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7 What is patient participation?

Reflections arising from the study of general practice, homoeopathy and psychoanalysis

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Commentary

This chapter continues the presentation of conversation analytic insights into patient participation, begun in Chapters 5 and 6. The focus of this chapter moves beyond the consultation's opening phase, and the activity of formulations, to explore the details of patient participation in relation to diagnostic and treatment phases in three different types of consultation.

The analyses centre on the following activities and types of consultation: (1) delivery and reception of diagnosis in general practice; (2) the delivery of treatment decisions in homoeopathy; and (3) the reception of interpretations in psychoanalysis. The analyses show that, in general practice consultations, the patient often remains silent after the doctor has delivered the diagnosis, and only comments in non-routine cases. In homoeopathy, practitioners provide varying amounts of space for the patient's comments in the treatment proposal. In psychoanalysis, practitioners actively pursue patients' comments to their interpretations.

Further to the illustration of different forms of patient participation across different consultation situations, the analyses also show that, in relation to each of the situations studied, there are alternative designs to professionals' turns at talk; one participatory, one non-participatory. Thus the particular consultation activities studied here highlight how the possible forms of patient participation are governed by the health professional's initial actions.

Beyond the specific findings it presents, this chapter also serves as an experiment in comparison. The data presented are from Finnish consultations in three clinical settings, and the analyses invite certain questions about patient participation and what it may be taken to mean in any given context.
In a strict conversation analytic (CA) sense, participation includes all forms of action or omission of action in which an interactant is involved. In this sense, you could say that 'you cannot not participate' – just as Bateson (1972) said about communication 'you cannot not communicate'. The patient is inevitably participating in all health care encounters – by being bodily present, by using gaze, and by talking in any form. However, we will start with a different and more specific understanding of participation. We will talk about participation as the potential for patients to take part in key activities in three different types of health care encounter. Thus participation, as it is understood here, involves the ways in which patients are given opportunities to contribute to the discussion on what the health problem is and what should be done about it. See the Educational Supplement, pp. 207–8, for related heterial and exercises.

We approach this form of patient participation by presenting some of our observations concerning general practice, homeopathy and psychoanalysis. The question of participation presents itself in a different way in each of these three forms of service encounters, depending on the main task at hand. We will not be able to give an overall picture of patient participation in these three settings. Instead, we focus on one key activity in each that is essential in terms of the purpose of the consultation. In general practice, we examine the delivery and reception of diagnosis, in homeopathy, we study the delivery and reception of treatment proposals and in psychoanalysis we analyse the reception of interpretations.

The data comprise 100 video-recorded and transcribed general practice consultations with 14 physicians, 40 homeopathic consultations with five homeopaths, and 58 audio-recordings of psychoanalytical sessions with three analysts. The original data were recorded in Finnish.

**Patient participation in the delivery and reception of diagnosis in general practice**

**Non-participatory diagnosis**

In general practice consultations, diagnosis forms a central part of the general goal of alleviating patients’ health-related problems. In the Finnish data of 71 diagnostic statements, two distinctively different trajectories in the delivery and reception of diagnosis can be found (and see Peräkylä 1998; 2002; 2006). One of them involves only minimal patient participation, whereas in the other, the patient is more active. In the ‘non-participatory’ trajectory, the diagnosis is preceded by a medical examination that is straightforward and routine, involving simple actions such as listening to the lungs of the patient or looking at X-ray pictures. This is followed by the delivery of diagnosis designed as a simple declarative statement, ‘plain assertion’. The diagnosis is received by the patient staying silent or producing a minimal acknowledgement token (such as ‘yeah’ or in Finnish joo) (cf. Heath 1992). A move to discussion of treatment, or other future action, ensues. Extract 1 is one such case:

**Extract 1 (D = doctor; P = patient)**

1 D: (.hmm) Then the other dear had been a lit-> sorry the< gar
2 had been a little (0.3) reddish[the] { (looking at papers) }
3 P: [↑YE]AH::=
4 D: = nurse told ↑ let’s look at that too.
5 (0.5) {(Dr takes the instruments from the table) }
6 P: ↑yeah:: it was this righ[the] . hh I do have
7 tried to bear it and then one gets those,
8 (12.0) {(Dr. looks into the ear) }
9 D: There’s still an infection in the
10 auditory canal = I’ll prescribe (.)."kind of" (.).
11 drug" for it.
12 P: I’ve here this (kind of ones which I got, (hand in pocket) )
13 D: (Video-recorded consultation in general practice, Dgn 96 4681)

The diagnosis (line 9–10: ‘There’s still an infection in the auditory canal’) is preceded by a simple examination, as the doctor looks into the patient’s ear. The direction from which the diagnostic evidence comes is clear: the patient cannot avoid knowing that the doctor was looking in his ear. The diagnosis is not contested by the patient, and the doctor does not in any way show anticipation of it becoming contested. There is no uncertainty involved.

In our data in general, and in this case in particular, these features of the interaction preceding the diagnosis were associated with ‘plain assertion’ delivery (the design of the diagnostic statement as a simple declarative statement) and the patient’s passivity in receiving the diagnosis. In this particular case, the patient does not say anything in response to the diagnostic statement; his comment in line 12 concerns the treatment. Nor does the doctor show any orientation to the possibility of the patient talking about the diagnosis: in fact, he ‘rushes’ to the talk about prescription in line 10, thereby not leaving space for the patient to comment.
Participatory diagnosis

The ‘participatory’ diagnosis is usually preceded by a medical examination that is non-routine or problematic. This kind of examination can involve manifest uncertainty concerning the nature of the ailment, or discrepancy between the view expressed by the patient during the examination, and the actual diagnosis. Or alternatively, the examination can just be long and complicated. In such cases, the doctor often verbally refers to the evidence of the diagnosis, either explicitly or indirectly, and in response, patients may offer their comments. As a result, the progression of the consultation is halted, as the doctor cannot move directly to the discussion on future action. Extract 2 is a case in point:

Extract 2

1 D: Well (. ) we’ll have to follow up how this thigh of yours, (.0 .6 ) hh begins to respond and (.0 .8 ) it has indeed now clearly improved from what it is( and )
2 P: [It has at least in terms of pain th|e:n.
3 D: [Yeah:. 4 (.0 .4 )
5 6 D: Yes:. h>Did you have laboratory tests< now: still]
7 P: [NO:. (Ten lines omitted: talk about the timing of the tests))
8 9 D: Yes:
10 (.2 .0)
11 12 D: .hh Well (.0 .8 ) I haven’t (.0 .2 ) I I (.1 .0 ) haven’t (.0 .3 ) considered it as (.0 .2 ) thrombosis.
13 14 P: Mn hm.
15 D: I think it isn’t,. (.0 .5 ) it would have, = if there would have been a beginning of a thrombosis then it would have been much more painful.
16 17 P: Yes right.
18 19 D: So certainly there are the VARICOSE veins.
20 (.0 .8 )
21 22 P: Somethi- yeah I can feel the very lumps there in a certain position and when one tightens it,. hh
23 then they appear quite here in the side so that, hh
24 it is really like (. ) one could say a bumpy
25 26 D: [Yeah.: 27 28 P: rgad. (. ) Eh bumps on a road ha ha [hh
29 D: [Yes.

(Video-recorded consultation in general practice, Dgn 3 1B2)

Here, the doctor explicitly rejects the diagnostic suggestion offered by the patient. The patient suffered from intense pain in her leg and was making a follow-up visit after sick leave. Early in the medical interview (data omitted for reasons of space), the patient suggested that the pain in her thigh might have been caused by exertion or by ‘something either coming or going’ in the thigh. The doctor treats this comment as referring to ‘thrombosis’, a diagnosis that the doctor subsequently rejects in her diagnostic utterance.

The rejection of the patient’s diagnostic proposal is first delivered in lines 22–3. Then, in line 25, after a neutral acknowledgment by the patient, the doctor renews the rejection. After this, she explicates evidence that supports her conclusion. A thrombosis would have been more painful. Another, less serious diagnosis, varicose veins, framed as certain but also as one that might not exhaustively explain the patient’s problems, is offered in line 29. After a brief interval, the patient in lines 31–6 tells the doctor about her own observations that support the diagnosis of varicose veins.

Thus, in Extract 2, a problematic or non-routine examination (which involved a degree of controversy and uncertainty) preceded a diagnostic statement that was couched with explication of evidence by the doctor, and the patient subsequently took part in discussing the diagnosis.

To summarize, in diagnosis, minimal patient participation in routine cases does not surface in the interaction as a problem, either for the patient or the doctor. In such cases, doctors do not invite the patient to participate, and patients do not actively offer their contributions. Patient participation is, however, relevant in the non-routine cases.

In the non-routine cases, we can then ask what the patient participation leads to. Roughly, a distinction can be made between cases where the patient’s extended response to the diagnosis is consequential for the unfolding of the consultation, and cases where it is not. The response is consequential if the doctor takes up the patient’s remarks concerning the diagnosis, for example, by returning to the medical interview or the physical examination. In our data, there are cases of both kinds (for more details, see Peräkylä 2002).

As a whole, the doctor possibly faces two choices in terms of patient participation in the diagnostic sequences. The first choice is whether or not to design the diagnosis in such a way that encourages more than a minimal response from the patient. As we have tried to show elsewhere (Peräkylä 1998; 2002), making explicit references to diagnosis is one way of encouraging that response. The second choice is what to do with the patient response: whether or not to topicalize it, whether or not to allow it to influence the unfolding of the consultation.
Patient participation in the delivery of treatment decisions in homoeopathy

Homoeopathy is a form of healing that relies on holistic principles – remedies are prescribed according to the totality of the person’s physical, emotional and mental symptoms (Vithoulkas 1980; Chappell and Andrews 1996). The cornerstone of homoeopathic healing is to match the patient’s reported symptoms to the codified descriptions of homoeopathic remedies in books such as Materia Medica and Repertory (Boericke et al. 1990). The aim is to find an individual treatment for the patient. Unlike in general practice consultations, actual diagnoses are not given but the treatment decision in itself implies the diagnosis. Medical tests or physical examination are usually not used; the treatment decision is preceded by and based upon an extensive verbal examination of the patient (for comparisons of homoeopathic and general practice consultations, see also Chatwin et al., Chapter 5 in this volume; Lindfors and Raevaara 2005; Ruusuvuori 2005).

In analysing the delivery and reception of treatment decisions in homoeopathic consultations, we concentrated on the extent to which the homoeopath offers or provides places for the patient to make verbal contributions related to the decision-making process (and see Lindfors 2005). In all 78 sequences of treatment discussion in the data, the treatment decision was either made or suggested by the homoeopath. Unlike in the diagnostic statements in general practice, some grounds for the decision were always integrated in its verbal formulation. In this sense, all patients were provided with at least some resources for commenting upon the homoeopath’s decision. However, there were differences in the extent to which patients were involved in the decision-making process. In the first type of trajectory, the homoeopaths gave the treatment decision, waited for the patients’ reply and continued with a new activity. In the second trajectory, the homoeopaths involved the patients by asking them to confirm their own perception about the present state of the healing process before announcing the treatment decision. In the third type of trajectory, patients were offered resources to agree or disagree with the upcoming treatment decision by giving either vocal or textual information concerning a potential match between their symptoms and the suggested homoeopathic symptom description. In all trajectories, patients’ responses to the treatment decision were treated as relevant, but there was variation in the extent to which patients’ agreement with the decision was pursued.

The following three extracts illustrate these different trajectories. In the first two, the proposal for treatment is given as the homoeopath’s unilateral informing. However, there are differences between the two, regarding how the evidence for the proposal is explicated, and thus how the proposal is made available for the patient to comment upon. We have called these two types of decision-making non-participatory. In the last extract the way in which the proposal is delivered clearly makes it relevant for the patient to show her agreement or disagreement with the decision. This type of decision-making we have named participatory.

Non-participatory decision-making

Extract 3 shows a case where the treatment proposal is given as a ‘plain’ informing by the homoeopath. In line 1, the homoeopath says ‘right’ after reading her book. Thus she closes the previous activity and starts the treatment discussion by reporting her choice of remedy (lines 1–5):

Extract 3 (H = homoeopath; P = patient)

0 (18.0) ((homoeopath looks at her books))
1 H: right (0.4) I’ll give you homoeopathic
2 be:lla:~n”na”, (0.3) rarely used for skin skin symp-
3 ((H looks at P, P nods))
4 for skin nuse Tskin (1.0) nuture (0.2) hu- (2.0)
5 used for skin problems, but now it feels that in any case we
6 will start with “it”. ((H looks down and arranges her
7 papers))
8 (0.8) ((P nods))
9 H: or I’ll also give you sulphuris to begin with
10 (0.2) so the sequela of cortisone (,) nuture (1.2)
11 would go away and clean it up. ((H looks up to P))
12 (1.2) ((P nods))
13 P: “m.:”
14 (29.0) ((H looks at her books))

(Video-recorded consultation in homoeopathy, 13.1)

In lines 1–6, the homoeopath delivers her decision ‘unilaterally’ (see Collins et al. 2005). The decision is designed as already made (‘I’ll give you’) and not as something they should discuss together, even if there are features that mark it as tentative (‘it feels that’, line 5). The evidence for the decision is embedded in the informing. In lines 2–6, the homoeopath states that even though this remedy is rarely used for skin problems, it would be the right choice in this case. In this way she implies that the decision is based on the individual characteristic of this patient’s problem.

In lines 9–11, the homoeopath informs the patient about another medication she will be given for her rash. Just as with the previous decision, this one also is designed as definitive. The patient acknowledges the decisions by nodding (lines 3, 8 and 12) and by saying “m.” (line 13). The patient’s acknowledgements could be interpreted as mere receipts of the information given, or alternatively as containing an element of agreement with the
decision. In any case, the homoeopath treats the patient’s responses as sufficient to move on to another activity.

In Extract 4, the treatment proposal is also presented definitively (lines 64–66, 69–70). However, unlike in the previous extract, the chain of reasoning leading to the decision is made explicit, and the patient’s viewpoint is integrated in the reasoning:

Extract 4

P: [(but in any case, yes but in any case)
the kind of whole situation (0.2) is better.
(.)
H: yg[s.
(.)

so if it can’t (.) it can’t be thought about as
a period of an hour or even a day after if you think about a
one-week period “so”,
(0.2)

H: of course.

P: [(it’s better =

H: =right.

(0.4)

H: and (.) if (.) we then think about this whole thing now
you (.) last spring we started emo (2.8)
your (3.0). ng hhh the sixteenth of June (.) [(H looks at
notes)] [(you visited)] here the first [(time)]

P: [yes, ]

[yes. ]

(.)

H: right, (1.0) mt at that time you’ve had s:- weakness
in your hand quite a lot and, (2.0) diploTpia
almost every day. (0.2)

P: [gt ] every now and then

H: [(3.6) [(H reads her notes)]

anyway this has like all the time little by little
(0.8) got better now then.

(.)

P: yes it has.

[(7 lines omitted, P talks about his hand that has healed)]

H: =yes, and it was that phosphorus which was such( that

P: [it (.)

H: helped.])

P: it felt ] good[the ]hh.

H: [mm. ]
she proceeds to give an explanation for the symptoms the patient has mentioned earlier as problematic (42–57). She integrates this explanation with the grounds that she gives (lines 57–60) for her treatment proposal that follows (lines 61–63, 66–67).

Thus, in this case, the homoeopath makes explicit the chain of reasoning leading to her decision, and attaches this reasoning to the patient’s own evaluation of his state of health. She also works to attain a shared understanding of the patient’s present condition before suggesting further treatment (and see Maynard 1992). Even though the actual proposal is given as definitive, the homoeopath treats the patient’s own evaluation of his condition and the helpful remedy as relevant, and thus enhances patient participation.

A further look at the consultation shows that the patient receives the decision with a complying joo-particle (lines 64 and 69) (see Sorjonen 2001). The joo-particle in line 64 is given immediately, and the one in line 69 almost immediately, after the homoeopath’s decision: there are no signs of treating it as problematic (Pomerantz 1984). Both joes end with a falling terminal contour, indicating that the patient will not continue his turn. The patient also nods with his latter joo-response. Even after this there is space for the patient to topitalize the decision, but the patient does not use this possibility. These features, together with earlier research by Sorjonen on joo as a proposal of compliance in this context, indicate that the patient treats the homoeopath’s decision as acceptable.

Participatory decision-making

In the next extract (5), the patient’s agreement with the homoeopath’s treatment decision is explicitly pursued, and the patient is offered resources to form an independent opinion about the suggested remedy. Just before the extract the homoeopath has said that she is about to refer to a book to check the description of a remedy called calaminicarbonicum. The homoeopath gives the patient the homoeopathic book to read and to consider if the remedy under scrutiny matches her symptoms. The homoeopath also gives instructions to the patient on where she should start reading:

Extract 5

18 H: I’ll get you reach. ((H gives the book to P))
19 P: today.
20 (2.0) ((P picks up the book))
21 H: have a look<
22 (1.0)
23 P: in there.
24 H: yes.

((127 lines omitted, P reads and topilizes symptom descriptions in relation to her own symptoms))

152 (11.0) ((both are reading))
153 P: mg mm, anxiety, (0.2) appears?, (1.5) around the
154 upper middle of the abdomen yes, this is the place
155 where that grump always appears when I’m uneasy.
156 (3.0)
157 H: hh hh
158 (1.0)
159 P: this does match quite nicely.
160 H: mm.

((10 lines omitted, H talks about the benefit of P reading the book herself))

171 P: met I’m not afraid of being algal nor dark- darkness
172 nor ghosts but high places scare the hell out of me.
173 H: hnn. ((Finnish dialogue particle))
174 (4.0) ((P reads and H writes down))
175 P: that’s not mentioned here.
176 H: mg mm?,
177 (3.0) ((P reads and H writes down))
178 P: but it doesn’t have to cover everything.
179 (13.0) ((P reads and H writes down))
180 P: yeah a lot of them are in here yeah?
181 (0.5)
182 P: hgh ho.
183 (1.0)
184 P: even arthritis that’s right.
185 H: mm.
186 (1.0)
187 P: painless (. ) from exercising.
188 (2.0)
189 P: numbness yes.
190 (0.8)
191 P: quite well.
192 (2.0)
193 P: sniffs it matches.

((P continues reading))

194 H: yes.
195 (1.0)
196 H: let’s put it in a bag.
197 P: ( ) ( )
198 P: joo. hh hh

(Video-recorded consultation in homoeopathy, 33)
The homeopath gives the homeopathic book to the patient (line 18) so the patient may check for herself whether her symptoms match with the suggested remedy. On receiving the book the patient takes an active role in searching for matches between her symptoms and the description in the book (e.g. lines 153–4, 171–2). She also produces explicit evaluations of how well the suggested descriptions match with her symptoms (line 159). She observes something lacking from the description of the book (line 175) but evaluates this as not a problem (line 178). Between lines 180–93 the patient points out the ‘good match’ between the book and her symptoms. In this way, she displays agreement with the homeopath’s treatment suggestion. Following this, in line 196 the homeopath makes the final decision, saying ‘let’s put it in a bag’, and the patient complies.

This extract contains participatory elements in that the homeopath works to get the patient’s compliance with her suggestion, by providing the patient with resources for arriving at the same conclusion. However, as in the other extracts (as well as in the whole data), the actual decision is made or suggested by the homeopath. Thus, the question remains as to whether one type of procedure described above offers the patient better chances to take part in the actual decision-making than any of the others. Do any of these procedures make it easier for the patient to reject the proposal offered, for example? On the other hand, the procedures of the homeopaths do seem to differ in the ways in which they make explicit the grounds of the decision to the patient, and in the extent to which they treat as relevant the attainment of shared understanding of these grounds with the patient. Thus, the different degrees of participation in the treatment proposals in homeopathy seem to have more to do with working towards the patients’ affiliation and compliance with the homeopath’s decision than with opportunities to take part in the actual decision-making.

Patient participation in the reception of interpretations in psychoanalysis

Psychoanalysis is a very particular type of patient–provider encounter. In psychoanalysis, the patient explores his or her mind and relations to significant others, with the aim of increasing his or her self-understanding and hence alleviating suffering. Psychoanalytic treatment involves frequent (three to four per week) sessions during which the patient talks freely about his or her life while the analyst listens and sometimes intervenes with questions or comments.

Interpretations are particular types of interventions in psychoanalysis. They are the analyst’s statements about the patient’s mind. They are meant to help the patient to see and understand unconscious aspects of his or her experience and behaviour (Greenon 1967: 39–45; Rycroft 1995: 85).

Interpretations are usually devised by the analyst using verbal material that the patient has produced in the analytic sessions. In a broad sense, most interpretations involve rearrangement of the elements of the patient’s narratives. In the interpretations, the analyst connects, highlights and re-contextualizes what the patient has said during the analytic hour. In this sense, interpretations involve a particular form of patient participation: they are largely made up of the materials that the patient has brought to the analyst.

In this chapter, however, we will be looking at the patient’s responses to the interpretations.

Non-participatory cases

Patients’ responses to interpretations can be divided into three broad classes; different classes of responses regularly occur in the same sequence. Sometimes patients produce acknowledgement tokens such as ‘Mm’ or ‘Yeah’: responses that are similar to those that patients most often give after hearing the diagnosis in general practice (see above). However, cases where such tokens constitute the patient’s sole response to an interpretation are very rare. The patients can also respond to interpretations by expressing their attitude towards the Interpretation in a compact form. This can involve outright rejection (for example, ‘I don’t think the rules were that strict’), displays of scepticism (for example, ‘Yeah who knows’), displays of commitment to ‘mental processing’ of the interpretation, without clearly agreeing or disagreeing with it (for example, ‘Wonders if it could be like that’), or agreement (for example, ‘It is absolutely true’). In more than half of cases in our data, the patients end up talking even more extensively about the interpretations. They take up some aspect of the interpretation and continue discussion on it, by illustrating or explaining what was proposed by the analyst. Peräkylä (2006) has called these responses elaborations of the interpretation. Elaborations convey agreement with and understanding of the interpretation. They are often preceded by other types of responses: the patient may first respond to an interpretation with an acknowledgement token and/or with a compact expression of attitude, and move thereafter to an elaboration.

We have argued elsewhere (Peräkylä 2005) that analysts and patients orient to elaborations as the kind of response that the interpretations seek. For the analysts’ part, this orientation is revealed in their actions that follow type one (minimal acknowledgement tokens) and type two (compact expressions of attitude) responses. After such responses, analysts regularly either remain silent, invite patients to say what is in their mind, or add new elements to the interpretation, thus creating a new opportunity for the patient to respond. In other words, analysts actively seek patients’ participation that goes beyond mere acknowledgement or acceptance/rejection of the interpretation.
Sometimes a similar orientation becomes manifest in the patient's conduct. Extract 6 is an example. Prior to the interpretation, the analyst has pointed out that no intense feelings appear in the patient's talk. In the interpretation (only the final part is shown here) she proposes that the patient somehow 'empties her mind' during the psychoanalytic sessions. The patient responds only minimally to the analyst's interpretation in line 11. After a silence of 8 seconds, the analyst formulates the patient's action as problem-indicative by saying 'You don't sound excited'. This formulation invites an account from the patient for her (minimal) recipient action vis-à-vis the interpretation. In response to the formulation, the patient puts into words her orientation to a 'duty' to produce talk that is linked to the interpretation (lines 15–19).

Extract 6 (A = analyst; P = patient)

1 A: .mth So that it will never be allowed to be
2 examined it. hhh it will never be like
3 allowed to examine to be examined and then it will not not
4 be possible .hhh #erm# to go >mehow< (0.5) ehhh#
5 learn to know it gr: or somehow (.). mthh
6 P: .mhhhhhh
7 A: or in that way to increase <your some kind of
8 (.5) integrity or# (. ) .something whatever
9 it would then <be>.
10 (0.4)
11 P: Mmm,
12 (8.0)
13 A: .hh You don't sound excited.
14 (.7)
15 P: mhha [ha I'm desperately trying to find something
16 A: [he heh he
17 P: #to say# .h(hhhh that that could
18 A: .hhhh Mmm,
19 P: be (th) connected to [this.
20 A: [mhhe
21 P: .shhh
22 (0.3)

Thus, in Extract 6, both parties put into words an expectation that the patient expresses her views concerning the interpretation through something more than a minimal acknowledgement. The analyst's formulation in line 11 invites an account from the patient, and in her account, the patient shows her orientation to an obligation to talk about the interpretation.

Participatory cases

As pointed out above, in more than half of the cases the interpretations lead to the patient taking up and elaborating what was proposed by the analyst. In elaborations, patients' participation in interpretation is at its fullest, as it were: the patient takes up the interpretation and continues it by adopting the perspective that was suggested in the interpretation, in relation to the objects of his/her life. Extract 7 is an example of an elaboration. The analyst proposes in his interpretation that the patient's experience of a rival colleague who is currently in trouble in her profession, is linked to the patient's experience of her siblings who were ill, and one of whom died, when the patient was a child. In Extract 7, the final part of the interpretation is shown:

Extract 7

1 A: so there's also that similarity that when (1.0)
2 Aino is in trouble, (.6) so she's like ill.
3 (1.6)
4 A: A bit like she was about to die.
5 (1.2)
6 A: (tch) Ah possibly will "die" in her profession.
7 (3.0)
8 A: So then it is difficult, (.8) really to be angry
9 enough at her, (.6) as you feel sympathy "for her''.
10 P: .mh (.4) It is absolutely true.
11 (11.0)
12 P: .thh it is absolutely true that I feel sympathy.
13 (1.4)
14 ?P: .nff
15 (2.6)
16 A: So: it is >I think that< it is pretty close to the feeling
17 that (.6) your ill siblings (.4) "arose in you''.
18 P: Mm
19 (10.0)
20 P: .thh difficult to be angry. difficult to compete.
21 =difficult to be envious.°
22 A: Yeh.
23 (4.6)
24 (4.6)
25 P: What is there to be envious for when the other °is
26 laying down (.8) about to °die °.
27 (0.4)
28 A: Quite °right °.

(Audio-recorded consultation in psychoanalysis, AI11 811-985)
The patient's elaboration begins in line 20 (lines 10 and 12 involve agreement, and not elaboration). She first illustrates what was proposed by the analyst in the interpretation, with a list of the feelings with which she has difficulties. The first item basically repeats what was suggested by the analyst in an earlier part of the interpretation (difficult to be angry, lines 8–9). After that, the patient names two other feelings. The 'object' of these feelings is left unspecified: the patient seems to show that they are applicable both to the sister and to the colleague—thereby maintaining the linkage suggested by the analyst in his interpretation. After an agreement token by the analyst (line 22), the patient continues the elaboration by animating her childhood self considering her sick sister's situation (lines 23–6). Through her elaboration, the patient takes up the interpretation and eventually continues it in her own terms.

After the analyst has delivered an interpretation, and the patient has responded to it, there is a slot for the 'third position' action in which the analyst has an opportunity to act on the patient's elaboration or other response (the 'second position'). The directions taken by the analysts in these third position actions vary: sometimes they build upon the patient's elaboration (thereby treating the elaboration as an 'adequate' response to the initial interpretation) but in some cases, they may—for example, by returning to and pursuing the initial interpretation—indicate that the patient's response was not the one being sought by the analyst. Sometimes, in cases where the analyst's third position action builds upon the patient's elaboration, that third position action may instigate a cycle of collaborative description in which the patient, along with the analyst, participates in sketching an aspect of the patient's experience. Extract 8 is a case in point.

At the beginning of the extract, the patient is talking about her grief after the recent death of her partner. In examining her own feelings, she has realized that she is worried that she might get stuck in her grief. In line 18, the analyst begins an interpretation in which he makes a link between the patient's current difficulties in grieving, and her 'childhood sorrows'. After a minimal agreement token by the patient (line 22), the analyst adds an increment to the interpretation in which he points out that in her childhood, the patient felt that sorrows have to be 'left behind' quickly (lines 24–5). Finally, overlapping with the patient's turn beginning, the analyst adds a third component (line 28) which animates the patient's attitude:

Extract 8:

01 P: ... maybe there is some kind of fear that I... ((five lines omitted))
02 P: or that I will become like [that
03 A: [(((coughs)) hmm

04 P: qld relative of mine so I will just walk
05 around then and say oh I wish I could get away.
06 (1.0)
07 P: I mean that is no (.). hhh. hhh (0.3) way to live.
08 (0.4)
09 P: You either live or you don't live.
10 (1.8)
11 A: hhh I do think that it has (0.5) uh considerable dimensions that thing so that it. hhh again I would indeed connect it to your (0.4) childhood situations to these
12 (. ) grp [at sorrows.
13 P: [Yeah:
14 (0.3)
15 A: When you have the kind of <feeling that they must just
16 (0.4) be left behind right "away".
17 (0.5)
18 P: yes (just<)
19 A: [One shouldn't be drawn in to grieving".
20 P: [To dance and to sing.
21 (.)
22 A: Yes,
23 P: So that others would be happy (. ) and pleased with me.
24 (.)
25 A: Yes and you too would feel better".
26 (2.3)
27 A: But there is the problem then that... hhh
28 how much of that grief then goes completely un"grieved".
29 P: Yes well: now at this moment so far there's not any... hhh
30 . hhh KROHHHHH (0.4) koh koh krehmm (0.4) m... hhh
31 great danger yet that I would get rid of it.
32 (3.3)
33 P: But but I (0.5) well I balance things so that,
34 (1.0) go around (0.5) and do things and. (0.8) hhh
35 I want to buy some bulbs of amaryllis and will put them
to the ground... .

(Audio-recorded consultation in psychoanalysis, Tui4: 1, B18: 2-7)

The first part of the patient's elaboration of the interpretation is started by the word 'just' after the second agreement token in line 27, then aborted, and completed in line 29. The elaboration is sequentially tied to the second part of the analyst's interpretation (lines 24–5) in which he described the patient's childhood scene. The patient uses metaphorical language to illustrate the same
experience that the analyst was describing: she moved on ‘to dance and to sing’, instead of allowing herself to take time for grieving. After an agreement token by the analyst (line 31), the patient expands her description of the childhood scene. She adds an explanatory dimension to the description, referring to the expectations of ‘others’ as a reason for her inability to mourn as a child (line 32).

The analyst’s third position action begins in line 34. After an agreement token ‘yes’ (Finnish nii, which does affiliative work in this context, Sorjonen 2001), he produces an utterance that is designed as a grammatical continuation of the patient’s preceding turn (line 32). Here, the analyst adds another reason for the patient’s inability to mourn: by not mourning, the patient also made herself feel better. As a whole, the interpretation-elaboration-extension sequence accomplishes a momentary communion of minds. The analyst and the patient collaboratively draw a sketch of sensitive aspects of the patient’s childhood experience. The analyst’s extension utterance complements the patient’s elaboration by offering a parallel reason for the patient’s childhood mourning behaviour.

However, the analyst’s extension also involves a shift in topical focus. The patient’s version of the ‘reasons for’ her childhood behaviour of mourning focuses on others: she sees this pattern as socially induced. In his third position utterance, the analyst points out the inner dynamics of the patient’s mind: getting rid of sorrows quickly, helped the patient, too. This may be important in terms of the psychotherapeutic process, as the analyst opens up a perspective for the patient to examine her own mind instead of explaining her behaviour through the expectations of others.

The patient does not verbally respond to the analyst’s extension, and after a silence of 2.3 seconds (line 35), the analyst continues his third position action with an assessment (lines 36–7). He explicitly adopts a new perspective to what was described in the preceding talk, by pointing out that the patient’s way of dealing with sorrows (described in the analyst’s interpretation, the patient’s elaboration, and the analyst’s extension) it has its drawbacks: grief remains unexpressed. Notably, the analyst adopts the generic present tense here, thus making his assessment applicable both to the patient’s childhood situation and to her current grief. In her subsequent talk (lines 38–40), and in a somewhat sarcastic tone, the patient declines the relevancy of the proposal for her current situation. Thereafter she moves on to another topic (lines 42–5).

In sum, psychoanalytic interpretations invite active patient participation. They make relevant not only acknowledgement, agreement or disagreement by the patient, but also that he or she adopts the perspective proposed in the interpretation and applies it to further examination of his or her experience. This kind of patient response can be part of a dialogical process where the participants collaboratively construct a verbal description of the patient’s mind.

### Conclusion

In each of the three settings, the question of participation set itself differently according to the key activity for that particular encounter. In general practice, we analysed participatory and non-participatory trajectories of giving and receiving diagnosis; in homeopathy, we described participatory and non-participatory ways to deliver the treatment decision; in psychoanalysis, we focused on the ways in which patients participate in the interpretations made by the analysts on the patients’ preceding talk. In each setting, we located different ways in which, and degrees to which, participation was made relevant with regard to these activities. In general practice, the relevancy of patient participation varied according to the characteristics of the cases (routine vs. non-routine) and was initially invoked by the doctors according to how they designed the diagnosis. In homeopathy, the relevancy of patient participation was tied to affiliating with the homoeopath’s treatment decision and was concretized to different degrees by the homoeopath. In psychoanalysis, patient participation in analysts’ interpretations was highly relevant for the key goal of the encounter: it ensured patient collaboration in exploring the patient’s mind.

CA as a method is suitable for the analysis of distinct activities. It makes it possible to describe the trajectories through which key goals of a particular institutional encounter are realized. It can show what sorts of actions are treated as relevant by the participants in the realization of these activities. Through description of these participants’ orientations, CA can explain how different structures and patterns of the activities analysed provide for different (blocking or enhancing) opportunities for patient participation. However, there are also limitations to what can be said about patient participation drawing upon CA and/or the analyses presented in this chapter.

In structural terms, all the activities explored in this chapter involve opportunities for patient participation in second position, i.e. in actions that are responsive to the professional’s actions. In each setting, there are also first position acts that could and should be examined in terms of patient participation. They involve patients’ questions, requests for advice (in homoeopathy), patients’ proposals for treatment (in homoeopathy), candidate diagnoses (in medical consultations), and stories (in psychoanalysis). Further CA-informed study of these first position activities would be needed in order to form a broader picture of patient participation in each setting.

Another limitation is that, as such, CA does not offer tools for description of patient participation in the context of the whole consultation. In this article, we focused on patients’ opportunities to take part in distinct activities (diagnosis in general practice, treatment proposals in homoeopathy, interpretations in psychoanalysis). These activities are recurrent and central in the
three settings, but there are also other key activities in each setting. Therefore, our observations should not be read as an analysis of all patient participation in these settings (and see Chatwin et al., Chapter 5 in this volume; Gafaranga and Britten, Chapter 6 in this volume; Jones and Collins, Chapter 8 in this volume). However, we might want to discuss the possibilities of broadening the analysis by also studying the other main activities in each setting from this perspective (and see the Educational Supplement, pp. 207–8). We could ask whether it would be possible or desirable to develop a ‘CA-informed’ measure for patient participation in each different setting by combining the analyses of the different activities from this perspective.

However, even with the analyses of distinct activities, the following substantial points can be made. In each setting that we studied (or, more specifically, in each setting-specific activity), patient participation took a distinct form. The relevancy of these forms of patient participation ultimately arises from the overall goal of the encounter, as well as from the theory of healing that guides the interaction (see Peräkylä et al. 2005). The observed orientation of the homoeopaths to securing the patients’ compliance with the treatment decision, for example, may originate with the necessity to rely exclusively on patients’ reported symptoms. We might want to discuss, however, whose relevancies these are – the professionals’, the patients’, the relevancies of both, or the relevancies of the researcher?

Patient participation (in the activities that we have described) can be described in terms of ‘more’ or ‘less’ participation. In each setting, we made a distinction between cases where the patient participated ‘more’ and cases where the patient participated ‘less’. Making comparisons regarding degrees of participation across each type of consultation, however, is analytically problematic. The activities studied are not entirely equivalent and the relevancy of participation is tied to the institutional goal of the encounter. Thus, a similar trajectory of action (e.g. when a professional integrates the grounds for his/her decision in the announcement to the patient) may seem more participatory in the context of delivering diagnosis in a general practice consultation than in making treatment decisions in homoeopathy.

Perhaps a better way to do a comparison is to look at the structure of setting-specific activities (diagnosis in general practice, treatment proposals in homoeopathy, and interpretations in psychoanalysis) regarding the amount of patient participation that is relevant in each. ‘More than minimal’ patient participation is constitutive in psychoanalytic interpretations as the interpretative sequence is treated as incomplete without such patient participation.

In general practice, ‘more than minimal’ participation is contingent: whether or not it is relevant depends on specific circumstances related to the diagnostic sequence. In homoeopathy, participation is centred on the idea that patients should be given resources to understand and to agree with the decision. The orientation to ‘more than minimal’ participation, to pursuing the patient’s compliance with the treatment decision, could be constitutive in two senses. On the one hand, it might be essential for the continuity of the treatment relationship and thus for the maintenance of the practice. On the other hand, it might be essential in terms of the holistic treatment ideology, where the recovery of the patient would require commitment to the suggested treatment.

Further, our analysis does not warrant the conclusion that ‘more’ participation (in the activities that we examined) is equal to a good or a successful encounter, and ‘less’ participation is equal to a bad or less successful encounter. The form and the amount of patient participation may be involved in the ‘goodness’ of an encounter, but in manifold ways. In general practice, for example, a good and successful diagnostic sequence may in many routine cases involve minimal patient participation. We might ask, to what extent is patient participation recommendable? Is it recommendable in any context? How does it affect professional authority?

In general practice, much of the patients’ participation seems to be dependent on the way in which GPs design the diagnosis and on whether GPs take up patients’ extended responses to diagnosis. Even though a patient’s joo as a response to a GP’s diagnosis or a homoeopath’s treatment decision is compliant, it is also minimal. It implies that patients do not consider that they would need to give a more extensive display of compliancy in this context, regardless of whether or not they agree with the decision. We could then ask, whether the observation that joo is treated as a sufficient response to diagnosis or treatment decision gives grounds to claim that it should be sufficient. It has been shown (Stivers 2002) that in American medical consultations a plain confirmation is not treated by the doctors as a sufficient response to a treatment decision. This raises questions concerning whether this has to do with cultural or linguistic differences or perhaps with the specific characteristics of the activity in question. Whether the American practice is more participatory than the Finnish one remains to be seen.

We also need to bear in mind that ‘more’ patient participation in terms of verbal contributions is not equal to the patient’s actual participation in clinical decision-making. In the homoeopathic consultations, the actual treatment decision is suggested and also made by the homoeopath. The homoeopath offers the patient opportunities to participate by making the grounds of the decision explicit and by treating the patient’s consent as relevant. We could discuss whether this level of participation can make a difference from the patient’s point of view. Is it enough that the patient’s own stance towards the problem is treated as important, or that he or she is given an active role in testing and approving the professional’s suggestion? On the other hand, we can ask whether patient participation can also be regarded as a form of persuasion, as a way to achieve certain professional goals. Or if it is really participation rather than another form of involvement, for example, consent.
Notes

1. The results presented here are from two research projects funded by the Academy of Finland.

2. According to Sorjonen, as a response to directives in Finnish, joo is a proposal of compliance while the alternative response particle nii treats the suggested course of action as possible, and this way foreshadows disagreement. The function of joo as proposing compliance is especially clear in cases when the directive is constructed as a 1st person plural imperative (as in the case above, where the Finnish version is ‘Et nyt ei sitte oikeestaan tehdä yhtään mitään vaan odotellaan’ ‘ja sitten vasta uusitaan tää annos’) (see Sorjonen 2001: 214–20, 257).

Recommendations: summary

- The significance of patient participation in terms of the purpose of the consultation varies in different types of encounters. Thus, recommendations concerning participation should always be considered in relation to the medical context in question.
- Before we can make recommendations about how to enhance patient participation, we need detailed descriptive analysis of the interactional consequences of each activity to which we refer.
- More verbal contributions by patients do not necessarily equate with more actual participation in the definition of the agenda or in the decision-making. In finding ways to enhance patient participation, attention must be paid to the placement of verbal contributions, both within a sequence of actions as well as in the context of the larger consultation activity (e.g. diagnosis, treatment discussion).
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