

Introduction: Diagnosing ‘lay diagnosis’

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The studies herein offer previously unarticulated insights about physician–patient–family relationships. Primary attention is drawn to interactions comprising medical interviews, though conversations among family members are also addressed:

- i. How do *patients* initiate and solicit social actions during clinical encounters?
- ii. Outside of the clinic (e.g., in home environments), how do *patients and family members* deliver and update news about an illness?

These questions raise several issues. First, it is *physicians*, not patients, who are most commonly associated with actively structuring interviews. Second, delivering news about a medical condition is traditionally understood as an essential component of the interviewing work that *physicians* accomplish, not as ordinary tasks faced by lay persons prior to and following consultations. Third, attending to how *interactional participants* collaborate in diagnoses, treatment, and ongoing care—both lay and medical, in clinical and nonclinical settings alike—most closely resembles the lived and routine experiences of persons dealing with medical problems over time.

The title, ‘Lay Diagnosis’, was initially invoked to emphasize (not overlook nor discount) the communicative practices recruited by patients and family members when navigating their way through often complex, perhaps also foreign, medical circumstances. Such a title is expansive in both scope and application. For example, ‘Lay Diagnosis’ draws attention to how lay persons, not formally trained to diagnose and treat ‘biomedical’ problems, nevertheless describe, explain, and otherwise make available their understandings and concerns to medical professionals, family members, and others. The alternative, ‘Lay *Diagnosis*’, suggests that *any* behaviors enacted by patients and family members

be analytically treated as meaningful contributions. In the ways lay persons attempt to shape and understand illness trajectories, so should researchers seek to discern the significance of such actions on their own merits.

Historically, 'lay diagnosis' stands in contrast to typifications of medical consultations, as well as close examinations of the organized nature of interviews themselves—a research tradition which has focused predominantly on medical authority and the institutional character of professional/lay communication. Particular and systematic attention has been given to whether and/or how possible 'asymmetries' (e.g., in power, control, status, and knowledge) are displayed as medical professionals (e.g., physicians, nurses, therapists, counselors) enact 'agenda-relevant actions'. By illuminating patients' and family members' involvements in medical care, the authors of this special issue frame their research as responsive to the need to move beyond such historical constraints. Indeed, the very capacity of such terms as 'asymmetry' and 'agenda' to adequately capture the communicative management of health and illness is questioned: moments replete with participants' fine-grained attempts to somehow deal with ordinary yet often uncertain medical circumstances, orientations too easily glossed by abstract theorizing.

The explication of key interactional moments, including lay persons' intricate involvements in co-producing ongoing interaction, also empirically grounds and extends 'patient-centered' models and prescriptions for care. Each of the following reflects real time, interactional achievements: being sensitive to and empathizing with patients' shared experiences, remaining open to patients' volunteered and/or solicited stories about unique life experiences, and utilizing such information as root issues central to generating medical histories and treatment regimens. But how so, and with what interactional and therefore medical consequences? This single question, situated among diverse and equally important concerns, reveals *interaction* as vehicular for *medical care*. Inevitably, caring for others involves ongoing communication choices interwoven throughout the course of daily life.

The title 'Lay Diagnosis' is not without its ambiguities, however, and (as it should) promotes more questions than definitive answers about medical care. Like any description, 'Lay Diagnosis' is not only essentially incomplete, but in the very least a likely source of interesting discussion among researchers and clinicians alike. In their responsive commentaries, for example, such a concept is treated as paradoxical (ten Have) and only one of several important aspects of patients' participations in medical consultations (Drew). Consider also an e-mail message forwarded to me by a physician in San Diego (Vincent Felitti, Kaiser

Permanente), offering an initial response to having read an earlier description for this special issue:

The title is misleading in that it is not about diagnosis by non-physicians, but about how medical diagnosis is understood by non-medical persons. ‘Understanding a Diagnosis’ or ‘Making Sense of Diagnoses’ or ‘Diagnosis: Understood and Misunderstood’ are more accurate descriptors.

And so the dialectic moves forward, grist-for-the-mill of heurism, matters which will hopefully continue to be addressed in future inquiries.

Fundamentally important, however, are empirical studies capable of reconfiguring theoretical landscapes. The following investigations are anchored in detailed observations about the social organization of elemental social actions: *requesting, diagnosing, assessing, answering, laughing, and updating news*. Without exception, authors reveal the delicate and contingent emergence of interactional environments within which such actions are co-constructed:

- The opening article by Robinson calls for a need to examine lay or mundane features of medical interviews, including ‘speaker initiatives’ and ‘utterance constraints’. By carefully attending to base, adjacently paired actions, a patient’s report and description of a prior discussion of ‘Tylenol’ is shown to implicate a ‘request for help’—a sensitively produced action through which the patient avoids intruding on the doctor’s judgment for prescription renewal, while simultaneously advocating the appropriateness of his requesting action. The normative organization of these moments evidence the inadequacy of decontextualized notions of ‘asymmetry, power, and dominance’.
- By examining how a patient hints and a physician recognizes the need for an HIV test, Gill, Halkowski, and Roberts also address how requesting and responding to medical requests are delicate matters. A series of reports offered by a patient reveal how direct requests may be avoided, in part because requesting may involve ‘doctor’s work’—activities such as candidate diagnoses and the proposing of risks. Patient-centered implications are raised connecting the interactional organization of medical interventions with such key issues as adherence to medical advice, patient satisfaction, and psychosocial support.
- Might a patient’s suicide be triggered by the delivery and reception of diagnostic news? What marked differences exist between professional and lay diagnosis, at what junctures do patients’ self-diagnoses ‘come into play’ during clinical encounters, and how might even

good diagnostic news provided by physicians be ill-fitted to the very problems and narratives provided by patients? Drawing upon a rich tradition of research and training designed to better understand and minimize communication problems during medical interviews, Frankel demonstrates the critical importance of integrating (not minimizing nor rejecting) patients' perspectives throughout the diagnosis and treatment process.

- In everyday (noninstitutional) interactions speakers routinely rely upon their knowledge when offering 'assessments', actions revealing speakers' evaluations of events, objects, persons, activities, and/or reports. For example, *That must hurt* can offer both support and empathy for another's reported discomfort, and encouragement to elaborate on the problem. Following patients' answers to physicians' questions, Jones draws attention to moments where physicians' assessments are treated as noticeably absent by patients (e.g., through pausing, withholding speaking, and enacting various unsuccessful strategies in pursuit of response). Analysis of these significant moments provides insights into often neglected issues involving relationships among medical constraints, affiliation, and support when caring for others.
- In contrast, patients may at times depart from offering minimal responses in restrictive (e.g., question–answer) history-taking environments. Patients' behaviors are not necessarily best understood as 'imprisoned' within traditionally understood interview formats. Rather, patients are quite capable of exploiting and abandoning attempts enacted by medical professionals to constrain both specific topics and ongoing courses of action. Stivers and Heritage consider several practices employed by a patient when expanding her answers to a physicians' questions. Included are narratives designed to move away from physicians' agenda, and into volunteered information about 'lifeworld' concerns addressing difficult topics such as 'her mother's death'. Volunteered and progressive departures such as these, during which physicians' own minimal responses display story reciprocity, can transform interviewing into interactions resembling ordinary conversations.
- When laughter occurs in doctor–patient interaction, it is typically produced by patients and not reciprocated by doctors. While prior research has treated nonreciprocation of laughter as evidence of medical asymmetry and social distancing by doctors, Haakana's research (drawn from a large corpus of Finnish primary care encounters) provides a series of alternative, empirically grounded explanations. Patients display their awareness and acceptance of

the ‘reasonableness’ of the fact that the activities in which they are involved—such as portraying themselves unfavorably, rejecting and/or marking discrepancy with doctors’ understandings—involve ‘delicate’ interactional business in need of possible remedy and even legitimization. Specific consideration is given to the beginning of medical consultations: by laughing when providing reasons for the visit, patients treat their reported problems as somehow untypical, strange, or extraordinary.

- Interactions addressing the diagnosis, treatment, and prognosis for cancer are not limited to clinical encounters. Focusing on excerpts from three telephone conversations occurring in a period of two days, Beach examines the serial and social organization of ‘news delivery sequences’ as family members deliver, receive, and update ambiguous news regarding mother’s ‘stability’. Distinctions are drawn between reporting the news as a patient (mother) and primary figure (son), and affiliating with but not owning news updates (son’s ex-wife). When acting ‘as if’ mother’s active dying were underway (‘a couple a weeks’), simultaneous problems are shown to emerge when announcing and elaborating on inherently uncertain news, and when responding and assessing to news by expressing concern but also relational distance. The interactional work comprising these involvements begins to reveal how ‘family cancer journeys’ are practical achievements over extended periods of time.

By commenting upon the foregoing articles, ten Have and Drew reflect upon the orientations and contributions these studies embody. Comparisons with prior research on medical interviews are offered, specific interactional practices are highlighted, and summaries are provided of key themes, empirical foci, and theoretical contributions arising from this special issue. Limitations reflected in current work on ‘Lay Diagnosis’ are raised, as are implications for future inquiries (e.g., more ‘holistic’ research across diverse interactional settings).

Unlike many extended projects, the inception of this special issue can be traced back to a series of memorable, even poignant, events. Several years ago, it was reported to me by Robert Hopper (Charles Sapp Centennial Professor, Department of Communication, University of Texas, Austin) that he had been invited by John Wilson (*Text* editor) to serve on a special advisory board for the journal. Board members were provided the opportunity to edit a special issue on a topic of their choosing, an option which Robert informed me he had accepted during a phone call which also involved brainstorming a possible focus on

'medical interactions'. With his growing interests in medical topics being influenced by his own diagnosis and ongoing treatment for cancer, Robert proceeded to solicit papers from authors (including myself). However, as the cancer he had been battling for over two years eventually made it impossible for him to complete this and related endeavors, I agreed to move forward with the special issue. Only two months later, he succumbed to a disease affecting three out of every four families in the Western world.

This special issue is therefore dedicated to Robert Hopper. The selection of a 'Lay Diagnosis' theme goes well beyond the many discussions with Robert and others about his cancer journey. Yet it also captures his spirited attempts to understand the illness he was experiencing, as well as unyielding efforts by countless lay persons and medical professionals when communicating about health dilemmas.

These are defining moments of human existence. It is my hope that this special issue adds momentum to unraveling the interactional significance of such moments as resources for caring about others' health.

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