Social Science & Medicine 265 (2020) 113278

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: http://www.elsevier.com/locate/socscimed

Why this clinic now? A context-sensitive aspect of accounting for visits

Shuya Kushida [a,*], Michie Kawashima [c], Tetsuya Abe [b]

[a] Department of Education, Osaka Kyoiku University, Japan
[b] Department of Psychosomatic and General Internal Medicine, Kansai Medical University, Japan
[c] Faculty of International Relations, Kyoto Sangyo University, Japan

ARTICLE INFO

Keywords:
Japan
Conversation analysis
Doctor-patient interaction
Primary care
Problem presentation
Free access system

ABSTRACT

In presenting problems in medical consultations, patients face the task of justifying their visit to the doctor. Previous studies have shown that patients establish the legitimacy of their visit by characterizing their problem as "doctorable" and presenting themselves as reasonable patients (Halkowski, 2006; Heritage and Robinson, 2006). This study explores a context-sensitive aspect of this justification issue by analyzing patients' first visits to a department of general medicine under the Japanese "free access" system. Patients are shown to present their problem in a way that conveys its relevance to the particular medical setting: they characterize their problem as suitable for relatively high-level medical care or as not easily falling under other specialties. The patient's problem's relevance to the setting is treated as normative in that participants take measures to remedy the possible mismatch between the problem and the setting. The institutional arrangement of the Japanese free access system is "talked into being" as a relevant context for the consultations through the practices participants use to establish the legitimacy of their visits.

1. Introduction

In medical consultations, problem presentation is important because it plays a significant role in shaping the subsequent interaction. It is the main opportunity patients have to convey information about their problem in their own words. In addition, patients are engaged in the moral activity of justifying their visit through presenting their problem. Doctors may regard patients who visit a doctor with a trivial, self-limited disorder as "unreasonable" (Charles-Jones, 2003; Jeffery, 1979; Morris et al., 2001; Roth, 1972). Patients are concerned about the possibility of this type of negative moral evaluation and thus take measures to avoid it (Llanwarne et al., 2017): their main opportunity to do so is during the problem presentation.

Studies that have examined recorded primary care consultations have shown that patients' concern with the legitimacy of their visit shapes the way in which they present their problem (Haakana, 2001; Halkowski, 2006; Heritage and Robinson, 2006; Ruusuvuori, 2000). Patients justify their visit by describing their problem as "doctorable" (Heritage and Robinson, 2006) as well as by presenting themselves as "reasonable" patients, who are properly monitoring their bodies (Halkowski, 2006). Ethnographic studies on emergency departments have noted an additional aspect to the issue of visit legitimacy: their patients need to convey that their problem is so urgent that they cannot wait for their primary care doctor's regular hours (Hillman, 2014; Jeffery, 1979; Roth, 1972). To justify their visit in this medical setting, patients not only have to convey the doctorability of their problem, but additionally must account for "why this place now."

In the societies where these previous studies were done (the US, the UK, and Finland), primary care doctors typically play the role of a gatekeeper and patients usually visit specialists only when referred by these doctors. In some other societies, however, patients can usually choose their doctors. In Japan, patients can, in principle, utilize whatever kinds of outpatient services they like without a referral. This health delivery system is called the "free access" system. In a medical consultation that takes place under this institutional arrangement, patients may be held accountable not only for their decision to visit a doctor but also for their choice of a particular medical setting. It is interesting to explore whether and how such a difference in the "macro" institutional arrangement actually shapes the way in which patients account for their visits. This study describes how patients present their problem in their first visit to the department of general medicine (DGM) at a university hospital in Japan. It shows that patients characterize their problem not only as doctorable but also as relevant to the DGM. This study argues that establishing the problem's relevance to the medical setting is a

* Corresponding author. Osaka Kyoiku University, 4-698-1 Asahigaoka, Kashiwara, Osaka, 582-8582, Japan.
E-mail address: kushida@cc.osaka-kyoiku.ac.jp (S. Kushida).

https://doi.org/10.1016/j.socscimed.2020.113278
Received in revised form 6 July 2020; Accepted 30 July 2020
Available online 15 August 2020

context-sensitive aspect of the justification of a medical visit, and that through the practice patients use to justify their visit, the institutional arrangement that surrounds a consultation is "talked into being" (Heritage, 1984) as a relevant context for interaction.

1.1. Background of the study

In his seminal analysis of medicine as an example of institution within a society, Parsons (1951) formulates the doctor-patient relationship as a functional set of reciprocal roles that serves to manage illness in modern society. As he clearly stated, however, this formulation is an ideal type. Actual doctor-patient encounters are not immune to the possibility of conflict due to the different perspectives of each party. Patients interpret the meaning of their problem under the influence of their lay cultures, and the social network that surrounds the patient may strengthen the meaning and influence the patient's behavior in seeking medical help (Freidson, 1970). Patients often visit a doctor not because their illness becomes serious but because they start to experience difficulty in their daily routines and personal relationships (Barsky, 1985; Zola, 1973). Also, patients may have several diagnostic possibilities in mind that diverge from what the doctor takes into consideration (Bergh, 1998).

The possibility of conflict lies not only in the fact that patients may view their problems from non-medical perspectives. Bloor and Horobin (1975) have argued persuasively that a potential source of conflict lies in the "double bind" nature of the institutionalized doctor-patient relationship itself: doctors expect their patients both to appropriately self-diagnose before they decide to visit the doctor and to yield to the doctor's opinion once the consultation has started. They have also argued, however, that actual doctor-patient encounters may be supported by mechanisms that minimize the possibility of conflict coming to the surface. From this perspective, it is essential for research on the doctor-patient relationship to explore what those mechanisms are and how they actually work.

For more than 30 years, Conversation Analysis has described how medical consultations are organized *in situ*, based on detailed analyses of recorded interactions. In this research tradition, some studies have described how the potential conflict related to the "double bind" situation is managed in medical consultations. Heath (1992) and Peräkylä (1998, 2002) have described how primary care doctors deliver diagnoses and how patients respond to them, in the UK and Finland respectively. They have shown that both doctors and patients strike a delicate balance between establishing the legitimacy of the patient's decision to seek medical care and treating the doctor's diagnosis as more authoritative and objective. Stivers (2007) has shown how the parents of patients defend the legitimacy of their visits by expanding no-problem answers in response to history-taking questions and by resisting no-problem diagnoses and their corresponding no-treatment recommendations in pediatric consultations. Based on these studies, Heritage (2009) argues that concerns about the legitimacy of a visit can surface during a consultation whenever the seriousness of the patient's problem is in jeopardy.

However, it is in the problem presentation that the patient's concerns about the legitimacy of a visit are first clearly expressed. Two seminal studies have provided basic findings about how patients justify their visits through presenting problems. Heritage and Robinson (2006) argue that the fundamental aspect of patients accounting for a visit is to display the "doctorability" of their problem. They define a doctorable problem as "one that is worthy of medical attention, worthy of evaluation as a potentially significant medical condition, worthy of counseling and, where necessary, treatment" (p. 58). They describe three descriptive practices patients use to establish doctorability: making diagnostic claims, invoking third parties, and displaying "troubles resistance." Halkowski (2006) has investigated patients' narratives of symptom discovery and has described two practices with which patients show that they have noticed their symptoms in an accountable and unmotivated way: the "At first I thought X" device and a sequence of noticings. He has argued that with these practices people show themselves to be "reasonable" patients, who are properly monitoring their bodies. These studies have shown basically similar findings to Ruusuvuori (2000) and Haakana (2001), which have described problem presentation in Finnish primary care consultations.

All of these studies are about primary care consultations in the US, the UK, and Finland. Only a few studies have described patients' justification of their seeking medical care in other medical settings. Hillman (2014) has reported that in an emergency department in the UK, a patient justified her visit by displaying awareness that her problem was possibly inappropriate to the department. Jean (2004) has shown that callers to specialist offices in the US collaborate with the front-office worker in an effort to shape their problem into one that is appropriate for the specialty offered in the clinic. Though these studies do not explore doctor-patient interaction in consultations, they suggest the possibility that patients face somewhat different versions of the justification issue depending on the institutional environment that surrounds the interaction.

Building on these studies, the present paper describes how patients justify their first visit to the DGM in a university hospital in Japan. Though these consultations consist of interactions between a generalist doctor and a patient, they may differ from the primary care consultations examined by the previous studies in that they take place in an institutional environment under which patients can choose the medical settings they visit. By investigating such examples, this study intends to enhance our understanding about how the legitimacy of patients' visit to doctors is displayed and responded to differently depending on the institutional environment.

1.2. The setting

As stated above, the Japanese health delivery system can be characterized as a "free access" system. Though the Medical Service Act distinguishes two types of medical institutions, *shinryoojo* ("clinics") and *byooin* ("hospitals"), they are distinguished not in terms of function but size: a clinic has fewer than 20 beds, and a hospital has more. Clinics each profess one or more specialties such as internal medicine, gastrointestinal medicine, urology, and so on, but usually also provide primary care to local patients. Hospitals also have large outpatient departments and provide outpatient as well as inpatient services. Patients can choose whatever outpatient service they like without a referral. And patients may be referred in a variety of directions, such as from a clinic to a hospital, from a hospital to a clinic, and from a hospital to another hospital (Ikegami and Campbell, 1996; Ikai, 2010).

All residents in Japan are obligated to obtain public insurance, which covers 70–90% of the actual cost on a fee-for-service basis. Wherever a patient is treated, the fee is the same for the same treatment. This payment system enables patients to choose the medical settings they visit depending on their self-diagnosis and other non-medical factors (e.g., geographical convenience). However, it tends to channel patients to large hospitals and thus tends to prevent an appropriate allocation of medical service fees (Ikegami and Campbell, 1996). To redress this problem, the Health, Labor and Welfare Ministry has introduced a payment system in which relatively large hospitals can charge an additional fee to patients who visit without a referral. However, relatively large hospitals still seem to be many patients' first choice. For example, a survey of hospital outpatients has reported that only 15.4% of them had chosen a clinic as the first place they visited (Health, Labor and Welfare Ministry, 2017).

The DGM is one of the hospital departments that was originally established in the 1970s, and it has become more widespread during the 1980s and thereafter. Its main purpose is to provide "primary" and "whole-patient" care to supplement segmentalized specialties (Fukui, 2002). Though the DGM functions to provide primary care in that it accepts all kinds of problems and cooperates with specialists to treat

them, it typically does not have high accessibility in geographical terms, nor does it provide continuous care to all family members. In the DGM where the data for this study were collected, about half of the first-visit patients were referred there from a clinic, another hospital, or another department. This fact suggests that while the DGM's avowed purpose is to provide primary care, it simultaneously functions as a setting which provides relatively high-level medical care and accepts problems which do not easily fall within other specialties. This ambivalent nature of the department, as well as the institutional arrangement of the free access system, is important as background of the analysis in Section 3.

2. Data and method

The data for this study are 51 first visits video-recorded at the DGM in a university hospital in Japan from 2015 to 2018. The department in principle provides only outpatient services. After the doctors make an initial diagnosis, they refer the patient to another department in the hospital, another hospital, or a clinic, if necessary. Nineteen doctors and 51 patients are included in this data. After the research protocol received Institutional Review Board approval, it was likewise approved by the research review board of the hospital where the recordings were made. Patients were recruited with study information sheets distributed at the reception of the department when they visited. Informed consent was obtained from both patients and doctors.

Out of the 51 patients, 22 have been referred to the department either from outside the hospital (16 patients) or from another department of the hospital (6 patients). The remaining 29 patients visited the department without a referral. Our analysis will focus on these 29 patients in order to compare our findings with those of previous studies about first visits to primary care doctors. Patients who visit the department without a referral can still obtain advice from a nurse seated near the hospital entrance concerning which department they should visit. And 4 patients mentioned this advice in accounting for their visit (See Extract (3b) and (4b) for example).

Prior to the consultation, doctors can obtain information about the patient from two sources. First, characteristically in Japan, patients are usually asked to fill out a medical questionnaire upon arriving at a clinic or a hospital. The second information source is the patient's clinical records. Even if the patient is visiting the DGM for the first time, doctors can have access to the patient's records from other departments in the hospital.

The method of this study is Conversation Analysis (CA). It aims to describe recurrent practices and procedures that parties-to-interaction use to implement practical actions in interaction by closely examining recorded data from actual interactions and their transcripts (Sidnell and Stivers, 2013). The transcripts have two lines for each utterance. The first line shows the original Japanese utterance with transcription conventions originally developed by Gail Jefferson (2004). The second line provides an idiomatic English translation.

3. Analysis

In this section, we illustrate how patients justify their visit through presenting problems. First, we show that patients account for their visit by displaying the relevance of their problem to the DGM (Section 3.1). Next, we show that both patients and doctors remedy possible mismatches between the problem and the setting (Section 3.2).

(1) [151219nomu_douki1_1 00:56]

01DOC: eeto:::(0.3)
Well,

02 karuku:: monshinhyoo haiken shi mashita ke[domo:,]
I've had a quick look at your questionnaire but,

03PAT: [ha:]i.=,
Uh huh.

04DOC: =konkai wa:(.)ee: doo sare mashita ka¿
what has happened to you this time?

05PAT: a(.)a:no: shinzoo ga::(0.2)dokidoki tte(.)[suru koto ga moo]=
Well, ((I've experienced)) heart throbbing,

06DOC: [dokidoki:: °(s-)°]
Throbbing-

07PAT: =juu nen gurai mae [kara:]=
since about ten years ago,

08DOC: [°n:n.°]
Uh huh.

09PAT: =.hh <aru no>[de:,]=
I've experienced ((that)) so,

10DOC: [nn.]
Uh huh.

11PAT: =.hh ano::::::(0.2)etto::(.)
uhm uhm

12 ma yoosu o ↑miteta n desu keredomo:,=
I was seeing how things went,

((8 lines omitted where the patient says that her symptoms started when she was busy taking care of her mother's hospitalization.))

21PAT: =ano:::(.)tama::ni <na node>,
((but)) it was only occasional, so,

22 (.)

23DOC: hai[hai.
Uh huh.

24PAT: [ma yoosu o mi tara ii no ka na: to(.)[<omo]tte>,
I thought I'd better see how things went,

25DOC: [hai.]
Uh huh.

26PAT: fuseemyaku <toka no> kensa mo .hhh
and in addition, ((I heard)) an examination of arrythmia or something

27 nanka >sugoku jikan ga kakaru yoo na koto o<
might take a lot of time,

28 kii tari <shita node,>
I heard ((that)), so

29DOC: hai.
Uh huh.

30PAT: nn, yoo(h)su(h) o(h): miteta n desu.
I was seeing how things went.

31DOC: hai [hai.
Uh huh.

32PAT: [<demo>.hhh ano:.hhhh(0.2)kyonen:: <haha ga:,>(.)
But last year my mother suffered from

33 eeto nookoosoku de taoreta sono geein ↑ga:,.hhh
uhm stroke, and its cause was

34 ano huseemyaku <kara no> mono da to yuu koto o kii-(0.4)
uhm arrythmia, that's what I heard-

35 ano <shi[tte]>,
uhm what I came to know,

36DOC: [hai.]
Uh huh.

37PAT: .hhh de chichi mo huseemyaku ga atta node,.hhh
and my father also had arrhythmia, so

38DOC: [hai.]
Uh huh.

39PAT: [yapp]ari identeki na mono ga,
as expected, ((I was wondering)) if it is a genetic issue

40DOC: a:[: naruhodo ne.]
Oh, I see.

41PAT: [aru no ka na to] omottari,=de kyoo .hh
I was wondering ((so)), and today,

42 ano::>josee shinryooka no hoo de< teeki::kenshin o
((I've had)) a regular checkup at uhm OBGYN in this hospital,

43 shiteru n desu kedo [mo,.h]hhh=
I've had ((it)), and,

44DOC: [hai.]
Uh huh.

45PAT: =sono::: shinsa(h)tsudai ni agatta toki ni:,
when I was up on the OBGYN examination table ((today)),

46 n:- mo- monosugoku >dokidoki< tte <shita no[de>,.hhh]=
I felt ((my heart)) throbbing horribly, so,

47DOC: [°n:n:n°]
Uh huh.

48PAT: =chotto:: .hhh ichido:?= mi te moratta hoo ga:
((I should)) be seen by a doctor once,

49 ii no [ka na]:: to(0.2)
I should do ((so)),

50DOC: [hai.]
Yes.

51PAT: omo[tte,]
I thought,

52DOC: [hai] hai.
Right.

53PAT: dochira ni(.)mi te mora ttara ii ka wakara nai node,
but I don't know which doctor I should see, so,

54DOC: hai.
Uh huh.

55PAT: .hh kochira o?(0.6)°u-°(.)<°ukesase te [itadaita n desu kedo°>]
I came here.

56DOC: [hai hai. .hhhhhh]
Okay.

57 (0.2)

58DOC: e::to::::(0.8)sono nis- e:: dokidoki:: ga hajimatta >no wa<
Well, the time your throbbing started is

59 2006 nen gu[rai >to yuu koto desu ka ne<¿
about 2006, is that right?

(*continued*).

3.1. Relevance of the problem to the medical setting

When patients present problems at the DGM, two features are recurrently observed: first, they characterize the problem as relevant to relatively high-level medical care; and second, they characterize the problem as not easily falling within other specialties. The first feature is typically produced by displaying puzzlement about unfamiliar symptoms and concern about the worst possibilities, and by conveying a wish for an examination to investigate the cause of the problem. The second feature is typically produced by reporting other doctors' failure to explain the problem and the patient's uncertainty about an appropriate destination of care. By incorporating these features in their problem presentations, patients justify their first visits to the DGM, as illustrated by Extract (1) and (2).

The patient in Extract (1) is a 56-year-old woman who has visited the hospital for a regular check-up at the obstetrics and gynecology (OBGYN) department; after the check-up, she visits the DGM on her own. As the doctor solicits the patient's problem (lines 01–04), the patient starts a narrative about her heart throbbing (line 05).

Note first that the patient presents her problem as "doctorable" by using the practices described by previous studies. She displays "troubles resistance" (Heritage and Robinson, 2006) by reporting how long she has waited to see a doctor since she first experienced the throbbing (lines 05–12). She also reports two "turning points" (Heritage and Robinson, 2006) which prompted her to seek medical care: that she came to know that the cause of her mother's stroke was arrythmia (lines 32–35); and that she experienced a horrible throbbing on the day she visited the DGM (lines 41–46). The construction of her narrative is a version of the "At first I thought X" device (Halkowski, 2006) in that she first reports her having considered the possibility of the symptoms being benign (lines 21/24), and then starts telling about episodes which undermined her first thought (lines 32–35/41–46). She thus presents herself as a "reasonable" patient (Halkowski, 2006). She also makes a diagnostic claim (Heritage and Robinson, 2006) by mentioning the possibility of arrythmia (lines 26/34/37). This case thus illustrates that the findings of the previous studies hold for consultations even in a quite different institutional arrangement.

It is also noticeable, however, that the patient uses these practices to present her problem as relevant to the DGM. She characterizes her problem as suitable for relatively high-level medical care in three ways. First, she displays concern about the worst possibilities. She displays her concern about the possibility of genetic cause of the high risk of a stroke

(2a) [170524mizu_cough1_1 00:19]

01DOC: .hhhh ni nen mae kara:: tsuzuite>ru n desu ka<?=
Is it for two years?

02 =hanamizu to se[ki to.]
that you've had the runny nose and the cough?

03PAT: [soo] desu ne::.=[sorede (ano-)
That's right.=And uhm

04 [((The bell rings.))

05DOC: a:: gomennasai moikkai (o[shite-)
Oops, sorry, ((can you)) push it agai-

06PAT: [saisho wa ano:::(0.5)
at first, uhm

07 shihan no kusuri de,
with an OTC drug,

08DOC: nn nn.
Uh huh.

09PAT: naoshi(yatta n ya) kedo ne,=
I treated them, but,

10DOC: =nn nn.
Uh huh.

11 (.)

12PAT: [naora n node ne,]
because they didn't go away,

((9 lines omitted where the doctor asks if the drug worked in the beginning and the patient confirms it.))

22PAT: ano:::::(1.0)are desu ne:(0.3)ano::(2.9)°asoko no k-k-°
((I went to)) uhm that place uhm,

23 XXXX(.)kurinikku ka,
XXXX Clinic,

24DOC: ha::i.((looking down at the questionnaire))
Yes.

25PAT: are ni: itte:(0.9)yatte:
I went there and got treated

26 itch-(0.3)ichi [nen gurai (kakatte)]
for about a year and

27 [((The bell rings.) [ ))]

28DOC: [a: (ko(h)re ya ne:)]
Oops, it's this button.

29DOC: [((pushes a button.))

30PAT: [↑chotto yoo natta n >desu (kedo)< ne:.
I got a bit better, but,

((10 lines omitted where the doctor asks what kind of treatment the patient received at the clinic and the patient says that he was given oral medicine.))

41PAT: °(sore ga)°(0.6)ano::(0.3)((turning back to his wife))
And uhm

42 ↑arerugii no(0.7)ano::::(1.0)(ke-)n: ketsuekikensa no shiito.
in terms of allergies, uhm ((Give me)) the blood test sheet.

(lines 39/41), which is grounded in her knowledge of her mother's stroke and her parents' arrythmia (lines 32–37). And this concern is treated by the doctor as legitimate grounds for the visit (line 40). Second, she alludes to her wish for an examination of arrythmia by accounting for her postponed visit to a doctor in terms of her concern about the time necessary for the examination (lines 26–28). Third, she displays puzzlement about unfamiliar symptoms by using an intensifier *monosugoku* ("horribly") and by pronouncing the mimetic expression *dokidoki* rapidly and with prominence when she describes her symptoms on the day of her visit (line 46). Thus, the patient accounts for her visit mainly in terms of her concern about whether she is genetically prone to developing a fatal disease, which would be suitable for relatively high-level medical care.

The patient also takes measures to convey that her problem is appropriate for a setting which accepts problems that do not easily fall within other specialties. Though the doctor claims understanding (lines 50/52) the patient's summary of her problem (lines 48–49/51), the patient goes on to explicitly state her reason for choosing the DGM before completing her account ("but I don't know which doctor I should see, so I came here"; lines 53/55). Remember that the patient has experienced a horrible throbbing during her checkup at the OBGYN department (lines 41–46). This report suggests that she has a legitimate reason for visiting the hospital on the same day, and yet she did not complain about her throbbing to the OBGYN doctor. Being placed after that, the stated reason implies that the patient has searched for departments other than the OBGYN which may be suitable for her problem, without success. By thus invoking her uncertainty about an appropriate destination of care, the patient displays her orientation to the "whole-patient" nature of the DGM. The doctor treats the account sufficient (line 56) and starts a history-taking (lines 58–59).

Extract (2) is another example in which the patient presents a problem in a way that conveys the relevance of the problem to relatively high-level and whole-patient medical care. In this case, the patient does so by telling a story about his prior visits to other doctors who did not provide a convincing explanation for his symptoms. The patient is a 79-year-old man who is visiting the DGM with his wife and a daughter. A medical student who interviewed the patient for training before the consultation is also in the room to observe the consultation. The doctor solicits the problem by requesting a confirmation of the patient's having suffered from a runny nose and cough for about two years, which is written on the questionnaire (lines 01–02). The patient confirms this and expands the turn to initiate a narrative about his problem (line 03). Parenthetically, in the following segment, a portable bell used to summon a patient in the waiting room accidently rings twice and the interaction has been interdicted to deal with it (lines 04–05/27–29).

(2b)[170524mizu_cough1_1 04:16]

01PAT: de:::(.)ano::(0.3)a- ano-
And uhm

02 >(kare ni mo)((points to the medical student)) mooshiageta kedo
I've already said this to him, but,

03 (0.3)YYYY:(.)sensee n toko de,
when I went to Doctor YYYY's office,

04DOC: nn nn.
Uh huh.

05PAT: de ano: a-u-u- byooin de(0.5)jibika de(.)ano:(0.3)
an ENT doctor,

06 >chikunooshoo< ya te iwarete ne,
I was told that this might be a sinus problem,

07 (0.3)

08DOC: ha:i.=
Uh huh.

09PAT: =kotoshi no haru ni ne,
it was last spring,

10DOC: nn nn.=
Uh huh.

11PAT: =de:::::(0.4)>chikunooshoo< no(0.3)ano::(0.7)koo(.)ma(.)
and ((he did)) the test for sinus problems, y'know,

12 hana:mizu n naka koo (.)guruguru mawasu kensa,
he twirled in my nose like this,

13 (0.3)

14DOC: ha:i.=
Uh huh.

15PAT: =yatta n desu kedo:,
he did ((that)) but,

16 (0.6)

17PAT: n: nan kai ka yatte: hhh(.)ano:(0.3)
after he did it several times,

18 sensee ga
he told me that

19 koreijoo wa ano:::: wa(0.3)hanamizu deteko n shi na:
there is no more mucus coming out so

20 >are-<(0.4)ano:: are >chikunoo (ja na-)< chi-chigau to.
this is not a sinus problem,

21DOC: nn [nn.]
Uh huh.

22PAT: [da-] na- naizoo:: u- n- kara(0.3)kitoru mon ya kara ne,=
rather it may be caused by inner organs so,

23DOC: =nn nn.
Uh huh.

24PAT: naizoo de(.)ano kensa shite morae to.
I should get checked,

25DOC: nn nn.
Uh huh.

26PAT: de sono kekka o:(.)>kika shite kure< to.
and tell him the results,

27 (0.5)

28PAT: ↑soko made iwareta n desu wa.
that's what he told me.

29DOC: nn nn.=
Uh huh.

30PAT: =de:::(0.4)ano:::(0.7)ZZ byooin no::(.)sensee wa(0.6)
But the doctor at uhm ZZ Hospital said

31 kore wa ano(.)sonnan ano hanamizu toka yuu no wa(0.5)
that things like a runny nose are

32 naizoo kara kuru mon chau to(h).
not caused by inner organs.

33DOC: nn n:n.
Uh huh.

34PAT: iwarete wa- ↑watashi toshite wa: °hoede°(0.5)do-n-do::u iu ni ne,
Being told that, I was wondering how I should ((understand)), y'know,

35DOC: docchi ya nen te [kanji ya ne(h):(h):.]
It's like "which is right?"

36PAT: [a:(h):(h)n.]
Yeah.

37DOC: [(soo)] naru ne:.
You may well feel so.

38PAT: [>sorede]
So,

39PAT: sore(h) no .hhh ↑geein o ne,
((I want you to identify)) its cause

40DOC: nn nn.
Uh huh.

41PAT: koko de(0.5)ano: hakkiri shite hoshii na to.=
at this department I want ((you)) to identify ((it)).

42DOC: =nn nn.
Okay.

(*continued*).

The patient first displays troubles resistance by reporting his self-medication using an OTC drug before he had visited the first doctor (lines 06–12). Then the patient refers to the first medical setting he visited by its name "XXXX Clinic" (line 23), which is written on the questionnaire. The name conveys that the place is a local clinic, a typical medical setting for complaints about a runny nose and cough. The doctor looks down at the questionnaire and claims recognition (line 24). The patient goes on to report a partial recovery after about a year's treatment (lines 25–26/30), but projects reporting the problem as unresolved ("but"; line 30). The patient then mentions a blood test for examining allergies which he had at XXXX Clinic (lines 41–42).

After this, the patient asks his wife to get the blood test results report from her bag, but she can't find it. The patient takes the bag, finds it himself, and shows it to the doctor. While the doctor goes through it, the patient coughs several times. The doctor asks some questions about the patient's cough and other symptoms, and the patient answers these questions. Then, about 3 min after the end of Extract (2a), the patient resumes his narrative in line 01 of Extract (2b).

After prefacing the next episode as a repetition of what he has already told the medical student (line 02), the patient starts telling the doctor what prior doctors have told him about his runny nose. His second doctor, YYYY (line 03), an ENT doctor (line 05), did an examination of sinus problems and concluded that the patient's runny nose is not caused by a sinus problem (lines 06–20). He suggested the possibility that it may be caused by a problem with the inner organs and encouraged the patient to have it checked (lines 22–28). However, another doctor at ZZ Hospital (line 30), who has treated the patient's stomach ulcer for more than ten years, gave him the contradicting explanation that things like a runny nose are not caused by inner organs (lines 31–32). The patient then expresses his uneasiness about these contradictory explanations ("Being told that, I was wondering how I should ((understand)), y'know"; line 34). Before the patient brings this syntactic unit to a possible completion, the doctor displays his empathic understanding using a reported thought of how the patient must feel ("It's like 'which is right?'"; line 35). After the patient confirms this (line 36) and the doctor validates the patient's uneasiness (line 37), the patient summarizes the upshot of his narrative by saying that he wants to find out what is causing the problem here at the DGM (lines 38–41).

In this case, the patient's problem presentation consists of two elements which work together to justify his visit. First, he characterizes his reaction to his symptoms as reasonable in that he first attempted self-medication, and then chose a typical medical setting to seek medical care. Second, however, he characterizes his prior doctors as not having provided a satisfactory resolution or explanation for his problem: in particular, the prior doctors provided contradictory explanations based on their respective expertise. By constructing his narrative out of these elements, the patient conveys that he needs both relatively high-level and whole-patient care that can provide a satisfactory explanation for his problem, which did not appropriately fall within prior doctors' specialties. Like in Extract (1), the patient takes measures to present his problem as not only doctorable but also relevant to the particular medical setting he has chosen to visit.

The analysis of these two cases illustrates two points. First, though these consultations take place under quite a different institutional arrangement from that of relevant previous studies (Haakana, 2001; Halkowski, 2006; Heath, 1992; Heritage, 2009; Heritage and Robinson, 2006; Ruusuvuori, 2000; Stivers, 2007), the previous findings hold for

our data as well: the basic practices patients use to justify their visit are to characterize their problem as doctorable and present themselves as reasonable people. Second, however, patients additionally present their problem as relevant to the medical setting they visit, under an institutional arrangement in which they can choose among medical settings on their own. In the case of the DGM, patients take measures to present their problem as appropriate for relatively high-level and whole-patient medical care. Patients thus treat the free access system as a relevant institutional context for the justification of their visit, and thereby "talk into being" (Heritage, 1984) the "macro" institutional arrangement of the Japanese health delivery system.

3.2. Coping with a possible mismatch between the problem and the setting

In this section, further evidence is provided for the claim that patients orient themselves to the relevance of their problem to the medical setting they visit. We describe two cases in which the participants cope with a possible mismatch between the patient's problem and the DGM by adding or soliciting further justification for the visit. In Extract (3), the patient volunteers an additional justification for her visit, whereas in Extract (4), the doctor solicits it. Through the sequence initiated by these practices, the participants collaboratively establish the legitimacy of the visit by remedying the possible inappropriateness of the patient's problem for the DGM.

In Extract (3), the patient defends the legitimacy of her visit in responding to a history-taking question. The patient is a 66-year-old woman who has visited the hospital to have a pre-surgery examination in the department of otolaryngology (DO). After the examination, she was given a booklet about the surgery, where she read instructions that directed her to notify the reception staff if she had symptoms of a cold or something similar. Her visit to the DGM is a result of her following these instructions. In Extract (3a), the doctor starts the consultation by asking for confirmation about this background information written on the questionnaire (lines 01/04–05/07) and the patient confirms it (lines 02/06). The doctor thus validates the patient's visit at the beginning of the consultation. Then the doctor solicits the patient's symptoms (line 08).

(3a)[17115matsu_cold 00:09]

01DOC: <jibika de> kondo shujutsu sareteru n desu yo ne.
you'll have a surgery at the DO, right?

02PAT: hai.
Yes.

03 (.)

04DOC: hai.(0.2)de soreꜜde::(.)soko de:
Okay. And there,

05 kaze nado ga are ba iwareru yoo [ni to yuu] koto deꜜ(.)=
you were instructed to let ((us)) know if you have a cold or something,

06PAT: [hai hai.]
Yes.

07DOC: =°>kite itadaita to yuu< koto desu ne°.=
and you came here.

08 =.hhhh ima donna shoojoo desu °(ka)°
What symptoms do you have now?

In response to the question, the patient says that she has the sniffles, a headache, and a sore throat. The doctor asks a series of questions about these symptoms. About 3 min after the Extract (3a), the doctor asks a question about the patient's self-medication in lines 01–02 of Extract (3b).

As stated above, the doctor validates the patient's visit at the beginning of the consultation. However, the patient orients herself to the possible weakness of the legitimacy of her visit. In response to the doctor's question about the patient's self-medication (lines 01–02), the patient first provides a confirmation (line 03). However, the patient expands her response to defend the legitimacy of her visit. First, the patient displays an awareness of her problem possibly being appropriate for her regular doctor ("I could have been seen by my regular doctor near my house"; line 08), and thereby presents herself as a reasonable patient who knows what kinds of problems are relevant to the DGM. Second, the patient provides a justification for her visit. She starts to account for her visit, focusing on the fact that the DGM is in the same hospital where she will have her surgery ("consulting a doctor in the same hospital would be, y'know"; lines 11–12). While the doctor claims agreement with what the patient is about to articulate (line 13), the patient abandons the trajectory-thus-far and reconstructs her account by invoking third parties (Heritage and Robinson, 2006) ("I read in the guide-" "in the explanatory booklet of the surgery that I should talk to the reception staff." "So I talked to them and they said I should come here."; lines 14/16–17/20). She thus justifies her visit as a result of her following the instructions of authoritative people. In response to her account, the doctor claims recognition of the authoritative source (line 15), claims understanding of the reason (line 21), and validates the visit by elaborating upon the patient's abandoned account ("Well, that makes sense. If you see a doctor here, all information in your chart will be accessible to doctors at the DO, that may be the reason. I guess."; lines 23–26). To sum up, although the patient displays her awareness that her problem might be more appropriate to another medical setting, she defends the legitimacy of her visit by locating the agency for the decision to visit the DGM with authoritative people. And the doctor collaborates with the patient by re-validating her visit.

In Extract (4), the doctor asks a question which addresses the possible inappropriateness of the patient's problem for the DGM. The patient is a 75-year-old woman. The doctor solicits problem presentation by requesting a confirmation of the patient's hearing voices in her right ear, which is written on the questionnaire (lines 01–02). The patient confirms this (line 03). The doctor then requests that the patient describe the voices (line 04) and she describes them (lines 06–11).

After this, the doctor asks further questions about the hearing problem and then asks for confirmation of the fact written on the questionnaire that the symptoms had started about ten days prior. In response, the patient starts a narrative of symptom discovery (Halkowski, 2006), saying that she was initially seeing how things went, but she heard the double sound very clearly the other day, and after that she continuously has the same problem. Then, about 2 min after the end of Extract (4a), the doctor asks a question that addresses a possible mismatch between the problem and the setting in lines 02–03 of Extract (4b).

The doctor addresses the possible mismatch between the patient's problem and the DGM by asking if the patient has considered a more appropriate setting for her problem: the DO ("Well, in terms of visiting the DO, didn't you think about that?"; line 02). By inquiring into the decision-making process behind the visit, the doctor treats the patient's visit as not yet fully legitimate and requiring further justification. It

(3b) [17115matsu_cold 03:16]

01DOC: konkai no kaze no >koto de<
To cope with this cold,

02 shihan no okusuri toka(0.2)[sonnan wa nonde nai] desu°(ka)°¿
you haven't taken an OTC drug or anything like that?

03PAT: [°(sore wa nonde nai)°]
No, I haven't.

04 (1.6) ((The doctor types on the PC.))

05DOC: °hn hn.°
I see.

06 (2.6) ((The doctor types on the PC.))

07PAT: >(se ya)< kara ano
Therefore,

08 chikakuno::: kakaritsukei ni: itte mo yokatta n desu kedo ne,
I could have been seen by my regular doctor near my house but,

09DOC: nn.
Uh huh.

10 (0.9)

11PAT: moo:::: byooin no naka de:: mite motratta hoo ga,
consulting a doctor in the same hospital would be

12 .hhh nanka
y'know,

13DOC: [a so ya ne:::.
Oh, that's right.

14PAT: [ano- shujutsu no sono annai-
I read in the guide-

15DOC: aa, [hai hai hai.]
Oh, yes, yes.

16PAT: [setsumeesho ni] kaitearu n desu yo ne:.=
in the explanatory booklet of the surgery that

17 =uketsuke de itte kudasai [(tte).
I should talk to the reception staff.

18DOC: [hai.
Uh huh.

19 (0.4)

20PAT: de, yutta ra:: koko e(.)yotte kudasai tte [°osshatte°]
So I talked to them and they said I should come here.

21DOC: [°ha::n°]
I see.

22 (1.3) ((The doctor is looking at the PC.))

23DOC: >ma tashikani soo desu ne<
Well, that makes sense.

24 koko nara karute ga zenbu ne:
If you see a doctor here, all information in your chart

25 jibika no sensee toka mo mireru shi
will be accessible to doctors at the DO,

26 tte yuu koto desu [ne.= kitto ne.]
that may be the reason. I guess.

27PAT: [soo deshoo ne.]
That may be right.

turns out, however, that the patient did visit the DO (line 03) and has had some tests done (line 06), though she has not yet seen a doctor there (line 10). The doctor receives these pieces of information as news (lines 04/11). However, this information does not provide further justification of the visit. Rather, it may further undermine the legitimacy of her visit because her problem is already under the control of appropriate specialists.

Not surprisingly, the doctor pursues further justification by explicitly soliciting an account for the visit ("It is not only the DO but also this department that you decided to visit, is it because you have something in addition to the ear problem?"; lines 31–33). The patient confirms this (line 35) and provides further justification for her visit. First, the patient invokes a third party who can authorize her visit ("((When I talked to the person)) at the reception, I uhm"; line 36). She appears to start reporting the exchange between the reception staff and herself, but this is abandoned mid-turn to report hearing double sound right at the moment (lines 37–38). Second, she explicitly states the reason for her visit by presenting another, as-yet-unmentioned problem: her headache (lines 39–44), which is also noted on her questionnaire. Thus, in this case, though the doctor pays attention to the possible mismatch between the initial problem and the DGM, he assumes the patient has made a reasonable choice of the medical setting and goes on to solicit the "real" chief complaint that is relevant to the DGM. And by presenting another problem that is apparently more relevant to the DGM, the patient justifies her visit. The participants thus collaboratively establish the legitimacy of the visit.

In both cases examined in this section, the initial problem presented by the patient may be regarded as not fully appropriate to the DGM. In Extract (3), the problem may not require relatively high-level medical care. In Extract (4), the problem may more appropriately fall under another specialty. The participants address these possible mismatches between the problem and the setting, and initiate a sequence through which they strengthen the legitimacy of the visit. These cases thus illustrate the normative nature of the match between the problem and the setting. Interestingly, as Extract (4) illustrates, when the patient's problem does not appear to be fully appropriate to the DGM, the doctor does not proceed with the consultation by treating that problem as the reason for the visit. Rather, they attempt to collaboratively establish the legitimacy of the visit by soliciting another, more appropriate reason for visiting the DGM. Arguably, through this type of response to a not-fully-

(4b) [180214mizu_headache1_1 05:03]

01 (18.5) ((The doctor types on his computer.))

02DOC: °n::°(.)↑jibika:::(0.3)jushinshi yoo to wa omowa nkatta no?
Well, in terms of visiting the DO, didn't you think about that?

03PAT: a(.)ima itte ki mashita.=
Well, I was there just now.

04DOC: =a ima itte kita n de[su ka.]
Oh, you were there now.

05PAT: [(hai.)]
Yes.

06PAT: ima itte hoide kensa shite ki mashi[ta.]
I had some tests there now.

07DOC: [ha]::n.=
I see.

08PAT: =nan te yuware mashita::?
What did they say?

09 (0.3)

10PAT: shinsatsu wa::: mada na n desu kedo ↑ne.=
Well, I haven't yet seen a doctor there, though.

11DOC: =aaa:: >soo na n desu [ka.<
Oh, you haven't.

((18 lines omitted where the patient describes the tests.))

30DOC: [nn.=
Okay.

31 =.hhhh >kore< jibika dake ja naku te
It is not only the DO but

32 kocchi mo ko yoo omouta n wa:(.)
also this department that you decided to visit,

33 nanka:(.)mimi igai no:: koto o shinpai sare te::?
is it because you have something in addition to the ear problem?

34 (1.2)

35PAT: a soo na n desu.=
Oh, yes, I do.

36 =uketsuke de ↑ne(0.4)ano:::(.)watashi: wa ano::(0.7)
((When I talked to the person)) at the reception, I uhm

37 ima mo ko(h)re(h) cho(h)tto(h):.hh hanashi sore masu kedo
by the way, just now

38 ki:- >jibun no koe kikoeteru n desu kedo ne<,
I'm hearing my own voice,

39 .hhhh °ano nande ka yuu te yuu to ne°(0.3).hh ko:-(0.6)
well, the reason ((I came here)) is

40 ee:to ne*:::::::::*(.)<i sshuukan gurai mae yatta ka:>
uhm about a week ago,

41 tokuni ne:(0.5)ano asa mee sameta-(.)
especially when I wake up in the morning

42 chau yonaka ni mee sameta ra ne,
no, when I wake up during the night,

43 (1.0) ((The doctor nods.))

44PAT: atama no <ten> to ne(0.7)atama no ten ga itakute ne,
I had a headache on the top of my head,

((The patient goes on to say that she has experienced headaches and felt cold on her head for years.))

appropriate problem, doctors display their orientation to one of the central missions of the DGM: to accept problems that fall outside other specialties. By thus pursuing an as-yet-unmentioned problem that may be relevant to the DGM, the doctors actively participate in the achievement of DGM-relevant problems.

4. Conclusion

In medical consultations, patients and their problems are not only evaluated in medical terms but also in moral terms. For example, a patient who visits a doctor with trivial problems may be regarded as an "unreasonable" person who is wasting the doctor's valuable time. And this type of evaluation by the doctor may influence their treatment of the patient. Not surprisingly, patients are concerned about avoiding such negative moral evaluations. In presenting problems, patients convince the doctor of the legitimacy of their visit by using practices with which they convey the doctorability of their problem (Halkowski, 2006; Heritage and Robinson, 2006; Ruusuvuori, 2000). Even after the doctor provisionally validates the visit by initiating a history-taking, patients defend the legitimacy of the visit when the seriousness of their problem is undermined (Heath, 1992; Heritage, 2009; Peräkylä, 1998, 2002; Stivers, 2007). While past research has examined mostly primary care consultations in a few western societies, this study has described how patients justify their visits to the DGM at a university hospital in Japan, and has reported the following findings.

First, this study provides powerful support for the findings of previous studies by examining cases from quite a different institutional environment. Under the Japanese free access system where patients can visit whatever outpatient services they like without a referral and where the fees are the same for the same treatment, regardless of the location, patients have been shown to justify their visits basically in the same way as described by previous studies: by characterizing their problem as doctorable as well as by presenting themselves as reasonable people. This study has thus provided evidence for the claim that these practices are context-free aspects of the justification issue that holds for consultations under different types of health delivery systems.

Second, however, this study also illustrates a context-sensitive aspect of the justification of medical visits. Past CA studies have already shown variations in the way the legitimacy of a medical visit is treated: parents of patients in pediatric contexts are under fewer constraints to legitimize their visit than patients in adult acute visits (Stivers, 2007); the usual legitimacy of seeking medical help can be jeopardized in the case of a smoking-related probem (Pilnick and Coleman, 2003). The present study has added to this literature another context-sensitive aspect of visit legitimacy. Patients have been shown to take measures to present their problem as relevant to the particular medical setting they are visiting, the DGM, in that their problem is suitable for relatively high-level medical care or does not easily fall under another specialty.

(4a)[180214mizu_headache1_1 02:27]

01DOC: .hhhhhh ee::tto::(0.7)
Well,

02 migi: mimi: kara:koe ga kikoe te kuru n desu ka:?
do you hear voices in your right ear?

03PAT: soo na n desu.=
Yes, I do.

04DOC: =hn:n.(.)donna koe::?
Okay. What kind of voices?

05 (1.6)

06PAT: ee::tto ne:(.)nanka:(1.2)juuhukushita (yo)o na ↑ne,
We::ll, it's like double sound y'know,

07DOC: hn↓::n.
Uh huh.

08PAT: >ano<(.)hutsuuni kikoeru no: to::,(.)
((I hear)) usual sounds and,

09 mata aratani:,[.hhhh]ano kocchi no (i-) kara=
another one on this side,

10DOC: [n::n.]
Uh huh.

11PAT: =migi kara ne, ano(1.4)kikoe te ku n desu yo.
in my right ear, I hear ((that)).

The patient's problem's relevance to the setting is treated as normative in that both patients and doctors recurrently cope with the possible mismatch between the problem and the setting, by collaboratively producing an additional justification for the visit. This study has thus shown that both patients and doctors can orient themselves to the free access system as a relevant context for their interaction, establishing the legitimacy of the visit in a way that is sensitive to this institutional arrangement.

Third, this study also illustrates the ambivalent nature of the DGM as a medical setting. In principle, no problem falls outside the purview of the DGM in that its avowed purpose is to provide "primary" and "whole-patient" care. However, there are types of problems that can be regarded as more suitable for the DGM: those which require relatively high level medical care and do not easily fall under other specialties. And this is because, under the free access system, patients could otherwise choose to visit other medical settings such as a local clinic or a specialty department in a hospital. This ambivalent nature becomes conspicuous in the way doctors respond to a problem that appears to be not fully relevant to the DGM: doctors pursue an as-yet-unmentioned "real" chief complaint and thereby actively participate in constructing a DGM-relevant problem. This type of response on the part of the doctors may be shaped by their orientation to the ambivalent nature of the department.

Overall, this study illustrates that an aspect of the "macro" institutional arrangement of the Japanese health delivery system is treated by participants as a relevant context for their practical task in consultations, and they thereby "talk into being" (Heritage, 1984) the institutional arrangement. However, this study does not argue that the institutional arrangement of a free access system is *always* relevant in patients' accounting for visits. The object of this study is quite limited: first visits to the DGM in a university hospital. We do not yet know whether patients in other types of medical settings, such as a local clinic or a specialty department in a hospital, justify their visits in the same way. Likewise, we know very little about whether patients in referral-based visits take measures to justify their visits and, if so, how they do so. Further research is needed to deepen our understanding about how the legitimacy of a visit is established and how the agenda of a consultation is co-constructed for different types of medical conditions, in different kinds of medical settings, and in different societies.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

This study was funded by JSPS KAKENHI Grant Numbers 15K03842, 16K04133, 16K15312, 18K02026. A previous version of this paper was

presented at the 5th International Conference on Conversation Analysis. The authors are grateful to the audience for their helpful feedback. The authors especially appreciate John Heritage, Tanya Stivers, Satomi Kuroshima for their feedback on earlier versions of this study, and Allison Adelman for her editorial assistance.

References

Barsky, Arthur J., 1985. Hidden reasons some patients visit doctors. Ann. Intern. Med. 94, 492–498.
Bergh, Kent D., 1998. The patient's differential diagnosis: unpredictable concerns in visits for acute cough. J. Fam. Pract. 46 (2), 153–158.
Bloor, Michael J., Horobin, Gordon W., 1975. Conflict and conflict resolution in doctor/patient interactions. In: Cox, C., Mead, A. (Eds.), A Sociology of Medical Practice. Collier Macmillan, London, pp. 271–285.
Charles-Jones, Huw, Latimer, Joanna, May, Carl, 2003. Transforming general practice: the redistribution of medical work in primary care. Sociol. Health Illness 25 (1), 71–92.
Freidson, Eliot, 1970. Profession of Medicine: A Study in the Sociology of Applied Knowledge. The University of Chicago Press, Chicago.
Fukui, Tsugiya, 2002. I. Naika oodanryooiki no hyaku-nen 1. Soogooshinryooka [I. One hundred years of internal medicine crossing area 1. Department of general medicine]. Nihon Naika Gakkai Zassi. J. Japan. Soc. Internal Med. 91 (11), 3106–3110.
Haakana, Markku, 2001. Laughter as a patient's resource: dealing with delicate aspects of medical interaction. Text 21 (1/2), 187–220.
Halkowski, Timothy, 2006. Realizing the illness: patients' narratives of symptom discovery. In: Heritage, John, Maynard, Douglas W. (Eds.), Communication in Medical Care: Interaction between Primary Care Physicians and Patients. Cambridge University Press, Cambridge, pp. 86–114.
Health, Labor, Welfare Ministry, 2017. Patient's Behavior Survey. https://www.mhlw.go.jp/toukei/saikin/hw/jyuryo/17/dl/kakutei-kekka-gaiyo.pdf Acceced 1st. Jul.2020.
Heath, Christian, 1992. The delivery and reception of diagnosis in the general-practice consultation. In: Drew, Paul, Heritage, John (Eds.), Talk at Work: Interaction in Institutional Settings. Cambridge University Press, Cambridge, pp. 235–267.
Heritage, John, 1984. Garfinkel and Ethnomethodology. Cambridge University Press, Cambridge.
Heritage, John, 2009. Negotiating the legitimacy of medical problems: a multi-phase concern for patients and physicians. In: Brashers, Dale, Goldsmith, Deana (Eds.), Communicating to Manage Health and Illness. Routledge, New York, pp. 147–164.
Heritage, John, Robinson, Jeffery D., 2006. Accounting for the visit: giving reasons for seeking medical care. In: Heritage, John, Maynard, Douglas W. (Eds.), Communication in Medical Care: Interaction between Primary Care Physicians and Patients. Cambridge University Press, Cambridge, pp. 48–85.
Hillman, Alexandra, 2014. 'Why must I wait?' the performance of legitimacy in a hospital emergency department. Sociol. Health Illness 36 (4), 485–499.
Ikai, Shuuhei, 2010. *Byooin no Seiki no Riron* [The Theory of Hospital Century]. Yuuhikaku, Tokyo.
Ikegami, Naoki, Campbell, John C., 1996. *Nihon no Iryoo: Toosei to Baransu Kankaku* [Japanese Medicine: Control and the Sense of Balance]. Chuukoo-shinsho, Tokyo.
Jean, Yvette A., 2004. Inclusive intake screening: shaping medical problems into specialist-appropriate cases. Sociol. Health Illness 26 (4), 385–410.
Jefferson, Gail, 2004. Glossary of transcript symbols with an introduction. In: Lerner, Gene H. (Ed.), Conversation Analysis: Studies from the First Generation. John Benjamins, Amsterdam/Philadelphia, pp. 13–31.
Jeffery, Roger, 1979. Normal rubbish: deviant patients in casualty departments. Sociol. Health Illness 1 (1), 90–107.
Llanwarne, Nadia, Newbould, Jennifer, Burt, Jenni, Campbell, John L., Roland, Martin, 2017. Wasting the doctor's time? A video-elicitation interview study with patients in primary care. Soc. Sci. Med. 176, 113–122.
Morris, C.J., Cantrill, J.A., Weiss, M.C., 2001. GP's attitudes to minor ailments. Fam. Pract. 18 (6), 581–585.
Parsons, Talcott, 1951. The Social System. Free Press, New York.
Peräkylä, Anssi, 1998. Authority and accountability: the delivery of diagnosis in primary health care. Soc. Psychol. Q. 61 (4), 301–320.
Peräkylä, Anssi, 2002. Agency and authority: extended responses to diagnostic statements in primary care encounters. Res. Lang. Soc. Interact. 35 (2), 219–247.
Pilnick, Alison, Coleman, Tim, 2003. "I'll give up smoking when you get me better": patients' resistance to attempts to problematic smoking in general practice (GP) consultations. Soc. Sci. Med. 57, 135–145.
Roth, Julius A., 1972. Some contingencies of the moral evaluation and control of clientele: the case of the hospital emergency service. Am. J. Sociol. 77 (5), 839–856.
Ruusuvuori, Johannna, 2000. Control in the Medical Consultation: Practices of Giving and Receiving the Reason for Visit in Primary Health Care. Unpublished Ph. D. dissertation, University of Tampere, Finland.
Sidnell, Jack, Stivers, Tanya (Eds.), 2013. The Handbook of Conversation Analysis. Blackwell, Oxford.
Stivers, Tanya, 2007. Prescribing under Pressure: Parent-Physician Conversations and Antibiotics. Oxford University Press, Oxford.
Zola, Irving K., 1973. Pathways to the doctor: from person to patient. Soc. Sci. Med. 7, 677–689.