Communication in Medical Care

Interaction between primary care physicians and patients

Edited by
John Heritage and Douglas W. Maynard

This page intentionally left blank

Communication in Medical Care

This new and path-breaking volume provides a comprehensive discussion of communication between doctors and patients in primary care consultations. The first of its kind for thirty years, it brings together a team of leading contributors from the fields of linguistics, sociology, and medicine to describe each phase of the primary care consultation, identifying the distinctive tasks, goals, and activities that make up each phase of primary care as social interaction. Using conversation analysis techniques, the authors analyze the sequential unfolding of a visit, and describe the dilemmas and conflicts faced by physicians and patients as they work through each of these activities. The result is a view of the medical encounter that takes the perspective of both physicians and patients in a way that is rigorous and humane. Clear and comprehensive, this book will be essential reading for students and researchers in sociolinguistics, communication studies, sociology, and medicine.

JOHN HERITAGE is Professor of Sociology at the University of California, Los Angeles, working in the field of communication and interaction with particular reference to health care and political communication. His previous books include *Talk at Work: Interaction in Institutional Settings* (co-edited with Paul Drew, Cambridge University Press, 1992) and *The News Interview: Journalists and Public Figures on the Air* (with Steven Clayman, Cambridge, Cambridge University Press, 2002).

DOUGLAS W. MAYNARD is Professor of Sociology at the University of Wisconsin-Madison. He has carried out interaction-based research in a variety of settings, including legal medical, educational testing, and survey interviews. He is author of *Bad News, Good News: Conversational Order in Everyday Talk and Clinical Settings* (2003) and co-editor of *Standardization and Tacit Knowledge: Interaction and Practice in the Survey Interview* (2002).

Studies in Interactional Sociolinguistics

Communication in Medical Care

Interaction between Primary Care
Physicians and Patients

Edited by

JOHN HERITAGE
University of California, Los Angeles

and

DOUGLAS W. MAYNARD
University of Wisconsin-Madison

CAMBRIDGE
UNIVERSITY PRESS

Contents

Figures

Tables

Contributors

Professor Elizabeth Boyd, Department of Clinical Pharmacy, University of California, San Francisco, USA

Professor Paul Drew, Department of Sociology, York University, UK

Professor Richard Frankel, Department of General Internal Medicine, Indiana University School of Medicine, USA

Professor Virginia Teas Gill, Department of Sociology, Illinois State University, USA

Professor David Greatbatch, Department of Education, University of Nottingham, UK

Dr. Markku Haakana, Department of Finnish, University of Helsinki, Finland

Professor Timothy Halkowski, Department of Communication, State University of New York at Albany, USA

Professor Christian Heath, Centre for Work, Interaction and Technology, King's College, University of London, UK

Professor John Heritage, Department of Sociology, University of California, Los Angeles, USA

Professor Douglas W. Maynard, Department of Sociology, University of Wisconsin-Madison, USA

Professor Anssi Peräkylä, Department of Sociology, University of Helsinki, Finland

Dr. Liisa Raevaara, Research Institute for the Languages of Finland, Helsinki, Finland

Professor Jeffrey D. Robinson, Department of Communication, Rutgers University, USA

Professor Debra Roter, School of Public Health, Johns Hopkins University, USA

Dr. Marja-Leena Sorjonen, Research Institute for the Languages of Finland, Helsinki, Finland

Dr. Tanya Stivers, Max Planck Institute for Psycholinguistics, Netherlands

Dr. Tuukka Tammi, Department of Sociology, University of Helsinki, Finland

Professor Candace West, Department of Sociology, University of California, Santa Cruz, USA

Foreword

Debra Roter

This very thoughtful volume, assembled by two of the field's leading conversation analysts, is a notable contribution to the literature on medical communication by taking the reader through the examination room door to the heart of the medical dialogue. The book is expressly conversation-analytic in orientation and presents authentic dialogue from patients and physicians as it unfolds, thus capturing the social and medical dynamic within which medicine is practiced. The book also presents chapters in which quantitative analyses are built upon conversational analytic material. By doing this, the significance of the book goes beyond the contribution of its individual chapters. It provides support for the development of a new kind of interaction study – one with the potential for rich and meaningful synthesis of the medical dialogue derived from an integration of qualitative and quantitative methods.

The integration of quantitative and qualitative approaches in a study of medical dialogue is not without controversy. Indeed, a debate of longstanding intensity has centered on the perception that these approaches reflect incompatible scientific paradigms. Advocates of each have not only argued their own relative merits, but have maintained unusually critical and polarized positions. These positions are reflected in a well-worn list of attributes that are widely used to characterize quantitative and qualitative approaches, as well as their practitioners. The quantitative perspective is characterized as hypothetico-deductive, particularistic, objective, and outcome-oriented; its researchers are logical positivists. In contrast, the qualitative approach is characterized as social-anthropological, inductive, holistic, subjective, and process-oriented; its researchers are phenomenologists (Reichardt and Cook 1969).

The paradigmatic schism so apparent in the well-established areas of scientific inquiry described above is also evident in studies of the medical dialogue. Association with a particular paradigm not only implies a worldview, but also a paradigm-specific method of inquiry and even different styles of presentation. Quantitative studies of medical interaction are characterized as narrowly reflecting the biomedical model's emphasis on deductive methods and a tendency to translate observations of patient and provider behavior into statistical summaries. Qualitatively inclined researchers, on the other hand, record data in the language of their subjects, almost always presenting actual speech through verbatim transcripts of audio- and videotape recordings and rarely assigning numerical values to their observations. Despite obvious overlap in the questions asked and problems tackled, the two approaches are seldom combined.

In lamenting the advances and insights lost to intellectual isolation, my good colleague and friend Richard Frankel and I began a series of conversations pertaining to the research traditions and the professional circles that placed each of us, and our work, within opposing paradigm camps (Roter and Frankel 1992). In doing so, we found a parallel may be drawn between the systems of open-sea navigation described by the cultural anthropologist Thomas Gladwin, and the debate among researchers of the medical encounter over qualitative and quantitative methods (Gladwin 1964). The system of navigation represented by the European tradition is characterized by the plotting of a course prior to a journey's beginning that subsequently guides all decisions regarding location. The extent to which the journey "stays the course" is a testament to the European navigator's skill. The islanders of Truk face the problem of managing long distances over uncertain conditions in a very different manner than the Europeans. The Trukese navigator has no pre-established plan of any kind; rather, experience from previous voyages and information at hand during the current sailing trip account completely for Trukese navigational expertise.

The paradigmatic perspective which promotes mutual exclusivity is in error; there is no inherent logic in the limitations established by the traditions, other than tradition itself. Much of the debate in medical interaction research has focused on comparing methods independent of particular contexts, questions, or outcomes. Although it is quite clear that the methods used by Gladwin's navigators differ

in both kind and degree, it is also the case that they both solve the same practical problem successfully. The value of Gladwin's analysis is that it includes both context and outcome as determinants of methodological utility. The presence or absence of map-making skills is essentially irrelevant to the Trukese navigator, as is the ability or inability of European navigators to read local wave patterns. Methods of research, like those of navigation, are open to description in their own terms, and should be judged on the extent to which they succeed in answering the questions which they raise in the context in which they were raised. However, respect for alternative methods does not preclude combining methods to maximize discovery and insight.

In this book, Douglas Maynard and John Heritage have assembled a thoughtful collection of papers in which the richness of the communication experience is reflected in a variety of ways. In doing so, this book makes a meaningful contribution to the literature and begins to address the formidable challenge of breaking paradigmatic boundaries.

Transcript symbols

The transcript notation used in this book, and in conversation analytic research more generally, was developed by Gail Jefferson. It is designed to capture the details of talk in interaction as it actually occurs, and is a system that continues to evolve in response to current research interests and needs.

Temporal and sequential relationships

A.   Overlapping or simultaneous talk is indicated in a variety of ways.

[Separate left square brackets, one above the other on two
[successive lines with utterances by different speakers, indicates a point of overlap onset, whether at the start of an utterance or later.

]   Separate right square brackets, one above the other on two
]   successive lines with utterances by different speakers, indicates a point at which two overlapping utterances both end, where one ends while the other continues, or simultaneous moments in overlaps which continue.

//   In some older transcripts or where graphic arrangement of the transcript requires it, a double slash indicates the point at which a current speaker's utterance is overlapped by the talk of another, which appears on the next line attributed to another speaker. If there is more than one double slash in an utterance, then the second indicates where a second overlap begins, the overlapping talk appearing on the next line attributed to another speaker, etc. In transcripts using the // notation for overlap onset, the end of the overlap may be
*   marked by a right bracket (as above) or by an asterisk.

So, the following are alternative ways of representing the same event: Bee's "Uh really?" overlaps Ava's talk starting at "a" and ending at the "t" of "tough."

```
Ava:  I 'av [a lotta  t]ough cou:rses.
Bee:        [Uh really?]

Ava:  I 'av // a lotta t*ough cou:rses.
Bee:  Uh really?
```

=   B. Equal signs ordinarily come in pairs – one at the end of a line and another at the start of the next line or one shortly thereafter. They are used to indicate two things:

   1) If the two lines connected by the equal signs are by the same speaker, then there was a single, continuous utterance with no break or pause, which was broken up in order to accommodate the placement of overlapping talk. For example,

```
Bee:  In the gy:m? [(hh)
Ava:              [Yea:h. Like grou(h)p
      therapy.Yuh know [half the grou]p thet=
Bee:                   [ O h : : : . ]˙hh
Ava:  =we had la:s' term wz there en we [jus'=
Bee:                                     [˙hh
Ava:  =playing arou:nd.
```

Ava's talk is continuous, but room has been made for Bee's overlapping talk (the "Oh").
   2) If the lines connected by two equal signs are by different speakers, then the second followed the first with no discernable silence between them, or was "latched" to it.

(0.5)   C. Numbers in parentheses indicate silence, represented in tenths of a second; what is given here in the left margin indicates 5/10 second (half a second) of silence. Silences may be marked either within an utterance or between utterances, as in the two excerpts below:

```
Bee:  ˙hhh Uh::, (0.3) I don'know I guess
      she's aw- she's awright she went to
      thee uh:: hhospital again tihda:y,
Bee:  Tch! .hh So uh I don't kno:w,
      (0.3)
Bee:  En:=
```

(.)	D.	A dot in parentheses indicates a "micropause," hearable but not readily measurable; ordinarily less than 2/10 of a second.
((pause))	E.	In some older or less carefully prepared transcripts, untimed silences may be indicated by the word "pause" in double parentheses.

Aspects of speech delivery, including aspects of intonation

. ? , ?, ¿	A.	The punctuation marks are *not* used grammatically, but to indicate intonation. The period indicates a falling, or final, intonation contour, not necessarily the end of a sentence. Similarly, a question mark indicates rising intonation, not necessarily a question, and a comma indicates "continuing" intonation, not necessarily a clause boundary. In some transcript fragments in your readings you may see a combined question mark and comma, which indicates a rise stronger than a comma but weaker than a question mark. Because this symbol cannot be produced by the computer, the inverted question mark (¿) is used for this purpose. Sometimes completely "level" intonation is indicated by an "empty" underline at the end of a word, e.g., *"word__".
: :	B.	Colons are used to indicate the prolongation or stretching of the sound just preceding them. The more colons, the longer the stretching. On the other hand, graphically stretching a word on the page by inserting blank spaces between the letters does *not* necessarily indicate how it was pronounced; it is used to allow alignment with overlapping talk. Thus,

```
Bee:    Tch! (M'n)/(En ) they can't delay much
        lo:nguh they [jus' wannid] uh-˙hhh=
Ava:                 [ O h  :  . ]
Bee:    =yihknow have anothuh consulta:tion,
Ava:    Ri::ght.
Bee:    En then deci::de.
```

The word "Ri::ght" in Ava's second turn, or "deci::de" in Bee's third are more stretched than "Oh:" in Ava's first turn, even though "Oh:" appears to occupy more space. But "Oh" has only one colon, and the others have two; "Oh:" has been spaced out so that its brackets will align with the talk in Bee's ("jus' wannid") turn with which it is in overlap.

-	C.	A hyphen after a word or part of a word indicates a cut-off or self-interruption, often done with a glottal or dental stop.

<u>w</u>ord	D. Underlining is used to indicate some form of stress or emphasis, either by increased loudness or higher pitch.
<u>wo</u>rd	The more underlining, the greater the emphasis. Therefore, underlining sometimes is placed under the first letter or two of a word, rather than under the letters which are
WOrd	actually raised in pitch or volume. Especially loud talk may be indicated by upper case; again, the louder, the more letters in upper case. And in extreme cases, upper case may be underlined.
°	E. The degree sign indicates that the talk following it was markedly quiet or soft. When there are two degree signs, the
°°	talk between them is markedly softer than the talk around it.
	F. Combinations of underlining and colons are used to indicate intonation contours, as follows:
<u> </u>:	If the letter(s) preceding a colon is underlined, then there is an "inflected" *falling* intonation contour (you can hear the pitch turn downward).
<u>:</u>	If a colon is itself underlined, then there is an inflected *rising* intonation contour (i.e., you can hear the pitch turn upward).

So, in

```
Bee: In the gy:m? [(hh)
Ava:              [Yea:h. Like grou(h)p
     therapy.Yuh know [half the grou]p thet=
Bee:                  [ O h : : : . ]˙hh
Ava: =we had la:s' term wz there en we [jus'=
Bee:                                   [˙hh
Ava: =playing arou:nd.
Bee: Uh-fo[oling around.
Ava:      [˙hhh
Ava: Eh-yeah so, some a' the guys who were
     bedder y'know wen' off by themselves so
     it wz two girls against this one guy en
     he's ta:ll.Y'know? [˙hh
Bee:                     [ Mm hm?
```

the "Oh:::." in Bee's second turn has an upward inflection while it is being stretched (even though it ends with falling intonation, as indicated by the period). On the other hand, "<u>ta</u>:ll" at the end of Ava's last turn is inflected downward ("bends downward," so to speak, over and above its "period intonation").

↑ ∧ ↓ ∨	G. The up and down arrows mark sharper rises or falls in pitch than would be indicated by combinations of colons and underlining, or may mark a whole shift, or resetting, of the pitch register at which the talk is being produced.
> < < > <	H. The combination of "more than" and "less than" symbols indicates that the talk between them is compressed or rushed. Used in the reverse order, they can indicate that a stretch of talk is markedly slowed or drawn out. The "less than" symbol by itself indicates that the immediately following talk is "jump-started," i.e., sounds like it starts with a rush.
hhh (hh) ·hh	I. Hearable aspiration is shown where it occurs in the talk by the letter "h" – the more "h"s, the more aspiration. The aspiration may represent breathing, laughter, etc. If it occurs inside the boundaries of a word, it may be enclosed in parentheses in order to set it apart from the sounds of the word (below). If the aspiration is an inhalation, it is shown with a dot before it (sometimes a raised dot).
 # £/$	J. Some elements of voice quality are marked in these transcripts. A rasping or "creaky" voice quality is indicated with the "#" sign. Similarly, a "smile voice" – a voice quality which betrays the fact that the speaker is smiling while speaking – is normally indicated with the "£" (or "$") sign.

Other markings

(( ))	A. Double parentheses are used to mark transcriber's descriptions of events, rather than representations of them. Thus ((cough)), ((sniff)), ((telephone rings)), ((footsteps)), ((whispered)), ((pause)), and the like.
(word) ( )	B. When all or part of an utterance is in parentheses, or the speaker identification is, this indicates uncertainty on the transcriber's part, but represents a likely possibility. Empty parentheses indicate that something is being said, but no hearing (or, in some cases, speaker identification) can be achieved.
(try 1) (try 2)	C. In some transcript excerpts, two parentheses may be printed, one above the other: these represent alternative hearings of the same strip of talk. In some instances this format cannot be printed, and is replaced by putting the alternative hearings in parentheses, separated by a single oblique or slash, as in

```
Bee:    °(Bu::t.)=/°(Goo:d.)=
```

Here, the degree marks show that the utterance is very soft. The transcript remains indeterminate between "Bu::t." and "Goo:d." Each is in parentheses and they are separated by a slash.

1

Introduction: Analyzing interaction between doctors and patients in primary care encounters

John Heritage and Douglas W. Maynard

In 1976, Patrick Byrne and Barrie Long published a path-breaking study of the doctor–patient relationship. Based on some 2,500 tape-recorded primary care encounters, *Doctors Talking to Patients* anatomized the medical visit into a series of stages, and developed an elaborate characterization of doctor behaviors in each of them. Drawing on Michael Balint's (1957) proposal that the primary care visit has therapeutic value in its own right, Byrne and Long focused on the ways in which its therapeutic possibilities were attenuated by the prevalence of doctor-centered behaviors in the encounters they studied. The study was also conceived as an intervention: physicians were invited to use its coding framework to evaluate their own conduct, and to modify it in a more patient-centered direction. Not surprisingly, given these goals, *Doctors Talking to Patients* was itself somewhat doctor-centered. The authors had little to say about patients' contributions to the encounter or the sociocultural context of social interaction in primary care.

In the present volume we revisit Byrne and Long's project of anatomizing the primary care visit, doing so from a primarily sociological and interactional perspective. We begin from the standpoint that physician and patient – with various levels of mutual understanding, conflict, cooperation, authority, and subordination – jointly construct the medical visit as a real-time interactional product. Within this orientation, we consider some of the social, moral, and technical dilemmas that physicians and patients face in primary care, and the resources that they deploy in solving them. Our objective is to open the study of doctor–patient relations to a wide range of social and interactional considerations.

We begin this Introduction with a sketch of recent approaches to the analysis of the physician–patient relationship, before going on to describe the methodological underpinnings of our research. The objective is to set out the conceptual context of the studies making up this volume, and to consider what they might contribute both to the social scientific investigation of primary care and, in keeping with Byrne and Long's original objective, to its practice.

Studies of doctor–patient interaction: a brief overview

Sociological concern with the doctor–patient relationship received its classic formulation in a chapter of Parsons' (1951) theoretical work, *The Social System*. Working within the functionalist perspective that he did much to develop, Parsons conceptualized the institution of medicine as a social system's mechanism for assisting those who fall ill and returning them to their regular contributory capacities. Rather abstract and generalized, the role-based model that Parsons formulated did not generate much empirical investigation. Instead, starting in the 1960s, research on doctor–patient interaction has increased greatly according to two main approaches: process analysis, and the microanalysis of discourse (Charon et al. 1994).

Process analysis

Process analysis was introduced into medicine in a series of path-breaking studies by Barbara Korsch and associates on interaction in a pediatric emergency room (Francis et al. 1969; Korsch et al. 1968; Freemon et al. 1971; Korsch and Negrete 1972). Using the "interaction process analysis" coding scheme which had been developed by Robert Bales (1950), these studies demonstrated that mothers, desiring more information than they actually obtained from the physicians, were reticent about asking questions, disappointed at the amount of information they received, and frequently (one-fourth of the subjects) did not mention their most important concern to the physician. These observations were linked to adherence: patients whose needs for information were least satisfied were also least cooperative with treatment recommendations and also less satisfied with the outcome of the visit. Such findings made a powerful case for the study of physician–patient interaction, because they showed

that systematic study in the field is achievable, and that the results can be significant for patient health outcomes.

As noted, the original Korsch studies quantified interaction using Bales' interaction process analysis, which had been developed for classifying role behavior in task-oriented small groups in terms of a contrast between task-oriented behaviors and socio-emotional categories. The Bales scheme had real strengths, including the attempt to be exhaustive and to facilitate administration so that a trained Bales researcher can code interaction in real time, without the need even of a tape recorder. As an approach to doctor–patient interaction, however, the scheme also had significant drawbacks. Its categories are exceedingly general, yielding a picture of the physician–patient encounter that is fuzzy at best. Nor were they adapted to the specificities of doctor–patient communication and the phases of the medical encounter.

Subsequently, coding schemes have undergone progressive refinements over the years to address these problems, becoming adjusted to dyadic interaction and to the specific content of physician–patient interactions (for overviews, see Inui et al. 1982; Wassermann and Inui 1983; Inui and Carter 1985; Roter et al. 1988; Roter and McNeilis 2003). By far the most influential is that developed by Roter and colleagues. The current Roter interaction analysis system (RIAS) contains 39 categories, broadly subdivided into socioemotional (15 categories) and task-focused (24 categories) (Roter 2004). Like the Bales system, RIAS (Roter and Larson 2001, 2002) is designed to implement an exhaustive classification of the events of the medical visit, while using categories that are compatible with the three-function model of the medical visit described by Cohen-Cole and Bird (Cohen-Cole 1991; Cohen-Cole and Bird 1991).

The RIAS framework has opened up the physician–patient relationship to a significant degree, accommodating a wide range of contents and circumstances beyond primary care, including oncology, obstetrics and gynecology, end-of-life discussions, well-baby care, and specific diagnostic categories such as asthma, hypertension, and diabetes (Roter and Larson 2002). Related studies showed that eliciting the patient's view of the illness increased recall, understanding, and commitment to following a physician's advice (see Stewart [1995] and Brown et al. [2003] for overviews of outcomes related to physician–patient interaction). Shown by comparative studies to

be superior to other coding systems (Inui et al. [1982]; see also
Thompson [2001] for a broad overview of systems), it has revealed
important differences in how men and women (both physicians and
patients) interact in the medical visit and how these interaction pat-
terns are related to physician and patient satisfaction (Hall et al.
1994a, 1994b; Roter and Hall 1992). It has formed the basis for a
valuable empirical specification of the main styles of primary care
visits (Roter et al. 1997), and it has been used in nearly a hundred
empirical investigations of a wide variety of medical contexts (Roter
and Larson 2002).

Although the Roter system has served as the backbone for the
study of the physician–patient relationship over the past twenty
years, it is not without controversy. Criticisms of the RIAS system
have focused on the very features that have contributed to its suc-
cess – its capacity to deliver an exhaustive and quantified overview
of the medical encounter. Critics of the RIAS system argue that its
categories fail to address issues of content, context, and meaning in
medical interaction, sacrificing these for an overview across medical
encounters in which the interactivity – the capacity for one party to
influence the behavior of another, or to adjust behavior in response
to another – becomes invisible (Charon et al. 1994; Mishler 1984;
Stiles 1989). Many of these criticisms have been developed from the
microanalysis perspective, to which we now turn.

Microanalysis

At the opposite pole of the analytic continuum lie studies that
focus on the microanalysis of medical discourse. Originating within
anthropology and sociology, these studies deploy an essentially
ethnographic and interpretive methodology to disclose the back-
ground orientations, individual experiences, sensibilities, under-
standings, and objectives that inhabit the medical visit. In sociology,
microanalytic studies have a heritage that includes the "Chicago
School" of ethnography and Hughes' (1963) work on occupations
and professions. Hughes was among those in sociology to note the
professionalization of work and occupations, but because of this
focus, shared by Freidson (Hughes' student) and others, an astute
observation by Fox (1989:38) still holds true: "Sociologists have

written more about health professionals – especially about physicians – than they have about patients."

We would add that, besides patients themselves, the physician–patient *relationship* is also much neglected. In recent years, ethnographers have included discourse analysis as part of their investigation of doctoring, investigating patients' experiences, sensibilities, understandings, and objectives to suggest that patients' subjectivity resides, like an iceberg, mainly below the surface of talk. It is maintained in this submerged condition by a combination of patient diffidence and self-censorship (Strong 1979), and practitioner disattention and obfuscation. Practitioner suppression of patient experience, investigators argue, is due to status and authority as built from educational, socioeconomic, ethnic, gender, and other differences between patients and physicians (Atkinson 1995; Clair and Allman 1993; Davis 1963; Fisher 1984; Todd 1989; Zola 1964, 1973). Ethnographic research in this vein is consistent with the perspective of social constructionism (Brown 1995; Miller and Holstein 1993; Spector and Kitsuse 1977). Where process techniques like those of Roter concentrate on what is present in medical conversations, the microanalytic approach, in highlighting absences in the dialogue, imparts a strongly critical edge to appraisals of medical practice.

Elliot Mishler's (1984) *The Discourse of Medicine* is a most compelling implementation of microanalysis. Mainly focusing on the medical history, Mishler observes that physician and patient often pursue distinct, and sometimes conflicting, agendas in the medical visit: the doctor's medical agenda focuses on biomedical evaluation and treatment, and the patient's "lifeworld" agenda concentrates on personal fears, anxieties, and other everyday lifeworld circumstances. Implementing the medical agenda, physicians recurrently suppress the patient's concerns, even though they can be important resources for understanding medical problems.

In the context of history-taking, the basic mechanism of this suppression is the simple three-part sequence of actions through which history-taking is recurrently transacted:

Doctor:	Symptom question
Patient:	Response
Doctor:	Evaluation or acknowledgment (e.g., "OK") and/or Next question

Mishler observes that this interaction sequence, while ordinary and unremarkable, is in fact a mechanism by which the physician controls three important matters: initiation of particular topics, extent of their development, and the degree to which patients can respond. Although a patient may "leak" lifeworld concerns into the interview by offering "surplus information" in response to medically focused questions, regularly physicians' subsequent questions avoid taking up the moral, social, and existential issues the patient raises in favor of a narrowly focused medical agenda (Mishler 1984:85).

Mishler's observations were expanded in Howard Waitzkin's *The Politics of Medical Encounters*, where he (1991:231–2) argues that the underlying, and largely unrecognized, structure of medical discourse militates against the expression of personal troubles including "difficulties with work, economic insecurity, family life and gender roles, the process of aging, the patterning of substance use and other 'vices,' and resources to deal with emotional stress." Instead, the medical management of patients' contextually generated problems focuses on technical solutions, reinforces ideologically dominant outlooks and prohibitions, and contributes to social control by reinforcing the patient's accommodation to the social contexts from which illness arises. Waitzkin observes that these dysfunctional features of the medical visit emerged in 70 per cent of the 336 cases he examines. Similar findings are reported in microanalytic studies involving women's reproductive choices (Fisher 1986; Todd 1989; see also Fisher and Todd 1993), which also address a variety of other aspects of the medical visit.

Taking stock

It is now time to take stock of these two traditions of interaction research: the Bales-based RIAS coding model and the microanalytic approach. In principle, the strengths and weaknesses of the two approaches are complementary, and combining them should result in a greatly enhanced view of the medical encounter (Roter and Frankel 1992; Waitzkin 1990). In practice, this has not come about (Roter and McNeilis 2003). Process approaches have resulted in findings about the medical encounter that are systematic and replicable. The most robust findings have centered on relationships between

interaction variables and patient and provider characteristics, and to a lesser extent with patient satisfaction and adherence outcomes. Process approaches have not developed associations between inter-action variables and medical decision-making (surely one of the core areas of medical practice), nor in relation to patients' treatment pref-erences or physicians' perceptions of those preferences.

Such deficiencies are probably associated with the kinds of cod-ing categories used in process analysis. In the effort to generalize across practice contexts, coding categories are pitched at a very general level. This is a well-rehearsed criticism of process analy-sis (see Mishler 1984; Inui and Carter 1985; Tuckett et al. 1985; Tuckett and Williams 1984; Pendleton 1983), and it is associated with two related problems. The first is that, in the course of coding, the *content* of the medical encounter is largely washed out. What the physician and patient were talking about is lost, often irretriev-ably, when the original tapes are destroyed and the coded material effectively becomes "the data" (Mishler 1984; Charon et al. 1994). A second problem is that coding expunges the *context* of utterances and actions – their location in a phased activity within the encounter such as history-taking or counseling, and their placement in a specific and autochthonously intelligible sequence and course of action. It is precisely these aspects of context that give utterances and actions the meaning they have.

On the other side of the ledger, microanalytic approaches have retained crucial elements of medical sense-making and interpreta-tion, but issues remain. One of these is how to integrate ethnographic inquiry (interviews and observations) with the study of interaction and language use (Maynard 2003: Chapter 3). Even when that integration is successful, many small-scale quasi-ethnographic stud-ies of discourse have not been able to establish a non-interpretive evidential base for associations between meaningful communica-tive practices on the one hand, and medical outcomes on the other.

Of course, many studies in this tradition, including those in this book, analyze generic practices of talk-in-interaction, and thereby are able to make recommendations about specific practices for enhancing the medical interview. In delivering diagnostic news, for instance, it is demonstrable from interactional evidence that,

and how, physicians can enhance the understanding and acceptance of patients or other recipients. Or in making treatment recommendations, it is also clear that proposing particular therapies in one fashion rather than another can decrease the likelihood of patient resistance. Each of our chapters, on the basis of the conversation-analytic methodology employed, has implications for medical practice, whether it is how to open the interview, take an effective and sensitive history, conduct the physical exam, explain illness and convey diagnostic news, make treatment recommendations and prescribe medicine, deal with lifestyle matters, or close the encounter.

Nonetheless to extract robust outcome-based conclusions about how physicians (or patients) should conduct themselves in specific moments in the flow of the medical encounter, it is important to find a meeting point between the two methodologies of coding and microanalysis (Roter 2000; Roter and Frankel 1992; Roter and McNeilis 2003). In other words, beyond the intrinsic worth of analytical framework responsive to very granular, individual moments in the physician–patient encounter, we need one that simultaneously supports coding at a broader level of granularity sufficient to reach beyond individual cases to generate findings at a statistical evidential standard. For example, qualitative studies of pediatric interactions involving patients who present with upper respiratory tract infections (Stivers 2002b, 2005a, 2005b, this volume; Heritage and Stivers 1999) have resulted in quantitative studies that show how these various conversational actions are associated with the perception of demand for antibiotics and inappropriate prescribing (Stivers et al. 2003) and parent resistance to treatment recommendations. These studies identify communicative resources that physicians can deploy to resist these negative outcomes (Mangione-Smith et al. 2003, 2004). In addition to their generic implications for medical practice, accordingly, the chapters of this book offer a framework for granular *and* quantitative, outcome-oriented analyses. In the remainder of this Introduction, we provide an overview of the theory of interaction and its methodology as they provide for clinical implications of our individual chapters, and as they allow for connections between microanalysis and coding operations for overall assessment of medical communication.

**Conversation analysis as an approach to
medical communication**

In this section, we will first give a brief preview of the orientation
of conversation analysis (henceforth CA) to social interaction in
general. Second, we will sketch several levels of application of CA
to the medical interview, and address the relationship of qualitative
and quantitative analysis. Finally we will give a thematic overview
of the contents of this book.

(1) Conversation analysis: a brief introduction

Conversation analysis emerged as a field in the 1970s from pio-
neering research by Harvey Sacks, Emanuel Schegloff, Gail Jeffer-
son, and others. Initially focused on ordinary conversations between
relatives, friends and acquaintances, and (later) on interactions in
more formal or institutional settings such as medical clinics, the
field coalesced around a set of fundamental theoretical assumptions:
(1) social interaction is an autonomously organized domain – an
"interaction order" (Goffman 1983) – that exists independently of
particular motivational, psychological, or demographic (race, class,
gender, ethnic) characteristics of participants; (2) gestures, utter-
ances, turns of talk, and their subcomponents perform recognizable
actions that are both context-shaped and context-renewing; (3) these
first two properties inhere in the very minutiae of interaction, which
means that no order of detail in conversation is to be dismissed a
priori as disorderly, accidental, or irrelevant to participants' con-
certed endeavors; (4) appreciating the sequential organization of
conversation could mean an important methodological advance in
the analysis of everyday talk that would make that analysis both
"reliable" and "valid" in the terms of normal social science.

(1) The bedrock upon which conversation analysis stands is
sequencing, which was explored in early papers on turn-taking
(Sacks et al. 1974) and the organization of adjacency pairs – turns
of talk like questions and answers that are two utterances long and
have other regular characteristics (Schegloff and Sacks 1973). To
start analysis with a focus on turn-taking and adjacency pairs trans-
lates in the medical context into a concern with everything from

"how are you" questions and their replies, to history-taking questions and answers, to diagnostic announcements and their receipts, to treatment proposals and their acceptance or rejection, to many other kinds of sequences (as the chapters in this volume show). The analysis of turn-taking and adjacency pairs permits the appreciation of how parties to conversation make it possible to coordinate understanding and joint actions at all, whatever the sociodemographic backgrounds or psychological dispositions of these parties may be. This approach is taken, for example, in studies of interruptions by men and women in conversation and medical interviews (Kollock et al. 1985; West and Zimmerman 1983; Zimmerman and West 1975; West 1984).

(2) Spoken utterances (as well as nonvocal gestures and other embodied behavior) accomplish activities. In one of his early lectures, Sacks proposed that the most banal and familiar conversational utterances are social objects that *do* actions and activities without necessarily formulating them as such. He noted that with "This is Mr. Smith," a call recipient at a suicide prevention center can unofficially ask a caller to identify himself and to do so with the same mode of address (Sacks 1992a:3). With "I was trying you all day and the line was busy for, like, hours," a caller can "fish" for information as to her caller's whereabouts by giving her own version of things, which invites the recipient to tell hers (Pomerantz 1980). Conversation analysis represents the attempt to describe and analyze a host of ordinary activities – informing, describing, criticizing, insulting, complaining, giving advice, requesting, apologizing, joking, greeting, and many more. These activities are rarely announced in so many words. Nor does the syntactic structure of an utterance often convey its force as an action. For example, we use question forms to align with a speaker's talk ("Oh, isn't he dreadful?"), we use declarative forms to make requests ("It's cold in here."), and we use imperatives to invite ("Come in."). The production and understanding of an utterance as an action derives from *features of the social context*, most especially an utterance's place in an organized sequence of talk. Sequencing is what conversation analysts regard as an utterance's fundamental context.

Any participant's communicative action is doubly contextual. First, the action is *context-shaped*. Its contribution to an ongoing activity derives in part from the immediately preceding utterance or

set of utterances in which it occurs. Second, conversational actions are *context-renewing*. Every current utterance will itself form the primary framework for some next action in a sequence. In this sense, the context of a next action is inevitably renewed with each current action. To put it differently, the local sequencing of utterances is significant both because *speakers* routinely draw upon it as a resource in designing their current utterances and because, correspondingly, *hearers* draw upon it in order to make adequate sense of what is said. Moreover, sequencing functions to recondition (i.e., maintain, adjust, or alter) any broader or more generally prevailing sense of context which is the object of the participants' orientations and actions. That is, the doubly contextual quality of utterances contributes to the "larger" interactional environment or overall activity (such as the medical interview) within which these utterances make their step-by-step appearance.

(3) Research in conversation analysis has shown that there are no aspects of interaction that are disorderly or insignificant "noise." Another reason why conversation analysts avoid initial considerations of how attributes like race, class, and gender affect conversational interaction is that any initial dealing with these kinds of abstractions eviscerates the detail that is involved in the orderly achievement of mutual understanding. As a sociologist, Sacks turned to conversation as a domain of inquiry because mechanical devices were available for recording interactions and thus preserving the minutiae and particulars of everyday talk. Drawing on Garfinkel's (1967) ethnomethodological sensibility, conversation analysts realized that it was within this detail that the orderliness of action and meaning-making were to be found. Thus a working principle of CA is that "No scale of detail, however fine, is exempt from interactional organization, and hence must be presumed to be orderly" (Zimmerman 1988:415). This implies an interest not just in what participants say but also in silences, in overlapping talk, in sound stretches, breathing, and so on. Hence, conversation analysts transcribe tape recordings to be used in conjunction with the recordings and to show as many of these features as possible in orthographic form.

(4) An important methodological consequence flows from this theoretical perspective. As a feature of a turn of talk in conversation, a current speaker will display an understanding of the talk in

previous turns (Sacks et al. 1974:728). Hence, speakers can look to the next turn after their own to find an analysis of what they have just said. If the displayed understanding in that next turn does not align with the speaker's own, then the *next* turn of the speaker can be devoted to correcting the matter. By and large, *repair* of all kinds of conversational trouble exhibits sequentially systematic properties (Schegloff et al. 1977), which means that conversation has in-built procedures for its maintenance as a mechanism of social action and interaction. This is *local determination*, whereby participants manage the course of conversational interaction on a turn-by-turn basis. And because of the requirement that participants display their understanding on this local, turn-by-turn basis, analysts have a "proof criterion" and a "search procedure" for the analysis of any given turn, to see how recipients construct their understanding of it.

The CA perspective aims to develop claims about systematic structural organization in interaction. However, such claims can only be supported by substantial accumulations of instances of a practice, each instance of which the investigator examines as an individual "case." For example, if it is to be claimed that responses to Yes/No questions should ordinarily begin with the word "Yes" or "No," large numbers of instances need to be collected and examined with each instance examined individually. When departures from this practice occur – by qualifying an answer or, indeed, by avoiding the words "Yes" and "No" altogether – the investigator needs to see if something special or distinctive is happening. For example, a participant may be rejecting the presuppositions embedded in the form of the question (Raymond 2003). Related to examining departures from an interactional regularity is the analysis of "deviant" cases, which allows researchers to move from the observation of the regularity to capture what a practice achieves in terms of the meaning-making process and the assembly of social actions. Along the way, deviant case analysis also contributes to the validation of empirical findings.

These features of conversation analysis theory and method imply a systematic approach to the organization in interaction that distinguishes it from studies that rely on anecdote, educated intuition, or sophisticated prior theorizing to make propositions about how talk operates for the people who produce it. In addition, once structural

organization in talk is explicated, it can function as an "internally validated" basis on which to base quantitative analysis that connects interactional practices to the social, psychological, and motivational characteristics of individuals and to the contexts and outcomes of interactions.

We will not labor these points further. However, there are three important conclusions to be drawn about the application of CA to the medical interview. First, interactional practices through which persons conduct themselves elsewhere are not abandoned at the threshold of the medical clinic. That is, the organization of inter-action described in CA studies is largely carried forward from the everyday world into the doctor's office. Second, and connected with our first point, practices for effecting particular kinds of actions – for example, describing a problem or trouble (Jefferson 1980b, 1988) or telling bad or good news (Maynard 2003) – are also carried across the threshold of the doctor's office and affect how doctors and patients go about addressing particular interactional tasks. Third, the organization of interaction is fundamentally geared to the joint management of self–other relations (Goffman 1955; Brown and Levinson 1987; Heritage and Raymond 2005; Maynard and Zim-merman 1984). Departures from this organization, as in the inter-ruption of one speaker by another, represent violations of this joint management process, though there are practices for dealing with these violations (Schegloff 2000c; Jefferson 2004b). These issues of interaction order, communicative practices in the clinic, and the management of social relations, emerged in early conversation-analytic research on doctor–patient interaction (Frankel 1984a, 1984b, 1990), and will appear repeatedly in the studies making up this volume.

The primary care interview: levels of analysis
In this section of our CA overview, we review three levels through which investigators can conduct the analysis of medical conversa-tions. These include: (1) the overall structure of the primary care visit, (2) the sequence structures through which its particular com-ponent activities and tasks are realized, and (3) the designs of the individual turns at talk that make up those sequences. As will be apparent, these three levels of analysis are interrelated: turn design

```
  I  Opening: Doctor and patient establish an
     interactional relationship.
 II  Presenting Complaint: The patient presents
     the problem/reason for the visit.
III  Examination: The doctor conducts a verbal
     or physical examination or both.
 IV  Diagnosis: The doctor evaluates the patient's
     condition.
  V  Treatment: The doctor (in consultation with
     the patient) details treatment or further
     investigation.
 VI  Closing: The consultation is terminated.
```

Figure 1.1 Overall structure of acute primary care visits

is a feature of sequence organization, sequences are compiled into particular activities which, finally, compose the visit as a whole.

Overall structural organization

Most kinds of interactions have some overall structural features. In ordinary conversation, these structural features include specific located activities such as openings and closings, and slots for "first topics" (Schegloff 1968, 1986; Schegloff and Sacks 1973; Button 1987; Button and Casey 1984, 1985), whose absence may be noticeable and accountable. However, within the "body" of an ordinary conversation, matters are comparatively fluid and free to vary with the inclinations of the participants. In contrast, the medical visit has a more specific internal shape or overall structural organization, in which physicians are trained in medical school and with which patients are ordinarily familiar as a matter of repeated experience. This structural organization is built from component phases or activities which characteristically emerge in a particular order.

Acute care doctor–patient interactions (interactions involving the presentation of a new medical problem) thus have a highly structured overall organization (Byrne and Long 1976; Robinson 1998, 2001b, 2003).

Although this structure is a great deal more complex than the structure of some other kinds of task-focused interactions – for

example, 911 emergency calls (Zimmerman 1992) – and is subject to a great deal more variation, doctors' and patients' conduct can be examined for how they orient and negotiate the boundaries of each of the main activity components (Heritage 1997). For example, the ways in which patients handle history-taking questions may clearly exhibit an analysis of their purpose, and even of the progress of a differential diagnosis. Or again, particular behaviors during problem presentation pointing towards the physical examination, diagnosis, or treatment (Robinson 2003; Robinson and Stivers 2001; Ruusuvuori 2000; Robinson and Heritage 2003) may be used to indicate that, from the patient's point of view, the problem presentation is complete. In these ways, the overall structure of an encounter may be evoked as a resource for moving the encounter forward.

Using this structural framework, it can be relatively easy to identify the relevant sections of the acute primary care encounter (follow-up and routine visits are often less clearly structured). However, the purpose of these classifications is not to identify each section of a medical visit exhaustively. And it is not to claim that each of these sections will always occur in the same order in each and every acute primary care visit. Still less should it be an objective to force the analysis in terms of these sections, not least because, for example, the parties may well break out of and return to particular activities, reopen them and reinstate task orientations that they had previously treated as complete. However, these very possibilities testify to the lively sense that the participants have, and exhibit for one another, of the existence and relevance of specific task-focused activities within the medical visit. Accordingly, investigating the overall structural organization of the medical visit is not aimed at the creation of a Procrustean taxonomy. Rather, it is valuable in providing access to understandings about the nature of the medical visit which are drawn upon by physicians and patients in their joint management of its progress.

Sequence organization
Sequence organization is the "engine room" of interaction. It is through sequence organization that the activities and tasks central to the medical visit are managed. Sequence organization is the primary means through which context-bound utterances achieve

their sense, and interactional identities and roles (storyteller, news deliverer, sympathizer) and larger social and institutional identities (woman, grandparent, Latino, physician, patient, etc.) are established, maintained, and manipulated. This role for sequence organization is true for both ordinary conversation and the medical visit. To illustrate this role for sequence organization, we will focus on sequences in which physicians offer diagnoses and make treatment recommendations.

A substantial body of CA research has shown that physicians and patients treat the management of diagnosis and treatment discussions in sequentially distinctive ways. Diagnoses tend to be offered and accepted "on authority" and ordinarily do not attract significant overt acknowledgment or "acceptance" by patients (Heath 1992; Peräkylä 1998, 2002, this volume; Stivers 2000, 2005a, 2005b, this volume), although when diagnostic news is bad, silence also may be a patient's exhibit of stoicism (Maynard 2003). Moreover, patients may view the diagnosis as a precursor to treatment proposals (Freidson 1970a) and tend to withhold a response in light of that consideration (Robinson 2003). In sequential terms, this manifests itself in little or no patient responsiveness to clinicians' diagnostic statements.

Treatment proposals, by contrast with diagnostic announcements, tend to receive some form of acknowledgment, most often in the form of a fully overt acceptance (cf. Heritage and Sefi 1992). Underlying this sequential variation are profound differences in the social, epistemic, and interactional foundations of the two actions. Diagnoses are produced and recognized as actions performed by an expert who is licensed to perform medicine and render authoritative judgments about the nature of medical conditions. However, in orienting to treatment recommendations as *proposals*, physicians and patients treat these sequences as complete only when some exhibit of *acceptance* is produced. The contrasting properties of diagnostic announcements and treatment proposals offer different affordances to patients who wish to resist diagnoses, by comparison with those who wish to resist treatment recommendations (Stivers this volume). Diagnoses that the patient views as undesirable must be resisted *actively* (e.g., "You don't think it's strep?"). Treatment recommendations, by comparison, can be resisted *passively*: patients, by withholding acceptance to a treatment recommendation, can pressure

clinicians into elaborate justifications of a recommendation and, not infrequently, to alter or reverse it.

Before leaving the topic of sequence organization, it is also relevant to note that physicians often systematically and strategically manipulate sequence structures to achieve rather specific objectives. For example, in a series of papers Maynard (1991c, 1991d, 1992, 1996) has identified practices involved in the perspective-display sequence (PDS) whereby clinicians prepare recipients for the delivery of adverse medical diagnoses. In pre-sequential fashion, patients are invited to describe their own view of the medical problem before clinicians present their own diagnostic conclusions. At one level, use of these practices can seem like a grotesque manipulation of medical authority: what possible value can the lay person's view be in a context where a professional medical judgement is about to be expertly rendered? But Maynard shows that, among other things, the PDS facilitates "forecasting" the news, not only preparing the patient for the difficult information they must receive, but also establishing an auspicious interactional environment in which the professional can build on the patient's perspective through agreement rather than confrontation. The patient's perspective is *co-implicated* in the diagnostic presentation. The PDS does involve a strategic manipulation of the asymmetric relations between doctor and patient, but in a displayed benign way and with consequences which are often beneficial to the patient's understanding and acceptance (Maynard 1996).

Turn design
Sequences are made up of turns and, therefore, require analysis of turn design. This is a massive topic and only glimpses of its ramifications can be presented in a short review. Among the contributions to this volume, Robinson shows that physicians' phrasing of questions that open the business of the medical visit index whether the physician believes that the patient is presenting for a new, follow-up, or chronic concern. Similarly, Boyd and Heritage observe that medical questioning is shaped by the twin principles of "optimization" and "recipient design" (see also Heritage 2002a; Stivers and Heritage 2001). "Optimized" questions embody presuppositions and preferences that favor "best-case" or "no-problem" responses. These question designs are departed from when

mandated by the particulars of the recipient's circumstances. And in his contribution, Peräkylä describes the different ways in which the articulation of diagnoses can manage the balance between authority and accountability that is intrinsic to the practice of contemporary medicine.

Just as clinicians' questions are designed with sensitivities to the medical and interactional exigencies "in play," so too are patients' responses. Heritage and Robinson show that problem presentations are designed with distinctive trajectories that are sensitive to whether the problem is new, recurrent, or routine. Halkowski analyzes the ways in which patients manage descriptions of how they became aware of particular symptoms so as to convey that they are not excessively preoccupied with their bodily functions. Gill and Maynard observe ways in which patients present etiological hypotheses so as not to require an immediate response. Boyd and Heritage describe ways in which answers to questions can be designed with a brevity aimed at collaborating in the production of "checklist" questioning. And Drew describes ways in which patients, who find themselves giving "no problem" responses to questions that pursue a particular diagnostic outcome, engage in what he terms "dramatic detailing" of somewhat related symptoms.

This section began with the suggestion that turn design is a massive and complex subject. But it is clear that its investigation can be enormously fruitful, with strong potential for large-scale analysis of data. For example, in a follow-up to Robinson's contribution, it has been shown that openings which invite the patient to confirm symptoms previously disclosed to other practice staff (e.g., "So fever and headache for three days huh?") strongly curtail patient problem presentations, though this format is associated with presenting concerns, such as upper respiratory infections, which are highly routine (Heritage and Robinson forthcoming). Consider also how patients (as opposed to clinicians) offer explanations for disease. Patients produce them in hesitant and disguised ways, while doctors are more forthright and declarative (Gill 1998a; Gill and Maynard this volume). And Stivers (2002b; Stivers et al. 2003) has shown that a patient's initial problem presentation that offers a candidate diagnosis (e.g., "I think I have an ear infection"), is frequently understood by physicians as indexing a desire for antibiotic treatment, whereas a simple description of symptoms (e.g., "I have a fever

and my ear hurts") is not understood in this way. Also in the realm of diagnosis, Maynard (2003) and Maynard and Frankel (this volume) show that physicians alter the design of announcing turns depending on whether their news is bad or good. When the news is good, the announcement *exposes* the diagnosis and its valence, whereas with bad news the diagnosis and valence are *shrouded* in various ways (see also Stivers 1998; Heritage and Stivers 1999; Leppänen 1998).

More generally, turn design is a vehicle for dealing with dilemmas that the physicians and patients often face on a fairly recurrent basis. Accordingly, turn design is an arena in which participants to the medical interview unavoidably exhibit the trade-offs to be made between getting medical tasks done while paying attention to issues of knowledge and authority (Peräkylä, 1998, this volume), solidarity and distance, understanding and misunderstanding, and many other features.

Conclusion

In constructing this volume, we have attempted to replicate Byrne and Long's (1976) pioneering study by bringing together contributions that address most of the major aspects of the primary care visit from beginning to end. While far from exhaustive, our studies address a variety of dilemmas inhabiting the medical visit as an occasion that is simultaneously social *and* medical. These dilemmas are, then, sociomedical, and they take different forms during different phases of the medical visit. Moreover, they involve a variety of procedural solutions that are sensitive to many particular contingencies in the visit's content.

The chapters making up this volume depart from the Byrne and Long (1976) approach and other studies in one very specific and important way. Where previous research has concentrated primarily on the conduct of doctors, or on patients, the "co-constructive" approach in this book emphasizes the conduct of *both* parties. It is by acting together that doctor and patient assemble each particular visit with its interactional textures, perceived features, and outcomes. Our approach is not just a research imperative. The theme of co-construction derives from a complex interplay of theoretical, methodological, and ethical considerations.

Analyzing co-construction is a direct research embodiment of patient-centeredness, because it includes physicians and patients both within the nexus of communication through which medicine is practiced.

If this book has a single message, however, it is that ordinary norms and practices of language use and social interaction exert a powerful and systematic influence on the texture and features of medical visits, and do so in fine detail. For example, patients may hedge their disclosure of troubles in the medical interview according to generic interactional and cultural practices that favor a stoic, "troubles-resistant," or "stiff-upper-lip" stance. Such practices, and the orientations they reflect (Jefferson 1980b, 1988; Jefferson and Lee 1992), profoundly shape social dynamics in the clinic in ways that practitioners of technical medicine have not been trained to handle.

Medical practice is similarly laminated onto the sociocultural base of interaction and cannot be separated from it (Heritage 1984a; Maynard 1991c, 2004), and this creates many difficulties and paradoxes. Though every medical practitioner should remember that a patient may understand the "occult blood test" to involve magic rather than a search for hidden blood, remedying difficult interactional problems is not simply a matter of being careful with abstruse terminology. Nor does it mean knowing how to confront the sometimes "overeducated" but naive understandings patients bring to the interview – when they claim that an "ear infection" is present, they are not necessarily lobbying for antibiotic medication (Stivers et al. 2003). As important as these terminological matters are, we believe there is something more fundamental to problems and paradoxes in the medical interview. This concerns how interaction works: becoming aware of the inexplicit tactics by which patients approach physicians on various topics, and the taken-for-granted ways by which physicians deploy their specialized knowledge through conversational means whose effects they may not fully comprehend. Without such awareness, doctors and patients may jointly produce the appearance of shared understanding rather than the reality.

Detailed analysis of physician–patient interaction can tease apart perplexing difficulties, lay bare the multiple paradoxes and

dilemmas that inhabit the medical interview, and suggest valuable remedies. If interaction analysis can show the ways in which physicians and patients, distanced in terms of official expertise yet bound in the communicational sphere, manage the practice of primary care, then much can be done not only to improve the scientific understanding of medical practice but also to improve it.

Soliciting patients' presenting concerns

Jeffrey D. Robinson

Although patients may have multiple concerns, their visits with primary care physicians are typically arranged for, and organized around, particular reasons. These reasons are referred to as patients' chief complaints or *presenting concerns*. After visits are opened (Heath 1981; Robinson 1998),[1] physicians typically solicit patients' presenting concerns with questions such as *What can I do for you today?*[2] These questions are an important locus for research because different question designs/formats (i.e., different wordings) can differentially shape and constrain patients' answers (for review, see Boyd and Heritage, this volume). Physicians' solicitations of patients' presenting concerns directly affect the manner in which patients present their problems, and this can have a variety of medical consequences (e.g., for diagnosis and treatment, Fisher, 1991; Larsson et al. 1987; Lipkin, Frankel et al. 1995; McWhinney 1981, 1989; Mishler 1984; Sankar 1986; Todd 1984, 1989). In order to improve health care, both researchers and medical educators have advised physicians to use open-ended questions (Bates et al. 1995; Cohen-Cole 1991; Coupland et al. 1994; Frankel 1995b; Swartz 1998). However, this is a very general dictum, and very little is

---

[1] During openings, before physicians solicit patients' presenting concerns, they commonly greet patients, sit down, identify patients, and read patients' medical records (Heath 1981; Robinson 1998); many other types of actions can also occur (Byrne and Long 1976; Coupland et al. 1994; Robinson 1999).

[2] Patients' presenting concerns can be established in other, less common ways. For instance, physicians can treat patients' concerns as having already been established (in prior interactions with medical staff) by simply beginning to take the history of patients' concerns, with questions such as *How long has this cough been going on?* (Stivers 2000). Alternatively, patients can initiate the presentation of their concerns (Heath 1986; Robinson 1999; Stivers 2000).

known about physicians' solicitations of patients' presenting concerns, per se.

This chapter advances research in two ways. First, it demonstrates that even subtle differences in how physicians design questions can change the action that questions perform (Coupland et al. 1994; Frankel 1995b; see Boyd and Heritage this volume). The distinction between open- and closed-ended questions is not sufficient to capture these differences. For instance, although the question formats *What can I do for you?, How are you?*, and *What's new?* can all be characterized as being open-ended, this chapter demonstrates that they each perform a different social action. Insofar as differently formatted questions perform different actions, they can communicate different things and thus be understood, and responded to, differently by patients.

Second, this chapter demonstrates that physicians and patients orient to the existence of at least three different types of reasons for visiting physicians: to deal with (1) relatively *new* concerns (i.e., ones that are being presented for the first time to a particular physician or clinic, or for the first time since previously being "cured"); (2) *follow-up* concerns (i.e., ones that were raised and dealt with during previous visits and are now being followed up on in terms of patients' recoveries); and (3) *chronic-routine* concerns (i.e., ones that are generally ongoing but under control, such as blood pressure and diabetes, and that are dealt with on a regular basis). This observation is neither new nor unexpected – the National Ambulatory Medical Care Survey (http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm) has long coded patients' reasons for visiting physicians into similar categories.[3] Each of these different reasons make relevant different types of medical goals and activities, and thus different interactional trajectories, for visits (Byrne and Long 1976; Robinson 2003).[4] This chapter demonstrates that the question

---

[3] The 1999 version of the National Ambulatory Medical Care Survey includes codes for five major reasons that patients visit physicians: (1) acute problem (30.3 percent of all visits to primary-care physicians); (2) chronic problem (routine) (34.9 percent of all visits); (3) chronic problem (flare-up) (9.6 percent of all visits); (4) pre- or post-surgery, injury follow-up (11.8 percent of all visits); and (4) non-illness care (11.2 percent of all visits). The remaining 2.2 percent of all visits are coded as blank or unknown.

[4] For example, medical textbooks suggest that there are at least four different types of medical histories that physicians can take: complete, inventory, problem

formats that physicians use to solicit patients' presenting concerns communicate physicians' understandings of patients' reasons for visiting physicians. As such, physicians design, are understood to design, and are held accountable for designing, their solicitations so as to address, or be fitted to, the specific reasons why patients are visiting physicians.[5] As will be argued, this accountability has implications for both the content and shape of ensuing communication, as well as for patients' perceptions of physicians' competence and credibility.

This chapter (1) describes question formats that are designed to index *new, follow-up*, and *chronic-routine* reasons for visiting; (2) describes question formats that do *not* index patients' institutionally relevant concerns; (3) describes cases in which physicians' question formats are inappropriately fitted to patients' reasons for visiting; and (4) discusses the implications of physicians' question formats for medical care.

Data

The data include 182 audio- and videotapes of actual, primary care, physician–patient visits. Seventy-three visits were collected from community-based clinics in Southern California, 23 from hospital-based clinics in Southern California and Texas, and 86 from a community-based clinic in Britain.[6] The data consist of 77 new visits, 15 follow-up visits, and 90 chronic-routine visits. Data were transcribed by the author according to the conventions developed

---

(or focused), and interim (Seidel et al. 1995). Each of these histories is tailored to different types of presenting concerns and their interactional contingencies. For instance, the problem (or focused) history "is taken when the problem is acute, possibly life threatening, requiring immediate attention so that only the need of the moment is given full attention" (Seidel et al. 1995:32).

[5] This is in accordance with the general principle of *recipient design*, which refers to the "multitude of respects in which the talk by a party in a conversation is constructed or designed in ways which display an orientation and sensitivity to the particular other(s) who are the coparticipants" (Sacks et al. 1974:727). Part of this accountability may stem from the fact that patients' reasons for visiting physicians are almost always institutionalized. That is, although patients may have a variety of distinct concerns when they visit physicians, they generally make an appointment for a particular concern, which is typically documented in their medical records, and thus available to physicians, prior to consultations (Heath, 1982b).

[6] I would like to thank Peter Campion, Virginia Elderkin-Thompson, Sarah Fox, John Heritage, Tanya Stivers, and Howard Waitzkin for making their data available.

by Gail Jefferson (Atkinson and Heritage 1984). Names and identifying characteristics of the participants have been changed. Data collection was approved by university human-subjects' protection committees.

Analysis

Question formats designed to solicit new concerns

New-concern question formats, which can be either open- or closed-ended, are designed to communicate physicians' understandings that patients are visiting to deal with *new* (vs. follow-up or chronic-routine) concerns. Some examples of open-ended formats are, *What can I do for you today?, What brings you in to see me?, How can I help you today?, What's going on today?*, and *What's the problem?* These formats are designed to communicate that the concerns being solicited are unknown to physicians. It is in this way that they communicate physicians' *lack* of knowledge of patients' concerns and thus that, for physicians, the concerns are new (see Heath 1981).

For example, see Extract (1). In response to the physician's "So what can I do for you today." (line 18), the patient produces her presenting concern: "W'll- (.) I have (.) som:e shoulder pa:in a:nd (0.2) a:nd (.) (from) the top of my a:rm." (lines 19–21).

Extract 1:   SHOULDER PAIN

```
18   DOC:   So what can I do for you today.
19    PAT:   W'll- (.) I have (.) som:e shoulder pa:in
20            a:nd (0.2) a:nd (.) (from) the top of my
21            a:rm. a:nd (0.2) thuh reason I'm here is
22            because >a couple years ago< I had frozen
23            shoulder in thee other a:rm, an' I had to
24            have surgery. and=( ) this is starting to
25            get stuck, and I want to stop it before it
26            gets stuck.
27            (0.4)
28   DOC:   A[d h e : s  i]ve capsuli[tis.    ]
29    PAT:    [I'm losing]          [Ri:gh]t.
30    PAT:   I'm losi:ng (0.4) range of motion in my
31            a:rm.
32            (2.2)
33   DOC:   We:ll. (.) .hh (ng)- ( ) can't you tell
```

```
34           me: thuh=w:asn't there some trau:ma,
35           er s[omethin'_ you=(w-) s:]:wung at
36    PAT:       [    I've    ha:d    ]
37    DOC:  [some]b[ody [er  [.hhhh
38    PAT:  [No. ]  [I've [had [a history of
39    DOC:  [s::     fe[:ll  ]
40    PAT:                [bursitis [fer-]=
41    DOC:  =er:=uh n-=there's n:o r:ecent >thing
42           thet ya< s:ma:shed it, an[ything] you
43    PAT:                          [(No)  ]
44           can tell me thet .hhh mi:ght've,
45    DOC:  .hh So: it's been bothering you now
46           since whe:n.
47    PAT:  'Bout two weeks.
48    DOC:  Just two wee:[ks:.      ]
49    PAT:              [It's get]ti:ng a little bit
50           stiffer: an' stiffer.
51    DOC:  .tch Whe[:re.  ]
52    PAT:          [I wa]ke up in the morning.
53           Right here:=in thuh shoulder joint.
```

There is evidence that the patient understands that the physician's question at line 18 solicits a new concern. For instance, Terasaki (1976) argued that speakers do not normally tell recipients news that speakers figure that recipients already know. When the patient informs the physician "I have (.) som:e shoulder pa:in a:nd (0.2) a:nd (.) (from) the top of my a:rm." (lines 19–21), she presents her concern as if the physician does not already know about it (i.e., as if it were new for him). Furthermore, the patient describes her concern as if it were new by saying that it is "starting" (line 24) to get stuck and indicating that it has only existed for "'Bout two weeks." (line 47). There is also evidence that this problem is new for the physician. For example, after the patient finishes presenting her concern, the physician proceeds to ask a series of questions about the concern's cause (see lines 33–39 and 41–44), duration (lines 45–46), and location (line 51). All of these questions display the physician's lack of prior knowledge of the concern and thus that, for him, it is new.

Two examples of closed-ended, new-concern question formats are *You have a problem with your index finger?* and *Your ears are popping, huh?* Physicians frequently produce these questions while reading patients' medical records and thus communicate that

they are addressing a concern that was documented by a nurse prior to the visit. Although closed-ended formats communicate that physicians have some idea about the nature of patients' concerns, they nonetheless communicate that such concerns are new to physicians.

For example, in Extract (2), while the physician reads the records, he solicits the patient's presenting concern: "Your ear's ('re) poppin'. huh," (line 14).

Extract 2:   EAR PROBLEM

```
14    DOC:    Your ear's ('re) [pop]pin'. huh,
15     PAT:                [ (I) ]
16             (0.7)
17     PAT:    Yeah it's like- (.) (either)/(maybe) there's
18             f:luid er wax build up.
19             (0.2)
20     PAT:    °But° (.) tuhday's not as ba:d.
21             (1.5)
22     PAT:    Actually it started like- (.) week- two weeks
23             ago:=uh week,=h
               ((19 lines deleted))
43    DOC:    Any drainage at a:ll,
44             (0.3)
45     PAT:    Only with cue tips.
46             (0.2)
47    DOC:    What color is that stuff.
48             (1.7)
49     PAT:    .hhh Dark o:range,
```

There is evidence that the patient's concern is new for the physician. First, the physician's question (line 14), which is produced while reading the patient's medical records, is designed as what Labov and Fanshel (1977) termed a *b-event* statement. *B-event* statements are statements by one speaker (e.g., the physician) that include events (e.g., medical concerns) that another speaker (e.g., the patient) has primary authority over, including access, knowledge, and so on. Stated negatively, *b-event* statements communicate that their speakers (e.g., the physician) do not have primary authority (including knowledge) concerning the event. Physicians' *b-event* solicitations typically seek confirmation or disconfirmation by patients and thus communicate that, for physicians, the concern

Table 2.1 *The relationship between new-concern visits and different question formats*

	New-concern question format	Follow-up-concern question format	"Other"-concern question format	Total
New-concern Visits	68 (88.3%)	0 (0%)	9 (11.7%)	77 (100%)

is new.[7] Second, by proceeding to ask a series of questions about the problem (lines 43 and 47), the physician displays his lack of knowledge about the concern and thus that, for him, the concern is new. There is also evidence that the patient understands that the physician's question solicits a new concern. Similar to the patient in Extract (1), by informing the physician of when the concern started, "Actually it started like- (.) week- tw<u>o</u> weeks ago:=uh week,=h" (lines 22–23), the patient displays an orientation to both the recency of the problem and to the physician not already knowing about the problem (Terasaki 1976).

Quantitative results for new-concern question formats
The data contain 77 cases where patients are visiting physicians with new concerns. Table 1 displays the relationship between visits in which patients had new concerns (i.e., new-concern visits) and the types of question formats that physicians used to solicit those concerns (i.e., new, follow-up, or other).

In 68 out of 77 visits (88.3 percent) in which patients had new concerns, physicians used new-concern question formats. In no cases did physicians use follow-up formats (which are discussed below). In nine cases (11.7 percent), physicians used some other question format. Table 2.1 shows that, in visits where patients had new presenting concerns, physicians were much more likely to use new-concern question formats than they were to use follow-up formats or other formats. This supports the previous, qualitatively supported claim that new-concern formats communicate physicians' understandings that patients have new concerns.

---

[7] This is supported by the fact that the physician uses the *tag question* "huh," (line 14) to pursue confirmation/disconfirmation (for tag questions, see Sacks et al. 1974) and that the patient produces a confirmation: "Yeah" (line 17).

Question formats designed to solicit follow-up concerns

Follow-up-concern question formats tend to share three features. First, they display physicians' knowledge of a particular concern. Second, they frequently perform the action of soliciting an evaluation or assessment of, or an update on, a particular concern. Third, in doing so, they embody physicians' claims to have had prior experience with the concern in question. (Thus, the concern is specifically *not* new to physicians.) As their name implies, follow-up formats are designed to communicate physicians' understandings that patients have follow-up (vs. new or routine) concerns. For example, Extract (3) is drawn from a follow-up visit for a sore arm.

Extract 3:   SORE ARM

```
6    DOC:   How is it?
7           (0.5)
8    PAT:   Its fi:ne=its: (0.8) >still a bit< so:re.
9           but s: alright now.
```

The physician's question, "How is it?" (line 6), solicits an update or evaluation of a particular concern, which is referenced by "it". By using the reference form "it" – rather than others, such as "the arm" – the physician displays an assumption that his knowledge of the concern is shared by the patient (Schegloff 1996c).[8] In his response, the patient uses the word "still" (line 8) to describe his arm as continuing to be "a bit so:re" relative to a prior point in time. Additionally, he uses the word "now" (line 9) to contrast the current condition of his arm with that during a prior point in time. The prior point in time is the patient's prior visit with the physician. Here, the patient's relative evaluations display his orientation to the concern as being *old* (i.e., non-new) and his presumption that the physician already knows about the concern.

How are you feeling?
It is not too difficult to see that question formats such as "How is it?" solicit follow-up concerns. However, there are other, less obvious formats. In particular, this subsection focuses on the format *How are*

---

[8] According to Schegloff (1996c), the patient's "it" is a *locally subsequent reference form* located in a *locally initial reference position*.