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ABSTRACT When physicians take readings of health indices such as temperature or blood pressure, the practices that physicians and patients employ in discussing the readings both reflect and propose a set of expectations regarding the level of technical medical information the patients should acquire and understand. In this article we demonstrate how physicians' reporting practices reflect and propose the roles of *paternalism* or *independent expertise* and how patients' responding practices either ratify or contest the roles cast by the physicians' practices. In contrast to the usual assumption that roles are relatively stable for individuals over the course of encounters, we treat role enactments as matters that are negotiated turn by turn in interaction. Physicians' practices for reporting test results implicate various sets of expectations about the knowledge, interest, and responsibility state of each participant; patients employ responding practices that ratify or contest the expectations implicated by the physicians' prior report. In each subsequent turn within the information exchange sequence, a speaker indicates (explicitly or implicitly) whether the level and kind of information being exchanged is appropriate/inappropriate and sufficient/insufficient for the participants.

KEY WORDS: *conversation analysis, doctor–patient interaction, doctor–patient roles, health communication, information exchange, medical consultations, reporting news*

Patients and physicians enter medical encounters with a sense of what is appropriate and inappropriate conduct in medical encounters. The sense of appropriate/inappropriate conduct is tied to the participants' assumptions that physicians do, and patients do not, have the technical medical expertise to diagnose and/or develop treatment plans for the medical problems at issue. The assumption of asymmetric expertise provides a backdrop for the agenda-based organization of medical consultations. Houtkoop (2000) points out that mutual understandings regarding agendas for particular types of encounters have crucial consequences for interactions; participants orient to a set of ordered actions

as appropriately done in those types of encounters. Patients and physicians both understand the medical consultation as involving a sequence of activities that culminates in the physician's arriving at a diagnosis and/or treatment plan for the patient's medical problem.

The practices that physicians and patients use during medical consultations both display their orientation to an asymmetry of the participants' medical technical knowledge and provide for the enactment of the physician as an authoritative expert. Conversation analysts have studied how physicians and patients deliver and receive diagnoses and medical assessments while orienting to an asymmetry of expertise and authority. Maynard (1991) showed that in delivering news and diagnoses, authority and expertise are achieved interactionally, with physicians' versions being privileged over patients' versions. Heath (1992) analyzed interactional practices for giving and receiving diagnoses that socially constitute the physician as expert and showed how patients register their discrepant lay diagnoses of their medical conditions in ways that preserve the physician as expert. Gill (1998) demonstrated that physicians and patients orient to patients as authorities on their experiences and to physicians as authorities on analyzing the causes and management of medical problems. While they are treated as having experiential authority, patients nevertheless downplay their knowledge and avoid disaffiliating with physicians' diagnoses. Peräkylä (1998) found that patients' orientation to physicians' authority is delicately balanced, with patients' orientating to the physicians' accountability for the evidentiary basis of their diagnoses. In sum, numerous studies provide evidence that participants enter medical consultations with the expectation of differential expertise and they engage in practices that both reflect and constitute the physician as medical expert and patient as experiential but not medical expert.

While the broad picture confirms the participants' orientation to an asymmetry of expertise, closer inspection reveals tensions that operate regarding patients' expertise. Heath described the operation of one tension regarding patients' expertise:

> It was suggested earlier that the 'mutually dependent and interrelated' roles of doctor and sick person place the patient under contradictory and potentially conflicting responsibilities and obligations. On the one hand, the patient is unqualified to diagnose or treat his condition and must place himself in the hands of technically competent help; on the other, contemporary medical practice relies upon the individual's ability and expertise to recognize illness, decide when it is appropriate to seek professional help, and describe competently their symptoms and suffering.
>
> (1992: 263–4)

In addition to tensions regarding patients' expertise, there are different models of physician–patient roles or relationships currently in US culture. The current emphasis on consumerism in health care and the abundance of available medical information promote, at least in some people, a strong moral imperative to be informed about and responsible for their health. For these people, the 'traditional patient' role connotes passivity, subordination, and only sporadically attending

to health status (Sharf and Street, 1997). In its place new roles are evolving, ones in which persons actively consider and maintain their health status and participate in decisions about their health (Kaplan, 1997; Street, 2001). The more active patient role has been referred to with the labels 'health consumer' or 'health citizen' (Lambert et al., 1997; Rimal et al., 1997; Sharf and Street, 1997).

Thus, even within the framework of asymmetric expertise, there are several different sets of scripted practices available in today's society. We outline two distinct sets of practices as they are related to two distinct views of the rights and responsibilities of patients to obtain and understand medical information. The first set of expectations/practices is associated with accepting and enacting broad differences of expertise favoring the physician; the second set is associated with acquiring/promoting patients' independent expertise.

The traditional set of expectations and practices for medical consultations have been characterized as *paternalistic* expectations and practices (Charles et al., 1999; Emanuel and Emanuel, 1992; Roter and Hall, 1992; Stewart and Roter, 1989). Three sets of paternalistic expectations/practices are: (1) the physician will provide medical information to the patient only as needed; the patient will rely on the judgments, advice, and expertise of the physician; (2) the physician will make decisions in what he or she perceives to be the patient's best interest and the patient will cooperate with and adhere to the medical advice; and (3) the physician will determine what needs to be talked about and done during the consultation; the patient will follow the physician's lead.

The paternalistic expectations described above point to three dimensions of responsibility related to conduct during medical consultations: (1) how much and what kind of information should a physician provide to a patient; (2) which party or parties should be responsible for making treatment decisions; and (3) which party or parties should direct the focus of the consultation.

On these three dimensions, the expectations that contrast with paternalistic expectations are: (1) patients should acquire and understand some level of technical medical information; (2) patients (with physicians or alone) should be responsible for making decisions about treatment options; and (3) patients (with physicians or primarily) should direct the focus of the consultation. In the literature, two different orientations based on these expectations have been recognized (Charles et al., 1999; Emanuel and Emanuel, 1992; Roter and Hall, 1992). To use Roter and Hall's (1992) labels, 'consumerism' involves patients expecting to make decisions alone and treat physicians as technical consultants. Alternatively, 'mutuality' involves patients expecting decisions to be made jointly with the physician. For the purpose of this article, we see both consumerism and mutuality as representing expectations and practices that contrast with paternalism.

Some physicians and/or patients assume that, drawing from physicians' medical expertise, patients can acquire some level of technical medical knowledge and have the right or obligation to use the knowledge to understand the

state of their health. Within this framework, patients work to become increasingly able to interpret indices of their states of health and track them while still relying on physicians' greater expertise when needed.

When patients employ practices to learn technical medical information about their health status and medical conditions and/or to monitor their health using available medical technology, they are enacting the role of *gaining independent expertise.* By 'independent expertise', we mean that they gain the knowledge to analyze the test results of indices of their health without relying exclusively on the physician's analyses. Likewise, when physicians employ practices that encourage patients to learn technical medical information about their health status and medical conditions and when they instruct patients to monitor their health using available medical technology, they are enacting the role of *promoting patients' independent expertise*.

It is important to clarify our assumptions concerning the concepts of 'roles' and 'role enactments'. Generally in the social sciences, researchers have treated role expectations as brought to an interaction and as relatively stable across the duration of an interaction. While they recognize that role expectations in medical consultations may change over time in response to changing life circumstances (Stewart and Roter, 1989), they nevertheless treat the expectations as carried into an interaction and determining or shaping conduct in the interaction. Our view is that while persons enter into medical consultations with some assumptions and expectations regarding the rights and obligations of doctors and patients, it is far from straightforward whether their conduct is consistent with their assumptions and expectations. This is so because interactional conduct is shaped by a variety of concerns and contingencies, including whether occasions present themselves to enact practices that are consistent with role expectations, whether co-participants produce responses that are the expected next actions and hence ratify provisional role enactments, and whether the agendas of the co-participants are complementary or are in tension. As analysts, we have no access to the sets of expectations that the participants take for granted and hold upon entering a medical consultation. However, we do have access to the practices participants use, and we can view those practices in relation to sets of expectations related to information exchange in medical consultations. In other words, they can be seen as role enactments inasmuch as the practices are consistent with expectations associated with a role. As participants negotiate what is appropriate and sufficient information for physicians to provide and for patients to acquire on a turn-by-turn basis, the roles being enacted are likewise negotiated on a turn-by-turn basis.

In contexts in which physicians convey information to the patient, physicians and patients collaboratively determine the kind and extent of information that is conveyed. One context in which information is conveyed is when physicians inform patients of diagnoses; a second is when they inform them about treatment options. In this article, we examine a third informing context: when physicians report test results to patients. Depending on the nature of the visit

and the organization's office routines, a physician may take readings of health indices such as temperature, pulse, and/or blood pressure, or may do tests on blood or urine samples. The practices that physicians and patients employ in discussing test results both reflect and propose a set of expectations regarding the level of technical medical information the patients should acquire and understand. In the analysis section, we show how physicians' reporting practices reflect and propose paternalistic or independent expertise role enactments and we demonstrate how patients' responding practices either ratify or contest the role enactments cast by the physicians' reporting practices.

Methods

Two sets of videotapes were collected by one of the authors, one set from a general medical ambulatory clinic, the other from a family practice ambulatory clinic. Some 33 videotaped consultations were searched for situations in which physicians and patients discussed the results of readings of health indices. Of the 33 total consultations, 18 included physical examinations, and of those four included readings of health indices: three cases of blood pressure readings and one case of a temperature reading. Although the consultations were videotaped, either a curtain was drawn or a camera cover was in place during the physical examinations. As a result, the analyses relied on only the audio channel. We note the problems that resulted from not having access to a visual record when those problems were recognized as relevant for the analysis. The four instances in our collection contain reports that were presented as 'normal' or 'borderline'. We make no claims about practices used to report the results of readings indicating serious medical problems. In addition to the four instances in our collection, we discuss one further instance drawn from an article by ten Have (2002).

The data were analyzed using the methods of Conversation Analysis. One author searched all of the consultations for reports on readings of health indices, and then both authors viewed and analyzed the candidate cases. For each case identified, the authors analyzed the physician's report on the reading of the health index and the patients' reactions to the report. The authors analyzed the sequential organization of physicians' giving reports of results on health indices readings, the methods that patients used to elicit different types of information related to the results of health indices readings, and the constitution of patients' roles as related to providing and/or soliciting information about reports of the results of health indices readings.

Analysis

One of the sequential positions in which physicians may provide the results of tests of health indices to patients is just after the test results are read. The typical assumption is that conveying reports of test results to patients should result in patients understanding the *import* of the test readings with respect to their states

of health. That is, participants generally assume that the reports of test results should be designed for patients to understand whether or not health problems are indicated and, if they are, the magnitude of the problems. Participants convey and display their understandings of the import of the test results with assessments (e.g. 'okay', 'fine' or 'too low').

Physicians' reports on test results provide the relevance of patients' responses. The minimal actions in the sequence consist of physicians' reporting test results followed by patients' claiming or displaying understanding of the import of the test results for their state of health. If patients claim or display a problem in either understanding the results or in the sufficiency of the information presented, the sequence becomes extended. In the ways that patients respond, they treat the prior report as adequate and sufficient or inadequate and insufficient.

The analysis contains four sections: (1) physicians' reporting practices that reflect/propose paternalistic roles; (2) reporting practices that reflect/propose independent expertise roles; (3) reporting practices that reflect/propose roles that are not clearly paternalistic or independent expertise; and (4) an instance of when a physician's report is problematic and subsequently remedied by the patient. Within each section on physicians' reporting practices, we discuss patients' responding practices that ratify, contest, define, or redefine the roles implicated by the reporting practices.

PHYSICIANS' REPORTING PRACTICES THAT REFLECT AND PROPOSE PATERNALISTIC ROLES

Recall that the expectations associated with paternalistic roles are that the physician will make medically sound recommendations that are in the interest of the patient and the patient will trust that the physician's recommendations are in his or her best interest, that the physician will provide information only as he or she judges is needed and the patient will seek information only if needed to follow the advice of the physician. When physicians provide patients with interpretations of numerical readings without providing the readings, they cast themselves as providing patients with authoritative interpretations and cast patients as those who should accept the interpretation on the basis of the physicians' authority. Thus, the practice of providing only an interpretation of the reading without providing a numerical reading reflects and proposes paternalistic roles.

The following excerpt was taken from a case in which the patient presented chest pains as his reason for the medical visit. While he claimed that he doubted that the pains were indications of heart disease, he wanted to have them checked out since family members had a history of heart disease. After taking the blood pressure reading, the physician provided her interpretation of the blood pressure reading. She provided her interpretation of the blood pressure reading in lines 1–2 and 7–9.

Excerpt 1 [8/13/01 #1, Simplified]

1 Physician: Well for being in the doctor's office your, hh blood pressure's ok<u>A</u>(h)AY?

2 [.hhhh [I- [I know yer:
3 Patient: [eh heh [heh [heh
4 Patient: I You tend to hold your breath I get tim-[hnh ih heh heh haah hy[aah
5 Physician: [Yeyah::eh [UH:m
6 (0.4)
7 Physician: It's very s:- It's on thë (.) It's high normal,
8 (0.4)
9 Physician: which is not somethin:g eh- I'm g'nna get (.)worried about et all in you-

In her initial report on the results of the blood pressure test, the physician provided an assessment which indicated no medical problem ('okay') but packaged it with a qualification ('Well for being in the doctor's office your, hh blood pressure's okA(h)AY?'). In a subsequent turn, she started to utter two assessments that indicated a minor medical problem but aborted both prior to completion ('It's very s:- It's on thë '), and then offered another assessment indicating no medical problem ('normal') but with a specification that indicated it was not quite 'no problem' ('It's high normal'). In her next turn, she offered her medical judgment concerning the relevance of the reading, reassuring the patient that the reading was of no medical concern ('which is not somethin:g eh- I'm g'nna get (.)worried about et all in you-'). In providing the assessments and judgment without providing a numerical reading, the physician cast herself as one whose interpretations and judgments were authoritative; she cast the patient as one who should rely exclusively on her medical authority.

PATIENTS' RESPONDING PRACTICES THAT RATIFY OR CONTEST PATERNALISTIC ROLES

When patients respond by accepting physicians' interpretations of readings as sufficient, patients casts physicians as the only needed authoritative source and themselves as those who rely solely on medical authority for interpreting test results that indicate their state of health. This type of response ratifies the paternalistic expectations associated with the prior report that consisted of only the physician's assessments or interpretations.

In excerpt (1), the patient did not ratify the paternalistic expectations by treating the physician's interpretation and reassurance as sufficient. Rather, he sought further information related to the numerical reading of the health index, and hence implicitly contested the paternalistic roles. The patient, here and throughout the interview,[1] enacted practices that are consistent with the roles of independent expertise. While incorporating indicators of deference, he nevertheless sought the type of information that would allow him to be a more informed health citizen, seeking information on the actual blood pressure reading.

Excerpt 1 [8/13/01] (Simplified) (continued)

1 Physician: Well for being in the physician's office your, hh blood pressure's
2 okA(h)AY? [.hhhh [I- [I know yer:
3 Patient: [eh heh [heh [heh
4 Patient: I you tend to hold your breath I get tim-[hnh ih heh heh haah hy[aah
5 Physician: [Yeyah::eh [UH:m

6 (0.4)
7 Physician: It's very s:- It's on thë (.) It's high normal,
8 (0.4)
9 Physician: which is not somethin:g eh- I'm g'nna get (.)w[orried about et all in you-
10 Patient: [What do you m'n-
11 (0.4)
12 Physician: C'z [I assume that tha(h)t's becuz,h
13 Patient: [What- °nh-°
14 Patient: °wih° What actually is thë (0.3) bl[ood pressure (a' mine)
15 Physician: [°eh-°
16 (.)
17 Patient: They always [ask me and I ne
18 Physician: [We:ll one thirty over ninedy?h
19 Patient: Okay
20 Physician: °M[hm°
21 Patient: [They always ask me I never know what it is
22 Physician: °Mm°.hh I mean iw- (.) woo-we: talk about one forty over ninedy
23 b[eing
24 Patient: [Mmhm?
25 (1.4)
26 Physician: That's where we (.) start calling it high b[lood pressure?
27 Patient: [O k a y,
28 Patient: .t.hh Buh one twunny is normal?
29 (0.4)
30 Physician: Uh::,hhh average'd be one twunny o[ver,hhh
31 Patient: [Okay,
32 Physician: w-one twunny over eighty?hh
33 (0.4)
34 Patient: A'right
35 (0.5)
36 Physician: °So:? I mean it (0.4) ihyours is (.) slightly on high normal but (0.4)
37 y'know, there ih- (1.1) 't's not something I would k- (.) GET WORRIED
38 ABOUT

The patient's responses reflect and propose the patient/physician roles of independent expertise in two ways: first, by actively pursuing information in accord with his own interests even though the physician had not proffered it (see lines 10, 13, and 14) and, second, by seeking the numerical reading with which he would be able to track readings of health indices over time, monitor changes in such readings, and possibly modify his conduct accordingly. Patients' practices of voicing their own interests during the interview and hence influencing the topical agenda and pursuing information such as test readings that is not initially proffered are part of the negotiation through which the participants determine the expectations or roles that are appropriate for one another.

PHYSICIANS' REPORTING PRACTICES THAT REFLECT AND PROPOSE INDEPENDENT EXPERTISE ROLES

A reporting practice that reflects/proposes independent expertise roles involves

providing a numerical reading as the entire report on the reading. In giving reports of readings to patients as an entire turn constructional unit, physicians provide patients with the opportunity to display their understandings of the import of the readings.

As described by Sacks, one aspect of the notion of recipient design is 'design your talk to another with an orientation to what you know they know' (1992, vol. 2: 564). Physicians know that patients vary in how knowledgeable they are about readings of health indices. Patients may be knowledgeable about interpreting the readings of some health indices but not others. In accord with the general principle of recipient design, physicians make guesses about whether a given patient can interpret the numerical reading when they report the results of a health index reading. In providing only a reading, physicians cast patients as likely or possibly capable of interpreting the reading independent of their own interpretation of the reading.

In the following instance, the patient has just complained about perspiring and feeling very warm. In response, the physician took the patient's temperature. In the turn after taking the patient's temperature, the physician provided a report of the numerical reading (line 3):

Excerpt 2 [2/16/93 #2:16]

1	Physician:	Okay. Hold this underneath your tongue. Lift up your tongue. Okay Great.
2		(58.3)
3	Physician:	( )- uh ninety nine one.
4		(0.5)
5	Patient:	([ )
6	Physician:	[Jus:t- (0.5) Normal is ah:::: (0.8) ninety seven point eight.
7	Patient:	( )
8	Physician:	So it's a little. uh a little high but nothing that I would call a fever. Usually
9		over one oh:?.hh One hundred point fi:ve, one oh one,.hh but (.) it's a
10		little high.hh Okay. .hh You c'n have a seat.

In line 3, the physician provided the temperature reading of 'ninety-nine one'. In the United States, taking one's temperature at home is a fairly common practice so it would not have been unreasonable for the physician to guess that the patient was knowledgeable about temperature readings. In initially reporting only the numerical reading, the physician could be seen as expecting the patient to understand the import of the numerical reading without relying on the physician's interpretation of the temperature. In this way, the physician cast herself and the patient in independent expertise roles.

PATIENTS' RESPONDING PRACTICES THAT RATIFY OR CONTEST INDEPENDENT EXPERTISE ROLES

While the initial report by the physician reflects/provides a provisional definition of the situation as one in which the patient can independently interpret the reading, each succeeding move provides for further casting and recasting of roles and expectations. In the next turn, patients may ratify the independent expertise

roles by displaying an understanding of the numerical reading or they may implicitly disconfirm the roles by not displaying an understanding of the numerical reading.

In excerpt (2), the patient did not ratify the independent expertise roles by displaying an understanding of the import in the next turn space (line 4). Rather, one half-second of silence emerged. With the curtains pulled, we do not know what occurred with eye gaze or facial expressions during the half-second that elapsed after the physician reported the numerical reading. Following the silence and very close on to the patient's starting to say something, the physician provided information to the patient, giving her a standard for normal temperature, and followed that with her interpretation of the temperature reading. It is plausible that the physician monitored the patient's behavior during the half-second and saw no display of understanding the import of the numerical reading. In providing a standard for normal temperature, the physician gave a resource to interpret temperature readings to the patient. In this way, she was promoting independent expertise roles for herself and the patient.

To summarize, the physician created an opportunity for the patient to show that she understood the meaning of the temperature reading. When the patient failed to indicate her understanding, the physician provided the type of information that would help the patient to interpret temperature readings, both by giving a standard for a normal reading (line 6) and by giving a cut-off point for deciding when a temperature reading should be considered a fever (lines 8–10). When the patient failed to confirm the initial casting of the roles as independent expertise, the physician re-evaluated the prior expectations and offered information that could serve as resources to enable the patient to adopt a more independent role with respect to interpreting temperature readings.

PHYSICIANS' REPORTING PRACTICES THAT REFLECT AND PROPOSE NEITHER FULL PATERNALISTIC ROLES NOR FULL INDEPENDENT EXPERTISE ROLES

Upon determining the results of tests, physicians may report numerical readings and an interpretation of them to patients within a turn constructional unit, that is, with no opportunity space after reporting the reading for the patient to display an understanding of the reading. On the one hand, in reporting numerical readings in addition to interpretations, physicians cast patients as potentially interested in understanding numerical readings and potentially interested in monitoring their states of health apart from solely relying on physicians' authoritative interpretations. In this way, this reporting practice treats patients somewhat in the role of independent expertise. On the other hand, packaging the numerical readings with no immediate opportunity for patients to display their understanding casts patients as not necessarily expected to have the expertise to interpret the numerical readings and possibly needing to rely on physicians for authoritative interpretations. In that way, this practice seems to cast the participants in neither fully paternalistic nor fully independent expertise roles because it provides patients with some information that can be used to further their

informed citizen role yet does not sequentially build in a slot for their demonstrating their independent understanding of the reading.

Two excerpts are offered to illustrate this practice. The first one, reported by ten Have (2002), has three parties in a consultation – physician, child as patient, and mother. When the physician returned from giving the girl a blood test, he provided the report in excerpt (3):

Excerpt 3 [ten Have, 2002, Extract 1.3, using only the English translation, labels and line numbers edited]

1	Physician:	but anyway the blood level is six point eight
2	Physician:	that's clearly too low
3	Mother:	O::h
4	Physician:	.hh so there u:hm
5	Mother:	(that) may well be a large cause of it=
6	Physician:	=what's what I think
7		(0.4)
8	Physician:	in case it would appear that she in spite of the fact that
9		she gets iron tablets just as lim- then I want to look further
10		but in the fir[st instance I stick to this
11	Mother:	[nyes:?

The physician delivered the numerical reading ('six point eight') and followed it by an assessment or interpretation of the reading ('clearly too low'). Without listening to the tape, we do not know whether the physician allowed an opportunity space for the patient to demonstrate her understanding of the numerical reading; no gap is indicated in the transcript. If the physician provided the numerical reading and, without a pause, gave his interpretation of the reading, he would have implied that there was no expectation for the mother to independently interpret the numerical reading.

A second instance of physician's reporting both the numerical reading and an assessment within a turn constructional unit can be seen in excerpt (4):

Excerpt 4 [HUP 5–14–93 #1:25]

(Context: The intern has just taken the patient's blood pressure.)

1	Physician:	One twenty over seventy that's [fine
2		[((sound of velcro ripping))
3		(1.2)
4	Patient:	I' might be, I- I <u>ran</u> this morning so,
5		(.)
6	Physician:	Okay,
7	Patient:	Must be that.

The physician first reported the actual numerical reading ('One twenty over seventy') and then without delay offered his assessment ('that's fine'). In doing so, the doctor provided the patient with technical medical information that he could use to track his state of health over time but also provided his assessment of the reading, which casts the patient as not necessarily expected to have the expertise to interpret blood pressure readings.

PATIENTS' RESPONDING PRACTICES THAT REFLECT OR PROPOSE/IMPLY SOMEWHAT PATERNALISTIC OR SOMEWHAT INDEPENDENT EXPERTISE ROLES

In response to physicians' reports consisting of numerical readings and interpretations of them, patients can show interest in receipt of just the physician's interpretation or show interest and understanding in the numerical reading as well. In addressing their responses to just the physicians' interpretation, patients implicitly cast themselves as relying solely on the physicians' authority and hence align themselves somewhat with paternalistic expectations. In forming their responses both to their understanding of the reading and to acknowledge the physician's interpretation, patients implicitly cast themselves as having the authority to independently interpret the test results. This aligns them somewhat with the independent expertise roles. In excerpt (3), the mother's response to the numerical reading cast the participants in somewhat paternalistic roles; in excerpt (4), the patient's response cast the participants in somewhat independent expertise roles.

In excerpt (3), the mother offered no response upon hearing the physician's report of the numerical reading but rather waited until after she heard the physician's interpretation of the reading as indicating a medical problem to display understanding (line 3). In the timing and content of her next response (line 5), the mother displayed no interest in the numerical reading as technical information about her daughter's state of health but rather exclusively tied her response to the physician's interpretation of the readings. In treating the physician's interpretation as the noteworthy piece of information and not addressing or engaging with the numerical reading, the mother cast the physician as the sole party with the expertise to interpret the reading and she cast herself as relying on the physician's interpretation. However, as noted by ten Have (2002), the mother does propose that the problematic blood reading may be the cause of the daughter's medical problem. Taken together, the mother's responses are consistent with a somewhat paternalistic orientation with respect to interpreting the numerical readings and with a somewhat independent expertise orientation with respect to diagnostic reasoning.

In excerpt (4), the patient produced responses that were consistent with the roles of independent expertise. With the physician not obviously producing more of an interpretation than 'that's fine', after a pause of just over a second the patient begins to produce an account 'I' might be,' I- I ran this morning so'. This action presupposes that what came before, either the numerical reading itself or the interpretation as 'fine', is something for which the patient feels accountable. This accountability connotes at the least responsibility for the patient's state of health, and also interest. The physician indicates that he has heard and is not discounting the patient's account with 'Okay', after which the patient reinforces the reflection that he is interested in his own health and proposing that he can make independent judgments about it by drawing a conclusion between running and 'fine' blood pressure, 'Must be that.'

PHYSICIAN'S REPORT PROBLEMATIC; REMEDIED BY PATIENT

Above, we argued that the practice of reporting only a numerical reading as an entire report reflected and proposed the expectation that physician and patient had independent expertise. We suggested that the participants may guess the level of knowledge and expertise of each other in designing their talk and that they may/should monitor each other's responses to determine if their guesses were appropriate. The following excerpt does not fit this pattern.

The physician reported only a numerical reading as the entire turn (line 3); this was followed with no further talk from either the physician or patient for the next six seconds:

Excerpt 5 [10/25/94:00:24:07]

1	Physician:	Jus gonna take your blood pressure
2		(37.0) ((Sounds of sphygmomanometer))
3	Physician:	One forty over ninedy
4		(6.0)
5	Patient:	How high iz at?
6	Physician:	↑Mm (1.5) ((Sound of ripping velcro))
7		↓well (2.0) I think ↑blood pressures are different for different people
8		°(>but<)° (0.2) some (.) people (0.2) sort of live under a different number
9		range (0.5) um (0.2) it's a little bit on the high side.
10	Patient:	Oh::
11	Physician:	But (0.2) u:ma lot of times with blood pressu:re we need to take a few
12		repeated measurements before we (0.2) consider [what
13	Patient:	[((cough)) ((cough)) ( )
14		(3.0)
15	Physician:	It's not too high. Just a little bit
16		(2.0)
17	Physician:	Jus relax your arm (again) okay?
18		(25.0) ((sounds of sphygmomanometer))
19	Patient:	Is it the same on that si:(de)?
20	Physician:	Just about the same [(just a little difference)
21	Patient:	[Oh

With the curtain drawn, we have no access to the scene in which the physician initially provided the patient with only a numerical reading. However, we can say that had she been monitoring the patient's reaction to the report of the reading, we expect she would have known that the patient was not displaying an understanding of the import of the reading. Regardless of the reason for her not providing an interpretation in the same turn or in the following six seconds, the patient treated the report as deficient; the numerical reading was insufficient for her to understand the import of the test reading. She remedied the problem by requesting an interpretation from the physician. The patient's attempt to remedy the problem reaffirms our claims that participants assume that reports on the results of readings of health indices should be designed so that patients understand their import and that having patients understand the import is done via providing assessments or interpretations of the readings.

Discussion

The roles that physicians and patients enact are a product of collaborative and on-going work in interaction. In this article, we have analyzed some ways in which role enactment is achieved in the context of giving and receiving reports on the readings of patients' health indices. In their initial reports, physicians unavoidably implicate some set of expectations regarding the knowledge and expertise of both themselves and the patients. The practices they use to report the test results may implicate patients are persons who accept physicians' interpretations solely on the basis of their authority, or may implicate patients as persons who have an interest in tracking the readings of their health indices and monitor their own heath status. While physicians' practices provisionally cast patients in paternalistic or independent expertise roles, the roles that will turn out to have been enacted are achieved not by one turn alone but on a turn-by-turn basis; each turn in interaction is a site in which the actor's conduct implicates role expectations. In the ways in which patients respond to the prior physicians' reports, they may ratify or contest the expectations implicated by the way the prior report was constructed. Patients who have been cast in a paternalistic role may negotiate that role by seeking further information and by asking for the basis upon which the physicians' interpretations were made. Patients who have been cast in an independent expertise role may contest or disconfirm that role by disattending to, and/or rapidly forgetting, any technical information that would allow them to independently interpret readings and use them monitor their health status.

One way in which physicians implicate paternalistic expectations is by providing their interpretations of readings without informing patients of the numerical readings (excerpt 1). In doing so, physicians treat the interpretations being offered as sufficient for the patients and imply that the patients should rely solely on physicians' authority rather than form independent interpretations using the readings as a basis. If patients respond to physicians providing an interpretation as sufficient, they ratify the paternalistic roles; if they treat the report as insufficient and request technical information about the reading, they contest the roles.

By providing numerical readings of health indices (with or without interpretations of them), physicians imply that patients are/should be interested in developing understanding of numerical readings and are/should be interested in monitoring their health. When physicians provide numerical readings but decline to give their interpretations of the readings within the turn, they provide opportunities for patients to display their own understandings of the import of the readings in next turns. If patients display an understanding of the relevance of the numerical reading for their health, they enact being medically informed and ratify the independent expertise roles. If patients provide no display of understanding in the turn space that follows, physicians can re-evaluate their previous assessment of the patients' knowledge and proceed to treat patients as less medically knowledgeable (excerpt 2).

This article provides some empirical footing for the analysis of how role and relationship expectations come to be manifest things-in-the-world and, as such, have an impact on behavior. First, this research bears out Pomerantz and Mandelbaum's (forthcoming) contention that roles and relationships are difficult concepts to separate – the physician–patient relationship is difficult to articulate without reverting to talk about how the role of the physician and the role of the patient are played out, separately, interactivity, and sequentially. While it is nothing new to say that role expectations are negotiated collaboratively in interaction, in this article we have shown two behavioral practices through which roles come to be made manifest things-in-the-world. First, roles are made manifest via the first-turn practice of casting oneself and the other participant in a way that reflects/proposes some expectations about the knowledge, interest, and responsibility state of each participant. Second, regardless of how a role is cast in a first turn, role castings are contingent on ratification or contestation practices in second and subsequent turns.

Physicians' reports of and patients' responses to the results of readings of tests of health indices are related to the practice that Heritage and Stivers (1999) called 'online commentary'. They each involve talk done along-the-way by physicians during physical examinations, both can involve physicians reporting mechanically measured information, and both are pre-diagnostic. However, Heritage and Stivers' analytic focus differs from ours. For Heritage and Stivers, physicians' online commentary about what they are seeing, hearing, and feeling a number of times during the physical examination allows physicians to strategically demonstrate that they are in the course of finding no serious medical problem while at the same time reinforcing patients' judgments that bringing problems to physicians is the right thing to do. Given that this practice was analyzed in the context of over-reliance on antibiotics, Heritage and Stivers argue that by using online commentary, physicians can preview the upcoming diagnosis of a medical condition as one that does not warrant a prescription of antibiotics, a practice which can function to prepare a patient to accept an alternative upcoming diagnosis and treatment plan. Our analysis focuses on the negotiated nature of physician and patient roles, and how the inclusion of different components, combinations of components, and sequences of components functions to implicate paternalistic or independent expertise expectations. If we conceptualize online commentary in our terms of roles and expectations, given that online commentary can function as a way for physicians to respond to patients' lay diagnoses or resistance, it could be argued that by using it physicians are taking seriously patients' arguments, so are in a sense ratifying that patients have some independent expertise expectations.

Ultimately, whether or not the transformation from paternalistic to independent expertise roles is worthwhile depends on whether enacting independent expertise leads to better patient health outcomes than paternalism. There is a growing body of evidence that, in general, there are positive outcomes when patients assume an active, participatory role in the medical interview. When

patients are able to present their medical concerns, ask questions, and seek clarifications, they tend to be more satisfied, more compliant, and have better health outcomes than patients who are more passive (Kaplan et al., 1989; Kaplan et al., 1996; Makoul, 1998; Roter and Hall, 1992; Street, 2001). To the list of actions that are related to achieving an active patient role, we would add the following: patients showing an interest in, and displaying an understanding of, readings of health indices cast the participants in independent expertise roles and provide resources for patients to track their states of health over time.

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NOTE

1. During the history-taking segment of the consultation, the physician asked the patient if he knew anything about his cholesterol. In his response, the patient proffered both a numerical reading and the medical interpretation of it from a number of years ago (lines 9–11):

Excerpt 1A [8–13–01] (Simplified)

1	Physician:	.hhhh Uh:m (0.2) D'you know anything about yer ch'lestraw.
2		(1.3)
3	Patient:	O:N duh LAS' test uh- I wih- thet- (.) the[t I t o o k.]
4	Physician:	[It may be:.] It may be in the
5		packet inf(hh)er↑MAtion I ha[ve
6	Patient:	[°uh laa-° I don't think it wa:s, ((smile
7		voice)) La[s' time I w'z] here they dl- tshe- uh:m=
8	Physician:	[O k a y]
9	Patient:	=she- (.) the lady looked for it 'n en she couldn't find it 'n there,.hhhh
10		(0.5) When ih w'z taken approxim'ly uh think, wanna say five years ago,
11		(.) I th:::ink ih w'z two fordy (.) °fou:r?° (.).hh they said ih w'z elevated?
12		but not a risk.
13		(1.7)
14	Patient	°I don't know I° (.) I've- I've been a month now eatin:g better.

Through his reports, the patient displayed an orientation that is consistent with independent expertise roles. His report of both a numerical cholesterol reading ('two fordy (.) °fou:r?°') and the medical interpretation of it ('elevated but not a risk') from a number of years earlier suggest that he did track his health indices, understood the medical interpretation of them, and displayed an awareness that his lifestyle choices affect such indicators.

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