

## How Patients Handle Lay Diagnoses during Medical Consultations

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### 1. Research Problem

The problem that I have been studying, how patients handle their lay diagnoses during medical consultations, is derived from two research traditions: normative research within the area of health communication and descriptive research in the area of Language and Social Interaction. I will provide a brief discussion of how this problem is of interest from each of those perspectives.

#### *1.1 Normative Research within Health Communication*

In the most general sense, patients seek medical care with the hope that someone with medical expertise will diagnose the cause of their symptoms and/or provide treatment for their medical problems. For this aim to be realized, the health care provider and patient collaboratively conduct the medical consultation as a series of ordered activities, including the patient's presenting the health-related problem(s), the provider's gathering information via interview and/or physical exam, and the provider's presenting the diagnosis and treatment plans to the patient. While this characterization serves as an overview of the medical consultation, it oversimplifies these activities and particularly glosses over the kinds of participation expected from, and performed by, each of the parties.

In some areas of medicine, particularly in Family Practice, there is an interest in moving away from a traditional orientation, sometimes called a "doctor-centered" clinical approach, to a more "patient-centered" orientation. Within a traditional framework, the patient's role is to report his or her symptoms; the doctor's role is to obtain the information necessary to arrive at a likely diagnosis and/or appropriate treatment plan. With a patient-centered approach, more importance is placed on the patient's thoughts, beliefs, experiences, and interpretations. According to McWhinney (1989), a "patient-centered" approach is one in which the doctor attempts to enter the patient's world and sees the illness through their eyes. Vanderford, Jenks and Sharf (1997) suggest that a patient-centered approach appreciates the importance of the patient's story, which includes not only the patient's description of the medical problems, but also his or her understanding of the symptoms and the impact of the medical problems on his or her life.

Advocates of a patient-centered approach argue that patients' accounts of their thoughts, feelings, experiences, interpretations, and concerns belong in the medical

consultation. They recognize that whether or not patients provide such accounts is shaped by interactional contingencies. If patients are to provide such accounts, both doctor and patient must facilitate or cooperate; if either one does not, the exchange of that sort of information will not occur.

While much of the early attention to the role of communication was directed at training health care providers, more recently attention have been given to training patients as well. The training generally takes the form of an intervention consisting of either material sent to the patient's home to be filled out prior to going to the visit or material to be gone over while the patient is in the waiting room. Cegala and his colleagues (1997) have put together a booklet for their series of interventions. Much of the training material is designed with two aims: 1) to promote a sense of appropriateness regarding patients' taking a more active role in medical consultations, and 2) to provide preparation and practice for patients in describing their medical conditions in order to seek information that they may want.

Advocates of a patient-centered approach believe that patients should give voice to their experiences, concerns, and beliefs, including their beliefs about the cause of their symptoms. Training materials may instruct patients to report their lay diagnoses "as soon as the doctor asks for the reason for the visit", as can be seen in the passage below:

Are you worried that you might have a particular medical condition, for example, cancer, heart disease, diabetes? If so, do you think the reason you made the appointment is in some way related to any of these concerns? If you answered "yes" to this question, be sure to express your concerns as soon as the doctor asks you the reason for your appointment (emphasis in the original) (Cegala, 1997, p.2)

These and other instructions advise patients to share their concerns, thoughts, and feelings about possible causes of their medical conditions. The instructions seem aimed at countering views presumably held by patients that such information would be irrelevant or inappropriate to provide to the doctor. The intervention aims to inform or persuade patients that such information is appropriate and relevant to proffer.

In studying how patients handle their lay diagnoses during medical consultations, it is hoped that discovering the issues surrounding telling/not telling lay diagnoses and describing various methods of telling lay diagnoses will provide a better foundation upon which to ground recommendations.

### *1.2 Descriptive Research within Language and Social Interaction*

When patients go to see a health care practitioner, they bring not only their bodies to the consultation; they bring, if you will, a purpose for the visit, notions about what is wrong with them, notions about the seriousness of various illnesses, and their experiences of the symptoms. Generally in a medical consultation, they have a slot in which they can state something of the purpose of the visit and/or their health related concerns. They make choices as to what to do with that slot, including simply describing the health related symptoms, providing a narrative of their experiences with the symptoms, and revealing their lay diagnoses.

Patients often arrive at a medical consultation with their own suspicions, theories, or beliefs about the cause of their symptoms. They arrive at the consultation more or less certain of their suspicions, theories, or beliefs and may have had discussions or arguments with others who are more or less certain about the cause of their condition. What do patients

gain or lose from revealing their own lay diagnoses early in the consultation? Do patients' levels of certainty influence whether or not they to reveal their diagnoses? Does the seriousness of the suspected medical condition influence patients' decisions to discuss their theories or keep quiet about them?

This paper describes some of the complexities that relate to whether or not, and how, patients indicate their lay diagnoses to health care providers. I show that the practices that patients employ to indicate (or withhold) their lay diagnoses are shaped by their particular local projects and by their interest in achieving particular stances and identities for themselves and for the health care providers. Particular stances and identities are in part accomplished through the use of particular discourses. In proffering and negotiating a lay diagnosis, a patient may use the "voice of medicine" or the "voice of the lifeworld" (Mishler, 1984). In the context of discussing lay diagnoses, these voices are recognized as reflecting different reasoning processes.

In this paper, I discuss two cases, each of which involves a patient with a hypothesis or guess about the cause of his symptoms. I show that the ways in which the patients put forward their lay diagnoses (including the voices that they use and their claims of certainty/uncertainty) are shaped by, and in turn shape, their role identities and their local projects. For each case, I first briefly characterize the health related problem, then I present evidence that the patient had a lay diagnosis, then I analyze the way the patient initially put forward his lay diagnosis. After analyzing the two cases, I conclude with a discussion of how this research addresses interests of health communication and language and social interaction scholars.

## 2. Analysis

### 2.1. Case 1: "Is It Cat Allergy?"

#### 2.1.1. Characterization of Health Related Problem

In this medical visit, the patient described his symptoms as having trouble breathing, coughing at night, having watery eyes, and continually blowing his nose. He reported that the symptoms had persisted for several months and that he finally made a doctor's appointment at the urging of his wife.

#### 2.1.2. Evidence that Patient has Made Lay Diagnosis

At various points throughout the consultation, it became clear to the doctor, Gustav, that the patient, McRae, believed his symptoms were due to allergies related to a household cat. The following three excerpts provide convincing evidence that the patient favored this explanation:

(1) [8/17/01:6]

- 1 Gustav: Any PETS in yer ↑home?=  
 2 McRae: =Yes.  
 3 (0.2)  
 4 Gustav: Wuhyih have fer pets:.  
 5 (0.2)  
 6 ((BLAM!))  
 7 McRae: One dog 'n one ↑cat.

8 (2.7)  
 9 McRae: Had th' dog probably::: (0.2) nine years a' cat .p! (0.3) probably two years.  
 10 (0.4)  
 11 Gustav: °°Okay°°  
 12 (0.7)  
 13 Gustav: Any [(b)ower)  
 14 McRae: [Ah'm blamin' the cat of course, °°hmhh°°  
 15 (1.7)  
 16 McRae: But uh- I don' know- I (khe[s fahn[ altmuh- )  
 17 Gustav: [nh hn [Is t h i : s] thi(k) .hhh-  
 18 (0.3)  
 19 McRae: °°(me:rt mu[h]°°  
 20 Gustav: [Eh- who's th-is the di:agnooziz the [(cat)  
 21 McRae: [Wɛ:l,=  
 22 Gustav: =mnh nEH[HHH ] heh heh heh [.hehh eh-°he]h°  
 23 McRae: [You(g)] [ G U E S S ]

In line 14, the patient provided his diagnosis with a humorous delivery, using non-medical terminology ("I'm blaming the cat of course"). In formulating his diagnosis with no uncertainty markers and as a given, he cast himself as an involved party with a particular interest in which diagnosis the doctor would endorse or validate.

(2) [8/17/01:13]

1 Gustav: Any new::: (0.3) fɔo::ds recently::,  
 2 McRae: nNah,  
 3 (3.4)  
 4 (McRae):.snff  
 5 Gustav: °Uh:m,°  
 6 (. )  
 7 McRae: The newest thing iz been the ca[:t.(Ahb'n)]  
 8 Gustav: [The ca:t ]  
 9 McRae: [ ( p e r p u h - ) ]  
 10 Gustav: [Yer BLAMIN'] the ca:::t, °°okeh°°=

When the patient answered a question about new foods by reporting on the acquisition of the cat (line 7), the doctor used the very term that the patient used earlier to characterize the patient's hypothesis regarding the cause of the symptoms ("your blaming the cat, okay"). By this time in the consultation,, the doctor cast the patient in the role of one who provided information according to his personal interests.

(3) [8/17/01:19]

1 Gustav: Ah'll look in yer ears fɪ:rst,[hh  
 2 McRae: [°°Kay?°°  
 3 (0.8)  
 4 Gustav: 'N work ar way aroun' THERE,hheh  
 5 (7.4)  
 6 Gustav: 'T's clea↑r?  
 7 (0.6)  
 8 McRae: Get a note fr'm the doctor saying et we \_haftih git ridda the cat,

- 9 ((CLANK))  
 10 Gustav: ↑hm-hm (.) huh ey who the-huh (h)yer (.) (h)really hn .t.hh ↑pushin' fer that  
 11 ↑arn'tcha. ((CLANK))  
 12 Gustav: .h[hh  
 13 McRae: [Nah: [nɔt r-I [don't- I like ]t h e c a t ]  
 14 Gustav: [hg hu:h[h. h e h-h i h]↑heh ↑↑hə] ha,

While the doctor was examining the patient's ears, the patient made a joke about getting a note from the doctor that recommended that they get rid of the cat. The joke seems to be playing off of what he anticipated the doctor could infer about his interest – that he came to the consultation in hopes of getting the doctor side with him in the dispute over the cat.

### 2.1.3. Analysis of patient's putting forward lay diagnosis

In response to the doctor's inquiry, the patient reported a symptom ("struggling breathing") and continued on to provide his lay diagnosis, or explanation, of the symptom.

(4) [8/17/01:2]

- 1 Gustav: °Okay° >Tell ↑me w[t's been [going< o:n]  
 2 McRae: [I'm- [Ah'm jist- ]  
 3 (1.1)  
 4 McRae: I'm strugglin' breathin'. Eh I mean uh I g'd-I'm: think I might have al- I don't know  
 5 'f ah'm developing allergie::s er .hhh (.) I have a CO:LD en iss been (.) mI've been  
 6 aahh (.) y'know, (0.2) jus' been ba:ttl with it.

The patient gave several versions of his lay diagnosis. Although barely audible, the first version probably was "I got-." The start may have projected something like "I got allergies." Regardless of what it projected, it was quickly aborted and replaced with a second version: "I think I might have al-." An obvious difference between the first and this version is that in this one the patient incorporated the uncertainly markers "I think" and "might." By incorporating uncertainty markers while forwarding his lay diagnosis, the patient cast the doctor in the role of medical expert and himself in the role of lacking medical expertise. It is also a way of warranting the visit to the doctor, i.e. to get a definitive diagnosis.

To reiterate, in the second version, the patient presented himself as having a lay diagnosis, though one of which he was not certain ("I think I might have al-"). In his third version, the patient presented not one uncertain diagnosis but as entertaining two plausible diagnoses. He elaborated the earlier diagnosis formulating it as "developing allergies" instead of simply "allergies" and added a second diagnosis of a cold with which he had been battling. The formulations of "developing allergies" and "battling with a cold" provide each of the causes to be consistent with the reported duration of the symptoms.

This instance raises two matters of analytic interest. The first involves identifying the various ways that patients present their favored diagnosis, particularly ways of presenting favored diagnoses such that they appear to be not fully endorsed. In this consultation, the patient presented the diagnosis in one version as uncertain and in another version as one possibility between two plausible possibilities. The second related matter of analytic interest involves describing the kinds of concerns and/or circumstances that engender persons to be reluctant to claim authorship of positions that they otherwise would embrace. We would want to describe the functions served by putting forward a lay diagnosis with uncertainty or by framing it as if it were one of two equally possible explanations. I will suggest several

interrelated concerns and circumstances which account for patients' reluctance to go 'on record' with their lay diagnoses.

#### 2.1.4 *The Voice of Investigation versus the Voice of the Life-World*

In section 2.1,2, I presented segments in which the patient fully endorsed his lay diagnosis. When he did so, he used a very different kind of discourse than he used when he first presented his lay diagnosis to the physician ("I'm: think I might have al-"). Whereas early in the consultation he put forward the lay diagnosis as either tentative or as one of several possibilities, later in the consultation, he used highly moral language with no mitigation (line 14):

##### (5) Shortened Version of Excerpt 1 [8/17/01:6]

- 1 Gustav: Any PETS in yer home?=  
 2 McRae: =Yes.  
 3 (0.2)  
 4 Gustav: Wuhyih have fer pets:.  
 5 (0.2)  
 6 ((BLAM!!))  
 7 McRae: One dog 'n one cat.  
 8 (2.7)  
 9 McRae: Had th' dog probably::: (0.2) nine years a' cat .p! (0.3) probablytwo years.  
 10 (0.4)  
 11 Gustav: °°Okay  
 12 (0.7)  
 13 Gustav: Any [(b)ower)  
 14 McRae: [Ah'm blamin' the cat of course, °°hmhh°°

In formulating his view of the cause as "blaming the cat," the patient playfully admitted that his stance was not investigative and neutral. Rather it was the voice of the life-world (Michler, 1984). Recall it is precisely that voice which the doctor repeated in excerpt 2 "yer BLAMIN' the ca:::t, °°okeh°°"

A problem with adopting the voice of the life-world is that it may damage a presentation of self as a credible, unprejudiced, disinterested reporter. By displaying a moral judgment early on in the encounter, a patient may undermine his or her stance of being a credible reporter. The issue of credible, unprejudiced reports arises later in the medical consultation. I reproduce Excerpt 3, this time extending the dialogue further than before. Note particularly lines 35 and 38.

##### (6) Extension of Excerpt 3 [8/17/01:19]

- 1 Gustav: Ah'll look in yer ears f<sub>i</sub>:rst,[hh  
 2 McRae: [°°Kay?°  
 3 (0.8)  
 4 Gustav: 'N work ar way aroun' THERE,hheh  
 5 (7.4)  
 6 Gustav: 'T's clea↑:r?  
 7 (0.6)  
 8 McRae: Get a note fr'm the doctor saying et we ↑haftih git ridda the cat,

- 9 ((CLANK))  
 10 Gustav: hm-hm (.) huh ey who the-huh (h)yer (.) (h)really hn .t.hh pushin' fer that arn'tcha.  
 11 ((CLANK))  
 12 Gustav: .h[hh  
 13 McRae: [Nah: [nɔt r-I [don't- I like ]t h e c a t ]  
 14 Gustav: [hg hu:h[h. h e h-h i h] ↑heh↑↑hə]ha,  
 15 (0.8)  
 16 McRae: °°(nhhao)°°  
 17 (5.2) ((various noises))  
 18 McRae: °B't I've I (.) dus° feel that it  
 19 (0.8)  
 20 Bkg°: Nɔ:  
 21 Gustav: (Look the retinee)  
 22 (3.0)  
 23 Gustav: When you pet the cat\*.  
 24 (0.8)  
 25 Gustav: If you ever (.) go near the ƒca:t.ƒ[.hh  
 26 McRae: [I do,  
 27 (0.2)  
 28 McRae: °Y[ih I-°  
 29 Gustav: [Dih you:.....  
 30 (0.5)  
 31 McRae: °°m- uh-°° [In my]i mi:nd now I'm,h thinkin' it's the [ca:t.  
 32 (0.8)  
 33 Gustav: Is,  
 34 (0.3)  
 35 Gustav: .t Try dih be iz:  
 36 (1.1)  
 37 McRae: °m[hh°  
 38 Gustav: [>open minded ez possible< dih you thin:k t h e t when yoo near the cat it's  
 39 worse?  
 40 (0.8)  
 41 Gustav: Duh the cat sleep in yer bedroom?

After several occasions in which the patient used the voice of the life-world, the doctor seemed to question whether the patient would provide objective answers to her questions. In her preface "Try to be as open minded as possible," the doctor cast the patient as someone capable of compromising the accuracy of his reports.

#### 2.1.5 Doing 'fairness' in dispute talk.

The patient implied that he and his wife had differing lay diagnoses of his symptoms. He also indicated that it was by virtue of his wife's urging that he was seeing the doctor. Assuming the consultation with a medical expert was a move to resolve the dispute with his wife, the patient may be doing 'fairness' by presenting both his and his wife's diagnoses rather than making a case for his favored diagnosis.

## 2.2. Case 2: "It isn't heart, is it?"

### 2.2.1 Characterization of health related problem

Four or five weeks before the medical visit, the patient experienced s pains that he thought might be heart-related, especially given the family history of a father and uncle who had bypass surgery. During the consultation, the patient complained about a variety of pains in the past month, including gas pains and burning sensations around his chest, stomach, and back. While he had become less concerned that his symptoms were heart-related and more convinced that they probably were gastro intestinal (GI) related, he wanted confirmation that the symptoms had not indicated a heart problem.

### 2.2.2. Evidence that patient made lay diagnoses

Prior to the medical consultation, the patient (Davis) was making ongoing lay diagnoses of his medical symptoms. Some evidence for this occurs in the patient's response to the doctor's (Meier) inquiry about the medications that he was taking. The patient referred to a change in his lay diagnoses (lines 5-7 and lines 12-13):

(7) [8/13/01]

- 1 Davis: How about- What else[:  
 2 Meier: [.t.hhh U<sub>h</sub>:m:, °hmh° (.) asperin every so often  
 3 (0.6)  
 4 Davis: How often °do you° (.) think,h  
 5 Meier: When I thought it when I thought it was something duh do wit' my heart w'z  
 6 taking it (0.3) two every four hours, I've been cutting back en I th'n like two every  
 7 da:y?  
 8 (0.9)  
 9 Davis: °°uh°° Two: regular strength?  
 10 Meier: Yes  
 11 (2.0)  
 12 Meier: .t En that's (.) again aw- just the first week when I thought it was something  
 13 serious I w'z takin' 'em every day?°=every two'r three days  
 14 (0.6)  
 15 Meier: °U<sub>h</sub>:m° (0.2) En ey also take garlic pills. If that makes a difference et all

The patient indicated that he no longer considered heart as the most probable diagnosis, and his conduct during the visit seems directed to getting that the symptoms are not heart related.

### 2.2.3. Analysis of patient's putting forward lay diagnosis

In the opening of the consultation, the patient did not explicitly endorse, i.e. put forward as his own, a lay diagnosis. Rather, he detailed a series of episodes in which he experienced different kinds of pains and sensations. In the narrative that he constructed, he included details that could have provided grounds for determining which of the possible diagnoses were more or less likely. For example, in including descriptions of the foods and beverages he consumed prior to the onset of the pains, he was providing for the conclusion that the pains may have been related to the kinds of items that he consumed, implying a possible GI related symptom. In reporting no pains in the arm, no shortness of breath, and

no discomfort after strenuous exercise, the patient provided grounds for concluding that the present symptoms were not cardiac related.

(8) [8/13/01:4]

- 1 Meier: But again (.) no pain no pains in the arm no shortness 'v breath .hhh ah:m  
 2 that's pretty much °wp-° (0.2) tapered o:ff, very occasionally now, .t.hh ah'll  
 3 get a slight burning< (0.3) on either side .t.h thē of: the chest, .pt an' sometimes  
 4 'pending w't I'm (.) what I'm eating er drinking .hhh it'll f'like there's a gas bubble  
 5 that goes (.) up and (.) almost t'my ba:ck, en °moves tuh the middle a' my ba:ck.°  
 6 But thess (.) again tha'dz'n las'very long. (0.3) .hh But again it feel ky? gas  
 7 bubble. (0.2) But .hh no other symptom' beyon' tha:t uh:m (0.2) I've played, sports  
 8 I play volleyball (0.3) eh: today played outside doubles fer three hours,  
 9 (1.0)  
 10 Meier: Didn't fleny discomfort, (.) ndjuring tha:t,  
 11 (0.2)  
 12 Davis: Okay,

The symptoms that the patient described as being present as well as those described as absent were apparently used by the patient as evidence for his lay diagnosis. They were being offered to the doctor as evidence she could use in arriving at a professional diagnosis.

When the patient concludes his narrative of the history of the symptoms by arriving at the present, he might have concluded by articulating his lay diagnosis for confirmation/disconfirmation from the doctor, for example, "So it doesn't sound like heart, does it?" Rather than explicitly authoring endorsing the lay diagnosis, the patient solicits a diagnostic opinion from the doctor (line 5):

(9) [8/13/01:4]

- 1 Meier: en it- if it makes a difference (0.7) prior (.) to: (.) even before that I w'z deet'n  
 2 lots'v uh:m (.) hot stuff (.) 'n getting s'm heartburn .hh didn't have inning take  
 3 Meier: fer it so ah dis (.) dealt with it. (0.2) en I wonder 'f (.) that's pert'v er not but,  
 4 (2.1)  
 5 Meier: So 'm 's curious w't (.) should I be concerned uh more about heart?  
 6 (0.4)  
 7 Davis: [ih Su:re.]  
 8 Meier: [(issue)? ]  
 9 (.)  
 10 Davis: [Sure I]  
 11 Meier: [Or is] it something e:lse,  
 12 (0.4)  
 13 Davis: °Sure wil° (.) Wi'll work through that.  
 14 Meier: Q[kay]  
 15 Davis [Uh:]m (0.2) .k.hh °Uh:° number a' questions about (0.2) about yer symptoms

Assuming the patient wanted confirmation that his symptoms were not likely a manifestation of a cardiac problem, there are a number of ways he could have solicited the doctor's diagnostic opinion. One way would have been to solicit an opinion without providing any possible diagnoses, e.g. "So I'm curious what [do you think is the problem]." (This may have been what he started to do in line 5.) Two problems with such a solicitation at this point in

the consultation are 1) the doctor had not interviewed or examined the patient, so the question would have been drastically premature, and 2) doctors and patients generally treat the doctor as the proper party to initiate giving the diagnosis.

At this point in the consultation, a way of soliciting the doctor's preliminary diagnosis without quite appearing to ask for it is form the inquiry around the patient's concerns. Rather than directly ask for the doctor's assessment, ("It's not likely that it's heart, is it?"), the patient formulated his question as seeking advice about where his concern should be directed ("So 'm 's curious w't (.) should I be concerned uh more about heart?")

One further observation about the inquiry: As noted earlier, the patient apparently hoped for a confirmation that the symptoms were not likely related to a heart problem. The patient could have formed up the question so as to 'prefer' confirmation or disconfirmation, e.g. "Should I be concerned less about heart?" or "Should I be concerned more about heart?" As it turns out, it seems this patient formulated the question so as to get disconfirmation. To reiterate, the patient put forward a possibility to be disconfirmed ("So 'm 's curious w't (.) should I be concerned uh more about heart?"). As it turned out, the doctor seemed to have misunderstood the intent of the question, apparently hearing the patient as wanting confirmation that his concerns were reasonable and that they warranted a medical consultation. When the patient clarified his query, the doctor indicated that she was not ready to give even a provisional diagnosis.

At an epilogue to this failed attempt by the patient, the patient was not without resources in satisfying his interest; he was not left to simply wait until the doctor offered her diagnosis. Later in the consultation, the patient reiterated his concern about his heart (lines 6-7). This move prompted the doctor to give a provisional diagnosis (lines 9-13, 15-16, 18).

(10) [8/13/01:22]

- 1 Meier: Qui[tt'n CO:FFEE w'z] tough (.) begin with  
 2 Davis: [°Y e a h° t hat 's]  
 3 (0.5)  
 4 Davis: Okay.  
 5 (3.9) ((loud voices in the background))  
 6 Meier: AN THEN AGAIN. There is a hist'ry of heart pro'ms en that(.)'s why I'm really  
 7 c'ncerned,  
 8 (0.6)  
 9 Davis: SU:RE. I MEAN UH- (1.2) y-you know 'n eh- enno wunnuh, hhh (0.3) jump'th'gun  
 10 here but (.) uh muh wey- what yer describin:g doesn't (0.6) ü-sou:nds more likely  
 11 duh be, G.I: related then .hh.hh ↑cardiac but (0.2) °yih know 'ss never°  
 12 (1.4)  
 13 Davis: °↑ih-° ih it en-ye-ee (.) you always think about both, en jus:t [becuz the=  
 14 Meier: [(Uh hm?)  
 15 Davis: =cardiac is always the more ↑dangerous then (0.4) then if it's gastro intestinal  
 16 we: (0.7) we ten' duh (0.4) really harp on thhē o(h)n the SYMPTO[MS en=  
 17 Meier: [hmhhh  
 18 Davis: =.hhh It's not thet I: (1.0) y'know I'm dus tryina (0.3) serta sort out °↑what-  
 19 what might be going o[n?°  
 20 Meier: [Mhm?

Whether or not the patient was intentionally attempting to elicit the doctor's provisional diagnosis at this point, his reiterating his concern functioned somewhat like describing a problem. Just as a common response to a description of a problem is the proffering of a solution, so too in response to the patient's description of his concern the doctor offered her diagnosis as a solution.

### **3. Discussion**

#### *3.1. Normative Interests in Health Communication*

One of the issues that health communication scholars address centers on how much mutual participation and joint decision-making occur in medical consultations. The normative stance is that it is wrong, damaging, and counterproductive to good health outcomes if/when patients are not able to voice their health related concerns and if they withhold beliefs and attitudes that may bear on their compliance with medical regimens.

As discussed earlier, one component of patient interventions seems designed to overcome the view that it is inappropriate or irrelevant for patients to tell their lay diagnoses to doctors. Current interventions seem well designed for patients who think that their lay diagnoses have no place in the medical consultation. However, this study suggests that some patients may withhold their lay diagnosis when they are seeking a medical expert's diagnosis that is produced independently of hearing the patient's diagnosis or may withhold lay diagnoses when different diagnoses are tied to a conflict situation. This small study suggests that further study should be done on how patients deal with lay diagnoses prior to the consultation as well as how they handle their lay diagnoses during the medical consultation.

#### *3.2. Descriptive Interests in Language and Social Interaction*

This study makes some contribution to several areas in Language and Social Interaction.

##### *3.2.1. Discursive Constitution of Laypersons and Experts*

Using of tentative/uncertainty markers by laypersons interacting with professionals is a way of casting the other as having special expertise and warranting the consultation.

##### *3.2.2. Portraying Oneself as Detached and Indifferent*

Putting one's own view as one possibility among several may be a way of doing being neutral and/or fair-minded in a dispute. Using the discourse of investigation rather than the morally laden discourse of the life-world may be part of constituting oneself as a credible, non-biased reporter.

##### *3.2.3. Confirming One's Assessment with an Expert's Assessment*

Presenting just the evidence (without one's own assessment) so as to get an expert's assessment may be a way getting more credible confirmation by an 'independent' party.

##### *3.2.4. Circumstances for Designing Utterances for Disconfirmation*

This case suggests the possibility that when a speaker seeks reassurance that a feared negative state of affairs is not likely, it is more reassuring if the requesting utterance is not designed for confirmation. Further research is needed to describe the circumstances in which patients hoping for disconfirmation of a serious illness, X, inquiry in the form "Is

X the case?” versus “X isn’t the case, is it?” and to analyze whether and how the two forms differ in their relational and interactional consequences.

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