Ritva Engeström

Imagine the World you Want to Live in:

A Study on Developmental Change in Doctor-Patient Interaction

Summary

The article focuses on talk and cognition in terms of action. It outlines methodological alternatives for approaches addressing meaning construction and the accounts people give of their actions. There are studies, rooted especially in phenomenology and ethnomethodology, that manifest the idea of intersubjective reality seen as achievements of situated actions. In this framework, conversation and communication are seen *per se* as significant forms of social action. Instead of intersubjective reality, often brought about with an inductive research method, the article argues for instrumental reality as the context for understanding talk and cognition in terms of action. The aim is a method that studies multivoicedness of activity in terms of situated actions. The method integrates situational features in dialogue with the cultural-historical process of meaning construction. It is based on the theoretical notion of activity as a system that emerges and changes in time and place through internal contradictions. In the context of instrumentality, dialogical processes are also considered historically emerging and internally conflicting processes of rationality. I discuss this method with data on conversations between a patient and a doctor at a primary health care consultation. The study considers medical knowledge less as a substance than as a historically produced perspective through which the rationality of problem solving is accomplished by doctor and patient. The study aims to break away from the epistemological dualism of conflicting domains of meaning: the one of medicine that is objective and the one of experience that is subjective. The context of instrumentality includes a working hypothesis of a zone of proximal development of the doctor-patient relationship.

Introduction

The doctor-patient relationship has been shown for several decades to be framed biomedically. This has been challenged by demand for more egalitarian approaches to health care. Confronted with that demand, the professional attitude marks the physician as an expert representing a profession. Freidson (1989, 22) concludes the attitude that some conflict in the doctor-patient relationship may indeed be forestalled by educating physicians to be somewhat more understanding and flexible with patients, but that there is a line beyond which the physician cannot go without ceasing to practice modern medicine. The line refers to the conflicting domains of meaning: the one of medicine that is objective and presented by the doctor and the one of experience that is subjective and presented by the patient. This study aims to break away from this epistemological dualism by analyzing meaning construction as an actual collaborative activity. The study draws on discourse-analytical methods that are seen as a part of communicative turn in social sciences (Knorr-Certina, 1981).

Discourse-analytical studies consider the profession through authority that prevails, not only in the relationship between the doctor and patient, but also in the society as a whole. The authority has been discussed from the social and moral point of view for remaking an asymmetrical interaction more democratic, egalitarian, and human. Epistemological dualism, partly because of the same authority, is an overall conceptual horizon in society. In order to study it, the analyst has to enter into a social world that is constructed through medicine, a world where disease is cognitively conceived, and interpreted for healing and taking care of the patient. To take the point of view of clinical problem solving by a social scientist, this study considers medical knowledge less as a substance than as a historically produced perspective, through which the rationality of problem solving is accomplished by doctor and patient. The empirical analysis is conducted with data consisting of transcripts from video recorded primary health care consultations, with the support of additional data obtained from stimulated recall interviews of the patient and doctor.

In this article, I shall point to intersections and re-emergencies of meanings for identifying developmental tensions of the doctor-patient relationship. The tensions are significant as pointers for efforts at breaking away from epistemological dualism. The results of the analysis challenges, for the patient's part, the meaning of illness as being a subjective and personal experience confronted with the attitude of medicine. Seeing the patient as a carrier of merely experiential and subjective knowledge makes her voiceless in a biomedically construed, disease-oriented discussion. In the data, patients were making sense out of their illnesses not only in terms of their life situation and social network, but also in terms of medicine. Empirically, the analyst has to take for discussion the line between medicine and experience.

Another tension was found within the clinical interview, commonly considered the most important instrument for general practitioners. In egalitarian and patient-centered approaches, the interview has been a target of reshaping. Nevertheless, the clinical interview is itself an embodiment of biomedical thinking, crystallizing the articulation of disease into techniques and routines for working on the patient's problem. In the conversations of our data, the clinical interview appeared as an interactional structure that is in opposition with negotiation between multiple perspectives. A negotiated order did not reject the clinical interview as a resource of thinking and communication, but instead called for its social re-evaluation in the doctor-patient relationship.

The communicative turn is reflected in developments in a number of disciplines and perspectives, such as sociology, sociolinguistics, discourse analysis, discursive psychology, ethnography of speaking, microethnography of face-to-face interaction, and conversation analysis (see Potter & Wetherell, 1987; Billig et al., 1988; Drew & Heritage, 1992; Edwards & Potter, 1992; Engeström & Middleton, 1996; Goodwin & Duranti, 1992; Heritage, 1984; van Dijk, 1997). My interest in discourse is related to people's collaborative actions which can be carried out in different forms in particular activities. The actual use of language is central, in this article, because of the data drawn from face-to-face conversation. One example of mediational means of people's collaboration, reveals the special nature of language in the context of activity. Being an instrument, language designates also that of other instruments, due to its reflexive capacities. For theoretical points of this study, I shall first comment some of the notions included in the framework of the communicative turn.

My comments point to highly selective ideas presented altogether in this framework and especially in discourse analysis, due to a rich source of its research.

Communicative Action

The communicative turn points to a key deficit in traditional social sciences when these are used to analyze action. As many scholars have pointed out, traditional social sciences do not pay attention to the actor (see Garfinkel, 1967; Cicourel, 1973, Heritage, 1984). Rather, "action was to be analyzed as the product of causal processes which, although operating 'in the minds' of the actors, were all but inaccessible to them and, hence, uncontrollable by them" (Heritage, 1984, p. 22). By the turn, the attention was directed to the importance of meaning and the accounts people gave of their actions. Studies were/ are mostly rooted in phenomenology and ethnomethodology. The studied reality constitutes many realities, where the world is dependent on our ways of naming it and talking about it, and where the symbolic expressions make sense only in the context of indexicality and through local interpretations by people.

In current studies, communication and conversation are seen *per se* as significant forms of social action. With ethnomethodology, the "situated" approach pays attention to the rationality that is achieved through the process of action (Lave, 1988). Conversation Analysis points to conversation as a form of social action where intersubjective understandings are publicly displayed by the parties embodying for one another the relevances of interaction and action (Schegloff, 1992). 'Action' designates, first of all, the *process* where inevitable uncertainty is managed locally as achievements of situated actions in interaction. The outstanding question for social sciences, as Suchman (1987, p. 57-58) points out, is not whether social facts are objectively grounded, but how objective grounding is accomplished. Objectivity is a product of systematic practices, or of members' methods for rendering our unique experience and relative circumstances mutually intelligible (ibid.).

To attend to the issue of objectivity in the context of discourse analysis, it is necessary also "allow analysis to move beyond, outside, versions of intersubjective reality" (Parker, 1992, p. 36). Parker refers to a realist position which takes into account different senses of reality, and reality outside sense. My study makes this move, drawing on theoretical reasoning presented by cultural-historical activity theory. The theory also challenges the traditional notion of action, particularly in psychology (Vygotsky, 1978; Luria, 1979; Leont'ev, 1978). The Cartesian notion of human conduct is replaced by a unit that intertwines psychological, social and cultural particulars of conduct. The basic constituents of this unit are subject, object, and mediational means (see Cole, 1996; Y. Engeström, 1987).[1] In such an approach, action is defined as *a productive process where the subject is connected to the object with culturally constituted (tools, signs) mediational means*. In this unit of analysis, language is viewed as a specific means, an instrument, and an instrument for other instruments, due to its potentials and resources for sense making.

[1] Y. Engeström (1987) has expanded the unit with community, division of labor, and rules (see also Cole & Engeström, 1993).

As an activity-theoretically oriented analyst approaches a situation, she takes advantage of the unit of analysis. Conversation (between a patient and doctor) is made representable by terms of action in the form of actors (a sick person and doctor), object (related to the person's health), and mediational means (medical knowledge, clinical interview, instruments of physical examination, patient's medical records, etc.). All these components of a situation have in time and space their historically changing appearances. As Giddens (1984, p. 35) states, a fundamental question of social theory is to explicate how the limitations of individual 'presence' are transcended by the 'stretching' of social relations across time and space.

To keep the focus of the study on the cultural-historical nature of 'action', activity theory offers a conceptual framework that distinguishes between *activity*, *action*, and *operation* (Leont'ev, 1978). Activity is a collective, object-driven complex which is transformed over a considerable span of time. Actions are local and carried out by individuals. Operations bear certain typified, repeated features of actions and are launched in response to ongoing conditions of activity. The internal relations of this framework generate a structure where artifactually mediated actions are part of a cultural and historical process, and where the same process is produced and displayed through and with these actions. I shall appropriate this structure for studying culturally-specific rationalities of clinical problem solving as a situationally accomplished meaning construction. For that purpose, I turn to the work of Mikhail Bakhtin and his collaborators, whose theoretical viewpoints are particularly relevant for the understanding of the dialogicality of meaning construction.

Instrumentality as Context

Giving up the traditional view of communication as a transportation of fixed meanings (the conduit metaphor of communication), dialogue is here considered "the locus for the dynamic construction and reconstruction of meaning" (Linell, 1990, p. 150). What makes me interested in Bakhtinian writings is that their insights are deeply opposed to the conception of dialogue as an unhistorical speech with an intrinsic meaning. Language is treated in its heteroglot developments in society. Dialogue expresses, reflects and determines social relations and culture-specific rationalities that "intersect one another in a multitude ways, some fail to develop, some die off, but others blossom into authentic languages" (Bakhtin, 1981, p. 356).

In a position of discourse analysis which also takes account of reality outside of the different senses of it, the concrete purpose of language use is central. Although the purpose of finding out "what is wrong with the patient" is dependent on language and through it on "the stable realities of human body and disease", as construed and objectified by medicine (Bury, 1986), the consultation produces some proposal of concrete actions for healing and taking care of the patient. Language use, and the concrete purpose which it is being used for, are the cornerstones in Bakhtin's and his collaborators' works. Their questions were directed to "the mode of being of language in the subjective speech consciousness", by producing the system of language in the context "carried out by the speaker", as well as carried out "for the immediate purposes of speaking" (Volosinov, 1973, p. 67). The linguistic form becomes "a sign adequate to the conditions of the given concrete situation" (p. 68). Denoting a stand against abstract objectivism of linguistic forms, Bakhtin defined an

utterance as being a unit of speech communication.

Holquist (1990, p. 60) states that a Bakhtinian utterance is "dialogic precisely in the degree to which every aspect of it is a give-and-take between the local need of a particular speaker to communicate a specific meaning, and the global requirements of language as a generalizing system." While the utterance itself is individual and carried out by the speaker, it is achieved in the face of pre-existing restraints. Some of these restraints, as Holquist points out, had always been recognized by linguists, and some of them Bakhtin was the first to recognize. He *re*organized the properties of the word. Instead of the two, systemic and individual, aspects in which the word exists for the speaker, Bakhtin proposed three:

"[One] can say that any word exists for the speaker in three aspects: as a neutral word of a language, belonging to nobody; as an *other's* word, which belongs to another person and is filled with echoes of the other's utterance; and finally, as *my* word, for, since I am dealing with it in a particular situation, with a particular speech plan, it is already imbued with my expression" (Bakhtin, 1986, p. 88).

Acknowledging that the neutral dictionary meaning of the word (belonging to nobody) guarantees that all the speakers of a given language will understand one another, the use of words in live speech communication was seen by Bakhtin as having an individual, as well as contextual, nature. Within my word, the sign is expressive and related to the speaker's consciousness. The other's word attaches the meaning to others' utterances (previous/expected utterances). In all areas of life and activity, there are particular traditions within communities that are expressed and retained in verbal vestments: in written works, in utterances, in sayings, and so forth. There are also authoritative utterances that set the tone on which one relies, to which one refers, which are cited, imitated, and followed. The unique speech experience of each individual, therefore, is shaped and developed in the continuous and constant process of *assimilation* – more or less creative – of others' words and not the words of a language (ibid., p.89).

Since Bakhtin, a number of scholars have commented on the way communities develop unique social and cognitive repertoires which guide their interpretations of the world. Bakhtin, nevertheless, draws on the context of instrumentality where the repertoires are historically changing and internally conflicting culture-specific rationalities. For this study, intersectional dynamics between the languages, their internal ruptures, re-emergences, and new possibilities in making and taking perspectives are central. These notions deal with the internal contradictions of activity occuring as developmental tensions and disturbances of actual activities. Activity theory invites us to ask about the dynamics and possibilities of change and development involved in situated actions. It points to "the zone of proximal development" as the basic category of expansive delopmental research methodology (Vygotsky, 1978; Engeström, Y., 1987).

With regard to scientific knowledge, Parker (1992, p. 27) denotes these kinds of tensions. On the one hand, scientific knowledge employs rational criteria which have been developed in particular ways with varying views of rationality. On the other hand, there is also an appeal to rationality because there is a world existing independent of experience. This means, as Parker points out, that scientific knowledge is at once historically bounded, provisional, and is also practical, true. Parker concludes that, "this tension is not to be resolved (as if it were a problem), for it is actually one of the conditions for the production of knowledge"

(ibid.). In terms of activity theory, the subject-object-relation calls for a counter-process. The process originates at the object, the world outside we are working on, never fully known to the actors (Raeithel, 1992). The counter-process will adjust to the activity, as well as lead to unexpected circumstances – possibilities of a new kind of reality (Engeström, Y., 1990). What is relevant and makes sense will change by receiving new objects with new rationalities.

The Method of Voices

The Bakhtinian unit of utterance, with clear-cut boundaries in a communication chain, resembles a turn in conversation. The turn, however, seems to be too narrow for studying meaning construction through local dialogue. Locally, there is an active and productive process in which word meaning becomes constructed by means of situated actions. Situated actions are based on previous/expected utterances that are transformed into raw materials (object) and mediational means of the actors' individual sense making. For the method, I shall take advantage of the distinction, introduced by Bakhtin, between social languages, voices and speech genres. I shall consider this distinction in the framework of activity theory (see also Engeström, 1995).

Leont'ev	Bakhtin	Bakhtin
ACTIVITY	SOCIAL LANGUAGES	SOCIAL CONTEXT OF MEANING (other's word)
ACTIONS	VOICES	SUBJECTIVITY OF THE SPEAKER (my word)
OPERATIONS	SPEECH GENRES	TYPICAL FORMS OF UTTERANCES

Figure 1. Conceptual schema of analysis

In Figure 1, *social languages* are represented as activities which reveal the meaning as external collective activity, rather than as individual consciousness. With their expressions and evaluative tones, the world is objectified for us and becomes transformed in the real world for us to act on. One key proposition of Bakhtin's is that a speaker always invokes a social language in producing her own utterance. By assimilating and reworking the words of others, the speaker produces an utterance voiced by her. *Voice* depicts the speaker's subjective perspective, through which her perception of the world is accomplished. By *speech genres,* Bakhtin refers to relatively stable types of utterances (Bakhtin, 1986, p. 60). Todorov (1984, p. 85) writes about collective memory, whose "content is described in the formal properties of the genre." A speech genre is like "a ready-made way of packeting speech", that allows for "creative, emergent, and even unique individual performances" (see Wertsch, 1991, p. 61).

Within the communicative turn, the method that understands action through inter-

actional and situational aspects has in some cases been critical towards any theoretical or investigator-stipulated concepts. Conversation Analysis focuses on the interactional work which produces the meanings to be empirically observed by the analyst (Pomerantz & Fehr, 1997). Conversation Analysis, as well as other situated approaches, do not argue that the social world is constituted without structural features of human conduct. They do not want to reduce meaningful action to the scientific method (see Suchman, 1987, p. 57-58).

Analyses which keep to empirical observations as the starting point of any theoretical considerations and generalizations require an inductive method. In line with Erving Goffman's work, the method is inductive for identifying features of interaction to which people actually attend (on Goffman, see Drew & Wootton, 1988). A method based on language use in the context of instrumentality needs to follow the process, where artifactually mediated actions are part of a cultural and historical process in the same way as the process is produced and displayed through and with these actions. The suggested method is not inductive, but one *that integrates situated features of dialogue with the cultural-historical process of meaning construction.* This kind of task may be approached with two different data gathering procedures (see also Cicourel, 1987; Mehan, 1991). One deals with the objectified reality through "previous utterances", based on data from historical and biographical literature, ethnography, documents, practitioners' interviews, etc. The other deals with actual actions of speakers (naturally occurring talk), usually in the form of transcribed speech.

The method presupposes a matrix of culture- and community-specific social languages. At the same time, it also operates through voices. In transcripts, the speakers' voices are identified with the help of social languages. Instead of being a predetermined socio-cultural explanation of human conduct, social languages display resources that people invoke in their own sense making. The resources have to be activated by the actors through interpretation, for their own purposes in the situation. The analysis focuses on actors' options, choices, and their reworking of languages. Culture- and community-specific languages are seen through the possibilities of change and development. This is done with the help of a historically grounded working hypothesis of rationalities in clinical problem solving, exemplified here in the delineation of a zone of proximal development for the doctor-patient relationship (see below Fig. 2).

Multivoicedness in Medical Encounters

In medical discourse occurring while a patient consults a general practitioner, the concrete purpose of language use is to find out "what is wrong with the patient." From the viewpoint of the study of interaction, the analysis does not focus on doctors' clinical reasoning but on the interactive process in which a person's problem, perceived by her as requiring consultation, gets transformed into a solvable problem. A problem is solvable when a doctor proposes a disposal: a limited set of actions which she perceives to be a sufficient answer at this time and place to a specific patient problem (see Berg, 1992, p. 155-156). This does not necessarily imply that the patient's problem is relieved. Solutions such as a referral to tests, a medical prescription, or an advice to wait and see, are all meaningful actions on the object.

The object related to a person's health is complicated to articulate because it is quite

independent of any materially existing forms. The object is not what it appears to be – the stable realities of human body and disease (Bury, 1986. Good, 1994). Rather than discoveries of reality, medicine displays realities that are rational fabrications of scientific and clinical practice. Medical knowledge objectifies through language the object of activity. At first glance, the world seems to be interpreted by an extremely broad range of social languages. Medicine alone has different paradigms across cultures. In a study related to situated actions, the variety, however, turns out to be restricted. Public health care in Finland is based on Western medicine. It gives a perspective through which the activity is accomplished. The variety of social languages are found from the community-specific rationalities.

Form the viewpoint of situated actions, there are *two kinds of dialogical sources* in the variety of social languages. The first one comes from the object-related activity (purpose of language use). The second one is the context where language is used by the particular speakers for a purpose. The object is the reality that is objectified through modern medicine, to be worked on. The first variety is found inside the perspective of Western medicine. The community of knowledge refines its vocabulary, its methods, its theories and values, and its accepted logics through language and action (Boland & Tenkasi, 1995, p. 354). The historically developing heterogeneity in meanings, based on medical knowledge for the clinical problem solving, is depicted in Figure 2.

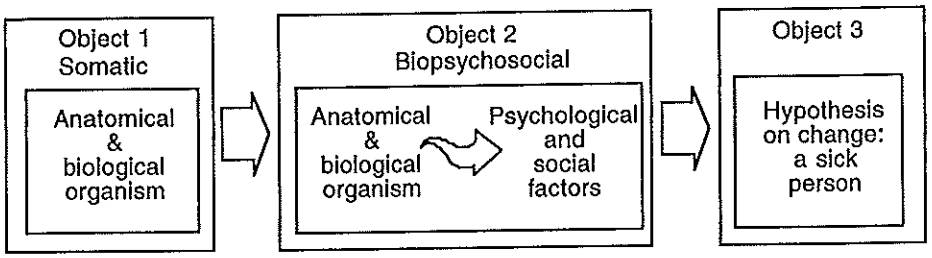

Figure 2. Historically constructed object of clinical problem solving

In Figure 2, "object 1" refers to the reality where health is constructed biomedically. This reality has been mapped out by a number of empirical studies (Aronson & al., 1997; Fisher & Todd, 1983; Frankel, 1990; Heath, 1992; Johanson, 1994; West, 1984). Historically, this object has been challenged. As a corrective to the conceptual limitations of the biomedical view, holistic or psychosomatic medicine has been offered. "Object 2" refers to this new orientation as a "biopsychosocial" model and an approach that would give equal consideration in diagnosis and treatment to biological, psychological and social levels "in a natural hierarchy of organization" (see Lock & Gordon, 1988). Emerging out of the tensions that originate from integrating psychosocial information into disease-oriented practice, "object 3" focuses on another possible reality, namely, the zone of proximal development in clinical practice. For articulating this object, I shall draw on the insights proposed by Jensen (1987). Based on the analysis of historically developed rationalities, he points to a contradiction between disease theory in modern medicine and illnesses as evolving processes in individual bodies. He recon-

ceptualizes the reality of "disease" to be considered as an evolving entity in the life of a particular person.

Instead of being the purpose in itself, medicine is, in consultation, the instrument for making sense out of the problem experienced by the patient. In a concrete situation, medical knowledge is used by the speakers who are, simultaneously, accomplishing a service offered by the primary health care clinic. The multiplicity of the situation is reflected in language. The interactional context expands the clinical problem solving with other cultural and community-specific rationalities that make sense. I have organized this heterogeneity in meanings with the model of an activity system related to the speaker's consciousness – one of the patient and the other of the doctor (see also Engeström, Y., 1990, p. 107-129). This second type of variety in meanings is based on dialogical processes within the everyday, medical and bureaucratic communities (see also Cicourel, 1981).

Figure 3 shows the matrix of social languages to be considered communicative resources in a primary health care encounter.

	Use of Language		
Object of Activity	Medicine	Bureaucracy	Everyday Life
Somatic	1. language	4. language	6. language
Psychological	2. language	5. language	8. language
Social	3. language	6. language	9. language

Figure 3. The matrix of social languages

In Figure 3, "Object of Activity" needs an explanation. It corresponds to Figure 2 as follows: Somatic is object 1. Psychosocial information (object 2) has been dispersed into differently construed objects, due to its empirically noticed forms in the speech of the doctor and patient (I shall discuss this later with references to the data). Object 3 is a considered hypothesis that offers an imagined rationality, but does occur in forms not yet articulated in the matrix. The nine social languages were named as follows:

1. medical language on the somatic
2. medical language on the psychological
3. medical language on the social
4. bureaucratic language on the somatic
5. bureaucratic language on the psychological
6. bureaucratic language on the social
7. everyday language on the somatic
8. everyday language on the psychological
9. everyday language on the social

In order to analyze voices, the dialogue in transcripts was divided into episodes, according to the topics and semantic moves (see Markova, 1990, p. 142). In every episode, the voices of the patient and doctor were analyzed with the help of the framework depicted in Figure 3. The empirical analysis of situated actions is based on the transcripts with the support of additional data obtained from stimulated recall interviews of the patient and doctor (see Engeström, 1995). The method does not imply that every voice should be fixed with a given language. Languages, as historically produced rationa-

lities, are themselves seen as developing processes that offer communicative resources used or not used by the patient and doctor. Every local voice by the speaker is anchored in three situationally achieved contexts of problem solving: (1) the problem, experienced by the patient, becomes transformed into a problem (*chief complaint*) to be worked on at the consultation, (2) the problem becomes defined (*naming the problem*), usually with a particular diagnosis, and (3) the problem turns into the solution of the consultation (*proposed actions*).

Dynamics, Intersections and Re-emergences of Social Language

The transcripts of 32 consultations were analyzed into 525 episodes. The voices showed the biomedical rationale in the majority of the episodes. Resolutions to somatically construed problems were based on specific treatment, and on the doctor's authority in bureaucracy and society expressed, respectively, through bureaucratic language on the somatic. Psychosocial information was quite rarely involved in clinical problem solving.[2]

The results seem to support the overall dominance of biomedicine (object 1, see Fig. 2). However, that is not the only result of the analysis. The study also shows that situated actions by the speakers do not reject psychosomatic medicine (object 2). Rather, the rationality of the biopsychosocial model was achieved locally through process of action that was mostly mediated with meanings originating from biomedicine and conflicting with the new possibilities in action. Actions reproduced the dualism between the soma and the psyche. Excerpt 1 provides an example. It is taken from a visit where a male patient complains about continual stomach pains. He takes the initiative in the phase of setting the problem by suggesting that something "nerve-related" could be considered a causative factor to his problem.[3]

Excerpt 1 (consultation 3: 6/11)

P: Could it also be *nerve-related* that stomach pain?
D: It is possible that it's caused by, let's say, *psychological factors*
P: Yes
D: *But* you have also lost some weight, at the same time
P: Yes
D: So it is better to look into it, a little bit. You have been in *lab tests* recently [continues]

In excerpt 1, the problem is collaborately extended to 'psychological factors,' but in addition to that, the doctor takes another initiative that leads to the exclusion of some possibilities of pathology in the body. Excerpt 2 is taken from another consultation. It presents a conversation where an extension beyond the somatic problem was suggested by the doctor. In this case, the patient's body had already been checked by laboratory tests and treated by pain killers pre-

[2] Of all the 1047 voices in the consultations I analyzed, 45 (4%) represented the languages on the psychological and 132 (13%) the languages of the social.

[3] Transcription symbols: P = patient; D = doctor. // A single oblique marker indicates where an overlap starts. // // A passage between double oblique markers indicates that it is overlapped. * An asterisk indicates that the next speaker cuts the turn. [ ] Brackets indicate verbal descriptions added by the researcher. *Italics* indicate phrases that have key importance for the analysis.

scribed by the doctor in the preceding consultation. Although everything seemed to be 'fine' with the patient according to the tests, the patient still experienced the problem. In excerpt 2, the patient continues with his own topic after having responded to the doctor's prior question.

Excerpt 2 (consultation 3: 8/19)

P: It just occurred to me, *what it could be.* Since a friend of mine, he also has had a sore back [continues by telling about the cancer of his friend]

D: Uh-um, yes well, well it's difficult to say, of course, it seems that you've got *the mind* somewhat involved in this [//yeah//] here. Do you sleep well?

P: Yes, I sleep well, so that's no problem

D: What do you think if we now *x-rayed* that sore spot [continues]

In excerpt 2, the doctor summarizes her diagnostic and interactional observations, by the statement "you've got the mind somewhat involved in this" and adds a related question. After that, she returns to the somatic for producing a resolution for the patient's problem. Both excerpt 1 and excerpt 2 display how psychological factors are taken into consideration from the disease-centered perspective. As a definition of the patient's problem, the psychological turned to be itself problematic being an unproductive way to process a solution. The ruling-out procedures established the *psychological* that was separated from the problem of the patient's illness/health experiences with his body. It became marginalized as mental and transformed into something that is not a real disease but an imaginary illness (see Kirmayer, 1988). Psychological factors, reconstructed through biomedicine, were also detached from the patient's everyday life experiences and social environment. As a consequence, the social also became restricted. In our data, it accumulated in the work-related area of the person's life. Most commonly, it was touched upon with the question of social history "what is your occupation?" After that information, the conversation continued with other questions of the clinical interview. Psychosocial information was constructed, for the most part of cases in which it occured, as unconnected to the patient's illness/health experiences with the body.

In social sciences, a common way to understand the psychosocial dimension has been to see it through the everyday life experiences of the patient. The "lifeworld" is considered an opposite to the "scientific attitude" and technical interest. Mishler (1984) makes this kind of distinction between two voices, that of "medicine" and that of "the lifeworld". Medicine constructs meaning through abstract rules that serve to decontextualize events, to remove them from particular personal and social contexts. Lifeworld refers to the patient's contextually grounded experiences of events and problems in her life. The meaning of illness as a subjective and personal experience has been attached to the lifeworld. A patient's view of illness is, therefore, mainly psychosocial and philosophical in nature and discordant with the view of medicine. Although some developmental overlapping between the views has been recognized, few studies have been conducted conceptually and empirically to follow how the different views interact in the actual process of sense making.

The pioneering study of Hunt, Jordan and Irwin (1989) focused on the resources individuals bring to bear when making sense out of what they experience. The study was designed to follow the process, mainly by interviews with the patients, for a timespan of at least four months. My study focuses on the orchestration of voices achieved through

the social languages, as well as on ruptures and intersections between and within the languages. Everyday language gained a distinctive character in the analysis. Through the language, instead of presenting the role of a layperson (voiced by the medical language), the patient was an active sense maker, in the same way as the doctor who invited the patient to join in problem solving at the consultation.[4] Patients were making sense out of their illnesses, not only in terms of their life situation and social network, but also in terms of medicine. Thus, empirically the analyst has to decide where to draw the line between medical and everyday languages, especially as the latter has a subjective and personal meaning. Excerpts 3 and 4 show examples of the patient's speech, through which the speaker constructs her own interpretation of what is wrong with her.

Excerpt 3 (consultation 4: 2/17)

P: Last Wednesday it really exploded. I've been wondering that if *I go biking* I have a terrific headache immediately afterwards back home. But this time I screamed straight out. *I still cannot read* or *watch TV*. There is some problem in focusing.

Excerpt 4 (consultation 15: 1/11)

P: I have this time the problem that I had last night a terrible pain in the throat, just like, I thought I had a *strep throat* or something. Once it happened to me that I had a *strep throat* for a week and I did not know anything about it. I don't necessarily get fever.

In excerpt 3, the patient's terms used to describe her headache do not originate from the pathology of the body but are referenced by the patient's experiences of how she is accustomed to act through and with her body, and what kind of problems she has found in accomplishing her everyday life in biking, reading, or watching tv. She, among other patients, constructed herself as an active person who is in-the-world through an embodied relation to that world (see Pollio & al., 1997). In excerpt 4, the patient's speech about the painful throat is voiced through medicine ("strep throat"). The patient in excerpt 3 also took up, later in the conversation, a medically construed interpretation of headache. In the same way, patients presented their own opinions on medical treatments and on results of medical tests used to control chronic illnesses (see excerpt 5).

Excerpt 5 (consultation 24: 5/17)

P: and the last time I was here, I was prescribed this Nuelia, Nuelan
D: Nuelan depo, yes
P: So that, it is that two hundred and fifty, but I couldn't take a whole one so I took a half three times a day. But it does not work that well, then, as such, so I've been thinking that if it is possible to think about that milder one Teodul. Would it be better if I tried that one?

The medical terminology used by the patients in excerpts 4 and 5 might be seen as a medicalized discourse. The context of the doctor-patient relationship directs attention differently. Modern medicine implies that the body reveals its disease through the instruments that are available only to the doctor. In medicine, there is a dualism between the physician as an active knower and the patient as a passive known. The patient's

[4] Everyday language on the somatic, psychological or social was very rarely used by the doctors. Nevertheless, the few instances where this happened made visible what kind of situated actions may occur when everyday language is invoked by the doctor.

self interpretation is excluded from the discourse between doctor and patient (Kirmayer, 1988, p. 59). From this point of view, the patient's speech is in conflict with its interpretation as medical language. Instead of being locked in predicated differences between the medical and everyday languages, it seems more promising to focus on ruptures and emerging new possibilities of languages in the activity. For that purpose, I shall take a closer look at the role medicine played in patients' own interpretations.

My analysis reveals that medicine, being a constituent of patients' expressions, was always incorporated in patients' prior illness experiences and in their contacts with other health care providers. Patients made sense out of their current problems within the framework of prior understandings of their bodily experiences articulated through medicine. Diagnoses and medical interpretations were not simply borrowed by the patients as explanations for their symptoms. Rather, they were reworked with experiences of the significance of these judgements in biographical contexts and situations, and these interpretations were accommodated to the circumstances of the daily life of the patients. Illness constructions emerged as a continuing process in which tentative ideas were built upon and elaborated (see also Hunt & al., 1989). This can be seen in excerpts 4 and 5. The patient of excerpt 4 uses her prior experience of being diagnosed as having *strep throat* for also shaping her conduct to see a doctor immediately after having perceived the first symptoms ("Once it happened to me that I had a *strep throat* for a week and I did not know anything about it"). She also volunteers some biographical information observed by herself, namely, that she did not necessarily develop temperature. In excerpt 5, the patient reports how she built her ideas upon a medical treatment that fit her own bodily experiences and familiarity with medications.

As a result of these observations, we can recognize two different medical histories related to a patient. The patient may be referred to many health care providers, different specialists, hospitals, etc. In our primary health care clinics, several doctors may also work on the patient in successive consultations, especially if the visits are acute. The health care system collects and stores a continuously growing file on every patient. In my data, particular tensions and disturbances in the doctor-patient relationship surfaced, due to the distinction between the real self (the concrete person with a history) and filed self (medical file collected by and for the system of expertise) (see Harré, 1983, Jensen, 1987, p. 160-161). These tensions may be illustrated with an example from the consultation of the patient in excerpt 1. He referred to his stomach pain suggesting that something "nerve-related" could be considered as a causative factor behind his problem. Before that sequence, the conversation included an episode where both the doctor and the patient are referring to the medical history of the patient (see excerpt 6).

Excerpt 6 (consultation 3: 2/11)

D: I can see [looks at the computerized patient record] that you have visited here a month ago and you have been prescribed [by Dr. N] Antacid in liquid form. Have you tried it?
P: Yes, I have but it has not helped // and I have something
D: //not at all?//
P: caused by the nerves in the neck and other things. Er...that my neck's been operated surgically. I brought with me those papers*
D: I noticed [in the computerized record] that it has been a rather major operation*

Both speakers are using prior medical interpretations about the patient while gathering knowledge for the process of transforming the patient's problem into a problem to be worked on in the consultation. The medical history is, for the doctor, part of the clinical interview. The patient brought with him a written chart received from the hospital a couple of years ago. The difference between these historical references is connected to the context in which time becomes constructed. The doctor takes up the history of acute disease or symptoms, a time-slice of illness. The patient refers to the history of his bodily experiences in the course of his life, seeing himself as a concrete person. By bringing along the medical chart, the patient also displays the relevance of these linkages to interpretations of the current experience. The consultation continued with the patient's question about the content of the chart that was unclear to him. The doctor asked the patient to point his finger at the lines in question and after reading them summarized that there is nothing significant to know there.[5] After these episodes the patient took up the suggestion presented in excerpt 1.

The ensuing disturbance is seen in excerpt 1. The doctor and the patient have different problems to work on at the consultation. The reference of the patient to something that is nerve-related is connected to his prior bodily experiences, whereas the doctor holds on to the stomach problem initially mentioned as the chief complaint by the patient. The disturbance is not an overt conflict between the doctor and patient, nor a communication gap or misunderstanding, but rather something rooted in tensions of meaning construction in the doctor-patient relationship.

My analysis recognized the role of the patient as being a sense maker. But that role was not intentionally pointed out or explicitly recognized by the patient. On the contrary, the speakers seemed to accomplish, through their situated actions, a shared understanding of different ways of knowing taking place at the medical consultation (see also Heath, 1992). Knowledge that matters is impersonal, scientific, and empirically verifiable. Knowledge that is personal, tacit, experiential, or intuitive is a subjective point of view (McWhinney, 1995, p. 7). In a process that aims at an objective attitude, the latter is hardly recognized as knowledge at all.

Developmental Tensions in the Doctor-Patient Relationship

The biopsychosocial model (object 2) is an attempt to reshape the essential difference between the objective and subjective point of view by adding to clinical interview open questions, listening to patients without interruptions, and learning to use a sense of empathy. Nevertheless, this model has not been able to break away from the epistemological dualism that originates from biomedicine (object 1). To make accountable the possibilities of development involved in the studied situated actions, I will identify two key tensions in the doctor-patient relationship. These tensions are significant as pointers for efforts at remaking the perspective of clinical problem-solving. Their articulation is based on the historically grounded working hypothesis regarding the zone of development in the activity in question. The zone (object 3) constructs a

[5] In his stimulated recall interview, the doctor commented on his answer to the patient that the chart was written in detailed neurological terms, and the text was partly undecipherable to him, too.

possible reality, where a contradiction between disease theory in modern medicine and illnesses as evolving processes in individual bodies is resolved with the "disease," to be considered as an evolving entity in the life of a particular person (a person as an object).

The first tension concerns the meaning of illness as being a subjective and personal experience. Seeing the patient as a carrier of merely experiential and subjective knowledge makes her voiceless in a biomedically construed, disease-oriented discussion. Instead of reproducing the distinction between the subjective and the objective ways of knowing, the patient's knowledge needs to be articulated from the viewpoint of clinical problem solving. As we have seen in excerpts 4, 5, and 6, there are different kinds of medical knowledge about the patient. The files and medical records of the health care system represent a collective memory from the perspective of medicine. Without being reinterpreted as concerning a concrete person with her illness/health experiences, including medical interventions and their contextual circumstances, the information in the files remains an insufficient tool for problem solving in primary health care.

Another developmental tension in the doctor-patient relationship has to do with the clinical interview, commonly considered the most important instrument for general practitioners. The disturbances found in our data point to a need to reconsider the clinical interview as a collaborative tool of expertise. The standard clinical interview is largely an embodiment of biomedical thinking, crystallizing the articulation of disease into techniques and routines for working on the patient's problem. As an interactional structure, the clinical interview is opposite to the negotiation between multiple perspectives on a shared object of problem solving.

Negotiation is more than an instrumental search for a compromise decision. In my data, negotiation attempts called for 'meta-talk', talk about talk used to build a negotiated order, in which the participants can pursue their different interests and interpretations without losing sight of their shared object. Such a negotiated order should give interactional space for the interweaving of narrative framing and paradigmatic analysis into a coherent solution. In addition, interactional space and means are needed for communicating about the nature of the doctor-patient relationship itself, about desired limits concerning the patient's privacy, about uncertainties and alternatives in problem solving, and about how to talk and proceed within given time constraints. Such a negotiated order does not reject the clinical interview as a resource of thinking and communication, but calls for its social re-evaluation.

Objectivity in clinical problem solving, and its means and routines embodied in the clinical interview, can be seen as the world that is indisputably real. As a reality, it also reflects moral values according to which right and wrong actions on the patient's best interest are to be judged. I have given up a stable world of meanings and have tried to follow historically changing processes of meaning construction through situated actions. Within the framework of developmental work research (see Engeström & Engeström, 1986), I focused my interest on developmental tensions of the doctor-patient relationship. In these tensions, prior meanings encounter new elements of meaning that come into our social interest. Processes of transformation are displayed as changing relevances through new objects of the activity. The analysis of this study points to the relevancy of the patient's role, in the clinical problem solving, as a knower and sense maker based on the knowledge of a biographically active person. Rather than conflicting

with the physician's expertise, the active role of the patient draws attention to the creative achievement of knowledge through collaboration between doctor and patient.

The method proposed in this article integrates situational features in dialogue with the cultural-historical process of meaning construction. It is based on the theoretical notion of activity as a system that emerges and changes in time and place through internal contradictions. In the context of instrumentality, dialogical processes were also considered historically emerging and internally conflicting processes of rationality. The context of instrumentality included a hypothesis of a zone of proximal development of the doctor-patient relationship. This hypothesis does not play the role of a fixed proposition to be verified or falsified with the data. The working hypothesis offers a perspective for making visible and bringing into articulation practically emerging possibilities of change and development. The hypothesis itself shall be elaborated, discussed and validated through practical interventions by communities of practitioners and scholars involved in the activity under scrutiny.

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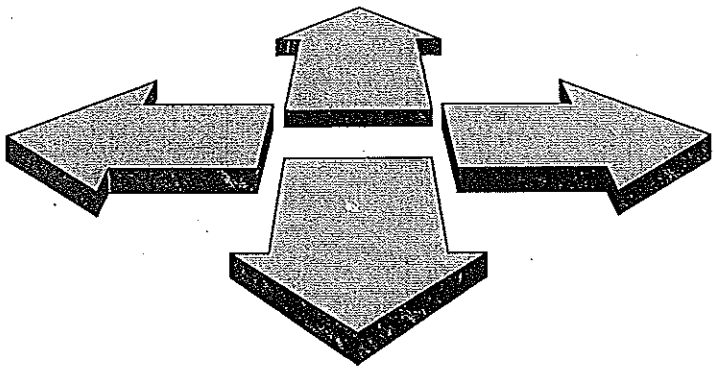

Dansk psykologisk Forlag

About the authors:

Ole Dreier, Dr.Phil., is professor of Personality Psychology, Department of Psychology, University of Copenhagen [email: dreier@axp.psl.ku.dk]

Ritva Engeström is a sociologist and researcher at the Center of Activity Theory and Developmental Work Research, University of Helsinki

Hysse Birgitte Forchhammer is neuropsychologist, Ph.D., at the Neurological Department at Gentofte Amtssygehus, Copenhagen, and Center for Elder Research, Copenhagen City Hospital [email: hysse@post6.tele.dk]

Brenda Goldberg is an Associate Fellow of the Discourse Unit, Department of Psychology and Speech Pathology, The Manchester Metropolitan University [email: B.Goldberg@mmu.ac.uk]

Morus Markard is Privat-Dozent, Dr. phil. habil., Dipl.-Psych., at the Studiengang Psychologie at the Free University, Berlin [email: mmarkard@zedat.fu-berlin.de]

*Renke Fah*l, Dr. phil, Dipl.-Psych, was an Associate Fellow at the Studiengang Psychologie at the Free University, Berlin, and now works in a private research institute

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