1997; 1998). In institutional situations, this basic organization of conversation is accommodated into each specific type of situation, the specific goals and institutional rights and obligations are 'talked into being' with modifications to an ordinary conversation (Heritage 1984).

Thus, interaction is not considered to be institutional because of its setting (Drew and Heritage 1992, 3). Institutional features may or may not be present in a particular situation, and at a particular moment of this situation (Peräkylä 1995, 32). For instance, in medical consultation, the patient may answer the doctor's 'how are you' question with a description of a happy family event whereby she has become a grandmother, thus postponing the initiation of the actual medical business which is the reason for the visit. As Drew and Heritage define it, "Interaction is institutional insofar as participants' institutional or professional identities are somehow made relevant to the work activities in which they are engaged." (Drew and Heritage 1992, 4). This is not to say, however, that the existence of institutional realities as they appear in legal regulations, spatial arrangements, professional documents and the like, is confined to talk, but that these institutional realities are invoked in talk. The ways in which this is done - "how these institutional realities are evoked, manipulated and even transformed in interaction" (Heritage 1997) are an important object of study.

As in the study of ordinary conversation, the situations examined are studied by reference to features of context which are made relevant by the participants (Schegloff 1987a, 209). Thus, predispositions of the analyst, presuppositions concerning the institutional constraints present in the situation, should be avoided (to the extent that this is possible). Instead, the analyst's task is to find and describe the participants' own orientations observable in their interaction. In this way it may be possible to abstain from premature explanations or overgeneralized views whereby, for example, the doctors are presented as unilaterally controlling the course of medical consultations through their professional or medical authority. A view of this kind leaves little leeway for the patients to act or to resist this institutional order in any way. The idea is that the participants' orientations are observable and available for the participants and the analyst alike as embedded in the activities of the participants sequentially following each other. (Ibid; see also Arminen 1998).

In studying institutional interaction, it is not enough to describe the institutional contexts made relevant by the participants. It should also be shown how these contexts are consequential for the interaction going on, how what is said brings forward the context (Schegloff 1991b; Peräkylä 1995, 33).

Drew & Heritage (1992) suggest that there are at least three sorts of features which distinguish institutional interaction from ordinary conversation (see also Levinson 1992; Heritage 1997; 1998): goal orientation, institutional constraints, and specific inferential frameworks. In what follows, I will briefly introduce each feature by describing previous studies on institutional talk and by linking each feature to the objectives of the present study.

Goal orientation refers to the way in which the participants of a situation organize their activities by reference to specific tasks of a particular social institution. It is not always clear that the understanding of the participants concerning the goals is shared, and even if they are, the specific ways in which the tasks are accomplished may vary due to local contingencies of interaction. (Drew and Heritage 1992). With regard to doctor-patient interaction, there seems to be mutual understanding at least on the doctor's task as the medical expert who should make the diagnosis and give recommendations for treatment, and on the patient's task of providing sufficient information for the diagnosis. However, Heritage has shown that there may be also additional tasks present at the consultation. He describes how, throughout the visit, the participants of a medical consultation orient to justifying the doctorability of the problem. By doctorability he refers to the patients' concern with presenting themselves as persons who have legitimate reasons for visiting a doctor for their ailment. (Heritage frth.). Compared to talk about troubles in ordinary conversation, this orientation is quite specific. (Zimmerman et. al have, however, found similar orientations in emergency calls (e.g. Whalen and Zimmerman 1990)). Instead of the medical tasks, it addresses the moral order present at the medical consultation. Through orientations to doctorability the medical consultation is viewed as a gateway to the rights and obligations associated with the sick role (cf. Parsons 1951). By virtue of their medical expertise (Parsons 1951) and professional power (Freidson 1970) doctors are treated as gate-keepers to this role. In this study, orientations of patients to specific goals while presenting the problem to the doctor (such as giving information and showing doctorability) will be further examined with Finnish data.

Institutional constraints on contributions of the participants are observable in certain types of institutional interaction as, for example, specific organization of turn-taking and turn-allocation, which restrict the rights of participation of specific participant categories. Specific turn-taking organizations which

constrain the contributions of participants have been found, for instance, in court (Atkinson and Drew 1979), in classroom interaction (Mehan 1985), in news-interviews (Clayman 1988; Heritage and Greatbatch 1991), and in AA meetings (Arminen 1998).

In doctor-patient interaction the constraints on turn-taking are less strict, and may vary "from phase to phase (or task to task)" even within one consultation (Drew and Heritage 1992, 23-24). In relation to more formal institutional environments (such as the courtroom, for instance) turn-taking in medical consultation can be described as 'quasi-conversational', and the setting as 'informal' (Drew and Heritage 1992; Peräkylä 1995). Thus, it may be difficult to locate institutional constraints on turn-taking which would extend through the whole consultation. Frankel (1990) has suggested that one such constraint would be dispreference for patient-initiated questions in medical consultation. Such a constraint does not seem to apply for the doctors' activities (West 1983; 1984). It is questionable, however, whether this constraint can be generalized to apply to the whole consultation, or whether it better describes the situation during some particular phases of the consultation: some later studies with more extended data have suggested that 1) patients may ask relatively many questions during medical consultation, but that 2) these questions are concentrated in the stage of discussing the future treatment of the patient (Heritage et. al. prep). Thus, it seems possible that 'dispreference for patient-initiated questions' is local to the phase (or the current activity in the institutionalized organization of activities) of the consultation. In this study, the potential phase (or activity) -specific nature of institutional constraints in medical consultation will serve as an important guideline for the analysis.

For the most part, the study of less formal settings has concentrated on systematic aspects of the organization of sequences and of turn design. Gill (1995; 1998) and Raevaara (forth) have pointed out how patients, unlike doctors, when making diagnostic statements regularly design them as tentative. In studying diagnosis and its reception, Heath (1992) and Peräkylä (1998b) have shown that in medical consultations patients often refrain from commenting on the diagnosis delivered. This is not the case when receiving news in ordinary conversation, where it is customary to show the newsworthy character of the news or evaluate them in some way (Maynard 1997).

In this study the theme of institutional constraints on the participants' contributions will come up as an examination of the ways in which control over the course of consultation is managed in interaction between the doctors and the patients during problem presentation (see section 1.5 below).

Inferential frameworks in institutional interaction may be different from the ones used in ordinary conversation. In institutional contexts, remarks which in ordinary conversation would be regarded as 'innocent' may be interpreted as threatening. For example, a health-visitor's comment on a baby sucking a toy eagerly may be interpreted by the parents as an act of evaluating their competence in taking care of the baby (as referring to a possibility that the baby could be hungry, not having been fed sufficiently). (Heritage and Sefi 1992). Similarly, a question such as 'how are you' is regularly treated as an initiation of medical business when presented at the beginning of a medical consultation (Frankel 1995).

In this study I will examine the specific inferential framework of medical consultation by studying the ways in which participants treat each others' turns of talk compared to similar sequences in ordinary conversation. For example, I will discuss how patients treat any kind of opening question as a request or as a prompt to give the reason for the visit rather than as a genuine question, and how doctors treat the patients' presentations of their problems as requests for help rather than as troubles-talk.

The final important point of departure is the notion that, compared to more formal interactions such as courtroom interaction or news interviews, medical consultation is less official. There is no strict predestined turn-taking organization, and in many respects the interaction resembles ordinary conversation (cf. Maynard 1991a). Thus, in addition to studying what is specifically institutional in doctor-patient interaction I will also point out similarities to practices found in ordinary conversation. This is a very important aspect of the study, as ordinary conversation is exactly the 'device' through which patients seem to acquire resources for autonomy. For instance, they are able to use practices of ordinary conversation for extending their problem presentations in order to add to them elements under their own control (Davis 1988; Heritage and Stivers prep). This closeness to ordinary conversation is implied also in Peräkylä's (1998b) examination of the

doctors' duty to maintain a balance between authority and accountability of their activities.

The three constituents of institutional talk will all be touched upon in this study. However, the main focus will be on *control*, and on the ways in which controlling the course of consultation, when giving and receiving the reason for the visit in medical consultation, can on the one hand be perceived as specifically institutional, and on the other hand, as similar procedures in ordinary conversation.

1.5. Conversation analytic view on control

A recurrent theme in the study of power and doctor-patient interaction is the notion that doctors have almost exclusive control over the agenda and the topics of medical consultation (Mishler 1984; Sätterlund-Larsson 1989; Fisher 1991; Waitzkin 1991; Roter and Hall 1992; Melander-Marttala 1996). In medical interaction it is said to be the doctors who initiate the sequences, who choose the topics to be talked about and further, predefine the parameters of the patient's turns of talk. (Beckman and Frankel 1984; Mishler 1984, 90). This control over the course of the encounter is one form of asymmetry present in medical consultation¹².

There seems to be a unanimous agreement that the doctors control the course of consultation. However, no consensus has been achieved on where this control is situated. According to a more static view, control is seen as residing in professional authority or sociopolitical structures, whereas from a more dynamic standpoint control is achieved and negotiated in interaction (Maynard 1991a). From the first point of view control in medical consultation is seen as structural, embedded in existing professional hierarchies (Parsons 1951; Freidson 1970) , or in existing class relations and ideological discourses (Waitzkin 1991). From the point of view which emphasizes a more communicational aspect of control in medical consultation, every action in the interaction is thought to embody some degrees of control (cf. Foucault 1984; Davis 1988).

¹² On asymmetry in doctor-patient interaction, see e.g. Maynard (1991a); ten Have (1991).

More than actual controversies, however, these views should be regarded as different foci of interest, as different standpoints taken towards the object of study. Whereas the structural approach deals with the macro aspects of control, the communicational approach studies the level of actual interaction. The focus of the latter is on the management of control in actual interaction, on the production of asymmetries of power in talk-in-interaction.

Definitions of control in social psychological study on communication seem congruent with the latter point of view. For example, Wiemann and Giles define control as follows: "Control is the constellation of constraints people place on one another by what they say and how they structure conversation, which in turn limits the options available to participants" (1997, 322). The definition does not differ considerably from the conversation analytical idea on sequentiality and 'doubly contextual' character of each turn of talk. However, the line more commonly followed in social psychology has concentrated on experimental study of attributions and perceptions made on the basis of specific features of a person's speech, such as accent (Giles and Coupland 1991), or speech dysfluencies (Goldman-Eisler 1968). These studies seem to presuppose a relatively standard meaning attached to specific features of talk, thus possibly undermining the relevance of a more immediate context for the interpretation of a feature of talk.

In studying medical interaction, a popular approach has been to distinguish specific indicators of asymmetries of control, such as interruptions and questions, and to study their prevalence in each participant's talk throughout the consultation. Frankel's (1990; 1995) results on dispreference for patient-initiated questions followed this approach. West's (1984) findings on interruptions in medical consultations were made according to this logic. Mishler's (1984) and Ainsworth-Vaughn's (1992) considerations on topic transitions in doctor-patient interaction also follow this course of analysis.

These studies have provided an overall picture on the distribution of specific practices of control throughout the whole consultation. Simultaneously they have made new areas of research relevant: it seems possible that depending on their context practices taken as indications of control may have also other functions. For example, Haakana (1999) has shown that laughter in medical consultation may have functions different from those suggested in earlier studies. Whereas West has studied laughter as inherently displaying one's

humorous connotations of the situation, and suggested that in medical consultation laughter is always an invitation for the other participant to share the laughter, Haakana has shown this not to be the case. Instead, overwhelmingly, laughter seems to be used as a means for managing delicacy in consultation. Furthermore, the suggested unequal distribution of laughter between patients and doctors may be more a product of their distinctive tasks than of their asymmetric relations of control. And still further, as Haakana has shown, during different phases of the consultation laughter may be interpreted and treated differently.

In this study I hope to be able to complement and comment on preceding ideas on the constituents of control and proceedings by which control actualizes in medical consultation. Unlike West, Frankel et. al. I will not follow any specific activity throughout the consultation, I will not nominate a particular action as an indicator of control. Instead I will analyze one phase of the medical consultation to consider how control is managed in interaction, how it is present in every turn of talk, in every action (verbal or non-verbal) of the participants. Furthermore, I will describe in detail the activities of the participants in a specified location of the consultation, and analyze manifestations of control in these activities. This approach makes it possible to see what measures of control are invested in each turn of talk, and whether these means of control are different for the doctors and for the patients. It will be observed, for instance how patients may use means such as the narrative format in order to regulate the space they are given for describing their reason for the visit (chapter 4). Furthermore, attention will be paid to the doctors' gaze-direction and posture with regard to the patient as a means of controlling the patient's space. In sum, I will describe the ways in which control is 'embedded' in what each participant is doing in the specific phase of giving and receiving the reason for the visit.

Thus, control in this study is understood as residing in every action of the participants in interaction. It has to do with the ways in which turns are ordered with regard to the other participant's turns of talk, and with the sequential implications which each turn posits for the following turn. It is perceived as the extent to which participants are able to initiate, maintain and close up sequences of action, i.e., to maintain their version of the ongoing activity when giving and receiving the reason for the visit. This view on control is by no means offered as an alternative to more structural

considerations. Instead, my meaning is to highlight the ways in which the idea of unilateral control over the medical consultation by the doctor may not give sufficient credit to the patient as an active participant in consultation, and to complement the prevailing view as far as these aspects are concerned.

1.6. Data and method

The data used in the study consists of 100 video-recorded and transcribed medical consultations. The consultations took place within Finnish general practice and occupational health care, in one small town and one larger city in Southern Finland, during the years 1993-1994. Private practices are not included, the consultations studied come under the municipal health care. Seven of the consulting doctors are women and seven are men. Among the patients women have a slight majority. The patients represent different social classes, and their ages vary from 5-90. In the data transcribed each consultation deals with a different patient.

The problems presented by the patients vary. Mostly they consist of common illnesses such as colds and musculo-skeletal problems, and no life-threatening diagnoses are delivered. There are, however, some cases where the patient suspects a more serious illness, such as cancer, but none of these cases is evaluated by the consulting doctors as severe, at least not during the consultation in question. There are almost equal numbers of acute and follow-up visits in the data, while routine encounters for regular check-ups are a minority. Acute visits refer to consultations where the patient had arrived on her or his own initiative, whereas follow-up and routine visits are pre-arranged with the doctor.

1.6.1. CA approach to the data

In conversation analysis an important starting point is to highlight the dimensions of context which the participants of the conversation themselves treat as relevant. Thus, for example, the nature of the problem is not chosen a priori as a potentially relevant factor in the structuring of the phase of problem presentation. It is thought that if this dimension is relevant to the participants in the situation studied, this will become observable in the analysis. The primary context presupposed are the generic structures of

ordinary conversation which serve as the basis for interaction in medical consultation.

The data is limited to the description of interaction in primary health care, presenting patients with common, usually less serious, illnesses. Thus, of course, the results and claims made in this study are equally limited to this specific environment within health care. In hospital wards, for instance, where patients with more serious illnesses are sent, the logic of interaction may be different and would be the subject of another study.

1.6.2. Research process

The data was collected in a project named "Doctor-patient interaction in Finnish general practice consultations" led by Anssi Peräkylä and Marja-Leena Sorjonen. The other studies in the project focus on the giving and receiving of diagnosis (Peräkylä 1998a; Peräkylä 1998b), diagnostic utterances by the patients (Raevaara frth), advice-giving (Sorjonen 1996a; 1996b), laughter in consultation (Haakana 1999), and talk about lifestyle issues in medical consultation (Peräkylä and Sorjonen 1997; Sorjonen et al. frth).

In collecting the data, the relevant permissions were obtained from the municipalities as well as from the participants concerned. The aim of the study was explained to be the examination of the doctor-patient interaction, of the ways in which the doctor and the patient interact with each other. Approximately 75% of the patients agreed to the recording. The videotapes were recorded by a research assistant and researchers who were not present in the doctor's office.

After the recording, the conversations were transcribed following a system commonly used in CA studies, developed by Gail Jefferson. The system aims at fulfilling the requirement or ideal prevalent in CA research that no detail of interaction should be dismissed as unimportant. In the system, specific attention is paid to features such as: intonation as one indicator of a possible completion of a turn-of-talk, silences in between the turns which help in detecting possible completions but also disturbances in the normal order of the turn-taking, onsets and offsets of overlapping talk which are relevant in

studying interruption. The key to the whole system is found in the appendix.¹³ The transcriptions were made by the researchers and research-assistants of the project. To date, 100 consultations out of a total of 250 have been transcribed, and these 100 constitute the data of this study.

To start the analysis of data the transcriptions were read through, and a collection was made of all the sections where the patient presented a problem to the doctor (by describing symptoms or by locating the trouble) and the doctor received this presentation in one way or another. In order to isolate a specific sequential slot, to standardize as far as possible the local contingencies influencing the interaction, the main focus of interest was placed on the problem presentations following the doctor's opening question at the beginning of the consultation. The activity of presenting the problem at the beginning of the consultation and receiving this presentation was also considered important on the basis of previous research on doctor-patient interaction (see section 2.2.). Later descriptions of symptoms or illness were occasionally returned to in order to make comparisons, or to otherwise check on the analysis.

In the course of analysis the beginning and the end of the activity of 'doing problem presentation' were defined as starting with the doctor's question on the reason for the visit, and closing at or around the slot where the doctor started the verbal or physical examination. These boundaries of the activity in question were by no means strictly defined. There were cases where the patients started their problem presentation without waiting for the doctor's opening question. Likewise, there were cases where the patients expanded on their problem presentation after the doctor had already started verbal examination. The sequence thus extracted usually consisted of at least two subsequent turns of talk, one by the doctor (the opening question) and the other by the patient (the problem presentation), while the following turn by the doctor could in some cases be considered to start a new activity. These two turns of talk together with the suggestion by the doctor to start either verbal or physical examination were taken as the locus of analysis.

¹³ One must note at this point that the transcription of the original tapes already involves some analysis of the data. However, when doing the actual analysis, the original tapes are used, and if necessary, corrections are made to the original transcription.

In analyzing the data, I made collections of each specific turn structure observed in the data. Previous knowledge on structures of talk in both ordinary conversation and in institutional interaction achieved in CA studies served as a resource in the analysis. Especially with regard to the designs of problem presentations and the doctor's subsequent actions, the variation was ample (cf. Heritage 1984). Thus deviant case analysis, considered an integral part of CA studies, remained marginal in this study.

CA is characteristically 'co-operative', and some of the observations presented in this study originally sprouted in data sessions held in Finland and the USA¹⁴. Data sessions are situations in which researchers co-operatively analyze data-extracts and discuss their observations. In Finland the participants were linguists and social scientists from the universities of Tampere and Helsinki, in the USA data sessions were held at UCLA, with researchers in sociology, anthropology, and applied linguistics. The data sessions offered a possibility to check upon the analysis made privately, to discuss its implications drawing upon the data and also to complement my personal observations with other possibly relevant ones in terms of the object of study. In this way, the data sessions also added to the reliability of the analysis.

Having located the sequence to be studied and extracted the turn-designs commonly used in giving and receiving the reason for the visit, I arranged the observations in chapters. In organizing the contents I followed the sequential order of the activities studied. A separate chapter was written on non-verbal activities by the doctors during the patient's problem presentation. The structure of the study will be presented in more detail in the next section.

1.7. The structure of the study

Chapter 2 describes the location of the sequence in focus in the overall structure of the consultation, and the turn-by-turn organization of the sequence. In order to locate the sequence 'an ideal structure' first introduced by Byrne and Long (1984(1974)) is applied.

¹⁴ The most prominent or relevant of these observations will be attributed to the persons responsible in the empirical part of the study.

Chapter 3 describes the different ways in which doctors design their opening question, and the ways in which patients answer it. It shows how the patients (and also doctors) treat the slot opened by the doctor's opening question as a place to describe their problem, as a slot reserved for an activity of information delivery, not just for providing an answer to the doctor's question. This indicates an orientation to the overall sequential organization of the medical consultation which may temporarily override the immediate sequential constraints projected by the design of the doctors opening questions. Doctors do initiate the medical business, but their question designs are not necessarily so consequential to the length and content of the patients' problem presentations as has been suggested.

Chapter 4 analyzes the different ways in which patients describe their reason for the visit. It points out that these ways are not strictly dependent on the form of the doctor's opening question. Especially one way of presenting the problem, i.e., narrative design will be focused upon as embodying the patients' possibilities to control the course of consultation. Narrative design is used as a way to extend a turn, to postpone the next transition relevance place. Even if the doctor takes the turn in the midst of the patient's storytelling, the patient is able to return to his story, as the doctor's intervening turns of talk can be recontextualized as parts of or intermissions in the story.

Another theme in this chapter is to investigate the functions of the narrative designs. It will be shown how the structure is used to include in the telling elements which support the moral worth of the patient and justify the doctorability of the problem.

Chapter 5 studies the ways in which patients conclude their problem presentations. Some of these ways are shown to embody patients' efforts to suggest a shift forward in consultation. The chapter also discusses the extent to which problem presentation at the beginning of consultation is constructed as troubles-telling vs. a request for help by the participants.

Chapter 6 describes the different practices of doctors in receiving the patients' problem presentations, and discusses the extent of control embedded in these different designs. It will be shown that explicit acts of control such as interruptions and topical disruptions are relatively rare, and that the next turns

by the doctors seem to leave quite ample space for the patients to continue their problem presentations if necessary. However, the ultimate control in shifting forward in consultation remains with the doctors.

Chapter 7 is an excursion on a non-verbal aspect relevant in terms of controlling the consultation. It studies the ways in which doctors may (unintentionally) heckle the patient during the problem presentations by withdrawing their gaze from the patient at a critical point in the narration.

In chapter 8 conclusions are drawn on the basis of the analytic chapters. They concern 1) the nature of the ongoing activity, 2) the constituents and distribution of control in consultation, and 3) the linking of moral aspects to the activity of problem presentation. The implications of the study for social psychological research, for the study of institutional interaction, and for medical practice will be discussed.

2. THE ROLE AND POSITION OF PROBLEM PRESENTATION IN MEDICAL CONSULTATION

This chapter will offer a framework for the analysis which will be presented in the following empirical chapters 3-7. Instead of describing actual empirical results, I will present some basic observations which have served as the basis for organizing the analysis. First, I will describe the location of the sequence analyzed in the overall structure of the consultation drawing upon Byrne & Long's (1984 (1976)) well-known scheme. Thereafter, I will discuss the role of the sequence (the phase of problem presentation) with regard to the specific features attached to it in previous literature on doctor-patient interaction. To conclude, I will present an overview of the turn-by-turn organization of the sequence.

2.1. The overall structure of the consultation

In their seminal study, Byrne and Long presented an ideal model of the course of medical consultation where they complemented the standard medical model with a more interactional approach. Drawing upon a data analysis of almost 2500 medical consultations they agreed upon the medical consultation as consisting of the following sequence of events:

- I The doctor establishes a relationship with the patient
 - II The doctor either attempts to discover or actually discovers the reason for the patient's attendance
 - III The doctor conducts a verbal or physical examination or both
 - IV The doctor, or the doctor and the patient, or the patient (in that order of probability) consider the condition
 - V The doctor, and occasionally the patient, detail treatment or further investigation
 - VI The consultation is terminated usually by the doctor.
- (Byrne and Long 1984 (1976), 21)

Byrne and Long stress that the model is ideal; in practice the phases rarely appear in such a strict order, but may be overlapping, and their order may vary. However, the phase of discovering the reason for the visit is out of necessity usually situated at the beginning of the consultation.

Since Byrne & Long, conversation analysts have studied the structure of medical consultation as consisting of phases with distinctive tasks and goals. (see e.g. Heath 1986; Silverman 1987; ten Have 1991; 1995; Robinson 1998). The essential notion with regard to the study at hand has been that each phase in the medical consultation forms a specific context for interaction, a (primary) frame of reference for the activities of the participants. Thus, for example, the observation that restrictions on patient-initiated questions may be most effectively present during the phase of verbal examination, whereas during the phase of deciding upon treatment patients may more readily come forward with questions and suggestions (cf. ten Have 1991, 148-149) would implicate that the eagerness of the patients to ask questions could connect with their orientation to specific tasks or goals to be achieved in each phase of the consultation. Thus, patients asking few questions in the phase of the verbal examination, for example, would be constitutive of the phase and the activity going on and would portray the patients' understanding of the task at hand in this particular phase.

Similarly, it can be assumed that patients and doctors orient to specific tasks to be achieved during the phase of "discovering the reason for the patient's attendance" (Byrne and Long 1984 (1976)). Following Heritage, in this study this phase will be renamed as 'problem presentation'. This naming also gives credit to the patient's active role in the interaction studied.

2.2. The importance of the phase of problem presentation

The phase of problem presentation is often mentioned as crucial in terms of the outcome of the visit. A common view on the task of the patient at this phase of the consultation is that he is there to give information. From the medical point of view, the patient should be able to convey to the doctor proper and relevant information on the illness so that the doctor can arrive at the correct diagnosis. (Pendleton 1983; Keinänen-Kiukaanniemi and Mäkelä 1991, 90; Virtanen 1991; Ong et al. 1995). Managing this task in a satisfactory way may have far-reaching consequences for the rest of the consultation and, consequently, for the patient's health. It is well documented in both medical and social scientific literature that only the problem or problems presented at the beginning of the consultation are regularly taken into consideration by the doctor and that the ones presented later in the consultation are more easily ignored (Korsch and Negrete 1972; Beckman

and Frankel 1984; Kokko 1990). This is especially tragic in relation to so called delicate issues, which due to their taboo-like nature are not 'revealed' without hesitation even in less structured situations (see Peräkylä 1995, 232-286; Silverman 1997, 61-108). The ways in which the patient tries to transform her/his experiences of unease into descriptions of the reason for the visit, and the ways in which the doctor receives and elaborates these descriptions, are seen to be of essential importance in diagnosing and treating the illness of the patient (Clark and Mishler 1992).

From the point of view of the doctor the main goal of the phase may well be to discover the reason for the patient's attendance as suggested by Byrne and Long. However, drawing upon earlier studies on patients' stories (Mishler 1984; Davis 1988; Clark and Mishler 1992), Heritage's seminal study on problem presentation (Heritage and Stivers 1999; Heritage frth; Heritage and Maynard frth), and the data-analysis for this study it seems clear that delivering information may not be an adequate characterization, at least of what the patients are doing in this phase, what aspects of context they treat as relevant for the ongoing activity. Presenting illness experience at the medical consultation is not only a question of giving information. It involves various kinds of barriers which have to be overcome first. Just as troubles-telling in ordinary conversation is not a simple matter but requires a certain amount of preparation and negotiation between the participants (Jefferson 1980a; 1980b), in institutional contexts it may face even further constraints (also Davis 1988; Heritage frth).

As has been suggested in numerous studies on institutional interaction, parallel with the 'rational' frame in which interaction proceeds, there is a more implicit moral frame (e.g. Bergmann 1992; Heritage and Sefi 1992). Though it is plausible that this moral frame permeates all discourse, it may be specifically characteristic to institutional interaction. Bergmann even suggests that "the whole enterprise of people-processing in institutions rests on assessments and decisions about people's normality and moral accountability (Bergmann 1998, 291).

The presence of this moral aspect in medical consultations has been earlier pointed at both theoretically and empirically (eg. Parsons 1951; Bloor and Horobin 1975; Heritage frth). In his theory of the social system Parsons (1951) used doctor-patient interaction as an example of the functioning of the

whole society. He introduced specific rights and obligations belonging to the institutional role of the doctor on the one hand and to the sick person on the other. In Parsons' scheme the doctors' rights and obligations center around responsibility for the welfare of the patient by using technical competence in medical science (447). Patients, on the other hand, have rights such as exemption from normal social responsibilities such as going to work or to school, and exemption from responsibility for their own illness – they are not expected to get well by their own will-power. On the other side of the coin there are obligations such as wanting to get well, seeking technically competent help and cooperating with the professional providing this help. (437). Parsons points out how these rights and obligations may become objects of secondary gain, how they are in danger to be misused for instance by claiming illness in hope for sick-leave. Thus, according to Parsons, one of the functions of the institution of medicine is the control of disease as a deviant form of behavior. In this framework, the doctor (drawing upon his expert knowledge) acts as a gatekeeper to the sick role.

Parsons' ideas on the constituents of sick role are widely cited in social scientific research (e.g. Bloor and Horobin 1975; Turner 1987; Gerhardt 1989). However, in empirical research they have evolved only fairly recently, mainly in the context of CA-tuned study of institutional interaction (Heritage and Stivers 1999; Halkowski frth; Heritage frth). Heritage has in several contexts used Parsons' sick role scheme as a starting point for his own considerations, but has toned down the structural explanations and put more stress on the patients' activities and orientations. Following Bloor and Horobin (1975), he has suggested that in primary care consultation there is a double duty for the patients: on the one hand they must show competence in deciding on when to seek medical help for their problems, while on the other, they must defer to the doctor's evaluation on the appropriateness of their decision. Consequently, a major task for the patients in the phase of giving and receiving the reason for the visit is achieving what he calls the 'doctorability' for the problem in question. Heritage points out how in presenting their reason for the visit the patients work to establish their problem as worthy of medical attention, worthy of evaluation as a medical condition, and worthy of advice and, if necessary, medical treatment. This establishment of the doctorability of their problem then serves to justify their decision to visit a doctor (Heritage frth).

The realizations of this moral aspect of problem presentation will be perceived as one possible consideration which informs the organization of the participants' activities in medical consultations¹⁵.

2.3. The structure of the phase of problem presentation

I have investigated each turn of talk as they unfold in conversation beginning from the doctor's opening question until the shift to verbal examination. The flexible pattern which resulted from this analysis consists of a range of alternative turns of talk with a loosely organized order. The range of variation of the actions by the participants is presented below. Each number equals a sequential position for a turn.

1. Solicitation

- a. The doctor's opening question
- b. The doctor's suggestion for the reason for the visit

2. Delivery

- a. The patient's problem presentation
- b. The patient's agreement with the doctor concerning the reason for the visit
- c. The patient's rejection of the doctor's suggestion and presentation of another problem

3. Alignment as a recipient / Closure implicature

- a. The doctor's provision of space or request for a further description from the patient (alignment as a recipient)
- b. The doctor's neutral acknowledgment
- c. The doctor's actions which convey a suggestion for starting the verbal or physical examination (closure implicature)

¹⁵ There may also be other tasks oriented to in presenting the problem to the doctor. Heritage and Stivers have pointed out how bidding for remedies may form one distinct project for the patients in giving their reason for the visit. Especially in pediatric consultations parents may engage in 'requesting a quick fix': their diagnostic suggestions such as talk about ear-infection are often heard by the doctors as bids for antibiotics. (Heritage and Stivers 1999; Stivers frth).

4. Expansion / Closure implicature

- a. The patient's actions implicating closure (such as silence)
- b. The patient's expansion of problem presentation
- c. The patient's agreement with the doctor's suggestion to start the verbal or physical examination

The two first turns of talk are dependent on each other so that after 1a, the doctor's opening question, there follows 2a, the patient's problem presentation, and after 1b, the doctor's suggestion for the reason for the visit, there follows either 2b, or 2c, the patient's agreement or rejection of the suggestion. It is also possible that the patient starts to present the problem before the doctor has initiated the medical business.

The doctor's turns from 3a to 3c may follow any action by the patient in position 2.

The patient may remain silent (4a) only after either 3a or 3b, whereas agreeing with the doctor's suggestion (4c) may follow only after 3c. The expansion of problem presentation (4b) may follow any turn by the doctor, though after 3c, it may first require addressing the sequential constraints projected in the doctor's preceding turn.

Turns from 3 to 4 may recur, and the phase may continue until the doctor has suggested to start examining the patient and the patient has agreed.

Two possible courses of the phase are illustrated below. The first example illustrates a more compact version whereas the second describes a situation where the problem presentation is expanded. The key to the transcription symbols is found in the appendix.

Example #1 (12A2 Fever)

D: Maamies Päivi ((the doctor calls the patient in))
(2.2)
D: Hello,
P: Hello,
D: [Risto-Matti °Kurkimäki°. ((doctor introduces himself))
Sit down please.
P: (Mm,)
(1.1)

1a

D: hhh Well,h (.) what's (.) the matter.hh

2a

P: 'Cause I have like erm (0.7) I had fever last- >or
yesterday evening like thirty-eight and̄ si:x and .hhh
>then< (0.2) I have throat in he:re really sore. >And
then I'm feeling kind of ill: and wea#k all the time
and#,

3c

D: Have you ever had ton:sillitis.

4c

P: Yes, (0.2) <two times> .hhh last summer and two
times the sum^omer before^o.=.hhh But now I
was there (0.2) in the cultivation and they said
that it is negative.
D: °Righ:t. Let's have a look.°

In this example the doctor's suggestion for starting the verbal examination is quite straightforward. His question on tonsillitis embodies the first turn of talk of verbal examination, and the patient agrees with it by answering the question and not returning to her problem presentation.

In example #2 the sequence is expanded:

Example #2 (1B1 Naprapath)

D: We'll have to write your information here on the comput-
>>twenty-fifth of July thirty-°ni[ne.°
P: [Exactly.
(14.0) ((Doctor writes on computer))

1b

D: And you've had some tests made.

2c

P: No:, (.) My problem is the following. I have been on sick-leave now maybe (0.3) almost four weeks. My back has been so awful. .hhhhh and erm (.) Dr. Mäki-Penttilä has now treated it so that now I've (.) I've been to all sorts of naprapaths?, .hh and now I'm presently in physio-therapy. .hh[h

3a

D: [Ye:s.=

4b

P: =And (.) I last week as I finished my sick leave yesterday< I thought maybe I'll try to go to work, .hh but (.) when I was in the therapy on Friday.=this therapist did tell me that .hhh it may start aching (.) in a different way. (.) And it's been so sore for the weekend so she said that you shouldn't then like strain it at all nor .hhh that< I'd still have therapy now tomorrow and on Thursday. So I (thought) that I didn't dare go to work as this .hhh >hip was aching so terribly and a kind of< ache different ache ↓like from that it °used to be.°

3a

(0.4)

3b

D: Ye:s.

4a

(1.0)

3b

Ye[s,

4b

P: [And erm (1.7) just because of that I came then-
that I do have medication it's not that but,

(0.2)

3c

D: ↓Would you come and lie down so we'll have a
look at it,

4c

(2.5) ((P starts undressing))

The participants go through several rounds of turns belonging to categories 3-4 before agreeing upon the proper location to start examining the problem.

The pattern presented above describes the range of practices used by (and available to) the doctors and the patients in constructing a shared understanding on the problem(s) of the patient before launching the verbal or physical examination. In terms of controlling the course of consultation, the essential loci for attention are 1) the points at which the turn passes to the other participant, 2) the sequential implicativeness of the turn preceding this point, 3) the ways in which these implications are addressed in the turn following the point.

The following six empirical chapters are arranged to cover the shifts between the turns, focusing on the ways in which each turn limits or provides space for the range of alternatives available for choosing the placement and the activity of the following turn.

3. THE OPENING QUESTION AND HOW THE PATIENTS BEGIN THEIR COMPLAINTS

In discourse and conversation analytic studies on doctor-patient interaction, one major focus of interest have been the ways in which doctors are able to control the consultation in practice. Mostly drawing upon the results by West, Mishler, and Beckman & Frankel, Waitzkin (1991, 24) defines the main ways of controlling the course of consultation as questioning and interrupting (see Beckman and Frankel 1984; Mishler 1984; West 1984). By taking the turn before the completion of the patient's problem presentation doctors are able to regulate the space available to patients for describing their present illness¹. With the design of their questions the doctors are able to limit the patients' answers to a certain range of options.

The suggestion that the design of a question limits the alternatives available for answering it increases the particular importance of the design of the opening question. The patient's description of the reason for the visit introduces the first, and often the sole topic of the ensuing conversation (Korsch and Negrete 1972; Beckman and Frankel 1984; Kokko 1990; Roter and Hall 1992). Therefore, it has been considered specifically important that the patient is allowed to tell freely about the reason for the visit at the beginning of the consultation. In this sense, the design of the opening question may have consequences even for the result of the visit.

Largely drawing upon the kind of reasoning presented above, various medical text books, as well as course plans designed for training future doctors in interactional skills, teach a simple rule: 'To start the medical business, always use open-ended rather than closed-ended questions. Later, you may help the patient to specify his narrative by asking closed-ended questions' (Keinänen-Kiukaanniemi and Mäkelä 1991; Birgegård 1993; Pyörälä 1993; Pelkonen 1994). With closed-ended questions the writers refer to questions which focus on a particular problem, or in some other way limit the range of alternatives the patients have available for answering the question. For example, a question such as "How have you been feeling lately, have you had trouble with your bowels?" would direct the patient's answer towards a particular focus. On the other hand, an open ended question, such as "What brings you

¹ The ways in which doctors take the turn after patients' problem presentations will be analyzed in chapter 6.

here, could you tell me” would encourage the patient to a more extensive presentation of the problem. The general consensus seems to be that by opening with open-ended questions doctors provide more space for patients to say what they have to say, and ensure that all necessary information gets through to the doctor. However, these recommendations have been so far based more on common sense reasoning than on empirical studies drawing upon actual interaction in a medical consultation.

One particular aspect which has gained little attention in considerations concerning open-ended vs. closed ended opening questions is the connection between their grammatical design and the nature of the visit in question. So far, I know of only two studies dealing with this issue. Heath (1981) has showed with British data how closed questions may be specifically recipient-designed for return visits. More recently, Robinson (1999; frth) has observed in Northern American medical consultations how doctors use specific question designs for patient-initiated acute visits, for doctor-initiated follow up visits, and for visits connected with a routine check-up. These observations would suggest that the grammatical structure of a question or its topical focus may not be the only aspects relevant with regard to the sequential implications embodied in the question².

In this chapter I will study with the help of empirical data what kind of limitations the doctors’ opening questions set to the patients’ answers in actual medical consultations. My starting point is that the grammatical design of the question and the suggestion it makes for the focus of the following problem presentation may be only some of the many factors taken into account in the patient’s answer. In order to find out the actual pragmatic significance of different designs of the opening questions, I will study the patients’ answers to these questions. I will follow the conversation analytic idea that the interpretations of the questions will be displayed in the answers (Heritage 1984, 255; 1995; Frankel 1995). Thereby, I will try to add to previous studies on control in medical encounters by adapting a perspective which treats the patient as an active participant in the construction of the situation.

² This observation is significant and would deserve a larger space than can be awarded to it in this study. I hope to be able to return to it in future studies.

In the analysis I will define closed-ended questions as questions which make relevant either a 'yes' or 'no' answer. For example, "Did you come for your asthma, or do you have something else on your mind?" or "And you've had some tests made." would be regarded as closed questions. All the other ways of the doctors of starting the medical business are defined as open-ended. These would include questions such as "How's your arm.", for instance (cf. Heath 1981). Thus, my analysis on closed-ended questions will concentrate on the most restrictive ones with regard to the scope of possible answers.

In what follows, I will show how, even after closed-ended opening questions, patients are able to extend the topic (or the problem area) suggested by the doctor's question and/or propose another topic instead. I will also describe ways in which the patients' ways of structuring their problem presentations do not follow the structure of the opening question. Drawing upon the analyses, I will suggest that the design of the doctors' opening questions as open or closed is less consequential for the length and content of patients' problem presentations than has been assumed. What seems to count more than the grammatical structure of the opening questions is the activity context in which they are presented. I will suggest that patients treat the particular slot following the doctor's opening question as 'reserved' for their problem presentation. Instead of plainly answering the question the patients treat it as a signal for shifting the ongoing activity from the opening to the medical business. In this way they show an orientation to the overall structural organization of the consultation, to the encounter as organized in phases each consisting of a specific task or activity.

The chapter is organized in four parts. First, I will briefly locate the opening question in the overall structure of the consultation and introduce the major dimensions of analysis (3.1). Thereafter, I will analyze patients' complaints which follow closed-ended opening questions (3.2). In the next section I will examine patients' problem presentations which follow an open-ended question by the doctor. I will also briefly study patients' complaints starting before the actual opening question, or presented after doctors' turns of talk which have an ambiguous status as an opening question. (3.3). In the closing section, I will discuss the implications of the observations made (3.4).

The data for the chapter consist of 96 beginnings of medical consultations. Of these, in 13 the patient started without waiting for the doctor's opening

question. In just under half of the rest of the cases (37 consultations) the doctor suggested a reason for the visit to the patient, whereas in the other half (46 consultations) the doctor left the reason for the visit for the patient to define.

3.1. The position of the opening question in the overall structure of the consultation and major dimensions of analysis

In a medical consultation, before it is possible to start working with the patient's problem the doctor and the patient have to accomplish several preparative tasks. Robinson (1998) has identified four such tasks in Northern American consultations: establishing a relation of interaction (greetings), spatially arranging oneself into opening positions (sitting down, choosing a home position vis-à-vis each other), identification, and for doctors, preparing themselves bureaucratically by reading the records. Only after these preparations is the doctor ready to ask the opening question (see also Heath 1981).

Similar kinds of tasks can be identified in Finnish general practice consultations, although their order is different. In Finnish consultations the initial identification of the patient occurs when the doctor calls the patient in by his name. After the identification the participants enter the examination room. At the entrance they greet each other and shake hands. While greeting the patient the doctor introduces herself and the patient may also repeat his name, thus re-identifying himself. The doctor asks the patient to have a seat, they walk to their seats and sit down. Whereas in the US consultations, at this point, the doctors regularly engage in reading the records (Robinson 1998), in the Finnish encounters the doctors' practices are more varied. They may take a glance at the medical record before asking the opening question, or they may turn towards the patient straight after sitting down. Only two of the 14 doctors of the data engaged extensively in reading the patient files before asking the opening question.

The following analysis of a typical adjacency pair of an opening question and an ensuing answer serves to introduce the basic dimensions in terms of which I will analyze the doctors' opening questions and the patients' answers to them. We will enter the consultation at the point where the participants start

the medical business, i.e., just after they have dealt with the preparatory actions, such as greetings and sitting down.

Example A. (24A2 Boils)

- 1 D: Joh,
Right,
- 2 (4,0)
- 3 P: (Mul oli tämmönen<)
I had this kind of
(I've got this<)
- 4 (0,2) ((P passes a piece of paper³ to D))
- 5 D: Tähän saat käydä istumaan.
Here may+you go sit+down
You can sit down over here.
- 6 (3,2) ((P sits down))
- 7 D: → Minkäs takia sinä olet liikkeellä.
What FOR you are moving+on
What brings you here.

(D is sitting down))
- 8 (.)
- 9 P: → N:o, (0,7) (°mm: öh°) öv:: viime tor:staina
well last Thursday
W:ell, (0.7) (°mm: eh°) el:: last Thur:sday
- 10 → rupes iskemää ↑flunssanpoikasta ja .mmh (('sisään-
started strike cold+little and sniffing
I felt I was catching a little ↑cold and .mmh
- 11 → päi niistäen')) (0,2) mä ajatt'i että se menee oh↑litte
I thought that it go pass
(sniffing)) (0.2) I thought that it'll ↑pass
- 12 → ja .mh
and .mh
- 13 D: ↑Mm:[m,
- 14 P: → [S-sit rupes tulee kurkkukipua
then started coming throat-ache
[T-then my throat started aching
- 15 → ja nyt (siel on) semmoisia pa:iseita tai
and now there are kind of boils or
and now (there are) kind of bo:ils or
- 16 → semmosia .hmmthh mönttejä. Hh
kind of lumps
some kind of .hmmthh lumps. hh

³ This paper is probably the license signed by the patient to record the consultation.

17 D: ↑Jaa ↓jaa.
 ↑I ↓see. ((D is moving her chair towards P))

The question the doctor asks in line 7, while sitting down ‘What brings you here’ seems a typical one, the kind which one would expect to hear as the opening question. The question does not incorporate assumptions on the patient’s reason for the visit: As well as a health related problem, the reason could be a check up required for a driving license, for instance. The only expectation concerning the reason for the visit inherent in the question is that the patient should have some grounds for having made the appointment. The question leaves the focus of the visit for the patient to define, i.e., in this sense it is open ended. Whether the design of the opening question suggests a specific reason for the visit or leaves it for the patient to explain was one aspect of the initial analysis which served as the basis for structuring the chapter.

With the question ‘What brings you here’ the doctor claims that she does not have previous information about the patient’s problem. Thus, unlike questions such as ”How’s your arm” the question treats the visit as potentially acute, initiated by the patient himself. In this sense the question is not completely ‘open-ended’: Although it does not focus on any particular problem it is designed for a patient visiting the doctor for the first time for the problem in question (cf. Heath 1981). In the Finnish data, the opening questions could be roughly divided into four categories according to this aspect: there were questions designed for acute, follow up, and routine visits specifically. Furthermore, there were questions which were ambiguous in terms of whether the doctor had previous knowledge on the reason for the visit. For example, questions such as ”What is the situation like?” or requests to begin an explanation such as ”Tell me.” were included in the latter category. Recipient design of the opening questions separately for acute, follow up, or routine visits will be briefly touched upon in the analysis. However, a considerable part of the opening questions (22 out of 96) were ambiguous in this sense. Furthermore, in many cases which did incorporate assumptions of the nature of the visit these assumptions were incorrect and had to be corrected by the patients. Thus I will not draw major conclusions with respect to this aspect, it will serve mainly as a tool for analysis.

Although the doctor's opening question in line 7 leaves open the focus of the visit, it contains a preference for the grammatical design of the answer: It specifically asks 'What for' the patient has come to the consultation⁴. Thus, it suggests that the patient's answer should be designed as an explanation, grammatically of the form: 'because of X'. The grammatical preference incorporated in the question will be one aspect to be examined (cf. Sacks 1973; Schegloff 1988)

Pragmatically, as the doctor's first topic initiation is designed as a question, it asks for an answer as the relevant second-pair part. The preference for next action incorporated in the design of the question will be another aspect to be studied. (cf. Pomerantz 1984a, Schegloff, 1988 #980)

The answer, in line 9, is started after a micropause and is marked with hesitations and pauses, i.e., it is designed as a dispreferred second-pair part to the doctor's first (Levinson 1983, 307; Heritage 1984, 266-267; Pomerantz 1984a; Schegloff 1988). The hedging in the beginning of the answer may show an orientation to passing either the grammatical or the pragmatical preference encoded in the opening question: to introducing a different design than was suggested by the question.⁵ Instead of just answering the question with a gloss, e.g. "because of a sore throat" or formatting the answer sententially, e.g. "I have a cold, a sore throat, and there are some sort of boils in my throat" the patient tells a short story on the development of her illness. Strictly speaking, instead of being a second-pair part to a question, the patient's answer would be more fitted for a request for a description, such as "Go ahead and tell me", (which is routinely used as an opening question by one doctor in the data.) The ways in which the patients treat the doctor's opening question in their answers are the main aspect to be studied.

⁴ See the gloss in line 7.

⁵ Another potential explanation for the patient's dysfluencies would be that they occur as the patient is unsure of the availability of the doctor as a recipient to the patient's problem presentation, e.g. the doctor has not yet turned towards the patient but may still be reading the records (cf. Goodwin 1981; Heath 1985). However, in the example the doctor is gazing at the patient when the patient begins her turn of talk. A detailed study on the relation of patients' dysfluencies to doctors' displays of availability as recipients is offered in chapter 7.

3.2. Closed-ended questions - minimal answers?

Yes/no questions could be described as ‘the most closed-ended of the closed-ended questions’ in that unlike some questions suggesting a specific reason for the visit (such as ‘How’s your arm’), yes/no questions do not make relevant any report on the development of the problem in their design. Instead, a plain confirmation may serve as a sufficient answer to them. This definition enables the analysis of grammatical preferences incorporated in the questions. A grammatically positive question such as ”Is that your worst problem?” would prefer a positive answer, whereas grammatically negative question such as ”You haven’t had chest pains?” would prefer a negative answer. In the data, such questions were most frequently used during follow-up visits, where the patient had been called in by the doctor to check the recovery process or to review the test results in order to confirm the diagnosis⁶.

In this section I will suggest that the prevailing understanding on how closed-ended questions limit the answering alternatives available for the patient has been too simple in not taking into account the patients’ own orientations in the situation. I will show i) how even when patients answer the doctor’s opening question with a minimal yes or no, they may treat their answer as completed and sufficient as such. This would indicate they do not always consider it necessary to expand their answer at this point. I will also show how patients, in their answers to yes/no questions, are able to ii) expand the focus suggested by the doctor, or even iii) correct it.

In the following I will first look at patients’ answers which are both minimal and designed to fit the preferences displayed in the question (3.2.1.). After that I shall examine more extended answers (3.2.2. and 3.2.3.).

3.2.1. Minimal answers to closed-ended yes/no questions

In the data of 96 consultations there were altogether 28 consultations in which the opening questions were designed as yes/no questions. These questions were typically used to start the medical business in follow up or routine visits. The doctors hardly ever opened an acute visit with a yes/no

⁶ This would support the suggestions according to which the design of the question is connected with the assumed nature of the visit.

question⁷. In one third (12) of the consultations, the patients gave a minimal confirmation to the doctor's opening question. All these 12 consultations were either doctor-initiated or statutory. Example 1 illustrates such a minimal answer. In the example the patient indicates explicitly that she has reached the completion of her turn at the end of her initial answer to the doctor's opening question in line 4:

Example 1. (8A3 Dizziness)

- 1 D: ((turned towards the desk, takes papers from a folder, glances at the computer))
°#Otetaanpas näitä nyt esiin,#°
take+let's these now visible
°#Let's see what it says in here,#°
- 2 (0.3) ((D turns toward P))
- 3 D: → .mthh >Niin te ootte näissä kokeissa käy_ny n[yt.
PRT you have these+in tests+in been now
.mthh >So you've had these tests made n[ow?
- 4 P: → [Juu.
[Yeah.
- 5 (.) ((D turns gaze towards the desk))
- 6 P: Juu kävin.
PRT was+I
Yeah I have.
- 7 (1.5) ((D turns away from the patient to take some papers))
- 8 D: Vii:kko sit°te°.
Week ago
A wee::k a°go°?
- 9 P: Juu.
Yeah.
- 10 D: Joo. °.hhhhh hh° Eli teille tuo:ta,hh huimauksen takia
PRT in-other-words you+for erm dizziness for
Right. °.hhhhh hh° So you er:m,hh you were here because of
- 11 tulit:te sil:l_oin,
came then
dizziness the:n?
- 12 P: Juu:.
Yea:h.
- 13 (0.2) ((D reads the papers))
- 14 D: Vii:kko taka>peri< °.hhh° (0.7) #o- >ootteko te sitte<
week backwards have you then
One week from now °.hhh° (0.7) #h- >have you then<

⁷ There were four such cases altogether, but in only one the patient's problem had not been previously diagnosed.

- 15 (0.2) tän kevään ja kesän ollu >tähän asti niinkun ihan
 this spring and summer been this until like quite
 (0.2) for this spring and summer been >until now like quite
- 16 hyvässä kunnossa [muu°te°<.]
 good condition otherwise
 feeling well [other°wise°<.]
- 17 P: [Oo:n et]tei mh väsymystä. Heh
 be+I that+not tiredness
 [Ye:ah I hav|en't been tired. Heh
- 18 (.)
- 19 D: Väsymyst[ä,
 tiredness
 tired,

The doctor's question in line 3 is a request for confirmation with a preference for a positive answer. It focuses on a past activity of the patient and displays access to it. In line 4, the patient gives the preferred answer *Juu* 'yes' with a falling intonation. This⁸ and the ensuing silence indicates she passes the turn back to the doctor. However, as the doctor does not take the turn immediately, the patient repeats her answer in line 6, enforcing it by repeating the verb the doctor used in his request. By repeating her answer the patient suggests that the doctor may not have heard her first answer. As she does not add any new elements to her answer she also displays that she considers her positive answer as sufficient. There ensues a long gap of 1.5 seconds during which the doctor turns to take some papers from the desk. The doctor's temporary disengagement from the conversation with the patient indicates that he is not waiting for the patient to continue⁹, but displays involvement in the side activity of checking the patient's records (see Goodwin 1981; Heath 1986; Robinson 1998, chapter 7). After the gap, in line 8 the doctor continues by making another request for confirmation concerning the moment of occurrence of the patient's test. After the patient has confirmed his suggestion in line 9, the doctor closes the sequence and moves on to focus on the actual medical problem of the patient. The doctor's turn in line 10 is once again designed as a yes/no question, more specifically a candidate understanding probably derived from the medical records. And once again the patient receives the doctor's turn with a plain confirmation, passing the turn back to the doctor.

⁸ According to Schegloff (1995, 113) preferred or agreeing second-pair parts tend to lead to closing the sequence.

⁹ On the other hand, the silences also indicate that there is space provided for the patient to continue her answer, were she inclined to do so. (See chapter 6 for a description of the doctor's reception of the problem presentations).

- 5 D: → sul oli toi ajokortti,=
you had that driving license
you had the driving license,=
- 6 P: → =↑kyllä mul on [seki mut] sitte mää oisin vielä
PRT I have that+also but then I would also
=I ↑do have [that as well but] then I'd also like to
- 7 D: [#asiana#hhh.]
issue+as
[#as your business#]
- 8 P: → kysässy ku tota: .hhh mää hoiran niitä lapsia ja >ne
ask as erm I take+care them children and they
ask as er:m .hhh I take care of them children and >they've
- 9 → on nuhas ollu ja muhun on puhkiimas ittelläki nuha ja<
have cold+in been and me+to is starting myself cold and
been having cold and I'm starting to get cold myself and<
- 10 → (.) mun on lyöny korvat lukkoonhh.
my have slammed ears blocked
(.) my ears have been getting blocked.
- 11 → =[että katot]tas että .hhh
that look+pas+cond that
=[that you could take a] look that .hhh

The doctor's opening question in line 5 makes relevant a confirmation of her suggestion on the reason for the visit. The patient begins her turn with a more official locution for agreeing with the doctor *kyllä* 'yes', and continues by repeating the grammatical structure of the question: *sul oli x -> mul on x* 'you had x -> I have x', and adding the suffix *-kin* (meaning 'as well', 'also') to the pronoun *se*. With the suffix she indicates that the suggested business is not the only one she would like to talk about. She continues further with the contrastive connector 'but' and by using the construction 'then I would also like to ask' which reserves space for a longer turn. After this she starts a narrative explaining her other business. The patient's whole turn is designed as one prosodic unit with no space provided for the doctor to take the turn. By using a common design for a dispreferred answer 'yes - but' (Pomerantz 1984a; Schegloff 1995, 67-68) the patient is able to extend the focus suggested by the closed-ended opening question of the doctor.

In example #3 the doctor (lines 5-6) suggests 'headache and dizziness' as the first topic of the consultation. The topic is initiated with a statement on observations which the doctor has made reading the medical records of the patient. As the doctor's turn finishes with a continuing intonation it may not be complete yet. For example, it could be constructed as background for an upcoming question. However, as the question concerns the past experience of

the patient it is hearable as asking for his confirmation (Peräkylä and Silverman 1991a; Peräkylä 1995).

Example 3. (29A2 Hernia)

- 1 P: =Hyvää [huomenta.]
good morning
=Good [morning.]
- 2 D: [Päivää °v]aan°.
Hello just
[Good °m]orning°.
- 3 D: °Käykää istumaan°.
Go sit down
°Sit down please°.
- 4 (2.2)
- 5 D: → N:o niin, katsoin että tässä välillä on: (0.5)
PRT PRT looked+I that here in between has
Ri:ght, I noticed that here in between there has (0.5)
- 6 → muutama käynti ollu päänsärkyä ja (0.3) huimausta,
a couple visit been head-ache and dizziness
been a couple of visits with head-ache and (0.3) dizziness,
- 7 P: → On,hh joo ja,=
PRT PRT and
Yes,hh there has and,=
- 8 D: =.°o[oh°
=.°y[eah°
- 9 P: → [ja tuota, (0.5) se huimaus alkaa >monta kertaa<
and erm that dizziness starts many times
[and erm, (0.5) that dizziness starts >many times<
- 10 sillä tavalla että (1.5) kun mä oon: nukkumassa ja
that way that when I am sleeping and
so that (1.5) when I'm: sleeping and
- 11 nousen ylös, (1.5) nin: (.) ei parane nousta suoraan
get up so not can get+up right away
I get up, (1.5) so: (.) you can't get up right away
- 12 muuten menee: (.) °n'ku°< seinää päin vaan pitää...
otherwise goes like wall agains just has to
or you'll (.) °like°< fall against the wall but you should...

With her utterance in lines 5-6 the doctor presents an update of the level of shared knowledge between herself and the patient. She indicates that they have met before, but does not make clear assumptions on the nature of the visit. The word *välillä* 'in between' refers to the time passed since they last saw each other, and introduces two problems for which the patient has visited a (different) doctor since their last appointment. However, the doctor does not

explicitly suggest those two problems as the reason for this visit, but only implies this possibility, simultaneously making it possible for the patient to tell about these problems.

Even though the doctor's question is not explicitly complete yet the patient treats it as a first-topic initiator suggesting his past ailments as the reason for the visit. He responds by repeating the verb in the doctor's turn (cf. *on* in lines 5 and 7) and continues his turn immediately with a continuation-implicative connector *ja* 'and', indicating he is not finished yet. His first response, repeating the verb, would be the default answer to a direct yes/no question (Sorjonen 1997, 75) whereas actually the doctor's turn is in the form of a *statement*. By repeating the verb, the patient treats the preceding question as one asking for new information (Raevaara 1993, 137; Sorjonen 1997, 85). Thus, even though the doctor has indicated that she has read the information from the medical files the patient chooses to treat the topic as something which has not been talked about before. In this way the patient is able to preserve the topic as 'fore-grounded', as part of an activity which has somewhere to go (Sorjonen 1997, 91), as a topic on which more may be said.

In ordinary conversation, statements concerning the experience of the recipient, i.e., what are called statements of B-event, which display limited access of the speaker to the topic, can be used for 'fishing for more information' from the recipient (Pomerantz 1980). Here, too, the doctor's opening statement in lines 5-6 is heard by the patient as making relevant an expansion on the topic.

Moreover the positioning of the doctor's utterance serves to support the patient's interpretation of the doctor's preceding statement. In the overall structural organization of the consultation it occurs after the greetings and sitting down, i.e., it stands in the place of the opening question. Although it is not formed as a direct question, it is segmented from the prior topic and clearly starts a new one. Furthermore, even though the doctor does not mark her turn as complete by intonation, it is grammatically and pragmatically hearable as complete, and as it occupies the slot reserved for initiating the medical business the patient is able to treat it in this way.

The doctor's turn in line 8, an inhaled 'yeah', is uttered just after the patient has projected a continuation with *ja* 'and'. In this way it is not located in an

actual TRP. However, Hakulinen (1993) has shown that in ordinary Finnish conversation one function of inhaling is to display withdrawal. Furthermore, as the doctor's 'yeah' is also uttered in a very soft voice, it does not work to interrupt the patient.

The patient goes on with his utterance by topicalizing the latter one of the ailments introduced by the doctor, dizziness. He gives a description of the onset of the problem in the form of a narrative, in this way keeping the turn to himself ¹¹. Thus, it seems evident that the other ailment (implicitly) suggested by the doctor as the reason for the visit is treated by the patient as the 'proper' reason.

Despite the closed-ended design of the doctor's question the patient forwards a specific topic of the conversation by treating the doctor's request for confirmation as a first-topic initiator. The patient picks an element of the question and goes on to present his problem with an extensive narrative. The example describes a situation where the doctor's closed-ended initiation of the visit is received by the patient as appropriate. It shows how the patient orients to the overall structural organization of the consultation: at the transition from opening to launching the medical business the patient treats the doctor's (even incomplete) turn as a first-topic initiator opening the slot for explaining the reason for the visit. Thus, as the first element of the sequence in question, yes/no questions may proffer further talk from the patient (cf. Schegloff 1995, 171-185).

In the next example, the doctor suggests a very specific focus for the patient's answer:

Example 4 (40A2 Sore leg)

- 1 P: Ja Karls↑son, (hh .hhh) ((D sits down))
and Lname
And Karls↑son, (hh .hhh)
- 2 D: J::oo,
Righ::t,
- 3 (1,5)

¹¹ On different designs of problem presentations, see chapter 4.

4 D: → Elikkä,
So,

5 (1,2)

6 D: → Teillä on siis se,
you have then that
You have then that/the,

7 (1,6)

8 P: Tämä jal↑ka,=
this leg
This ↑leg,=

9 D: → =jalka kipeä >se vasen< puoli.
leg sore that left side
=sore leg >the left< side.

10 (0,3)

11 P: → Juu: ja (.) minä olen siitä käynyt (0,3)
PRT and I have it+for went
Ye:s and (.) I've been to (0.3)

12 → päivystyksessä?, h .hh ↑ja korvalääkärikin anto
emergency+in and ear-doctor+also gave
emergency room for it?, h .hh ↑and the otologist gave

13 → tällasta nyt sitte s- (0,2) minä kävin täällä
this+kind now then I was here
me this now then s- (0.2) I had an appointment with

14 Kaukosel (.) h korvieni takia niin että .hhh
Last+name ears+my for so that
Kaukonen here (.) h because of my ears so that .hhh

15 että saa ottaa näitä sitte jos (tota noin kovia)<
that may take these then if like erm hard
that one can have these then if (like hard)<

16 ei kun olen ottanut niitä nyt (0,2) jotain kuus
no as have+I taken them now about six
no but I've taken them now (0.2) about six

17 seitsemän kappaletta.=.hh ja tämmästä sain e:-
seven pieces and this+kind got+I
or seven tablets.=.hh and this I got e:-

18 (.) tuolla vaan päivystyksessä ↑ja, .hhh (0,4)
there just emergency+in and
(.) just there in the emergency room ↑and, .hhh (0.4)

19 eihän nää o ehtiny viel auttaa ja
not+of course these have had+time yet to help and
of course these haven't had time to help yet and

20 nää ei autanu ↓kans.
these not helped also
these didn't help ↓either.

21 (0,6)

22 P: Niih.
So.

23 (0,3)
 24 D: .mthhh
 25 (.)
 26 D: °Nii::[:::°
 °Ye::[:::s°

The doctor moves from the opening to the medical business in lines 4-6 by suggesting a problem using the pronoun *se* ‘that/the’. The patient completes the suggestion by defining the location of the problem *tämä jalka* ‘this leg’. After this, in line 9, the doctor completes his initial utterance first describing the nature of the problem: *jalka kipeä* ‘sore leg’ and second, the exact location of the problem: *se vasen puoli* ‘the left side’. This request for confirmation has a strictly specified focus: it predefines the location of the problem to the left side of the leg. The use of the pronoun *se* ‘that’ presents the problem as known to both participants. Thus a plain confirmation of the information by the patient, as was given in example #1, would suffice for the doctor to be able to proceed to verbal or physical examination¹².

In her next action in line 11 the patient confirms the doctor’s suggestion. However, after the confirmation she seamlessly continues her turn by informing the doctor of her previous visits to emergency room and to an otologist, and on the medication she has received for treating her leg and her ears. Apparently she has been using the pain-killers meant for her ears also to treat the problem with her leg. She finishes her narration with a description of the inefficacy of the medication, using lay terms: ‘these didn’t help either’. Instead of a plain confirmation, the patient thus uses the slot available to volunteer new information. In the course of her turn the patient expands the focus suggested by the doctor: She shifts from treating the problem at hand as objectively available for examination (the location of the problem) to a subjective description of suffering (describing how the medication has not helped implies that she is still in pain). Despite the specified focus suggested by the doctor, the patient is able to redefine the area of her main complaint. Simultaneously she is able to prolong the phase of problem presentation and postpone the shift to verbal or physical examination which would have been possible or even likely had she simply confirmed the doctor’s suggestion on the nature and location of her problem.

¹² Often specifying the location of the problem and referring to it with indexicals immediately precedes either verbal or physical examination (see chapter 5).

3.2.3. Correcting the focus

The patients may also correct the focus suggested by the doctor as the reason for the visit. In the following example the doctor (line 5) shifts to medical business by using a yes/no question which suggests that the patient has come to hear test results.

Example 5. (1B1 Naprapath)

- 1 D: Joudutaan laittamaan teiät tänne konee-,
We'll have to write your information here on the comput-,
- 2 >>kaheskymmenesviides seitsemättä kolme^oyhdeks[än^o.
>>twenty-fifth of July thirty-^oni[n^o.
- 3 P: [Justiisa.
[Exactly.
- 4 (14.0) ((D types on computer))
- 5 D: → Ja teillä oli kokeita.
And you had tests
And you've had some tests made.
- 6 P: → Ei:, (.) vaanh minulla oli semmonen juttu. Olen ollut
no but I had such issue I have been
No:, (.) My problem is the following. I have been on
- 7 → sairaslomalla nyt varmaan (0.3) kohta neljä viikkoo.
sick-leave now maybe almost four weeks
sick-leave now maybe (0.3) almost four weeks.
- 8 → Mun on ollut selkäni niin huono. .hhhhh ja tota (.)
my has been back so bad and erm
My back has been so awful. .hhhhh and erm (.)
- 9 Mäki-Penttilä on nyt sitä sillä lailla hoitanu että
Last name has now it in-such-a-way treated that
Dr. Mäki-Penttilä has now treated it so that
- 10 nyt mä oon (.) mä oon käyny kaiken maailman
now I have I have been all world's
now I've (.) I've been to all sorts of
- 11 naprapaatit?, .hhh ja nyt mul on fysikaalinen hoito
naprapaths and now I have physical treatment
naprapaths?, .hh and now I'm presently in physio-
- 12 kesken. .hh[h
unfinished
therapy. .hh[h
- 13 D: [Joo:.=
[Ye:s.=
- 14 P: =Ja (.) mä viime viikolla ku mulla loppu niinku eilen
and I last week as I finished like yesterday
=And (.) I last week as I finished my sick leave yesterday

15 loma< mä aattelin jos mä kokeilisin töihin, .hh mutta (.)
vacation I thought if I would+try work+to but
I thought maybe I'll try to go to work, .hh but (.)

16 ku mä olin perjantaina siel hoidossa.= mulle sano
as I was Friday+on there therapy+in me said
when I was in the therapy on Friday.=this therapist

17 kyllä tää hoitaja että .hhh se voi kipeytyäh (.)
even this therapist that it may become+sore
did tell me that .hhh it may start aching (.)

18 erilailla. (.) Ja se on ollu niin viikonlopun kipee ni
in-a-different-way and it has been so weekend+for sore so
in a different way. (.) And it's been so sore for the weekend so

19 se sano että ei saisi sillen niinku sitä rasittaa
she said that not should then like it strain
she said that you shouldn't then like strain it

20 yhtään eikä .hhh että< mul ois ny huomana ja torstaina
at all nor that I have+would now tomorrow and Thursday
at all nor .hhh that< I'd still have therapy now tomorrow

21 viel hoi°toa°. Ni mää (aat) et mä en uskaltanu lähtee
still therapy so I thought that I not dared go
and on Thursday. So I (thought) that I didn't dare go

22 töihin ku mul oli niin kauheen kipee tää .hhh >lonkka
work+to as I had so terribly sore this hip
to work as this .hhh >hip was aching so terribly

23 ja semmonen< särky erilainen särky (niinku se mitä se
and kind of ache different ache like that what it
and a kind of< ache different ache (like from that it

24 °oli.°
was
(used to be.)

25 (0.4)

26 D: Joo:.
Ye:s.

27 (1.0)

28 D: Jo[o,
Ye[s,

29 P: [Ja tota (1.7) ihan sen tähden sitten tul- että
and just that for then came that
[And erm (1.7) just because of that I came then- that

30 kylä mulla lääkkeitä on ettei se siittä oo mutta,
even I medicine have not+that it that+of is but
I do have medication it's not that but,

31 (0.2)

32 D: (Tuutteko tuohon pitkällenne ni katotaan vähä sitä,
come+Q there lying down so look+pas a little it+at
(Would you come and lie down so we'll have a look at it,

33 (2.5)

The doctor's question in line 5 is uttered while both participants are already seated. Until the last syllable of the question '-ta' the doctor is gazing at the patient. The question is made in the form of a statement which asks for confirmation from the patient. The doctor's utterance construes the visit as a follow up visit made in order to hear test results. It lands straight into the medical business, ready to start reviewing the test results, not expecting from the patient anything more than a plain 'yes'. Grammatically, the question prefers a positive answer.

The patient's answer is 'No', indicating that the doctor's suggestion for the reason for the visit is incorrect. Despite the grammatical preference set by the question the negative answer is given in a straightforward way, without hesitation or a gap which would normally mark a dispreferred answer (see Schegloff 1988). The 'no' is followed by a narrative describing the actual reason for the visit, which is a request for more sick-leave.

Such a straightforward negation of the doctor's assumption is given also in the four other consultations where the doctor's suggestion for the reason for the visit is incorrect. Extract 6 provides another example:

Example 6. 36A2 Henkisellä puolella

- 1 P: .hh Joo tässä sitä taas istuta°[an°.
 PRT here it again sit+pas
 .hh Right here we are sitting a°[gain°.
- 2 D: [Non*ii*:.
 PRT
 [Righ:t.
- 3 (1.0) ((D is gazing at the documents))
- 4 D: Näihän s- me suunniteltii.
 This+of course we planned
 This is the way we planned it.
- 5 (0.4)
- 6 P: °Mm.°
- 7 D: Tota,
 Erm,
- 8 (2.0) ((D scans the papers and turns his gaze to P))

- 9 D: → sulta piti olla niitä verikokeita °eiks nii°.
 you+of should be those blood-tests not+Q so
 you were supposed to have had some tests made °weren't you°.
- 10 P: → Ei. [(E-)]
 No. [(N-)]
- 11 D: [Et] ↑sää oo vie käyny. Joo. Joo. .hhhhh
 not you have yet been PRT PRT
 [You] ↑haven't been there yet. Right. Okay. .hhhhh
- 12 Ne suunniteltiin vasta sitten myöhempään niinköh hhhh.
 They planned+pas only then later right+Q
 They were planned only for later is that right hhhh.
- 13 P: No ei siittäkään ol[lu puhetta °vielä°.
 PRT not that+even was talk yet
 Well we didn't yet tal[k about that °either°.
- 14 D: [Ei ollu viel puhetta.
 [We didn't talk about it yet.
- 15 P: °(Ei)°.
 °(No)°.
- 16 D: No: nii mää vaan (0.2) jotenki muistan semmosia nähneeni
 well PRT I just somehow remember that+kind seen
 Well: okay I just (0.2) somehow remember seeing them
- 17 mutta mää [muis↑tan] sitten °väärin°.
 But I remember then wrong
 but I [remember] wrong °then°.
- 18 P: [Nii.]
 [Yeah.]
- 19 P: Täähän oli niinko
 This+of course was sort of
 This was actually like
- 20 henkisellä puolel[la].
 mental side+on
 on the mental s[ide].
- 21 D: [Nii, Ju[st joo.
 PRT exactly PRT
 [Right, Ex[actly yeah.
- 22 P: [(En tiä)
 not know
 [(don't know)
- 23 onkse verestä sit(h)e se syy (heh).
 Is+it blood+of then that reason
 whether blood is the reas(h)on then (heh).
- 24 D: E[:i ne on voon muuten] vain noin niinkun,
 not they are just otherwise only so like
 N[o: they're just otherwise] kind of like,
- 25 P: [.hhh (se on vähän hassu)]
 it is a little funny
 [.hhh (it's a little funny)]

26 P: .hhh
27 D: .hhhhh
28 (0.3)

With his utterance in line 1 the patient defines the visit as one in a series. The doctor answers gazing at the papers: 'Right. (1.0) This is the way we planned it.' The doctor's actual opening question comes later, in line 9. He asks: 'You were supposed to have had some tests made weren't you. With the tag *eiks nii* 'weren't you' the doctor adds to his request for confirmation an element of reservation: with the tag he changes his utterance from a declarative request for confirmation to a question, i.e., he marks his suggestion as less positive. As in the previous example, the patient rejects the doctor's proposal for the reason for the visit with a straightforward 'no', in line 10. The doctor receives this with a display of understanding. In line 12 he makes another suggestion concerning the test, finishing his turn again with a tag question *niinkö* 'is that right'. The tag-question shifts the balance of 'who knows what' even more than the previous, negatively designed tag, from the doctor to the patient. The patient starts his answer in line 13 with 'well' which may indicate a slight hesitation. However, there are no other signs of him orienting to his answer as dispreferred, although he again rejects the doctor's suggestion. After this the doctor (lines 16-17) gives an explanation on his incorrect assumption on the reason for the visit, and admits having been wrong. Subsequently, the patient (line 19) volunteers his own definition of the problem at hand: 'This was actually like on the mental side'.

The patient's description of the reason for the visit is delayed. Partly this is due to the doctor's incorrect suggestions in lines 9 and 12 but the patient himself also seems to delay the presentation of his actual problem. In example #5, the patient rushed to give the proper reason for her visit immediately following the rejection of the doctor's suggestion, whereas in #6 the patient finishes his 'no' in line 10 with a falling intonation, indicating he will not necessarily continue his turn of talk. Further, in line 13 the patient merely answers the doctor's question, and in line 15 only confirms the doctor's understanding, without giving any indication of preparing for volunteering the reason for the visit. In lines 19-20, he finally delivers the reason describing it as residing 'like on the mental side'. It seems possible

that this delay has to do with the delicate nature of the problem as a mental one¹³.

In the data, when the doctor's closed-ended opening question incorporates a wrong assumption on the reason for the visit the patients seem not to orient to the grammatical preferences on positive vs. negative answers. They follow the structure of the question in their answers, but do not design a structurally dispreferred answer as dispreferred (Schegloff 1988). Despite the predefined institutional authority of the doctor the patients do not display any reservations when demonstrating the doctor's suggestion for the reason for the visit as incorrect. Instead, they proceed to describe the actual reason for the visit.

3.2.4. Discussion

We have seen that if there is reason to expand or correct the doctor's assumption on the reason for the visit, with regard to the nature of the visit or to the problem at hand, the patients do not hesitate to do so. Although closed-ended questions do limit the possible design of the patients' answers they do not prevent the patients from correcting false assumptions, nor from shifting the focus towards a more appropriate one for the patient's own purposes (cf. Boyd & Heritage frth).

These possibilities are readily available for the patients as regular structures in ordinary conversation, embedded in turn-taking organization and sequence organization. As in ordinary conversation, although there is a transition relevance place straight after the patient has confirmed the doctor's suggestion, the patients are able to rush through this TRP without complications, using continuing intonation, and constructions such as 'My problem is the following' which project further talk. The answer may be continued with an elaborate narrative which either expands or sets a completely new focus for the consultation.

Furthermore, although usually after a closed-ended question such as a request for confirmation, a plain confirmation is a sufficient answer, in specific contexts it may make relevant an expansion of the sequence¹⁴. A context in

¹³ This possibility was pointed to me by Anssi Peräkylä.

¹⁴ I am most grateful to Marja-Leena Sorjonen for directing my attention to this.

which a topic is proffered at the beginning of a sequence with a yes/no question projects such an expansion (Schegloff 1995, 171-185). Topic proffers are used to propose a topic but leave it to the recipient to forward the topic or to decline it. Typically the topics proffered are ones where the recipient is considered as the authoritative speaker. Many of the doctor's opening questions presented in this section resemble such turns of talk. They concern a matter to which the patient has the primary access. In ordinary conversation such 'B-event statements' (Labov and Fanshel 1977) or 'my-side tellings' (Pomerantz 1980) are often designed for expanding the topic, and when used as opening questions in a medical consultation, they are analyzably designed for patient expansion. For instance, in example #1 the doctor did not treat the patient's minimal answer to the opening question as sufficient in terms of proceeding with the medical business. Instead, she left space for the patient to continue and, when the patient did not do so, she made another proposal for a topic.

Consequently, this way of initiating the medical business does not appear as specifically enhancing the doctor's control over the choice of topics (cf. Roter and Hall 1992, 83). Rather than representing a practice specific for medical consultations and characteristic to diagnostic procedures, in this specific location the doctors' closed-ended questions are in fact used very much as in ordinary conversation. By proposing a topic with a topic-proffer and by abstaining from taking the turn immediately after a plain confirmation by the patient, the doctors treat the patients' minimal answers as expandable.

Another specific context where the expansion of an answer becomes relevant is when the answer is contrastive to the preferences inscribed in the question. For example, a question such as 'Are you from Germany?' would usually not be answered with a plain 'No.' but with 'No, I'm from Finland.' In a similar manner, in examples #5 and #6, incorrect suggestions by the doctors for the reason for the visit are rejected, and correct ones are presented to the doctor.

In the data, the patients were able to continue their problem presentation straight after they had delivered an answer to the yes/no question asked. In cases where they did not expand their complaint, it was shown that they also treated their minimal answers as sufficient. Furthermore it was shown that the closed-ended structure of the doctors' opening questions did not necessarily restrict the scope of the patients' answers. Rather, as B-event inquiries (as

declarative statements about a matter to which the recipient has primary access) at the beginning of the sequence, closed-ended questions worked for patient expansion. Thus, the claim according to which the closed-ended structure of the opening question would result in missing important aspects of the patients' reasons for the visit is not supported by the analysis.

3.3. Open-ended questions - answering the question or delivering the complaint?

As regards closed-ended yes/no questions, the grammatical preferences for a positive or a negative answer are readily observable within the question itself. The case is different with what are called open-ended wh-questions. In medical textbooks the term 'open-ended' refers to questions which start with a question-word, and do not propose any specific problem as the reason for the visit. For example, questions such as "What brings you here?" or "How can I help you?" have been given as examples of open-ended opening questions. Open-ended questions do not set the expectation for a negative or a positive answer, but leave more space for the patient's independent design of a response. Because of this feature wh-questions are regularly recommended as first-topic initiators/opening questions. (Keinänen-Kiukaanniemi and Mäkelä 1991; Birgegård 1993; Pelkonen 1994).

My intention in this section is to complement the prevalent understanding on the relation between open-ended opening questions and the answers following them. I will maintain that to assume an uncomplicated relation between the design of the opening question and the design of the following answer is oversimplified. This is significant, as over-estimating the influence of the structure of the doctor's opening question on the following talk easily leads to exaggerating the doctor's degree of control over the course of consultation. I will show how, for the participants, in addition to the structure of the question, also its location in the overall structural organization of the sequence is relevant in deciding what would constitute an appropriate next turn.

In the following analysis I will pay specific attention to the ways in which patients treat and interpret open-ended wh-questions in their problem presentations. I will proceed by examining the extent to which the problem presentations are designed as fitted to the preceding opening question. That

is, I will take into consideration possible ways in which even open-ended questions set limitations for the scope of possible answers (cf. Boyd & Heritage frth). I will analyze this 'fit' from both grammatical and pragmatic point of view. By grammatical fit I refer to the extent to which the patients' answers are structured according to the design of the opening question, e.g. the extent to which patients use similar grammatical forms, cases etc. Pragmatic fit refers to the extent to which the patients' problem presentations are designed as second-pair parts to the doctor's first-pair part. By studying the latter aspect I will examine how the patients treat the preceding action by the doctor in their complaints. As a result of this analysis I will suggest that patients orient to the doctor's opening question as offering a slot for the patients to give the reason for the visit rather than as making relevant a structurally fitted answer to the opening question.

A further point rendering problematic the recommendations to always use open-ended questions as the opening question is the connection observed between the design of the opening questions and the nature of the visit. It seems probable that open-ended questions such as the ones illustrated above are specifically recipient designed for acute visits (Heath 1981; Robinson frth). This implies that asking an open-ended question such as 'What brings you here' in a follow up visit may in fact be misplaced as the doctor has initiated the visit herself and thus is supposed to know why the patient has arrived to the consultation. In the Finnish data there were 44 open-ended opening questions¹⁵. Of these the most (26) occurred in acute visits, 4 in follow up visits, and 3 in routine visits. In 11 cases the nature of the visit remained ambiguous. Thus, in the Finnish data as well, closed-ended questions were typically used as opening questions in follow-up visits, whereas open-ended questions were usual in acute visits. However, as the main issue in this section is to study the patients' orientations and the ways in which they treat the doctor's opening question, the connection observed between the question-designs and the nature of the visit will be only briefly touched upon in the analysis.

In the following sections I will study the designs of the patients' answers in comparison with the doctors' preceding questions, starting with the most fitted and finishing with the least fitted answer. I will first describe some

¹⁵ In addition, there were two first-topic initiations of the form 'tell me'.

differences between lexically or phrasally and sententially formatted complaints with respect to their grammatical and pragmatic fit to the preceding question. I will point out how sentential designs make it possible for patients to volunteer information which has not been asked by the doctor's opening question (3.3.1.). Next, I will present a group of complaints which the patients mark as pragmatically fitted to a different first-pair part than the opening question. (3.3.2.). Thereafter I will proceed by showing how the patients may start their problem presentation after a turn by the doctor which is not clearly a first-topic initiation (3.3.3.), or without even waiting for the doctor's opening question (3.3.4.). I will conclude by considering the possibility that these observations in combination, i.e., a) the tendency to choose sentential designs less fitted to the opening question instead of better fitted lexical and phrasal designs, b) treating the opening question as a suggestion to start the medical business rather than a 'real' question, and c) starting the problem presentation before the actual opening question, indicate that patients orient to the slot following the opening phase of the consultation as the place for presenting their problem, displaying an orientation to the overall structural organization of the consultation at the expense of more local expectations concerning their relevant next action.

3.3.1. Fitting the design of the answer to the design of the doctor's question

Only a few of the patients' complaints following the opening question are designed as lexical or phrasal, i.e., the shortest possible ones. Among the 44 consultations starting with an open-ended question in only 5 the patient's complaint was designed as a 'minimal answer'¹⁶. In 39 consultations the patients delivered their complaint in sentential form. The following two examples illustrate lexical and phrasal answers.

¹⁶ A minimal but sufficient answer to a common open-ended wh-question, such as *Minkäs takia sinä olet liikkeellä* 'What for have you come to consultation' would consist of the name of the problem inflected in the case incorporated in the question 'minkäs takia' (what for) - 'tän jalan' (for my leg).

Example 7 (19A1 Leg problem)

- 10 (1.4)
- 11 D: → Minkäs takia sinä olet liikkeel[äh.
What+GEN for you are moving
What brings you he[re.
- 12 P: → [(Noh)
[(Well)
- 13 (0.4)
- 14 P: → Tän saman va[ivan
this+GEN same+GEN problem+GEN
This same pr[oblem
- 15 D: [>vaiivan< (t-)
problem+for
[>problem< (t-)
- 16 (0.3)
- 17 P: Ni[i,
Ye[ah,
- 18 D: [.nhhh
- 19 (0.5)
- 20 P: Tää on nyt kolme yötä särkeny ihan tosissaan.=Että
this has now three nights aching+been really seriously that
This has been aching three nights now really awfully.=That

The doctor's opening question in line 4 *Minkäs takia sinä olet liikkeellä* 'What brings you here' is a common type of question in the data. The word-by-word translation of the question would be 'what for are you on the move'. The patient's answer is minimal, she is only producing the words *tän saman vaivan* 'this same problem' in the same case (genitive) as the question was made¹⁷: *minkäs takia - tän saman vaivan*. The patient does not even repeat the postposition *takia* 'for'. When the answer follows the structure of the question as it does in example #7 I will call it 'grammatically fitted' to the question.

¹⁷ See the gloss in lines 11 and 14.

Example 8 (5A1 Verenpaineet)

- 1 D: → .mthhh Eli,h (.) minkästäpasta asiaa.hh
in other words what kind of issue+PAR
.mthhh So:, (.) what brings you here.hh
- 2 P: → Vererenpaineet.
blood pressure+PL
Blood pressure.
- 3 (.)
- 4 P: → On aika korkeella. .hh Ollu pitkän aikaa.
is quite high has been long time
Is quite high. .hh Has been for a long time.
- 5 (.)
- 6 P: .hhh Sit[te]
.hhh A[nd]
- 7 D: [Onks:] sulla korttia.
[is+Q] you card
[Do:] you have a card.
- 8 P: O:n.hh
is
Ye:s.hh

In the second example the doctor asks (line 1) *Eli (.) minkästäpasta asiaa*, which is as common a design for an opening question as *Minkäs takia sinä olet liikkeellä* presented in the previous example. The word-by-word translation of the question would be ‘So (.) what kind of issue’. This is a structure which would grammatically continue with *sulla on* ‘do you have’. In Finnish, this structure would ask for a whole sentence as an answer. However, the patient starts by only mentioning the name of the problem *verenpaineet* ‘blood pressure’. He finishes his utterance with a falling intonation and in line 3 there follows a gap during which the doctor could take the turn. However, as he does not, the patient produces a grammatical continuation of his utterance making it a whole sentence: *on aika korkeella* ‘is quite high’. The patient’s initial design of his complaint is lexical, consisting only of one compound noun ‘blood pressure’. At this point it is hearable as complete, ‘blood pressure’ is an illness category which may be understood as ‘an issue’ to visit a doctor for. However, grammatically the patient’s utterance is not yet fitted to the doctor’s question at this point (in line 2). It becomes grammatically fitted in line 4 when the patient completes it with the increment ‘is quite high’.

By answering with a sentential instead of a lexical or phrasal TCU the patients are able to introduce aspects of their problem or problematic situation which could otherwise be ignored¹⁸. In this way, they also gain more control over the topic. We have seen that it is possible for the patients to give only a brief answer to the doctor's opening question and pass the turn (and the control over the course of consultation) back to the doctor. Yet, such answers seem to be very rare. Furthermore, only in one case out of five were such brief answers considered by the doctor as sufficient answers to the opening question. This suggests that there may be an orientation on the part of both the patient and the doctor to the slot following the opening question as a place for a more elaborated problem presentation. The tendency to use sentential answers to wh-questions could also indicate that the patients treat the slot as 'institutionally reserved' for delivering whatever information they consider relevant. Next, we will consider cases in which this orientation is more explicit.

3.3.2. Designing answers as responses to a suggestion to start the medical business

Turn beginnings are an important resource for the recipient for projecting the structure or the type of the turn to be produced. For the speaker, turn beginning is the place to display the connection the turn of talk initiated has with earlier utterances (Schegloff 1987b). Of the 44 complaints following an open-ended wh-question, two started with the connector *ku* 'because', 18 started with the particle *no* 'well', and four started with the response words *niin* or *joo* 'yes'.

According to Raevaara (1989), in ordinary conversation the *no* preface marks a shift in topic or activity. In story-telling, for example, it displays a marked shift back to the main line of talk, or a shift in which the anticipated main line of talk is started. It seems possible that prefacing problem presentations after the doctor's opening question with *no* could mark the slot as an anticipated shift in activity. This would support the idea that patients orient to the opening question rather as offering a slot for presenting their problem than as making relevant an answer fitted to the question. However, I will leave the detailed analysis of *no*-prefaced answers for future research.

¹⁸ Of course, introducing these aspects does not guarantee that the doctor will take them up in his response to the patient's problem presentation.

In the following, I will concentrate on analyzing complaints which start with response words. Starting a turn after an open-ended wh-question with a response word *niin* or *joo*, which both come close to the English response word yes, suggests both grammatical and pragmatic non-fit to the preceding question. A wh-question makes relevant some kind of description, not a positive or a negative answer. What is it then that the patients do by beginning in such a way?

In the following example, the patient is a 13-year-old girl accompanied by her mother. After the doctor's opening question in line 7, the patient begins her answer with the particle *niin* in line 8:

Example 10 (2A6 A boil in the neck)

```

1  D:                [Kantola  Anni]ina,=
                    Lname    Fname
                    [Kantola  Anni]ina,=

2  M:                =Sää saat kertoo murhees      si[ttte.
                    You may tell sorrows+your then
                    =You may tell your problems th[en.

3  D:                [Toinen kymmenettä
                    [the second of October

4                    kaheksankymmentä.
                    Nineteen-eighty.

5                    (0.2)

6  ?:                Joo:,=
                    PRT
                    Ye:s,=

7  D: →             =Ja minkäslaista vaivaa.
                    And what kind problem
                    =And what brings you here.

8  P: →             Nin tää< mul on< neljät- >tai ninku< nel:jä päivää nytte
                    PRT this I have fourt or like four days now
                    Yeah this< I've been< fourth- >or like< four days now

9                    ollu kuumetta ja mul on särkeny kauheesti pää:tä si'n ny
                    had fever and I have aching terribly head there now
                    running a temperature and my head has been aching terribly there now

10                   koko, °n'nku sama'n aikaan°.
                    Whole like same time+at
                    the whole, °like at the same time°.

11                   (0.5)

12 P:                Sitte mul on, tänne tullu >semmonen< pat:°ti°.
                    Then I have here become kind of boil
                    Then I have, in here >a kind of< boi:l.

13 D:                @Nin on:ki@. ((sounding worried))
                    @So you ha:ve@.

```

The doctor's question in line 7 starts with the 'and'-preface, which according to Heritage and Sorjonen often marks the question as agenda-based, i.e., that the question is next in a previously set order (Heritage & Sorjonen 1994). The question is designed to elicit the description of an ailment. It does not claim any previous information about the reason for the visit, and in this way treats the visit as acute. It also presupposes that there is an ailment which the patient can tell about. The question phrase is in the form of partitive singular, and by virtue of that it asks the patient to tell about just one problem.

The answer is given in the form of a report. The patient gives a list of three symptoms: temperature, headache and a boil in the neck. However, she starts her answer with the particle *niin*, adding a pronoun *tää* 'this' which refers to her problem. The particle *niin* is in a turn initial position, which in my intuition implies that it is used as a marker for a movement to the actual business. What follows after *niin* is designed to fit the design of the opening question: *minkäslaista vaivaa - ollu kuumetta* 'what brings you here' - 'I've been running a temperature'. With her turn-initial *niin*, instead of starting to answer the question asked, the patient seems to treat the previous turn as offering a space to start the actual business: starting with *niin* emphasizes the qualities in the preceding turn which allocate the next turn to the patient, (leaving temporarily aside the features which ask for a description of the reason for the visit). When *niin*, as here, is not serving as a continuer it claims some knowledge of what the coparticipant is talking about (Sorjonen 1997, 500). It is possible that by starting with *niin* the patient is marking the suggestion of the doctor to start the first topic as an expected one: both participants have known in advance that this will become the issue to talk about.

Uttering the *niin* before answering the question shows an orientation to the activity of giving the reason for the visit as pertinent, as something which has been impending since the beginning of the consultation: it may indicate an orientation to problem presentation as a predetermined, institutionalized phase of a medical consultation.

In addition, it is observable in line 2 how also the mother treats the beginning of the consultation as 'designed' for giving the reason for the visit. She allocates to the daughter the task of presenting her problem by saying: "You may tell

your problems then.” even though the doctor has not yet marked the slot with her opening question.

In example #11, the patient starts answering with a different particle, *joo*.

Example 11 (39B3 ‘This kind of’ problem)

- 1 D: Ole hyvä ja istu,
please and sit down
Sit down please,
- 2 (6,0) ((D and P sit down. D then lifts a file from the desk to the window sill))
- 4 D: → [↑]Minkämoista< (0,8) ts vaivaa sul^ola on^o.
What kinds problem you have
[↑]What< (0.8) ts brings yo^ou here^o.
- 5 (.)
- 6 P: → Joo tää on oikeestaan tää'n et tää o ollu (0,2)
PRT this is actually this+kind that this has been
Yes this is actually the kind that I've had (0.2)
- 7 ollu mulla jo: aikaa sitten ^o>tää että<^o (0,4)
been mine already time ago this that
had this already: some time ago ^o>this that<^o (0.4)
- 8 tillannu niinku jälki (.) jälk-
ordered like after after
requested like the control (.) contr-
- 9 jälkitar'st's^ovastaukset (ja mutta)^o ana- analyysi
after+examination+answers and but analysis
the results from the control visit (and but)^o the ana- analysis
- 10 jostain (1,5) oliko virtsanäyte(^oki^o) (.)
some+of was+Q urine+sample also
of some (1.5) was it urine sample as well (.)
- 11 virtsanäyte ja sit joku tällöinen ^opiti
urine+sample and then some this+kind should
urine sample and then something like this ^owas
- 12 olla täällä^o,
be here
supposed to be here^o,
- 13 (1,5)
- 14 D: J:::o[o.
PRT
Righ:[t.

As the particle *nii*, the particle *joo* at the turn-initial position after the opening question also by-passes the grammatical design of the question. It also seems

that, just as *nii, joo* treats the previous turn as providing a space for giving the reason for the visit rather than as making specifically relevant an answer to the question asked. The *joo* serves as a kind of pro forma agreement to the shift of activity from the opening to the problem presentation. In other words, it treats the opening question as a suggestion to start the medical business, and agrees with this suggestion.

A similar beginning is found in example 12:

Example 12 (1A5 Application for retirement)

1 P: ((groans:)) *y*hmm
2 (.)
3 D: No *nii*. *Is*:tumaa vaa.
Well so *sit* down just
Right. Do *si*:t down.
4 (2.0)
5 D: °Ja se oli Kotipohja ↑*Annikki*,
and it was Lname Fname
°And it was Kotipohja ↑*Annikki*,
6 (0.2)
7 D: kahdestoista maaliskuuta, kolmekymmentäseitsemän.
Twelfth March thirty-seven
the twelfth of March, nineteen-thirty-seven.
8 P: *Joo*:.
Ye:s.
9 D: → Ja minkäslainen ti[lanne.]
and what kind situation
And what's the si[tuation like.]
10 P: → [Joo mä kävin s]iel (.)
PRT I went there
[Yes I had t]hat (.)
11 ultraäänitutkimuksessa ja (0.4) pitä^s olla ne (.)
ultra-sound+examination and should be those
ultrasoundexamination made and (0.4) there should be those (.)
12 tulokset.
results.
13 (1.1)
14 D: *Joo*, katotaan↑*pa*,
PRT let's see
Right, let's ↑*see*,

In line 9 the doctor asks: *Ja minkäslainen tilanne* ‘And what is the situation like’, and the patient answers: *Joo mä kävin siel ultraäänitutkimuksessa ja pitä^s olla ne tulokset* ‘Yes I had that ultrasound examination made and there

should be those results'. As in the previous example, by starting with 'yes' the patient treats the doctor's opening question as a suggestion to start the medical business, and 'pro forma' agrees with this suggestion.

The fourth case is slightly different, as the question on the patient's current concern and the answer to it occur only after an extensive doctor-initiated discussion on the patient's medical history. However, the example illustrates the possibility that *joo* at the beginning of problem presentation serves as an agreement to a suggestion to get down to actual business (i.e., giving the reason for the visit).

In the example, the patient is finishing her account of her late father's care during his last year (explaining why she only cared for him at home two thirds of the time) when the doctor brings the discussion back to the present:

Example 13 (42A1 A cough)

- 1 D: .hh] hhh
 2 (.)
 3 D: Mutta (tuota noi) mennäämpäs nyt näihin: °hh° a:jan fuusimpiin
 but well erm let+go+us now these time+gen newest
 But (well erm) let's talk about these °hh° fmost current
 4 asioihin_f ni,=
 matters so
 matters_f of the time now so,=
 5 P: =Mm,
 6 D: mikä oli sitten tää varsinainen asia °nyt° minkä #ta#kia
 what was then this actual matter now what for
 what was then the actual reason °now° for
 7 tulitte vastaanotol[le,]
 came+you consultation+to
 making the appoint[ment,]
 8 P: [Nyt<] tää_{nä}[äh.°]
 now today
 [now<] to_{da}[yh.°]
 9 D: [Ni]i:h,
 [Ye] :s,
 10 P: → Joo:. Tämä:. [Köhä:.
Ye:s. Thi:s. [Cou:gh.
 ((P lifts a hand on her chest))
 11 (0.2)
 12 P: .hh[hhh] Hköhh ((P coughs)) M[ulle] kävi la[uantaina,
 me happened Saturday+on
 .hh[hhh] Hköhh ((P coughs)) I [was] on Sa[turday,

the visit, i.e., they do not just draw upon the local environment (the structure of the immediately preceding question) but show that they too have knowledge of the agenda of the medical consultation. This becomes explicit in the next example which describes how patients may treat as opening questions turns of talk by the doctor which are not clearly designed as such.

3.3.3. Treating doctors' ambiguous turns as opening questions

In example 14 the doctor initiates the medical business with a pre-announcement 'Oh you're the easiest patient in the world':

Example 14 (33B1 Tonsillitis)

```

1  D:  Olli Koivula.
      Fname Lname

2      (1.7) ((D returns from the door to his desk))

3  D:  Hhkrrrh.

4      (5.9) ((P enters the room; they shake hands))

5  D:  Terve.
      Hello.

6      (.)

7  D:  I[stu  ] alas ole >hyvä,<
      sit      down  please
      S[it    ] down please,

8  P:  [°( )°]

9      (3.7) ((D and P sit down))

10 D: → <Ai> sä oot >maailman< helpoin poti°las.°
      oh you are world's  easiest patient
      <Oh> you're the easiest patient in the wor°ld.°

11 P: → m- Joo. niä:lemisvehkeet      [ ( ) ]
      PRT  swallowing+equipment
      m- Yeah. The swallowing things [ ( ) ]

12 D:                                     [_odotas hetki ] _odotas hetki
      wait minute wait minute
      [Wait a minute] wait a minute

13      mulla fjä(h)i t(h)oi.f .h
      I forgot fto g(h)ive t(h)hat.f .h

14      (0.6) ((D rises and leaves holding a paper))

```

The doctor's initiation in line 10 would make relevant a topicalizer or a go-ahead, a turn marking this announcement as news, e.g. *Ai, miten niin* (Really,

how so.), thus giving the doctor the multi-unit turn he had asked for with his pre-announcement (see e.g. Sacks 1974). The doctor's question is exceptional as a way to initiate medical business, it does not ask anything from the patient but offers to deliver news, and also contains a humourous tone. However, what is of interest here is the way the patient answers. He starts with 'm-', cuts off and registers the doctor's utterance with *joo* 'yes'. It has a falling intonation and thus it can not be understood as a continuer. With his *joo* the patient just neutrally acknowledges the doctor's turn. As a second-pair part to a pre-announcement, *joo*. is not fitted.

Furthermore, the patient does not stop to listen to what the doctor would have to say, but instead goes on introducing his problem: *niälemisvehkeet* 'swallowing equipment'¹⁹. The way in which the patient treats the doctor's initiation of medical business seems fitted to the overall structure of the medical encounter: he starts delivering his initial complaint after the doctor's turn which is situated just after greetings and sitting down. However, the patient's design is not fitted to the immediately preceding sequential context. Instead of performing the relevant next action of delivering a topicalizer or a go-ahead to the doctor's pre-announcement, the patient does a pro-forma registration of the previous action, and continues by starting to describe the reason for the visit.

Some patients do not even wait for the doctor to ask the opening question, but treat the slot which immediately follows the opening section of the encounter as an appropriate place to start presenting their problem.

3.3.4. Starting without the doctor's opening question

The following is an example of a unilateral start of the medical business by the patient. A common way to make a unilateral start in the data was to begin with the particle *joo*.

Example 15 (42B2 Leg problem)

1 D: [No niin,
[Right,
2 (0,8) ((D and P shake hands))

¹⁹ *niälemisvehkeet* is an extremely vernacular reference to the throat or organs inside the throat. This caused difficulty in translation.

25 (0,4)

26 D: Joo↑o,
Ye↑i:s,

27 (2,4)

28 P: .nff

29 (1,4)

30 D: Elikä tuota noin jalkavaiva.
So erm you have a leg problem.

31 (.)

32 P: Nii.
Yes.

After the participants have sat down the doctor is gazing at the papers on her desk. In line 8 she utters *£Nii:£* ‘£Yea:h.£’ in a smiley voice. The doctor’s turn receives the patient’s comment on the videocamera in line 5: ‘And here’s the video-machine as well’ - ‘Yea:h’. Pronouncing it in a smiley voice after the short laughing period in lines 6 and 7 indicates that it is constructed as a part of that same laughing sequence (Haakana 1999). Further, there is no gaze from the doctor to the patient as usually when asking the opening question (see chapter 7 on gaze), so it is difficult to hear this ‘£Yeah£’ as an initiation of the medical business. Still, in her following turn, starting at line 9, the patient delivers her initial complaint.

By starting her problem presentation at this point the patient orients to the slot following the doctor’s turn in line 8 as a possible place for giving the reason for the visit. However, as often happens with unilateral starts, later on some problems in interaction emerge as the doctor initiates repair in line 14, and even later, in line 30, offers a new slot for confirming the reason for the visit by asking ‘So you have a leg problem’. Instead of moving on to verbal examination the doctor proceeds to re-check her understanding on the reason for the visit. This indicates that the doctor treats the patient’s action as deviant, as breaking the agenda. However, such unilateral starts show from their part how patients may orient to the pre-existing agenda of the medical consultation over the immediate local sequential context of the conversation: some patients regard the slot following the identification and the greetings as appropriate for starting to describe their current concern.

What is also of interest here is the turn-initial *joo*. In the data of 96 consultations there were 13 cases where the patient initiated the medical business without waiting for the doctor's opening question. In more than half (7) of these the patient started the complaint with the response word *joo*. The remaining six problem presentations were sentence-formatted and there were no turn-initial particles (such as *no* 'well'). Possibly here, too, the turn-initial *joo* could serve as of 'pro forma' agreement to an anticipated (though in these cases not yet delivered) suggestion to start the medical business. It could be a way of displaying to the doctor the understanding that the suggestion for starting the medical business has already been delivered. In any case, it seems clear that starting without waiting for the doctor's opening question, and specifically designing this unilateral start (with turn-initial *joo*) as if it were an agreement to a suggestion to present one's current concern indicates that patients are aware of there existing a slot in the agenda of the medical consultation for giving the reason for the visit, and that this slot is situated somewhere close to the opening of the encounter.

3.3.5. Discussion

In the database, following the doctor's open-ended question, the patients thus often choose the design of their complaint with respect to the location of their turn of talk in the overall structure of the consultation, instead of trying to fit their complaints to the immediately preceding sequential context, i.e., the design of the opening question. There is an interesting parallel to this in 911 emergency calls²⁰. In Zimmerman et al.'s studies, in one emergency center, the first turn by the call-takers is routinely designed to move directly to an account of the caller's emergency. In answering the call the call-takers first identify and then ask immediately: "Nine one one what is your emergency?". Although this turn of talk projects an answer as the next action, it does not guarantee that the callers will choose an answer as their next turn. Instead the callers may preface or otherwise postpone their answer with exclamations or acknowledgments, for example. Of the examples presented by Zimmerman the following comes close to the *joo*-prefaced answers in the Finnish data. (1992, 443 {LC:EMS:5}):

²⁰ I am grateful to John Heritage and Marja-Leena Sorjonen for directing my attention to this parallel.

[CT: What is your emergency?]
C: =Uh yeah we have a little boy who can't breathe at sixty
nine hundred Marvin Lane

Thus, at this specific sequential place, as in answering the doctor's opening question in primary health care, in emergency calls, whatever the constraints inscribed in the call-taking format used, the callers have procedures available for by-passing them at least temporarily.

In sum, the patients' orientation to the slot offered for them by the doctor's opening question as a possible place for giving the reason for the visit is visible in the way the patients a) tend to answer with whole sentences instead of giving minimal answers, b) may treat the opening question as a turn of talk opening a slot for problem presentation in addition to making relevant an answer, and c) may start their problem presentation even before the doctor has asked the opening question.

3.4. Conclusion

Above, we have seen that in choosing and designing their relevant next action after the doctors' opening questions, patients also draw upon other resources than those offered by the immediately preceding turn of talk. The patients make use of the specific status of the sequential slot in the overall structural organization of the medical consultation, and extend their problem presentations from the restricted focus suggested by the doctor's opening question, overriding the grammatical preferences incorporated in the question. In the same way, they may correct the focus suggested by the question. Furthermore, in numerous cases the patients seem to treat the doctor's opening question as 'not a question' but rather as a suggestion to start the medical business, or as a request to tell about their problem.

The results do not give support to the prevailing ideas that, merely by the design of their opening question, doctors limit the range of options available to patients for their problem presentations. On the contrary, closed-ended opening questions do not stop the patients from giving the information they regard as relevant, rather they are analyzably designed for patient expansion. In medical practice, the directive to prefer open-ended opening questions is widely used as a rule of thumb for clinicians. However, the ample variation the patients have available when designing their answers to the doctors'

opening questions indicates that issues other than grammar, the structure of an utterance, may become more important with regard to choosing and designing the complaint (Schegloff 1984).

Thus, the categories open-ended vs. closed-ended, or yes/no vs. wh-questions do not seem to serve as useful categories for analyzing the doctors' opening questions (cf. Robinson *frth*). Rather, the questions should be studied with regard to their function in the ongoing (phase-specific) activity (also Boyd & Heritage *frth*). At this point of the consultation the opening question serves to invoke an institutionalized slot for the patient for presenting the problem. Robinson (1999, *frth*) has recently shown how it also works to invoke a social relationship with the patient²¹. In the phase of history taking the tasks are different and the doctors questions are treated with regard to these tasks. Thus, the categories open-ended vs. closed or yes/no- vs. wh-questions may well be relevant also. (Boyd & Heritage *frth*).

When considering issues of control with regard to the opening question and the way in which it limits the alternatives for answering it, we could conclude that initiating the shift to medical business is oriented to as the doctor's privilege. However, the doctors' power to control the patients' problem presentations with the opening question beyond this initiation seems limited. Even when the doctors' questions specifically focus on one ailment the patients have a myriad of ways to pass the doctors' suggestions and redefine the focus, thus keeping to their own agenda. Practices inherent in ordinary conversation together with the patients' knowledge on the overall structural organization of the consultation serve as resources for maintaining their own definition of the ongoing activity.

The way in which patients often choose the design of their complaint with respect to the location of their turn of talk in the overall structure of the consultation (rather than fitting it to the design of the immediately preceding turn of talk) makes relevant some further considerations concerning the overall structure of the medical consultation. It evokes the relevance of the

²¹ Heritage has suggested that the categorization into open-ended vs. closed questions in studies on doctor-patient interaction is illegitimately imported from survey interviews. In survey interviews the relationship between the participants is based on anonymity, and is thus quite different from the relationship between the doctor and the patient. (Boyd & Heritage *frth*; Heritage *frth*, b).

larger activity context (serving as the source of coherence for the whole consultation) for the participants' selection of action, and provides a possibility to reconsider the character of the problem presentation as a second position act.

Conversation analytic studies on citizens' calls to the police have shown that a service call is organized as the caller's request for service and the dispatcher's granting or denying this service (Zimmerman 1984; 1992; Whalen et al. 1988; Whalen and Zimmerman 1990). Zimmerman (1992, 419) describes the overall structural organization of a call to the emergency service in the U.S. as follows:

- Pre-beginning
- Opening/identification/acknowledgment
- Request
- Interrogative series
- Response
- Closing

The whole situation is structured around the request for help by the caller, and the response to it (a promise to send help or a refusal) by the dispatcher.

According to Bergmann (1993) this kind of organization is on a rather high level of abstraction and may not be descriptive of the organization of emergency calls exclusively. It may well be fit for a larger set of service encounters, including the medical consultation. We may think of a medical encounter as a sequence consisting of one single activity, the patient's request for service and the doctor's providing the service asked²². The description of the reason for the visit by the patient is analyzable as a request to the doctor for help with the patient's problem. The diagnosis and the advice and prescriptions for treatment may be perceived as the doctor's response to the patient's request. Although the discussion proceeds through several topics (e.g. the medical history of the patient, his present physical condition, treatment and future action), the adjacency pair: request - granting may be

²²Heritage has also referred to the problem presentations at the beginning of the medical encounter as a 'request for service' (1998, personal communication).

seen as serving as the basis for coherence in the whole sequence (see Schegloff 1990; 1995, 109)²³.

Medical consultations begin with an opening sequence during which the participants take the positions from which the medical business is launched (Heath 1991; Robinson 1998). Whereas in emergency calls the request follows straight after the dispatcher has identified the receiving institution and the caller has acknowledged this identification, in medical consultations the actual medical business is usually begun with the doctor's opening question or some other first-topic initiation. This changes the sequential organization, as the first turn of the medically relevant talk is taken by the doctor, and in a way which makes relevant a second-pair part by the patient. Consequently, in medical consultations, the request is usually made as an answer to doctor's question, as a second-pair part. In this chapter we have seen how, despite the 'apparent second-pair part' position granted to the patients by the doctor's opening question, the patients often design their problem presentations as independent descriptions and not as answers to the doctor's opening question (cf. Zimmerman 1992, 445).

The overall structure of the consultation, then, may be perceived as built upon the structure of a service encounter (cf. Whalen and Zimmerman 1990; Zimmerman 1992, see also Bergmann 1993), in which the task which reaches through the whole consultation is responding to the patient's request for service: in the overall structure of the consultation the slot where the patient presents his problem constitutes the slot where the request for service is made. In this chapter we have seen instances where the patients orient to such a 'predefined' slot in choosing and designing their relevant next action after the doctor's opening question.

At this point of the consultation then, the patients have temporarily gained the control over the course of the conversation, they have taken the floor to themselves. Our next task will be to study whether, for how long, and in which way they are able to keep it. This will be the topic of the next chapter

²³ On an extensive discussion of topical vs. sequential bases for conversational coherence see Schegloff (1990).

4. PATIENTS' PROBLEM PRESENTATIONS: GETTING THE FLOOR AND KEEPING IT, ESTABLISHING THE VIEWPOINT

Much of previous social scientific literature on doctor-patient interaction has approached the subject by emphasizing the fundamental difference between the standpoints of doctor and patient (Beckman and Frankel 1984; Mishler 1984; Roter and Hall 1992). A common view has been that the more space patients have for presenting their problems from their own standpoint using their own terms to describe their illness experience the better for the patients. Doctors have been seen as constraining this liberty of the patients by imposing biomedical definitions on the patients' descriptions of their reason for the visit much too early in consultation (Korsch and Negrete 1972; Beckman and Frankel 1984). In this way, they have been seen as both limiting the space patients have available for describing their problems (Beckman & Frankel 1984; Mishler 1984), and ignoring the patients' own definitions of the problem which arise from their own life-world situations (Mishler 1984; Clark & Mishler 1992). However, as we have observed in the previous chapter, after the doctors' opening questions the patients do manage to gain at least temporary control over the course of the consultation. In the following, I will focus on analyzing the ways in which they manage to keep this control and what they seem to achieve by keeping it. I will show how some patients leave it to the doctor to decide whether they should extend their problem presentation beyond a short gloss of their problem, whereas some reserve themselves an extended turn by designing their problem presentations as narratives with a beginning and a projectable ending. I will also show how, especially when giving narrativized descriptions of their problems, patients address the moral aspect attached to the situation of presenting a problem in medical consultation, i.e., they work to show that their problem is real trouble on the other hand and not transgression on the other. It seems that for the patients, presenting the problem in a medical consultation does not simply mean describing your troubles. Instead, they often consider it necessary to explain how they made the decision to visit the doctor. And when they do, they have a means of keeping control over the consultation to themselves.

In his famous book 'Discourse of medicine' Eliot Mishler (1984) introduces a structure of turn taking which he claims to run through the whole medical consultation. In this three-part structure which he calls 'the basic structural unit of discourse in medical consultation' the doctor asks a question - the

patient answers the question - and the doctor assesses the answer or asks the next question. According to Mishler, this structure maintains the doctor's control over both the turn-taking process and the content of talk (1984, 69). The doctor is able to control the course of the consultation as the one who initiates the first topic, and thus always gets the initial turn. As the doctor's initial turn is a question, it makes relevant an answer to it, thus leaving the patient in a position where he only has a responsive turn available to him. Mishler states that this structure confirms the institutionalized positions of the participants: he treats the structure as a vehicle of the doctor's dominance and control over the course of the consultation. In addition, in his view, by getting the initial turn the doctors are able to introduce the topics to be talked about¹, and in their third turn, they are able to attend to those parts in the patients' problem presentations which they themselves consider relevant.

Various other researchers have referred to the doctor as almost exclusively controlling the flow of talk in medical encounters. Beckman & Frankel (1984) claim that physicians regulate the patients' space for presenting their problems by interrupting the patients prematurely, and by using closed-ended questions to control the topical flow of the discussion. Waitzkin (1991, 28) maintains that doctors interrupt the patients in order to reduce storytelling and focus the description of the present illness on diagnostically relevant issues.

In these studies the main focus has been on the activities of the doctor². Here I will take a different stance and approach the interaction in medical consultation as co-constructed by both participants (cf. Davis 1988). I will pay attention to the patients' own actions and orientations in reserving space for their problem presentations and in designing their initial complaints. I will suggest that in presenting their problem patients do not necessarily volunteer to give lengthy explanations of their illness. Nor do they attempt in every case to display their personal definition of their illness. Instead, they sometimes limit their problem presentations to the minimum and use the characterizations offered in the doctor's opening question, even when they are provided ample space by the doctor to tell about their ailment. On the other hand, there are consultations where patients engage in specific procedures in order to reserve themselves a multi-unit turn to postpone the doctor's uptake,

¹ See the discussion on open-ended vs. closed-ended questions in the previous chapter.

² Patients' activities have been previously analyzed in the context of patients' diagnostic statements (Gill 1998; Raevaara *frth*), and patients' responses to diagnosis (Peräkylä 1998a).

using terms and standpoints of their own choice to describe their illness experience.

When giving lengthy problem presentations, patients seem to show an orientation to some quite specific considerations: either implicitly or explicitly they refer to their process of deciding when to seek for medical help, and point out that in making the decision they have monitored their state of health in an 'unmotivated' but 'responsible' way (Halkowski frth; Heritage frth). Or they take pains to display that they have fallen ill irrespective of their own actions (cf, Davis 1988; Heritage frth). Or when complaining about uncured illnesses they work to show that they have followed the doctor's previous orders and striven to get better. Simultaneously with these features which address their role as a patient they may engage in constructing their particular case as severe, or at least severe enough to consult a doctor. Thus, these longer designs of the patients' complaints seem to have a moral flavor to them. They are connected with prevailing moral expectations concerning admittance to the sick role (Parsons 1951, 433-439; Heritage frth). In the following, the patients' problem presentations will be analyzed in terms of the patients' need to establish their reason for the visit as doctorable, and to establish themselves as in need for help from the medical expert (cf. Heath 1992; Heritage frth; Halkowski frth).

In Chapter #3 I analyzed the ways in which the doctors' opening questions limit the patients' next turns of talk and concluded that despite the doctors' question design the overall structural organization of medical encounters provides patients with a license to speak: patients are able to pass the local constraints set by the preceding turn by the doctor and use the space opened by it as a slot for describing their reason for the visit 'in-their-own-words'. Here I will continue by further investigating how the patients use this license. Keeping in mind the claims (in earlier research) of the almost absolute control by doctors over the course of consultation I will study how (and whether) the patients are able to present their problem to the doctor without interruption. In addition I will examine the issues which the patients consider relevant to include in their problem presentations once they are granted the space to describe their problem (cf. Schegloff 1992a), and what they seem to achieve by doing that.

4.1. Variation in complaint design

The initial observation made in analyzing the data of 96 problem presentations was that there is great variation in the design of the complaints: patients could answer the doctor's opening question with a plain one-word-answer, but they could equally well engage in a long story on the development of their ailment. They could follow the design of the doctor's opening question using words and grammatical structures fitted to the question, or they could construct a totally new framework of interpretation and themselves define the viewpoint from which they would make their complaint.

In earlier conversation analytic research the variation in the descriptions of trouble and the implications of these variations on the social organization of an institutional situation have been studied mostly in the context of citizens' calls to the police or emergency services³ (Zimmerman 1984; 1992; Whalen and Zimmerman 1987; 1990; 1998; Whalen et al. 1988; Meehan 1989; Bergmann 1998). Whalen and Zimmerman (1987, 178) list three different turn shapes in reporting the problem to the call-taker: descriptions, such as "I'd like to report a domestic argument", direct or indirect requests, such as "Could you send the police to [address]", and ambient events where the caller hangs up after hearing the identification of the dispatcher. The different ways of describing the reason for the call launch an activity by the dispatcher which ends up in either granting or rejecting the caller's request: they are all treated as requests for assistance by the dispatcher.

Similarly, in medical consultations varied turn shapes were used in describing the trouble, i.e., the reason for the visit. In the following I will analyze the designs of the patients' problem presentations by describing the scope of their variation, and studying what kind of issues on which levels of context could account for this variation. I will show how, with one particular turn shape, i.e., the narrative design, the patients can control the moment of onset of the verbal examination (4.2.). After this I will examine what kind of issues the patients seem to orient to in their problem presentations: I will analyze the

³ Descriptions in institutional contexts have been analyzed by, e.g., Pomerantz (1987, legal settings). In addition, Vehviläinen (1999) has studied troubles-telling in a loosely organized institutional situation of career counseling. Heritage has examined the packaging of reason for the visit statements in private medical practice in the Southern California area (Heritage frth).

differences in the patients' orientations when using different turn shapes for their problem presentation (4.3.). To conclude I will discuss the moral issues which patients construct as relevant and important in choosing a narrative design for their problem presentation (4.4.).

4.2. Controlling the space available for presenting the problem

In order to present the scope of variation in the size of space occupied by problem presentations I will compare both very short and very long complaints, especially with regard to the way the turn is passed back to the doctor with each type of turn-shape. For clarity I have chosen as examples mainly complaints which follow a similar opening question. The scope of variation presented below is, however, also observable in problem presentations which follow question designs of another kind (such as 'How are you' questions or 'Tell me' topic initiators). I have excluded complaints which follow focused questions designed for follow up visits (see chapter 3) as in those the choice of the design of the problem presentation seems to be closely linked to the correctness/incorrectness of the focus suggested by the doctor⁴. With the exclusion of these consultations, the data consists of 59 sequences of problem presentations.

In the five examples below the doctor initiates the medical business with a question which explicitly treats the patient's problem as new, as unfamiliar to the doctor. The first three extracts (#1, #2 and #3) exemplify minimal answers, whereas the last two (#4 and #5) illustrate a 'narrative design' by which the patients acquire an extended space to describe their problem.

4.2.1. Temporally fitted minimal answers

In answering the doctor's opening question the patients may present their problem as a gloss which is grammatically fitted to the question, preserves the temporal frame incorporated in the question and gives a very general description of the problem, after which the turn is passed back to the doctor (cf. Jefferson 1985).

⁴ After focused first-topic-initiations by the doctor, such as 'And you've had some tests made', or 'You have come to show your arm', the patients seem to give minimal answers to a correct focus, and extended answers when the focus is wrong or they have additional problems to the one suggested by the doctor. (See chapter 3).

Example 1. (30A1 Exzema)

- 9 (1.7)
- 10 D: ↑minkälaisista asioista oot >liikkeelläh<?,
what+kind+FOR issues+FOR are+you moving
↑what brings you >here<,
- 11 (0.7) ((P is taking her coat off, still standing))
- 12 P: → nyth (.) olen (.) liikkeellä ihottumastah[hh].
Now I am moving rash+FOR
now (.) I've come because of rash[hh].
- 13 D: [↓jaha,
[↓I see,
- 14 (0.5)
- 15 P: °oikeen° .hhh oikeen (.) makeestihh, (0.3) lähteny
really really sweetly has started
°really° .hhh really (.) nicely, (0.3) this rash
- 16 tää ihottuma leviää ja-
this rash to spread and
has started to spread and-
- 17 D: millon sä oot saanus se,
when you have got it
when did you get it,
- 18 P: ↑no >se on oikeestaan sen jälkeen k-< (.) synnytyksen jälkeen.
PRT it is actually it after birth after
↑well >it is actually after th-< (.) after childbirth.

The doctor's opening question in line 10, *Minkälaisista asioista oo liikkeellä?* 'What brings you here' is in plural, proposing there could be more than just one problem. It is asked while the patient is taking off her coat, not yet having sat down. The patient does not start her problem presentation immediately, as she is taking off her coat. She starts talking while placing her coat over the back of her chair.

The patient starts her answer with 'now' indicating there has been previous visits, probably for another reason. Her design is fitted to the design of the doctor's question, she uses the same words and the same case (partitive *-ta*) as the doctor, though she produces only one problem. Also the temporal frame of the complaint is the same as in the opening question. Her utterance is pragmatically, intonationally and grammatically complete at the end of line 12 (see Ford and Thompson 1996; Schegloff 1996b).

At this point the doctor temporarily takes the turn, uttering *jaha*, 'I see,' (line 13). In Finnish *jaha* is used as a way to receive new information. With the continuing intonation and emphasis on the last syllable *jaha*, works as a continuer, passing the turn back to the patient.

After a silence of (0.5) seconds the patient continues with an ironic complaint (line 15): 'really .hhh really nicely this rash has started to spread and,' . The turn-final 'and' that is cut off suggests the patient may not have finished yet. However, the doctor takes the turn and starts the verbal examination asking more specific questions on the symptom.

The matter at stake here is that the patient treats her problem presentation as sufficient for all practical purposes already at the end of line 12. Even if she were prepared to continue, she leaves the decision on whether this is necessary to the doctor (cf. Jefferson 1985). The continuance of her description is brought about by the doctor's continuer (line 13) and the following silence (line 14), which indicate that the doctor is not going to take the turn.

Consequently, the initial problem presentation by the patient consists of one turn-constructive-unit (TCU)⁵ which is designed as an answer to the doctor's opening question. 'Now I've come because of rash' repeats the basic elements from the doctor's question (the verb and the case), and is grammatically fitted to the question: 'what for' - 'because of rash'. The only element with no equivalent in the doctor's question is the temporal modifier 'now'.

With her turn-design the patient leaves it to the doctor to decide whether she needs to add anything to her problem presentation. Only as the doctor passes the turn back to her does she continue her problem presentation with the ironical qualification 'really really nicely' and the description of the start of a process 'has started to spread', which both indicate a turn towards worse in her state of health.

In example #2 the patient also passes the turn to the doctor at an early stage:

⁵ On definition of TCU, see introduction, page 32.

Example 2 (31A3 Operated knee)

- 1 D: Okei. =Minkälaisen asian takia sää oot (.)
PRT what+kind issue for you have
Right. =What brings you (.)
- 2 ny[t >lähteny liikkeell]e<.
Now got moving
he[re now].
- 3 P: → [Polvee,]
knee
[My knee,]
- 4 (0.4)
- 5 D: Polvi kipee.
knee sore
Your knee is aching.
- 6 (.)
- 7 P: Nih.
Yes.
- 8 (0.2)
- 9 D: Onks [se tull]u< (.) iha yhtäkkiseltään
has it turned just suddenly
Did [it start< (.) just suddenly
- 10 P: [tai<]
[or<]
- 11 D: [kipee vai ootsä loukannu °sen°.]
sore or have+you hurt it
[aching or have you hurt °it°.]
- 12 P: [siis ei mulla o leikattu polvi.=
I mean no my has been operated knee
[I mean no my knee has] been operated.=
- 13 D: Nii.
Yes.
- 14 (0.2)
- 15 P: Seitkytluvun lopulla.
70's at the end
At the end of the 70's.
- 16 D: N[ii.]
Y[eah.]
- 17 P: [>Leika]ttii ja tota noin nyt se on ruvennu vaivaa,
was operated and erm now it has started to ache
[>It wals operated and erm now it has started to ache,
- 18 (0.6)

The doctor's question resembles the one in example #1, except that this time the question is in singular. The patient starts her answer before the doctor's utterance is complete. This results in overlapping talk as the doctor completes his question in line 2 (though his slight pausing in line 1 may have indicated otherwise). The patient delivers the reason for the visit with one word *polvee* 'my knee' finishing with continuing intonation. Because of the overlap it is difficult to say whether the patient considers her answer as complete already at this point. The brevity of the answer may be due to the patient cutting off her utterance in order to let the doctor finish his turn. It is possible that also a part of the following silence of 0.4 may ensue from the temporary disturbance in the order of turn taking. However, the silence of 0.4 is considerably long, and leaves the patient plenty of space to repeat or redesign her reason for the visit. Thus, even though her initial complaint 'My knee' was overlapped by the doctor's simultaneous talk and possibly could not quite be heard because of this the patient does not show any indication of continuing or re-doing her turn.

Furthermore, when the doctor offers a candidate understanding in line 5 drawing upon the patient's utterance, saying: 'Your knee is aching' the patient answers by clearly confirming the doctor's understanding. There follows a silence of 0.2, after which, in line 9, the doctor starts the verbal examination.

The patient's confirmation in line 7 is the default answer to a candidate understanding such as the doctor's turn in line 5 (Sorjonen 1997, 110). It is uttered with a falling intonation, and also the following silence of (0.2) suggests that the patient passes the turn back to the doctor. Although she starts to repair her utterance in line 10 she drops her initiation, and the continuance of her turn in line 12 is designed as an answer to the doctor's question in line 9, not as a repair independent of the doctor's turn: 'I mean no' answers the first part of the doctor's question in line 9, it does not disagree with the doctor's suggestion that the patient's knee is sore (which the patient has already confirmed). With her utterance in line 12 the patient indicates that the problem has not started suddenly but offers instead her past operation (some 20 years ago) as a potential cause of origin for her knee-ache. By this time the participants have already switched from the phase of problem presentation to verbal examination.

The patient's way of describing her reason for coming may be considered minimal: first she only states the location of the problem, and after this merely confirms the doctor's candidate understanding in line 5. By pausing after the confirmation the patient lets the doctor take the next turn, and guide the conversation forward towards the verbal examination.

Example #3 is yet another example of a minimal answer to an opening question.

Example 3 (19A1 A sore leg)

1 D: Saarikko Leena. Ole hyvä.
Last name First name Please
Saarikko Leena. Please.

2 ((Foot steps))

3 ((Door closes))

4 D: Istuv vaah,
sit just
Do sit down,

5 (0.6)

6 P: Kitos:
Thank you:

7 (2.8)

8 D: Joo (.) otetaanpas sehh (1.0) #lai#tetaan tonne
PRT let's+take that let's+put there
Right (.) let's take that (1.0) #put# it there

9 p#apereitten vä#lii,
papers between
b#etween the pa#pers,

10 (1.4)

11 D: Minkäs takia sinä olet liikkeel[äh.
What+GEN for you are moving
What brings you he[re.

12 P: [(Noh)
[(Well)

13 (0.4)

14 P: → Tän saman va[ivan
this+GEN same+GEN problem+GEN
This same pr[oblem

15 D: [>vaivan< (t-)
problem+GEN
[>problem< (t-)

16 (0.3)

17 P: Ni[i,
Ye[ah,

18 D: [.nhhh

19 (0.5)

20 P: Tää on nyt kolme yötä särkeny ihan tosissaan.=Että
this has now three nights aching+been really seriously that
This has been aching three nights now really awfully.=That

21 viime yönäki puol kolmelta mää hain (0.2) jääpussi(a)
last night+also half three I got ice-bag
even last night at half past two I had to get (0.2) an ice-bag

22 siihe. (.hhh)
it+for
for it. (.hhh)

23 D: Joo,=
Yes,=

In line 11 the doctor asks the patient what brings her to consultation. The patient starts her answer in line 12 overlapping the last syllable of the doctor's question, but still inside the transition place (Jefferson 1983, 3). By starting with an appositional beginning *noh* 'well' the patient displays that she has taken the turn and started her answer (Sacks et al. 1974, 718-719). Thus the silence in line 13 belongs to the patient, it is inside the patient's turn⁶. In line 14 the patient continues her turn and answers to the doctor's question: *tän saman vaivan* 'this same problem'. She uses the case suggested by the doctor's question design, though she does not repeat the particle *takia* 'for' included in the doctor's question. Her answer preserves the temporal frame offered in the opening question, though she adds to her problem presentation indications that she has visited the doctor for the same problem before: *tän saman* 'this same'. The doctor repeats (line 15) the last element of the patient's utterance thus receiving the patient's answer as understood. There follows a silence of 0.3 seconds, after which the patient says *Nii*, 'so' in a soft voice as a confirmation of the doctor's turn in line 15. In line 18 the doctor minimally acknowledges the patient's previous turn, simultaneously taking an inbreath. There follows a silence of 0.5. After this, in line 20, the patient continues her problem presentation with a more extreme description, similar to example #1. She describes a negative development in her state of health, saying 'this has been aching three nights now really awfully'.

⁶ The doctor and the patient are gazing at each other during the silence, so it is not explainable as inviting the gaze of the doctor (see Goodwin 1981; Heath 1986; Chapter 7). The silence may be due to the doctor moving her chair closer to the patient, as the pause starts and finishes in accordance with the beginning and ending of the doctor's movement (see Goodwin, M.H. 1980; Goodwin 1986 on mutual monitoring in conversation).

As in previous examples #1 and #2, in example #3 the patient designs her initial problem presentation as one TCU, as an answer to the doctor's question. Her utterance 'This same problem' suggests that the doctor is familiar with her problem, thus implicitly suggesting the doctor already has resources at this point of the consultation to start the verbal examination. The patient only continues her complaint after a gap of 0.5 seconds following the doctor's minimal receipt of her confirmation.

The previous examples illustrate consultations in which the patients constructed their initial complaint as short, as consisting of only one TCU, and quickly passed the turn back to the doctor. These patients treated their one-TCU complaint as sufficient, they did not display any attempt to go on with their complaint. Furthermore, the patients limited their complaints to describing only the present situation, they did not volunteer information on past events or speculate on the future development of their illness (though in #1 and #3 the patients' initial complaints contained implications of earlier visits to a doctor).

By passing the turn back to the doctor in the first possible slot, and by keeping to the temporal frame offered in the doctor's opening question in presenting their problem, the patients leave the control over the course of the consultation to the doctor. By offering just 'a title' or 'a gloss' (Jefferson 1985) to their reason for the visit as an answer to the doctors' opening questions the patients pass the decision on 'the relevant details of the problem' to the doctor: the doctor is given the opportunity to make the next move, for instance, to encourage the patient to continue or to start asking questions.

4.2.2. Narrativized complaints

The temporally fitted one-TCU complaints were only one way of designing the initial complaint. The following two extracts serve as examples of complaints where the patients extend their turn of talk and use more than just one TCU to describe their problem. In addition, they modify the temporal frame of reference incorporated in the preceding question. The doctor's opening questions are similar to the questions in #1, #2, and #3.

Example 4 (24A2 Boils)

- 1 D: Minkäs takia sinä olet liikkeellä.
What for you are move+on
What brings you here. ((D is sitting down))
- 2 P: → N:o, (0.7) (mm: öh) äv:: viime tor:staina rupes
PRT last thursday started+0
W:ell (0.7) (mm: eh) er:: last Thur:sday
- 3 → iskemää flunssanpoikasta ja .mmh
striking cold+diminutive and
I started suffering from a slight cold and .mmh ((sniffing))
- 4 → (0.2) mä ajatt'i että se menee ohitte ja .mh
I thought that it goes past and
(0.2) I thought that it'll pass and .mh
- 5 D: Mm:[m,
- 6 P: → [S-sit rupes tulee kurkkukipua
then started coming throat-ache
[T-then my throat started aching
- 7 → ja nyt (siel on) semmoisia pa:iseita tai
and now there are kind of boils or
and now (there are) kind of bo:ils or
- 8 → semmosia .hhmthh mönttejä. Hh
kind of lumps
some kind of .hhmthh lumps. hh
- 9 D: ↑Jaa ↓jaa.
↑I ↓see. ((D is moving her chair towards P))
- 10 P: Lämpöö ei oo ollu (.) (mul on) tää karamelli s(h)uuss(h)a.
Fever not has been+0 I have this candy mouth+in
I haven't had any fever (.) (I've got) this candy in my m(h)out(h)h.
- 11 D: Otappas fp(h)oisf.
Take+IMP away
Take it fo(h)utf.

The doctor's question 'What brings you here' is exactly the same as in example #3 (as is also the doctor). As in example #3 the patient starts her problem presentation with an appositional beginning 'well', displaying that she has taken the turn, after which she pauses for a moment (Sacks et al. 1974, 718-719). What follows then, however, is very different from the previous examples where the patient merely answered the doctor's question using a similar structure as in the opening question. Here, the patient starts with a temporal reference 'last Thursday' situating the following utterance in the past. It can also be heard as a characteristic beginning for a (first) story, a story which is delivered as newsworthy (Sacks 1992, Vol. 2, 25). In this first utterance (lines 2 and 3) the patient describes the beginning of a process (which is still continuing): 'I started suffering from a slight cold'. She finishes the utterance with a connector 'and', a continuing intonation, and an

inbreath, marking her turn as intonationally incomplete. At this point the turn is incomplete also pragmatically: with the temporal modifier 'last Thursday', which refers to a past moment in time, and the verb 'started to' which projects the initiation of a larger process, the patient has created a situation in which the recipient (the doctor) can detect that the patient has more to tell, that she has not finished yet.

The patient continues in line 4 by saying 'I thought that it'll pass and', again finishing with 'and' and an inbreath displaying her intention to go on. With the utterance she refers to her own thinking during the past moment described. The structure: 'I thought that' refers to the initial thoughts she had when encountering the event (the slight cold) thus enhancing the projection that this thought did not turn out to be true (cf. Jefferson 1986; Halkowski frth), and that something happened after that thought which she will soon tell about. Again, the patient is displaying both by intonation and by the structure of her complaint that she has not yet reached a place relevant for transition.

At this point the doctor gives a continuer 'Mm: m,' (line 5) by which she aligns as a recipient of the patient's story and displays that she is waiting to hear more (Schegloff 1982).

In line 6 the patient moves her utterance forward in time, starting with 'then' but recycling the expression 'started to' which refers to a start of a process. In this way she indicates that turn transition may not be relevant yet.

In line 7 the patient returns back to the present moment uttering: 'and now'. Instead of a process verb 'started to' she uses a verb describing a stable state 'there is'. Her utterance in lines 7-8 describes the completion point of a process, the state of her problem at the moment of explanation. She completes her utterance with a closing-implicative falling intonation. At this point the patient's turn is also pragmatically complete: she has reached the present time and the completion of the process she had described.

With her \uparrow jaa \downarrow jaa ‘ \uparrow I \downarrow see’ (line 9), the doctor receives the patient’s utterance as new information. Simultaneously she moves her chair close to the patient obviously in order to start examining her. The patient rapidly adds that she has not had fever, and that she has a piece of candy in her mouth. The last utterance shows explicitly that also the patient orients to the doctor starting to examine her throat.

The patient’s problem presentation is designed as a temporal transition through three phases which are chronologically ordered: ‘Last Thursday’, ‘Then’ and ‘And now’. It lists three symptoms: ‘slight cold’, ‘aching throat’ and ‘kind of boils or lumps’ and presents them as having developed consecutively in the course of time. With verbs that describe a process starting the patient creates suspense which unwinds as she brings the story back to the present. Until the return to the present the patient’s utterance is observably incomplete: the first possible completion (and simultaneously the first place where a turn transition would be relevant) follows the closing of her utterance in line 8.

Compared to the first three examples, the design of the patient’s complaint is not grammatically or temporally fitted to the design of the doctor’s question, and it reserves a longer space for the patient’s own turn of talk. In order to find out the present state of health of the patient the doctor has to listen until the patient reaches the present moment. By describing her problem as a temporal transition and by creating suspense with the use of process verbs the patient temporarily abandons the normal turn-taking order (Sacks et al. 1974; Sacks 1992, Vol. 2, 18) and steps into a storytelling mode of conversation (Sacks 1974; Routarinne 1997).

By presenting her problem in a story format the patient is able to reserve herself a multi-unit turn; she is able to keep the turn to herself for longer than just for one turn-constructional-unit (Sacks et al. 1974). The patient’s description is not a clear-cut storytelling sequence as described by Sacks, as it does not include a preface sequence in which the speaker presents an offer to tell something which makes relevant ‘a go-ahead’ or ‘a blocking answer’ from the recipient. Instead, the patient treats the doctor’s opening question (or first-topic-initiation) as a license to start describing the reason and proceeds directly to ‘the telling-sequence’ (Sacks 1974).

In the next example #5 the patient switches into storytelling mode with a long orientation:

Example 5 (32A4 Sore elbow)

- 1 D: No? (.) minkälaisen asian takia oot liikkeellä °nyt°.=
 PRT what kind +of issue for are+you moving now
 Well? (.) what brings you here °today°.=
- 2 P: → =No mul on kuule semmonen (.) semmonen tuota jos mää (.)
 PRT I have listen kind of kind of like if I
 =Well I've got y'know kind of (.) kind of like if I (.)
- 3 P: → heitän tuon tak[in pois ni mä] voin näyttää tuo[ta<,
 throw that coat away so I can show like/that
 take that coat off so I] can show like/th[at<,
 4 D: [Joo? °heitä°,] [Pis]tä
 PRT throw put
 [Yes? °go ahead°,] [Pu]t it
 5 vaikka tohon (.) nau°laan tossa noi[n°,]
 for example there rack+on there+in
 over there (.) on the r°ack for examp[le°,]
 6 P: [°J]oo (sen) saman tien
 PRT simultaneously
 [°O]kay (it)
 7 kun° ,=
 as
 while°=
 8 D: =°Joo°: ,
 =°Oka:y° ,
 9 (0.9) ((patient steps out of the picture to hang his coat, doctor
 gazes at the patient))
 10 ? : °hhhh°

The doctor's question is almost identical with the question in example #2, where the patient gave a minimal answer to the opening question. The doctor is also the same.

The patient begins his answer quickly, without delay. He starts his turn of talk with a preface 'Well I have y'know a kind of' which reserves the turn to the patient and projects a longer piece of talk upcoming. As in the previous example #4, the design of the answer does not follow exactly the design of the question. *Kuule* 'y'know' (a word-by-word translation would be 'listen')

is an attention marker, asking the other participant to align as a listener. With the indexical *semmonen* ‘a kind of’ which projects further talk, and with the attention marker the patient displays that he will need an extended turn in order to describe his problem. However, he does not describe the actual problem yet, but goes on to suggest that he will take his coat off first so he can show his problem to the doctor. At this point, at the end of line 3 the patient’s utterance is observably incomplete: he has indicated that he needs extended space for telling about his problem, he has inserted that he will have to take his coat off before he can show the location of the problem, he has finished his utterance at the point where the actual main point is still missing, he has finished with a rising intonation, and he has stood up while saying *näyttää* ‘show’ displaying that he is engaged in an action other than giving the reason for the visit.⁷

The doctor’s overlapping turns in line 4 react to the patient’s insertion on taking his coat off, first agreeing to the patient’s indirect request ‘if I take this coat off - Yes? °go ahead°’, and then directing the patient to hang it on the rack.

The patient acknowledges the doctor’s directive with a complying *Joo* ‘Okay’ (see Sorjonen 1997, 213) and takes his coat to the rack. In the same intonational unit the patient continues the utterance which he cut off when the doctor started his directive in line 4. In line 3 the patient says: ‘so I can show (like/that)<’, and in line 6 he goes on: ‘(it) while’. Again the patient pauses while his utterance is incomplete, indicating he will continue his turn. Furthermore, he has still not described his actual problem. The doctor’s neutral acknowledgment °*Joo*:° ‘°Oka:y°’, seems to serve the same purpose as his previous acknowledgment in line 4.

While pausing for 0.9 seconds (line 9) the patient walks over to hang his coat up. Despite the doctor’s insertion, the directive and the side-activities, the patient still has the turn to himself.

After taking off his coat, the patient continues his turn (line 11). The actual story starts with a temporal reference ‘a couple of weeks’ which pivots between two utterances: ‘I’ve like had now a couple of weeks’ and: ‘A couple

⁷ Actions such as taking off your coat are normally performed before stepping in to the consultation room or during the opening section, before explaining the reason for the visit.

of weeks ago like (0.5) .mt I hit my elbow on the'.

- 11 P: → °Mulla <tuota>hhhh° (0.8) on nyt ollu sitte pari viikkoo
I like have now had then couple weeks+of
°I've <like> hhhh° (0.8) had now a couple of weeks
- 12 sitten ni (0.5) .mt kolhasin
ago so hit+I
ago like (0.5) ((patient walks back to his seat)) .mt I hit
- 13 kyynärpäätäni tohon (0.2) tohon tota?
elbow+my that+on that+on like
my elbow on thee (0.2) thee uhh?
- 14 (0.2) ((patient rolls up his sleeve and shows the sore point,
doctor moves his chair close to the patient gazing at
his sore arm))
- 15 D: Ahaa. ((D moves closer to P in his chair))
I see.
- 16 P: tohon (0.2) tuolin selkänöjaan ja°hh° .mthhh ja ((D bends forward))
that+on chair+of back and and
on thuh (0.2) back of a chair and°hh° .mthhh and
- 17 sii[nä havah-] havahduin että tota (0.2) et täs on
there notic- noticed+I that like that here is+0
the[re I not-] noticed that like (0.2) that in here there is
- 18 D: [no onko se<]
well is it
[well is it<]
- 19 P: semmonen pussi i[kään]kuin (0.2) >semmonen< vaan
kind of pouch like kind of just
a kind of a pouch l[ike] (0.2) >just< like
- 20 D: [Nii:??]
[Ye:s?]
- 21 P: >semmonen< pieni kipee ko°hta°.=
kind of small sore point
>a kind of< small area that hu°rts°.=
- 22 D: =N[ii.]
=Y[es.]
- 23 P: [.mt]hh Se oli niinku jota[in?]
it was like something
[.mt]hh It was like someth[ing?]
- 24 D: [Pe]hmee pussi,
[A so]ft pouch,
- 25 P: Nii:,
Ri:ght,

26 D: Jossa on nestettä sisällä.
That has fluid inside.

27 P: → Nii:. ↑sit se tota? (0.3) seuraavana päivänä (.) °.hhh°
Right:. ↑then it like? (0.3) next day (.) °.hhh°

28 päivänä aamulla se oli niinku kadonnu ja sit °mä vaan
day in the morning it had like disappeared and then °I just

29 °hh° hetken päästä huomasin että täs on nää=nää oli (-)
°hh° after a while I noticed that there is these=these had (-)

30 to:della< et (tää oli) viikossa,
re:ally< that (this had) in a week,

31 D: Joo:,
Yea:h,

32 (0.6) ((patient strokes the bruise in his sore arm and gazes
at the doctor, doctor gazes at the bruise))

33 P: aivan (.) aiv[an tota m]enny mustaks.=
completely (.) com[pletely like g]rown black.=

34 D: [Mustaks.]
[Blackened.]

35 D: =Jo[o:.]
=Ye[a:h.]

36 P: [°hh° .h]hh Ja nyt sitte tuntu eilen illallakin hhse
[°hh° .h]hh And now then I felt it even yesterday night

37 nyt pussi ei ollu semmonen °ihan mutta että°,
hh that pouch now wasn't quite like °that but uh°,

38 D: Jo[o:.]
Ye[a:h.]

39 P: [°.mth]hh°

40 D: El[ikkä t]ää on to#ta:# tää:?
In[other words t]his is e#rm# thi:s?

Compared to previous example #4, where the doctor aligned to listen to the patient's narrative, this consultation exemplifies a case in which the doctor tries to interrupt the patient's story but, due to the patient having switched to the storytelling mode, is not able to do so. The doctor tries to start examining the elbow already in lines 16-18 when the patient has mentioned how the problem was initiated, rolled up his sleeve and shown the 'pouch' to the doctor. The doctor bends forward to look at the patient's elbow and starts to ask 'well has it<'. However, while the doctor tries to cut in, the patient is telling about a past moment, which indicates that he has not reached the final point of his story yet. In addition, the patient has indicated with the connector

‘and’ that he is going to continue. As the doctor cuts in the patient stops for a moment, but continues then by repeating the word he had cut off: ‘I not-noticed’ (line 17).

With his next utterance ‘and then I noticed that in here there is a kind of pouch’ the patient develops his story further. He is still describing past events, and thus, even though he has referred to what turns out to be the actual problem (the pouch), he has described it as the focus of his noticing in the past: in his story he has not arrived to the present moment yet.

At this point the doctor re-aligns as the recipient of the narrative, uttering a continuer *Nii:?* ‘Ye:s?’ (line 20). The patient continues his utterance overlapping the doctor’s continuer and specifying the pouch as ‘a kind of small area that hurts’. The doctor acknowledges this minimally (line 23), and the patient goes on with his narrative in the past tense: ‘it was like something’.

Again (line 24) the doctor tries to cut in to the patient’s turn by suggesting a characterization of the ‘pouch’, saying: ‘A soft pouch’. It seems that as the doctor’s suggestion for specification is made inside a storytelling sequence, it may be treated as a repair-initiation, ”asserting the occurrence of an understandability problem” (Sacks 1974, 345) which constitutes an ‘allowed interruption’ to the telling of a story. In his next turn the patient confirms the doctor’s suggestion, but does not treat the doctor’s turn as closing his narrative and starting a new phase, as a shift to verbal examination. Instead, with his continuing intonation in line 25 ‘Righ:t,’ he indicates he will continue his story. In line 26 the doctor completes his earlier suggestion: ‘a soft pouch *that has fluid inside*’ which also gets confirmed by the patient. The doctor’s suggestion ends with falling intonation, and there are no question elements in it; it both displays an understanding and looks for confirmation from the patient (Raevaara 1993, 46-48). This design may indicate that the doctor already has an idea of the diagnosis (ibid). The doctor seems to be using the opportunity to return permanently to the present and start examining the elbow, which is given to him when the patient temporarily arrives at the present moment (I noticed there is) although his story is still incomplete. The doctor’s comment refers to the present moment, but as it follows and is based on an utterance where the present is embedded in the past, the doctor’s present tense can also be heard as embedded in the same past moment.

Not surprisingly, then, the patient treats the doctor's comment as belonging to his story, as if the doctor was temporarily co-telling the narrative, animating potential observations of the patient when he noticed the problem (cf. Goodwin 1995). He confirms the doctor's comment and goes on with his story (line 27).

The example shows how the storytelling mode provides for the patient a space which he can regulate, and in which it is difficult for the doctor to intrude before the narrative has come to an end. By designing their complaints as stories, with a detectable beginning and end, patients are able to gain at least temporary control over the space available for presenting their problem.

Thus, even after similar opening questions the patients seem to choose varying designs for presenting their problems. The designs of the problem presentations range between straightforward answers consisting of one TCU and confining to the temporal framework incorporated in the doctor's question, and extended storytelling sequences combining several temporally consecutive units in one turn of talk. But how can we account for this variation? What makes it so important for some of the patients to gain all that space, while others are happy to pass the turn back to the doctor as soon as possible? I shall approach this question by studying what other aspects, besides taking a multi-unit turn and invoking a framework of temporal development, seem to characterize these longer problem presentations called 'storytelling' or 'narrative designs'.

4.3. Different orientations in different designs

Why do some patients switch to storytelling in describing their problems? What is the pay-off of using a narrative design in presenting the problem to the doctor? I will try to answer these questions by juxtaposing non-narrativized problem presentations with narrativized complaints and examining what features of context the patients invoke in each type of design. I shall start by looking at the narrativized complaints. The distinction is by no means easy to make in every case. Rather, 'narrativized' and 'non-narrativized' should be understood as opposite ends of a continuum on which the problem presentations are placed. However, one could say that the data (with the 37 consultations starting with the doctor's focused question

15 SE OLI #öh# SE OLI TOTA S[E KÄVI TÄÄLLÄ MU]JUTEN.
 It was erm it was erm it happened here other+way
 IT WAS #eh# IT WAS ERM I[T WAS HERE IN AN]OTHER OCCASION.

16 D: [Tiistaina.]
 Tuesday+on
 [On Tuesday.]

17 D: Joo.
 Yeah.

18 P: Joo se toine.
 PRT that other one
 Yeah the other one.

19 D: .Hjoo
 .right

20 (0.8) ((coughing in the corridor))

21 P: 2→ Ja tota:, (0.5) ja jah. Sitte mä^o oon ny makoillu tässä
 and erm and and then I have now rested here
 And er:m, (0.5) and andh. Then I've been resting now

22 sitten (0.3) sitten oikeestaan °öh° (0.2) siitä saakka
 then then actually erm that since
 then (0.3) then actually °eh° (0.2) since that

23 sitte (.) eilise[en,
 then yesterday+until
 then (.) until yeste[rday,

24 D: [°Joo.°
 [°Yeah.°

25 D: Mikä sull' o. (.) Saija ei oo tohon kirjottanu muttah,
 What's wrong with you. (.) Saija hasn't written it down but,

26 (0.5)

27 D: .hhh[h pahin valiva sillon oli.
 .hhh[h was your]worst problem then.

28 P: [Nyt tota:,]
 [Now well:,]

29 P: No: (.) sillon oli oikeestaan toi: (.) kuume ja: sitte
 Well: (.) then it was actually tha:t (.) fever an:d then

30 särki paikkoja ja #ö# ja (.) kauhee yskä ja (.) kurkku
 my body was aching and #e# and (.) terrible cough and (.) a sore

31 kip[ee] ja.
 thr[oa]t and.

32 D: [Mm.]

33 (0.5)

34 P: >Sillon oli< kaikenmoista mutta tota,
 >Then I had< all kinds of problems but erm,

35 (0.3)

36 P: Mutta se kurkkukipu ny on menny ohitte (ja) nuhaa tietysti
But my throat is not sore any more (and) my nose is still running

37 vielä on ja,
of course and,

38 (0.7) ((P inhales))

39 P: 3→ >tuommosta kröhinää ja tuom-< mutta nyt rupes sitte tänään
>that kind of wheezing and tha-< but now then today I started to

40 nii huimaan että (.) sitte heippaa semmosta,
feel so dizzy that (.) then I lose my balance kind of,

41 (1.0)

42 P: Ihan sillai ähhh
Just like eh**h**

43 D: Joo.
PRT
Yeah.

44 (0.5)

45 P: Sillai sinne sun tänne e[ttä.
Like staggering to and fro t[hat.

46 D: [Onks lämpöö ny viä ollu.
[Have you still been running a
temperature.

The patient describes his problem as a transition in time in three parts (cf. #4) marked by numbered arrows in the extract: 1) Last Thursday, 2) And then, 3) but now today. As the problem presentations presented in extracts #4 and #5, this complaint is designed as a narrative, the narrative form preserving for the patient the opportunity of continuing his turn across the doctor's 'interruptions'. As in extract #5, as the doctor's specifying questions (lines 13 and 25-27) are asked within the patient's storytelling sequence, they can be heard as understanding checks signaling the doctor's alignment as a recipient of the story (Sacks 1974; see also Schegloff 1990), thus letting the patient keep his multi-unit turn and finish the narrative.

In his utterance in lines 5 and 6 the patient describes a setting in which he situates himself as a character. He describes the scene by locating it temporally by mentioning a specific moment in the past and spatially by referring to a previous appointment with another doctor 'I went to see Saija'. In lines 8-10 he continues by explaining his reason for the past visit: 'I had that cold and a little fever then', and recounts how this other doctor (Saija) gave him sick leave for the rest of the week. The patient posits himself in his narrative as somebody who saw a doctor for his problem and who was given sick leave by the doctor. With the design 'She prescribed me sick leave' the

patient displays a particular stance towards his role as a patient: that he is not the type that asks for sick leave, he only takes leave under obligation. At this point in his complaint the patient talks about his problem on the one hand as non-severe: ‘I had that cold and a little fever’, but on the other hand severe enough to merit sick-leave.

After answering the doctor’s understanding check in line 13 the patient continues his story:

21 P: 2→ Ja tota:, (0.5) ja jah. Sitte mää oon ny makoillu tässä
 and erm and and then I have now rested here
 And er:m, (0.5) and andh. Then I’ve been resting now

22 sitten (0.3) sitten oikeestaan °oh° (0.2) siitä saakka
 then then actually erm that since
 then (0.3) then actually °eh° (0.2) since that

23 sitte (.) eilise[en,
 then yesterday
 then (.) until yeste[rday,

24 D: [Joo.
 [Yeah.

With the temporal modifier ‘then’ (line 21) the patient guides the story forward in time. He changes the past tense into a perfect tense ‘have been resting’, specifying the duration of his resting as lasting from the previous appointment to the day before. With this utterance the patient covers the time passed since his previous appointment and projects that the focal point of the story and the return to the present time will ensue next. In his story he describes himself as having been resting since ‘then’, i.e., last Thursday, preserving a similar stance to the event as in the first part of his narrative: he has been given sick leave and he has been complying with the doctor’s prescription.

In lines 25-27 the doctor makes another understanding check. It is noteworthy that at first, in line 25, the doctor asks his question in the present tense ‘What’s wrong with you’, thus (temporarily) stepping out of the storytelling sequence. As the patient does not answer immediately, he goes on to explain why he asked his question: ‘Saija hasn’t written it down but’. This explanation moves his question back to the past situation and back inside the patient’s story. However, the patient does not react to this immediately. The patient’s turn beginning in line 28 ‘now well’ could be responsive to the doctor’s question as it refers to the present, but it is cut off as the doctor continues his utterance (line 27). The long gap before the answer could result

from the doctor's presupposition (which turns out to be wrong) that the patient is still suffering from the same problem. Probably due to this long gap following his initial question, the doctor continues his turn by repairing his question to focus on the past situation which the patient has spoken about: 'was your worst problem then'', in this way renewing the frame of storytelling which was temporarily lost. This time the patient answers the question. In lines 29-31 he describes his past symptoms more specifically, repeating having had fever and unpackaging the gloss 'cold' (see Jefferson 1985) which he had used in his initial construction (line 8) into three separate symptoms. He also upgrades the seriousness of his previous symptoms by talking about 'that fever' (line 29) instead of the diminutive 'a little fever' (line 8), and by describing one of the symptoms as 'terrible' (line 30). After this he continues with a contrast marker 'but' in line 34 to explain that these symptoms have passed or are not so serious any more ('a terrible cough' is changed into 'that kind of wheezing and that'). He cuts off his answer in the middle of line 39, and utters the last part of his narrative:

39 P: 3→ tuommosta kröhinää ja tuom- mutta nyt rupes sitte tänään
that kind of wheezing and tha- but now then today I started to

40 nii huimaan että (.) sitte heippaa semmosta,
feel so dizzy that (.) then I lose my balance kind of,

41 (1.0)

42 P: Ihan sillai ähhh
Just like eh

43 D: Joo.
Yeah.

44 (0.5)

45 P: Sillai sinne sun tänne e[ttä.
Like staggering to and fro t[hat.

46 D: [Onks lämpöö ny viä ollu.
[Have you still been running a
temperature.

In this last part of his narrative the patient brings his story back to the present with 'now' and 'today', and describes the beginning of a new problem 'I started to feel so dizzy that'. He starts the last part of the narrative with 'but' which marks the following utterance as contrasting with the previous talk, or as something unexpected. With this 'but' the patient describes the following complication in his healing process as something unexpected, simultaneously implying that he as a character in his story had thought his resting period as adequate for healing, and had not anticipated this turn for worse. The way he

describes his new symptom ‘dizziness’ has features of an extreme case formulation (Pomerantz 1986): it is very acute as it has just started ‘today’, he upgrades the symptom with ‘so’, and he conveys a sense of complete loss of control with ‘then I lose my balance kind of (1.0) just like ... staggering to and fro’. He also emphasizes his description with gesturing. In this way he underlines the last part of his narrative as the ‘core’ or as the culmination of his story⁹.

Within his story the patient displays a twofold stance towards his falling ill: on the one hand the patient displays a stance towards his position as a patient. In this case he presents himself as an obedient patient, following the instructions of a doctor in order to get well. Furthermore, he marks the turn for worse as unexpected. In this way he is working to display not only his will to get better, but also his ‘innocence’ with regard to the emergence of the new symptom. By describing how he was given sick leave by a doctor, instead of asking for it, and how he had expected to get better, he constructs his role as a patient as responsible and troubles-resistant (cf. Jefferson and Lee 1992; Halkowski frth; Heritage frth). On the other hand, by finishing his narrative as an extreme case formulation the patient draws attention to his present problem as specific. By narrativizing his complaint the patient is able to show that he is a ‘good’ and ‘ordinary’ patient who complies with the doctor’s orders and expects to get better, but that his problem is ‘particular’ and in this sense requires special care.

As in extract #6, in extract #7 (which is the same as extract #5), the patient constructs for himself a specific role in his narrative:

Example #7, (32A4 Pouch in the elbow)

```
11 P:      °Mulla <tuota>h h h h° (0.8) on nyt ollu sitte pari viikkoo
           I      like          have now had then couple weeks+of
           °I've <like> h h h h° (0.8) had now a couple of weeks

12          sitten ni (0.5) .mt kolhasin
           ago    so          hit+I
           ago like (0.5) ((patient walks back to his seat)) .mt I hit
```

⁹ I am grateful to Christian Heath and his students for this observation.

- 13 kyynärpäätäni tohon (0.2) tohon tota?
Elbow+my that+on that+on like
my elbow on thee (0.2) thee uhh?
- 14 (0.2) ((patient rolls up his sleeve and shows the sore point,
doctor moves his chair close to the patient gazing at
his sore arm))
- 15 D: Ahaa.
I see.
- 16 P: tohon (0.2) tuolin selkänojaan ja*hh* .mthhh ja
that+on chair+of back and and
thuh (0.2) back of an armchair and°hh° .mthhh and
- 17 sii[nä havah-] havahduin että tota (0.2) et täs on
there notic- noticed+I that like that here is+0
the[re I not-] noticed that like (0.2) that in here there is
- 18 D: [no onko se]
well is it
[well is it]
- 19 P: semmonen pussi i[kään]kuin (0.2) >semmonen< vaan
kind of pouch like kind of just
a kind of a pouch l[ike] (0.2) >just< like
- 20 D: [Nii:??]
[Ye:s??]
- 21 P: >semmonen< pieni kipee ko°hta°.=
kind of small sore point
>a kind of< small area that hu°rts°.=

The narrative starts by outlining the circumstances in which the patient first noticed the problem. He describes how a couple of weeks ago he hit his elbow on the back of a chair. He continues in the same prosodic unit to animate his thoughts at the time: to explain how he noticed that in his elbow ‘there is a kind of a pouch like (0.2) just like a kind of small area that hurts.’ He is using a ‘course-of-action’ formulation followed by a noticing which, according to Halkowski (frth), is a way to display the unmotivated discovery of something (see also Jefferson 1986). The patient points out how, having hit his elbow, only at that particular moment he came to realize there was something wrong with it: ‘there I not- noticed’. With his turn design the patient is displaying himself as “an ordinary, disinterested, reasonable witness” (Zimmerman 1992, 439), of his state of health. He is not deliberately looking for health problems, he is not a hypochondriac. Instead he pays attention to his bodily states just as much as he is supposed to in order to be an ordinary person (Sacks 1984).

As in previous example #6, in #7 the patient describes his initial problem as non-severe: a pouch in Finnish is a word referring to a round form, it is neutral with regard to illness unlike e.g. ‘a boil’ or ‘a swelling’ would be. In addition, he describes the sore spot as ‘small’.

In the next part of his narrative the patient moves forward in time still reporting his observations:

27 P: Nii:. ↑sit se tota? (0.3) seuraavana päivänä/ (.) °.hhh°
 Right:.. ↑then it like? (0.3) next day (.) °.hhh°

28 päivänä aamulla se oli niinku kadonnu ja sit °mä vaan
 day in the morning it had like disappeared and then °I just

29 °hh° hetken päästä huomasin että täs on nää=nää oli (-)
 °hh° noticed after a while that there is these=these were (-)

30 to:della< et (tää oli) viikossa,
 re:ally< that (this had) in a week,

31 D: Joo:,
 Yea:h,

32 (0.6) ((patient strokes the bruise in his sore arm and gazes at the
 doctor, doctor gazes at the bruise))

33 P: aivan (.) aiv[an tota m]eni mustaks.=
 completely (.) com[pletely like g]rew black.=

34 D: [Mustaks.]
 [Blackened.]

35 D: =Jo[o:.]
 =Ye[a:h.]

In line 27 the patient explains how ‘next day in the morning it had like disappeared and then I just noticed after a while that there are these=these were really that this had in a week completely (.) completely grown black’. As is the first part of the narrative, the second part is designed as a course-of-action formulation followed by a noticing. The first utterance (line 27) implies that he kept an eye on the pouch until the next morning, but that it had vanished. In this way the patient displays himself as a responsible patient: once having noticed something was wrong he had observed its development (by implication, in order to decide whether he would need professional help to deal with the problem). On the other hand, once the pouch had vanished he is again ‘back to normal’, i.e., in a position where excessive attention to his state of health could be considered inappropriate (cf. Halkowski, frth.). Thus, his description in lines 27-28: ‘and then I just noticed after a while’, with the

mitigating particle ‘just’, seems to underline the unmotivated, ‘innocent’ way in which the patient noticed his ailment, in the same way as in the first part of his narrative.

In this second part of his narrative he uses more problem indicative language with regard to his ailment. His descriptions: ‘these were really’ (lines 28-29), ‘this had in a week’ (line 29, with the emphasis on the word ‘week’ implying the rapid development of the problem), ‘completely’ and its repeat (line 32) point to the extreme characteristics of his case. In this way the patient seems to emphasize features of his problem which point at the particular nature of his problem as doctorable, as in need of medical care.

36 P: [°hh° .h]hh Ja nyt sitte tuntu eilen illallakin< (.) hhse
 [°hh° .h]hh And now then I felt even yesterday night hh that

37 nyt pussi ei ollu semmonen ihan °mutta että°,
 pouch now wasn't quite like that °but uh°,

38 D: Jo[o:.]
 Ye[a:h.]

39 P: [°.mth]hh°

40 D: El[ikkä t]ää on to#ta:# tää:?
 In[other words t]his is e#rm# thi:s?

In the last part of his story the patient returns to the present saying ‘and now then’. Compared with the second part of his narrative this last part includes elements indicating that the problem may be less severe than it used to be. This time the patient uses a verb of a different modality: instead of a noticing, he reports a feeling ‘I felt even yesterday night<’. He cuts off his utterance, not displaying what it is he actually felt. He inserts that ‘that pouch now wasn’t quite like that’ implying that it may have turned smaller or less noticeable. And finally, his utterance trails off with ‘but uh,’ in a soft voice. On the one hand, with ‘but’ the patient claims that there is still a problem despite the pouch being less noticeable, but on the other hand, his trail-off shows that he does not really make an effort to define the character of the problem more specifically.

The patient goes through an extensive description of the development of his ailment, specifically underlining his unmotivated way of noticing the problem, but also implying an explanation on why he did not contact the

doctor in the first place, when the problem was more explicit¹⁰. In addition, he constructs a case in which his ailment is depicted as severe. Thus, as in the previous example #6, the patient seems to display a twofold stance towards his case. On the one hand he displays himself as a patient who tries to find a delicate balance between paying sufficient but not too excessive attention to his state of health (cf. Halkowski, frth.). He displays a stance towards his position as a patient as 'ordinary' but also 'responsible'. On the other hand he makes clear that his problem is (or at least has been) of a particular kind, i.e., severe enough to make an appointment with the doctor (cf. Heritage, frth.).

In some narrativized complaints the personal stance of the patient is not included in the actual narrative. In example #8 (which is the same as example #4) the patient describes the temporal development of her problem from mild to more severe. She does not posit herself as the main character of the story; instead, the illness has the leading role:

Example #8 (24A2 Boils)

- 1 D: Minkäs takia sinä olet liikkeellä.
What for you are move+on
What brings you here. ((D is sitting down))
- 2 P: → N:o, (0.7) (mm: öh) äv:: viime tor:staina rupes
PRT last thursday started+0
W:ell (0.7) (mm: eh) er:: last Thur:sday
- 3 iskemää flunssanpoikasta ja .mmh
striking cold+diminutive and
I started suffering from a slight cold and .mmh ((sniffing))
- 4 (0.2) mä ajatt'i että se menee ohitte ja .mh
I thought that it goes past and
(0.2) I thought that it'll pass and .mh
- 5 D: Mm: [m,
- 6 P: [S-sit rupes tulee kurkkukupua
then started coming throat-ache
[T-then my throat started aching
- 7 ja nyt (siel on) semmoisia pa:iseita tai
and now there are kind of boils or
and now (there are) kind of bo:ils or
- 8 semmosia .hmmthh mönttejä. Hh
kind of lumps
some kind of .hmmthh lumps. hh

¹⁰ This aspect was pointed out to me by the participants in the data-session given by Jörg Bergmann in the University of Tampere 1999. My thanks to all the participants in the session for sharing their ideas.

9 D: ↑Jaa ↓jaa.
 ↑I ↓see. ((D is moving her chair towards P))

The patient describes the development of an ailment from a slight cold, via a sore throat to the emergence of lumps in her throat. In the Finnish original version all the three symptoms are presented as the agent of the process: the cold ‘started to strike’, the throat-ache ‘started to come’ and the lumps ‘are there’. The patient does not make explicit her presence in this body of the developmental narrative. However, having described the first symptom the patient describes her own stance towards the problem at the time: ‘I thought that it’ll pass’. With this insertion the patient does not add anything to the actual description of her symptoms. Instead, she displays that at the emergence of the first (and mild) symptom she had thought it will pass and makes explicit her opinion that in her view this first symptom is not yet enough to go and see a doctor. Thereby she implies that she is not the kind of person who rushes to the doctor at the first small problem.

Although the patient displays her own stance in an insertion to her narrative, not in the actual narrative, it is the narrativized design which provides the possibility of making the insertion. After the first part of the narrative it is clear that the problem presentation is not complete. The story is observably unfinished, and everything said within the storytelling sequence can be understood as a part of that sequence.

The patient continues her description by presenting the emergence of an additional symptom: ‘a sore throat’ and finishes by describing yet another symptom which is observable: ‘and now there are kind of boils or lumps’. This description implies that the patient has engaged in either looking at or palpating her throat and found boils there. It also implies that these boils are observable by the doctor. Although the patient does not describe these symptoms as extreme in any way, it is evident that they are a deviation from normal. In addition, with her narrative she manages to convey a sense of a cumulative process in which the symptoms first start to appear, and contrary to expectations they do not pass, but add up. She constructs her problem as having developed from less to more severe¹¹.

¹¹ A more detailed analysis of the ways in which the patients organize the elements of the complaints will be found in chapter 5.

Consequently, as in example #7, in example #8 a two-fold stance is displayed: on the other hand the patient constructs herself as troubles-resistant (see Heritage, frth.), monitoring her state of health for some time before deciding to seek for medical help, and on the other she presents her problem as particular or severe enough to see a doctor by indicating that it has got worse in the course of time.

The common factor in most narrativized complaints given as answers to open-ended opening questions by the doctor seems to be that in each the patients work to display their stance both towards their role as a patient and towards their particular ailment. On the one hand they display a troubles-resistant but still responsible observation of their state of health, on the other hand they construct their problems as specific and severe enough to seek medical help. In designing their complaints they work to achieve a balance between 'ordinary' and 'particular'. In sum, they show an orientation to expectations attached to applying for the sick-role: they are not to be held responsible for their illness, they have striven to get better by home remedies, but still, they have fallen ill and need professional help in order to get better (cf. Heritage, frth., see also Parsons 1951).

4.3.2. Narratives presenting uncured problems: focusing on compliance as an aspect of the patient role

In three of the narrativized complaints (i.e., which incorporate a temporal development), unlike in the rest of the narrative designs, the patients' problems are only marginally depicted as particular (as extreme or as in need of special care). In addition, the patients' orientation to their role as responsible but still troubles-resistant patients is more implicit. However, all three designs seem to incorporate a description of the persistence of the problem as unexpected, in all of them the patient describes 'having received treatment but not getting better'¹².

¹² Such a design was also found in three of the four complaints following an opening question recipient designed for a routine consultation. (E.g. How have you been for the past month?)

Example 9 (1A4 Lost voice)

- 1 D: Ja teiän nimenne oli,
And your name was,
- 2 (0.5)
- 3 P: Kurkinen,
P's name
- 4 D: Kurkinen Veli Matti neljäs yhdeksättä kuuskymmentäkolme.
P's last name + first name + date of birth
- 5 P: Joo.
Yeah.
- 6 (1.0)
- 7 D: Ja min:käslaine tilanne.h
and what+king situation
And what's the situation like.h
- 8 P: → Eiku toi kur:kku. vaivaa m (.) siitä o (.) pitkälti
no+as that throat troubles it is long
Well that thro:at. troubles me (.) it's been (.) almost
- 9 toista kuukautta ku mä kävin täällä ja .hhh et-
second+to month+to since I was here and that
two months since I was here and .hhh that-
- 10 (0.2) se ol- oli (.) silloin kipee: ja,
it was was then sore and
(0.2) it wa- was (.) so:re then and,
- 11 (1.1) ((D takes glasses out of her pocket))
- 12 P: antibioottikuuri,h >ja tota< (2|.1) kyllähä siinä ny
antibiotics+course and erm PRT+as+you+know there now
antibiotics,h >and erm< (2|.1) the pain did
- 13 kipu lähti mutta .hhh ää:ni ei oo viel palautunu.
pain passed but voice not has yet returned
go away but .hhh my vo:ice has not yet returned.
- 14 (1.5)
- 15 P: Eli=
I mean=
- 16 D: =Minkälainen työ teillä on nyt.
=What kind of work do you have now.

The patient starts his answer in line 8 by giving a gloss of the problem: 'Well that throat. troubles me.' In his initial gloss he refers to his throat with the deictic expression 'that' instead of 'this'. In this way he presumes the doctor has enough common ground to know what he is talking about, and equal access to the referent (cf. Etelämäki 1998), i.e., the patient suggests his problem is 'an old problem' and already known to the doctor. However, he does not wait for the doctor's possible next turn but volunteers to unpackage his gloss with a narrative on his past visit and the treatment he received then finishing with the present situation of his ailment. Thus the patient treats the

details he gives in his narrative as relevant for telling to the doctor at this point of the consultation.

In the first part of his narrative ‘it’s been almost two months since I was here’ the patient refers to the length of time passed since his last visit. This information is delivered as new to the doctor, although one could presume the doctor to be aware of it as well as of the nature of his continuing problem. In his first grammatical TCU the patient uses the expression *pitkälti toista kuukautta* ‘long towards the second month’. Another possible way of describing the same duration would have been ‘long past one month’, for example, but the patient opts for the version which conveys the sense of a long rather than a short time. In this way the patient implies that he has waited for a considerable length of time for his problem to pass. By claiming ‘it was sore then’ he also implies that this might no longer be the case. He glosses the next part of his narrative with one word ‘course of antibiotics’ and proceeds to tell about their effect¹³. He finishes his narration with the structure ‘the pain did go away but’. With the ending *-hän* ‘did go away’ he describes the passing of pain as mutually expectable: in many contexts, the ending *-han/-hän* in Finnish constructs the object of talk as a mutually known fact. He begins the last part of his narrative with the contrast-marker ‘but’, indicating the following utterance as something contrary to the preceding utterance. In the last part he describes a remaining symptom, that his voice has not yet returned to normal.

In his narrative the patient recounts that he has seen a doctor for his ailments, he implies that he has waited rather a long time to get better, he has expected the antibiotics treatment to help, but contrary to expectations he has not yet totally recovered. A similar pattern is found in example #10 where the patient has had tests taken on a blastomycotic problem, the test results have been negative, but she still suffers from an itch.

¹³ His passing of this part of his narrative with a gloss may be due to the doctor displaying disengagement from interaction with the patient and engagement with the study of records. The on-going non-verbal interaction in the example will be analyzed in detail in chapter 7.

Example 10 (2A2 An itch)

1 D: °(Non ni),°
°(Right),°

2 (3.5)

3 D: °Joo, <istukaahan vaan>°.
°Okay, <do sit down>°.

4 (1.0)

5 D: Hartikainen ↑Virpi kuudes kahdeksatta
P's last name first name date of birth
Hartikainen ↑Virpi sixth of August

6 (kuu)skymmentäseitsemän.
date of birth
(six)ty-seven.

7 P: Kyllä.
Yes.

8 (0.5)

9 D: No nii:n. Ja minkäslainen tilanne teillä nyt on.=
well so and what kind situation you now have
Right:t. And what's your situation like now.=

10 P: =Mä kävin eilen laboratoriossa ja (.) otettiin niinku
I went yesterday lab+in and was taken like
=I went to the lab yesterday and (.) like those tests on

11 niitä hiivakokeita mutta .hh ne oli negatiivisia mutta
those yeast+tests but they were negative but
the yeast were taken but .hh they were negative but

12 mulla on semmosta vaivaa kyllä, (0.5) s'tä kutinaa ja,
I have that kind of trouble PRT that itching and
I do have that kind of trouble, (0.5) that itching and,

13 D: Ahaa. Joo:.
I see. Okay:.

14 (1.0)

15 P: Aika voimakasta.
Pretty intense.

16 (.)

17 D: >Minkälainen työ teillä olikaan<.
>What was your job like now again<.

The doctor marks the patient's visit as a follow-up with the word 'now', which indicates that the patient has been to the doctor before. The doctor's suggestion for the nature of the visit turns out to be correct: the patient has been to the lab and has had some tests taken. In addition, by talking about 'those tests' she indicates the doctor to have equal access to what she is talking about. She continues with a contrast marker 'but' which marks the following utterance 'they were negative' as something contrary to

expectations and continues with yet another ‘but’ to explain that she is still suffering from an itch. The itch is also described as something which the doctor already knows of (that itching).

Here, the patient uses ‘but’ in a slightly different context than it was used in example #9. She has not yet received medication or even a diagnosis for her ailment. However, her problem resembles the problem in example #9 in the sense that from the medical point of view she ‘should’ be well (as should have been the patient in example #9 after taking the course of antibiotics): as the tests were negative there should be no itch, but she still suffers from the same symptoms.

In these two examples, the patients present their problem as something which ‘should not be there’, something unexpected. In this way they display their stance towards their patient role as compliant patients who have trusted that they will be cured or diagnosed with medical care. The particular nature of their problem is implied in the way in which it is constructed as unexpected and in contrast to expectations.

In example #11 the patient presents himself more explicitly as a responsible patient:

Example 11 (12B1 High blood pressure)

```
1 D:      ((at the door:)) Peltoniemi,  
          last name (P)  
2          (2.7)  
3 D:      °(Joo, päivää. Kurkisu.)°  
          PRT hello last name (D)  
          °(Yes, hello. Kurkisu.)°  
4          (0.8) ((D and P enter the room))  
5 D:      Istukaa vaa alas.  
          Do sit down.  
6          (1.0) ((D and P sit down))  
7 P:      emhhhh
```

8 D: Mitäs (.) [murheita,]
 what sorrows
 What (.) [seems to be the trouble]

9 P: [mhhh] ((taking blood pressure card
 10 → out of his pocket, giving it to the doctor)) Tommonen korkee
 that kind of high
 That kind of high

11 verenpai:ne mä oon ollu siitä kyllä mittauksissa et (0.2) se ei
 blood pressure I have been it+for indeed tests+in that it not
 blood pressure I have indeed had it measured that (0.2) it has

12 oo vaa (.) laskenu (0.2) se [(mittaus] arvo) ja,
 has just decreased the measurement value and
 just not (.) come down (0.2) the [(measurement] value) and,

13 D: [Joo.]
 PRT
 [Yes.]

14 (2.0) ((D examines the card))

15 P: mk kh öhhhm

16 D: Se on nyt mitattu tammikuusta lähtien että ihan,
 it has now been measured January since that quite
 You've had it measured since January now that quite,

17 P: Joo,=
 PRT
 Yeah,=

18 D: =r[iittävä]n (0.2) kauan, (.)
 enough long
 =l[ong] (0.2) enough, (.)

The patient begins his complaint with a gloss ‘that kind of high blood pressure’ which he (as in example #9) starts to unpackage in the same prosodic unit, without waiting for the doctor to take the turn. As the patients in examples #9 and #10 he starts his narrative by describing his past contacts with the health care organization for the problem in question. He adds the particle *kyllä* ‘indeed’ in this description, which in this context works as a means of convincing or assuring the doctor that he has had his blood pressure measured. This implies that the patient has been monitoring his state of health like a responsible patient. With the ensuing negative observation ‘that it has just not come down the measurement value’ the patient indicates the existence of a goal or an expectation which has not been achieved. This sense of his utterance is further emphasized by the particle ‘just’, which implicates a continuation such as ‘despite x’ or ‘although an effort has been made’. Furthermore, the patient talks about his blood pressure value as an independent (and ‘stubborn’) ‘agent’ which ‘has just not come down’, on which the patient has no influence.

The description conveys a similar expectation of recovery as the previous examples, but in this case the patient's orientation to the role of a responsible patient with an interest in getting better is displayed more explicitly. This difference to examples #9 and #10 may be due to the nature of the illness. In #11 the problem is high blood pressure, which is commonly considered to be connected with the patient's lifestyle, as something the patient should be able to influence himself. In contrast, the problems in #9 and #10, sore throat and itching, would not explicitly connect with lifestyle issues.

The three examples illustrate a specific structure also found in seven other narrativized complaints with old problems (though, unlike in #9, #10 and #11, these complaints also present the problem explicitly as particular.) In these ten consultations the patient has already received treatment or has otherwise been in contact with a health care organization, but despite the expectations created by negative test results or prescribed courses of medication, the patient is still suffering from the symptoms which have been the object of treatment. It seems possible that in cases of this kind the narrative design serves to provide the space and structure necessary a) to show compliance with the doctor's previous orders, thus that implying the patient has acted as a responsible patient should, i.e., striven to get better, and simultaneously b) to make one's case although it implicates a conflict with or a complaint against the health care organization, in the sense that the past treatment has not helped or that the symptoms continue despite the negative test results. It may also be worth noting here that in 8 out of 9 narrativized complaints which are given before the doctor's opening question¹⁴ the patients seem to orient to either a problem of compliance or another kind of conflict or misunderstanding with the health care staff which has occurred during the patient's previous visit¹⁵.

¹⁴ The total number of such complaints in the data was 13. Three of the problem presentations which started before the actual opening question were not narrativized right from the start, and one was delivered in the form of a report.

¹⁵ In a preliminary analysis of all the 13 complaints starting before the doctor's initiation of the medical business, it turned out that the patients oriented to an 'increased susceptibility to doubt' with regard to the doctorability of their problem. This susceptibility was due to their earlier negative experiences with health care staff, failure to follow the orders given to them by health care staff, or a suspicion on the part of the patient that the problem presented had already passed.

4.3.3. Non-narrativized complaints: patient role is not made relevant

In narrativized complaints the patients show some orientation to ‘being good patients’. They make relevant their role as a patient. Such orientations seem to be absent from complaints which are not narrativized but preserve the temporal framework incorporated in the doctor’s question (cf. Heritage frth.). Also in these, a narrative may ensue at a later point, but is not volunteered by the patient. Instead it is either initiated by a question by the doctor or built as a continuation of the initial utterance, following a silence during which the doctor has passed her chance to take the turn.

In example #12 the patient presents high blood pressure as the reason for the visit:

Example 12 (5A1, Blood pressure)

- 1 D: .mthhh Eli,h (.) minkästäpasta asiaa.hh
in other words what kind issue
.mthhh So:, (.) what brings you here.hh
- 2 P: → Vererenpaineet.
blood pressure+PL
Blood pressure.
- 3 (.)
- 4 P: On aika korkeella. .hh Ollu pitkän aikaa.
is quite high has been long time
Is quite high. .hh Has been for a long time.
- 5 (.)
- 6 P: .hhh Sit[te]
.hhh The[n]
[]
- 7 D: [Onks:] sulla korttia.
[is+Q] you card
[Do:] you have a card?
- 8 P: O:n.hh
is
Ye:s.hh
- 9 (1.0) ((P stands up and takes the card out of his back pocket))
- 10 D: Lääkitystä ei oo,
medication not is
No medication,
- 11 P: Ei o[o.
no is
No:.

The doctor's question in line 1 is open-ended, asking what brings the patient to the consultation. In line 2 the patient gives a short answer: 'Blood pressure', naming the reason for the visit with one compound noun, and indicating with a finishing intonation the relevance for a turn transition at the end of his utterance. The doctor does not, however, take the turn, and the patient continues his turn in line 4, adding: 'Is quite high' which completes his earlier utterance. Again his intonation marks his utterance as complete, but still the doctor does not take the turn.

The patient continues by adding an increment to his turn: 'Has been for a long time'. After a short silence the patient is about to add another element in his turn, but this time the doctor cuts in and asks to see the patient's blood pressure card¹⁶.

The patient's utterance 'Blood pressure is quite high' is officially an assessment (Goodwin & Goodwin1992). It describes a state of affairs in which the agent is one medically defined constituent of a state of health 'blood pressure' and gives an evaluation of the quality of this state. In order to be able to give such an evaluation the patient has either had to use medical services to get his blood pressure measured or he has to know beforehand the possible symptoms of high blood pressure. Thus, he seems to be referring to a previously diagnosed problem.

In his next utterance 'has been for a long time' he adds a temporal element to his description, indicating that the problem is not new, but not specifying how old it is actually. However, compared to the six previous examples (#6 - #11) there are no indications of a developing temporal continuum in the utterance. The patient's complaint is marked as complete already after mentioning the illness category 'blood pressure' in line 2. Furthermore, what seems to be completely missing from the complaint is the patient's own stance towards his role as a patient. He is merely reporting a state of affairs previously defined as medically relevant. He does not make any explicit reference to his own actions or considerations with regard to his problem, nor does he report his previous visits where he has had his blood pressure checked. Although this implication can be read from his problem presentation, from the way in which he describes his ailment, he leaves this conclusion for the doctor to

¹⁶ The blood pressure card is a record of a patient's blood pressure rates. It is used by patients who have or are considered as potentially needing blood pressure medication.

make. Furthermore, compared with examples #6, #7 and #8, the patient does not construct his problem as specifically severe.

These orientations, on the one hand to the patient role as an ordinary and responsible patient, and on the other hand to the complaint as particularly severe or in need of medical care were missing in altogether 13 complaints which were designed as plain one-TCU answers temporally fitted to an open-ended question by the doctor (see examples #1, #2 and #3).

However, there were also cases in the data in which the patients designed their complaint with no implication of their stance towards the patient role but making relevant the particular nature of their problem by using extreme case formulations. Two of these complaints were designed as lists of symptoms, whereas in the others the patients only reported one symptom, in some cases volunteering specifications in the following TCUs. Although there were temporal aspects in some of them, they were unlike the narrativized complaints in that they were not constructed to depict an explicit temporal development.

In the next extract, #13, the patient describes a problem in his knee with a design consisting of a single TCU:

Example 13 (33B3 A sore knee)

- 1 D: Kerros.=
tell
Tell me.=
- 2 P: → =.h (Mull on) polvi (kai) pari päivää ollu kauheen
I have knee maybe a couple of days been terribly
=.h (My) knee has been (maybe) a couple of days
- 3 → kipee.
sore
aching terribly.
- 4 (.)
- 5 D: Polvi.
knee
Knee.
- 6 P: Polvi tästä sivusta (e)t se o
knee here side that it is
Knee here on the side (t)hat it is
- 7 (.) ((D glances at P's knee))

8 P: Vähäki kävelee ni [sattuu °tähän°.]
a little+just walk+pas then hurt+pas here
You walk even a little [it hurts °over here°.]

9 D: [Mitä sä oot] tehny
what you have done
[What have you] done

10 °sille°.
it+to
°to it.°

The doctor opens the medical business by giving a directive to the patient to describe his problem: *Kerros* ‘Tell me’. This opening asks for a story or a report. It cannot be answered with a description which would be fitted to the design of the question.

The patient starts his description in line 2, latching on to the doctor’s opening. He locates the problem in his knee using a common Finnish turn design when talking about health-related problems *Mullon polvi kipee* ‘I have a sore knee’¹⁷. He inserts the duration of the problem ‘maybe a couple of days’ in the middle of the utterance. The patient’s intonation at the end of line 3 indicates that he has reached the end of his turn. The patient’s description is also both grammatically and pragmatically complete (see Ford and Thompson 1996; Schegloff 1996b). The doctor could take the turn in line 5, and start interviewing the patient.

Looking more closely at the patient’s utterance, we can notice two differences with regard to the examples on narrativized complaints. The way in which the patient refers to time does not indicate a temporal development, but describes a static state of pain (my knee has been aching terribly) during a specific period of time (a couple of days) which is still valid at the moment of telling. Furthermore, it is difficult to hear even implicit references to his role as a patient in his description. In his initial TCU the patient merely reports the location of a sensation of pain and its duration. However, the way in which he refers to pain, with an adjective ‘kauheen’ (terribly), constructs the pain as severe. Furthermore, by inserting the duration of his problem in the middle of the description he works to finish his initial complaint with the severe pain reference ‘terribly sore’. In this way the patient seems to point at his problem as specific, as in need of medical care.

¹⁷ See the gloss in lines 2 and 3.

In his initial description of the reason for the visit the patient does not explicitly take a stance towards his role as a patient. His design of the problem presentation leaves his previous actions as a potential patient untold. He does not refer to the way in which he noticed the problem (see example #5, Pouch in the elbow), nor does he make any effort to display that he has waited for the problem to pass before he has come to the consultation (cf. Example #4, Boils). In addition, his reference to the time passed since he first started suffering from the problem ‘maybe a couple of days’ is nonspecific, there is no effort to state the exact duration of the pain. Even after the doctor requests for confirmation ‘Knee’, in line 5, in this context hearable as initiating more description on the symptom rather than as starting the questioning phase of verbal examination, the patient keeps to the present tense, first specifying the location of the pain and later, in line 8, describing a particular situation in which the pain is intense.

In the next example the patient presents her complaint with several grammatical TCUs, first giving a gloss of her problem but volunteering the following specifications:

Example 14 (32A2 Sore elbow)

```

1  P:      Mä#ä:# #°ää°# mul on nyt tää tämmönen=onks tää niinku
          I#:# #°eh°# I've got now this this sort of=is this like

2          mulle tä[ä paperi vaih, he hee: joo:. ]
          for me th[is paper orh, he hee: yea:h. ]

3  D:      [Se on varmaan ihan sulle joo. ]
          [That's probably just for you yes.]

4          (0.8) ((D sits down))

5  D:      No nii=
          Right=

6  P:      =J[oo, ]
          =Y[eah,]

```

7 D: [Sä] oot liikkeellä nyt minkälaisen asian >takia<°hh°,
you are move+on now what kind issue for
[what] brings you here now °hh°,

8 (0.2) ((D and P are gazing at the desk))

9 P: → >Mun on< (.) tää vasen käsi (0.2) tästä,
I have this left arm here+in
>I've got< (.) this left arm (0.2) in here,

10 (0.2) ((P pats her elbow, D gazes at it))

11 D: Ky[ynerpäästä kipeetä,]
elbow+in sore
so[re in the elbow,]

12 P: [kyynärpäästä ki p lee? ja se on ti[etys lti sit°te°
elbow+in sore and it is of course then
[sore in the elbo]w? And then it's of [cours]e

13 D: [Ahaa.]
[I see.]

14 P: (0.3) enemmän ja vähemmän (.) kipee että välillä sitä
more and less sore that from time to time it
(0.3) more and less (.) sore that from time to time it

15 sitten (0.2) särkee oi[kein kovasti.]
then aches really hard
is then (0.2) aching r[eally severely.]

16 D: [Kuinka pitkää] se kipee on
[How long] has it been

17 >°ollu°<.
>°sore°<.

18 P: .mt Se: on tota noin (.) se tuli joskus (0.2) >kesällä<
.mt I:t has like erm (.) it started some time (0.2) >in the summer<

19 oisko heinä elokuussa*h*,
maybe July August°h°,

20 (0.2) ((D and P gaze at each other))

21 D: °A[ha.°]
°I [see.°]

22 P: [MÄ] oon v_asenkätinen (.) et se on,=
[I'M] left-handed (.) that it's,=

In her initial answer to the doctor's question (line 9) the patient gives a specific location to the problem, making a pointing gesture which elicits the doctor's gaze to the object pointed at. Her pausing in line 10 gives the doctor a chance to complete her utterance. However, she also completes it herself, using almost exactly the same words as the doctor. Her utterance is

grammatically and pragmatically complete in the middle of line 12, but with a continuing intonation the patient indicates that she is going to continue her turn. Her utterance is not prosodically complete until the end of line 15.

In the two utterances between lines 12 and 15 the patient specifies the nature of the pain. First she explains its fluctuating character, saying 'it's of course then more and less sore'. She finishes with a paraphrase that upgrades the intensity of her problem: 'it is aching really severely'. There is one element in her description which refers to an issue external to the actual pain and location of pain: by stating that the elbow is 'of course then more and less sore' the patient constructs the fluctuation of pain as something which both participants of the situation have access to and knowledge of, the word 'of course' refers to something which is either self-evident or something which 'could have been guessed'. This way the patient claims that there is a common expectation concerning the kind of pain she is experiencing. However, in my intuition an average member's knowledge does not support such a claim. The patient's implication that the fluctuation of pain is 'to be expected' though it is not, may work to extend this fluctuation of pain to apply to other problems as well, not just her particular problem¹⁸. One would think that being less sore potentially threatens the doctorability of the problem in question. Thus, it seems to me that by inserting 'of course' to her description the patient orients to the potential doubt on the doctorability of her ailment. In addition, the fact that she finishes her description by concentrating on the moments when the elbow is aching more offers further evidence for the interpretation. By these means she constructs her case as particular and in need of medical care.

Compared to the explicitly narrativized complaints, the complaint lacks a description of the course of past events and past actions performed by the speaker with regard to her ailment. It reports a state of health with no mention of when it started, how it developed, how the patient noticed it, and what she thought about her problem. Her 'of course' is the only implication of her stance, though it is not so much displayed as a stance towards her role as a patient, as towards her problem as potentially not doctorable.

¹⁸ There is also an ironic tone in uttering the 'of course'. By implication 'of course' may be heard as addressing the common experience that once you decide to make an appointment with the doctor the problem disappears.

Compared to narrativized problem presentations in which both temporal development and stance towards the patient role are volunteered within the initial complaint, in non-narrativized complaints ‘the facts are left to speak for themselves’. The patients show less effort to explain their own position in applying for the sick role. (cf. Heritage, *frth.*). However, the problem was constructed as severe and in need for medical care in ten out of thirteen of such complaints (see examples #13 and #14).

Constructing one’s problem as severe or extreme draws attention to the case in question as particular, as something which causes suffering to the patient and complicates his life. In the ten non-narrativized cases with a reference to the problem as severe, this was always made last in the complaint: either in the last TCU or in the only TCU if there was only one. Thus, describing the problem as severe or extreme was usually done immediately before the turn was passed to the doctor. It is possible that by emphasizing the nature of their problem as severe in this particular location, the patients specifically mark their problems as doctorable, and thus work to get the doctor to approve them as such and to take the turn to proceed to the verbal examination¹⁹. They will only engage in displaying their stance towards patient role if prompted by the doctor’s questions (e.g. ‘How did it start?’).

3.4. Conclusion

By narrativizing their complaints patients are able to reserve extended space for describing their reason for the visit. By switching to storytelling, eventual comments of the doctor before the completion of the narrative can be treated as belonging to the story, thus making it easier for the patients to continue their narrative after the doctor’s remarks. Once having been given the space to present their problem, patients seem to be able to start their narrative without the preface which precedes the actual storytelling sequence in ordinary conversation. Sacks writes: “In contrast with the organization of the preface sequence, place for the talk of recipients within the course of the telling sequence need not be provided by the teller . . . If recipients choose to talk within the telling sequence, they may have to do their talking interruptively” (1974, 344). As we have seen, however, interrupting the patient’s story may be difficult.

¹⁹ This possibility will be further examined in chapter 5.

Another observation made was that the patients use the narrative design in establishing their personal viewpoint towards the process of applying for the sick role. That narrative design and a project of establishing a personal viewpoint are intertwined is, of course, not news: innumerable studies have regarded narrative as a typical way of organizing personal experience (e.g. Goffman 1974; Bruner 1990; Hänninen 1996; Ochs et al. 1996; Schiffrin 1996). However, what is at stake here is to notice that narrative is not the only way of formulating a trouble-experience: a health-problem may also be described with a plain answer to the doctor's question or with a non-narrativized reporting. The distinction between narrativized and non-narrativized problem presentations gives us a specific viewpoint from which to look at some features of context which patients make relevant in their problem presentations: in giving narrativized vs. non-narrativized descriptions patients seem to orient differently to the need to display their stance towards the patient role.

On the continuum starting from minimal grammatically fitted answers to the doctor's opening question and finishing in extended narrativized problem presentations, the extent to which patients engage in doing implicit moral work in their complaints seems to increase with the extension of the patient's turn (cf. Heritage, frth.). Whereas in some complaints patients do not volunteer their stance towards the problem or to their role as patients, in others both of these aspects of the sick-role are addressed. (cf. Drew 1998).²⁰

The implicit moral work is to a great extent managed by narrativizing the complaint. In most narrativized complaints the patients construct themselves as 'ordinary but responsible patients' on the one hand and their problem as 'particular' on the other. The narrative design seems to provide the means of displaying to the doctor that the visit is about real trouble, not transgression (cf. Jefferson 1985), and that the patient is a responsible patient looking after himself, but not looking for problems. However, patients presenting a complaint on an uncured problem as a narrative do not always seem to engage in emphasizing the severe nature of their problem.

²⁰ There is only one case in the data where the patient *explicitly* refers to his visit as possibly not necessary. Even in this case he does this by naming his visit 'an April fool's visit' instead of using a direct expression such as 'this visit is probably not necessary'.

In non-narrativized complaints the patient role is not addressed to the same extent as in narrativized complaints, but the doctorability of the problem may be treated as relevant. Situating an extreme case formulation or another description of the worsening of the problem at the end of the complaint may work as a way of constructing the problem as particular, as severe enough for seeking medical care. However, there were non-narrativized complaints in the data where the patient displayed orientation neither to the patient role nor to doctorability.

In their studies on calls to the emergency office Whalen & Zimmerman talk about showing stance as an epistemological display of how the caller came to know about the reported event. They show how every description of a policeable incident is potentially suspect to doubt, and how a display of the caller's stance works to relax this doubt: the dispatchers want to find out how the caller can know about the occurrence, is it possible for him to see it, and/or to which extent he is entitled to tell about it in the first place (whether it happens in his own backyard or in the neighboring building, for example). They want to know the caller's relationship to the event. According to Whalen & Zimmerman (1990), displaying personal stance is an expected feature in emergency calls.

In medical consultations the situation is, of course, different. Patients are always personally involved in their problem. Thus, the patients in medical consultations may not necessarily have to explain to the doctor 'how they are in the position to know' about the problem. What is occasionally made relevant by the patients, however, is 'how they made the decision to seek for medical help'. The patients presenting their complaint in a narrative form tell the doctor, for instance, how they first tried some home-remedies or how they waited for the symptoms to pass before making the appointment, or further, how they were minding their business as usual when they suddenly noticed the problem. They did not expect to get worse but *viewed being sick as undesirable*. On the other hand, patients may show how they have been responsible patients, how they have monitored their state of health as ordinary people would, so that they have not caused the problem themselves and *are not to be held responsible for the illness*. As regards renewed problems, patients may point out that they have followed the doctor's orders, that they have rested and taken the medication, and expected the problem to pass, *they*

have striven to get better. All these aspects seem to address the rights and obligations which are attached to sick role according to Parsons (1951).

Consequently, it seems probable that the features made relevant by the patients who design their reason for the visit as a narrative are connected with general expectations concerning the license to enter the sick role (Heritage *frth.*, see also Parsons 1951). As in calls to emergency, the reason for the visit or the justification of seeking medical care may be susceptible to doubt (cf. Whalen & Zimmerman 1990, 465). Meehan (1989, 121) analyzes the ‘police-worthiness’ of citizen’s calls to the police and writes: ”(..) the task of the caller is not only to provide a description of the location and problem, but rather to select from the available possible descriptions the one which maximizes its relevance for the police.” Analogously, in medical consultations, an important task for the patients would be to provide a description of the reason for the visit which would maximize the relevance of their visit for the doctor. This problem of doctorability arises before the visit as the patient has to decide that he has a problem which needs medical care, but the final decision on the problem’s ‘eligibility’ is made by the doctor. Heritage suggests the problem of developing doctorability to be one of the patient’s main tasks in explaining their reason for the visit (Heritage *frth.*).

To assure the doctor of one’s good intentions as a responsible and troubles-resistant patient is, however, only one side of the coin. The problem of showing that one’s ailment is severe enough to receive medical help remains. However, displaying troubles-resistance simultaneously with complaining about severe suffering may place the patient in a dilemma. Narrative design provides a device which enables the combination of these potentially contradicting tasks in one complaint, simultaneously making sure that one gets to keep one’s turn until the both tasks are fulfilled.

The organization of a narrative as a temporal development offers the patients a device which enables the display of more than just one way of relating to the issue at hand. For example, in example #8 the patient displayed her stance at the emergence of first symptoms, implying that later, when additional symptoms appeared, she decided her problem to be severe enough for seeking medical help. In addition, storytelling provides a way of introducing other characters which help to enforce the stance one wants to display. For instance, the patient in example #6 mentions the other doctor who prescribed

him sick leave in the very first part of his story. Thus he is first able to diffuse the responsibility for deciding that his previous problem was severe and to display troubles-resistance with regard to his old problem, but still, in the last part of his narrative, to claim that his new problem is very severe. Most of all, however, switching to storytelling provides the patients with space to display their stance by maximizing their possibilities to keep the turn to themselves.

By organizing events in the form of a temporal development patients are able to introduce a sense-making scheme, a theory of events, and thus to construct their particular cases as a rational and possible version of the course of events (Bruner 1991; Ochs 1997). By switching to storytelling they are able to reserve more space for their complaints and arrange the elements of their descriptions in such an order that they form a coherent and logical whole. With the space and the temporal developmental structure offered by the narrative form the patients are able to introduce and arrange background information, specific circumstances and additional characters in such a way that their case can be seen in the 'best possible light'. By presenting a believable, possible theory of events where their role as a patient is constructed as 'responsible and troubles-resistant' and their ailment as 'severe enough', they are able to avoid possible suspicion of moral flaws.

In non-narrativized complaints, although the problem is often depicted as particular, as severe enough for consulting a doctor, the orientation to patient role is less explicit. It is not volunteered, but is only revealed if prompted by a question by the doctor.

Thus, the extent to which patients consider it necessary to bring up the moral aspects involved in seeking medical help varies and is detectable from the design of problem presentation (cf. Heritage frth.). Possible explanations for this variation could be found by looking at the varied nature of the problems or patients' earlier experiences in medical care. There could be something in the nature of the problem that patients would consider to evoke potential doubts concerning their conduct as patients or the doctorability of their specific problem. For example the observation on problem presentations starting before the doctor's opening question would support this idea: 9 out of 13 such complaints were designed as narratives, and every single one of them appeared to contain either some previous conflict or misunderstanding with regard to the previous contact of the patient with health-care institutions, a

problem with compliance, or a suspicion by the patient that the problem may not be severe enough for showing to the doctor²¹.

However, in choosing the designs of their problem presentations patients also opt for a longer or a shorter turn of talk. They may work to get an extended turn for themselves, in order to display their own stance towards their illness, or they may pass the turn quickly back to the doctor and leave the control over the course of the consultation to the professional. Whatever their reasons for needing an extended turn, with their narrative designs patients construct the phase of giving the reason for the visit as a place where they should justify their moral worth as good patients, and the worth of their problem as doctorable.

These observations indicate that a) patients have means to keep the turn to themselves if they consider it necessary, b) patients have orientations (independent from the doctor's question) concerning the content of problem presentation, i.e., what issues should be taken up there, c) these orientations have to do not only with giving information on the nature of the problem, but also with specific moral aspects attached to seeking medical help.

The above analysis is concerned with the ways in which the patients keep the floor in presenting their problem and what they do with their minimal vs. extended designs of their complaint. The analysis brought to light that, even when the complaints were not narrativized, they were completed with a description of the severe or extreme nature of their situation. In other words, the patients passed the turn back to the doctor with a description of suffering of some kind. In chapter #5 I will analyze this and other ways in which the patients complete their problem presentations: what utterances do they use to pass the turn back to the doctor.

²¹ Originally, the observation on there being some (undefined) conflict in the consultations where patients start their problem presentations without waiting for the doctor's opening question was pointed to me by Timo Vottonen.

on semm'ne huo:no heikko ol#o koko aja ja#,
 have that+kind+of bad weak feeling whole time and
 feeling kind of ill: and wea#k all the time and#,

In the example, the first part of the patient's utterance concerning the fever seems to be differentiated from its last part concerning the patient's feelings by the way in which the sections were or were not presented as characterizations for the recipient. Sacks (1992, Vol 2, 404-405) gives an apparently parallel example in the following analysis (though he talks about two different ways of describing emotion) :

P: I've got a date coming in a half hour and I (sob)
 D: I see
 P: I can't go through with it I can't go through
 with the evening I can't

Sacks points out how 'I can't go through with it' is subsequently explicated with 'I can't go through with the evening', and suggests that the first statement reflects how the feeling was felt, whereas the latter is a characterization made for the recipient. He maintains that non-complete, non-objective references may be pointing at a speaker's 'real feelings'; they are uttered to convey how the feelings are experienced by the speaker without the additional layer of specifically trying to communicate them, make them accessible to the recipient. In this chapter I will examine the patients' utterances preceding a possible completion of the problem presentation with regard to whether they can be seen as characterizations of states of affairs for the speaker or as characterizations for the recipient.

In addition, I will touch upon the ways in which these different last utterances by the patients are received by the doctors. In more general terms, my focus will lie on the manner in which the closure of the problem presentation phase and the shift to the next phase is managed by the participants.

Detecting the point where the patient regards his complaint as complete and is ready for moving forward in the consultation is important in terms of the control over the course of medical encounters. In various studies the way in which physicians interrupt the patients and thus deprive them of the opportunity of completing their initial complaint is described as a major problem. Perhaps the most famous of these studies is Beckman & Frankel's (1984) research on internists, in which they observed that patients are given on the average only 18 seconds to present their problem before they are

interrupted. However, the study was conducted within a specialized branch of medicine in a hospital environment, and the definition of interruption was very broad¹. In an ordinary general practice encounter the case may be different. At least in Finnish general practice consultations patients usually do seem to get to complete what they have to say. Beckman and Frankel appeared to presuppose that more often than not, patients would have several problems to present and that the doctors' 'interruptions' would result in the loss of information on these. However, in the Finnish data, the opposite problem seems to arise in many cases: the doctors do not take the turn although the patients have clearly indicated that they have finished.

My main task in the chapter is to show how the closure of the problem presentation tends to be co-constructed by both the patient and the doctor, rather than unilaterally managed by the doctor alone. I will present various ways in which patients pass the turn back to the doctor at the closure of their problem presentation. It will be shown how each variant in its distinctive way may work as an invitation for the doctor to start examining the patient, as a first move in negotiating the proper point to move forward in the consultation.

We have seen in chapter 4 how the patients, in addition to giving information on their reason for the visit, orient to the question about the doctorability of the problem, by showing that their ailment is severe enough for seeking medical help. In this sense, the point where the doctor starts to interview the patient in order to make an appropriate diagnosis and recommend treatment is important to the patient. The doctor's first history-taking question incorporates the patient's concern in a medical frame of reference and may thus be seen to validate it as worthy of medical attention (Heritage frth). Conversely, the doctor's silence at the completion of the patient's problem presentation may be heard as making relevant a further description of the problem, as treating the problem presentation so far as insufficient. In this sense it may even be heard as casting doubt on the justification of the patient's decision to seek medical help. In this sense, it is important to study how the patients themselves work to imply that their problem presentation is complete and the doctor is welcome to start the examination.

¹ For Beckman and Frankel, in addition to questions, any turn of talk by the doctor which recycles an element of the patient's previous utterance was defined an interruption. In their opinion, turns of this kind inhibited further topical development.

The analysis revealed that the patients used several distinctive practices in completing their problem presentations. These practices can be roughly divided in three groups: escalating the complaint (e.g., by upgrading the intensity of the problematic experience), giving further details on the symptoms, and providing better availability for the doctor to the patient's experiences. These three groups of practices recur in the patients' complaints throughout the data of 66 problem presentations². The practices are complementary and partly overlapping, and they may be used consecutively. Further, there seems to be some regularity in the manner in which each practice is received by the doctor. The following analysis is organized with regard to the extent to which the practices presented transparently invite an uptake from the doctor. I will start with problem presentations finishing with questions directed to the doctor, and continue by presenting practices with which patients work to provide the recipients with better availability to their concerns (5.1.). Thereafter, I will describe the practice of detailing by which patients offer resources for the doctor for a co-construction of the shift forward in the consultation (5.2.). In section 5.3. I will study complaints finishing with extreme-case formulations or upgrades of the intensity of the problem, and will show how even such descriptions of a unique and exceptional situation may imply that a move forward in the consultation would be relevant. To conclude, I will discuss how the patients in and through these practices construct the nature of the activity as help-seeking rather than troubles-telling (5.4).

5.1. Providing availability for the recipient

There are several ways in which the patients make their problem presentations more available to the recipient. One obvious way of doing this is to appeal to the doctor's role as a medical expert (5.1.1). Patients may pass the turn to the doctor directly, by asking a medically related question or requesting service (5.1.1.1.), or they may approach the medical territory by making diagnostic suggestions (5.1.1.2.) or by using medical terms in describing their problems (5.1.1.3). Patients may also provide availability by invoking a shared local focus of interest (5.1.2.), or by invoking a shared

² 36 complaints in which the patients only confirmed the doctor's suggestion for the reason for the visit or the doctor started the verbal examination after the patient had given a short gloss of his problem (such as 'I need a medical for a driving license') were excluded from the analysis.

activity environment (5.1.3.) In the two latter cases they do not address the doctor's role as a medical expert, but as 'any recipient', in the first case as a co-participant in the current situation, and in the latter case as a member of the same human culture.

5.1.1. Stepping into the doctor's territory

The problem presentation can be modified in several ways to touch upon the doctor's area of expertise. The patients may present very explicit claims invoking the asymmetrical positions of the doctor and the patient, for example: 'I wouldn't know, I'm not a doctor.' Alternatively, they may just touch upon the medical frame of reference by using medically toned expressions, for example: 'that they (joints) are now swollen and like somehow tense and fluidal and they are like always white like that.' The use of such expressions as the last element of problem presentation addresses the recipient's institutional role as a doctor. In this sequential place such an implication of the relevancy of the recipient's role as the medical expert may work to indicate that the patient is ready to pass the problem to the doctor to be dealt with. If the doctor's first history-taking question is understood as a validation of the patient's problem as doctorable, i.e., if incorporating the patient's problem in the medical frame of reference simultaneously solves the problem of doctorability for the patient (Heritage frth), closing the problem presentation with medically toned language may embody a warrant (or even a plea) for the doctor to start examining the problem. This possibility becomes explicit when the patients finish their accounts with a request or a question to the doctor. In the following, I will present three ways in which the patients completed their problem presentations by stepping into the doctor's territory: overtly addressing the doctor's expertise (5.1.1.1.), making diagnostic suggestions (5.1.1.2.), and using medical terms or describing medical procedures (5.1.1.3.).

5.1.1.1. Overtly addressing the doctor's expertise: asking questions from the doctor

An explicit way of addressing the doctor's expertise is to make a direct request for information or a request for service to the doctor. With these practices patients show transparently that they have completed their turn and expect the doctor to take the next turn. In the following example #1 the patient has come to the consultation because of a swelling in his sole.

Example 1 (18A1 Sole)

- 1 D: No nii (0.2) päivää va[a.
Right (0.2) let's say hel[lo.
- 2 P: [päivää ()
[Hello ()
- 3 (1.8)
- 4 D: (.mt) [Mi]tä[s (.) kuuluu.
(.mt) [How] (.) are you.
- 5 P: [tä-]
- 6 P: hh
- 7 (1.4)
- 8 P: M'n täyty tulla tänneh (1.4) .hh tän jalkani takia,
I had to come here this foot+my for
I had to come here (1.4) .hh because of this foot of mine,
- 9 (0.4) >ku sillon< (0.6) >ku mä kävin.<
as then as I came
(0.4) >as then< (0.6) >as I was here.<
- 10 D: Joo (.) mää muistan siittä oli<
PRT I remember it+since was
Yes (.) I remember it was<
- 11 (0.3)
- 12 P: Joo.
PRT
Yeah.
- 13 (0.4)
- 14 P: Ni mun täyty ku tää ol semmonen juttu että (0.2) tää
so I had to as this was the kind story that this
So I had to as this was the kind of thing that (0.2) this
- 15 → ruppee punottaa kävellessä, (0.9) että mitähän mitä
starts become+red walking+in that what what
turns red when I walk, (0.9) that what

16 → (.) mitä tän oikeen tekis.=
 what this actually do+cond+0 (passive)
 (.) what should you do about this.=

17 D: =°Mitä niille° tekis.
 What them+to do+cond+0
 =°What to do° with them.

18 P: Ni.
 PRT
 Right.

19 (0.4)

20 .nff[f

21 D: [Mites (1.2) rintakipujen< (0.3) s- (.) suhteen on menny.
 How chest+pains relative+to has gone
 [How (1.2.) has it been with< (0.3) the (.) chest pains.

((21 lines of discussion on previous problems omitted))

43 D: Joo, (0.3) katotaas sitä jalkaa °mikä°,
 PRT look+pas that foot what
 Okay, (0.3) let's have a look at that foot °what°,

The patient first refers to his previous visit apparently for the same problem. In presenting his problem he diffuses the responsibility for coming by stating that ‘he had to come’, as if something or somebody independent of himself had made him come to see the doctor because of his foot. In lines 14-15 he says ‘so I had to come as this was the kind of thing that this turns red when I walk.’ Thus, he formulates ‘turning red’ as the reason for the visit. Drawing upon member’s knowledge, a foot turning red when walking does not appear a problem which forces someone to see a doctor. Furthermore, in lines 9, 10, and 14 the problem is constructed as one which has been dealt with during the previous visit by the patient, and the patient’s utterance in line 14 does not indicate that anything new had happened since his last visit. Through these features the patient constructs the doctorability of his ailment as problematic. (Heritage frth).

Doubts on the justification of the visit could also explain why the patient proceeds in the same prosodic unit to pose the doctor a question: ‘that what (.) what should you do about this.’ His question makes an answer the relevant next action, thus passing the turn to the doctor. The first question word *mitähän* includes the ending *-hän* which in my intuition marks the activity of wondering a shared activity: unlike an utterance starting with the question word *mitä* only, *mitähän* includes the speaker in the group of those who might know the

answer. Thus, at this point the question is also hearable as a contemplation by the patient. However, the patient repairs his utterance into a direct question omitting the ending *-hän*. Furthermore his question is designed as a paraphrase, an inference from what he said before. He states that he had to come and see the doctor for his foot, after which he summarizes his problem by asking what should be done to it. By asking about a remedy the patient simultaneously suggests that his problem needs treatment. In this way he constructs his problem as doctorable. Furthermore, with his question the patient constructs the consultation as a service encounter, positing a problem that needs to be solved.

Cases where the patient asks for instructions for future action concerning a problem presented as the reason for visiting a doctor can be regarded as invoking the recipient's position as an expert in medical issues. Asking a question is also an efficient way of passing the turn to the recipient, as it makes an answer the relevant next action.

Not surprisingly then, in the example above, the doctor takes the turn after the patient's question. However, instead of treating the patient's turn as a question, he treats it as invoking a common sphere of contemplation, making use of the patient's initial design including the question word *mitähän*. The doctor aligns with the patient's comment, repeating it almost word-by-word: 'what to do with them.', thus joining with the patient to ponder about the problem. It is noteworthy that at this point the doctor posits himself in the role of a sympathetic recipient. He does not activate his position as the medical expert. By staying in the role of the recipient he also passes his chance to start examining the patient's problem at this point.

However, the patient's following turn: 'Right' in line 18 displays that he has intended his earlier comment as a question. With *ni* the patient treats the doctor's previous turn as a repair initiation presenting a candidate understanding of his question, and confirms this understanding. In this way the patient renews the relevancy of an answer to his question. By answering the patient's request for information on the possible treatment for his problem, the doctor would confirm that the problem is 'real', as it needs treatment. However, the doctor does not take up the problem yet. Instead he asks about the patient's previous problems which appear to have nothing to do with the redness of his foot. After the patient has answered his questions on the previous ailments the doctor finally starts to examine the foot in line 43.

It is noteworthy that the patient's direct request for information on what to do about the problem does not necessarily result in granting the request, i.e., the initiation of the examination by the doctor. However, as the patient's 'right' (line 18) clearly indicates that he has finished his problem presentation, the doctor is obliged at least to take the turn.

5.1.1.2. Making diagnostic suggestions

In the following example, the patient passes the turn back to the doctor with a diagnostic suggestion:

Example 2 (35B1 Sciatica)

- 1 P: ()
- 2 D: No (.) terve,
Well (.) hello,
- 3 (0.6)
- 4 P: Terve,
Hello,
- 5 D: Is:tuma[an.
Sit down + TO
Si:t do[wn.
- 6 P: [°(.hjoo,)°
[°(.hyeah,)°
- 7 (4.0) ((P sits down with difficulty, D shuts the door,
walks to his seat, looks at P while P is sitting down))
- 8 P: vh#JOO:[:#mhhh]
vh#YEA:[:h#mhhh]
- 9 D: [↑Jäykästi kul]jeth.
Stiffly walk+you
[You're walki]ng ↑stiffly.
- 10 P: No repii totah (0.2) pakaraa ja jalakaa.
Well tear+3 that buttock and leg
Well I've got a tearing pain in that (0.2)buttock and leg.
- 11 D: (.hjo)
(.hye)
- 12 P: Soon v^äh^änaikaa ollu ja,
it+has a little+time been and
I've had it for a little whⁱle and,
- 13 (2.5) ((D pulls out the top two pages of the patient file,
glances at them briefly as if looking for something else,
and puts them aside))

- 14 P: koko ajan ninku menny pahempaan.
 all the time like has gone+it worse+towards
 all the time it's like got worse.
- 15 (0.2)
- 16 P: → (Vissii) issiasta on.
 Maybe sciatica+par is
 → (May) be it's sciatica³.
- 17 D: Onko sulla semm[osta vaivaa ollu ennen.=Mä
 have you that kind of trouble had before I
 Have you had th[at kind of trouble before.=I

After two points relevant for transition (lines 11 and 15) where the doctor does not take the turn the patient utters in line 16 ‘Maybe it’s sciatica.’ This is a diagnostic suggestion by which the patient steps into the medical territory, though he marks his suggestion as tentative with ‘maybe’. Thus the patient constructs himself as a participant who lacks exact knowledge on the diagnosis. This has an interesting resemblance to the ‘my side tellings’ introduced by Pomerantz. She refers to descriptions of limited access to the recipient’s activities as a ‘fishing’ device to gain more information. (Pomerantz 1980). According to Pomerantz (1984b, 152): ”If a speaker makes an assertion to a recipient who is knowledgeable on the matter, he or she may expect the recipient to confirm (or disconfirm) the assertion.” In a medical consultation, a tentative diagnostic suggestion by the patient would imply that on medical issues, the doctor is the knowledgeable participant. In the specific location, following two possible completions of the problem presentation where the doctor has not taken the turn, a diagnostic suggestion constructing the doctor as the knowledgeable participant could be a way of implying that an uptake by the doctor, approving as medically relevant the problem presented as the reason for the visit, would be relevant next.

In the example above, the doctor does take the turn, although his response does not address the present problem of the patient, but rather focuses on the patient’s diagnostic suggestion, asking about the occurrence of previous sciatica-related problems. In this way, rather than approving the patient’s problem as a medically relevant reason for the visit, the doctor implies that the patient should/may have some grounds for thinking that his present problem could be sciatica.

³ In Finnish a common lay way of calling the health problem in which the sciatica nerve is compressed by a vertebra is ‘sciatica’.

It has been suggested that presenting a diagnostic suggestion as a part of problem presentation may work to solve a situation in which the doctorability of the patient's problem may be in doubt (Heritage frth; Raevaara frth). In such cases it may be advantageous to the patient that the doctor takes up the presented problem as soon as possible. In example #2, such an orientation is not explicit. However, the patient's utterance in line 16 would seem to offer the turn to the doctor. As his utterance concerns the diagnosis of the problem, it would seem to invite the doctor to start examining the problem.

By stepping into the doctor's territory in completing their problem presentation, just before passing the turn to the doctor, the patients seem to work to provide maximal access to their problem and simultaneously fish for a quick uptake by the doctor. However, apparently, diagnostic utterances by the patients do not succeed any better than overt requests and questions in getting the doctor to start examining the patient.

5.1.1.3. Using medical terms or describing medical procedures

The following complaint (example #3) is both started and finished with a reference to the doctor's sphere of expertise. However, here we are specifically interested in the last TCU before the turn is passed to the doctor.

Example 3 (5A3 Varicose veins)

- 1 D: Ja minkähän:: tapas:ta [asiaa?,]
 And what kind of matter
 And what:: kin:d of [problem?]
- 2 P: [.hhh] No kuule ku täl:lää
 Well listen 'cause this+at
 [.hhh] Well y'know 'cause at thi:s
- 3 ikkää rupee jo suonik(h)ohj(h)ut v(h)ai(h)v(h)aa
 age starts already varicose veins to trouble
 age already varic(h)ose v(h)eins are starting to tr(h)ou(h)bl(h)e
 me
- 4 .hhhh [se on tuos vase]mmassa jalassa,
 it is that+in left+in foot+in
 .hhhh [it's in that le]ft foot,
- 5 D: [J~~a~~aaha,]
 [I see,]
- 6 (.)

In her initial gloss of the problem the patient makes a diagnostic suggestion⁴: ‘varicose veins are starting to trouble me’, and locates the problem by pointing at her left leg. However, she finishes the utterance with a continuing intonation at the end of line 4, which may indicate that she intends to go on with her complaint. Furthermore, at the end of her utterance she looks at her leg, not at the doctor, which also indicates that she is not orienting to this possible completion as a transition relevance place (cf. Goodwin 1981; Kendon 1990). After a micropause in line 6 she proceeds by telling a story on the development of the problem:

- 7 P: Se on nyt (.) #ö# oli (0.2) tässä kuule pari viikkoo
 it is now was here listen a couple of weeks
 It is now (.) #eh# it was (0.2) about y'know a couple of weeks
- 8 sitte ku mää sulle aikaa tilasin ni .nffh se oli
 ago when I you+to time was ordering so it was
 ago when I made the appointment with you so .nffh it was
- 9 oikeen oi:kukas se oli yhren vii:kon niin kiukkunen
 very chieky it was one+for week+for so angry
 really chie:ky it was so angry for one wee:k
- 10 että #m m# mulla otti rappusten nouseminen< (.)
 that me took stairs going up
 that #m m# going up the stairs really caused me< (.)
- 11 (to:siaan siis) se löi niinku lukkoon taikka sillai
 really like it struck like jammed or kind of
 (re:ally like) it got kind of jammed or in a kind of
- 12 ovelasti. .mth[h h h]hh Et sattuu aina ku ↓käveli ja
 tricky+how that it hurt always when one walked and
 tricky way..mth [h h h]hh That it hurt every time you ↓walked and
- 13 D: [>Joo.<]
 [>Yes.<]
- 14 P: tota (0.2) mnoh hhhh ↑nyt sitte se niinku pikkasen
 erm (0.2) well now then it kind of a little
 erm (0.2) mwell hhhh ↑now it then kind of got a little
- 15 ↑parani et nyt sil ei ↑taas oo >hirveetä vaivaa mutta
 got better that now it+with not again is terrible trouble but
 ↑better that now ↑again it doesn't cause >a terrible trouble but
- 16 aina välillä se oikuttelee niin että se< .hhh
 always from time to time it gets capricious so that it
 from time to time it gets capricious so that it< .hhh
- 17 tollai rappusia niinku noustessa niin siinä >se kaikista
 that way stairs like going up+while so there it of all
 like going like up the stairs so that's where >it can best

⁴ Raevara (frth) and Haakana (1999, 103) have analyzed the diagnostic suggestion in lines 2-3 in detail.

sounds like an expression which a doctor could use to ask about a patient's symptoms. Furthermore, instead of 'knee' she talks about 'knee-cap', an anatomic term which in lay conversations sounds unfit. (Cf. example #4 below where the patient uses only the word 'knee' to describe a problem at the same location.)

The patient's last TCU is constructed as a paraphrase of her complaint, indicating that she may be completing her turn (although the intonation is continuing). Also the micropause (line 23) following her utterance in line 22 indicates a space for the doctor to take the turn. The doctor does not take the turn immediately and the patient begins a new utterance, but when the doctor starts to speak the patient at once cuts off her turn. The doctor asks: 'Is that the pain that is the most explicit', referring to the patient's last utterance and starting to interview her on her problem. In this way the doctor treats the patient's preceding utterance as sufficient for starting the verbal examination.

A same kind of, but somewhat different, reference to the medical sphere by the patient is depicted in the following example #4. The patient presents a 'bad knee' as the reason for his visit. As the doctor asks for specification, the patient describes a difficulty in climbing up and down the stairs (lines 8-11). He completes his complaint with a description of past medical procedures concerning his knee (lines 12-13):

Example 4 (11A2 Sore knee)

- 1 D: Istukaa olkaa hyvä tähän tuoliin sitte.
 Sit+imp be+imp good this chair+in then
 Please sit down in this chair then.
- 2 (4.5)
- 3 D: No< mitä, h
 PRT what
 Well< what, h
- 4 P: Polvi, h on, on semmone huononlaa:tune vähä >taikka se<
 knee is is that kind of bad+quality a little or it
 The knee, h is, is kind of in a bad sha:pe a little >or it<
- 5 o:n ollu pitkään nyt on oikein paha ollu tommotten
 has been long+for now has very bad been about
 ha:s been for a long time now it has been very bad like
- 6 <kaks kuukautta>.
 two months
 <two months>.

7 D: Minkälaisista oireista se aiheuttaa.
 what+kind symptom it causes
 What kind of trouble does it cau[se].

8 P: [.hh No silläi
 PRT so
 [.hh Well so that

9 ettei oikein ninku ↓rappuja ei voi täällä jalalla
 not+3 really like stairs not can+3 this+with leg+with
 you can't really like go up the ↓stairs with this leg,

10 nousta, (.) .hhh eikä laskee. .hh Ja, alamäkkeä (.)
 go up (.) .hhh nor go down and downhill
 (.) .hhh nor down. .hh And, downhill (.)

11 ei voi, oikein k(h)unnolla kävellä eikä, ylöskä°päi°.
 Not can+3 really properly walk nor uphill
 you can't really pr(h)operly walk nor, up°hill°.

12 P: → .hhh (.) Tässähän on ollu hh sii(s) mutta nyt on ainakin
 here has been like but now is at least
 .hhh (.) There has been hh like but now it's been at least

13 → (0.2) kaksikymmentäviis vuotta ku tätä on punkteerat°tu°.
 Twenty-five years when this has been punctured
 (0.2) twenty-five years since this has been punctur°ed°.

14 (0.8) ((D is gazing at P))

15 P: mutta siit on (0.3) taitaa olla jo lähemmäs neljäkymmentä
 but it's been (0.3) I think it's already close to forty

16 vuotta ku se on (.) joskus mä oon ollu kaheksantoista
 years since it has (.) once I've been eighteen years

17 vanha ni se on ninkun, linksahtanut jotenkin tälläi.=
 old so it's like, twisted kind of like this.=

18 D: =siin o ollu vamma.
 =there has been an injury.

The patient starts his utterance in line 12 with the design 'there has been'. The utterance seems to be developing into naming the problem. However, he does not complete this utterance but chooses instead to mention a medical procedure, 'puncturing', which has occurred in the past. The ensuing long silence in line 14 indicates that the patient is offering the doctor a possibility to take the turn after this utterance.

The description approaches the doctor's area of expertise: by referring to a past medical procedure the patient steps off from the area of common everyday experience towards the medical sphere. Invoking a topic from the doctor's area of expertise provides the doctor a better access to the patient's problem and may thus make it easier for the doctor to take up the problem and start examining it. In this sense, stepping 'topically' on the doctor's territory renders the problem more available to the doctor.

Especially overt questions or diagnostic utterances by the patients, when used in closing the problem presentation, make it relevant or at least imply a relevancy for the doctor to take the turn. It is interesting, though, that doctors may by-pass even obvious efforts by the patients to shift the turn back to the doctor. A possible explanation for this would be that doctors reserve for themselves the right to decide the proper moment for activating their medical expertise, i.e., for shifting forward in consultation. When patients overtly try to control the course of consultation, e.g., a shift forward in consultation, by asking the doctor a question on the diagnosis or the treatment, the doctors may resist such efforts, resorting to their role as the medical authority, as the party which is and should be more knowledgeable both on the agenda and on the medical relevancy of the problem presented.

A more subtle way in which patients provide the doctor with availability to their problem is to design the last utterance as ‘understandable and available’ for ‘any recipient’. In these cases, rather than addressing the doctor’s medical expertise, patients resort to resources available in everyday conversation. They may elicit the recipient’s attention to a common focus of interest by pointing (5.1.2.), or they may translate the description of their sensation of pain into a more functional language by invoking a common everyday activity to describe it (5.1.3).

5.1.2. Availability by pointing (invoking a common focus of interest in situ)

In example #5 the patient has come to see the doctor for a back-ache. She starts her problem presentation in line 5 by glossing her problem in one sentence: ‘my back has been totally jammed since yesterday’, giving further details in each consecutive utterance. In lines 15-16 the patient stretches out to point at a particular location in her back. (See appendix for a key to the transcription symbols on gestures and gaze-direction.)

Example 5 (21A2 Jammed back)

1 D: °(Pitää kat-)°
 have+3 to lo- ((probably beginning of the word ‘look’))
 °(Have to lo-)°

2 (1.8) ((D takes a green leaflet and starts to write))

3 D: Minkästäk_i sinä oot liikk^oeellä^o,
 What+for you are move+on
 What brings you he^ore^o,

4 P: .hhhh ((P starts breathily, as in pain))

5 P: Mun selkä on ollu iha jumissa hhh eilisestä asti,
 my back has been totally jammed yesterday since
 My back's been totally jammed hhh since yesterday,

6 hhh (0.5)

7 P: Meni tos iltapäivällä< (0.5) ei tällä
 went+it there/just afternoon+in not this+with
 It happened there in the afternoon< (0.5) you couldn't

8 oikeen< (0.4) pystyny mitään tekee, hh
 really could anything do+3
 really< (0.4) do anything (with this), hh

9 (0.3)

10 P: Jvälillä tuntu et ei pysty seison
 from time to time feels+3 that not can+3 stand
 JFrom time to time it feels like [you] can't stand up

11 (ku) (0.2) polvet tärisee niin et men(ee) Jjalat
 cause knees shake so that go+PAS legs
 ('cause) (0.2) the knees are shaking so that the J legs

12 alta.=.hhh
 down+from
 don't hold.=.hhh

13 (0.4)

14 D: |Nj_o: [o: o,
 PRT
 /P bends right and starts a left-hand movement toward her back

15 P: → [Tuonne |ristiselän kohtaa |se on enemmän niinku
 there |small of the back at |it is more like
 [There in the |small of the back | it is more like
 ::::::::::: /P points to left side /P moves to point to

16 → täällä oikeella kohtaa.
 Here right+on at
 here on the right.
 right side of the back
 Pg:X--- [P from middle distance to Doctor]

17 D: Iha omia aikojaako se alko vai t-
 just on its own time+par+Q it started or
 Did it start just like that or d-

Prosodically, the patient's complaint is complete at the end of line 12. However, in between the three grammatical TCUs of her complaint, the patient leaves space (in lines 6 and 9) for the doctor to come in if necessary. Each TCU is constructed as an extreme-case formulation: the back is 'completely jammed', she 'couldn't do anything' with it, her knees 'are shaking so that her legs don't hold'. Temporally, the description proceeds from general to

particular: the patient starts in lines 5-6 by describing a general state which is problematic 'having a jammed back since yesterday'. In her second TCU in lines 7-8 the patient details the moment when the back got jammed 'it started in the afternoon' and in her last TCU in lines 10-12 with the utterance 'from time to time' she refers to an even more limited time within the continuum defined. She describes her difficulty in managing everyday activities first with a gloss: 'you couldn't really do anything with this' and then by mentioning a specific activity 'standing'⁵. (see section 5.2. on detailing).

As is common after extreme-case formulations (see section 5.3.), the doctor does not take the turn at this point, but gives a continuer in line 14. The patient continues her complaint by describing the detailed location of the problem: 'There in the small of the back it's more like here on the right'. Simultaneously she points at the locations mentioned. Pointing together with deictic expressions such as 'there' and 'here' is a way of eliciting the recipient's attention to a common focus of interest (Goodwin 1986). By pointing, the patient explicitly indicates the availability of the object of talk to her recipient. As the patient has at this point already presented her problem as complete, this action may work to invite the doctor to start the physical examination.

Just before completing her utterance (line 16) the patient turns to gaze at the doctor, still pointing at her back. This, together with the falling intonation, displays to the doctor that the patient has completed her utterance and is ready to pass the turn to the doctor (cf. Goodwin 1981, 32; Kendon 1990, 61-62). The doctor also interprets the patient's actions as passing the turn to her, as she takes it and starts interviewing the patient. However, she does not immediately start the physical examination, which the patient in her preceding turn may have implied as a relevant next action.

In the next example there are several occasions where the patient points at a location, simultaneously using an indexical expression and a locational descriptor. The doctor takes the turn only when the pointings are close to a possible completion point in the patient's turn of talk.

⁵ It may be worth noting that as in example #4 the patient does not directly refer to pain or ache at any point in her description of the problem. This may indicate a degree of troubles-resistance on the part of the patient (Heritage frth).

gazing at her. She finishes the utterance with an end intonation at the beginning of line 18. This time, at the completion of the patient's utterance, the doctor displays for the first time that he is about to take the turn: just after the patient has finished saying 'this hip on this side' the doctor opens his mouth as if starting to say something. However, as the patient takes an inbreath and continues her complaint, the doctor closes his mouth and remains silent.

It seems that when a pointing gesture combined with a deictic expression and a locational descriptor is made as supposedly the last element of the complaint (as in examples #5, and #6, line 18), it can be interpreted as a display of passing the turn back to the doctor. At least, pointing seems to serve as a way for the patients to render their problem more available to their recipient by making it the object of a shared focus of interest.

Another way of providing availability is to invoke a common everyday activity of which the speaker is deprived due to his ailment. In this way, the recipient is posited as a co-participant in the speaker's culture, as a co-member sharing the same view on 'what is to be considered normal or ordinary'.

5.1.3. Availability by invoking a common everyday activity

Let us reconsider example #6 above. Following her pointing gestures in lines 17-18, the patient continues her problem presentation with an extreme-case formulation 'and this feels like this leg wasn't even my own from time to time.' Shortly before this she has completed her narrative, and she finishes her utterance in line 19 with a falling intonation. Though this is a place relevant for transition, the doctor does not take the turn. In line 21 the patient continues her problem presentation:

as *tähän lonkkaan* 'into this hip'. Thus, it is difficult to say whether the patient is repairing her utterance, substituting *tähän* 'this' with *tän puolimmaisee* 'on this side', or whether she is first referring to the location independently 'here', then specifying her expression with *tän puolimmaisee* 'on this side'.

Example 7 (same as example #6, 11B3 Sore hip)

- 14 .hhh hh Lonkkani (.) on nii j:umalauta kipee.<.h Mun on
hip+Pos is so god damn sore my has
.hhh h My hip (.) is so g:od damn sore.<.h I've had an
- 15 särkeny,h viime talvest saakka,h siis hirveest, näit (.)
ached last winter since like terribly these
ache,h since last winter,h a really awful one, in these
- 16 e: pitkiä luita, .hv niinku koko jalkoi. mhht Ja tota:
long bones like whole legs+par and you know
eh: long bones, .hv like all over my legs. mhht And uh:
- 17 nyt se o sit siirtyny, (.) tähän, (.) tän puolimmaisee
now it has then moved this+into this side+into
now it's moved then, (.) into this(.) this hip on this
- 18 lonkkaa. .hhh Ja tää tuntuu niinku tää jalka ei ois
hip+into and this feels like this leg not was+cond
side. .hhh And this feels like this leg wasn't even
- 19 ollenkaa niinku omakaa välil.
At all like own+even from time to time
my own from time to time.
- 20 (.) ((D nods; looking at the patient))
- 21 P: → >Ja se: (.) rappusia men:nen tai tullen, (.) ylös alas .hh
and it stairs going or coming up down
>And the: (.) stairs com:ing or going, (.) up or down .hh
- 22 → ni polvi on ni|in ettei taho ottaa eh päälleen.
Then knee is such that+not want+3 take on
the knee's li|ke you can't put your weight on it.
/D suddenly straightens his back
- 23 .h{hh
- 24 D: [Se on siis liikearka.
It is then motion+sensitive
[It is sensitive to motion then.

After the extreme-case formulation in lines 18-19, and the doctor passing his chance to take the turn in line 20, the patient describes the everyday situation of going up and down the stairs where she has particular difficulties with her knee. Compared to her last TCU before the initial completion: 'And this feels like this leg wasn't even my own from time to time' the latter utterance in lines 21-22 is of a very different mode. Instead of describing an exceptional sensation, of losing control of her leg, it depicts a common everyday situation and the inability to manage such a situation. With her utterance the patient invokes a commonly shared and ordinary sphere of activity and depicts herself as deprived of it, she unravels her problem through a negative observation on her diminished level of activity compared to what is known to be the common standard.

Extract #8 is another example of such a practice:

Example 8 (same as #4, 11A2 Sore knee)

- 3 D: No< mitäs, h
PRT what
Well< what, h
- 4 P: Polvi,h on, on semmone huononlaa:tune vähä >taikka se<
knee is is that kind of bad+quality a little or it
The knee,h is, is kind of in a bad sha:pe a little >or it<
- 5 o:n ollu pitkään nyt on oikein paha ollu tommotten
has been long+for now has very bad been about
ha:s been for a long time now it has been very bad like
- 6 <kaks kuukautta>.
two months
<two months>.
- 7 D: Minkälaista oiretta se aiheutta[a].
what+kind symptom it causes
What kind of trouble does it cau[se].
- 8 P: → [.hh No silläi
PRT so
[.hh Well so that
- 9 → ettei oikein ninku ↓rappuja ei voi tällä jalalla
not+3 really like stairs not can+3 this+with leg+with
you can't really like go up the ↓stairs with this leg,
- 10 → nousta, (.) .hhh eikä laskee. .hh Ja, alamäkkee (.)
go up nor go down and downhill
(.) .hhh nor down. .hh And, downhill (.)
- 11 → ei voi, oikein k(h)unnolla kävellä eikä, ylöskä°päi°.
Not can+3 really properly walk nor uphill
you can't really pr(h)operly walk nor, up°hill°.

The doctor's request for clarification in line 7 shows that he considers the patient's initial complaint (lines 3-6) insufficient for moving forward in the consultation. As an answer to the doctor's request the patient makes a negative observation on not being able to climb up and down the stairs and up- and downhill (lines 9-11). Compared to alternative descriptions available after the doctor's question 'What kind of trouble does it cause', such as 'it hurts at night' which the patient uses later in the consultation, this description is quite specific. Whereas 'feeling pain' is usually considered an exceptional state, the activities the patient describes in example #8 form a part of normal everyday behavior. By describing his problem with the deprivation from an activity which people often have to perform several times a day, the patient designs his utterance for the recipient as a member of a common culture. With his negative observation the patient invokes an ordinary activity shared

by most people in their daily life, including the doctor. By invoking this common activity environment the patient simultaneously provides the doctor with a better access to his experience.

5.2. Detailing

Detailing, i.e., giving extensive, specific descriptions of one's own procedures (Jefferson 1985; Drew 1998), is yet another prominent way of completing problem presentations. Both Jefferson and Drew talk about detailing in the context of defending one's case. In the context of problem presentation in primary care consultations, detailing often follows a sequence where the patient, having introduced her problem, has given space for the doctor to take the turn, but the doctor has remained silent. Thus, extensive detailing may be used to convince the recipient that the question is about real trouble and not transgression.

Detailing as the last element before possible completion was mainly found when patients started their problem presentations with a title-like gloss summing up their main complaint. The extent to which the patients volunteered to specify the general complaint varied: some proceeded in the same intonational unit to detail their problem, whereas others waited to see whether and how the doctor would respond before continuing their problem presentation (cf. Jefferson 1985). In example #9 the patient continues to give details on her concern immediately after her initial gloss of the complaint. In example #10 the patient waits for the doctor's reaction before continuing. However, also in #9, when the patient reaches a possible completion of her complaint and the doctor remains silent, the patient continues by detailing her concern further. In both examples the patients treat the doctors' actions as making a further detailing of their ailment relevant.

Example 9 (continuation of example #7, 11B3 Sore hip)

- 18 lonkkaa. .hhh Ja tää tuntuu niinku tää jalka ei ois
hip+into and this feels like this leg not was+cond
side. .hhh And this feels like this leg wasn't even
- 19 ollenkaa niinku omakaa välil.
At all like own+even from time to time
my own from time to time.

Example 10 (33B3 Sore knee)

- 9 D: Kerros.=
Tell me.=
- 10 P: =.h (mull on) polvi (kai) pari päivää ollu kauheen
I have knee maybe a couple days been terribly
=.h (I have) my knee has been (maybe) a couple of days
- 11 kipee.
sore.
- 12 (.)
- 13 D: Polvi.
knee
Your knee.
- 14 P: → Polvi tästä sivusta (e)t se o
knee here side that it is
My knee here on the side (t)hat it is
- 15 (.) ((D glances at P's knee))
- 16 P: → Vähäki kävelee ni [sattuu °tähän°.]
little walk+0 so hurts here
You walk even a little so [it hurts °over here°.]
- 17 D: [Mitä sää oot tehny sille.]
[What have you done to it.]

As in example #9, here the patient starts his problem presentation with a gloss summing up his concern (lines 10-11). Here, however, the patient leaves it to the doctor to decide whether more detailing is needed. The patient's initial complaint is complete in line 11. There follows a short silence after which the doctor reproduces an element in the patient's complaint: 'knee'. This repeat is treated by the patient as making more problem presentation relevant. He confirms the doctor's understanding in line 14 and continues by specifying the location of his ailment. Once the patient has added the description of a difficulty in performing common everyday activities (you walk even a little so), the doctor takes the turn and starts the verbal examination (line 17).

By detailing, the patients provide further opportunities for the doctor for taking up the problem. The details which they give on their ailment serve as new, more specific elements or aspects of their problem, which add to the stock of alternatives from which the doctor can draw when topicalizing the problem. Detailing is a practice which embodies an effort towards the co-construction of the shift forward on the part of the patient.⁹ This also became evident in that,

⁹ I am grateful to John Heritage for directing my attention to this possibility.

after detailing, doctors seemed to have no difficulty in taking the turn and moving forward in the consultation.

Detailing was often used by patients after the doctors had passed their opportunity to take the turn at the first possible completion of their problem presentation. In example #9, for example, detailing followed an utterance which had been completed with an escalation of the complaint. Such an escalation was a common way of finishing problem presentations, specifically when they were given in a narrative form. In these cases providing availability to the recipient was not treated as an important aspect. Rather, the patient's experience of the trouble in question was described as somehow 'unique'.

5.3. Escalating the complaint

In the data, the patients very often finished their initial complaint with extreme-case formulations (25 cases out of 66). Extreme-case formulations were also used in other locations of the complaint, but the most regularly at a possible completion of the problem presentation. By extreme-case formulations I mean designs which portray some aspect of the situation described as extreme, as referring to the 'totality' or 'inclusiveness' of the phenomenon in question, for example (in italics): 'I think the problem is in my heart as for the last two weeks *my life has been awful*. Or 'My chest was X-rayed on Monday and they didn't find anything and, but it's just sore still that I feel *as if my entire side were ripping off* when I cough.' According to Pomerantz (1986, 228) extreme-case formulations may be used for instance "to legitimize a complaint and portray the complainable situation as worthy of the complaint". Thus, in the specific context of presenting a problem to the doctor they can be perceived as means of constructing the patient's problem or case as something which cannot be dismissed as minor, of constructing it as intolerable, i.e., as 'real trouble' (cf. Jefferson 1988; Jefferson and Lee 1992).

Another way of escalating the complaint, coming close to extreme-case formulations, was to upgrade the intensity of the problem described. For example, patients could start their problem presentation by a description such as 'the knee is kind of in a bad shape a little' and finish with 'now it has been really bad like two months.' Both extreme-case formulations and upgrades of the intensity of the problem focused on 'inner' experiences of the patient,

describing the intensity of pain or worry as inherently ‘subjective’, as it reveals itself to the speaker/feeler him- or herself (Sacks 1992, Vol 2, 404-405). Almost half of the patients posited an utterance of this kind as the last one preceding the first possible completion of the complaint.

In example #11 the first time when the patient clearly leaves space for the doctor to take the turn is in line 19¹⁰:

Example 11 (11B3 Sore hip)

- 8 (2.0) ((P & D enter the picture; P walks to the chair breathing heavily; P moves the chair in a different angle))
- 9 D: Pidetään se tuoli, | v(h) t(h)ossa [fkuitenki] (on)ɛ.
 Let's that chair | there anyway is
 Let's keep the chair| v(h) t(h)here [fanyway] (is)ɛ
 / ((D moves the chair back
 to where it was before))
- 10 P: [A:ha<]
 [I see<]
- 11 P: No hyvä<.
 well good
 Alright<.
- 12 D: ɛTekee mieli siirtää °si[tä s'tte,°ɛ] (.) [vähän.]
 would like move it then a little
 ɛ[you] would like to move °i[t then,°ɛ] (.) [a little.]
- 13 P: [Okei<,] [krhh]
 [Okay<,] [krhh]
- 14 .hhh hh Lonkkani (.)on nii j:umalauta kipee.<.h Mun on
 hip+my is so god damn sore my has
 .hhh h My hip (.) is so g:od damn sore.<.h I've had an
- 15 särkeny,h viime talvest saakka,h siis hirveest, näit (.)
 ached last winter since like terribly these
 ache,h since last winter,h a really awful one, in these
- 16 e: pitkiä luita, .hv niinku koko jalkoi. mhht Ja tota:
 long bones like whole legs and you know
 eh: long bones, .hv like all over my legs. mhht And uh:
- 17 nyt se o sit siirtyny, (.) tähän, (.) tän puolimmaisee
 now it has then moved this+into this side+into
 now it's moved then, (.) into this, (.) this hip on this

¹⁰ There are possible completion points in lines 14, and 18, but the patient rapidly goes on with her turn, not stopping to wait for the doctor's response.

- 18 → lonkkaa. .hhh Ja tää tuntuu niinku tää jalka ei ois
hip+into and this feels like this leg not was
side. .hhh And this feels like this leg wasn't even
- 19 → ollenkaa niinku omakaa välil.
At all like own+even from time to time
my own at all from time to time.
- 20 (.) ((D nods; still looking at the patient))
- 21 P: >Ja se: (.) rappusia men:nen tai tullen, (.) ylös alas .hh
and it stairs going or coming up down
>And the: (.) stairs com:ing or going, (.) up or down .hh
- 22 ni polvi on ni|in ettei taho ottaa eh päälleen.
Then knee is such that+not want+3 take on
the knee's li|ke you can't put your weight on it.
/((D suddenly straightens his back))

In her first utterance in line 14 ‘My hip is so god damn sore.’ the patient states the existence of a severe pain and locates it in her hip. She takes a quick inbreath and goes on with her complaint by specifying the duration of the ache (since last winter), re-asserting with different words the severe nature of the pain (a really awful one) and describing a new location for the pain: ‘in these long bones, .hv like all over my legs.’ The increment ‘like all over my legs’ is already an extreme-case formulation extending the area of the problem. However, the patient does not stop yet but breathes in, continuing her complaint. In her next utterance in lines 17-18 she describes a recent development with regard to the location of the pain: ‘And now it’s moved then, into this, this hip on this side.’ She concludes by describing the sensation in her other leg. Her utterance: ‘And this feels like this leg wasn’t even my own at all from time to time.’ is an extreme-case formulation and, furthermore, a negative observation depicting a situation which is out of ordinary. Although she is referring to a temporary situation ‘from time to time’, her turn describes a ‘doubly’ extreme situation: the leg does not ‘even’ fulfill minimal expectations, and it does not fulfill them ‘at all’. Furthermore, with her last extreme-case formulation in lines 18-19, the patient brings up a new dimension of her problem: that of losing control of her body. With such a description of her problem she explicitly refers to her situation as intolerable, as something which she is unable to manage by herself.

At the end of line 19 there is a falling intonation followed by a micro-pause, indicating that the patient has reached a possible completion of her utterance. During the silence in line 20 the doctor does not take the turn, but gives a neutral acknowledgment to the patient by nodding. Facing no uptake from the doctor at the closing of her narrative, the patient continues by adding another

element to her problem presentation (line 21). It is noteworthy that she does not pursue the line of describing her unique experiences, but presents a new symptom and invokes a common sphere of activity, thus providing the doctor with better access to her ailment (see section 5.1.3.). In example #12, the patient uses less dramatic language in describing his ailment. However, compared with the beginning of the complaint, the completing utterance depicts his situation as more severe.

Example 12 (11A2 Sore knee)

- 1 D: Istukaa olkaa hyvä tähän tuoliin sitte.
Sit+imp be+imp good this chair+in then
Please sit down in this chair then.
- 2 (4.5)
- 3 D: No< mitä, h
PRT what
Well< what, h
- 4 P: Polvi, h on, on semmone huononlaa:tune vähä >taikka se<
knee is is that kind of bad+quality a little or it
The knee, h is, is kind of in a bad sha:pe a little >or it<
- 5 → o:n ollu pitkään nyt on oikein paha ollu tommotten
has been long+for now has very bad been about
ha:s been for a long time now it has been very bad like
- 6 → <kaks kuukautta>.
two months
<two months>.
- 7 D: Minkälaiista oiretta se aiheutta[a].
What kind symptom it causes
What kind of trouble does it cau[se
- 8 P: [.hh No silläi ettei oikein
well so that+not really
[.hh well so that you can't

The patient starts his complaint by a general description of the state of his knee: he locates the problem in his knee and describes it as being in a bad shape. He further modifies the assessment with a diminutive expression 'a little', thus at first constructing his problem as not-so-serious. By choosing the expression 'huononlaatuine' (of bad quality) he implies there may be something 'essentially' wrong with his knee. However, he repairs this implication rushing with '>or it<' to the next TCU to limit the duration of the problem to an undefined but yet confined 'long time'.

In his last TCU 'now it has been very bad like <two months>.' the patient gives a specific duration of approximately two months during which his continuous

problem has been especially severe. He upgrades the intensity of his problem from 'being in a bad shape a little' to 'having been very bad' recently. Thus he finishes with a description of his problem as very severe.

He lengthens the last two words <two months> indicating he may be completing his turn (see e.g. Schegloff 1998). He also finishes his last TCU with a closure-implicative falling intonation. In addition, his arrival at the present situation with 'now' indicates that he may have reached the completion of his turn here. The doctor interprets the patient's turn as complete and takes the turn. However, he does not yet proceed to the verbal examination of the patient, but asks: 'What kind of trouble does it cause'. With this utterance the doctor requests information on how the patient is affected by his bad knee. He treats the patient's preceding utterance as insufficient, as lacking information on the actual 'symptoms' (see the gloss in line 7) which the problem causes for the patient. The doctor treats the patient's utterance as a 'naming of the problem', a gloss to be unpackaged (Jefferson 1985) before he is ready to move forward in the consultation. The doctor's question indicates that describing something as 'very bad' may not as such be transparent to its recipient, but needs further specification.

Frequently, after the patients finished their initial complaint with an extreme-case formulation or by describing an intensification of their suffering the doctors either neutrally acknowledged that they had heard the patient (by nodding or pronouncing 'Yes.'), remained silent, or asked for a new description. In the few consultations where the doctors started the verbal examination immediately after the patients' extreme-case formulations they ignored the patients' last TCU and focused on earlier issues in the patients' complaints. This is illustrated in example #13 below. The patient has been telling the doctor an extensive story of his previous cold for which he had been given sick-leave (see chapter 4, example #6). In lines 45-48 he answers the doctor's question (lines 34, 36) which temporarily interrupts his story, after which he returns to his story in the middle of line 48:

Example 13 (35A4 Dizziness):

34 D: Mikä sull' o. (.) Saija ei oo tohon kirjottanu muttah,
what you have Fname not has there written but
What's wrong with you. (.) Saija hasn't written it down but,

35 (0.5)

36 D: .hhh[h pahin vajiva sillon oli.
worst problem then was
.hhh[h was your]worst problem then.

37 P: [Nyt tota:,]
now well
[Now well:,]

38 P: No: (.) sillon oli oikeestaan toi: (.) kuume ja: sitte
well then was actually that fever and then
Well: (.) then it was actually tha:t (.) fever an:d then

39 särki paikkoja ja #ö# ja (.) kauhee yskä ja (.) kurkku
ached (body)parts and and terrible cough and throat
my body was aching and #e# and (.) terrible cough and (.) a sore

40 kip[ee] ja.
sore and
thr[oa]t and.

41 D: [Mm.]

42 (0.5)

43 P: >Sillon oli< kaikenmoista mutta tota,
then were all+sorts but erm
>Then I had< all kinds of problems but erm,

44 (0.3)

45 P: Mutta se kurkkukipu ny on menny ohitte (ja) nuhaa tietysti
but that throat-ache now has gone past and head-cold of course
But my throat is not sore any more (and) my nose is still running

46 vielä on ja,
still is and
of course and,

47 (0.7) ((P inhales))

48 P: → tuommosta kröhinää ja tuo- mutta nyt rupes sitte tänään
that+kind+of wheezing and that but now started then today
that kind of wheezing and tha- but now then today I started to

49 → nii huimaan että (.) sitte heippaa semmosta,
so feeling+dizzy that then staggers+0 that+kind+of
feel so dizzy that (.) I lose my balance kind of,

50 (1.0)

51 P: → Ihan sillai ähhh
just/quite/completely like
Just like ehhh

52 D: Joo.
Yeah.

53 (0.5)

54 P: → Sillai sinne sun tänne e[ttä.
Like to and fro that
Like staggering to and fro t[hat.

55 D: [Onks lämpöö ny viä ollu.
has temperature now still been
[Have you still been running a
temperature.

In lines 38-40 and 43 the patient answers the doctor's question which has temporarily interrupted his story. After this he returns to the present, cuts off his utterance and continues his story, starting in the middle of line 48. In his last TCU in lines 48-54 the patient presents a new symptom, dizziness, formulating it as extreme by describing a severe loss of control over his body: 'I lose my balance - just like staggering to and fro'. The description of a loss of control as such refers to an extreme state of being. Further, the patient modifies his description of 'staggering' by *ihan* (just/quite/completely) which refers to the inclusiveness of the state. The doctor takes the turn in line 55. However, he does not address the new symptom presented by the patient as last in his complaint, but returns to the patient's previous symptoms, asking whether he has still been running a temperature. This question can be traced back to line 38 where the patient said that on his last visit he had temperature, a cough and a sore throat. After this he mentions in lines 45 and 48 that the throat-ache has passed and the cough still persists, but does not mention the temperature. This may prompt the doctor to topicalize this particular symptom. However, what is noteworthy here is that when topicalizing the patient's previous symptoms the doctor simultaneously ignores the new symptom presented by the patient.

Patients commonly include some sort of escalation of their complaint as the last element of their problem presentation. This seems to be particularly common in the closing of narratives. As these escalated utterances precede a possible completion point of the patient's utterance, a response of some kind seems to be expected from the doctor. However, unlike in ordinary conversation, the response expected does not seem to be affiliation. Although the doctors pass the patient's extreme-case formulations with neutral acknowledgments or by topicalizing some other aspect of the preceding complaint, the patients do not pursue an affiliation¹¹. Instead, following the doctor's missing response, patients proceed with their problem presentation with a different type of utterance, for example by detailing the circumstances in which the problem is

¹¹ I am grateful to Anssi Peräkylä for this observation.

most prominent. Thus, the response which the patients seem to pursue is a shift forward in the consultation, an uptake by the doctor, which would justify their decision to seek medical help. By portraying their situation as one of losing control, as helpless, the patients could be constructing their turn of talk as a plea for service, a request for the doctor to provide help for their problem.

5.4. Conclusion

Common practices which the patients used to finish their problem presentation were: escalating the complaint with extreme-case formulations or upgrades of the intensity of their problem, detailing, and providing availability by pointing, by invoking a common sphere of activity, or by evoking the doctor's medical expertise. These practices were almost equally represented as the last element before the first, second, and third possible completion of the patient's problem presentation. In the few consultations where the uptake was delayed over the third possible completion, stepping into the doctor's territory became more frequent.

The practices are partly overlapping and partly seem even contrastive with each other. Detailing and pointing are practices which can be combined with both escalation of the complaint and excursions into the doctor's territory. The two latter practices, on the other hand, are opposite ends of a continuum, one of them being a characterization of the trouble concentrating on the unique experience of the speaker, and the other end a characterization providing 'the best possible availability to the recipient'. However, these practices may be used consecutively in the same problem presentation, and not necessarily in the supposedly logical order of proceeding from less towards more accessible. Rather, each type of turn-design is frequently used in the same sequential place, as the last element of the problem presentation. Thus, each of these practices seem to be treated by the patients as one possibly appropriate way of completing the problem presentation and passing the turn to the doctor, as an exit-device from the phase of problem presentation.

In terms of availability to the recipient, the escalation of the complaint (extreme-case formulations and upgrades of the intensity of the problem) constitutes a special case. Whereas pointing, invoking a common sphere of activity, and stepping into the doctor's territory, are all designs providing availability to the problem or to the patient's experience, extreme-case

formulations and upgrading seem to concentrate on the subjective and unavailable side of the problem. When talking about 'I'm feeling ill and weak all the time' or 'now it's (pain) so tearing already that it almost feels like my lungs are bursting' the patients are defining their problem through their own experience, referring to an unshared world of experience, describing their situation as exceptional.

These utterances resemble troubles-telling as it could occur in an ordinary conversation. The focus there would lie on the troubles-teller and his experiences, the activity going on would be 'sharing experiences' or from the point of view of the troubles-teller, 'getting empathy and understanding'. The relevant response from the recipient in such a context would be affiliation. (Jefferson & Lee 1992).

Jefferson and Lee (1992) draw attention to the different characteristics of troubles-telling in service encounters, such as medical consultation. There, the main task is to find a solution to the patient's problem, not to seek intimacy by affiliating with the troubles-teller. More than the person with the trouble, the focus is on 'the problem and its properties'.

Detailing, pointing and using medical language tell more about the problem and its properties than about the troubles-teller and his experiences. With these practices patients posit the problem in exact terms by pointing at its location, by describing in detail the situations in which it appears, or by treating it as belonging to a specific diagnostically defined class of diseases. By bringing the problem available to the doctor the patients work to achieve a suitable environment for the doctor to start examining it. Although doctors do not in every case start to examine the patient's problem as medically relevant, at least they have been provided with an environment where such an activity would be relevant. These practices provide for co-constructing the shift to next phase.

Escalation of the complaint, on the other hand, would at first glance seem to make an affiliative or empathetic response relevant. Such an affiliation by the doctors does not occur, though sometimes doctors may display that they have understood the patient. Usually, after a description of an intense or unique experience of disorder, the doctors remain silent, or if they do start to examine the patient's problem, they topicalize some earlier element of the problem

presentation. This indicates the doctors' orientation to the medical consultation as primarily a service encounter.

But what about the patients' orientation in cases where they finish their problem presentation by escalating their complaint? It is, of course, possible that by passing the turn to the doctor with an extreme-case formulation or an upgrade of the intensity of their problem as the last element, they try to do troubles-telling as in an ordinary conversation and look for empathy on the part of the doctor. However, they do not work very hard for such an alternative. They do not pursue the missing affiliation from the doctors, but continue their problem presentation, for instance, by detailing the properties of the problem, making it more available to the doctor. They do not treat the doctor's missing affiliation as accountable or even dispreferred in any way. Thus, it would seem that affiliation is not the expected response to their intensified description of trouble. Rather, their tendency to portray the situation as specifically intense just before passing the turn to the doctor could be interpreted in the light of obligations and rights attached to the sick role in industrial countries (Parsons 1951; Heritage *frth*). The escalation could be perceived as accounting for the seeking of medical help for the problem in question. Extreme- case formulations describing a loss of control, for instance, would indicate that the patients cannot help their condition, and would enhance the implication that they should be taken care of. Thus, using extreme- case formulations to finish a problem presentation would connect directly with the issue of doctorability. Further, such displays of helplessness would in themselves embody a request for service, a plea for the doctor to respond to the request and start examining what is wrong with the patient. Thus, an escalation of the complaint would also point to their constructing the activity going on as seeking help rather than as troubles-telling.

In terms of controlling the course of conversation the different practices embody different sorts of efforts at achieving control. Invoking the doctor's medical expertise by asking a question from the doctor constitutes an explicit suggestion for the doctor to start examining the problem, almost an effort to 'force' the doctor to accept the problem on the agenda. However, as we have seen in section 5.1., such an explicit suggestion to move forward in the consultation is not always efficient. Doctors have ways of going round such requests. Pointing, as a way of drawing attention to a common focus of interest situated in the patient's body, is also an act of control, in suggesting a location

where the doctor should look. This practice, however, does not make relevant any spoken next turn by the doctor, but expects a shift of gaze to the defined direction by the recipient. Usually, after pointing, doctors also bring their gaze to the intended locus of interest. An escalation of the complaint may also be seen as a way of offering one's problem for the doctor to be examined, as an exit-device from the phase of problem presentation. It does not make relevant any specific second action in this context, but as an implicit request for help it passes the turn and the initiative to the doctor.

Despite their differences, all these procedures embody ways in which the patients construct the activity going on in medical consultation as seeking help rather than troubles-telling. Thus, at this location of the consultation the patients seem not so much to work to describe their troubles extensively, but to justify to the doctor their need for medical help and to get the doctor to find a solution to their problem. Thus, claims according to which doctors should allow as much space as possible for the patient at this slot in the consultation, may require reconsideration (cf. Heritage frth). By looking at the patients' orientations in the situation it seems that a quick uptake by the doctor may not be treated so much as an interruption, but as a relevant response to the patient's problem presentation. Especially when patients evoke the doctor's medical expertise in utterances preceding the possible completion of their problem presentation, they clearly expect the doctor to start examining their problem.

The following example illustrates a case where the patient has to resort to all the practices presented before the doctor agrees to take up her problem as doctorable and moves forward in the consultation.

Example 14 (19A1 sore leg)

- 1 D: Minkäs takia sinä olet liikkeel[äh.
What for you are moving
What brings you he[re.
- 2 P: [(Noh)
[(Well)
- 3 (0.4)
- 4 P: Tän saman va[ivan
This same pr[oblem
- 5 D: [>vaivan< (t-)
[>problem< (t-)
- 6 (0.3)

7 P: Ni[i,
Ri[ght,
8 D: [.nhhh
9 (0.5)

The patient answers the doctor's opening question minimally. By referring to her problem with the deictic expression 'this same' without naming the problem, she indicates that she expects the doctor to know her problem already. Because of the doctor's overlapping talk it is difficult to hear the patient's intonation at the end of line 4. However, from what follows it becomes clear that the patient does not volunteer any more information. In line 7 she treats the doctor's turn in line 5 as a request for confirmation, and confirms the doctor's understanding of her own turn with *Nii*. Although her intonation may indicate that she is going to continue her turn, the following silence of 0.5 seconds speaks for the patient having reached the conclusion of her complaint. In addition, as the doctor inhales in line 8, the patient may assume that the doctor will start talking. Furthermore, as she has already indicated the doctor should know what she is talking about, she evidently considers her complaint complete and sufficient for moving forward in the consultation at this point. However, the doctor does not start examining the problem verbally or physically. Consequently, in line 10 the patient continues her problem presentation:

10 P: Tää on nyt kolme yötä särkeny ihan tosissaan.=Että
this has now three nights ached really severely that
This has now been aching three nights really severely.=That
11 viime yönäki puol kolmelta mää hain (0.2) jääpussi(a)
last night half threee I got ice-bag
even last night at half past two I had to get (0.2) an ice-bag
12 siihe. (.hhh)
it+for
for it. (.hhh)
13 D: Joo,=
Yes,=

In lines 10-12 the patient describes a severe ache, making her point with details and specifications: her leg has been aching for three nights, and the ache has been so severe that she had to get up in the middle of the night to try a home-remedy. The utterance in lines 11-12 is given as an illustration to the preceding utterance in line 10. It provides evidence of the intensity of ache just described by the patient. Thus, the detailing which the patient engages in

could be interpreted as a way of convincing the doctor of the existence of a real trouble.

However, the doctor passes her chance to take the turn in line 13, and the patient adds a new element to her description:

14 P: =Se on tää a- (.) tää (0.4) alue (.) °tämä näin.°
it is this this area this here
=It is this a- (.) this (0.4) area (.) °this over here.°

15 D: Näin on särkee nyt t[aa]s sitte.
So is aches now again then
Yes it is aching now a[ga]in then.

16 P: [Nii:.
[Ye:s.

In line 14 the patient says: ‘It is this a- (.) this (0.4) area (.) °this over here.°’. Simultaneously she points at her leg. By pointing the patient specifies the location of the problem, but also brings it more available to her recipient by referring to a common sphere of perception.

However, in line 15, instead of starting to examine the location pointed at, the doctor indicates that she has recognized the location by saying ‘Yes’, and claims that she has understood the patient’s meaning by repeating the patient’s description of her leg aching. With ‘again’ she also indicates that she has previous knowledge about the problem. However, though she acknowledges the patient’s problem and shows that she understands what the patient is talking about, she does not take it up as an object of examination yet. Starting in line 17, the patient goes on with her problem presentation:

17 P: Että,? .hh .h mää itte aatteli että siinon niinku
that I myself thought that there+is like
That,? .hh .h I thought myself that there’s like

18 samallaiset oireet ku sillon kun ne anto mulle tään
similar symptoms as then when they gave me this
similar symptoms as then when they gave me this

19 sieltä Salmesta.=>Kun mä siel Salmessa< olin ni,
there+from Loc.name as I there Loc.name was so
in Salmi¹². =>As I was in Salmi< so,

¹² A local psychiatric hospital.

44 P: Että mitä määhän oikeen [ruppeis]in tekeen.
 That what I this really started to do
 That what should I really[do with]h this.

45 D: [()]

46 D: Mm:m.

47 (0,8)

The turn-initial 'that' marks this utterance as a paraphrase of her preceding problem presentation. Even this direct request does not succeed in eliciting a response from the doctor. There follows a section where the patient mentions a new symptom and the doctor acknowledges it but does not start examination. After this the patient proceeds in line 62 by suggesting a possible treatment herself:

61 (0,4)

62 P: Pitäskö mu(n olla) täällä ↓vallan rauhottua täällä
 should I be this+with completely start to rest this+with
 Should I (be) with this ↓totally calm it down with this

63 jalalla vai:,
 leg or:,

64 (0,6)

65 D: .hhh No: (0,2) kyllä sitä pitäs hhh voida< (0,2)
 .hhh Well: (0.2) one should really be hhh able to< (0.2)

66 käyttää:kin: eli et#tä:::# .hhh jos: hh (0,7) se on:
 also use it I mean th#a:::t# .hhh if: hh (0.7) it is:

((the doctor continues her instruction))

The patient's suggestion is presented as a question to the doctor. It invokes the doctor's position as a medical expert by proposing that she has information concerning the treatment in question. Finally, after a silence of (0.6) seconds the doctor answers. Through answering the patient's question on the appropriate treatment for her leg problem, the doctor finally also takes it up as a doctorable reason for the visit, as by answering she indicates that there is a problem which should be treated.

The example illustrates a case where the patient uses a multitude of exit devices at her disposal in order to imply to the doctor that her problem presentation is complete and that she is ready to move forward in the consultation, but where the patient's implications are not taken up by the doctor. This leads to a prolongation of the phase, and simultaneously to a

postponement of the validation of the patient's problem as doctorable, as requiring medical help¹³.

We have seen that patients have at their disposal various practices through which they can try to exit the phase of problem presentation and suggest a shift forward to the doctor. Often (though not always) the doctor's next turn is made as a response to such a suggestion. Consequently, rather than being unilaterally managed by the doctor (as Beckamn & Frankel have suggested), the shift from problem presentation to verbal or physical examination tends to be a co-construction by both the patient and the doctor.

This point will be further highlighted in the following chapter, where we will concentrate more closely on the doctors' activities. The focus will lie on the different ways in which the doctors perform the uptakes and which they employ to take the turn at the possible completion of the patient's problem presentation.

¹³ This is not to suggest that the doctor is mistreating the patient in any way. Obviously this particular case is especially difficult, the patient has continuing, long-term problems, for which a remedy has not been found so far. Given the fact that the patient mentions treatment in a mental hospital ('Salmi', line 19) her problems could also partly be psycho-somatic.

6. RECEIVING THE PROBLEM PRESENTATIONS: DIFFERENT WAYS OF CONTROLLING THE COURSE OF CONSULTATION

Chapter 4 focused on the ways in which the patients finish their problem presentations and pass the turn back to the doctor. In this chapter I will study the ways in which the doctors receive the patients' problem presentations and the ways in which they proceed towards verbal or physical examination. The focus will lie on the ways in which doctors control this shift forward in consultation.

Previous studies have suggested that doctors control the course of consultation by interrupting and questioning the patient (Beckman and Frankel 1984; West 1984, 62; Fisher 1991). Another technique mentioned is resorting to doctors' expert knowledge instead of patients' experiences in interviewing the patient (Korsch and Negrete 1972; Mishler 1984; Byrne and Long 1984 (1976)). Beckman and Frankel have pointed out that interrupting and questioning may lead to loss of valuable details which the patients would be able to produce if allowed to describe their problems without interference by the doctor. One such patient-friendly technique would be to remain silent and wait for the patient to continue. Mishler, on the other hand, points out that doctors tend to steer the conversation away from social concerns towards medical issues, towards the area of the doctor's expertise, thus potentially preventing the patients from expressing their own concerns and understandings of their illnesses.

The descriptions of doctors interrupting and questioning the patient or using medical language have rapidly spread from their original research contexts to medical training. During this process, coinciding with recent developments where the patient is increasingly depicted as a consumer actively taking part in his healing process, these practices of the doctors have come to be seen as something of an antithesis to the desired empathic mode of response and cooperative relationship with the patient (cf. Clark and Mishler 1992).

These practices criticized in earlier research do not, however, show up very much in the Finnish data. Interrupting seems exceedingly rare, and questioning includes several different levels of obligation which has not been attended to in earlier studies. Furthermore, as we have seen in chapter 5, steering the conversation towards medical issues is not solely the doctor's

privilege, as also the patients may use medical language for specific purposes (cf. Silverman 1987).

In this chapter, I will study these practices of the doctors in the specific sequential place of managing the shift from receiving the problem presentation to interviewing or examining the patient. I will also examine how these 'next turns' by the doctors are treated in the patients' following turns of talk. In this way, I hope to provide a description of the different ways in which doctors exercise control over the course of the consultation at this particular point. I will also draw attention to the observation that not only the choice of activity but also the topical continuity displayed in the doctors' next turns, with their sequential placement in the overall structural organization of the medical consultation are relevant when studying how doctors control the course of consultation.

In the following, I will first offer a short overview of the placement of the doctors' next turns with regard to the patients' problem presentation. I will show that, in most cases, the doctors abstain from taking the turn at the first possible completion of the patients' turn of talk. I will go on to present the variation of types in the doctors' next turns with regard to the extent to which they preserve the conversational roles of the participants, thus either providing space for the patient to continue, or working to start interviewing the patient. (6.1.). In the remainder of the chapter (6.2), I will concentrate on analyzing the types of turns through which the doctor shifts from listening to the patient's problem presentation to interviewing the patient. I will pay specific attention to the patients' opportunities to return to their preceding line of talk after each type of 'next turn' by the doctor.

The data consists of the doctors' next actions following the patients' descriptions of the reason for the visit in 84 consultations. 17 consultations were excluded, as they included no description of the reason for the visit by the patient. In these consultations the doctors suggested a specific reason and the patients accepted this with no further comments. (cf. Beckman and Frankel 1984).

6.1. Placement and ‘type’ of doctors’ next turns with regard to problem presentation

In order to gain an overview of the data I coded and counted the cases in terms of the placement of the doctors’ next turns in relation to the possible completions of the patients’ problem presentations. A problem presentation was regarded as complete when the patient’s turn could be understood as grammatically, intonationally and pragmatically complete¹. For example, when the problem presentations were designed as narratives, they were considered complete only when the patient had reached the present moment and simultaneously the end of his story (see chapter 4).

As noticed in chapter 5, when the patients had completed their problem presentations the doctors did not always take the turn. In fact, most of the doctors passed their chance to take the turn at the first possible completion. In these cases the patients usually continued their description of the reason for the visit. Thus, some of the problem presentations included several places where the complaint could have been regarded as complete, and correspondingly there were several ‘next actions’ or ‘next turns’ by the doctor.

To examine the scale of variation in the doctors’ next turns I divided them into two categories: types which preserve the doctor’s position as the recipient of the patient’s problem presentation, and types where the doctor (at least temporarily) abandons this position. ‘Collaborative completions’ as next turns fell in between these two categories². According to Lerner (1996, 308), “[o]ne consequence of completing another speaker’s compound TCU is that it changes the participants’ positions in relation to the ongoing sequence”. By completing the patient’s utterance the doctor suggests a change of the conversational roles to the patient so that the doctor will get an opportunity to produce initiating actions instead of responsive ones. In this way an

¹ Within the CA methodology, the completion of a turn of talk is always ‘only possible’ as its completion is dependent on the following actions of each participant of the conversation. For example, if the recipient passes her chance to take the turn the current speaker may continue his turn of talk

² Collaborative completions are made possible by compound turn construction, where uttering the first part, e.g. of the form “if X”, provides resources for an anticipatory completion by another speaker. The following example is from Lerner: Example A. (GTS, Lerner 1996, 307)

Dan: When the group reconvenes in two weeks =
Roger: = they’re gunna issue straitjackets

anticipatory completion by the doctor seems to suggest a shift forward to the verbal examination. However, in case patients do not confirm the doctor's completion but complete their turn of talk themselves (as usually happens in the data), they are able to reject the doctor's suggestion and maintain the ongoing activity as problem presentation. The control over the 'final construction' of the ongoing TCU remains with the patient (Lerner 1991; 1996). Thus, I have perceived collaborative completions as a sort of 'middle category' in terms of the extent to which they preserve or abandon the doctor's position as the recipient of the patient's problem presentation.

The following table (Table 1) presents the proportions of different types of doctors' next turn following the first possible completion point of the patients' problem presentations.

Table 1: Proportions of different types of doctors' next turns at the first possible completion of the patients' problem presentations

type of turn	Freq.	Percentage
preserving the recipient position	57	68
collaboratives	3	4
abandoning the recipient position	24	38
Total	84	100

In almost 68% of the cases (n=84) doctors received the complaint with an action which preserved the patient's position as the speaker and the doctor's as the recipient of the problem presentation. This was done, for instance, by nodding or by producing a continuer. In three cases the doctors made a collaborative completion, and in 38% of the cases the doctors' turn of talk suggested abandoning their position as a recipient of the patient's talk, e.g., by asking a question from the patient. At the second possible completion the situation was different. There, as much as 61% of the doctors' next turns were of the kind which at least suggested, if not accomplished, a shift in conversational roles.

The preliminary count indicates that more often than not doctors abstain from taking the turn at the first possible completion of the patient's complaint. Consequently, many of the doctors also seem to orient to the slot where the patients give their reason for the visit as making possible an extended turn by the patient. Even when suggesting a move forward, away from problem presentation, this suggestion is often designed so as to give the patient an opportunity to continue his problem presentation if necessary.

The categories in table 1 above are crude, merely illustrating the main axis relevant in terms of studying the control of the shift forward in consultation. In the following, I will use examples to introduce in more detail the types presented.

6.1.1. Next turns preserving the recipient position

Most commonly the patients' turns were received with an action which preserved the doctor's recipient position. These included actions where the doctors either remained silent³, asked the patient to continue, acknowledged the complaint with a neutral *joo* 'yes', displayed understanding or alignment, or used a combination of these. Example #1 illustrates a case where the doctor first waits for the patient to continue, and then receives the patient's turn with a neutral acknowledgment. She still waits for over a second before she asks the patient a question in line 16.

Example 1 (1A2 Intervertebral disk)

- 1 D: Koskela ↑Jouni,
Last name First name
- 2 P: ((grunting:)) °hJoo:.hh°
°hYe:s.hh°
- 3 (1.3)
- 4 D: Ja tuota, (2.1) kolmastoista seitsemättä
and erm thirteenth seventh+of
And erm, (2.1) the thirteenth of July

³ There are no doctors' next actions in the data where they would remain silent at the first possible completion, but non-verbally initiate physical examination. That is, cases where the doctors remained silent at the first possible completion of the patient's problem presentation preserved their position as recipients of the complaint without exception.

5 kuuskymmentäneljä.
sixty-four.
nineteen sixty-four

6 P: Joo.
Yes.

7 (.)

8 D: Minkälainen on tilanne.
What kind is situation
What's the situation like.

9 P: No mulla on tota (.) mä (0.2) mh kävin tota noin,
well I have erm I went like
Well I have erm (.) I (0.2) mh had an appointment like,

10 viikko sitte täällä >(tuolla)< Yli-Anttilalla ja sano
week ago here that last name and said
a week ago here >(with that)< Yli-Anttila and he said

11 et mul on välilevyn pullistuma.
That I have intervertebral+disk bulge
that I have a bulge in an intervertebral disk.

12 → (1.1)

13 D: → Jaa.
→ I see.

14 → (1.0)

15 ? : .mt

16 D: Kumpi jalka on kipeempi.=
which leg is more sore
Which leg is more sore.=

In lines 9-11 the patient gives his reason for the visit by reporting a diagnosis made by another doctor on his earlier visit. His turn is complete for all practical purposes at the end of line 11. In the first transition relevance place (line 12), the doctor passes her first chance to take the turn. The silence is long enough for the patient to continue his turn if necessary. Facing the patient's silence, the doctor registers that she has heard the patient, saying *Jaa*. 'I see.' With this comment the doctor neutrally acknowledges the patient's turn as new information. There are no signs of the doctor suggesting to take the position of the speaker at this point. The following silence in line 14 further preserves the patient's chance to continue his complaint. However, the patient remains silent, and the doctor starts to interview him by asking 'Which leg is more sore.' in line 16.

In example #2, the doctor displays to the patient that she has understood his meaning, but still remains in the position of the recipient:

Example 2 (41A1 Hypertension)

- 1 D: Ja mitäs kuuluu,
And how are you,
- 2 P: No tota::, (0,6) mä olin tuola (.) aikuisten
Well er::m, (0.6) I was there (.) in the adult
- 3 neuvolassa tuol Jyskässä ja,
health center there in Jyskä and,
- 4 (0,5)
- 5 D: Joo: o
Ye: s
- 6 P: Ja terveys sisaret (Salminen),
And the health nurses (surname of a health nurse),
- 7 (3,5) ((P is looking for something in his wallet.))
- 8 P: Ajatteli että ehkä mun ois:: syytä tulla tänne
Thought that maybe I should come here
- /((P passes a paper to D, after which he
turns his gaze straight back to his wallet))
- 9 ku mul on toi °v:°veren |paine,
cause I have that °bl°oo |d pressure,
- 10 D: → Niipäs oliki ja
PRT+clitic was+clitic and
→ Oh you're right she did and
- 11 → [hänhän soit]tiki[n si°(ittä)°.]
she+clitic called+clitic it+about
→ [she did also pho]ne a[bout °(it)°.]
- 12 P: [Aina tota:] [Aina tota:]
[Always li:ke] [Always like]
- 13 (0,4) ((P puts other papers back in his wallet; D looks
at the paper P gave her.))
- 14 P: Tahtoo nousta yliv- (0,2) yli sadan se alap°aine
Tends to rise over- (0.2) over hundred the lower °pressure
- 15 ja°,
and°,
- 16 D: Joo: o,
Ye: s,
- 17 (1,2)
- 18 D: J:[ust,
R:[ight,
- 19 P: [((coughs)) hhh
- 20 D: Ja häv varmaan kerto siitä että meillä on sellanen: veren-
and she probably told you that we have that kind of blood

21 painetut[kimus menossa(nsa),]
 pressure[study going on,]

22 P: [No hän puhu, (.) muttei ko]vinkaan tarkasti.
 [Well she did, (.) but not]so exactly.

The patient's complaint is complete for all practical purposes in line 9. The doctor's turn in line 10 'Oh you're right she did' aligns with the patient's story so far, and preserves the doctor's position as the recipient of the patient's problem presentation. Her following utterance in line 11 'and she did also phone about it' volunteers information on how she heard about the health nurse's referral, but does not suggest changing the conversational roles in any strong sense. Even though the doctor displays that she has previous information on the patient's referral to her, she does not claim previous knowledge on the patient's problem. In my intuition, the endings used by the doctor (*-päs* and *-kin*) and her intonation in the first utterance convey a sense that the doctor is reminded by the patient of the issue. Similarly, in her second utterance, the ending *-hän* attached to the pronoun 'she' and the ending *-kin* attached to the verb (as in the first utterance) convey a sudden act of remembering. The doctor acts as if she were reminded by the patient on the health nurse's call, and as if she were willing to hear more. Thus the doctor's utterance encourages further talk by the patient.

The patient also treats the doctor's turn of talk as preserving her recipient position. After the initial receipt by the doctor 'So it was and', the patient continues his problem presentation in line 11, overlapping with the doctor's receipt. While uttering the word 'pressure' in line 9, the patient passes a slip of paper to the doctor, his gaze following the paper, but not actually meeting the doctor's eyes. Having delivered the paper the patient immediately turns his gaze back to his wallet and arranges other papers in it. Kendon (1990, 61-62) has showed how, at the possible completion of their turn of talk, speakers tend to gaze at the recipient. The withdrawal of gaze would indicate that the patient does not intend to pass the turn to the doctor at this point (end of line 9). The fact that he repeats the beginning of his turn in overlap with the doctor in lines 10 and 11 also indicates his orientation to keeping the turn.

The patient goes on with his utterance in line 13. He finishes his utterance with 'and' and a continuing intonation, after which the doctor asks the patient to continue with *joo* and rising intonation. As the patient does not take the turn during the following silence in line 16, the doctor closes the sequence

with 'Right.' in line 17. This 'Right.' marks the end of the phase of problem presentation and anticipates a shift forward. In line 19 the doctor takes the position of a questioner, starting to interview the patient.

6.1.2. Next turns suggesting a shift in conversational roles

38% of the doctors' next turns after the patients' first possible completion of the problem presentation were of the type which suggested a shift in conversational roles of the participants. Interruptions of the patient's turn before the first possible completion were also included in this category⁴. In turns of this kind the doctors abandon their role as a recipient by designing their turn as the first-pair part of an adjacency pair (see Sacks 1972b; Peräkylä and Silverman 1991b; Silverman 1997, 42). Usually, these turns are questions or requests for confirmation, which make relevant an answer by the patient and thus rearrange the conversational roles. Depending on their exact design and on the patient's following actions, they may accomplish a shift from the phase of problem presentation to verbal or physical examination. The extent to which the next turns are tied to the patients' preceding complaint seems to be especially important in this sense.

The following two examples illustrate two different sorts of next turns suggesting a shift towards the verbal examination. Their most explicit differences seem to culminate in the degree of maintenance of topical continuity. One specific resource for this is the use of medical vs. lay terminology.

Example 3 (33B3 A sore knee)

- 9 D: Kerros.=
Tell me.=
- 10 P: =.h (Mull on) polvi (kai) pari päivää ollu kauheen
=.h (I have) my knee has been (maybe) a couple of days
- 11 kipee.
terribly sore.
- 12 (.)

⁴ Interruptions will be dealt with in a separate subchapter, 6.1.4.

- 13 D: → Polvi.
Your knee.
- 14 P: Polvi tästä sivusta (e)t se o
My knee here on the side (t)hat it is
- 15 (.) ((D glances at P's knee))
- 16 P: Vähäki kävelee ni [sattuu °täähän°.]
You walk even a little so [it hurts °over here°.]

The patient's initial complaint is complete in line 11. The doctor's next turn, in line 13, consists of a single word: 'polvi' (your knee). In his preceding turn the patient has foregrounded the word 'knee' by stressing the word heavily and by placing it close to the beginning of the utterance. In this way the patient marks 'the knee' as the most important part of his complaint. The doctor picks out this element and re-utters it with an almost equal emphasis, stressing the first syllable and using a falling intonation⁵. He does not reformulate the word or the patient's utterance in any way, but simply reproduces the word 'knee'. The doctor does not suggest any particular aspect of the problem to be specified; rather, he topicalizes the whole problem. Furthermore, his choice seems to be in accordance with the patient's. The patient treats the doctor's turn as a request for more information on his problem and continues his problem presentation in line 14.

Unlike the doctor's next turn in example #2, the doctor's turn is a first-pair part, which makes relevant a second-pair part by the patient. In this way, while in #2 the doctor preserved her conversational role as a recipient of the patient's complaint, in #3 the doctor shifts the roles by taking the role of a questioner.

In the next example #4, the patient's possibilities of continuing her problem presentation seem more limited:

Example 4 (12A2 Fever)

- 1 D: hhh No,h (.) mitäs (.) murheita.hh
well what sorrows
hhh Well,h (.) what's (.) the matter.hh

⁵ Had the doctor finished his utterance with a rising intonation, his turn could have been treated as a repair initiation, checking whether he had heard correctly. The doctor's falling intonation, with the patient's heavy emphasis on 'the knee' in the preceding utterance, suggests this not to be the case (the doctor should have heard him).

- 2 P: Ku mul on tota nin nin (0.7) oli kuumetta viim- >tai
because I have PRT PRT PRT had fever last or
'Cause I have like erm (0.7) I had fever last- >or
- 3 eilenillalla ni kolkytkaheksan ja kuu:s ja .hhh >s'tte<
yester-day evening like 38 and 6 and then
yesterday evening like thirty-eight and si:x and .hhh >then<
- 4 (0.2) mul on kurkku tää:ltä tosi kipee. >Ja sitte mul
I have throat here+from really sore and then I
(0.2) I have throat in he:re really sore. >And then I'm
- 5 on semm'ne huo:no heikko ol#o koko aja ja#,
have that+kind+of bad weak feeling whole time and
feeling kind of ill: and wea#k all the time and#,
- 6 D: → Onks ollu koskaan an:giinaa.
Has been ever tonsillitis
Have you ever had ton:sillitis.
- 7 P: Joo, (0.2) <kaks ker taa> .hhh viime kesänä ja kaks
PRT two times last summer and two
Yes, (0.2) <two times> .hhh last summer and two
- 8 kertaa sitä edelli°senä kesänä°.=.hhh Mut nytte mä
times that preceding summer but now I
times the sum°mer before°.=.hhh But now I
- 9 kävin tuolla (0.2) siinä viljelyssä ja ne sano että
went there that+in cultivation+in and they said that
was there (0.2) in the cultivation and they said that
- 10 se on nekatiivinen.
it is negative
it is negative.
- 11 D: °Joo:. Katotaas.°
PRT Let's see
°Righ:t. Let's have a look.°

The doctor's question in line 6 is made at the completion of a three-part list by the patient. The last part of the patient's utterance 'weak all the time and' is uttered in a creaky voice, also projecting a completion of her utterance. Thus, although she finishes with 'and' and a continuing intonation, her utterance seems to trail off at the end of line 5 projecting a transition relevance place. In his question the doctor asks for information on tonsillitis, which the patient has not so far mentioned in her problem presentation. Tonsillitis is a diagnostic category, and thus clearly a medical term. It seems probable that the symptoms mentioned by the patient are indicative of tonsillitis⁶, and that the doctor's question is based on his knowledge of this connection. However, this linkage is not made explicit to the patient. The doctor's question also lacks other linkages to the patient's preceding turn: it

⁶ The patient also orients to this connection as she continues in line 8 to link her present problem to the doctor's question with a contrast marker: 'but now I was there in the cultivation and they said it was negative.'

focuses on the patient's past illnesses whereas the patient herself has only mentioned symptoms which she is suffering from at the moment or has been suffering from very recently. By his abrupt shift from talk about the patient's present experiences towards her medical history the doctor clearly starts a new phase in the consultation. He indicates that he has heard enough of the present symptoms and is prepared to begin interviewing the patient in order to reach a proper diagnosis. Starting a new topic also makes it more difficult for the patient to return to her problem presentation.

By taking the position of a questioner, doctors may suggest a shift forward in consultation (example #3). By designing their turn as the first-pair part while introducing new elements to the conversation they may intensify the compelling character of this suggestion (example #4). These practices will be examined in more detail in chapter 6.2.

6.1.3. Collaborative completions

Though there were only three collaborative completions by the doctor before the first possible completion of the patient's turn (six of them altogether within the patients' problem presentations), they deserve some attention as a specific way of turn-taking. Collaboratives are ambiguous in terms of shifting the conversational roles of the participants (Lerner 1996, 308-309). The first part of a compound turn-constructive unit (such as 'if X - then Y') provides the resources for completion by another speaker, but does not require it (Lerner 1991, 454). Let us examine example #5 where the doctor completes the patient's problem presentation in line 6:

Example 5 (32A2 Pain in the elbow)

```
1 D:      [Sä ] oot liikkeellä nyt minkälaisen asian
          you are on the move now what kind+for matter+
          [You] are brought here now for what kind of

2          >takeia< °hh°,
          +for
          >matter< °hh°,

3          (0.2) ((D & P > the table))
```

4 P: >Mun on< (.)tää vasen käsi (0.2) tästä,
 I+poss is this left arm here+from
 >I have< (.) this left arm (0.2) in here,

5 (0.2)((P pats her hand, D > P))

6 D: → Ky[ynerpäästä kipeetä,]
 elbow+from sore+par
 So[re in the elbow,]

7 P: [kynärpäästä kip]lee? ja se on ti[etys]ti
 elbow+from sore and it is of course
 [sore in the elb]ow? and it is o[ff cour]se

8 D: [Ahaa.]
 [I see.]

9 P: sit°te° (0.3) enemmän ja vähemmän (.) kipee että
 then more and less sore that
 th°en° (0.3) more and less (.) sore that

10 välillä sitä sitten (0.2) särkee
 from time to time it then aches
 from time to time it then (0.2) aches

11 oi[kein kovasti.]
 Really a lot
 re[ally a lot.]

12 D: [Kuinka pitkää] se kipee on >°ollu°<.
 How long it sore has been
 [How long] has it sore >°been°<.

The patient starts her problem presentation in line 4, after the opening question. She describes the location of the problem ‘I have this left arm’ and specifies the location by pointing at her elbow while uttering the indexical ‘here’. The turn so far projects a common Finnish grammatical structure when telling about pain: *mulla on X kipeä* ‘I have X sore’. Furthermore, the patient’s pointing gesture while uttering the pro-term ‘here’, indicates the exact location of her pain. Thus the doctor has enough information to complete the patient’s utterance in line 6: ‘Sore in the elbow’.⁷ As the question is about the patient’s experience, to which she has the primary access, the doctor’s collaborative asks for her confirmation (cf. Peräkylä and Silverman 1991a; also Schegloff 1996a). This way, the conversational role of the doctor changes temporarily from a recipient to a questioner as in next turn repair initiations. However, in this case, the patient goes on with her problem presentation overlapping with the doctor’s collaborative. Thus, the collaborative did not permanently shift the conversational roles of the participants.

⁷ In the Finnish original the doctor adds the referent ‘elbow’ straight after the pro-term ‘here’, which does not show in the idiomatic translation.

A similar situation is presented in example #6:

Example 6 (45A1 Ear problem)

10 D: Sulla oli joku <@kor::va>ongelma@.
You had some ear problem
You had some kind of <@ear::>problem@.

11 P: Juu.
Yes.

12 (1.5)

13 D: Oot(ko) sää saanu jonkun <läimäisyn vai mitä>.
have you got some slap or what
did you get some sort of a <slap or what>.

14 P: Tuota (.) mä kaaduin tuossa perjanta[i (.)] päivällä
well I fell there friday noon
Well (.) I fell down there on Frida[y (.)] at noon

15 D: [Ni.]
[Yeah.]

16 P: aika kovasti ja,
pretty heavily and,

17 (0.2)

18 D: Löit,
Hit,

19 (0.4)

20 P: Löin tai niinkun koko tän puolen päätä ja,
hit or kind of the whole this side of my head and,

21 D: Ni.
Yeah.

22 (.)

23 P: #o oli# ((gruntingly while sitting down))
#i it was#

24 ihan (.) turvoksissa korva >ja mä huomasin vähän myöhemmin
totally (.) swollen the ear >and I noticed a little later

25 että siit oli<
that there+out of had/was
that there had been<

26 (0.4)

27 D: → >Tul[lu verta.<]
come blood
>som[e bleeding.<]

28 P: [oli kuivu]nutta verta [tossa.]
was dried blood there
[there was some dr]ied blood [there.]

29 D: [Ni.]
[Yeah.]

30 (1.0)

31 P: korvassa ja (.) sitte kun noi muut mustelmat tosta helpotti
in the ear and (.) then when those other bruises got better

32 ku (.) °sehä oli koko #pää ihan kipee[nä] ni°#.
As (.) °the whole #head was of course aching terr[ibly] so°#

33 D: [Ni.]
[yes.]

34 (0.3)

35 P: Sit ton korvan sisää oj jääny joku semmonen että,
then inside that ear there's still something that,

In the above example the doctor completes the patient's utterance after a silence of 0.4 seconds. She uses the grammatically fitting structure 'there had been - some bleeding'. However, the patient changes the structure of his utterance while overlapping with the doctor's turn in line 28, into a structure which does not fit his original utterance in line 25: 'there was some dried blood there'. Thus it seems possible that the patient's silence in line 26 was a word-search, searching for the proper expression, whereas the doctor treated it as an invitation to complete the utterance. In any case, the patient has no problem in continuing his utterance overlapping with the doctor's completion.

But what kind of action is it to collaboratively complete the patient's problem presentation? Why not just wait for the patient to finish and then either take the turn or pass it?

The ability to complete another speaker's utterance requires careful monitoring of his turn so far. In this way, collaborative completions may serve as displays of listening to the speaker (cf. Schegloff 1976, 42-43). In this sense, collaborative completions by the doctors resemble turns of the type presented in chapter 6.1.1., which preserve the patient's position as the speaker, merely conveying that the doctor has understood the patient's point. In the examples above, the patients treated them as such.

However, in the particular context of giving the reason for the visit in medical consultation, assisting the patient in bringing his problem presentation to its first possible completion may have a special function. Completing the patient's utterance is a particular action in terms of the continuation of the problem presentation and of preserving or shifting the conversational roles in the situation. Completing an utterance is, of course, a way of bringing it to its closure instead of letting the speaker himself finish it. Thus, while completing the patient's turn of talk, the doctor simultaneously suggests that the patient has arrived at a possible completion of his turn. In this way, the doctor might preempt possible efforts by the patient to extend his turn in usual ways (e.g. insertions). Instead of leaving the patient to finish the utterance independently, at a point where he chooses to, the doctor takes the initiative in suggesting a possible completion.

By suggesting a completion the doctor concurrently implies that she has heard enough of the problem presentation, that the patient's complaint is complete for all practical purposes, in this context for starting to examine the problem in more detail. Completing the patient's turn could constitute a polite way of performing an uptake: telling the patient his problem has been accepted as a doctorable reason for the visit, and simultaneously suggesting a move forward to the verbal examination. (cf. Lerner 1996).

However, as shown by the extracts, the patients did not seem to treat the doctors' completions as making relevant a closure of their problem presentation. Instead, they continued talking in overlap with the doctor's completion, continuing the description of the reason for the visit and preserving their position as the speaker. Thus (at least in the three cases available), the patients treated the doctors' collaborative completions as displays of understanding, not as suggestions to move forward in consultation.

6.1.4. Interruptions

In addition to collaborative completions⁸, there were five cases in the data where the doctor took the turn before the first possible completion. Of these five, four occurred within the patient's story-telling sequence. As was observed in chapter 4, in these cases the patients had no problem in continuing their story after the doctor's intervening turns. In one case the doctor took the turn within the patient's ongoing TCU, outside a transition relevance place⁹, interrupting the patient:

Example 7 (33B1 Pharyngitis)

```

1 D:      Olli          Koivula. ((D calls the patient in by name))
          Fname (male) Lname

2          (1.7) ((D returns from the door to his desk))

3 D:      HHhkrrrh.

4          (5.9) ((P enters the room; P and D shake hands))

5 D:      Terve.
          Hello.

6          (.)

7 D:      I[stu  ] alas ole >hyvä,<
          S[it  ] down please,

8 P:      [°( )°]

9          (3.7) ((D and P sit down))

10 D:     <Ai> sä oot >maailman< hel

oh you are world+gen easiest patient
          <Oh> you're the easiest patient in the woorld.o

11 P:     m- Joo.          niä:lemisvehkeet [ ( - - ) ]
          PRT             swallowing+things/equipment
          m- Yeah. the swallowing things [ ( - - ) ]

12 D: → [Odotas hetki ] odotas hetki
          wait moment wait moment
          [Wait a minute] wait a minute

13        mulla ejä(h)i t(h)oi.£ .h
          I+gen was+left that
          I fl(h)eft t(h)hat.£ .h


```

⁸ Though interruptions and collaboratives may be similarly located with regard to the turn-in-process, they entail quite a different type of action. As opposed to collaboratives which may serve as displaying attention to and/or understanding of the preceding turn, interruptions literally cut the speaker off.

⁹ On the detailed definition of the transition relevance place, see (Sacks et al. 1974; Jefferson 1983).

14 (0.6) ((D stands up and leaves with a paper in his hand))

15 D: Ei: ottanu.
Not has taken+3
She didn't take it.

16 (1.8) ((D at the door, facing the corridor, presumably calling the previous patient))

17 D: Riitta Engström,
Fname (female) Lname

18 (22.0) ((D is absent, then returns to his desk))

19 D: >Onks sulla< kuume^ottta.^o
have you temperature
>Are you running< a tempera^oture.^o

20 (0.4)

21 P: O:li mulla aamulla oli (.) kol^okytkahexa ja <puali>
had I morning+in had thirty-eight and half
Y:es I was in the morning I had (.) thirty-eight and a <half>

22 ja (noin.)
and so
and (so.)

23 (1.7)

24 D: Nimittäin täss on diagnoosi on sel^ovä.^o
that+is+to+say here is diagnosis is clear
That's to say here is the diagnosis is clear he^ore.^o

25 (1.6) ((D shows a piece of paper to P))

26 D: Nieluviljely plussaa,
pharyngeal+culture plus+marked
The pharyngeal culture is positive,

The consultation starts in an exceptional manner¹⁰. In line 10 the doctor says: 'Oh you're the easiest patient in the world.' This comment implies that the doctor already knows the diagnosis (as the doctor himself later explains in line 24). The patient receives the comment in line 10 with a brief acknowledgment *joo* 'Yeah' after which he starts to present his problem. The doctor cuts him off by asking the patient to wait a minute. It is worth noting, though, that he orients to this interruption as accountable, as he explains to the patient that he has forgotten something: 'I left that'. After this he walks to the door with a paper in his hand, apparently trying to reach the previous patient who has left the document to his desk. Once he returns to his desk he starts the verbal examination by asking whether the patient is running a temperature.

¹⁰ The doctor's turn in line 10 and the patient's following turn have been analyzed in more detail in chapter 3.

In this consultation the doctor changes the normal agenda by replacing the opening question with a pre-announcement of giving the diagnosis. Thus he seems to be pressing the agenda forward. However, as his pre-announcement is made in the slot usually reserved for the opening question, the patient orients to it as such and tries to proceed according to the institutionalized script for the beginning of the consultation (see chapter 3). At this point the doctor interrupts the patient.

In this example the interruption seems to work in exactly the way that interruptions have been suggested to work in medical consultations: with the interruption the doctor regains control over the course of the consultation. As he also leaves the room, it is impossible for the patient to try to continue his problem presentation. When the doctor returns, he immediately starts interviewing the patient on his symptoms, thus adopting the position of a questioner (cf. Peräkylä 1992; Silverman 1997). During the entire beginning of the consultation the doctor declines to posit himself as a recipient of the patient's problem presentation.

The doctor's question in line 19 focuses on a symptom attached to the problem which he knows the patient to be suffering from. It suggests this to be the patient's main problem, thus possibly limiting the scope of issues to be talked about after the question (Byrne and Long 1984 (1976)).

After the silence the doctor takes the turn in line 24 to give the diagnosis. His manner of beginning: 'That is to say' links his turn to his pre-announcement in line 10, explaining what he meant by 'the easiest patient in the world'. With this comment the doctor displays to the patient that he knew all along what was wrong with the patient, and that his opening remark was indeed intended to skip the problem presentation altogether.

In this consultation interruption certainly seems to be a practice which sustains and restores control over the course of the consultation. First the doctor presses the agenda forward with his pre-announcement which replaces a normal opening question. As the patient tries to act according to the supposed normal script of the consultation, the doctor interrupts him,

seemingly to take care of business external to the consultation at hand, with the effect that the participants return to the doctor's original plan for the course of the consultation.

However, even though interruption can be used for restoring control over the course of interaction, it is not used widely or without consideration. Even in example #7 above, the doctor treats his interruption as accountable. The interruption is legitimized by the doctor's duties towards another patient (see lines 16-17). This would suggest that, as in ordinary conversation, in medical consultation interruption is an accountable act, treated as an exception to the rules of turn taking (Sacks et al. 1974).

During an analysis of the reception of problem presentations after the first possible completion, six more interruptions were found. This is less than 3% of the 239 doctors' next turns found in the data. Mostly the doctor interrupted the patient in order to start the verbal examination or to otherwise rush the agenda (as in example #7). However, in some consultations interruptions worked in the opposite direction: delaying the shift forward.

In example #8 the patient (a middle-aged woman) has been to the doctor before for her problem. Her ailment has been diagnosed as arthrosis, which is a non-inflammatory illness, common among elderly people. In the following example, a problem arises with the doctorability of the trouble, as the patient suspects her illness to be more serious than the doctor is prepared to believe.

Example 8 (10A3 Arthrosis)

- 1 D: Minkähän tavasta asiaahh.
what kind of matter
What kind of problem.
- 2 (.)
- 3 P: mt no: tuota se liittyy nyt tohon mun aikasemp:aan (.)
well erm it has to do now that+with my earlier
mt well: erm it has to do now with that earlier (.)history of
- 4 historiaani (.) [edelleen eli, (0.3) eli huolissani oon
history+my still in-other-words i-o-w worried+I I am
mine (.) [still I mean, (0.3) I mean I'm very much worried

it is an interruption. It is noteworthy that the doctor does not treat it accountable as such but acts as if the patient had not yet started the increment in line 8. Furthermore, the doctor does not align with the patient's suggestion that he may have previous knowledge on the patient's problem, but asks the patient for a new description of her ailment. Thus, the doctor's turn seems somewhat mismatched with the patient's previous talk.

Despite the interruption, in line 11 the patient completes the utterance which she started in line 8. In this case, then, the doctor's interruption did not prevent the patient from continuing her problem presentation. But, although temporarily ignoring the doctor's question in line 9 by completing her utterance, she does attend to it afterwards by rushing through to a new TCU to answer the question (starting in line 11). The sequence is complicated even further, as the doctor in turn deletes the beginning of the patient's new turn, and in line 13 takes the turn and continues the patient's previous utterance 'have been examined in the course of time', uttering the nature of the problem himself (possibly having just found a description of it in the medical records):

13 D: ja kulumaa todettu.
 and wearing has been found
 and some wearing of the joints has been found.

14 (.)

So far, the doctor's turns seem indeed to suppress the patient's attempts to describe her problem. The doctor's turns are misplaced with regard to the patient's TCUs, starting either too late or too early. Furthermore, instead of waiting for the patient's answer to his question in line 9, the doctor offers the answer himself in line 13. After the doctor's turn in line 13, a simple confirmation by the patient would suffice as a second-pair part to the doctor's request for confirmation. However, the patient does not confirm the doctor's suggestion but offers a different version of the nature of her problem, thus continuing her problem presentation:

15 P: ↑n:o sitä on epäilty nivelrikoksi mitä on ainoastaan
 well it has been suspected arthrosis what has only
 ↑W:ell it has been suspected to be an arthrosis what

16 >nyt sitte< (.) selvinny ja, .hhh mu:tta >se mun mielestä<
 now then been discovered and but it in my opinion
 has only >now then< (.) been discovered and, .hhh bu:t >in my

not to have referred to ‘pain’ in her earlier utterance, she changes the referent to match with the doctor’s suggestion:

23 P: #e# nii: s::e <jäykyys> ja kipu jäh. sit ne tulee
 PRT that stiffness and pain and then they become
 #n-# ye:ah th::at <stiffness> and the pain and. then they begin

24 >tommoses< ouron näkös|ekskin et ne on tota:,|(0.3) tää
 that kind of strange looking that they are erm this
 to look strange >like |that< that they are er:m,|(0.3) this

25 |((P points at her joints))|((D examines
 the hand))

26 P: aamujäykyys on, (.) °.niisk° on tota <aika raju> et ne
 morning-stiffness is is erm quite fierce that they
 stiffness in the mornings is, (.) °.sniff° is I mean <rather

27 on, (1.0) ne on nyt ↑turvonneet ja niinkun jotenkin (.)
 are they are now swollen and like somehow
intense> that they are, (1.0) they are now ↑swollen and like

28 kireet ja n:estemmäiset >ja ne on tommoset< ihan valkoset
 tense and fluidal and they are that kind of very white
 somehow(.) tense and f:luidal >and they are< totally white like

29 ainahh.,
 that alwayshh.,

Even after this extract a long conversation is needed before the doctor takes up the problem presented by the patient as a doctorable reason for the visit. After the patient’s turn illustrated above the doctor even examines the patients hands briefly and claims they ‘do not seem to be [tense, fluidal and white] at the moment’. In this consultation the doctor’s next turns seem to be placed and designed so as to delay the shift to verbal examination. By their design as questions they initiate more description of the reason for the visit, but by their placement they cut the patient off. Thus, the doctor does not lead the conversation towards the next phase, but neither does he acquire the position of the recipient of the problem presentation. His conduct seems quite exceptional and may well have to do with the possibility that the problem offered to the doctor as doctorable does not seem so from the doctor’s point of view.

When comparing the two above consultations with interruptions, it is observable that in some cases interrupting the patient may rush the shift towards the next phase, whereas in others it may delay it. Thus, depending on its exact placement and immediate context, interruption may be used in carrying out completely opposite projects. The doctors may use it to shift to the verbal examination rapidly or to show their disagreement with the patient.

In terms of managing the course of the shift forward, though, interruption does seem to reflect an attempt at unilateral control.

In the next part of the chapter the dynamics of control will be studied from a different angle. The main focus will lie on specific turn designs and the extent of control which they embody with regard to managing the shift forward in consultation. Attention will also be paid to the use of medical vs. lay terminology. The data consists of doctors' next turns which abandon the recipient position and thus suggest a shift forward in consultation.

6.2. Different styles of suggesting a shift forward - different 'degrees' of control

As already observed, doctors have different practices for suggesting a shift in the conversational roles of the participants, different ways of shifting the activity and steering the consultation towards the verbal or physical examination. Example #3 showed a more delicate suggestion, whereas example #4 proposed a move forward more forcefully. One crucial difference between the two next turns by doctors was the extent to which the doctors based their turn of talk on the patients' preceding problem presentations.

Schegloff and Sacks (1973, 300-301) have suggested that 'fitting' is a preferred procedure in organizing topics within a single conversation. With this they simply refer to fitting new mentionables into the other participant's prior utterance, thus solving the omnirelevant question for participants in every conversation: 'why that now', why is a particular turn placed after the turn which has just occurred. They distinguish between bounding off a topic and shading it into other topics. By 'topic shading' they refer to a practice of "fitting [...] differently focused but related talk to some last utterance in a topic's development" (305). Thus, in 'shading the topic' or in 'stepwise transition' the speaker introduces new material to the talk, which due to 'fitting' may be seen as occasioned by some prior talk (Jefferson 1984). In bounding off a topic, the previous topic is first completed and new topic is only begun at the place specifically prepared for it. This seems a useful distinction in terms of studying the doctors' control over managing the shift forward. As we shall see in the following analyses, closing the previous topic before starting a new one (bounding off a topic) constitutes a more collaborative way of managing the shift, whereas shading the topic into a new

one seems a more unilateral procedure. I will use this distinction as a resource in analyzing the data in chapters 6.2.1. and 6.2.2.

With regard to the overall structural organization of the consultation, with their next turns the doctors do not only shift the topic (or an aspect of the topic) but also activity, and along with it, the 'phase' of consultation. When shifting from receiving the patient's problem presentation into questioning the patient on the details of the problem the doctor simultaneously shifts from discovering the reason for the visit to examining the patient (cf. Byrne and Long 1984 (1976), 21). At the same time, this shift constitutes an approval of the reason for the visit as a doctorable problem (Heritage frth). The specific sequential place of the doctors' next turns with regard to the overall structural organization will be taken into consideration in the analysis.

As our concern is an institutional situation, a medical consultation with the predefined positions of expert and lay person, one additional aspect deserves attention, namely the use of medical vs. lay terminology. As observed in chapter 5, patients sometimes resort to the use of medical language, step into the doctor's territory, to indicate the closure relevance of problem presentation. In this way they invite the doctor to take up their problem and move forward in consultation. The use of medical language is one way of encouraging the doctors to start their professional activities. Similarly, the doctors' use of medical or lay terminology is connected to managing the shift forward, as was observed in examples #7 and #8.

Depending on their placement and design, some next turns by the doctors provide for negotiating the suitable placement of the shift, leaving the patient space to decide whether his problem presentation is complete. On the other hand, there are turn designs which in the sequential place under scrutiny provide the patients with only limited opportunities to continue their problem presentation.

In the following I will analyze different ways in which doctors fit their next turns of talk to the patient's prior turns, and the ways in which they resort to the lay-medical distinction, in managing the shift forward in consultation. The different practices embody different measures of control exerted on the course of consultation by the doctor. Bounding off the topic with formulations entails negotiating with the patient on the suitable place to move

forward in consultation (6.2.1.). By topical shading the doctor suggests a move forward more forcefully, but as the connection to the patient's preceding problem presentation is preserved, the patient is able to continue his complaint if necessary (6.2.2.). Abrupt topic shifts embody the most unilateral control by the doctors (6.2.3.).

6.2.1. Bounding off - Negotiating the shift

Some doctors paid specific attention to closing the topic which the patient had been talking about in his problem presentation before moving forward in consultation. The next example illustrates a situation where the doctor bounds off the topic and thus provides resources for negotiating a proper place to close the problem presentation and moving forward in consultation:

Example 9 (38A1 Midriff)

- 1 D: .th Mitäs kuu:[luu.]
.th How are [you.]
- 2 P: [.hhh] No nyt on semmone vaiva ollu
[.hhh] Well now I've had such a trouble
- 3 vissii kesästä lähtie et mua painaa, (0.2) tähä.
maybe since last summer that something is pressing me, (0.2) here.
- 4 D: Joo:=
Ye:s=
- 5 P: =.hh Ja h- niinku hengittäessäki mul o vaikeeta
=.hh And h- like when breathing I have also a difficult time
- 6 °kävelyssä°.
°walking°.
- 7 D: Sit siin [(o joku)]
Then there[('s something)]
- 8 P: [Se ei anna joskus] niinku yöllä nuk:kuukkaa,
[Sometimes it doesn't] like let me sleep at night,
- 9 se on tää vasemma puol'ne (0.2) pallea tää rinta (o),
it's this midriff on the (0.2) left this chest (is),
- 10 (.)
- 11 D: Jo[↑h_o]
Ye[↑:s]
- 12 P: [hhh] Et ku niinku siin ku kävelles tuntuu se et siin
that cause like there as walking+while feels it that there
[hhh] That cause like there when you walk it feels like that

13 siin ois niinku (0.2) joku paino. ↑Semmone tun< (.) täl
there were like some weight that+kind+of feel this
as if there were like (0.2) some kind of weight. ↑That kind of a

14 puolel ei oo mitään.
side not is anything
Feel< (.) on this side there's nothing.

15 D: .h Joo:
.h Ye:s

16 P: Ni,
Yeah,

17 D: → Ja kävelles (se [sattuu]]
and walking+while it hurts
And it hurts (when [you walk)]

18 P: [Kävellessä ja siltte samallai niinku
[When I walk and thlen in the same way like

19 nukkuessa että,
when I sleep that,

20 (0.2)

21 D: → (Myös[ki yö)]
→ (Als[o at night)]

22 P: [Joskus on (.) y]ö:lläki semmos[ta että,]
[Sometimes it's (.) a]t night also such [that,]

23 D: [Joo:.] .nhh
[Ye:s.] .nhh

There are several possible completions in the extract before the doctor takes the turn in line 17. At the first possible completion in line 4, the doctor passes her chance to take the turn, and the patient continues her problem presentation. The doctor's turn in line 7 'Then there('s something)' starts as an inference of what the patient has said before 'then', and could be developing towards an alignment. The patient interrupts the doctor by adding more description of her problem. The doctor passes the turn back to the patient in line 11, and again after the next passage of description by the patient, in line 15. In line 16, with her *ni* 'Yeah', the patient shows that she has nothing to add and the doctor takes the turn.

The doctor's utterance in line 17, 'And it hurts when you walk', is a formulation or a candidate understanding¹² concerning one of the symptoms described by the patient. As it offers an interpretation of the patient's

¹² Though 'walking' has been mentioned twice by the patient, she has not directly referred to pain in her preceding problem presentation. Thus, the doctor's formulation 'It hurts' is an 'allusion' which asks for confirmation from the patient (Schegloff 1996a).

circumstances it is heard as requiring her confirmation (Heritage and Watson 1980; Pomerantz 1980; Peräkylä and Silverman 1991a; Schegloff 1996a). It makes an answer relevant, thus constituting the first part of an adjacency pair ‘candidate understanding - confirmation/ disconfirmation’. As a first-pair part, it also suggests a shift in the conversational roles, not embodying behavior as a recipient, but as a questioner (Peräkylä 1992; Silverman 1997).

Heritage and Watson (1980, 255) write that ”a generic feature of formulations is that they occasion a collaborative and reflexive consultation of foregoing sections of the conversation”. They also suggest that formulations can be used to close down topics. Whether the topic is closed, depends on whether the candidate understanding is confirmed or not, and further, on the style of confirmation. What seems most relevant with regard to controlling the shift towards verbal examination, is that (other-attentive) formulations are in essence suggestions for closing the topic and starting a new episode, a kind of pre-closings. They do not accomplish a shift in topic or activity by themselves, but leave space for negotiation about where to close the phase of problem presentation and start a new phase. (Schegloff and Sacks 1973).

With her candidate understanding the doctor focuses on a specific aspect of the patient’s complaint, on her difficulties in walking. However, the patient orients to this as a not entirely adequate interpretation, since she adds to her confirmation the other activity mentioned in her complaint ‘when sleeping’. Following this, in line 20 the doctor leaves space for the patient to continue her problem presentation. This also seems to indicate that the doctor treats her formulation in line 17 as an offer to negotiate over the suitable place for closure.

With regard to the lay-medical aspect the doctor’s formulation is clearly ‘unofficial’ or profane. It would have been equally possible for the doctor to choose a more general and professionally tuned design, for example *tuntuu kipua* ‘there’s a painful sensation’. Thus, through her lexical choice the doctor does not work to steer the consultation towards her own area of expertise.

Furthermore, with her turn-initial ‘and’ after the patient’s turn in line 16, which indicates that she has nothing to add, the doctor marks her candidate

understanding as a continuation of the patient's problem presentation, thus expanding the complaint sequence.

Thus, rather than actually accomplishing a shift in conversational roles, the doctor suggests a shift to the patient, who may then accept or reject it. Although the doctor is in control in the sense that she is the one suggesting the shift, her way of doing it leaves plenty of space for negotiation.

In the following example #10 there is also room for negotiation, although the doctor's suggestion of moving forward towards the area of his medical expertise is more pronounced:

Example 10 (11B3 Sore hip)

- 13 P: [Okei<,] [krhh]
[Okay<,] [krhh]
- 14 .hhh hh Lonkkani (.) on nii j:umalauta kipee.<.h Mun on
hip+Pos is so god damn sore my has
.hhh h My hip (.) is so g:od damn sore.<.h I've had an
- 15 särkeny,h viime talvest saakka,h siis hirveest, näit (.)
ached last winter since like terribly these
ache,h since last winter,h a really awful one, in these
- 16 e: pitkiä luita, | .hv niinku koko jalkoi. | mhht Ja tota:
long bones like whole legs+par and you know
eh: long bones, | .hv like all over my legs. | mhht And uh:
/D nods /D nods
- 17 nyt se o sit siirtyny, (.) tähän, (.) tän puolimmaisee
now it has then moved this+into this side+into
now it's moved then, (.) into this, (.) this hip on this
- 18 lonkkaa. .hhh Ja tää tuntuu niinku tää jalka ei ois
hip+into and this feels like this leg not was+cond
side. .hhh And this feels like this leg wasn't even
- 19 ollenkaa niinku omakaa välil.
At all like own+even from time to time
my own from time to time.
- 20 (.) ((D nods; still looking at the patient))
- 21 P: Ja se: (.) rappusia men:nen tai tullen, (.) ylös alas .hh
and it stairs going or coming up down
And the: (.) stairs com:ing or going, (.) up or down .hh
- 22 ni polvi on niin ettei taho ottaa eh päälleen.
Then knee is such that+not want+3 take on
the knee's like you can't put your weight on it.
- 23 .h[hh
- 24 D: → [Se on siis liikearka.
It is then motion+sensitive
[It is sensitive to motion then.

25 P: Se on liikearka, ja painoarka.
It is motion+sensitive and weight+sensitive
 It is sensitive to motion, and to weight.

26 D: Joo. Mi[tes na- n[ukkuessa,
 PRT how sleeping+while
 Right. Ho[w about s- s[leeping,

The doctor's turn in line 24 is made at the second possible completion of the patient's turn of talk. With the word 'then' the doctor marks it an inference of the patient's preceding turn. The doctor's formulation does not refer to the whole problem presentation of the patient, but to its last part describing the patient's problems in going up and down the stairs. In his formulation the doctor uses a pro-term 'it' to refer to the 'knee' used by the patient. He formulates the gist of the patient's utterance into one medically tuned word: *lii*kearka, 'sensitive to motion'. His turn is a first-pair part asking for a second and in this way suggesting a change in conversational roles.

Compared to the doctor's turn in example #9 the suggestion to move forward is slightly stronger: instead of keeping the talk on the patient's area of expertise, the doctor shifts to medical language, using a term which formulates the patient's experiences as a general category: 'it is X' instead of referring to the specific activities presented by the patient. With this formulation the doctor implies that he has started the diagnostic work of arranging the information presented into pre-existing disease categories.

In line 25 the patient confirms the doctor's candidate understanding but adds another description: 'and sensitive to weight', after which the doctor acknowledges the answer and proceeds with a question on a new symptom.

The implication of the doctor's having started the diagnostic work embodied in his formulation also suggests that the doctor has approved the patient's problem as doctorable: by using medical terms the doctor moves the patient's problem into the medical territory, to his own area of expertise, thus implying that the problem is treatable in this area. In this sense his turn in line 24 constitutes an uptake of the patient's problem as a legitimate reason for the visit. However, as a formulation based on the patient's prior turn it also allows for rejecting or adding to the doctor's understanding: the one who has authority over the meaning of the utterance in question is the patient. As we have observed in both examples #9 and #10, the patients confirm the doctors'

allusions not only by repeating them, but also by adding an element introduced in their previous talk. They are in a position to say whether the doctor's candidate understanding of their talk is right, and to add to it if necessary. Thus, bounding off the topic by formulations allows for a negotiation on the proper place to shift to the verbal examination.

6.2.2. Unilateral shift - shading the topic

In the previous two examples #9 and #10 the doctor worked to establish a warrant to close the topic, in other words negotiated with the patient on the proper place to shift forward in consultation. In the following example the doctor does not specifically orient to bounding off the topic, but moves away from problem presentation with a technique which Schegloff and Sacks (1973, 305) have called 'topic-shading' (see also Jefferson 1984). This involves the "fitting of differently focused but related talk to some last utterance in a topic's development" (305). Next turns of this type accomplish the shift towards the next phase, making relevant a turn of talk by the patient on an aspect of the topic which has not been introduced by the patient herself. They 'jump over', as it were, the closing of the problem presentation proceeding straight to the verbal examination.

Example 11 (30A3 Low arch of foot)

```

1 D: <tulitteko ihan: ast:man: takia> vai onko
      come+you just asthma for or is+Q
      <did you come jus:t becau:se of asthma:> or is there

2 [jotakin muutakin mielessä. ]
      something else+too mind+in
      [also something else in your mind.]

3 P: [no e:n nyt tällä ker]taa se on kyllä ihan menny,
      PRT no+I now this+at time+at it has PRT quite gone
      [well no: not at this ti]me it has been just going,

4 (0.7)

((11 lines deleted, where the patient and the doctor discuss the patient's
asthma))

16 P: >mutta mää tulín nyt tuon< jalkani tähren.=>tuossa< (.)
      but I came now that foot for there
      >but I came now because of that foot of mine.=>there in the ball

17 päkiäs on >semmonen< .hh .mt (.) hhh. vaiiva tulee aina
      ball is kind of trouble comes always
      of the foot there is >a kind of< .hh .mt (.) hhh. trouble

```

- 18 k^ävellessä että nyt mä^ä aina, (.)
walking+while that now I all the time
occurs when walking that now I'm able to walk, (.)
- 19 P: [>v^ähe]mmän ja vähemmän< pystyn käveleen.
less and less am able to walk
[>les]s and less< all the time.
- 20 D: [hⁿi.]
PRT
[h^right.]
- 21 D: → millonka se o^alkanu (.) oⁱreilla^h.
When it has started to show symptoms
When did it start (.) to show symptoms.
- 22 (.)

The doctor's next turn in line 21 is a question about the problem presented by the patient. It is made at the first possible completion of the patient's problem presentation. Preceding it, in line 20, the doctor utters one acknowledgment token *nii* 'yes' which despite of its downward intonation resembles a continuer, as it is placed just after a short pause by the patient in the middle of her utterance.

The doctor's question is observably based on the patient's preceding turn: the pro-term 'it' refers to the patient's foot which she has been complaining about. Furthermore, the question formulates the gist of what the patient has told with the verb *oireilla* 'to show symptoms' (word-by-word translation would be 'to symptomize'). This lexical choice, as the construct 'sensitive to motion' in example #9, implies a readiness to start diagnostic work.

The doctor's turn embodies a move forward in consultation. With her turn she shifts the conversational roles of the participants from speaker (patient) and recipient (doctor) to questioner (doctor) and answerer (patient). Unlike the doctors' next turns in examples #9 and #10, it introduces a new element not present so far in the patient's problem presentation: 'when' the problem has started. Here, the doctor is not merely eliciting confirmation of her understanding, but begins to gather more information on the patient's problem. Her turn makes relevant an answer by the patient which includes so far unmentioned information about her problem.

The doctor makes no effort to accomplish collaboratively the closure of the problem presentation. Thus, in terms of controlling the shift forward in

consultation this kind of turn would indicate a more unilateral procedure in managing the shift than did the previous two examples.

However, even here the patient is able to return temporarily to her problem presentation. Following the patient's answer in line 23 the doctor proceeds to start the physical examination in line 25, saying 'Let's have a look':

```
23 P:      no kyllä se koko (.) kesän °oj jos ei vielä ( )
          PRT PRT it whole summer has if not even
          well it has been the whole (.) summer °if not even ( )

24        [ ( ) pikku,°
          little/small
          [ ( ) little,° ]

25 D: → [katotaampa sitäh.]
          look+we that+par
          [let's have a look.]

26        (.)

27 P:      pikku hiljaa mutta tota (0.7) nyt ei taharo enää
          little-by-little but erm now not able to any more
          little by little but erm (0.7) now (you) don't seem to be able to

28        päästä (0.5) muutako nuo sata metriä °otankos mä tän sukanki
          walk more+than those 100 meters shall+I+Q I this sock
          walk (0.5) more than those hundred meters °shall I take off

29        [pois.<°
          away
          [this sock as well
```

While stretching her leg towards the doctor, in line 27, the patient extends her turn. She seems to be explaining the vagueness of her previous answer: the problem has started to bother her little by little, thus it is hard to name the exact moment when it began. In line 27 she goes on with her problem presentation by continuing the description of her walking difficulties. (Before the doctor's question she has been describing how she can walk less and less all the time, and after her answer she continues on the same topic saying 'now you don't seem to be able to walk more than those hundred meters'.)

6.3.2. Unilateral control of the shift - changing the topic

Another type of design where the doctors did not specifically attend to accomplishing a closure of the phase of problem presentation was a question not fitted to the patient's prior turn of talk. Turns of this kind were relatively rare at the first possible completion of the patient's utterance. Out of the 24 next turns which shifted the conversational roles of the participants only 5 were of this kind (including the interruption described in 6.1.4.). Thus, next turns of this kind seem not to be the doctors' primary choice when receiving the patients' problem presentation at the first possible completion.

In example #12 the doctor first remains silent and then takes the turn, asking a question not fitted to the patient's prior turn.

Example 12 (Hoarse voice)

- 1 D: Ja min:käslaine tilanne.h
And what's the situation like.h
- 2 P: Eiku toi kur:kku. vaivaa m (.) siitä o (.) pitkälti
Well that thro:at. is troubling (.) it's been (.) almost
- 3 toista kuukautta ku mä kävin täällä ja .hhhh et-
two months since I was here and .hhhh that-
- 4 (0.2)se ol- oli (.) silloin kipee: ja,
(0.2) it wa- was (.) so:re then and,
- 5 (1.1)
- 6 P: antibioottikuuri,h >ja tota< (2|.1) kyllähä siinä ny
antibiotics,h >and erm< (2|.1) the pain did
- 7 kipu lähti mutta .hhh ää:ni ei oo viel palautunu.
Go away but .hhh my vo:ice has not yet come back.
- 8 (1.5)
- 9 P: Eli=
I mean=
- 10 D: → =Minkälainen työ teillä on nyt.
=What kind of work do you have now.
- 11 (0.8)
- 12 P: Mä(hän) oon suu:nnitteluhommissa.

The doctor pauses for 1.5 seconds before taking the turn in line 10. There is no explicit connection with the patient's preceding problem presentation in her turn. As the doctor's comment is uttered in the context of medical consultation, it is naturally possible to make this connection, for example, to presume that the doctor is considering the difficulties which the problem may

cause at work. However, the patient seems to have difficulties in building this connection, as is indicated by the extensive gap of 0.8 in line 11, preceding the patient's answer to the question.

In example #13, on the other hand, the patient seems to be able to see the connection:

Example 13 (12A1 Fever)

- 1 D: hhh No,h (.) mitäs (.) murheita.hh
 well what sorrows
hhh Well,h (.) what's (.) the matter.hh
- 2 P: Ku mul on tota nin nin (0.7) oli kuumetta viim- >tai
 because I have PRT PRT PRT had fever last or
 'Cause I have like erm (0.7) I had fever last- >or
- 3 eilenillalla ni kolkytkaheksan ja kuu:s ja .hhh >s'tte<
 yester-day evening like 38 and 6 and then
 yesterday evening like thirty-eight and si:x and .hhh >then<
- 4 (0.2) mul on kurkku tää:ltä tosi kipee. >Ja sitte mul
 I have throat here+from really sore and then I
 (0.2) I have throat in he:re really sore. >And then I'm
- 5 on semm'ne huo:no heikko ol#o koko aja ja#,
 have that+kind+of bad weak feeling whole time and
 feeling kind of ill: and wea#k all the time and#,
- 6 D: → Onks ollu koskaan an:giinaa.
 Has been ever tonsillitis
 Have you ever had ton:sillitis.
- 7 P: Joo, (0.2) <kaks ker taa> .hhh viime kesänä ja kaks
 PRT two times last summer and two
 Yes, (0.2) <two times> .hhh last summer and two
- 8 kertaa sitä edelli°senä kesänä°.hhh Mut nytte mä
 times that preceding summer but now I
 times the sum°mer before°.hhh But now I
- 9 kävin tuolla (0.2) siinä viljelyssä ja ne sano että
 went there that+in cultivation+in and they said that
 was there (0.2) in the cultivation and they said that
- 10 se on nekatiivinen.
 it is negative
 it is negative.
- 11 D: °Joo:. Katotaas.°
 PRT Let's see
 °Right:t. Let's have a look.°

The doctor's next turn in line 6 'Have you ever had tonsillitis' has no transparent connection with the patient's preceding turn. Although, according to common lay understanding, sore throat and high fever are symptoms of tonsillitis, this connection is not made apparent in the doctor's turn of talk. It asks about the patient's medical history, not her present symptoms, and presents a disease category not mentioned by the patient

In this case, unlike in example #12, having answered the doctor's question in lines 7-8 the patient goes on to make the connection herself: according to test results she does not have tonsillitis at the moment. Furthermore, she answers the question without delay, which was not the case in example #12.

The types of turns illustrated in examples #12 and #13 both accomplish an abrupt shift of topic. They are not fitted to the patient's prior turn, but introduce a new topic to be talked about.

To sum up: formulations as doctors' next turns are used to accomplish a closure of problem presentation collaboratively, negotiating with the patients on the proper place for moving forward in consultation. Topical shading embodies a more unilateral control by the doctor, though by fitting the new aspect of the topic to the patient's prior turn, the connection to the problem presentation is conserved, and thus a return to presenting one's present symptoms remains a possibility. Abrupt topic shifts to either verbal examination or life-world issues are procedures through which doctors keep the control over the shift forward entirely to themselves.

6.3. Conclusion

This chapter described different ways in which doctors manage the shift from problem presentation to more doctor-driven phases of the consultation, and the corresponding degrees of control by doctors invested in each way of performing the shift. It was shown that the shift may be negotiated or made more unilaterally by displaying or not displaying the connection to the patients' problem presentation. Medical and lay terms were used as a means to rush or to delay the shift. More egalitarian ways of managing the shift were more common among the doctors. In only a small percentage of the cases were the patients cut off with an interruption or an abrupt shift of topic.

The results draw attention to the importance of the sequential placement of the actions in focus for the analyzing of their functions. Interrupting and questioning are often simply presented as practices of control, without considering that these practices may be interpreted differently in different contexts. In the above analyses we have considered the placement of the doctors' next turns with regard to two different levels of context: in terms of the overall structural organization of a medical consultation, and on a more local level as a turn following the patient's previous turn. As we have observed, both of these dimensions seem crucial when considering the meaning of different types of next turns as actions. Thus, questions fitted to the patient's preceding problem presentation gain a very different status than questions lacking this connection in terms of controlling the course of consultation. Also, the use of lay terms and medical terms at the particular location of receiving the patient's problem presentation may actually constitute equally unilateral acts of control by the doctor.

The following example is included to demonstrate the importance of analyzing actions in their context (both immediate and institutional). It illustrates a case where at the first possible completion of the problem presentation the doctor provides the patient with more space to describe her problem. However, the patient does not seem pleased with the offer:

Example 14 (39A3 Heart problem)

1 D: (mu)lla oliki täällä aikasemmi ↑paperit ni kato<taas
I have the earlier ↑papers here so let's see

2 sitte,>
then

3 (1.0)

4 D: Laaksonen Helmi Maria. ((D is arranging papers))
Last name First names

5 P: Kyl[lä,
Ye[s,

6 D: [(Justiisa.)
[(Right.)

7 D: °No nii:.h°
°Okay:.h°

8 (1.6)

9 D: Joo. Ni minkäslais[ta (0.3) [ongelmaa.
Right. So what kin[d of (0.2) [problem.

10 P: [.mhhh [No nyt mun suurempi
[.mhhh [Well now my bigger

11 vaivani on mää tykkäisin et se on sydämessä toi vika
trouble is I'd think that it's in my heart that defect

12 ku m|ul on kaks viimestä viikkoo [ollu kauheeta.
as I've had for the last two weeks [a terrible time.

13 D: [(↑Nii,)
[(↑Yes,)

14 (0.3)

15 D: >Elikkä< (0.2) kertokaa[s vähä tarkemmi.
>In other words< (0.2) could yo[u tell me more details.

16 P: [.hhh hhh

17 P: → Jaha, millä lailla.
PRT what+in way+in
PRT¹³ how do you[mean.

18 D: [Nii että min- millä tavalla.
[so that in wha- what way.

19 [Mm.]

20 P: [(Juh,)] hh ↑No se alkaa sillä lailla et mun lyö
[(Yes,)] hh ↑Well it starts so that my arms become

21 käteni aivan ↑vetkuiks, .hh [niinku ne] tippuis ↑alas
totally ↑soft, .hh [as if they're] dropping ↑down

In line 9 the doctor asks the opening question and the patient presents her problem in lines 10-12. The patient's turn is complete for all practical purposes at the end of line 12. There follows a silence of 0.3 seconds, after which the doctor starts her turn as a candidate understanding of the patient's problem, saying: 'in other words', pauses and changes direction to ask for specification: 'could you tell me more details'. However, in her following turn the patient receives the doctor's request as new information with *jaha*, and displays that she has not understood what the doctor is after as she asks: 'How do you mean.' Receiving the doctor's question as new information, the patient treats it as unexpected. The example shows that also patients, at specific points of the consultation, orient to their description as sufficient and that requests to continue the problem presentation after such a point may be treated as unwanted.

The example also indicates that showing attentiveness to what the patient says does not necessarily equal to keeping silent or providing more space for

¹³ The patient's *jaha* is used in Finnish when receiving new information.

problem presentation. In fact, if the patient has assumed that her problem presentation is sufficient for moving forward in consultation, doctor's silence or provision of more space at this point may even work contrary to patient's interests. It may suggest that the doctor has not been listening to the patient or considers the patient's problem presentation somehow insufficient. In the latter case the doctor's actions could be interpreted as keeping the control of the shift strictly to the doctor, not allowing negotiation on the proper placement of the shift.

These findings address the discussion on doctor-centered vs. patient-centered styles of consultation (cf. Byrne and Long 1984 (1976); Clark and Mishler 1992; Roter and Hall 1992). Recommendations for doctors' procedures which ignore the sequential context and promote such techniques as 'keeping silent' or 'using lay terminology' may in some contexts reflect more doctor-centered than patient-centered styles. The patient- or doctor-centered character of each activity of the doctor depends on the specific situation in which it occurs. Thus it is difficult to hook patient-centeredness, in the sense of attending to the patient's own experiences as the principal source of information, to any particular feature of turn-design, such as questioning (cf. Beckman and Frankel 1984; also Roter and Hall 1992). Neither can patient-centered style be unambiguously connected with the avoidance of medical terminology (cf. Mishler 1984; Clark and Mishler 1992). The best description of the common denominator for patient-centered styles would perhaps be 'other-attentiveness' or 'showing attention to the patient's problem and to his talk in general'. Then, 'designing the following actions to show their connection to the patient's preceding actions' would constitute one technique of displaying this kind of attention. In the next chapter I will study displays of attention within a different mode of interaction: an examination of doctors' postural orientation and gaze-withdrawal will illustrate more closely the ways in which the doctor's displays of listening to the patient become crucial in consultation.

7. GAZE AND POSTURE AS WAYS OF CONTROLLING THE COURSE OF PROBLEM PRESENTATION

In this chapter I will make an excursion into non-verbal practices accompanying the talk during the phase of problem presentation. I will focus on the doctor's posture and gaze-direction when receiving the patient's description of the reason for the visit. I will suggest that the doctors' postural orientation and gaze towards the patient constitute an important display of attention to the patient's problem presentation. I will show that the doctors' shift of focus away from interaction with the patient towards reading or writing the medical records is treated by the patient as problematic. Especially when the doctors turn away from the patient at crucial points in the patient's problem presentations or when their disengagement is manifest, the patients become dysfluent in their talk and engage in specific practices known to elicit the recipient's attention.

According to Goodwin (1981, 21), in conversation "[t]he ability to display different types of engagement in the talk of the moment provides recipients with resources for making visible to speakers not only their alignment to that talk but also their enthusiasm for it." Thus, with their posture and gaze-direction doctors are able to signal interest or disinterest towards the patient's problem presentation (cf. Bensing et al. 1995). Correspondingly, the observation that patients often become dysfluent at the moments when doctors withdraw their attention from them indicates that patients perceive the doctors' displays of interest in their problem presentation as important. Thus, non-verbal displays of attention seem to constitute an additional resource for the doctors to control the course of consultation.

In chapter 6 I suggested that 'showing attention to the patient's problem and to his talk in general' would constitute an important element of a patient-centered style of consultation. However, when receiving the patients' problem presentations, doctors may momentarily have to engage in side-activities such as checking the medical record or making notes. There are moments when giving the patient one's undivided attention may simply not be possible. In these situations paying attention to the coordination and timing of these shifts in orientation away from the patient is essential. In the following I will present how specific postural orientations and displaying attention at specific moments of the patients' unfolding narrative may be

crucial in terms of conveying to the patients that their problem presentation is being listened to.

I will begin by introducing my approach to the study of non-verbal interaction, specifically gaze-direction and posture (7.1.). Next, I will present some quantitative observations on the relation between withdrawals of attention by the doctors and disturbances in the patients' talk (7.2). Thereafter I will describe four specific situations in which patients treat the doctors' postural or gaze withdrawal as problematic (7.3.). To conclude, I will discuss the implications of my findings for the study of non-verbal interaction on the one hand, and of doctor-patient interaction on the other (7.4).

The data in this chapter consists of 35 problem presentations. The criterion used in selecting the consultations was that the problem presentations they contain should be longer than one sentence. Thus, the data consists of problem presentations where the patients show interest in telling a longer story to the doctor. In longer problem presentations the relevance of doctors' displays of attention would probably also be greater for the patients.

7.1. Engagement in doctor-patient interaction

It is well established in conversation analytic studies of interaction that the participants of a conversation constantly monitor each other and the unfolding speech in order to be able to perform the relevant next action when the present speaker has finished his turn of talk (Sacks et al. 1974; Schegloff et al. 1977; Goodwin 1980; 1981; Goodwin M.H. 1980). Much of this monitoring of the other participants' actions concentrates on non-verbal activities such as gaze-direction and posture. Gazing at the speaker has been found to constitute a display of attention by the recipient of talk (Goodwin 1981; Heath 1986). Furthermore, changing posture has been discovered to coincide with a shift in participatory status (such as from speaker to recipient, for example) (e.g. Kendon 1990, 99-104). These two aspects of non-verbal behavior are also intertwined with the talk in medical interaction.

By asking the opening question in medical consultations, doctors convey to their patients that they are available as recipients of the patient's problem presentation. Furthermore, by turning to gaze at the patient the doctors non-verbally display that their main focus is in interaction with the patient, not for

example, in reading the medical records. Doctors also display their availability as recipients of the patient's problem presentation by turning their body towards the patient. (Robinson 1998). However, the elicitation and the reception of the patients' complaints is complicated by the doctors' need to divide their attention between two major sources of information on patients' health problems: the patient in person and the documents containing medical information. Consequently, doctors find themselves in a position in which they should simultaneously interact with two different representations of the patient: 'the patient embodied' and 'the patient inscribed' in documents (terms coined by Robinson 1998).

In this section I will present my approach to the study of the non-verbal dimension of interaction. I will start by introducing some previous observations on the ways in which gaze-direction and posture display engagement in conversation (7.1.1. & 7.1.2.). Thereafter, I will briefly illustrate how patients monitor the doctors' non-verbal actions in medical consultation (7.1.3.).

7.1.1. Gaze and engagement in conversation

In his groundbreaking studies on conversational organization Charles Goodwin found that in face-to-face conversation, aligning as a recipient of somebody's report or narrative means turning to gaze at the speaker. Drawing upon analyses of naturally occurring conversations, he showed that "...speakers do in fact orient to the noticeable absence of a recipient's gaze at a specific point (for example by requesting such gaze)" (1981, 286). According to Goodwin, within the normative order of conversation, if a gazing recipient is not found, the speaker will engage in certain practices in order to get the gaze of the intended recipient (see also Heath 1986). These practices consist of perturbations in speech, such as pausing in the middle of the utterance or restarting the utterance once started (Goodwin 1981).

Goodwin mentions two basic procedures for requesting gaze from the intended recipient: restarts and pauses. Restarts are used when the speaker

turns to gaze at a non-gazing recipient. This is presented in Example A below, borrowed from Goodwin.¹

Example A: Restart (Goodwin 1981, 72)

```

speaker:      . . . X-----,,,
              "N he c a-  he calls me a Vassar sno:b."
recipient:    ↑      ↑ . . . . .X-----
              cut off restart
  
```

A restart is initiated with a cutoff. As is observable in the example, at the moment when the speaker turns to gaze at the recipient and finds that she is not gazing at her, she cuts off the word she is about to utter "N he c a-", and starts her utterance again.

The other practice signaling the relevance of the recipient gazing at the speaker is pausing while detecting a non-gazing recipient. This is represented in example B:

Example B: Pause (Goodwin 1981, 76)

```

speaker:      . . . . .X-----
              pause
              ↓
              "He pu:t uhm, (---) Tch! Put crabmeat on"
recipient:    . . . . .X-----
  
```

In this case the speaker withholds her gaze and pauses close after the beginning of her utterance until the recipient shifts her gaze to the speaker.

Heath has found that similar practices are used in medical consultations, where they also work to elicit the gaze of a non-gazing recipient (Heath 1984; 1986). In his studies on British medical consultations Heath (1986, 46) found practices such as withholding a sequentially relevant utterance and pausing in

¹ The speaker's gaze is transcribed above the utterance, and the recipient's gaze below it. A straight line means gazing at the other participant, no line means no gaze. Dots mark a movement towards the other participant, commas mark a movement away from the other. X marks the point at which the gaze meets the other participant.

the course of its articulation as "successfully encouraging the potential recipient to realign his gaze".

Thus, specific dysfluencies in speech have been found to have consequences for talk-in-interaction both in everyday conversation and in medical consultations. The participants of a conversation coordinate their respective actions so as to establish and maintain a situation in which successful conversation is possible. A situation of this kind, in which both participants are displaying mutual engagement in interaction with each other (i.e., the speaker is telling a tell-able to the intended recipient, gazing at him, and the recipient is non-verbally demonstrating that she is listening), will be called engagement framework. (Goodwin 1981; Robinson 1998).

7.1.2. Postural orientation

In addition to direction of gaze, an engagement framework may be created and maintained by postural shifts (Kendon 1990; Schegloff 1991a; Robinson 1998), or gesturing in the visible field of the intended recipient (Goodwin 1986; Heath 1986). Shifts in posture which may be treated as displays of attention or inattention can be analyzed as shifts of 'home position' of the body (Schegloff 1991a). The term refers to the hierarchy of three body-segments presented by Kendon (1990) and further developed by Schegloff (1991a) (see also Goodwin 1981; Robinson 1998). The positioning of these segments in relation to each other operates on the dimension of stability/instability of orientation: lower body-segments provide home positions for upper segments, and indicate a more stable orientation than the upper segments. The segments are divided at waist and at neck into three, and in the hierarchy the degree of instability of the position increases from bottom to top. The concept 'body-torque' refers to the unstable position in which the three segments are not harmoniously pointing at the same direction. The 'home position' is the direction at which the lower body-segment is pointing. For example, in figure #1a, while the doctor is asking the opening question her dominant orientation is towards the desk, and her head is in torque towards the patient. Figure #1b shows the same consultation after a few seconds, when the doctor has released her torque.

Figure #1a



Figure #1b



In addition to shifting the position of the lower part of the body, the participants of a conversation may display a shift in their postural orientation simply by engaging in another activity. Starting to read or to talk on the phone while the other participant is speaking signal to the speaker a major shift in orientation, thus, at least temporarily, breaking the engagement framework which had been established.

7.1.3. Monitoring of the doctors' movements by the patients

In this study, the production and interpretation of non-verbal actions will be analyzed in a similar manner as spoken turns of talk. In conversation analysis, all actions performed by the participants are considered both context-sensitive and context-renewing (e.g. Heritage 1984). Any action in conversation displays the actor's interpretation of the preceding actions: it accommodates them and/or is responsive to them (for example, an answer displays an analysis of the preceding action as a question). On the other hand, all actions are consequential for the way in which the conversation unfolds further, as they, from their part, form the context for future actions by the participants (for example, answering a question makes it relevant for the one who posed it to evaluate or to acknowledge the answer, or in case of the recipient having misunderstood the intended meaning of the question, to repeat or reformulate the question).

Correspondingly, it will be maintained that the patients' dysfluencies display their interpretation of the actions preceding the point where they became dysfluent. In an initial analysis of the data it was observed that the patients often became dysfluent after the doctor disengaged from interaction with the patient. These dysfluencies by the patients are suggested to indicate that they have recognized the doctor's disengagement as a meaningful and problematic event in interaction. On the other hand, the dysfluencies are also consequential: as earlier studies on ordinary conversation (Goodwin 1980; 1981) and on medical interaction (Heath 1986) have shown, becoming dysfluent while uttering a turn of talk works to elicit the gaze of the recipient of the talk. Thus, the patients' dysfluencies may also invite the doctors to show their attention.

As in everyday conversation, in doctor-patient interaction the participants constantly monitor each other's movements and direction of gaze (Heath 1986; Robinson 1998). The patients keep an eye on the proceedings of the doctor and coordinate their turns of talk to the doctor's level of engagement. The doctors' monitoring task, on the other hand, is complicated by their medical duties. Unlike patients, doctors have to divide their attention between a multiplicity of sources of diagnostic information. The way in which patients carefully follow the direction of the doctor's orientation and adjust their behavior to it is illustrated in extract #1 below. The positions of the participants vis-à-vis each other are presented in Figure #2. Before the beginning of the extract the patient has introduced her problem as varicose veins. The line immediately above the transcribed talk stands for the direction of the doctor's gaze, and the boxes above it for the doctor's movements. Correspondingly, the lines and boxes below the transcript illustrate the patient's gaze and movements.

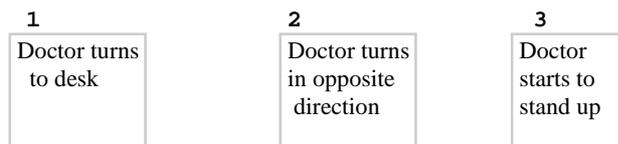
Figure #2



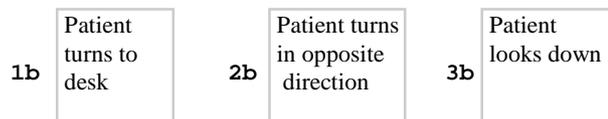
Example 1 (5A3 Varicose veins)

Dg: *to patient's leg* .. .X-----
 4 .hhh [se on tuos vase]m_vmassa j_alassa,
 it is that+in left+in foot+in
 .hhh [it's in that le_lft fo_ot,
 5 D: [Jaaha,]
 PRT
 [I see,]
 Pg: .. .X-----,, to her leg

Dg: , , ,
 6 (.)



Dg: *down desk ...opposite direction*
 7 P: It is now (.) #eh# it was (0.2) about y'know a couple of
 Pg: *down ..desk .opposite dir down*



8 weeks ago when I made the appointment with you so .nffh
 9 it was really tricky it was so angry for one wee:k
 10 that #m m# going up the stairs really caused me< (.)

In line 7 both the doctor's and the patient's postural orientations are towards each other (see Figure #2). They are both gazing down. Box 1 illustrates the point at which the doctor turns his gaze to the desk. It is observable how at the exact moment when the doctor turns his gaze away from the patient the patient stops her utterance for a moment: 'It is now (.)' and hesitates: 'eh'. Following the pause the patient lifts her head up and follows the doctor's gaze towards the desk (box 1b). The patient repairs her utterance saying 'it was' after which the doctor turns his head in the opposite direction, away from the desk and the patient (box 2). Again the patient pauses, for (0.2) seconds, and follows the doctor's gaze (box 2b). As the doctor makes a movement starting to rise from his seat (box 3) the patient turns to gaze down on her lap (box 3b). This coordination of the participants' actions is also observable in the patient's production of speech: The actual moments when the doctor withdraws his gaze (marked with boxes 1 and 2) coincide with pauses and hesitations (#eh#) in the patient's talk.

7.2. Quantitative observations on the interrelatedness of disengagements and dysfluencies

In a preliminary analysis of the data, patients' dysfluencies were often found to coincide with the doctors' disengagement from interaction with the patient. To get an overview of the phenomenon observed, all dysfluencies within the patients' problem presentations were identified. Dysfluencies were defined as self-interruptions, followed by perturbations in speech such as a pause, a filled pause (uh, uhm), an insertion, a repair of some sort (e.g. a new start, a restart), and/or a continuation of the cut-off utterance². Single micropauses (.) were not counted as self-interruptions unless there were additional perturbations attached to them. Where several of these 'disturbances' occurred consecutively they were treated as parts of the same repair sequence (see Schegloff et al. 1977), and counted as one dysfluency. Thus, a total of 172 dysfluencies by the patients was counted in the 35 problem presentations.

The 172 dysfluencies identified in the data were evenly divided in 33 complaints, whereas two complaints contained more than 10 dysfluencies each. These were cases where the patients constructed their problem as non-

² In conversation analytic literature these practices are referred to as practices of self-repair or repair-initiation (Schegloff et al. 1977; Schegloff 1992)

severe or almost non-existent³. It was also observed that patients who suspected their problem to be serious (such as cancer) were no more dysfluent than average.

One of the initial observations when examining the fluency of the patients' talk with regard to the doctors' level of engagement was that the patients were more dysfluent when the doctors were not gazing at them. In the preliminary analysis, periods of gazing at the patient and gazing away from the patient during the patient's talk were recorded from all extracts. As the doctors often shift their gaze to and fro between the patient and the records, the coding of the doctors' gaze-direction yielded 107 periods during which the doctors were gazing at the patients, and 86 periods during which they were not gazing at the patients. Each such period began and ended with the doctor's shift of gaze towards and away from the patient, or at a point where the doctor started to talk. The distribution of the patients' fluent vs. dysfluent talk in relation to the doctors' gaze-direction is illustrated in table 1:

Table 1: Doctors' gaze-direction vs. patients' fluency (193 periods of gazing or non-gazing)

Patient's talk	Doctor's gaze direction with regard to patient	
	Gazing	Not gazing
dysfluent	33%	78%
fluent	77%	22%
	100%	100% (n=193)

The patients' talk was fluent (with no dysfluency) in 2/3 (77%) of the 107 periods of the doctor gazing at the patient, while in more than 2/3 of the 86 periods where the doctor was not gazing at the patient, the patient became dysfluent at some point in the period. This observation concurs with Goodwin's (1980) results on speakers orienting to the noticeable absence of recipients' gaze.

³ The great number of dysfluencies in these two consultations could be connected with the patients placing doubt on the doctorability of their problem.

Next, I identified the points where the doctors disengaged from the role of the recipient. A 'disengagement' was defined as the moment at which the doctor turns her gaze away from the patient. Further, manifest gestures indicating a shift in postural orientation away from the patient towards the desk and the medical records, the gaze being already withdrawn from the patient, were counted as disengagements (cf. Goodwin 1981). Out of 121 occurrences of patient dysfluency when the doctor was not gazing at the patient, 42% were located immediately after the doctor's disengagement.

The placement of the doctors' points of disengagement in relation to the patients' utterances was identified. The disengagements were divided into two groups: those occurring within TCUs⁴ and those occurring between TCUs. In face-to-face interaction this is a crucial distinction, as a possible completion of a TCU is perceived as a possible moment for speaker change by the participants of a conversation (Sacks et al. 1974; Ford and Thompson 1996; Schegloff 1996b). Withdrawing gaze in the middle of the patient's TCU, when he has not yet reached a possible completion of the unit of his speech, may thus be understood as an interruption, as an accountable act of nullifying the rest of the patient's turn, whereas disengaging at a point where the patient's utterance is possibly complete concurs with the existing turn-taking organization, and is not perceived as demanding explanation.

The distinction between disengagements within TCUs vs. disengagements between TCUs was found to be crucial in terms of whether the doctor's withdrawal of attention was interpreted as problematic by the patients. In 72% of the cases when the doctors disengaged while the patient's TCU was incomplete the patients became dysfluent. On the other hand, when the doctors adjusted their disengagement at the possible completion of the patients' TCU, in only 15% of the cases the patients paused or cut off their utterance in response to the doctor's disengagement. These ratios are illustrated in table 2 below:

⁴ For the definition of a TCU, see Introduction, p 32.

Table 2 : Location of disengagements and their co-occurrence with dysfluencies. (n=91)

co-occurrence with dysfluency	Placement of disengagements		Total
	at boundary	within TCU	
no dysfluency	85%	28%	44%
dysfluency	15%	72%	56%
Total	100%	100%	100%

These preliminary observations indicate that the doctor's disengagements within TCU were more often responded to by the patients than disengagements between TCUs.

Before starting to examine in more detail the places where the doctors' disengagements were received as problematic by the patients, we must observe that there were also environments where patients did not treat the doctors' withdrawals of attention as making relevant an effort to re-engage them as recipients of problem presentation. Also Goodwin (1981, 105) points out how, in ordinary conversation, only some gaze withdrawals implicate disengagement from the role of recipient. In the data, there were three environments in which the doctor's gaze-withdrawal or manifest engagement in a side-activity were not treated as disengagements. First, as can be observed in table 2 above, when the doctors disengaged at TCU boundaries the patients seldom became dysfluent. Second, when the patients were not themselves gazing at the doctor they did not specifically respond to the doctors' withdrawals of attention. Third, when the doctors withdrew their gaze at the beginning of the problem presentation the patients did not treat this as a disengagement from the role of recipient. It seems possible that, as at the beginning of the problem presentation the doctor has just asked the opening question, this is considered to be a sufficient display of attention to the patient's story at this point.

7.3. Looking means listening - four environments in which displays of engagement are essential

In the following analysis I will present four specific environments in which patients lose the track of their problem presentation when the doctor turns away from them. The analysis is organized around two aspects of interaction: the spatial and the temporal. The spatial dimension refers to the postural orientations of the participants at the moment of the doctor's gaze-withdrawal (7.3.1. & 7.3.2.). The temporal dimension involves the timing of the gaze-withdrawal in relation to the patient's unfolding narrative (7.3.3. & 7.3.4.). It will be suggested that the moment of gaze-withdrawal with regard to the patient's narrative⁵ and its markedness/overtness play an important part in displaying availability as a recipient to the patients' problem presentation.

In the first instance the doctor turns away from the patient when her home position is towards the desk and medical records. There were 16 such cases in the data (7.3.1.). In the second environment the doctor's home position is towards the patient but she performs a manifest shift in orientation away from the patient (22 cases) (7.3.2.). In the third situation the doctor turns away as the patient is just about to utter the core of the problem (12 cases) (7.3.3.). In the last instance the doctor disengages when the patient is about to reach the completion of his turn (5 cases) (7.3.4.).

7.3.1. Disengagement with home position away from the patient

The doctors' disengagement when their home position was away from the patient was treated by the patients as problematic in the data. In a situation where the patient is sitting at the side of the desk and the doctor's postural orientation is towards the desk, the doctor's head is in torque when she turns to look at the patient. As she releases the torque she again faces the desk. In this situation the primary focus of the doctor's attention seems to be in the direction of the desk, and her attention towards the patient is easily treated as temporary. Figure #3 illustrates this situation.

⁵ I am grateful to John Heritage for this observation.

Figure #3 (same as Figure #1a)



The patient is looking at the doctor. The doctor is turned towards the desk. When asking the opening question (line 6) the doctor turns her head to torque to gaze at the patient. The problem presentation starts in line 7:

Example 2 (1A4 Hoarse voice)

```
1 D: Ja teiän nimenne oli,  
And your name was,  
  
(0.5)  
2 P: Kurkinen,  
P's name  
3 D: Kurkinen Veli-Matti neljäs yhdeksättä kuuskymmentäkolme.  
P's last name first name fourth ninth+of sixty-three  
Kurkinen Veli-Matti September the fourth nineteen-sixty-three.  
4 P: Joo.  
Yeah.  
5 (1.0)  
  
Dges: ::::::::::::::X (sits down)  
Dg: ..X-----  
6 D: Ja min:käslaine tilanne.h  
and what+kind situation  
And what's the situation like.h  
Pg: -----
```

:::::: (turns chair a little more to P)
 Dges: :::::: (reaches for a pen on the desk)
 Dg: -----, , .X-----
 7 P: → Eiku toi kur:kku. vaivaa m (.) siitä o (.)pitkälti
 no+as that thro:at is troubling that+of is by far
 Well that thro:at. is troublesome (.) it's been(.)almost
 Pg: -----

Dges: :::::: (opens records)
 Dg: -----, ,desk ..X----
 8 → toista kuukautta ku mä kävin täällä ja .hhh et-
 second+of months since I came here and that
 two months since I was here and .hhh that-
 Pg: -----

-----, ,records
 9 → (0.2) se ol- oli (.) sillan kipee: ja,
 it wa- was then sore and
 (0.2) it wa- was (.) so:re then and,
 Pg: -----

Dges: (takes glasses out of her pocket)
 10 (1.1)
 Pg: -----

Dg: ..X-----
 11 P: → antibioottikuuri,h >ja tota< (2.1) kyllähä siinä ny
 antibiotic+treatment PRT there now
 antibiotics,h >and uhm< (2.1) the pain did
 Pg: -----
 Pges: ::: (lifts hand to scratch
 his chin)

Dg: -----
 12 → kipu lähti mutta .hhh ää:ni ei oo viel palautunu.
 Pain went+away but voice not has yet come back
 Go away but .hhh my vo:ice has not yet come back.
 Pg: -----

Dg: , , , , to desk (puts glasses on)
 13 (1.5)
 Pg: -----

14 P: Eli=
 I mean=

15 D: =Minkälainen työ teillä on nyt.
 =What kind of work do you have now.

In line 8, when the doctor turns away from the patient towards the medical records, the patient's talk becomes dysfluent. The doctor's home position is towards the desk with her head in torque towards the patient (see Figure #3). She releases her torque simultaneously with withdrawing her gaze from the patient. This signals that her shift in attention from the patient to the records may be more permanent than temporary, and that she is directing her main

attention towards the medical record on the desk (Kendon 1990; Schegloff 1991a; Robinson 1998). This signal seems to be further enforced by her opening the medical record file, although her shift to reviewing the records may be a response to the patient's description of his previous visit. Immediately following the doctor releasing her torque and returning to gaze at the records on the desk the patient breaks off his utterance and inhales.

Following the cutoff, towards the end of line 8, the doctor turns her head back towards the patient, possibly in order to show that she is still attentive to the patient's talk. However, considering her overt disengagement just preceding this point and her home position towards the desk, the gaze back at the patient is likely to be interpreted as temporary (Schegloff 1991a). And as is observable in line 9, it is indeed temporary, as the doctor quickly reverts to the records straight after the patient has restarted his utterance after the pause of (0.2).

There follows a series of discontinuities in the patient's speech before he finally reaches the end of his problem presentation. In line 11, at the point where the patient has just uttered the beginning of the next element of his utterance ('and,') the doctor again communicates a shift of attention even further away from the 'patient embodied' towards the medical records by taking her reading glasses out of her pocket. The patient mirrors the doctor's movements by pausing for (1.1) seconds. Finally he goes on with his description, not producing a complete utterance, however, but just a keyword: 'antibiotics'. After this he quickly starts a new clause, saying 'and uhm', and pauses again. At the very end of the pause, which is notably long for any conversation (Jefferson 1989), and after the patient has made a hand-gesture in the doctor's visual field of the doctor (he lifts his hand to scratch his chin), the doctor finally returns her gaze to the patient. Only after the doctor has observably re-engaged as a recipient of the patient's description does the patient continue with the core of his problem, with his actual reason for the visit, saying: 'the pain did go away but my voice has not yet come back'.

By returning to her home-position towards the desk and away from the patient, simultaneously opening the medical records, the doctor displays an overt shift in her orientation from the 'patient embodied' to the 'patient inscribed'. The patient's cutoffs and gaze-eliciting practices (pausing and

scratching his chin) indicate that the patient treats the doctor's disengagements as expressions of non-availability as a recipient for his problem presentation.

Example #3 illustrates a similar situation; the orientations of the participants at the beginning of the problem presentation are similar as in figure #3:

Example 3 (1A5 Pension)

```
1 P: ((groans))
2 (.)
3 D: No nii. Is:tumaa vaa.
    Right. Do sit down.
4 (2.0)
5 D: °Ja se oli Kotipohja Annikki,°
    °And it was Kotipohja Annikki,°
6 (2.0)
7 D: kahdestoista maaliskuuta, kolmekymmentäseitsemän.
    twelfth of March nine-teen thirty-seven.
    Dges: ::: (puts on glasses)
    Dg: ,, (to desk)
8 P: Joo:.
    Ye:s.
    Pg: -----
    Dges: :::::::::::::::::::: (turns to computer)
9 D: Ja minkäslainen ti[lanne. ]
    And what's the si[tuation like. ]
    Pg: -----
10 P: [Joo mä kävin s]iel (.)
    [Yes I was the]re (.)
    Pg: -----
    Dg: ..X-----,, (to desk)
11 → ultraäänitutkimuksessa ja (0.4) pitäis olla ne (.) tulokset.
    in the ultrasound and (0.4) those results (.) should be here.
    Pg: -----
12 (1.1)
    Pg: -----
13 D: Joo, katotaanpa,
    Right, Let's have a look,
```

When the patient starts her problem presentation, the doctor's orientation is towards the computer. In line 11 the doctor briefly turns to gaze at the patient with the lower segment of her body still towards the computer and her head in torque towards the patient. Shortly after she releases her torque in line 11 and turns back to face the computer, the patient cuts off her utterance for 0.4 seconds. As in example #2, here the patient treats the doctor's withdrawal of gaze as indicating disengagement from the role of the recipient to her problem presentation.

In the following examples #4 and #5, in contrast to #2 and #3, the doctor's home position is towards the patient and the dysfluencies do not start immediately at the moment of gaze-withdrawal by the doctor.

7.3.2. Disengagement with manifest shift in orientation

Example #4 is a continuation of example #1⁶. The patient has already described the nature of her problem by naming it as 'varicose veins'. After this she has started a narrative on the onset of the problem, describing how the problem was worse when she made the appointment, and then got a little bit better. The doctor's home position is towards the patient. From time to time he turns the upper segment of his body towards the desk, taking notes. These two basic positions are illustrated in Figures 4a and 4b.

Figure #4a



Figure #4b



⁶ The transcript of the whole problem presentation is found in chapter 5, pp. 166-168

Example 4 (5A3 Varicose veins)

```

Dg: -----
17  rappusia niinku noustessa      niin siinä >se kaikista
    stairs  like going up+while so  there it of all
    going like up the stairs so that's where >it can

Dges:          ::::: X (to torque, starts
                writing)
Dg: -----,,Down,,,,to desk
18  → parhaiten tulee esille että se tota .mhhh #n# >se tota
    best      appears  that it like      it like
    best be   noticed   that it like .mhhh #n# >it
Pg: -----,,O
Pges:          :: (wipes nose)

Dg:          ..X-----
19  noin nin (0.2) tuntuu sillai kä#vellessä et >se on
    like (0.2) you can feel it while you're wa#lking that >it's

```

In this example, the perturbations in the patient's turn of talk do not start at the exact moment of the doctor's initial disengagement. They follow only after the doctor has turned his gaze towards the desk and turned the upper two segments of his body to torque, writing notes. When the doctor disengages in line 18 he first turns his gaze down while remaining posturally oriented towards the patient. With his home position still towards the patient, the downward shift of his gaze may be understood as temporary, thus indicating that he is still potentially maintaining his engagement as the recipient of the patient's narrative. There is no observable change in the pace or fluency of the patient's talk at this point.

However, the doctor starts a shift of posture, turning his upper body towards the desk (the movement is illustrated by the colons). At the exact moment when the doctor reaches the final point of his torque and starts writing (marked with X in the transcript), the patient inhales, speeds up (">it y'know like"), pauses, turns away from the doctor and starts wiping her nose. Thus, the first gaze-withdrawal by the doctor was not acknowledged by the patient as a shift of attention from her description to something else. Only when the doctor started writing and thus overtly displayed disengagement from the patient did the patient cut off her utterance and start 'stuttering'.

Example #5 illustrates another similar case. The postural orientations of the participants are as in figures #4a and #4b.

Example 5 (10A3 Arthrosis)

```

1          (2.0) ((D and P sit down))
          Dg: -----,, desk
2  D:      minkähän tavasta asiaaah.
          what kind of problemhh.
          Pg: -----

3          (.)
          Pg: ---

          Dges: (sitting towards the desk, writing)   ::: (turns towards P)
          Dg:      ..X-----,, (desk)
4  P:      .mt no: tuota se liittyy nyt tohon mun aikasemp:aan (.)
          well erm it has to do now that my earlier
          mt well: erm it has to do now with that earlier (.)history of
          Pg: -----

          Dges:      :::: takes paper in hand, starts reading
5  →  historiaani (.) edelleen eli, (0.3) eli huolissani oon
          history      still I mean I mean worried am+I
          mine (.) still I mean, (0.3) I mean I'm very much worried
          Pg: -----

6          kovasti noist nivelistäni.
          very much those joints+my
          about those joints of mine.
          Pg: -----

```

In the example the doctor turns in his chair to face the patient in line 4 while the patient says ‘that earlier’. His home position is half towards the patient while he turns his gaze back to the desk at the end of the same line. At this point the patient pauses only slightly. Later, in line 5 when the doctor displays a manifest shift in activity by taking a paper in his hand and starting to read it, the patient pauses for 0.3 seconds and restarts his utterance repeating the words ‘I mean’. As in the previous example, the patient responds to a manifest disengagement of the doctor with an observable dysfluency in her talk.

In the data, the extent to which the doctor communicates disengagement from the reciprocity of the patient’s description seems to be relevant in relation to the fluency of the patient’s speech. In examples #2 and #3 the doctor’s home position was away from the patient, her disengagement resulting in release of her torque, whereas in examples #4 and #5 the doctor’s whole body was turned towards the patient, turning to torque while disengaging from the patient. These postural orientations seem to signify different things to the patient. When the doctor’s home position is towards

the patient, her withdrawal of gaze is not received by the patient with any changes in the fluency of his talk. On the other hand, if the doctor's home position is away from the patient, her disengagement seems to be easily treated as problematic, received by the patient with cutoffs and pauses in his narrative. In addition, the manner and the moment of the doctor's taking up the new activity, whether reading the records or writing down notes on the patient's description, seem to be relevant: displaying a manifest shift (such as putting on reading glasses) to another activity in the middle of the patient's utterance seems to be interpreted as problematic by the patients.

7.3.3. Disengagement at critical point in description

In example #5 below the shift in the doctor's postural orientation is again treated as problematic by the patient, but there is an additional contingency which specifically complicates the moment of the doctor's disengagement: the doctor turns away from the patient right at the moment when the patient has specifically shown the relevancy of maintaining attention on a common focus of interest.

Prior to the passage transcribed, the doctor has suggested a previously diagnosed problem (asthma) as the reason for the patient's visit, and in response, the patient has explained that it is not troubling her at the moment. In line 14 the doctor acknowledges the patient's explanation and the topic is closed.

In line 17, which is the focus of our interest, the doctor's home position is towards the desk and she is gazing at the patient's leg. The patient is sitting on her right, her home position towards the doctor, gazing at her foot. (See Figure #5)

Figure #5



Example 5 (30A3 Low arch of foot)

```

14 D:  rig[ht.  ]
    P:  [.sniff]

    Dg:  . . . to leg
15 P:  >mutta mää tulin nyt tuon< jalkani tähren.
        >but I came now that foot for
        >but I came now because of that foot of mine.
    Pg:  . . . . . to leg
    Pges:  | (P lifts trouser leg)
           | (P bends forward)
           | (P moves leg)

    Dg:  at leg
16 P:  =>tuossa< (.) päkiäs on
        there ball+in is
        =>there< (.) in the ball of foot there is

    Dg:  at leg , , , , paper
17 → >semmonen< .hh .mt (.) hhh vaiva tulee aina
        kind of trouble comes always
        >a kind of< .hh .mt (.) hhh. trouble occurs when
    Pg:  at leg . . .X-----

    Dg:  . . . X-----
18 kävellessä että nyt mää aina, (.)
    walking+while that now I all the time
        walking that now I'm able to walk,(.)
    Pg:  -----

    Dg:  -----
19 P:  [>vähe]mmän ja vähemmän< pystyn käveleen.
        less and less am able to walk
        [ >les]s and less< all the time.

20 D:  [hriight.  ]
        PRT
    Pg:  [hriight.]
        -----

```

In line 17, immediately after the doctor withdraws her gaze from the patient's leg, the patient cuts off her utterance. She also lifts her gaze from her foot (and their previous common focus of interest) back to the doctor (who is now looking at the records on the desk). In line 18, following the patient's cutoff, hesitations and pause, the doctor turns her gaze back to the patient. Having caught the doctor's gaze the patient finishes her description to an engaged recipient.

In the example the doctor disengages at exactly the point where the patient should be uttering the actual core of the problem. This is to be anticipated by the design of her utterance so far. The beginning of the second TCU of her turn: 'there in the ball of the foot there is a kind of', which she has uttered just before the doctor's gaze-withdrawal, permits the anticipation that the agent of the utterance, i.e., the supposedly problematic issue, will occur next. The focal nature of the projected completion of the TCU is enhanced by the patient's non-verbal procedure accompanying the beginning of her utterance: During her first TCU 'but I came now because of that foot of mine' she had elicited the doctor's attention to her foot by turning to gaze at it and lifting her trouser leg while uttering 'that foot of mine'. During the beginning of her second TCU she further specifies the focus of her interest by lifting her foot and referring to the exact location of the problem by saying 'there in the ball of the foot'.

By twice pointing at her foot and so drawing attention to a common focus of interest (cf. Heath 1986; Goodwin 1998) the patient specifically marks the section of description co-occurring with the pointing as something which requires attention from its recipient. As the utterance, too, is designed so as to anticipate the core of the problem (situated in the pointed location of common interest) occurring next in the description, it can be claimed that such a position is critical from the point of view of problem presentation. Turning away at a moment when maintaining mutual involvement in a common focus of interest has been made specifically relevant, and when the utterance is still incomplete with only the very core of the complaint pending, seems to be interpreted by the speaker as a disengagement from the role of the recipient. (cf. Goodwin 1981; Heath 1986).

In example #6 the doctor withdraws her gaze as the patient has just pointed at her head, thus making relevant the doctor's display of attention:

Example 6 (30A2)

```

1  P:                                     [ja mää o]letan
                                       [and I th]ink

2      ny että se huimaus on niinkun .hh (.) lisääntynyt kun
      now that the dizziness has like .hh (.) got worse as
Pges:                                     :::::

Dg:                                     ..X-----,O
3      → >mla< niinkun tääl ois >semmonen< .hh nyt mul on tosin
      >I've< as if here I had >kind of< .hh now I have though
Pg:                                     X-----
Pges:                                     :::::X ((P hands up on back of her head))

Dg:                                     .. .X-----
4      (.) ↑pant:a päässä >ku mä hairasin sen nopeesti.=ku oli
      (.) ↑a head-band on >as I brushed my hair so quickly.=as
Pg:                                     -----

Dges:      |D nods
Dg:      -----
5      t|ukka niin kauhe< .hhh ni niinku mull olis semmonen
      m|y hair was so awful< .hhh so as if I had kind of
Pg:      -----,, Down ..

Dg:      -----
6      <vanne> täält mu täält aina:h.
      <band> here I feel it here alwaysh.
Pg:      .X-----

Dg:      ---
7      (.)
Pg:      ---

```

In line 3 the patient shows the doctor the back of her head uttering ‘here’ at the same time. She also adds ‘kind of’ which projects the name of the problem coming next in her utterance. However, right at the end of the words ‘kind of’ the doctor turns her gaze away from the patient. At the point of the doctor’s gaze-withdrawal the patient interrupts her utterance and makes an insertion to her utterance: ‘now I have though a head-band on’. She only completes her utterance with the name of the problem when the doctor has turned her gaze back to her in lines 5-6. The patient’s manner of drawing the doctor’s attention to a specific location on her body, and also her design ‘here as if I had a kind of’ which anticipates the core of the problem upcoming next, mark this point of her problem presentation as important, as making relevant the doctor’s display of attention.

7.3.4. Disengagement at critical point of storytelling

Example #7 illustrates a situation where the moment of the doctor's disengagement is critical in a different way than in the situations presented in the previous examples. It happens just before the possible completion of the patient's entire problem description. The example is extracted from the same consultation as example 4. The patient has been presenting a narrative on the onset of her problem and its development. At the beginning of the extract she has just switched to present tense, describing the occasional problems she still encounters when walking.

The doctor's home position is towards the patient. From time to time he turns his upper body to torque towards the desk, making notes. The doctor's two basic positions are illustrated in Figures #4a and #4b.

Example 7 (5A3 Varicose veins)

```

19      noin nin (0.2) tuntuu sillai
           it feels that way
       like      (0.2) you can feel it while you're

Dg:      ..X-----
20      kävellessä et >se on
       walking+while that it is
       walking that >it's

Dg:      -----,, to desk      .X--
21      niinku pis[tävä, ] (.) vaikutus tänne (0.2)
       like stinging          effect here+into
       like a [stinging] (.) effect over here (0.2)
           ^ ^

22      D:      [#Joo.# ]
           [#Yes.# ]

Pg:      .. .X-----
Pges:      (taps her knee at the little arrows)

Dg:      -----,,to desk
23      P: → pol vi lumpion (1.5) °.mhh° (0.2) lumpion
       knee-cap+of          cap+of
       where the knee-cap (1.5) °.mhh° (0.2) the knee-cap
Pg:      -----,, (to distance past doctor)
Pges:      ^ ^ ^ ^^^ ^^^^
       (taps her knee)

Dg:      ..Knee
24      P:      #o# kohdalla,hhh
           place+at
           #o# is,hhh

Pg:

25      (.)

```

26 P: Ja< (0.2) [si-
 And< (0.2) [th-

The disengagement in line 21 can be analysed in the same terms as the ones presented in examples #5 and #6: the doctor disengages at a point where maintaining attention on a common focus of interest had been specifically marked as relevant by the patient. The doctor's disengagement is followed by a dysfluency (a pause of 0.2) in the patient's speech. In the following, we will concentrate on the disengagement in line 23.

When the doctor shifts his gaze towards the desk in line 23 the perturbations in the patient's speech follow immediately. Here the question is not about withdrawing gaze just before the announcement of the core of the problem. The patient's utterance is practically complete, only one last word, which would have to be some kind of specification of the already fairly exact location of the problem 'the knee-cap', is missing. What it does have in common with the previous cases is the pointing gesture, tapping on her knee, which it is combined with. The patient starts the tapping while the doctor is still engaged. As the doctor turns his gaze away in the middle of the word 'knee-cap' the patient accelerates the pace of her tapping, reaching it over the beginning of the pause of (1.5) seconds. This shift in the tempo of tapping may be one practice of gaze-elicitation, indicating the relevancy of the engagement of the recipient.

In examples #5 and #6 the moment of the doctor's disengagement was found to be crucial because the pointing gesture indicated the relevancy of the recipient's engagement when referring to an intended common focus of interest, and because of the anticipation of the core of the problem to be uttered next. In the present example, the pointing seems to establish a similar relevancy, but what is projected to occur next is not the core of the problem, as it has already been revealed. Instead, maintaining the recipient's gaze seems to become crucial as the patient is arriving at the very final point of her description. Several features point to the utterance in progress as the final part of her narrative: The temporal development has proceeded from past tense into present ('you CAN FEEL it', 'it IS like a stinging effect over here'), she has just described the core of the problem ('a stinging effect over here where the knee-cap'), and she has made her utterance specifically accessible to her recipient with lexical choices

appropriate to the doctor's area of expertise ('stinging effect' instead of 'it stings', which would be a more vernacular type of design).

In ordinary conversation, at the closing of a narrative, speaker change becomes relevant. The multi-unit turn of the narrator should be appropriately received, providing assessments of the story, or second stories related to the one told. In this way the story-recipients are able to convey that they have properly understood the gist of the story and to acknowledge the story told as worth telling. (Sacks 1974; Jefferson 1978). It seems possible that at the moment of the doctor's disengagement in line 23, the patient is orienting to the relevance of getting a reaction to her narrative: immediately following the disengagement she pauses for 1.5 + 0.2 seconds just before the projected last word of her description. By pausing she engages in a practice known to elicit gaze from the recipient. What is especially noteworthy is that during the pause she gazes at the doctor and not at her leg. This would indicate that she is orienting more towards re-establishing the engagement framework and getting the doctor to gaze at her as a sign of reciprocity, than eliciting a common focusing on her knee. These features, together with the previously described indications of the narrative coming to an end, suggest that the patient will soon be ready to pass the turn on to the doctor, and in order to do this she needs to have the doctor gaze at her (Goodwin 1981).

The following extract #8 is an example of a similar situation. The patient has been telling a long narrative and is just arriving at its completion when the doctor first takes off her glasses and looks at the patient, but briefly preceding the projected last word of the patient's narrative withdraws her gaze:

Example 8 (1B1 Naprapath⁷)

14 P: =Ja (.) mä viime viikolla ku mulla loppu niinku eilen
and I last week as I finished like yesterday
=And (.) I last week as I finished my sick leave yesterday<
15 loma< mä aattelin jos mää kokeilisin töihin, .hh mutta (.)
vacation I thought if I would+try work+to but
I thought maybe I'll try to go to work, .hh but (.)

⁷ The transcript of the whole problem presentation is found in chapter 3, pp. 75-76.

withdraws her gaze and turns to look at the computer, even though the patient proceeds to elicit the doctor's attention by pointing at her hip while uttering 'this'. As the doctor turns away, the patient inhales and rushes to add a new completion to her utterance, uttering the completion of the previous TCU and the beginning of a new TCU with a quicker pace '>hip and a kind of<'. While adding a new element to her utterance the patient gestures with her hand on the desk, which is a gesture often used to elicit attention from the recipient (Goodwin 1986). By rushing through the completion of her narrative the patient seems to orient to the doctor's missing gaze as problematic. As in example #7, while the patient does pointing, she does not gaze at the target of pointing but at the doctor.

The moment of finishing the narrative on the reason for the visit is important with regard to 'doing doctorability' of the visit. When presenting the reason for the visit to the doctor the patients often work to justify their problem as requiring medical care (Heritage frth). Consequently, it may be of importance to them that the doctor approves their problem as doctorable by starting the verbal or physical examination after the problem presentation. In both #7 and #8 the patients delay the final point of their problem presentation, seemingly in order to ensure the doctors' attention at the point when the narrative is completed. As they do not get the doctor's attention at the first completion point of their narrative, they stretch their description over the completion point (see example #7, line 23, and example #8, line 22-24) . As the doctors still do not start to examine the problem the patients begin to add new elements to their problem presentations (see example #7, 26; example #8, 29-30).

In examples #1, #2, #3, and #4 the postural orientation of the doctors, and the way in which the doctors turned away from the patient to the records within the patients' turns, were enough to convey a disengagement from interaction with the patient. In examples #5, #6, #7, and #8, there were additional circumstances coinciding with the doctors' gaze-withdrawals: the disengagements were made at points specifically marked by the patients for their relevancy for maintaining attention on a common focus of interest (cf. Goodwin 1981, pp. 116-125). This specific relevancy of engagement was created by the anticipation of either the core of the problem or of a speaker change at the completion of a narrative ensuing next.

Consequently, there seem to exist specific environments in which disengaging from interaction with the patients is treated as problematic by them. The characteristics of these environments can be described in terms of certain spatial and/or temporal aspects of interaction. Spatially, the postural orientation of the participants towards each other, with the 'intensity' or 'overtness' with which the doctor shifts his orientation away from the patient, seem to be crucial in this respect: manifest disengagements are treated as more permanent. (cf. Goodwin 1980; 1981). Temporally, the placing of the doctor's disengagement in relation to the patient's problem presentation seems to be relevant: disengaging just before the core of the problem or the completion of the narrative tends to be responded to with dysfluences in the patients' speech.

7.4. Conclusion

In the qualitative case-by-case analysis, I identified four circumstances in which the patient became dysfluent after the doctor's disengagement from interaction. The first four examples illustrated a situation where the doctor manifestly displayed a shift in activity and thus also a potential unavailability as a recipient of the patient's description. The last four examples presented situations in which the patients marked parts of their ongoing telling as specifically requiring the recipient's attention, but failed to get it.

The observations presented provide further evidence for previous findings on the relevance of the non-verbal orientations of the participants (such as postural orientation and direction of gaze) for the organization of interaction (Goodwin M.H. 1980; Goodwin 1980; 1981; 1986; 1998; Heath 1984; 1986; Schegloff 1991a; Robinson 1998). Specifically, they draw attention to the importance of coordination of speech and gaze in displaying engagement as a recipient of talk in interaction.

In medical consultation doctors first display reciprocity to the patient's talk by asking the opening question. However, maintaining the engagement framework thus created may become problematic when, while listening to the problem presentation, doctors may have to engage in side-activities such as checking the medical records. In such a situation, even though the doctors actually were (or are) preserving the patient's problem as their main focus of interest, this orientation may not be transparent to the patients.

In line with Goodwin's studies on ordinary conversation (1981, 1986) it was found that patients work to maintain the engagement framework with themselves speaking and the doctors listening, by specifically marking the points at which the engagement of the recipient is critical. This is done by pausing and/or pointing. By pausing in the middle of their utterance, and/or by using a deictic construction such as 'this' or 'here' while simultaneously pointing at or showing the intended common focus of interest, the patients demonstrate the relevance of the recipient's attention (cf. Goodwin 1998, see also Heath 1986). These projections of the relevancy of the doctor's displays of reciprocity seem to be concentrated at moments where the core of the problem or the closure of the patient's narrative are imminent. Thus, although reading the medical records may be regarded as a relevant activity for the doctor to engage in at some point in the consultation, it is not treated as appropriate during the crucial points of problem presentation.

Furthermore, in ordinary conversation, if the intended recipient is posturally oriented to an activity other than conversation and only turns the upper segment of her body towards the speaker, her engagement as a recipient may be considered temporary, and the activity of conversation a side-activity (Kendon 1990; Schegloff 1991a; Robinson 1998). In a similar situation in medical consultation the patients treated the doctor's manifest disengagement from interaction with them as a shift of activity away from listening to their problem presentation to, for instance, reading the medical records. This orientation was embodied in the way in which the patients became dysfluent in such a situation.

Displaying attention to the patient's story by gaze and postural orientation at critical points of narration can be seen as one constituent of a patient-centered medical consultation. One particular technique presented for displaying attention in earlier studies is gazing at the patient. (see Roter and Hall 1992; Bensing et al. 1995). However, constant gazing at the patient during problem presentation is not always possible. The findings presented in this chapter imply that there are alternative, less interrupting ways of turning to read or write the medical records while listening to the patients' descriptions of their problems. For example, some doctors in the data have made use of spatial arrangements in which they maintain their home position towards the patient while simultaneously having the medical records at hand. Further,

considering that there are specific moments when displays of attention are treated as essential by the patients, shifts of gaze and attention away from the patient could be located elsewhere within the problem presentation. Thus, the observations made provide for a more detailed understanding of what could constitute a patient-centered style of consultation when receiving the patients' descriptions of their problems.

The observations made in this chapter also address the ways in which control is managed in medical consultation. Managing the distribution of attention between the patient and the medical records constitutes a resource for the doctors for controlling the course of consultation. For example, in cases when patients present their problem in the form of a narrative and thus gain control over the space available for their problem presentation (see chapter 4), doctors may non-verbally heckle the patient's narrative by withdrawing their attention from the patient and manifestly concentrating on some other activity. While narrative design enables the patients to extend the space available for describing their problem and to project the place at which their problem presentation is complete, by withdrawing gaze doctors may reject or obscure their role as the recipient of the narrative. In this way they could, for instance, be regarded as following the 'hidden agenda' of the medical consultation available to doctors through their professional position as experts, leaving the patients uncertain of what would constitute the relevant activity at such a moment. In ordinary conversation, where there is no pre-defined course of activities or topics once the participants have engaged in conversation, not aligning as a recipient to the speaking participant's talk could result, for example, in the speaker changing the topic. A medical consultation, on the other hand, consists of specific activities performed in a relatively rigid (though varying) order, and the recipient (doctor) is considered to be the knowledgeable participant with regard to the course of consultation. Thus, the doctor's disengagement from the role of the recipient could be interpreted as indicating that the section of the narrative delivered at the moment of disengagement is not specifically medically relevant.

From the conversation analytic point of view, any event in face-to-face interaction is constructed in and through the talk of the participants of a situation. The participants coordinate their actions in order to achieve a shared understanding on 'what is going on' in a situation. Coordination of gaze and posture with the ongoing talk is essential in constructing an

engagement framework suitable for achieving a shared understanding on the situation. In this chapter I have shown how this coordination is also essential for maintaining a shared understanding of the ongoing activity of giving and receiving the reason for the visit in medical consultation. In specific circumstances, when the doctor disengages from interaction with the patient, he also risks losing this shared understanding. This action entails a special aspect of the doctors' means of controlling the course of consultation.

8. CONCLUSION

The study has described in detail the interactive process in general practice consultations in which doctors ask the opening question, patients present their problem to the doctor, and doctors receive this presentation, subsequently moving forward in the consultation to examine the problem. The detailed description and analysis of the process produced observations concerning 1) the structure of the phase of problem presentation, and its linkage to the overall structural organization of the consultation, 2) the linking of moral aspects to the phase of problem presentation, and 3) the constituents and distribution of control in consultation. These intertwined themes represent different levels or aspects of context made relevant by the participants in giving and receiving the reason for the visit. In the following, I will first discuss the results concerning the relation of the immediate sequential context to the activity-context serving as a basis for coherence for the whole consultation, and the intertwining of moral themes with this larger activity-context (8.1). Thereafter I will concentrate on issues of control and its distribution (8.2). In each section I will relate the results to previous study on institutional interaction, and discuss their implications for the study of social interaction in general, and of doctor-patient interaction in particular. To conclude, I will briefly discuss some limits and possibilities of CA as a method of analyzing institutional interaction (8.3).

8.1. 'Request for service - response' as the activity context of the whole consultation

It was found that many patients treat the slot following the doctor's opening question as a slot for 'presenting their problem' rather than for 'answering the doctor's opening question'. This was observable in that patients often started their turns of talk as 'pro forma' answers to an invitation to tell the doctor about their problems, and in that they frequently presented their ailment in the form of a story. Further, doctors rarely interrupted the patients' problem presentations or took the turn after one-word answers to their questions by the patients. Rather, they provided space for the patients to talk about their ailment. Yet further, the data only contained a few cases where the patients gave a plain, one or two-word answer in response to the doctor's opening question. In these cases the problem presented had been diagnosed earlier, so it was to be expected that the doctors would already have some

information on the patient's ailment. In sum, these observations indicate that in this phase of the medical consultation participants orient not only to the immediately preceding context of interaction formed by the doctor's opening question, but also to a larger activity structure which serves as a basis for coherence for the whole consultation.

This activity seems to be organized as a paired activity consisting of a request for service and a response to this request. According to Bergmann, such an organization, originally found to structure emergency calls, can be perceived as providing structure for a large set of service encounters (Bergmann 1993). Drawing upon the analysis in this study, in medical consultation the patient's problem presentation can be perceived as constituting a request for help, and the doctor's procedures following the request as developing a response to it. In this larger activity context the doctor's opening question would work as an indication for the patient that starting the medical business is the relevant next step (cf. Heath 1981; Rostila 1997). Thus, in terms of the overall structural organization of medical consultation the phase of problem presentation may be depicted as the following sequence: the doctor indicates the relevance of starting the medical business, the patient presents his problem, i.e., makes his request for service, and the doctor starts to prepare a response to the patient's request by setting out to examine the problem, i.e., by starting 'the interrogative series' (cf. Whalen and Zimmerman 1990; Zimmerman 1992).

The figure below illustrates how the overall structure of the medical consultation can be perceived as comparable (or analogous) to the overall structure of emergency calls:

EMERGENCY CALLS

1. opening

2. request for service by the caller

* report on the events

* narrative on the events

3. interrogative series

4. response

* promise to send help

5. closing

MEDICAL CONSULTATIONS

1. opening

+ doctor's initiation of medical business

a) opening question

b) suggestion for the reason for the visit

2. request for service by the patient

* report on the problem

* narrative on the development of the problem or on the events that led to noticing the problem

+ agreement with doctor's suggestion

3. interrogative series

+ verbal examination

+ physical examination

4. response

+ diagnosis and treatment

5. closing

The factor added to the activity structure in medical consultations is the normative orientation to the doctor as the one who should initiate the actual business of the encounter, whereas in emergency calls the caller goes straight to the point just after the dispatcher has identified himself.

The analysis of the design of the patients' problem presentations offers further evidence of the patients orienting to it as based upon a request - response sequence: with the exception of problem presentations designed as plain answers to the doctor's opening question, the patients completed their problem presentations with elements which embodied or came close to embodying advice-seeking activity. For example, they could pose a direct question to the doctor on procedures concerning their problem, such as 'what should I do with this'. More subtly, patients could elicit the doctor's attention to a common focus of interest by pointing. Such an elicitation of attention would construct the problem as equally available to both participants, making relevant some comment or assessment on the object studied (cf. Goodwin 1986; 1998). Thus, although pointing is not advice seeking as such, it can

work as a proposal indicating the relevance of starting to examine the problem.

Yet another way to finish the problem presentations were utterances which resembled complaining or troubles-telling. However, these were treated by both doctors and patients alike as advice-seeking rather than troubles-telling. Instead of eliciting empathy and understanding from the recipient, they were treated neutrally by the doctors, in a similar manner as other (more 'objective') descriptions of the problem by the patients. The patients did not pursue the missing affiliation but continued their problem presentation by adding an element of a different quality (e.g. a request for advice or an elicitation of attention to a common focus of interest). Thus, they did not treat the doctors' neutral stance as accountable. It seems possible that, in this particular context, expressions of suffering (such as extreme case formulations or upgrades of the intensity pain) served to emphasize the patient's need for help by constructing the problem as particular and critical. For instance, by describing a sense of losing control of their body with extreme-case formulations, patients depicted themselves as helpless, as unable to control the situation on their own.

Thus, the overall organization of the ongoing activity as a sequence consisting of a request for help and a response to it seems to inform the participants' actions together with the more immediate sequential context. This observation adds to the existing understanding of the activity structure of the medical consultation, and makes relevant a rethinking of the distribution of control in the situation.

8.1.1. Immediate sequential context vs. activity context of the whole consultation

The findings of the present study directly address Mishler's suggestion according to which 'the basic structural unit of discourse in medical consultation' is a three-part structure in which the doctor asks a question - the patient answers the question - and the doctor assesses the answer or asks next question. According to Mishler, this structure serves to maintain the doctor's control over both the turn-taking process and the content of talk (1984, 69). The doctor is able to control the course of the consultation by virtue of always initiating the first topic, and thus always getting the initial turn, which renders

the patients' subsequent turns restricted by the design and content of this first turn by the doctor.

In the present study it is suggested that in addition to immediate sequence organization, it is the activity structure of the whole encounter that informs the patients in designing the turn which follows the doctor's opening question. Thus, Mishler's model does not seem to capture entirely the logic according to which actions are organized in medical consultation. Although, on a more immediate level of context, participants do orient to the preceding action as making relevant or possible a specific variation of next actions, they also have at their disposal another structure on another level of context and use it as a resource in designing their next action. Consequently, thinking about medical consultation as an activity structured around the basic adjacency pair of request - response serves as a resource to reconsider the suggested structural basis for the distribution of dominance and control in favor of the doctor.

These different but intertwined levels of context enable varying interpretations by the participants on the nature of the activity, as well as on the phase of consultation. Patients are not confined to act according to the restrictions embodied in the immediately preceding opening question, but may use the overall activity structure of the consultation as a resource for alternative interpretations of the ongoing activity. In this way, they are able to design their problem presentations as relatively independent from the structure of the doctor's question. Thus, the overall structural organization of the consultation, where the adjacency pair of request - response serves as the basis for coherence for the whole consultation, provides additional resources for the participants for negotiating a shared understanding.

Consequently, the present study provides empirical support for redefining the position of the patient as an active participant in consultation, as possessing means to influence the course of the consultation at least to some extent. Before proceeding to further discussion of control, we will consider yet another level of context made relevant by the participants, i.e., the moral issues attached to giving and receiving the reason for the visit.

8.1.2. Morality inherent in conversation vs. morality specific to institutional and/or medical interaction

Considering medical consultations in primary health care as built around a paired action of requesting for service and granting it points at the inherent morality of the whole action of requesting, and thus, at the inherent morality possibly present in every service encounter.

In ordinary conversation, requesting something is oriented to as a dispreferred activity. For instance, in making a telephone call in order to ask a favor from a friend, the actual request is not taken up as the first topic to be talked about, but is postponed for later (Schegloff 1990; see also Schegloff 1995). In medical consultation there is an additional twist to making the request for help. As the request often concerns the approval of the one making it into the category of a sick person (the granting of the request gives the patient the right to be exempted from his normal obligations to work, for instance), the situation becomes doubly delicate.

In ordinary telephone conversations postponing the request makes it possible for the caller to avoid the responsibility for deciding the proper time of making the request, and provides an opportunity for the call-taker to decide about the proper moment and to inquire the reason for the call or otherwise offer her services. In ordinary conversation it is also common to ‘fish’ for an offer of help from the recipient, thus avoiding the actual request altogether.

In ordinary conversation the delicacy work is managed more locally, while in medical consultation the institutionalized structure inside which doctors initiate the sequence guarantees the efficient arrival at business, by alleviating the production of the dispreferred action of requesting help¹.

Further dispreference concerning the activity of problem presentation is connected with its characteristics as a troubles-telling. In ordinary conversation troubles-telling is arrived at through a complex and contingent

¹ It seems possible that different institutions have developed different structures for managing the making of this request for service (i.e., for giving the reason for contacting the representative of the institution). As was mentioned, in emergency calls the caller proceeds to making the request straight after having heard the identification by the dispatcher, and having recognized it as the intended one. In such a situation an alleviating structure is possibly not necessary, as the urgency of the situation is enough to account for making the request.

procedure beginning with the negotiation of a suitable environment and engagement framework for telling about the trouble. (Jefferson and Lee 1992). The doctor's opening question helps to bypass this complicated sequence and to move directly to the business at hand.

Thus, on the level of the overall structural organization of the medical consultation, it seems that the opening question (which various previous studies have nominated as one constituent of the doctor's unilateral control over the course of consultation) can also be perceived as an alleviator which helps the patient to start making his request. By asking the opening question doctors offer their services² and thus lift the responsibility for requesting them from the patients.

However, the designs of the statements used by the patients to deliver their reason for the visit still indicate their moral considerations. These considerations arise from the specific nature of the activity as institutional interaction. With these moral considerations patients evoke their institutional position as patients requesting admittance to the sick role from the representative of an institution.

In applying for the sick role, on the one hand, the patients work to create and maintain their status as responsible patients looking after their health, whereas on the other hand, they work to construct their problem as particular, as real trouble which validates their visit to the doctor (also Halkowski frth; Heritage frth). These orientations are embodied in the elements voluntarily included in the problem presentations: the patients engage in long accounts of how they noticed the problem 'by accident' instead of specifically searching for it, how they have waited for the problem to be cured by itself or have tried all possible home remedies before deciding to see a doctor, how they are not themselves responsible for becoming ill due to careless behavior, for instance. On the other hand they include in their problem presentations descriptions of the particularly critical nature of the problem, for instance, by depicting the situation as out of their control.

² In the Anglo-American culture doctors may encode the offer in the design of their opening question, asking, for instance, 'What can I do for you today?'

These moral considerations of the patients are specifically linked with the institutional character of the consultation. Whereas the inclusion of the doctor's opening question to the structure of the consultation could be perceived as a facilitating institutional structure (managing the delicacy attached to making a request or doing troubles-telling), the moral orientations shown by the patients in applying for the sick role address the control function inherent in the institution of medical consultation. A similar orientation has been found to exist in many other service encounters (e.g. Bergmann 1992; 1993; Heritage and Lindström 1998).

Bergmann writes about professional-client interaction as a hybrid of rational and moral frames of reference. He points out that tasks and goals present in many institutional contexts, such as medical consultation, maternity health care, or social work, involve moral issues, but are still to be managed with a neutral stance. In reality this is an impossible equation, as these practices are inherently based on assessing people's normality and moral accountability. (Bergmann 1998).

Bergmann seems to point at the necessity of considering the paradoxical nature of institutional interaction in general. As we have seen, the patients' actions clearly indicate their moral considerations in seeking medical help, i.e., they treat doctors partly as gate-keepers to the sick role and take pains to argue for their moral accountability as legitimate candidates. Thus, the present study also provides further empirical evidence for Bergmann's idea of the intertwining of rationality and morality in managing citizens' problems in institutional situations.

Moreover, this study draws attention to a possible locus of analysis for comparing different institutions. If the adjacency pair of request for service - response is perceived as a basis for coherence in service encounters, it will be possible to extract the sequence around which the request for service is made, and compare the moral implications attached to the request in different settings.

For example, it would be intriguing to study the presence of the moral aspect in less official but still institutional environments. Medical consultation is a well-established institution, where doctors have the unilateral right of

defining whether the patient is ill or not. A medical certificate is usually the prerequisite for getting sick-leave from work, for a driving-license, or even for a job. It would be interesting to study a less established type of 'healing encounter', where the practitioners do not possess official rights to legitimate their clients' application for the sick role but which people still seek to get help in their problems. How would people present their problem, give a reason for their visit in a consultation of alternative medicine, such as homeopathy? How would the sequence be organized? Would the moral aspect still be oriented to, or would the situation in general be ordered according to more consumerist ideals?

Another obvious area of comparison would be privately funded medical care. Would the moral aspects attached to giving the reason for the visit become apparent in this area as well?³ Would there be a difference in the participants' orientations to their institutional roles as doctors and patients? Such comparisons could perhaps help to further understand the meanings attached to falling ill, as well as the logic of interaction in institutions.

8.1.3. Multiple levels of context and constituents of 'good interaction'

In sum, when giving their reason for the visit patients orient to three different levels of context:

- 1) the immediately preceding action by the doctor (usually the opening question),
- 2) the activity structure of the whole consultation (as advice-seeking with a request-response adjacency pair serving as the basis for coherence for the whole encounter),
- 3) the larger cultural context in which falling ill is understood as a deviation from the normal, and applying for the sick role is constructed as an accountable activity.

The observation on the multiple levels of context informing the participants' orientations directly addresses the prevailing understanding of the constituents of 'good interaction' between the doctor and the patient.

³ Heritage has shown that in Northern American private practice consultations in primary health care this is the case (frth).

To give an example, we could focus on Byrne & Long's (1984) model of patient-centered vs. doctor-centered styles of consultation. With the rise of the consumerist trend in discussions on doctor-patient interaction, a patient-centered style of consultation has become the recommendation, a model for 'good interaction'. It is defined as 'using patients' knowledge and expertise in diagnosing the illness', whereas a doctor-centered style would consist of 'using doctor's special skills and knowledge' to reach the diagnosis. In their study Byrne and Long used lists of activity categories derived from analyses of actual consultations, to describe in more detail what actions would correspond to the use of patient's vs. doctor's knowledge in diagnostic work. A patient-centered style would consist of actions such as 'seeking patient ideas' or 'using silence', whereas a doctor-centered style would include 'questioning' and 'summarizing', among other things.

As we have observed throughout this study, decontextualized action-categories on their own do not entirely capture the dynamics in and through which patients and doctors strive for shared understanding of the reason for the visit. We have seen how activities such as 'using silence' may restrain the patient from keeping to his own definition of the situation. Correspondingly, 'questioning' may in fact constitute an action which has been made relevant by the patient.

The observations on the different levels of context informing the participants' orientations draw attention to the contextuality of actions, and to the fact that the meaning of each action is constructed in relation to various different levels of context. Yet, these observations do not erase the possibility of examining constituents of patient-centered styles of consultation. Rather, they propose an alternative frame of reference for such examination.

The observation according to which, when presenting their problem, patients construct their activity as advice-seeking rather than troubles-telling suggests that the interaction could benefit from practices by the doctor which would assure the patient of her willingness to provide such help. Further, from the point of view of the moral context oriented to by the patients, it may sometimes be important to quickly approve the patient's problem as a topic on the agenda. In such a situation doctors could find it helpful to use specific ways of taking the turn to show understanding on the patient's presentation so far and still make it possible for the patient to continue the problem

presentation. The empirical chapters provide various examples on possible ways of proceeding in such a project. For example, formulations fitted to the patient's preceding turn have been shown to work as displays of understanding on the one hand, and as enabling a further extension of problem presentation on the other.

The notion of orientation to multiple contexts also helps to perceive the use of medical vs. lay terminology in a different framework. In previous studies, doctors' use of medical terms has often been criticized as causing problems of understanding for the patients, and as bypassing the life-world aspects which could be relevant in diagnosing the patient's illness (e.g. Mishler 1984; Waitzkin 1991; Roter and Hall 1992). However, drawing upon the analysis, in the phase of giving and receiving the reason for the visit, the use of medical vs. lay terms can be used as a way of indicating either approval or disapproval of the problem presented as medically relevant. Alternation of medical vs. lay terms in describing the patient's problem was used by both participants in negotiating the approval of the patient's problem on the agenda of the encounter. Thus, in specific contexts, the use of medical terms by doctors while receiving the patient's problem presentation could in fact serve to fulfill the expectations set by the patient in his preceding turn of talk, whereas the use of lay terms by doctors could work in an opposite direction (cf. Silverman 1987).

In and through these observations this study, for its part, both corrects and complements the current understanding on the dynamics of the doctor-patient interaction (cf. Peräkylä and Vehviläinen 1999). Thus, it also comments on the relation between empirical research on professional-client interaction and the theories or 'quasi-theories' informing such interaction in practice. It offers an example (even if a limited one) on how detailed empirical analyses of an actual interaction process may contribute to the development of 'good communication' in professional-client interaction.

8.2. Control in medical consultation

In the Introduction, control was defined as the extent to which participants are able to maintain their definition of the ongoing activity, the extent to which participants can initiate, maintain and close up sequences of actions. Control was perceived as residing in every action (or turn of talk) of the participants

in the interaction. In the framework of this definition, both participants automatically control the phase of giving and receiving the reason for the visit to some extent, as long as the other participant is not speaking all the time.

However, in addition to the control and means of control inherent in ordinary turn-taking, there were features of control in the data which could be defined as specifically institutional, and also features of control specific to medical consultation. The institutional features concerned a) differences in the distribution of control, and b) specific means of controlling the course of consultation. It was found that the participants orient to the doctor having the ultimate control over the shifts across phases: they orient to the doctor's right to initiate the activity of problem presentation, as well as the activity of verbal or physical examination. The patients' possibilities for control, then, were situated on the turn-taking level, so that they were able to maintain the ongoing activity or suggest a proper place to shift forward. The means of control used were mainly those inherent in ordinary conversation (turn expansion with narrative structure, for example). However, lexical choice between medical and lay terms combined with 'ordinary' methods of control could be used for negotiating on the nature of the activity, and thus for controlling the shift forward in consultation by both doctors and patients.

In the following, I will first describe the specific means of control used by doctors and patients in giving and receiving the reason for the visit. After this, I will discuss the characteristics of these practices as resources inherent in ordinary conversation on the one hand, and as specifically institutional on the other.

8.2.1. Participants' means for control

Patients usually started their problem presentation only after the doctor had asked the opening question. There were, however, 14 cases out of 100 in which the patients started without the opening question, i.e., worked to initiate the medical business themselves. In some cases doctors sanctioned this procedure by re-eliciting the problem presentation with utterances such as 'in other words you had such a fever once again', which made it relevant for the patient to redo their problem presentation. However, in some cases the doctor approved the patient's initiation of the phase and treated the patient's problem presentation as in cases where it had been initiated by the opening

question. Thus, even though patients could initiate the medical business without waiting for the doctor's opening question, this did not guarantee that their definition of the situation would hold.

In presenting their problem patients used roughly three sorts of designs: plain answers (which were in minority), sentential answers extended if made relevant by the doctor, and narratives or reports reserving a multi-unit turn for themselves. Narrative design constituted an efficient way for the patients to keep the floor and to reject the doctor's possible efforts to shift the activity and start examining the problem. Thus, through designing their complaints as narratives patients were able to maintain the activity as problem presentation if they found it necessary.

Doctors could, however, heckle the narratives⁴ by resorting to side-activities while receiving the patient's story. Side-activities, such as reading medical files or writing, represent an alternative focus of attention in consultation instead of focusing on the patient and his story. They can be understood, however, as connected with the patient's problem, though they constitute a different representation of it. To a certain extent doctors may have to divide their attention between the patient in person and the patient in records. Thus engaging in examining medical records can be accounted for as a legitimate form of disengagement. However, at specific points in their story patients treated an overt disengagement by the doctor as a display of the doctor's abandoning the recipient position, and became dysfluent in their narratives. The patients' stories became fragmented, they left out words, glossed over sentences with one word, etc. Thus, at times patients oriented to the doctor's non-verbal actions as acts of control, as suggesting a shift in the doctor's activity (from listening to the patient to reading medical records). In this way control could be embedded in non-verbal actions as well as verbal ones. However, there were no cases in the data where the patients abandoned their narratives altogether when facing displays of disengagement by the doctor. This would indicate that, although a non-verbal shift in activity may embody an act of control, it is not as efficient as a turn of talk for influencing a shared definition of the ongoing activity.

⁴ My intention is, of course, not to claim that this is somehow intentional on the part of the doctors.

In addition to extending their problem presentation over a shift suggested by the doctor, thus maintaining their own definition of the activity, patients could propose for the doctor a proper place for shifting activity. They did this by clearly indicating that they had reached the completion of their problem presentation, by passing the possibility offered to continue or by choosing an element to finish the problem presentation which made relevant a shift towards the verbal or physical examination by the doctor. For example, eliciting attention to a common focus of interest by pointing would make relevant an assessment concerning the chosen object of interest, so coaxing the doctor to initiate examination. Further, a question to the doctor concerning the diagnosis or proper treatment for the problem would constitute an even stronger attempt to get the doctor to move forward in consultation. However, although the patients could propose to the doctors a proper place for shifting the activity, the doctors preserved their right to do the actual shifting.

Doctors had various ways of moving forward in consultation after the patient's problem presentation. These ways varied in terms of the extent to which they embodied an unilateral effort to control the shift vs. allowed for negotiation on the placement of the shift. In previous studies interrupting the patient is mentioned as the ultimate form of unilateral control by the doctors. However, on the basis of what we have observed on the nature of the activity going on, and on the patient's project to justify his reason for the visit as a 'doctorable' problem, it would seem that at this point in the consultation an act quite opposite to interruption may constitute an equally unilateral act of control: the doctor's passing their chance to take the turn when the patient has indicated it would be relevant would equally serve to maintain the doctor's version of the activity going on at the expense of the patient's version. Whereas the patient has proposed that his problem presentation is complete and the next relevant act would be the shifting to verbal or physical examination, by passing the chance to take the turn the doctor rejects this understanding and maintains the activity as problem presentation. This act of control was far more frequent than interruption in the data.

Doctors could also control the shift forward by the design of their next turn following the patient's problem presentation. The division line between the ways which embodied unilateral control vs. ways which enhanced negotiation ran between the opposite ends of an abrupt topic shift and bounding off the

topic before moving forward in consultation. The less the doctor's utterance was fitted to the patient's preceding problem presentation, the fewer chances the patient had of expanding his problem presentation after the doctor's next turn, and vice versa. Further, doctors also used lexical choice between a medical and a lay term in controlling the proper place for shifting the activity. For example, in contexts where the patients had used a medical term to describe the nature of their problem, the doctor's use of a corresponding lay expression could work to maintain the activity of problem presentation, i.e., to postpone the start of verbal examination.

Consequently, it seems that as every act in interaction is contextual, so is also every act of control. The characteristics of the actions as such, detached from their sequential context, may not constitute a sufficient definition of 'what renders an action an act of unilateral control'. An interruption when the speaker has indicated that he has not finished his utterance may constitute an act of unilateral control, but equally the situation may be controlled by abstaining from taking the turn when it has been made relevant by the other participant. In different phases of the medical encounter, the characteristics of actions embodying control may also vary. In studying what constitutes an act of control it may be useful first to determine the participants' projects in the specific context studied, the goals and tasks made relevant by the participants in the situation.

8.2.2. Some implications for the study of control in medical consultation

In relation to previous study on the constituents and distribution of control in medical consultations it seems that with regard to the uneven distribution of control, this study supports the earlier findings. Doctors are indeed oriented to as having the right to initiate shifts in activities. However, the means by which they do this seem quite different from the ones suggested earlier. In earlier studies of the main constituents of control in doctor-patient interaction, only the doctors' actions have been perceived as embodying acts of unilateral control. The doctors have been seen as controlling the consultations 1) by virtue of the structure of the interaction as a continuum of question-answer-evaluation sequences, 2) by the design of the opening question, 3) by interrupting the patient, 4) by limiting the discussion to medical issues.

The apparent problems related to the first two of these aspects have been discussed in section 8.1. It was shown that the three-part structure apparent in the phase of giving and receiving the reason for the visit is only one level of context made relevant in constructing the activity. Further, it was shown that the design of the opening question does not restrict the patient's answer to a minimum. The observation that patients have at their disposal means inherent in ordinary conversation, such as the narrative structure, to expand their turns, also speaks against the restrictive potential of the opening question. In this section we have seen that the meaning of the last two actions, interruption and the use of medical terms, is dependent on their context. Further, we have observed that doctors are able to control the course of the consultation also by actions completely opposite to interruption and concentration on medical issues.

This study adds to and reconstructs the existing understanding on the constituents of control in the phase under scrutiny. On the basis of the analysis, the actions embodying unilateral control by the doctors in the phase of giving and receiving the reason for the visit consist of 1) abstaining from taking the turn at the possible completion of the patient's turn, 2) overt disengagement from attending to the patient's story, and 3) abrupt topic shifts as ways of starting the verbal examination. The common factor in the three acts of unilateral control listed above is omitting to listen to the patient in defining the nature of the ongoing activity. Actions which allow negotiation with the patient on the nature of the activity and on suitable places for shifting the activity consist of acts which are the opposites of these three. By taking the turn at the possible completion proposed by the patient as a proper place to move forward in consultation, the doctor displays that he has been listening to the patient and monitoring for a proper place to take the turn. Keeping one's dominant orientation towards the patient and maintaining attention to him at points which the patient has marked relevant for showing such attention also indicates that the doctor is interested and listening to the patient's narrative. Last, making an explicit connection to the patient's preceding problem presentation when receiving it also indicates that the doctor understands what the patient is talking about. Candidate understandings as a next turn explicitly reserve the patient a place to repair the doctor's understanding if necessary.

Another point where this study adds to the prevalent understanding is the observation that patients also have means of control at their disposal. The patients' acts which embody efforts of unilateral control over the nature of the activity include 1) starting without the opening question, 2) presenting the problem in the form of a narrative, and 3) posing a question to the doctor as the last element of the problem. However, the patients' means of control are contained within the limits of the right attributed to doctors to initiate sequences. Thus, what appears truly institutional in terms of controlling the phase of giving and receiving the reason for the visit is the orientation of both participants to the doctor's ultimate right to initiate the shift. The means of control utilized by patients are mainly the means inherent in and available for use in ordinary conversation.

This observation brings us straight down to the limitations of this study. The method used, conversation analysis, has enabled us to track down the minute details of control and to describe how these means of control are used in conversation, and how they restrict the actions of the other participants. To some extent we have also been able to make a distinction between specifically institutional features of control in this phase of the medical consultation and the features of control inherent in ordinary conversation. However, we cannot say much on the origins of the orientation to the doctor's right to initiate activities in medical consultation within the limits of the method.

Still, it is to be hoped that the study has made visible some aspects of interaction which should be taken into consideration when theorizing, for example, about asymmetries of control in doctor-patient interaction. Looking at control on the level of turns of talk as they unfold in consultation, studying it in its specific context, helps to understand the dynamic nature of control, and the contextual nature of its means. Further, it may be important to observe that especially the methods of control provided for each participant by the institution of conversation work not only to restrict the actions of the other participant, but also to provide a possibility of achieving a shared understanding on the activity going on, and in this case, on the phase of consultation as well.

The perception of control in this study also addresses the notion of medical consultation as a location of conflict and misunderstanding. Although patients

and doctors may at times have separate views on the relevant next action, they both seem to have resources for negotiating on these definitions, and also do so in interaction with each other. Instead of talking about separate worlds for doctors and patients, this study draws attention to the process of interaction in which these worlds meet, and to the possibilities of negotiation and cooperation between them. The study points out that in a setting often characterized as dominated by the professionals with their control power and authority, clients also have at their disposal resources which enable them to bring forward their own voice in the interaction. Rules inherent in the institution of ordinary conversation on the one hand, with specific institutionalized structures such as the predetermined slot for the patients to speak, guarantee a degree of control for the patients as well.

8.3. On generalizability and CA

In this study I have used conversation analysis as a method for studying a specific area of institutional interaction. This means that the findings presented also address this substance area, rather than the actual CA methodology. In other words, CA in this study has served as a method producing (potentially) cumulative knowledge on the structures of social interaction typical for the specific institutional situation of medical consultation.

What we have studied are not general or average ways of acting in medical consultation, but possible ways (cf. Peräkylä 1992, 462). The study describes possible procedures used in achieving a shared understanding on the reason for the visit. In this sense, the results are applicable as authentic examples of 'how an opening question can be asked' and 'how a specific question may be answered'. The method as such provides a possibility to observe the origins of the interpretations made, and also potentially to arrive at similar results when using similar data.

Another question is whether the results gained in studying a particular phase in Finnish medical practice consultation could be carried over to a different institutional context or generalized to concern corresponding medical contexts in other countries. According to the criteria of quantitative research, such as homogenizing the groups and situations studied, such generalizations are not possible, and in this study, efforts to this direction have not been

made. In this study, my search has been for ways in which participants give meaning to their respective actions in a specific situation, and we have seen how within such a framework some procedures and orientations appear as comparable. As has been shown, there are similarities in the participants' orientations in, for instance, Northern American and Finnish medical consultations. In both countries patients orient to justifying the reason for the visit in presenting their problem. Even the practices in and through which such orientations are realized are similar. (Halkowski frth; Heritage frth). Further, similar moral orientations have also been located in different types of service encounters, such as emergency calls, when giving the reason for the call (Whalen and Zimmerman 1990; Bergmann 1993). These observations entail a promise of the possibility of locating practices and orientations which would be basic for institutional interaction in general and medical interaction in particular, and of thus gaining a more thorough understanding of the dynamics of interaction in institutional environments. CA as a rigorous and context-sensitive method of analysis may have the potential for making such comparisons possible.

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LAWS:

L333/1998 Laki potilaan asemasta ja oikeuksista. Helsinki. Suomen säädöskokoelma.

L785/1992 Laki potilaan asemasta ja oikeuksista. Helsinki. Suomen säädöskokoelma.

APPENDIX:

TRANSCRIPTION OF THE EXAMPLES

The examples in the thesis are for the most part transcribed in three lines:

1. the Finnish original version
2. a word-by-word translation
3. a free translation in English

The analysis is based on the Finnish utterances. The gloss-line (2) is omitted in cases where it has not been considered relevant in terms of the analysis. In addition to talk-in-interaction, some non-verbal features (such as gaze-direction and gestures) have been noted in the transcription as far as they are relevant for the analysis presented. Generally, gestures are transcribed within double parentheses, but in chapter 7, where they are prominent in the analysis, a separate line is reserved for transcribing them. In chapter 7, Goodwin's (1981) system of transcribing gaze has been modified so that the patient's gaze-direction and gestures are continuously noted below the transcript of talk, and the doctor's gaze-direction and gestures above it.

The transcription system is the one generally used in conversation analysis.

Symbols used to identify the participants:

- D: Speaker identification: Doctor (D), Patient (P)
Dg: Identification of the owner of the gaze: Doctor's (Dg), Patient's (Pg)
Dges: Identification of the owner of the gesture: Doctor's (Dges), Patient's (Pges)

Transcription symbols:

- [] Brackets: Onset and offset of overlapping talk
= Equal sign: No gap between two utterances
(0.0) Timed pause: Silence measured in seconds and tenths of seconds
(.) A pause of less than 0.2 seconds
. Period: falling or terminal intonation

,	Comma: level intonation
?	Question mark: rising intonation
↑	Rise in pitch
↓	Fall in pitch
-	A dash at the end of a word: an abrupt cutoff
<	Immediately following talk is 'jump started', starts with a rush
> <	Faster-paced talk than the surrounding talk
< >	Slower-paced talk than the surrounding talk
_____	Underlining: some form of stress, audible in pitch or amplitude
:	Colon(s): Prolongation of the immediately preceding sound
° °	Degree signs surrounding a passage of talk: talk with lower volume than the surrounding talk
.hh	A row of 'h's prefixed by a dot: an inbreath
hh	A row of 'h's without a dot: an outbreath
#	Number signs surrounding a passage of talk: spoken in a 'creaky' voice (vocal fry)
£	Smiley voice
@	Animated voice

Transcription of the non-verbal actions:

-----	Hyphens: Gaze at another interactant or at an object
.....	Row of periods: Gaze moving towards another interactant or an object
,,,,,	Commas: Gaze moving away from another interactant or an object
..X---	Capital X: The moment when gaze arrives at another interactant or at an object
O	Capital O: Gazing at middle distance
:::::	Row of colons: body movement
::::X	Row of colons followed by X: body movement and its offset
^ ^	Upward arrows: Beats of a continuous gesture, such as tapping
()	item in doubt
((text in parentheses))	Transcriber's comments, e.g. participant's postural orientations