

Book Reviews/Comptes rendus

JOHN HERITAGE and DOUGLAS W. MAYNARD (Eds.)
Communication in Medical Care: Interaction Between Primary Care Physicians and Patients. Cambridge: Cambridge University Press, 2006, xix + 480 p., index.

John Heritage and Douglas W. Maynard are prolific authors and well-respected names in the field of conversation analysis. In their present text, they have compiled an edited volume which includes the work of more than a dozen researchers: medical clinicians, educators, language and communication experts, and sociologists. All of the research examines physician-patient interactions. The text consists of 14 concise, well-written chapters that walk the reader through various phases of a routine outpatient medical visit, intricately detailing the interactions that may occur between physician and patient within different phases. The intent of the collection is to advance the scientific understanding of medical practice as well as improve the quality of primary care, especially physician-patient communication (21). As such, this text represents a classic example of sociology *for* medicine.

The collection opens with a foreword by Debra Roter and a strong introductory chapter by John Heritage and Douglas Maynard which orients the reader to current debates within sociolinguistics. These debates pit qualitative methods against quantitative methods, and the microanalytic against the macroanalytic. The former favour the rich, qualitative detail of interactions and, according to proponents, illustrate individuals' actual agency in interaction; the latter favour the quantitative codification and classification of encounters which, proponents argue, reveal useful trends and generalizations. Heritage and Maynard claim that researchers must integrate these two extremes, often posed as oppositional and exclusionary, into a combined perspective resulting in both rich qualitative detail and quantitative generalizations. The introductory chapter also offers an overview of the theoretical underpinnings of the editors' particular branch of conversation analysis, one that prioritizes conversational detail and inductive reasoning as a means of answering questions regarding the production, coordination and accomplishment of action in lieu of participant and situational attributes and abstractions which "eviscerate the detail that is involved in the orderly achievement of mutual understanding" (11).

The text itself is organized according to the stages of a typical outpatient visit, walking the reader through key phases: patient presentation of

concerns (Jeffrey Robinson; John Heritage and Jefferey Robinson; Timothy Halkowski; Virginia Teas Gill and Douglas Maynard), examination of the patient (Elizabeth Boyd and John Heritage; Christian Heath), diagnosis of condition (Anssi Perakyla; Douglas Maynard and Richard Frankel), presentation of treatment options (Tanya Stivers; David Greatbatch), and closing (Candace West). The chapters describe interaction tendencies within particular phases of the visit and the resulting choices which are afforded and constrained by actions and utterances along the way, highlighting areas of concern and difficulty. Each chapter is a separate study of actual medical encounters usually concentrating on verbal utterances. A couple of exceptions are an interesting chapter by Christian Heath, who transcribes and analyzes gestures made during physical examinations, and Paul Drew's chapter about telephone consultations.

The foreword and introduction prepare the reader for a text which breaks the paradigmatic boundaries between qualitative and quantitative research. However, the blend presented here is minimal. It would be described more accurately as qualitative research with some basic quantitative data added on; the only quantitative data are simple frequencies and percentages. In addition to a more substantive blending of paradigms, the text would have benefited from a concluding chapter (summarizing the text and orienting the reader back to the broader issues of conversation analysis and physician-patient interactions) and a greater consideration of atypical patients and visits. With the exception of the study of treatment decisions by Tanya Stivers, all of the chapters focus on self-presenting patients. It would be interesting to consider how typical interaction patterns change when an adult child presents a frail, elderly parent or a long-term care aide accompanies an institutional resident.

I must offer a word of caution to readers about the authors' conceptions of "primary care." In Canada (and many other countries), a significant portion of the primary care discourse references patient-centered, team-based care. Primary care includes a focus on the broader determinants of health and, within the visit itself, an explicit team-based focus. It is not just the diagnosis and treatment of a specific illness or injury, but also the prevention of illness and injury as well as the promotion of health. This text, however, takes a traditional view of primary care, more or less substituting the term for outpatient care or general practice provided to a patient by a doctor. In light of the changing nature of primary care, it would have been interesting if the contributors had investigated the extended interactions which occur within patient-centered health care teams (comprised of health care providers from an array of professions and disciplines, along with patients and their family members). For instance, what should be considered within doctor-nurse practitioner interactions in primary care teams is how the internal structure of the medical visit needs to change to accommodate true primary care. While the chapter by Marja-Leena Sorjonen et al. is concerned with lifestyle, the text as a whole generally conceptualizes the visit of the patient as anchored within traditional medical practice (where a patient, after presenting a complaint to a physician, is examined, diagnosed and prescribed a treatment). Will this sequence, geared to be maximally efficient from the perspective of the

physician, continue to stand if primary care becomes truly patient-centered?

The exclusive use of conversation analysis can also be disconcerting to readers looking for a more fully contextualized understanding of patient-physician interactions. Rooted in ethnomethodological traditions, and remaining true to their micro-sociological roots, the contributors avoid structural questions and considerations. The editors themselves state in the introduction that they use conversation analysis to attend to the detail of interaction. Not wanting to lose the particulars within the general, they do not extend their exploration to participant and situational attributes or considerations of how one can affect the other. While researchers may use conversation analysis to analyze how interactions produce and reproduce structures, the present text rarely acknowledges variables other than spoken words, including key characteristics such as age, gender, or class which affect what is presented, interpreted and accomplished in interaction. As a result, readers coming to this text with broader questions, such as how health care reform in general, and primary care reform in particular, is changing communication, may leave disappointed at the lack of discussions about broad historical and social contexts.

A central piece of health care practice is the interaction between patient and health care practitioner. It makes sense to study these interactions. However, as medical sociologists, we are called on to do more than describe what is said within the walls of the clinic. We need to consider how these conversations contribute to the production and reproduction of structure. Health care is a system of *both* interaction and structure. Thus this text offers only a partial perspective. While an exclusive focus on structure has led critics to charge that the discipline has lost sight of agency, this text exemplifies the opposite, disposing of structure altogether. We know social factors affect who gets sick; from what types of illness; how they react to illness; and how they, in turn, are reacted to by the medical system. Ignoring these realities perpetuates the myth that medical practice is blind to social structure. In the same way that we must combine qualitative and quantitative approaches, we must also combine questions of agency and structure.

I came to this text not as a sociolinguist or an expert in conversation analysis but as a medical sociologist interested in health care reform. In the discourse of Canadian health care reform, common themes include “patient-centered practice” and “primary care.” Consequently, I approached this text with great interest to see how this discourse had permeated the clinic walls. But readers interested in structural issues may well leave unsettled, as may readers approaching this text from a broader primary health care perspective. Sociolinguists and communication researchers may appreciate the examples of conversation analysis. Primary care practitioners may find guidance for their daily practice, but they will have to search for it amidst highly detailed transcripts.

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