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An Interactional Structure of Medical Activities During Acute Visits and Its Implications for Patients’ Participation

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Within the context of primary-care, physician–patient visits, researchers have documented both patients’ low levels of communicative participation (e.g., question asking) and the advantages of such participation to healthcare (e.g., improved physical health and satisfaction). Prior research has offered a variety of partial, non-exclusive explanations for patients’ low levels of participation. This article investigates one underdeveloped source of explanation: the organization of interaction itself. This article argues that the establishment of new medical problems in acute visits makes relevant an organized structure of social action that is composed of an ordered series of medical activities: establishing the reason for the visit, physicians gathering additional information (i.e., history taking and physical examination), physicians delivering diagnoses, and physicians providing treatment recommendations. This “project” of medical activity shapes physicians’ and patients’ understanding and production of communicative behavior. Using the method of conversation analysis, and analyzing transcribed audio- and videotape data of actual acute visits, this article describes and grounds this project and discusses its implications for research, theory, and improvement on patient participation.

One of the most longstanding, important, and complex issues currently being addressed by scholars of physician–patient communication is patients’ levels of communicative involvement, or participation, during medical visits (e.g., from Szasz & Hollender, 1956, to McGee & Cegala, 1998). A consistent finding is that patients are relatively communicatively passive: Physicians primarily initiate actions and

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solicit responses, whereas patients primarily respond to physicians’ initiatives; stated negatively, patients rarely ask for information, explanations, or clarification, or volunteer information, opinions, preferences, or concerns (Frankel, 1990; Greenfield, Kaplan, & Ware, 1985; Linell, Gustavsson, & Juvonen, 1988; McGee & Cegala, 1998; Mishler, 1984; Peräkylä, 1995; Roter, 1977; Todd, 1983/1993; West, 1984). This is consequential because the more questions that patients ask, and the more concerns, worries, and emotions that they express, the more medical information that physicians provide (for review, see Anderson, DeVellis, & DeVellis, 1987; Street, 1991). Furthermore, both patient question-asking and physician information-giving are positively associated with patients’ satisfaction and, perhaps more importantly, physical health (Anderson, DeVellis, & DeVellis, 1987; Greenfield, Kaplan, & Ware, 1985). Such findings have prompted scholars to work to solve the explanatory puzzle of patients’ low levels of participation. Although many pieces of this puzzle have been articulated, at least one remains relatively unexplored: the organization of interaction itself. This article describes and defends an interactional structure of social action that provides a partial explanatory framework for patients’ low levels of participation. First, it briefly reviews the literature on patient participation. Second, it describes and defends a large-scale structure of interaction. Finally, it discusses the implications of this structure for theory, research, and improvement on patient participation.

PATIENT PARTICIPATION AND ITS EXPLANATIONS

There are a variety of types of nonmutual explanations for patients’ low levels of participation. One type concerns patients’ roles. For instance, patients can, and sometimes prefer to, adopt a passive-dependent “patient” role (Friedson, 1970a, 1970b; Parsons, 1975), which can involve the avoidance of decision-making responsibility (Beisecker & Beisecker, 1990; Bennett, Smith, & Irwin, 1999; Strull & Lo, 1984) and the perception that initiatory actions (e.g., questions) threaten physicians’ status (Friedson, 1970b). A second type of explanation concerns patients’ psychology. For example, patients’ information-seeking behavior can be affected by their fear, self-efficacy, and uncertainty associated with information outcomes (Babrow, Hines, & Kasch, 2000; Berger & Kellerman, 1994; Miller, Brody, & Summerton, 1988). A third type concerns patients’ resources for participation. For instance, patients can lack an understanding of the technical/specialized nature of medical knowledge and procedures, and thus lack the knowledge and language with which to inform and pursue their interests (Korsch, Gozzi, & Francis, 1968; Mathews, 1983). A fourth type concerns physicians’ communication. For example, patient question asking is positively associated with physician information giving, which is itself shaped by a variety of variables (Street, 1991). A fifth type concerns patients’ sociodemographic characteristics. For instance, more highly
educated patients tend to ask more questions (Street, 1991). A sixth type concerns visit-level variables. For example, different types of patients’ medical business (e.g., acute vs. routine) can make relevant different styles of physician–patient relationships, such as “guidance–cooperation” versus “mutual participation” (Szasz & Hollender, 1956), as well as different medical activities to be performed, such as the presence or absence of history taking (Byrne & Long, 1976). Patients seek more information the earlier some diseases (e.g., cancer) are diagnosed (Cassileth, Zupkis, Sutton-Smith, & March, 1980), and first diagnoses are more common in acute visits. Finally, patient participation can be affected by length of visit, the presence of companions, and whether or not the visit is a first visit (for review, see Beisecker & Beisecker, 1990).

Comparatively, scholars have offered few interaction-based explanations (for review and critique, see Robinson, 2001a). One commonality between a majority of the behaviors that scholars have identified as participative is that they are produced within face-to-face interaction. As Goffman (1964, 1983) conjectured, and as the subdiscipline of conversation analysis has amply demonstrated (Atkinson & Heritage, 1984; Drew & Heritage, 1992; Sacks, Schegloff, & Jefferson, 1974), the norms and rules of face-to-face interaction have their own, independent effects on communication. In both mundane and institutional interaction, both the production and understanding of most communicative actions (e.g., offers, requests, informings) are shaped by a variety of structures of sequence organization, such as the adjacency-pair sequence (Schegloff & Sacks, 1973). The constraint of adjacency-pair sequence organization on service-institutional talk has been demonstrated in Zimmerman’s (1984, 1992) analyses of requests for help in calls to 911, and Frankel’s (1984) and West’s (1984) analyses of how physicians and patients repair misunderstandings. Robinson (2001a) specifically demonstrated how a patient’s request for prescription medication, and its sequentially organized character, shapes and constrains his participation throughout the lengthy course of the request.

Individual courses of action can themselves be organized by larger, but equally orderly, interactional activities (re: action vs. activity, see Heritage & Sorjonen, 1994). This is true in both mundane interaction, such as with storytelling (for review, see Jefferson, 1978), troubles telling (Jefferson, 1980, 1988), and physician–patient interaction. For example, Roberts (1999) and Ten Have (1991) found that patient participation varies according to different phases, or activities, of visits (e.g., opening vs. history taking). Robinson (1998) described the normative organization of opening visits and argued that patients’ low level of initiative is a by-product of constraints associated with the accomplishment of the activity.

The purpose of this article is to describe and defend a large-scale structure of social action that organizes physician–patient interaction during acute visits. This article does three things. First, it describes the proposed structure. Second, it supports the existence of the structure with audio- and videotape data of actual acute
visits. Third, it discusses the implications of the structure for theory, research, and improvement on patient participation.

**A DESCRIPTION OF A LARGE-SCALE STRUCTURE (OR PROJECT) OF INTERACTION**

This article argues that, when patients’ new medical problems are established as first topics of visits, physicians and patients mutually enter into an interactional project that has the following structure of medical activities (see Figure 1).

Before describing this project, it is necessary to define the parameters of its application. First, the project currently only applies to situations where patients’ reasons for visiting physicians are to deal with medical “problems,” which I mean to differentiate from the more general category of medical “concerns.” Medical concerns can include requests for vaccinations, paperwork, repeat prescriptions, and family planning advice (Byrne & Long, 1976). These contrast with medical problems or symptoms, such as a rash, shoulder pain, ear pain, and so on. Second, the project currently only applies when these problems are “new”—that is, when the problems are being presented for the first time to a particular physician or clinic, or for the first time since previously being “cured.” The project does not currently apply in situations where patients are dealing with different types of medical business, such as following up on old problems (e.g., following up on a sinus infection that was previously treated with antibiotics) or dealing with routine problems (e.g., monitoring high blood pressure on a monthly basis). Third, the project currently only applies to situations where new problems are being dealt with as “first topics

![FIGURE 1](image-url) Structural schema for the project of solving patients’ new medical problems.
of visits”—that is, where physicians and patients orient to the problem as the (chief) reason for the visit (Heath, 1981; Schegloff & Sacks, 1973). Finally, I refer to this as a *project* in order to differentiate it from an *activity*. Heritage and Sorjonen (1994) defined *activity* as “the work that is achieved across a sequence or series of sequences as a unit or course of action—meaning by this a relatively sustained topically coherent and/or goal-coherent course of action” (p. 4). Although more research is necessary, it appears that establishing the reason for visits, history taking, physical examination, diagnosis, and treatment can be separate and coherent activities, each with their own interactional structure. The project, itself a coherent package of social action, contains multiple activities.

As modeled in Figure 1, it is argued that the establishment of a problem makes relevant a project that works toward, and is optimally completed by, the treatment of the problem (see arrow 1). However, physicians cannot effectively treat problems that they have not yet diagnosed, and thus the activity of treatment is contingent upon that of diagnosis (see arrow 2). Similarly, arriving at a medically sound diagnosis is contingent upon physicians obtaining additional information about patients’ problems, be it through history taking, physical examination, or a combination thereof. Thus, working toward the activity of diagnosis involves completing the intervening, prerequisite activities of gathering additional information (see arrow 3). Upon the establishment of a problem, physicians and patients are accountable for progressing through these activities to the project’s completion. Note that the activities of diagnosis and treatment may not always be realized. For example, in the course of gathering additional information, it may turn out that patients do not actually have a problem to treat, that patients’ problems are not treatable, or that physicians are not able to diagnose (and thus treat) patients’ problems. However, because treatment, and thus diagnosis, are objectives, they are oriented to by physicians and patients as being relevant, and their nonoccurrence is oriented to as being accountable as a deviation from a “normal” structure of activities. Although similar phase models of medical interaction have been proposed by Byrne and

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1As Freidson (1970a) observed, “the work of the doctor is first of all concretely directed to the solution of a practical problem” (p. 13); the patient’s request is “Doctor, do something,” not, “Doctor, tell me if this is true or not” (p. 22). In this article, *treatment* refers either to technical treatment or to physicians’ recommendations of treatment-oriented future action(s), such as referrals to specialists or the acquisition of further diagnostic tests (e.g., x-rays, blood/urine tests, etc.).

2To diagnose a problem is to be able to name a cause of a patient’s signs and symptoms in a way that distinguishes the patient’s illness from others with similar manifestations (Greenberger & Hinthorn, 1993). When this article refers to a *diagnosis*, it refers to the “official diagnosis,” versus a variety of forms of prediagnostic commentary (Heritage & Stivers, 1999; Stivers, 1998). When this article refers to the *delivery* of a diagnosis, it refers to instances where physicians name or characterize the patient’s disease by using a medical category or by locating the problem in a specific site in the patient’s body. These assertions can be either positive (the physician asserts the existence of a disease) or negative (the physician asserts the nonexistence of a named disease). (Peräkylä, 1998, p. 304)
Long (1976) and Waitzkin (1991), and although authors of textbooks on medical interviewing have argued that the activities of establishing a problem, gathering additional information, diagnosis, and treatment are both conceptually and interactionally related (Billings & Stoeckle, 1989; Cohen-Cole, 1991; Seidel, Ball, Dains, Joyce, & Benedict, 1995; Swartz, 1998; Waitzkin, 1991; Zoppi, 1997), it is crucial to note that no one has yet demonstrated the internal validity of the proposed project or its consequences for physicians’ and patients’ communication behavior.

### DATA AND METHOD

The data are drawn from a corpus of 69 audio- and videotaped adult, primary-care, acute visits conducted in Southern California between 1995–1998. Forty-eight visits were collected from seven community-based practices and 21 visits were collected from one university hospital-based practice. Participants included an availability sample of 9 physicians (internal and family medicine) and an opportunity sample of their patients ($M = 7$ patients per physician). All data collection was approved by a university human–subjects’ protection committee. Participants provided informed consent to be recorded prior to the study, were aware of being re-

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3 Byrne and Long (1976) proposed the following phase model for entire physician-patient visits: (a) relating to patients (i.e., opening visits); (b) discovering patients’ reasons for attendance (i.e., either physicians or patients establishing the reason for the visit); (c) conducting verbal (i.e., history taking) and/or physical examinations; (d) considering patients’ conditions (i.e., diagnosis); (e) detailing treatment or further investigation; and (f) terminating (i.e., closing visits; Byrne & Long, 1976; see also Waitzkin, 1991). Waitzkin’s (1991) model represents the traditional organization of medical discourse constructed and advocated by the profession of medicine: (a) eliciting patients’ chief complaints, (b) patients’ elaborating on their chief complaints, (c) taking patients’ medical histories, (d) physical examination, (e) other investigations, (f) diagnosis, and (g) treatment plan. Importantly, both of these phase models are Weberian (1949) ideal types—that is, they are intentionally theoretical or logical conceptions of organizations that, although constructed out of elements of reality, rarely occur in reality. For example, Byrne and Long noted,

One of our greatest problems was to pin down a sequence which could be seen to occur frequently. The real difficulty was not defining the events but sequencing them in a logical form. The logical form finally agreed rarely appears in practice and should be seen as an ideal. (Byrne & Long, 1976, p. 21, emphasis added)

And Waitzkin (1991) noted,

While the [chief complaint and present illness] are almost always present in medical visits ... other components may appear or not, depending on time, the doctor’s desire to complete a comprehensive evaluation, such financial issues as the patient’s insurance and how extensive an evaluation it permits, and other situational constraints. A doctor may choose to defer some or all of the remaining components to future visits, or may not cover them at all. (p. 29, emphasis added)

4 A portion of this data come from corpora collected by Virginia Elderkin-Thompson and Tanya Stivers, to whom I am grateful for sharing their data.
corded, and gave permission to publish the recordings. All data were transcribed according to the conventions developed by Jefferson (1984; see Appendix). The method used is conversation analysis (CA; for review, see Atkinson & Heritage, 1984), particularly as it is applied to the study of institutional interaction (for review, see Drew & Heritage, 1992). CA uses audio- and videotapes of naturally occurring conduct to inductively describe the norms and rules of interaction; this includes a description of the procedures by which people produce their own behavior and understand and deal with the behavior of others. For example, researchers have examined how people build and coordinate turns of talk (Sacks et al., 1974), repair problems of speaking, hearing, and understanding (Schegloff, Jefferson, & Sacks, 1977), and build actions (e.g., offers, requests, assessments) and activities (e.g., opening and closing interactions; Schegloff, 1968, 1995, 1996a).

**ANALYTIC SUPPORT FOR THE PROJECT**

The first type of evidence in support of the project is that its activities actually and routinely occur in order in visits in which patients present new medical problems as first topics of visits (space precludes a full-transcript example, which can be found in Robinson, 1999). However, the mere fact that a number of phases of behavior actually and routinely occur in order is not sufficient evidence to support the existence of a large-scale structure of interaction. In a variety of ways, it must additionally be demonstrated that the project’s activities are: (a) normatively ordered (re: norms, see Heritage, 1984b); (b) part of a larger-order, coherent “package” of social action; and (c) oriented to by persons in interaction and used to understand and construct social action (Bavelas, 1991; Heritage, 1997; Jefferson & Lee, 1980; Sacks, 1992b; Schegloff, 1992b). Thus, at least two other types of evidence are required. First, it must be demonstrated that participants orient to current activities as relevantly progressing toward, and being in the service of, particular next activities. Second, it must be demonstrated that each activity is produced with reference to the project as a whole. What follows are both of these types of evidence; each activity is examined in order.

**Activity 1: Establishing a New Medical Problem as the Reason for the Visit**

The openings of visits are organized around the goal of establishing patients’ reasons for those visits (Heath, 1981; Robinson, 1998, 1999). Although these reasons can be “established” in a number of ways, the most common way—which is espoused by modern textbooks on medical interviewing (Bates, Bickley, & Hoekelman, 1995; Cohen-Cole, 1991; Swartz, 1998) and endorsed by research (Coupland, Robinson, & Coupland, 1994; Frankel, 1995)—is for physicians to so-
licit patients’ problems with open-ended questions, such as “What can I do for you today?”

Physicians’ open-ended solicitations display their orientations to forthcoming interactions as being service encounters in which: (a) the parties’ roles are service seeker (i.e., patient) and service supplier (i.e., physician); (b) the business is solving a problem or dispatching a task; and (c) the focal object is the problem and its properties (Jefferson & Lee, 1981; Robinson, 2001a; Zimmerman, 1984, 1992, 1998). Physicians’ open-ended solicitations are members of a more general class of actions that can be referred to as offers to serve, which are not specifically institutional actions (Robinson, 2001a). Offers to serve constitute first parts of adjacency-pair sequences (Schegloff & Sacks, 1973) that solicit services or problems to be rendered or remedied by the offerer without overtly specifying particular services or problems. Offers to serve solicit either an acceptance, which includes the production of a service or problem, or a declination, which possibly closes the offer sequence. When patients present their problems, they do so in the service of having them remedied, and this remedy is implicated by their production.

If this argument is correct, then in order to secure physicians’ remedies, it should be sufficient for patients to simply present problems—that is, patients should not have to make requests or otherwise articulate why they are presenting problems. In support of this, Stivers (2002) found that, in pediatric contexts, one of the most frequent, nonaccountable, problem-presentation formats is the presentation of “just the symptoms.” This is also a common format in non-pediatric contexts. For example, see Extract 1.

Extract 1: COUGH

24 a→ DOC: So how I can help you.
25 [ PAT: h Well I’ve ha:d uh:m (0.8) a cou:gh,
26 (.)
27 DOC: Mm hm,
28 PAT: for=uh- quite a while an’ it really (.) just
29 got ha:d maybe last (week,) it’s just- h I
30 had a cold about two months ago,
31 DOC: Mm hm,
32 PAT: ‘h An’ I had a cough with thuh col:d and it
33 b→ seemed to be getting better but it never ha:d
34 (.) rin- gone away entirely?
35 PAT: ‘h Then about a week ago it jus:’ (0.4)
36 came back real[ly y ] (.) strong an’ it’s uh:m
37 DOC: [Mm hm,]
38 PAT: (0.5) tsk hh uh:=h I don’t feel- (.) any other
39 symptoms really other than hh st- getting

5Stivers (2000) found that, in pediatric contexts, physicians use open-ended solicitations 49% of the time.
headaches from coughing so much, DOC: Okay, PAT: =hh
c→ DOC: =hh Uh:m (0.2) didju take anything for that cough?

In response to the physician’s offer to serve (a→), the patient simply presents a series of symptoms (b→). Note that the patient explicitly orients to her course of action as presenting symptoms: “I don’t feel- (.) any other symptoms really other than =hh st- getting headaches from coughing so much” (lines 38–40). Here, the patient’s symptoms constitute the entirety of her problem presentation. After the patient finishes presenting her symptoms, the physician immediately progresses to the activity of gathering additional information by beginning to take the history of the problem (c→). In doing so, the physician displays an orientation to: (a) the fact that “just the symptoms” can constitute a complete problem presentation; (b) the fact that the presentation of symptoms implicates a progression through the project; and (c) the next relevant activity being that of gathering additional information, specifically history taking.

There is also evidence that patients understand that the activity of establishing (presenting) their problem initially makes relevant some form of medical evaluation (e.g., history taking and/or physical examination). For example, see Extract 2, which is borrowed from Beckman and Frankel (1984).

**Extract 2: HEART PROBLEM**

01 DOC: How you been doing?
02 PAT: Oh, well, I been doing okay, except for Saturday.
03 well Sunday night. You know I been kinda nervous off
04 and on but I had a little incident at my house
05 Saturday and it kinda shook me up a little bit.
06 DOC: Okay.
07 PAT: And my ulcer, its been burning me off and on like
08 when I eat something if it don’t agree, then I’ll
09 find out about it.
10 DOC: Right, okay.
11 PAT: But lately I’ve been getting this funny, like I’ll
12 lay down on my back, and my heart’ll go “brrrr” you
13 know like that. Like it’s skipping a beat or
14 something, and then it’ll just start on back off
15 beating like when I get upset it’ll just start
16 beating boom-bom-bom and it’ll just go back to its
17 normal beat.
18 DOC: Okay.
19 → PAT: Is that normal?
20 DOC: That’s, that’s a lot of things. Anything else that’s
21 bothering you.
22 PAT: No.
After the patient presents his problem and symptoms, and after the physician receives the problem presentation with, “Okay” (line 18), the patient asks, “Is that normal?” (line 19). Note that the patient does not ask for a diagnosis (e.g., “What is that?”) or a treatment (e.g., “What can I do about that?”). Rather, the patient solicits a medical evaluation (of his problem’s normality). The patient’s query holds the physician accountable for progressing from the activity of establishing the problem to one involved with evaluating the problem, which very likely involves history taking and physical examination.

When presenting their problems, patients also display an orientation to the project as a whole. The optimal objective of the project is treatment. However, treatment is contingent upon diagnosis. When patients present their problems, there is evidence that they do so in the service of the activity of diagnosis. For example, patients sometimes offer candidate causes of their symptoms or problems. For instance, see Extract 3.

**Extract 3: EYE TROUBLE**

11 DOC: What seems to be thuh problem?
12 PAT: hh I’ve been having a problem: (0.2) mostly with
13   this eye but I’m- with both.
14 DOC: Okay.
15   → PAT: tch I don’t know if it’s=uh:- when do I- when I
16   → was=uh: cutting lumber an’ hh a:nd=uh: thuh
17   → sawdust hit my (eyes),

With “I don’t know” the patient offers a candidate cause of the problem in a speculative fashion—that is, in a way that displays uncertainty about the cause. Gill (1998) termed these sorts of candidate causes “speculative explanations.” Along these lines, ten Have (1991) observed that patients very frequently formulate their “ignorance” or “doubts” in various medical matters. These utterances do not have a question form and do not create a “conditional relevance” for an answer in the next slot. But they do display what the patient would like to know, or on which issues he or she would like to have an expert’s opinion. (p. 146)

Sacks (1992b) talked about this phenomenon in terms of “musing out loud”:

things … are used by participants to a conversation in order to elicit interest, etc., by doing what would be heard as “musing out loud,” e.g., “I wonder what he meant by that,” thereby getting a question from someone who makes themselves an overhearer of it, taking it that they may not have been addressed. (p. 405)

In sum, as part of establishing their problem, when patients produce speculative, candidate causes they display that they are presenting their problems in search of, and in the service of acquiring, physicians’ diagnoses.
Additional evidence for this is when patients claim a lack of knowledge during the presentation of their problems, physicians appear to orient to it as a lack of diagnostic knowledge. For example, see Extract 4.

**Extract 4: SKIN’S FREAKIN’ OUT**

09  DOC: Uhm,=h Can you tell me what brings you in today?
10  PAT: Yeah my skin’s freakin’ out.
11  (0.2)
12  PAT: li:ke (this he-) thee. This is here’s from a burn.
13  from a- a radiator ho:se,
14  (.)
15  PAT: an’ this happened a couple days ago. but what I’m
cconcerned about th;ese gu:ys, (0.5) -h (u=they-)
16  startin’ to pop outa my toe:s,
17  (.)
18  PAT: An=uh on=uh back uh my n:cek an’ on my no:se
19  a→ (ove’ here,) an ah- I don’t know: what- what [(thuh heck)
20  b→ DOC: [What they are.
21  PAT: to dq ab[out ’em.
22  DOC: [Right.

After presenting his problem, the patient begins to claim a lack of knowledge, ”I don’t know: what- what” (a→). In overlap, the physician completes the patient’s turn with: “What they are” (b→). Here, the physician displays his understanding that the patient is presenting his problem in search of a diagnosis.

Another type of evidence for the claim that patients present their problems in the service of diagnosis is that physicians sometimes work to display that their diagnoses are responsive to patients’ problem presentations. This typically occurs when physicians’ diagnoses disconfirm patients’ earlier diagnostic implications (Stivers, 2002). For example, see Extract 5, which juxtaposes the patient’s problem presentation (lines 19–29) with the physicians’ diagnosis (lines 168–174).

**Extract 5: SHOULDER PAIN**

18  DOC: So what can I do for you today.
19  PAT: W’il- (.) I have (.) som:e shoulder pa:in
20  a:nd (0.2) a:nd (.) (from) the top of my a:rm.
21  a:nd (0.2) thuh reason I’m here is because >a couple
22  years ago< I had frozen shoulder in thee other a:rm,
23  an’ I had to have surgery. and=( ) this is starting
24  to get stuck, and I want to stop it before it gets
25  stuck.
26  {(0.4)/hhhh}
27  a→ DOC: [d h e:s i]ve capsuli[tis. ]
28  PAT: [I’m losing] [Ri:gh]t.
29  PAT: I’m losi:ng (0.4) range of motion in my a:rm.
     ((Doctor performs history taking and physical examination))
When the patient presents her problem, she offers a candidate diagnosis of her current shoulder problem by informing the physician of a previous diagnosis of her other shoulder: “frozen shoulder” (line 22). As the physician reads the patient’s medical records, he requests confirmation of the technical diagnosis of the previous problem: “Adhesive capsulitis” (a→). The patient confirms this with “Right” (line 28). The term “adhesive capsulitis” is not used again until the physician delivers the diagnosis (b→). By (re)using this term, the physician works to design his diagnosis as being responsive to the patient’s problem presentation, which implicated “adhesive capsulitis” as a diagnosis (re: word repeats, see Schegloff, 1996a). In doing so, the physician orients to the patient’s problem presentation as having implicated a diagnostic evaluation of the problem.

In sum, both physicians and patients appear to orient to the activity of establishing a problem as ultimately being performed in the service of at least the activity of diagnosis. Thus, both physicians and patients orient to the activity of establishing a problem as implicating a larger project of activities. Stivers (2002) argued that, when patients implicate diagnoses during problem presentation, they orient to their problem as being treatable and, thus, to presenting their problem in the service of treatment. Indeed, there is evidence that patients do, in fact, orient to the activity of establishing a problem as being performed in the service of treatment. For example, referring back to Extract 4, the patient finishes presenting his problem with a search for treatment options: “I don’t know: what what (thuh heck) to do about ’em.” (lines 20–22). Or again, referring back to Extract 5, in addition to offering a candidate diagnosis of her problem, “frozen shoulder” (line 22), the patient notes that “thuh reason” (line 21) for her visit is to treat her shoulder: “I want to stop it before it gets stuck” (lines 24–25). For another example, see Extract 6.

**Extract 6: ALLERGIES**

26 DOC: ‘Kah-ee-y, how I can help you today. Noel,
27 PAT: Well, thuh: reason I’m here is because
28 o(f) my allergy problems,
((patient presents problem; 12 lines omitted))
41 → PAT: So I decided to: come in an’ see you an’ see if
42 → you can gimme ·hh anything uh:rn ya know for thuh.
43 DOC: Goood.
The patient completes his presentation at lines 41–42, where he explicitly orients to the purpose of his visit as seeking treatment: “So I decided to: come in an’ see you an’ see if you can gimme ·hh anything uh:m ya know for that.”

Activity 2: Gathering Additional Information (History Taking and Physical Examination)

Physicians are trained to gather additional information about patients’ problems through history taking and physical examination, in that order (Seidel, Ball, Dains, Joyce, & Benedict, 1995; Swartz, 1998). In practice, physicians can omit one or both activities (e.g., if patients’ presentations of their problems are sufficiently informative, if patients’ problems are self-evident, etc.) or they can reorder or intertwine these activities (Waitzkin, 1991). As such, I have included both in a single activity of “gathering additional information.” There is evidence that both physicians and patients orient to this activity as being in the service of that of diagnosis. One place where patients’ orientations can be found is in the transition from history taking to physical examination. For example, see Extract 7. The transition begins at line 66.

Extract 7: SHOULDER PAIN

58 DOC: ·h It uh it’s difficult to putchur: (.) bra: (.)
59 back on there, [you c’n get your arm] back there?
60 (Mm::/Uh::)
61 PAT: [ ]
62 PAT: I c’n: (.) ha
63 [ ]
64 PAT: handling backward movement okay but it’s
65 (Mm::)
66 DOC: =Mm h[m, ]
67 PAT: [ ] hurting me right now.
68 (2.2)
69 DOC: =hhhhhhhhhh Alright. hhh uh:m hhhhh
70 (0.2)
71 PAT: This is not (.) bursitis. no:w.=it
72 doesn’t feel like a bursitis,=(an’) it’s
73 not a real sharp pain.=it’s just a ·hh an
74 ache, (.) all thuh ti:me.
75 DOC: Mm hm, It <might be,> Well let me show=ya what
76 thuh most co:mmon injury is.

After the physician says “Alright” (line 66), which can project a shift to a new activity (Beach, 1995a, 1995b), he sets the medical records aside and stands up in preparation for the exam. In response to these transition-relevant, verbal and non-verbal behaviors, the patient begins to uncross her legs and reposition her body in preparation for the physical examination. During the transition into physical examination, the patients says, “This is not (.) bursitis. no:w.=it doesn’t feel like a bursitis,=(an’) it’s not a real sharp pain.=it’s just a ·hh an ache, (.) all thuh ti:me” (lines
Here, the patient provides additional information about her problem by first discounting bursitis as a diagnosis of her problem and then providing evidence for her claim. In discounting bursitis as a diagnosis, and by doing so during the transition into physical examination, the patient displays an orientation to physical examination as being in the service of diagnosis (see Robinson & Stivers, 2001).

Another place where patients’ orientations can be found is where there are disruptions in the progression from the activity of gathering additional information to that of diagnosis. In these cases, patients sometimes attempt to restore such progression and, in doing so, orient to diagnosis delivery as the next relevant activity. For example, see Extract 8. As part of the activity of gathering additional information, the physician is examining the patient’s neck. After the patient indicates that the physician has located a painful area, “Right there. Ooh” (line 141), the physician spends almost 10 sec examining the patient’s neck while remaining silent (lines 142–144).

**Extract 8: EAR PAIN**

<table>
<thead>
<tr>
<th>Line</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>137</td>
<td>PAT: See now when you press there it hurts.</td>
</tr>
<tr>
<td>138</td>
<td>(1.0)</td>
</tr>
<tr>
<td>139</td>
<td>PAT: Little f=further down.</td>
</tr>
<tr>
<td>140</td>
<td>(3.4)</td>
</tr>
<tr>
<td>141</td>
<td>PAT: Right there. Ooh.</td>
</tr>
<tr>
<td>142</td>
<td>(1.2)</td>
</tr>
<tr>
<td>143</td>
<td>PAT: hhh (vocalized outbreath) that hurts.</td>
</tr>
<tr>
<td>144</td>
<td>(8.0)</td>
</tr>
<tr>
<td>145</td>
<td>→ PAT: we=it=ooh- couldn’t be sinus. could it?</td>
</tr>
<tr>
<td>146</td>
<td>(0.2)</td>
</tr>
<tr>
<td>147</td>
<td>DOC: No.:</td>
</tr>
</tbody>
</table>

Heritage and Stivers (1999) found that, during physical examinations of patients’ bodies, physicians frequently produce different forms of “online communication” that give “contemporaneous information concerning the procedures, findings, and prospective diagnostic implications of the examination in progress” (p. 1; see also Stivers, 1998). One form of online communication is “online commentary,” which “describes or evaluates what the physician is seeing, feeling or hearing during the physical examination of the patient” (Heritage & Stivers, 1999, p. 1). The absence of online commentary can sometimes be understood as foreshadowing some sort of trouble with physicians’ examinations. In Extract 8 (previously), the fact that the physician spends a relatively long time performing the same examination (e.g., he does not move on to another examination) and that he does so silently (e.g., without any form of online communication) may communicate some trouble with the examination process (e.g., the physician cannot find anything wrong or has found something seriously wrong). It is in this context that the patient asks, “couldn’t be sinus. could it?” (line 145). By proposing a virtual diagnosis of her problem (i.e., “sinus”) to be confirmed or disconfirmed, the patient
displays her understanding that the activity of physical examination is being performed in the service of diagnosing her problem. The patient also holds the physician accountable for progressing through the project to the activity of diagnosis.

Similar to patients, physicians also orient to physical examination as being in the service of diagnosis. For example, see Extract 9a. As the physician palpates the patient’s shoulder, he asks, “Does that hurt right there” (line 58).

Extract 9a: SHOULDER PAIN
58 → DOC: hh Does that hurt right there,  
59 (1.2)  
60 PAT: Mm: it doesn’t uhm I can feel it.  
61 ()  
62 PAT: But it’s not real painful.  
63 DOC: Right.  
64 DOC: Well what I’m asking you is can I reproduce your pain by pushing.

It is being argued that the physician’s palpation and question at line 58 are performed in the service of diagnosing the patient’s problem. Initially, this may strike the reader as obvious. However, although there is evidence that the physician is palpating the patient’s shoulder and asking if the palpation is producing pain, there are no behavioral clues with which to determine exactly what the physician is feeling for (e.g., muscle, bone, tendon) or to ground why the physician is palpating the shoulder (e.g., for the purpose of diagnosis). However, later in the visit, the physician retrospectively claims such diagnostic motivations. For example, see Extract 9b, which comes later during the physical examination.

Extract 9b: SHOULDER PAIN
86 → DOC: So again when I push on that tendon right  
87 the:re,  
88 PAT: Yeah-I c’n feel that.  
89 DOC: Yeah. I know.=it’s <never pleasant.> And  
90 I’m pretty good at smashin’. ya know,  
91 DOC: I But my question is, I when I push on  
92 that (0.4) is that (. ) much more tender  
93 than this side?  
94 (0.4)  
95 PAT: No.

At line 86, the physician displays that he is feeling for the “tendon.” However, we still do not have evidence that the physician is doing so in the service of diagnosis. As seen in Extract 9c, this is provided later during treatment.

Extract 9c: SHOULDER PAIN
182 DOC: Normally a cortisone injection’ll wor:k
At lines 184 and 186, the physician refers to his earlier examination through his reuse of words such as “tender” (line 184; compare to Extract 9b, line 92, “tender”) and “push” (line 184; compare to Extract 9a, line 65, “pushing” and to Extract 9b, line 65, “push”) and “reproduces the pain” (line 186; compare to Extract 9a, line 66, “reproduce your pain”). At lines 192–193, when the physician says, “>It doesn’t look< like a typical tendinitis,” he claims that he was palpating the tendon in the service of determining whether or not the diagnosis was tendinitis.

Activity 3: Diagnosis Delivery

In theory, physicians do not have to deliver diagnoses. For example, after privately arriving at a diagnosis, physicians could simply treat patients’ problems. However, such omission is nonexistent in my data of modern (1995–1998) American visits and is reportedly extremely rare in other modern data corpora (see Heath, 1992; Peräkylä, 1998; Stivers, 2000).

The literature suggests that the activity of diagnosis is performed in the service of treatment. Byrne and Long (1976) claimed that physicians’ diagnoses are sometimes designed to project further talk concerned with treatment, and Heath (1981) found that diagnoses “provide a systematic basis for the provision of some form of management to the patient’s troubles” (p. 88). Additionally, physicians are trained to initiate treatment-related activities immediately following the delivery of a diagno-

The examples in this section focused on physical examination. However, Heath (1992) provided evidence that patients also orient to physician’s history-taking questions as being asked in the service of diagnosing their problems. Heath gave the following example:

01  DOC:  How old are you now?
02  PAT:  Forty nine just coming up to forty nine.
03  (0.5)
04  →  PAT:  (Your right) it could be arthritis: (. ) hh . hhhhhheh

Heath noted “as the doctor is about to manipulate the patient’s foot, the patient proffers a candidate diagnosis of his complaint ‘touched off’ by the question concerning his age” (p. 266).
sis and this training is reproduced in practice (see Byrne & Long, 1976; Heath, 1992; Maynard, 1992). For example, one medical textbook advises: “Once the physician has reviewed the important diagnostic information and responded to the patient’s emotional reaction to the diagnostic news, the physician must negotiate a treatment plan with the patient and take steps to maintain this plan” (Cohen-Cole, 1991, p. 33).

Physicians employ a variety of vocal practices that display their understandings that their treatment recommendation does not merely follow, but is an upshot or consequence of, their diagnosis. In these ways, physicians display that treatment recommendations relevantly and accountably follow diagnoses. One of these practices involves the use of the particle “so,” which can communicate that what follows is an upshot of prior talk (Raymond, in press; Schiffrin, 1987). For example, see Extracts 10 and 11. In Extract 10, the patient is visiting the physician for a suspicious-looking mole. The physician delivers his diagnosis at lines 94–95, “those are due: to plu:gging up the po::res,” to which he appends a cause, “with:=uh: I guess: lo:tion an’ o:ils and that kinda stuff” (lines 95–98). The activity of diagnosis delivery is slightly expanded at lines 99–101, where the patient jokingly produces a self-deprecation and the physician reiterates the cause of her problem, “Excessive o::il.”

**Extract 10: NECK MOLE**

94 Dx→DOC: You know what those things are .mhh those are due: to
95   | plu:gging up the po::res .hh with:=uh: I guess:
96   lo:tion [an’ ]o:ils [and
97   PAT: [Hih [heh heh [heh
98   DOC: [that kinda s[tuff.]
99   PAT: [( )[Me. ] .h Mi(h)ne c(h)omes fr(h)om
100  ins(h)id o(h)ut .h[hh hheh ( )]
101 * DOC: [Excessive o::il.]
102 PAT: [Excessive o::il.]
103 Rx→DOC: [Right so the wa:y to: (. ) prevent those
104 Rx→DOC: thing[s is to- ]
105 PAT: [And that’s] not a mole.
106 (0.2)
107 DOC: No.
108 (0.3)
109 Rx→DOC: .h It the wa:y to prevent them is tup- (0.2) is to
110   | un:plu:g the po::res .hhh So you’ve got to s:crub:
111   .h °e:[:]° ]
112 PAT: I use] a buff puff on [my fa:ce. ]
113 DOC: [R:ight. a ^buff^] puff.

After the physician delivers the diagnosis, he proceeds to begin to deliver his treatment recommendation, which he prefaces with the particle “so”: “so the wa:y to: (. ) prevent those things is to-” (line 103–104). In Extract 11, the patient is visiting the physician for a painful ear. The physician delivers his diagnosis at line 125–126, “it looks like you have a little infe:ction (on the) ear drum.”
Extract 11: EAR PROBLEM

125 Dx → DOC: >Okay.< So it looks like you have a little infection (on the) ear drum.
126 Dx →
127 (0.8)
128 PAT: °hh=That’s what I thought it might be.°
129 (1.5)
130 DOC: °Okay,°
131 (0.2)
132 Rx → DOC: (>Alright< so) I’ll putchu on some antibiotics an’ a: decongestant, (0.5) An’ a nasal sprayer
133 | a: decongestant,
134 | (0.5)
135 * DOC: An’ a nasal sprayer

After the physician delivers the diagnosis, he proceeds to deliver his treatment recommendation, which is also prefaced with the particle “so”: “so I’ll putchu on some antibiotics an’ a: decongestant, (0.5) An’ a nasal sprayer” (lines 132–135).

In both Extracts 10 and 11 (previously), the physicians begin their treatment recommendation with the particle “so,” which communicates that it is an upshot or consequence of the previously delivered diagnosis (Raymond, in press; Schiffrin, 1987). This is particularly evident in Extract 10, where the physician’s diagnosis is “plu:gg:ing up the po::res” (line 95) and his treatment recommendation is to “u:plu:tg the po::res” (line 110). In these ways, physicians display their understandings that informing patients about treatment is a relevant next action after delivering diagnoses.

Patients also display their understandings and expectations that the activity of treatment relevantly follows that of diagnosis. For example, physicians sometimes digress from the project. When this happens, because progression through the project to its completion is accountable, patients sometimes make efforts to return physicians to the project. Extract 12 is an example where the physician digresses from the progression from the activity of diagnosis to that of treatment. Here, the patient is visiting the physician for a painful shoulder. The physician delivers the diagnosis at line 65: “It’s a tendoni:titis.” As the physician sympathizes with the patient (line 67), the patient inquires about a diagnosis of her knee, which has not previously been a topic of discussion: “Is that=that=that=that=what’s wrong with my knee too” (lines 68–69). After a brief physical examination, the physician delivers a diagnosis of her knee, “that’s arthri:titis” (line 77), which he then explains (lines 79–84).

Extract 12: TENDINITIS

65 DOC: ·hh It’s a- (.) It’s a tendini:titis.
66 PAT: Oh[:: ]
67 DOC: ·[hh Th]at’s a rea:l infu:riat[ing th:ing. ]
68 PAT: [Is that=that=that=that=what’s wrong with my knee too=because right he:re fgel it.=h (0.6)
DOC: Mm hm,
DOC: Right here?
(PAT: Feel it?
DOC: >Yeah.< the grinding.

(PAT: Oh: [(because) [ ( . ) . ]
DOC: [hhh] [See thuh- “th-°] thuh surfaces there are not smooth any more. They’re like sandpaper.
 DOC: And so when you move your-
 PAT: The last (few) [days has been]
 DOC: [knee=it [grind:.]
 PAT: =Really bothering [me.]
 DOC: [ Yeah ah. it’s: it’s: you know you
 got a little bit in here,
 PAT: So what [da ya [do: [No:thin’].
 DOC: [I guess [it’s worse: in your
 knee:s.

Although the patient’s question regarding her knee (lines 66–69) is topically related to the physician’s diagnosis of her shoulder, it represents a small digression from the project—that is, from progressing toward treatment of her shoulder. This digression is both highlighted and increased when the physician subsequently grabs the patient’s right hand and informs the patient: “you know you got a little bit in here” (lines 87–88). Although the physician retains the current topic of arthritis, he shifts his focus of attention away from the patient’s knee to her hand. The patient had not been drawing attention to her hand and this is the first time during the visit that the patient’s hand has been a focus of attention (vocally or nonvocally). The physician’s unmotivated shift of attention and activity to the patient’s hand constitutes a *non sequitur* of sorts—it does not follow in the sense that the physician applies a currently topical diagnosis (i.e., arthritis) to a portion of the patient’s body that had not been presented as being in need of medical attention. It is precisely after this *non sequitur* that the patient inquires about treatment: “So what da ya do: No:thin’” (line 89). Note that the patient prefices her request with the particle “so” (line 89), which marks it as an upshot or consequence of the physician’s diagnosis. In sum, with her inquiry, the patient orients to the pending relevance of treatment-related actions following the delivery of a diagnosis.

**Activity 4: Treatment Recommendation**

The possible completion of the activity of treatment constitutes the possible completion of the project. This is supported by cases where, after treatment is com-
pleted, physicians transition to other activities or medical concerns that are unrelated to patients’ project-related problem. For example, see Extract 13.

**Extract 13: EAR PROBLEM**

132 DOC: (>Alright< so) I’ll putchu on some antibiotics an’ a: decongestant,
134 (0.5)
135 DOC: An’ a nasal sprayer_ ((doctor gazes at, and writes in, medical records; doctor and patient talk socially about patient’s home life))
167 → DOC: You been exercisin’ at all,
168 (2.3)
169 PAT: (m) No, No time tuh do anything_
170 (1.0)
171 PAT: I’ve been walkin’ with María=That’s about it.
172 (1.0)
173 DOC: She losin’ weight now (with her)
174 PAT: Yeah.
175 (.)
176 DOC: Whatever,
177 (4.0)
178 → DOC: Still smo̱kin’ er
179 PAT: Yeah.

After the physician informs the patient of the treatment regimen (lines 132–135), he begins to gaze at, and write in, the patient’s medical records—presumably, the physician is documenting the treatment. For the next 26 sec, although the physician talks socially to the patient, he writes in the records. As soon as the physician finishes writing, he asks, “You been exercisin’ at all” (line 167). This is the first in a series of questions about the patient’s medical lifestyle, the second of which occurs at line 178, “Still smo̱kin’ er.” Insofar as the patient’s exercise and smoking habits are completely unrelated to his ear pain and related to a prior history of routine problems, the physician displays that he has shifted to new medical business. Thus, the physician orients to treatment as being the last activity of the project of solving the patient’s ear problem.

**DISCUSSION**

A growing amount of research has demonstrated that patients’ levels of communicative participation can be significantly raised with both patient- and physician-level interventions (Anderson, DeVellis, & DeVellis, 1987; Anderson & Sharpe, 1991; McGee & Cegala, 1998; Roter, 1977). At the same time, however, researchers need to heed Heath’s (1992) advice that practical recommendations to modify physicians’ and patients’ behaviors need to be “thoroughly embedded in a
detailed understanding of the local interactional organization and the various rights and responsibilities therein” (pp. 264–265). This article argued that the establishment of a new medical problem makes relevant a large-scale structure, or project, of interaction that shapes the production and understanding of communicative behavior. The project has, as its ultimate objective, the solution of patients’ problems, which is treatment. However, treatment is contingent upon diagnosis, which is itself contingent upon physicians obtaining information about patients’ problems, which is initially garnered from patients’ presentations of their problems and subsequently from history taking and/or physical examination. Importantly, physicians are accountable for progressing in a directional fashion through the project’s roughly ordered sequence of medical activities to its completion.

In more formal institutional contexts, such as courtroom plea bargaining (Maynard, 1984), activity structures are products of organizational agendas that are institutionalized and prescribed to one or all of the participants in advance of the interaction. In less formal contexts, such as calls for emergency assistance (for review, see Zimmerman, 1992), activity structures are products of organizational agendas whose relevance is determined in situ based on the demands of service seekers; these agendas may, or may not, be known or understood by service seekers, but they are implemented by service providers. The proposed project is of the latter type—it is the product of a particular type of service demand by patients (i.e., new medical problems) that makes relevant a particular medical agenda for dealing with it. A new medical problem is analogous to a 911 emergency in the sense that it can be an “urgent, threatening, deeply felt ‘right now, this moment, life-changing’ event” (Zimmerman, 1992, p. 458). Similar to the institutional structuring of 911 callers’ requests for help, the project functions to transform lived medical problems into institutionally manageable, routine events by standardizing what aspects of problems are dealt with, and how, when, and what order those aspects are dealt with (see Zimmerman, 1992). The project provides an explanatory context for multiple incarnations of patients’ communicative participation. What follows is an examination of some of these incarnations, a description of how they might be explained by the project, and a discussion of the project’s implications for theory, research, and improvement on physician–patient communication.

One incarnation of patients’ low levels of participation is that patients sometimes do not express, or topicalize, the full range of their medical concerns. Patients sometimes bring more than one concern to visits (Barsky, 1981; Stoeckle & Barsky, 1981; White, Levinson, & Roter, 1994; White, Rosson, Christensen, Hart, & Levinson, 1997). However, researchers have found that, after physicians’ opening solicitations of patients’ concerns (e.g., “What can I do for you today?”), physicians typically initiate talk after patients present a single concern (Beckman & Frankel, 1984; Marvel, Epstein, Flowers, & Beckman, 1999). Furthermore, after patients present a single concern, virtually all physician utterances—with the exception of continuers (Schegloff, 1982)—were found to inhibit patients’ presenta-
tions of additional concerns. That is, these utterances either explicitly initiated, or were understood to initiate, a shift into the activity of gathering additional information about patients’ initially presented concern. For example, in Extract 1 (previously), after the patient presents his problem (a cough; lines 25–40), the physician immediately begins to gather information about the cough (lines 43–44). Beckman and his colleagues concluded that, during patients’ initial presentations of their concerns, physicians tend to “interrupt” patients, preventing them from addressing their full agenda of concerns. In order to solve this problem, researchers have advocated that, when patients are finished presenting their first concern, rather than proceeding to the activity of gathering additional information, physicians should solicit additional concerns (Beckman & Frankel, 1984; Lipkin, Frankel, Beckman, Charon, & Fein, 1995; Marvel, Epstein, Flowers, & Beckman, 1999; Roter & Hall, 1992). For example, return to Extract 2. Rather than proceeding to gather more information about the patient’s racing heart, the physician solicits additional problems: “Anything else that’s bothering you” (lines 20–21).

The findings of Beckman and his colleagues indicate that physicians’ opening solicitations of patients’ concerns are routinely treated by physicians, and understood by patients, as solicitations of single concerns. For better or worse, this is in line with the project’s normative framework for action. That is, the establishment of a new medical problem makes relevant its solution (i.e., treatment) and, to that end, a progression through specific medical activities, the first of which is gathering additional information. Along these lines, upon completion of patients’ presentations of a single new problem, it may be specifically nonrelevant for physicians to solicit additional problems (i.e., for physicians to not proceed to the activity of gathering additional information). Furthermore, if physicians do solicit additional problems at this particular location, then there may be a project-based constraint or bias against patients presenting additional problems, even if they have them.

Of course, this is not to deny the seriousness of the empirical observations motivating prior research: Patients can have more than one concern and physicians’ lack of addressing the full spectrum of patients’ concerns has potentially serious health-related consequences. The organization of the project suggests an alternative behavioral remedy. The project is possibly complete on the possible completion of treatment. It is at this location, outside of the constraints of the relevancies of the project and its constituent activities, that physicians might be instructed to solicit additional concerns (e.g., “What else can I do for you today?”; White et al., 1994; White et al., 1997). This advice is somewhat complicated by the fact that visits organized around dealing with new problems are sometimes oriented (more often by physicians, but also by patients) as being monotonical (see Schegloff &

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7Anecdotally, when I taught a Continuing Medical Education (CME) course on communication to practicing physicians (2000), a physician commented that, after patients have presented their “chief complaint,” it is “inappropriate” for physicians to solicit additional problems.
Sacks, 1973), where the single topic is a single problem. If so, then the completion of the activity of treatment constitutes an interactional environment wherein it is relevant to close, or end, the visit (Heath, 1981, 1986; Robinson, 2001b). Upon the completion of treatment in monotopical visits, the relevance of closing can apply a pressure against physicians soliciting and/or patients topicalizing additional concerns. This points to the importance of understanding participants’ communicative practices for closing visits and how those practices might be “optimized” (verbally and nonverbally) for the topicalization of patients’ additional concerns (see Robinson, 2001b).

The interactional relevancies embodied in the project and its constituent activities begin to account for why patients do not initiate sequences of certain types of action. For example, Gill (1998) examined situations where patients offer explanations of their illness during the activity of gathering additional information. By their very nature, these explanations are related to diagnosis. According to the project, during the activity of gathering additional information, it is relevant for physicians (not patients) to be gathering information in the service of diagnosing patients’ problems. Furthermore, physicians are accountable for progressing through this activity toward the delivery of a diagnosis. Thus, during the activity of gathering additional information, patients’ questions concerning diagnosis are potentially “premature” and “interruptive.” This was supported by Gill, who found that patients:

avoid “asking,” and thus pressuring doctors to evaluate or assess their explanations, during the “investigative” phases … Rather, patients explain in ways that allow doctors to continue collecting empirical information about the nature of their symptoms. [Stated differently, patients] give doctors opportunities to focus on the work of diagnosing. (pp. 346–347, 357)

Gill suggested that, by formatting their explanations in ways that do not obligate physicians to respond, “patients provide for the possibility that doctors will not or cannot evaluate their explanations immediately. Patients thus can avoid occasioning disaffiliative treatment such as having their explanations be overtly ignored by doctors” (p. 343, emphasis omitted). In sum, the relevancies embodied in the project apply pressures that shape the initiation and design of patients’ turns and their constituent actions.

For another example, researchers have found that, following physicians’ diagnoses, patients rarely respond with anything other than silence or minimal acknowledgment tokens (Heath, 1992; Peräkylä, 1998). According to Heath (1992), patients routinely pass up, or actively “withhold,” an opportunity to produce an “inquiry concerning the nature of the illness, its relative seriousness or the course it is likely to follow” (p. 242). However, the assertion that patients “withhold” such inquiries, or even extended responses (Peräkylä, in press), implies an assumption
that they are somehow relevant. Both Heath and Peräkylä analogize, and thus compare, physicians’ diagnoses to “informings” in mundane contexts (see Heritage, 1984a; Jefferson, 1981a, 1981b; Maynard, 1997), where the informing can constitute the first part of an adjacency-pair sequence that obligates a response (see Schegloff, 1968; Schegloff & Sacks, 1973). Under these circumstances, participants’ responses are relevant and their “lack” constitute accountably “withheld” responses. However, according to the proposed project, physicians’ diagnoses are sequentially different objects than mundane informings. Diagnoses are, essentially, responses to patients’ presentations of their problems. Furthermore, after physicians deliver diagnoses, it is relevant for physicians to progress to the activity of treatment. This is not to say that patients’ responses to diagnoses are specifically non-relevant, but it is to say that they are not conditionally relevant (see Schegloff, 1968) and that there is a project-based pressure against their production. Thus, the scarcity and minimal nature of patients’ responses to physicians’ diagnoses can be explained by patients’ orientations to the project generally, and specifically to the pending relevance of treatment following diagnosis.

Researchers have identified particular circumstances in which patients do produce something other than silence or minimal acknowledgment tokens in response to physicians’ diagnoses: (a) when there is incongruence between physicians’ diagnoses and those previously expressed or implied by patients; this includes cases when physicians deliver “no-problem” diagnoses to patients who expect a problem; and (b) when physicians produce “uncertain” diagnoses (Gill, 1998; Heath, 1992; Peräkylä, 1998, in press; Stivers, 2000). Both of these are circumstances in which physicians’ diagnoses potentially violate patients’ expectations, impede patients’ treatment-related goals, or are potentially incorrect. According to the proposed project, diagnoses are performed in the service of making treatment recommendations, such recommendations are commonly delivered as upshots of diagnoses, and physicians are accountable for progressing directly from diagnosis to treatment. One possible explanation for why patients initiate sequences of action, or produce extended responses, after incongruent or uncertain diagnoses is due to patients’ orientations to the likelihood that (a) without “interference” (whatever that may be, such as a correction, request for confirmation, challenge, etc.), physicians will proceed to deliver potentially undesired or inappropriate treatment recommendations; and (b) once physicians deliver a treatment recommendation, talk that relates to physicians’ diagnoses will be ill-fitted or non-relevant (see Schegloff & Sacks, 1973). This is supported by Stivers (2000), who found that, when parents produce extended responses to pediatricians’ diagnoses, those diagnoses tend to be ones that imply “no antibiotic treatment,” and parents’ responses tend to resist such diagnoses in ways that justify a need for antibiotics. For an example in the present data, return to Extract 10. At the beginning of the visit, the patient presents her problem as being a “mole” that is growing near a location where she had previously had a potentially cancerous mole removed. There is incongru-
ence between the patient’s diagnosis of a mole and the physician’s diagnosis of a plugged-up pore (lines 94–95). After the physician reiterates the cause of the problem, “Excessive oil” (line 101), the patient produces a large in-breath (line 102). This can be a practice for projecting a turn of talk (Schegloff, 1996b). If so, this turn is interdicted by the physician, who begins to produce his treatment recommendation: “so the way to prevent those things is to” (lines 103–104). However, after the physician is hearable as being on his way to making the recommendation, but precisely before he produces it, the patient interruptively questions the physician’s diagnosis: “And that’s not a mole” (line 105). Here, the patient specifically interrupts the physician before he produces the recommendation in order to resolve the diagnostic incongruence.

With the project in mind, we can begin to predict locations where patients are more “free” to initiate sequences of action. For example, the possible completion of the activity of treatment marks the possible completion of the project. After treatment, at least the project no longer applies pressures against patient-initiated actions. It can be predicted that interational environments following treatment (i.e., following the completion of the project) are more conducive to patient-initiated actions, at least relative to the activities of establishing the problem, history taking, physical examination, and diagnosis. This is indirectly supported by a casual examination of published transcript data, which indicates that one location where patients ask questions is during the final stages of treatment, such as when physicians are writing prescriptions (Frankel, 1990; Gill, 1998). Along these lines, Kravitz, Bell, and Franz (1999) found that 49% of all patient requests for information concerned tests and diagnostic investigations, medications and treatments, and prevention, all of which tend to cluster around treatment. Additionally, Sleath, Roter, Chewning, and Svarstad (1999) found that, when patients ask questions about their medications, they ask an average of 2.4 questions. This is significant in light of McGee and Cegala’s (1998) recent finding that, without intervention, patients only ask an average of 2.1 medical questions per visit. It can be inferred that the bulk of patients’ questions tend to coincide with the possible completion of treatment.

Theoretically, researchers have argued that patients’ lack of opportunities to present their full agenda of concerns, as well as their general low levels of communicative participation, is evidence of an unequal distribution, or asymmetry, of authority or power in physician–patient visits (e.g., Frankel, 1990; Heath, 1992; West, 1984). From this point of view, various incarnations of power asymmetries are interactional manifestations—albeit co-constructed manifestations—of physicians’ and patients’ orientations to general and omnipresent notions of asymmetrical roles, rights, and obligations, ones that are embodied in visits as whole units, or contexts, of interaction. To the contrary, this article argues that, rather than visits embodying asymmetry, it is actions, activities, and projects of activities, and their constitutive relevancies, that account for asymmetry (see also, Robinson, 1998, 2001a).
This article has several limitations that provide directions for future research. First, the project is, at this stage, a model. An exhaustive analysis of the project’s component activities has not been performed and more data is needed to confirm the project’s validity. This is a limitation at least because the projects’ activities are themselves composed of sequences of action, which themselves constitute structures of interaction that shape and constrain behavior. Future research needs to describe the relationships and interplay between the structure and relevancies of the project, its component activities, and their component sequences of action. Second, this article focused on one type of patients’ medical business: dealing with new medical problems. There are other types of business, such as requesting medication, following up on old problems, and monitoring chronic/routine problems. If different types of medical business make relevant different interactional structures of social action, then it is imperative that researchers incorporate these distinctions into their analyses, theorizing, and recommendations for behavioral modification. For example, patients’ explanations of the causes of their problems (Gill, 1998), physicians’ diagnoses (Heath, 1992; Peräkylä, 1998), and patients’ responses to diagnoses (Heath, 1992; Peräkylä, in press) are likely to be different phenomena when they are produced in the context of dealing with new problems versus following-up on old problems. Finally, the project is but one piece in the explanatory puzzle of patient participation. Others exist, and future research needs to begin to build a heuristic model of participation, albeit one that is grounded in the exigencies of actual physician-patient interaction.

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REFERENCES


APPENDIX: TRANSCRIPTION CONVENTIONS

DOC/PAT: Speaker identification: Doctor (DOC); patient (PAT)


= Equal Sign: Utterances are latched or ran together, with no gap of silence.

- Hyphen: Preceding sound is cut off / self-interrupted.

#Word# Number sign: Words/sounds are produced with a gravel voice.

£word£ British pound sign: Talk is produced while smiling.

↑word↓ Up arrow/Down arrow: Increased pitch relative to surrounding talk.

↓word↑ Down arrow/Up arrow: Decreased pitch relative to surrounding talk.

(0.0) Timed Pause: Silence measured in seconds and tenths of seconds.

: Colon(s): Preceding sound is extended or stretched; the more the longer.

. Period: Falling or terminal intonation.

, Comma: Continuing or slightly rising intonation.

? Question mark: Rising intonation.

Word_Underline Underline after word: No intonation shift

°soft° Degree signs: Decreased volume relative to surrounding talk.

>fast< Greater/Less-than signs: Increased pace relative to surrounding talk.

<slow> Less/Greater-than signs: Decreased pace relative to surrounding talk.

-H's Superscripted periods preceding H's: Inbreaths; the more the longer.

h H's: Outbreaths (sometimes indicating laughter); the more the longer.

hah/heh Laugh token: Relative open or closed position of laughter

(that/hat) Filled single parentheses: Transcriptionist doubt about talk.

((Cough))) Filled double parentheses: Scenic detail/event/sound not easily transcribed.