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JUDITH FELSON DUCHAN AND DANA KOVARSKY (eds.), *Diagnosis as cultural practice*. Berlin & New York: Mouton de Gruyter, 2005. Pp. x, 307, Pb. \$32.95.

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This volume contributes to a growing body of literature on diagnosis as socio-cultural and interactional practices in medicine particularly and society generally. Diagnosis is typically defined solely in terms of expertise within a biomedical model: “the art or act of identifying a disease from its signs and symptoms” (Medline Plus 2005), a definition that incorporates medicine’s deeply ambivalent attitude toward lay knowledge with its distinction between symptoms subjectively reported by patients and signs objectively observed by physicians. In the first chapter of this volume, however, the editors set out a broader social model of diagnosis as (i) a way of experiencing, doing, and thinking that is pervasive in Western culture, (ii) constructed by lay people as well as professional experts, (iii) socially situated and culturally sensitive, (iv) a process and product of social interaction and social discourse, that (v) can have a life altering impact on those diagnosed (p. 1).

The volume is organized into three main sections: “Experiencing diagnosis,” with a focus on the interaction of diagnosis and social identity; “Doing diagnosis,” with a focus on the interactional practices of diagnosis; and “Reasoning diagnostically,” with a focus on extending the social view of diagnosis to other situations.

The collection is notably multidisciplinary, with authors from diverse fields, including linguistics and discourse analysis, sociology and conversation analysis, anthropology, communication studies, speech and language pathology, and medical education and health communication. Interestingly, one author (Mary Foster-Galasso) is a non-academic who contributes a personal essay on the lived experience of diagnosis for herself, her child with a developmental disability, and her family.

Foster-Galasso’s is the first chapter in the “Experiencing diagnosis” section, which examines how diagnosis is much more than the labeling of a disease for the purposes of appropriate therapeutic treatment. As she describes in “Diagnosis as an aid and a curse in dealing with others,” a diagnosis, if one is even available given the individuality of patients and the limits of medical knowledge, has a wide variety of consequences in social relationships with health professionals, government and service agencies, schools, family, friends, and (sometimes amazingly boorish) acquaintances and strangers. As this chapter demonstrates, a diagnosis is often the beginning, middle, or end of a narrative of lived experience that runs the gamut from extremely stigmatizing to extraordinarily life-affirming.

Another chapter in this section, by Barbara Bokhour, “A diagnosed life in an institutional setting: Can the dancer walk?” describes the consequences of diagnosis when it is used to replace the social identity of an individual. In a discourse analysis of team meetings concerning a new patient in an Alzheimer’s ward, Bokhour observes that the well-known tension between regarding the patient as a person and as a diagnosis is in part a tension of accountability. In the discourse of the meetings, staff used descriptors related to the diagnosis (e.g., unsteady gait) as the medical basis for allowing restraint PRN (as needed) in order to prevent falls, but the physician at the meeting rejected the suggestion of PRN based on institutional accountability: We cannot do that because hospital accreditation guidelines no longer allow standards for restraint that seem to favor staff convenience rather than patient need (42). Bokhour shows how the discourse of the meetings negotiates the dominance of the diagnosis, ending, as happens so regularly in medical settings, with the view of the patient as a passive institutional object rather than an active agentive person, so he needs to be restrained at all times (43).

The second section of the volume presents two types of arguments for a social view of diagnosis: discourse and conversation analyses showing that diagnosis is an interactional practice of negotiation in medical and therapeutic settings, and historical and ethnographic analyses showing that diagnosis is a socially and culturally situated activity. John Heritage (“Revisiting authority in physician-patient interaction”) notes that previous research has shown that diagnosis is often delivered interactionally as authoritative statements – for example, “Well now you seem to have nothing more than a bout of flu” (Byrne & Long 1976); “You’ve got bronchitis” (Heath 1992). However, he also draws upon Anssi Peräkylä’s (1998) work, which shows that diagnosis is sometimes delivered interactionally with the use of evidentials (“Now there appears to be an infection”) or with reference to diagnostic reasoning (“As tapping on the vertebrae didn’t cause any pain and there aren’t any actual reflection symptoms in your legs it corresponds with a muscle complication”). Peräkylä argues that these formulations of diagnosis reflect the need for a balance of authority and accountability. When there is a transparent relationship between the physical examination or tests and the diagnosis, the diagnosis can be delivered fairly straightforwardly, but when there is what he calls “inferential distance” between the examination or tests and the diagnosis, the physician indexes some aspects of the evidence or reasoning for the diagnosis; thus, the evidential verb “appears,” for example, indexes the recent physical examination as the basis for the diagnosis of flu. Drawing upon his work on antibiotic prescribing in pediatric encounters, Heritage also shows how diagnosis can be contested by parents and negotiated by physicians through the use of online commentary: Parents often contest the diagnosis of a virus (rather than a bacterial infection) by requesting antibiotics during the treatment recommendations (“just as a preventative thing should I give them some antibiotics?”), but physicians can forestall some of these re-

quests by forecasting a “no treatment” diagnosis during the physical examination (“Because his chest is perfectly all right he certainly doesn’t need penicillin”) (97–98).

In this section of the volume, Charlotte Jones and Wayne Beach, also working in conversation analysis, compare physician responses to patient attempts to solicit diagnostic information outside the typical structure and interaction of a medical encounter, where diagnosis is delivered solely by the physician after the history and physical examination. Often, these patient attempts incorporate patients’ own lay diagnoses of their condition (e.g., “or a cancer”) or their life-world experience of illness and uncertainty (e.g., “I’m hoping it’s nothing. But it’s just sorta been bothering me”) (115, 110–11). Many of these attempts to solicit diagnostic information or reassurance are treated as premature by physicians, who then use the interactional resources of an asymmetric encounter to return to the structure of the traditional medical interview (e.g., “P: But I just wonder if there’s a reason for this. Dr: Um hm. (1.0) Okay where have you been bruising?”) (110–11). Other times, physicians offer reassurance to patients in a way that minimizes their concerns or anxiety (e.g., “[with laughter tokens] Are you afraid it’s cancer? Doesn’t look like cancer”) (115). Jones & Beach relate these interactional patterns of premature diagnosis to physicians’ dispreference for patient-initiated questioning (Frankel 1990).

In other chapters in this section, authors turn to a variety of settings: G. H. Morris describes diagnostic problem formulations by family therapists that can be met with resistance from clients; Phillip Glen and Timothy Koschmann describe teams of medical students learning to diagnose in ways appropriate to deploying current medical knowledge in treatment; and Dana Kovarsky, Linda Snelling, and Elaine Meyer describe psychosocial rounds in a pediatric intensive care unit that are intended not only to further objective diagnostic questioning by medical residents but also to consider their subjective experience in response to difficult deaths in the ICU. Interestingly, Kovarsky and colleagues report on a death case where junior physicians were uncomfortable with the lack of diagnostic exploration and explanation provided by senior physicians.

Two final chapters in this section argue for the social and cultural nature of diagnosis. Although diagnosis is commonly thought of as the product of objective observation and reasoning within the existing body of medical knowledge, this process is always situated within a complex sociocultural contest, which argues for diagnosis as dynamic rather than static, both in time and in nature. Judith Duchan makes this argument by considering the historical changes in diagnosis within the field of speech and language pathology, showing that the field began within a teaching model in the late 1800s but changed to a medical model as this model became dominant in the United States in the 1900s. Duchan identifies a number of social developments in the United States that contributed to this evolution of diagnosis in the field, including the growth of the testing movement in the early 1900s, the increasing importance of normed

research instrumentation in the 1920s, and the effect of intensive rehabilitation programs developed during and after World War II. Laura Polich makes the argument for the sociocultural nature of diagnosis through her ethnographic work on deafness in Nicaragua. In this country, deafness is not regarded as a problem of the inability to hear, as it is in the United States, but a problem of the inability to speak. Polich also describes the social understandings and implications of diagnosis in contemporary Nicaragua: An individual who is mute is often considered a punishment from God, a shame and a burden on his or her family, as well as someone who cannot integrate successfully into a largely oral society. Despite the increasing influence of a special education model in diagnosing and remediating deafness through amplification and speech therapy, even more contemporary models of Deaf individuals as a sociocultural group have not penetrated very successfully in Nicaragua.

The third section of this volume extends the perspective on diagnosis as a social and cultural activity to situations and discourses outside traditional medical settings. Frances Trix provides a more generalized definition of diagnosis as “an authoritative naming practice, an evaluative discourse with consequences” (242). Trix offers a discourse analysis of letters of recommendation for medical faculty, analogically arguing that letters of recommendation incorporate both signs – the objective information of a curriculum vitae – and (sort of) symptoms, the subjective experience of working with a candidate. Cindy Suopis and Donal Carbaugh investigate lay talk about menopause, an increasingly medicalized stage of life. Their data come from in-person and electronic support groups, where self-diagnosis and self-assessment sometimes construct menopause as a medical condition but also as a life stage, the latter represented by the phrase “in menopause,” in contrast with a more medicalized phrase like “have menopause,” and the former is constructed as having symptoms and needing treatment. Suopis & Carbaugh argue for the importance of peer-group authority as women seek out multiple forms of information for decision making about the medical aspects of menopause.

This volume offers a welcome focus on data and analysis, with the social model of diagnosis set out in terms of a set of important theoretical concepts, which are then explored analytically rather than being rebuilt theoretically in every chapter. My view is that the chapters that focus on the interactional construction of diagnosis in medical settings (broadly defined) are more successful than the chapters that extend the concept of diagnosis more generally, although this may reflect my greater familiarity with the former research program than the latter. The chapters exploring diagnosis within medical and therapeutic encounters (Heritage, Beach, Morris) give the reader an update on several well-known research programs on diagnosis. The chapters describing group discourse about diagnosis (Bokhour, Glenn & Koschmann, Kovarsky et al., Suopis & Carbaugh) identify important sites to illustrate the view of diagnosis as socially and interactionally negotiated. The historical and ethnographic explorations of the socio-

cultural nature of diagnosis (Duchan, Polich) are useful for seeing how different kinds of arguments contribute to a view of diagnosis as dynamic rather than static. Altogether, the chapters and the volume as a whole make a solid contribution to the research literature on diagnosis as interactional practices in medical and lay discourse as well as sociocultural practices incorporating expert and lay knowledge and the tensions between them.

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In the past five years, several books (Baker 2002, Ricento 2006, Shohamy 2006) and a journal, all entitled *Language policy*, have appeared, attesting to the interest in this topic. Volumes in this Cambridge series, “Key Topics in Sociolinguistics,” are meant to provide “accessible yet challenging accounts of the most important issues to consider when examining the relationships between language and society” (n.p.). Spolsky’s volume explores many of the debates at the forefront of language policy: ideas of correctness and bad language, bilingualism and multilingualism, language death and efforts to preserve endangered languages, language choice as a human and civil right, and language education policy. Unlike the topical collections previously listed, it suggests a sustained theoretical model of what the field might entail.

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