

# 'I've come for his throat': roles and identities in doctor–parent–child communication

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## Abstract

Previous studies on doctor–parent–child communication at the general practitioner's surgery showed that the GP and the parent differ fundamentally in the way they enable or constrain child participation. The question how to explain these differences is at the core of the present study. The aim is to describe how the three participants display their orientation to their institutional roles and identities; how they collaboratively co-construct the course of action; and how these discursive constructions structure the ongoing interaction. A qualitative analysis of 106 videos shows that although GP and parent initially show incongruent orientations toward child participation, in the further course of the encounter all three participants jointly establish a situation in which child participation appears to be rather an exception. It is concluded that parental speaking for the child is, in a way, institutionally co-constructed; parents take their responsibility, which is hardly ever questioned by children, and GPs ratify this behaviour by refraining from meta-communicative comments and by aligning with the parent in the course of the interaction. The results are discussed in terms of enabling child participation and implications for medical practice.

## Keywords

doctor–parent–child communication, child participation, participation framework, general practice, medical communication

## Introduction

It is increasingly being acknowledged that children should be involved more in decisions about their own health care (Alderson & Montgomery 1996; Hart & Chesson 1998). An important argument is that a more direct communication between doctor and child improves health care in terms of satisfaction, compliance and better understanding (de Winter *et al.* 1999; Holtzheimer *et al.* 1998). However, actually the child's contribution in medical consultations is rather limited (some 10%), with the medical interaction being dominated by the physician and the parent (Tates & Meeuwesen, 2001). Previous analyses of doctor–parent–child communication at the general practitioner's

surgery showed that GP and parent differ fundamentally in the way they enable or constrain child participation. By taking into account the child's age, GPs are obviously striving for active child participation in medical communication. Parents, on the other hand, would appear to restrict child participation by interfering in doctor–child interactions, irrespective of their child's age (Tates & Meeuwesen, 2000; Tates *et al.*, 2002). How can these obvious differences in adult behaviour be explained? The adult participants might differ in their orientations to tasks and roles they expect to be appropriate in this type of triadic medical interaction. Parents, for example, may feel responsible for their child, and expect the doctor to rely on them to obtain information about their child's well-

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being. The aim of this study is to show how participants in the setting of the GP's surgery display their orientation to their institutional roles and identities through verbal and non-verbal behaviour, how they collaboratively co-construct the course of action and how these discursive constructions structure the ongoing interaction.

The theory and method underlying this study are derived from interactional sociolinguistics, which attempts to characterize how identity construction is accomplished interactionally and sequentially in a particular institutional context (Heritage 1997; Antaki & Widdicombe 1998; Sarangi & Roberts 1999). Participants display their orientations to institutional roles and identities through their use of linguistic devices. The selection of particular descriptive terms, such as person reference, lexical choice and grammatical forms is indicative of the participants' understanding of the situation they are in (Drew & Sorjonen 1997; Heritage 1997; Sarangi & Roberts 1999). In their use of personal pronouns, people may produce a clue about participant roles and display inclusion or exclusion of a person, for example by using the first plural pronoun *we* to denote a joint responsibility. Another clue about participants' orientations to institutional talk is the use of meta-communicative expressions by which people refer overtly to the way they organize their interaction with the others. The goal-orientated character of medical interaction is realized by a standard sequencing of three distinct segments: the history-taking; the physical examination; and the conclusion segment (diagnosis and treatment advice). Based on these global sequences, a descriptive analysis is presented, focusing on (1) discovering the reason for attendance; (2) the global and specific problem definition; and (3) the allocation of diagnosis and treatment information.

Usually, the medical encounter opens with an exchange of greetings, and an arrangement of the seating. Then the physician asks the patient to describe the reason for the attendance (Roter & Hall 1992). Heath (1981) emphasizes the special character of openings in medical conversations; they are sequentially implicative (in the sense that invitations set the addressee's response) and relationally affirmative (in the sense that openings (re-)define the relationships between participants). Children's

participation does not only depend on their communicative competence, but also on their awareness of how the interaction will proceed (Elbers & Kelderman 1994; Elbers & Streefland, 2000). As we are interested in how identity alignment in the opening phase in triadic medical encounters is orientated to establish a relevant context for child participation, we will examine to whom the GP addresses the invitation for describing the reason for attendance. The assumption is that the opening of the consultation is crucial for setting 'the mode of interaction' and the participants roles within the triad. The next step is to look at which participant responds to the invitation. After the 'global problem definition', the GP starts a chain of questions, elaborating on the formulation of the problem. With which participant does the doctor elaborate on the complaint, to get a picture of the 'specific problem definition'?

Mostly, GPs tend to rely on the child for obtaining medical information, but they direct diagnostic and treatment information primarily at the parent (Tates & Meeuwesen, 2001). In this study, we wonder whether setting the mode of interaction at the beginning of the encounter, by encouraging children to formulate the reason for attendance, leads to more active child participation in the course of the encounter, in terms of the GP more actively involving the child in the diagnosis and treatment segment.

## Method

### Sample characteristics

The study is based on 106 video recordings of doctor-parent-child interactions at GPs' surgeries in The Netherlands, with the child visiting the GP for temporary illness and minor complaints. The video recordings were drawn from a large collection ( $n = 2500$ ) of medical interviews, held by the NIVEL (Netherlands Institute of Health Services Research), and collected over three periods: 1975–78 ( $n = 36$ ), 1988–89 ( $n = 36$ ) and 1993 ( $n = 34$ ). All participants differed over the three periods, were of Dutch origin, and all children had seen previously the GP in question. In the majority of the interviews, the child was accompanied by the

mother ( $n = 88$ ). The child was between 4 and 12 years of age (mean age 8 years), and boys and girls were equally represented. A total of 58 GPs participated in the study, the majority being male ( $n = 53$ ).

### Coding procedures

The analyses were conducted on the basis of extensive transcripts of all 106 consultations. Non-verbal communication was noted as far as it was relevant for the coding (especially eye-contact). First, for each consultation we determined the exact formulation of the invitation to describe the reason for attendance. The sequential environment of the utterance was of vital importance; utterances were only labelled as invitations when (one of) the other participant(s) responded with a problem formulation. This allowed us to distinguish between real invitations and so-called greeting substitutes (Schegloff 1986). Then, we determined which participant formulated the invitation and to whom the invitation was allocated, as indicated by, for example, first-naming, pronoun form and politeness form. It should be noted that the Dutch informal second person singular pronouns *je* and the formal form *u* (similar to the distinction between the French *tu* and *vous*, and the German *Du* and *Sie*), as well as the second person plural form *jullie*, are all translated by *you* in English. In addition, it was determined which participant responded by giving a global problem definition and a specific problem definition respectively. Finally, it was determined to which participant the GP directed diagnosis and treatment information. Accurate notes were made on the characteristics of the formulations in terms of person reference, lexical and grammatical choice and form of politeness. The inter-rater reliability, by two trained raters, assessed by Cohen's Kappa was good (invitation: 0.88; global problem definition: 0.81; specific problem definition: 0.83; advice: 0.87).

## Results

### Discovering the reason for attendance

In 79% of all cases, the GP explicitly formulated an invitation to describe the reason for attendance (see

**Table 1.** Invitation to formulate the problem definition

| Invitation    | n   | %   |
|---------------|-----|-----|
| GP→child      | 35  | 33  |
| GP→parent     | 32  | 30  |
| GP→ambiguous  | 17  | 16  |
| Parent→child  | 5   | 5   |
| No invitation | 17  | 16  |
| Total         | 106 | 100 |

Table 1). In 33% of the consultations, the GP addressed the child directly (*John, tell me why you're here*, or *How are your ears?* and *OK Susan, can you tell me what the problem is?*), and in 16% the invitation was directed at the child and parent together [*Right, what seems to be the problem?* or *Tell me then, why have you come to see me?* (you = 2nd person plural form *jullie*)]. In addition, 30% of the GPs' invitations were explicitly parent-directed. In 5% of the consultations, it was the parent who invited the child to formulate the complaint, and in 16% there was no invitation at all, owing to the parent's self-initiated presentation of the child's health problem.

The older the child, the less the GP addressed the parent directly (age of child 4–6, 15%; age of child 7–9, 10%; age of child 10–12, 5%;  $r = -0.32$ ,  $p < 0.01$ ). There was also an effect of time: in the 1980s and 1990s, children were more often invited by the GP (period 1:  $n = 7$ , period 2:  $n = 13$ , period 3:  $n = 15$ ;  $r = -0.35$ ,  $p < 0.01$ ), and fewer invitations were directed at the parent.

The GPs lexical choice strongly reflected the allocation of the invitation. When addressing the child, GPs often used the child's first name or the second person pronoun form. The parent-directed invitations were marked quite differently, whereas the invitations directed at both child and parent reflected the ambiguity of the addressing.

Remarkably, the GPs did hardly make any meta-communicative statements when inviting the addressee. Exceptions were comments such as *It's OK if your Mum tells me* and *Paul, do you want to tell me or shall we let your Mum do it?* This finding contrasts sharply with the parental use of meta-communicative statements in four out of the five consultations in which the parent invited the child to describe the reason for attendance, by saying:

'Tell the doctor why we're here, Mark, tell him what's wrong with you' or 'You can tell him'.

### Responses to the invitations

Which participant responded to the GP's invitation and how did the participants co-construct the further course of the interaction? These patterns are described according to the four most frequent occurring types of invitations

#### Patterns following GP's child-directed invitations

Out of all 35 medical interviews in which the GP invited the child directly, in 46% the child responded with a global problem definition, and in 20% with a specific problem definition. In only six consultations it was the child who ultimately formulated both the global and the specific complaint. As the child's age increased, children more frequently formulated the global problem definition ( $r = -0.39, p < 0.01$ ), as well as the specific problem definition ( $r = -0.30, p < 0.01$ ) instead of their parents.

To whom did the GP finally direct the diagnosis and treatment information in the child-directed consultations? In only five consultations (12%) the GP informed the child explicitly about diagnosis and treatment. All these children were aged 10–12 years. In 20%, ( $n = 7$ ) the GP directed diagnosis and treatment information to both child and parent together, whereas in the other 68% all diagnosis and treatment information was directed to the parent. The dominant pattern following the GP's child-directed invitations is that, whereas both child and parent had about equal opportunity to formulate the global problem definition, the specific problem definition, as well as the information exchange of diagnosis and treatment, were accomplished exclusively between doctor and parent. Fragment 1 shows an example in which the GP invites a 12-year-old girl to formulate the problem definition.

Fragment 1. Consultation no. 53 (GP = general practitioner, P = parent, C = child; 12-year-old girl).

- 1 GP→C: What have you come to see me about? (.) tell me (you = 2nd person singular informal form *je*)  
 2 C→GP: (turns on her chair) yes (.)

- 3 I've got a lump on my foot  
 4 GP→C: a lump on your foot  
 5 C→GP: yes (.) on the ALONG my foot  
 6 GP→C: sorry?  
 7 P→GP: here, on the SIDE  
 8 C→GP: on the side  
 .....  
 10 GP→C: tell me something about this, eh, lump  
 11 C→GP: yes (.), eh (.)  
 12 something suddenly started to hurt  
 13 and when I looked I saw this strange LUMP  
 14 GP→C: how long have you had it?  
 15 C→P: I think about a week, isn't it? (looks at mother)  
 16 P→C: (nods her head)  
 GP→C: (examines the foot and explains his diagnosis to the child)  
 .....  
 29 GP→C: all you have to do is (focuses only on the child when talking about the treatment)

In lines 2–5, the child defines the global problem definition, after the explicit invitation of the GP. It is only at line 7, when the GP does not quite understand the girl's utterance 'along', that the mother is helping her child. After the mother's reformulation of her child's statement, the GP resumes his orientation to the child, and GP and child collaboratively construct the specific problem definition. After the GP's question about the duration of the complaints in line 14, the child seeks (non-) verbal support from her mother (line 15). The mother non-verbally acknowledges her child's answer and, in lines 29, the GP directs all the information about diagnosis and treatment to the child. Obviously, GP and parent agree on the child's participant status; the GP actively tries to increase child participation, whereas the parent implicitly supports child participation by remaining silent and just providing support when necessary. However, this picture of both adult participants establishing a relevant context for child participation was more an exception than the rule. Fragment 2 contains a more regular example, characterized by parental intervention.

Fragment 2. Consultation no. 10 (GP = general practitioner, P = parent, C = child: 10-year-old girl)

- 1 GP→C: Hello Rose, tell me what’s up (looks at Rose)
- 2 C→GP: (.)
- 3 P→GP: well (.), Rose hasn’t been feeling well for quite a long time
- 4 GP→C: oh (is looking at Rose)
- 5 P→GP: she has a sore throat
- 6 C→GP: I have a sharp PAIN over here (points to somewhere on her head)
- 7 P→GP: yes (.) and last week
- 8 C→P: last WEEK?
- 9 P→C: let MUM have her say!
- 10 GP→P: (folds arms and smiles, looks at mother)
- 11 P→GP: (continues with global problem definition)
- 12 GP→P: and how long has it been like that?
- 13 P→GP: those pains in her head, about two weeks
- 14 GP→P: and has she had any high temperatures?
- 15 P→GP: (goes on to formulate the specific problem definition)
- 16 GP→P: has she got a cough as well?
- 19 GP→P: well (.), I’d like to suggest the following (.)
- 20 GP→P: I’ll give her some nose drops for a week
- 21 and I’ll also give her a tablet you can dissolve in water

Despite the GP’s initial effort to draw the child into the interaction (in line 1, by addressing her by her first name, and by the implicit acknowledgement towards the child to continue the global problem definition in line 4), the mother took over the role of respondent right from the beginning. The mother shows her reluctance towards child participation in line 9 by means of a sharp intervention, claiming that the girl should let her mum do the talking. Noteworthy is line 10: by folding arms and smiling, the GP leaves the mother space to continue her global problem definition in line 11. Thereafter, the GP accepts the parental role of speaking for her child. This shift in alignment is reflected in the GP’s lexical choice; the use of the third person pronoun form to denote the girl (lines 14, 16, 20 and 21) establishes a new course of the interaction that

emphasizes the mother’s role as a respondent for her child. In the further course of the interaction, the child is cast as a non-addressed recipient, and parent and GP co-construct a dyadic interaction, with little space for the child to join the interaction.

*Patterns following GP’s invitations directed to child and parent together*

The ambiguity of this both-directed approach resulted in very low degree of child participation. In 18% of these consultations, the child formulated the global problem definition and, in only 6%, the child provided the specific problem definition. In all these consultations, the GP addressed diagnosis and treatment information solely to the parent. The both-directed form resulted mainly in parental reactions.

*Patterns following GP’s parent-directed invitations*

The least opportunities for child participation were in those cases where the GP explicitly invited the parent to formulate the problem. In nearly all these consultations (94%), the global problem definitions were established by the parent, as well as the specific problem definitions, and 91% of the information concerning diagnosis and treatment was parent-directed. This dominant pattern slightly diminished as an effect of the age of the child ( $r = -.29, p < 0.01$ ) and also as an effect of time ( $r = -0.30, p < 0.01$ ). Fragment 3 provides an example of this pattern:

Fragment 3. Consultation no. 80 (GP = general practitioner, P = parent, C = child: 5-year-old boy)

- 1 GP→P: right (.) tell me
- 2 P→GP: we won’t be long (.) he’s been really ill (.) FLU
- 3 GP→P: right
- 4 P→GP: and I’ve come for some kind of pick-me-up or something
- 5 we can’t go on like this (.) YEH, he’s just like some kid from the third world
- 6 GP→P: right (.)
- 7 P→GP: some minerals or vitamins or something

- 8 something you KNOW will do him good
- 9 GP→P: can (.) may I take a look?
- 10 P→GP: yes (the mother lifts the boy's shirt up)
- 11 (GP examines the boy)
- 12 P→GP: today's the first time in ages I've seen any colour in his cheeks
- 13 GP→P: yes (.)
- 14 P→GP: he's been so sick (.)really awful
- 15 GP→C: (uses stethoscope to listen to the boy's chest)) couldn't you go skating?
- 16 P→GP: but I think (.) you MUST have something for him
- 17 GP→P: well (.) I think I've got something for him

In this fragment, the GP sets the tone of an adult-centred interaction by explicitly inviting the parent to describe the reason for attendance. The parent immediately aligns to this type of participation framework by formulating the problem definition in lines 2–8. The parent's strong identification with the health problems of her child is expressed in her lexical choices; the use of the first person pronoun form in lines 4, 12 and 16, denotes that she conceives those health problems as her own responsibility. The GP implicitly agrees with this parental role by asking permission to examine the boy in line 9. Thus, both adults co-construct a situation in which the child is treated as a non-person; this is exemplified in line 10 where the mother lifts up the boy's shirt to let the doctor do his job. The only child-directed question by the GP in line 15 might be typified as small-talk; the pseudo-question probably aims at putting the child at ease, and has nothing to do with the course of the interaction. At the end of this fragment of interaction the GP emphasizes the child's (non-) participant status by means of the third person pronoun form 'I think I've got something for *him*'.

#### *Patterns following parental self-initiated problem definitions*

In 17 consultations, the parent immediately started with a presentation of the child's health problems, without waiting for an invitation. In 88% of

these cases, the parent also formulated the specific problem definition. In addition, 94% of diagnostic and treatment information appeared to be parent-directed. In one consultation, the GP immediately started the physical examination after the parental global problem definition. Fragment 4 offers an example of a parent-initiated problem definition.

Fragment 4. Consultation no. 113 (GP = general practitioner, P = parent, C = child: 10-year-old boy, B = both parent and child)

- 1 P→GP: I'm here for Peter (.) he's got a sore throat
- 2 GP→P: something wrong with his throat (.)
- 3 P→GP: (sighs) yes (sighs)
- 4 P→GP: and quite a BAD one at that
- 5 GP→C: hm (.) and can you yourself say anything about it? (.)
- 6 or does it hurt too much?
- 7 C→GP: it does hurt quite a bit
- 8 GP→C: (.) and (.) where (.) where does it hurt?
- 9 C→GP: (shrugs his shoulders)
- 10 GP→C: where (.) here, more at the top (points) or more at the bottom
- 11 C→GP: (coughs) yes, here at the bottom (coughs)
- 12 GP→C: do you have to cough a lot?
- 13 P→GP: (talks a great deal about the coughing and other symptoms)
- 19 P→GP: is this one of those new viruses or something?
- .....
- 20 GP→P: no
- 21 GP→B: no (.) there's a LOT of this about at the moment
- 22 GP→B: well, we can give him something for it
- 23 GP→C: you dissolve it (looks at child) and then drink it (pretends to drink)
- 24 and if you have a lot of problems with your voice (.)
- 25 then steaming's the answer
- 26 it'll help you to get rid of any phlegm that's there
- 27 C→GP: (nods)
- 28 P→GP: is it a good idea to let him stay at home for a few days? (.) or not

Despite the mother's firm display of speaking for her child in line 1, the GP actively tries to establish a context for the boy to participate in the specific problem definition. In line 5, the GP asks the child explicitly to speak for himself, and even after the minimal answers the boy provides in lines 9–11, the GP appears to be orientated towards the child instead of to the accompanying parent. Line 23 is an interesting one; after the parental elaboration on the problem definition in line 13, line 23 displays a rapid shift in the GP's alignment from the parent to the boy, by a shift from the first plural pronoun form *we* in line 22, to the second singular informal pronoun form *je* in line 23. By this switch, the GP resumes his orientation to the child as the actual patient within the encounter. The mother's statement in line 28 suggests that she does not seem to fully accept the child's participant status.

## Discussion

This study reveals that differences in GPs' and parental behaviour stem from dissimilarities in the participants' orientations regarding the desirable participation framework. Although GP and parent initially show incongruent orientations towards child participation, in the further course of the encounter all three participants jointly establish a situation in which child participation appears to be an exception. Parents obviously regard matters of the child's health as their own responsibility and, therefore, they usually treat their children in medical interviews as if they were absent. Frequently, the GPs accept this parental role of speaking for their child, shift their alignment, and co-construct a dyadic interaction with the parent, which renders the child as a non-addressed participant. We must, therefore, conclude that parental speaking for the child is, in a way, institutionally co-constructed; parents take their responsibility, which is hardly ever questioned by children, and GPs ratify this behaviour by refraining from meta-communicative comments and by aligning with the parent in the course of the interaction.

The findings of this study underline the dialogically constructed character of roles and identities within the doctor–parent–child triad, and Heath's claim (Heath 1981) about the sequentially implica-

tiveness of openings in medical interaction. The importance of setting the 'mode of interaction' at the beginning of the encounter is emphasized. Comparing the various patterns in terms of opportunities for the child to participate in the medical interaction, we conclude that inviting children to formulate the problem definition embeds the opportunities for child participation in the further course of the encounter. The patterns we described show that with every structurally important step in the consultation, such as the response to the invitation and the transition from global to specific problem definition, parents validate their position as primary speaker and increasingly get the floor.

The low degree of child participation in the doctor–parent–child triad should not be interpreted as a sign of incompetence on behalf of the children, but rather as a consequence of the participants' underlying participation framework. We have to conclude that the adult participants play a pivotal role in enhancing or restricting child participation. This conclusion is in line with Pyörälä (2000), who reported a fundamental difference between triadic dietician–parent–child encounters and dyadic encounters between the dietician and the diabetic child. In the dyadic encounters, children assumed an actively responding patient role, but in the triadic encounters the children turned into withdrawn bystanders. The passivity of the children in the triadic encounters was not because of not knowing or not understanding what was happening, but rather to the particular participation framework within that institutional setting. Although they do not discuss their findings in terms of roles and identities, Tannen & Wallat (1987) and Aronsson & Rundström (1989) also report the child's participant status as a non-addressed recipient of talk in their own consultations. However, in these studies the status of the parents as spokesmen for their children is hardly ever questioned, nor are the consequences of the participants' orientations regarding the child's participant status in terms of the opportunities for child participation.

Given that young children visiting the doctor are always accompanied by (one of) their parents, it is important to realize how adult language behaviour socializes child participation in triadic medical

interactions. Children are socialized indirectly in the ongoing verbal interactions with physician and parent and, therefore, it is important in terms of health education that both GP and parent guide the child towards management of illness and health care. Learning by participation instead of being excluded from the interaction is to be considered as a powerful tool to promote self-confidence and a sense of control of one's own life. Antaki & Widdicombe (1998) pointed to the dual aspect of identity both as a tool and an achievement. In this line of reasoning, child participation should be both the objective and the means of child-health promotion (de Winter *et al.* 1999). Empirical studies emphasize the health promoting value of active child participation (Holtzheimer *et al.* 1998; de Winter *et al.* 1999). Therefore, GPs and parents should attempt to create a developmental environment that offers children the opportunity to participate actively in medical contexts. Our study exposes the differences in the participants' orientations regarding child participation; orientations that are taken for granted by GPs appear to be unknown to the parent, and can be the source of miscommunication. Thus, the GP should provide clarity, for the child as well as for the parent, about the desirable participant roles in triadic medical encounters, and the importance of an active child participation. Enhancing child participation in triadic medical encounters may, therefore, force GPs and parents, as well as children, to question their roles and become aware of their responsibilities and obligations.

## References

- Alderson, P. & Montgomery, J. (1996) *Health Care Choices: Making Decisions with Children*, Institute for Policy Research, London.
- Antaki, C. & Widdicombe, S. (1998) *Identities in Talk*, Sage, London.
- Aronsson, K. & Rundström, B. (1989) Cats, dogs, and sweets in the clinical negotiation of reality: on politeness and coherence in pediatric discourse. *Language in Society*, **18**, 483–504.
- Drew, P. & Sorjonen, M. (1997) Institutional dialogue. In: *Discourse as Social Interaction. Discourse Studies: a Multidisciplinary Introduction* (ed. T. van Dijk), pp. 92–118, Sage Publications, London.
- Elbers, E. & Kelderman, A. (1994) Ground rules for testing: expectations and misunderstandings in test situations. *European Journal of Psychology of Education*, **9**, 111–120.
- Elbers, E. & Streefland, L. (2000) 'Shall we be researchers again?' Identity and social interaction in a community of inquiry. In: *Social Interaction in Learning and Instruction. The Meaning of Discourse for the construction of Knowledge* (eds H. Cowie & D. Van der Aalsvoort), pp. 35–51, Pergamon Press, Amsterdam.
- Hart, C. & Chesson, R. (1998) Children as consumers. *British Medical Journal*, **316**, 1600–1603.
- Heath, C. (ed.) (1981) The opening sequence in doctor–patient interaction. In: *Medical Work: Realities and Routines*, pp. 71–90, Gower, Farnborough.
- Heritage, J. (1997) Conversation analysis and institutional talk: analysing data. In: (ed. D. Silverman), *Qualitative Research: Theory, Method and Practice*, pp. 161–182, Sage, London.
- Holtzheimer, L., Mohay, H. & Masters, I. B. (1998) Educating young children about asthma: comparing the effectiveness of developmentally appropriate asthma education video tape and picture book. *Child: Care, Health and Development*, **24**, 85–99.
- Pyörälä, E. (2000). *Interaction in Dietary Counselling of Diabetic Children and Adolescents* [Dissertation], Helsinki University Press, Helsinki.
- Roter, D. L. & Hall, J. A. (1992) *Doctors Talking with Patients, Patients Talking with Doctor*, Auburn House, Westport, CT.
- Sarangí, S. & Roberts, C. (1999). *Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management Settings*, Mouton de Gruyter, Berlin.
- Schegloff, E. A. (1986) The routine as achievement. *Human Studies*, **9**, 111–151.
- Tannen, D. & Wallat, C. (1987) Interactive frames and knowledge schemas in interaction: examples from a medical examination/interview. *Social Psychology Quarterly*, **50**, 205–216.
- Tates, K. & Meeuwesen, L. (2000) 'Let Mum have her say': turntaking in doctor-parent-child communication. *Patient Education and Counselling*, **40**, 151–162.
- Tates, K., & Meeuwesen, L. (2001) Doctor-parent-child communication: a (re) view of the literature. *Social Science and Medicine*, **52**, 839–851.
- Tates, K., Meeuwesen, L., Bensing, J. M. *et al.* (2002) Joking or decision-making? Affective and instrumental behaviour in doctor-parent-child communication. *Psychology and Health*, in press.
- de Winter, M., Baerveldt, C. & Kooistra, J. (1999) Enabling children: participation as a new perspective on child-health promotion. *Child: Care, Health and Development*, **25**, 15–25.