Accounting for the visit: giving reasons for seeking medical care

John Heritage and Jeffrey D. Robinson

"In order to have the privilege of talking to your doctor, you must fulfill the essential precondition of being sick. Then you may go to him and ask him if he will perform his professional services upon you." Anonymous New Zealand Primary Care Physician (Byrne and Long 1976:20)

Introduction

It is a well-established principle of social psychology that, in presenting a description of some state of affairs, a person is simultaneously engaged in a presentation of self. The central aim of this chapter is to apply this observation to the medical visit, focusing on how patients' descriptions of their medical problems are designed to manage the social accountability of their decision to visit physicians and, in particular, to justify the decision to seek medical care.

In this chapter we examine the phase of acute medical visits in which patients give their reasons for seeking medical assistance. This phase is normally initiated by an inquiry of some kind from the physician (Robinson this volume; Heritage and Robinson forthcoming), and it is very often terminated by a course of medical questioning which is physician-centered and driven by the physician's technical expertise and medical-technical agenda (Beckman and Frankel 1984). Though it is often of brief duration (Beckman and Frankel 1984; Marvel et al. 1999; Langewitz et al. 2002), the problem presentation phase is one of the only (and often the only) structurally provided-for locations where patients are licensed to present their concerns in their own way and in accordance with their own agendas.

Although patients' problem presentations can sometimes appear to be monologues, this appearance is deceptive. Not only are they normally initiated and terminated by physicians, but their progressive development is shaped by physician behavior (Beckman and Frankel 1984). In this discussion, we will consider patient problem presentation as a co-construction: a phase of interaction in which circumstances recognizable as "problems" are presented with whatever elements of cogency or disorganization, affective expression, and recognizable structure and content. This phase is ordinarily terminated by physicians who, finding the moment to take the initiative with whatever elements of circumspection, fumbling, or precision, begin the history.

In this context, patients have a range of choices concerning both the content and the form of the presenting concern. These choices include questions of how symptoms are to be presented; that is, of portraying how the symptoms came to be discovered as objects of consciousness and investigation (Halkowski this volume), how they were recognized (or not), and how they are to be described. Then there is the matter of what patients theorize about the symptoms, and of whether they have social rights to know and describe the elements they talk about. Patients will find themselves electing ways to describe unfamiliar and perhaps alarming physical sensations in the midst of the anxieties engendered by these sensations, and also deciding whether the anxieties themselves and/or the reasoning behind them should be articulated or not. In addition, in terms of what relevancies should symptoms be described? Should patients describe symptoms in terms of their presumed medico-diagnostic relevance, thereby "second-guessing" the physician's reasoning, or alternatively frame descriptions in more self-oriented ways that focus on pain, inconvenience, or fear? Finally, patients will find themselves selecting particular formats with which to present a problem: for example, a simple enumeration of symptoms, or a chronological...
narrative of the illness culminating in the patient’s here-and-now presence in the physician’s office, and deciding between the expression or suppression of diagnostic or etiological hypotheses.

What drives these choices? In what follows we will describe three broad types of acute problem presentation, and suggest ways in which the nature of medical problems creates affordances for, as well as constraints on, presentational decisions. Subsequently, we will describe some presentational practices that occur in a variety of combinations, and consider their sociological background and significance.

Data

The data are primarily drawn from two videotaped corpora of acute primary care interactions conducted in community practices of family and internal medicine in Los Angeles County and a mid-sized town in Pennsylvania. These data comprise some 300 primary care visits. Although many visits were reviewed for the purpose of this chapter, the data analysis offered here is qualitative and conversation-analytic rather than quantitative. 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 recorded, and gave permission to publish the recordings.

Presenting a concern: initial considerations

In presenting medical concerns, patients often make an initial distinction between what we will call “known” and “unknown” problems. Known problems are medical conditions with which patients have had previous experience, and divide into two broad classes: (1) routine acute problems, such as upper respiratory infections, with which patients and their associates are generally familiar and which have vernacular names like “colds,” “flu,” etc. and (2) recurrences in which patients believe that the problem they are presenting is similar to a non-routine condition which was previously the object of specifically medical diagnosis and treatment. Unknown problems, by contrast, are framed as beyond the patient’s previous experience. These different types of problems pose distinctive challenges and offer particular affordances for justifying the medical visit.

Routine acute problems

By routine acute problems we mean illnesses that are relatively frequently experienced by most people – colds, flu, heartburn, and so on – which have vernacular names or medical names that are becoming vernacularized. These illnesses are commonly mild, self-limiting, and of short duration, and patients who present with them often describe them using minimizing qualifications like “just” to display an orientation to the fact that they are ordinarily mild complaints:

(1) [Flu]

1 DOC: What’s been goin’ on?
2 PAT: I just got (0.4) chest cold and it’s been uh goin’ on for a week. I don’t seem to be able to
3 [shake it].
5 DOC: [O:Kay]

Or the patient may simply describe a set of symptoms.

(2) [Sinus Infection]

1 DOC: Okay, (. . .) what’s been goin’ on?
2 PAT: Bad sinusies. (0.4) achey. (0.2) cold and host.
3 (0.6)
4 DOC: ‘Okay.’
5 PAT: Headaches.
6 (1.0)
7 PAT: ‘You know. (. . .) your usual.’
8 DOC: =When did they start. do you think.
9 DOC: [Thuh symptoms.
10 PAT: [Monday.

Here the patient’s list of symptoms (lines 2–7) is presented in a monotone which conveys their utter mundanity, and this is underscored with her observation “’You know. (. . .) your usual.—’”, which functions to complete her problem presentation.
In a heart attack the previous year, I felt a sense of impending doom, some shortness of breath, and I thought I was dying. This is usually a sign of a heart attack. I was taken to the hospital, and they gave me a shot of nitroglycerin. I felt immediate relief. I was able to walk around the hospital floor and go down the hall.

I have had several heart attacks since then, and I have been taking medication for high blood pressure and high cholesterol. I take aspirin daily and other medications as prescribed by my doctor. I also eat a healthy diet and exercise regularly. I have not had any heart attacks since then.

This time, I felt the same symptoms, but I noticed that my heart was racing. I called 911 and they came quickly. I was taken to the hospital and had a heart attack. I was given a pacemaker and several medications. I have been in the hospital for a few days, and I am improving.

I am taking this opportunity to talk to you about my health and to thank you for your support.

John Hunter and Never D. Robinson
Ligation "Something went down under my feet in my right area."

Here the patient's report of her symptoms is emphasized with a form-

\[
\text{7th day:}
\begin{align*}
\text{Diagnosis} & : \text{Heart attack} \\
\text{Heart attack] & : \text{Yes, I had a great deal of pain.} \\
\text{Doc.} & : \text{Yes, it's the same thing} \\
\text{Cardiologist} & : \text{I agree with the patient.} \\
\text{Gastroenterologist} & : \text{Not necessarily.} \\
\text{Intervention} & : \text{No additional intervention.}
\end{align*}
\]

Somehow it has been described here in my right area."

For the visit:

\[
\begin{align*}
\text{Yes} & : \text{Yes, this is true. I had eaten a} \\
\text{Yes} & : \text{No, I wouldn't eat here.} \\
\text{Yes} & : \text{No, I wouldn't eat here.} \\
\text{Yes} & : \text{No, I wouldn't eat here.} \\
\text{Yes} & : \text{No, I wouldn't eat here.}
\end{align*}
\]

Encouraged by the visit:

\[
\begin{align*}
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.}
\end{align*}
\]

Unknown medical problems. By contrast, these problems are basically:

\[
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.}
\]

And to rule out a "cold," the cause of her problem:

\[
\begin{align*}
\text{Yes} & : \text{Yes, I had a great deal of pain.} \\
\text{Yes} & : \text{No, I wouldn't eat here.} \\
\text{Yes} & : \text{No, I wouldn't eat here.} \\
\text{Yes} & : \text{No, I wouldn't eat here.} \\
\text{Yes} & : \text{No, I wouldn't eat here.}
\end{align*}
\]

Since a reasonable and plausible basis for a medical visit:

\[
\begin{align*}
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.}
\end{align*}
\]

"Ligation" is unnecessary.

The patient refuses to describe a condition which she has never

\[
\begin{align*}
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.} \\
\text{Yes} & : \text{Yes, I will eat here.}
\end{align*}
\]
Other presentations of unknown problems may begin with “first thoughts” (Jefferson 2004a; Halkowski this volume) in which patients present understandings of their concerns which are flagged as incorrect. In (10) below, the patient details the emergence of his symptoms some three months prior to the visit by reference to his first notion, now discounted (with “I thought”), that it was an insect bite. Subsequently he details the development of symptoms that are not compatible with this initial conception of the problem, thereby building an extensive depiction of a problem that is presently “unknown.”

(10) [Ringworm]

1 DOC: What happened.
2 ()
3 PAT: Well I got (...) what I thought (...) in June (...) uh was an insect bite.=in thuh back of my neck here.
4 DOC: Okay.
5 PAT: An’t (0.2) you know became aware of it ’cause it was itching an’=l (...) scratched at’.

Here the patient can describe his symptoms and their progression well enough, but he is at a loss to understand them (see below).

We conclude by noting that this is a rough classification of problem presentations. There is not an automatic one-to-one correspondence between the type of problem that a patient is presenting with and its style of presentation. The patient may be mistaken in proposing a recurrence—as was eventually determined in (4) and (5) above. Moreover, a patient may offer a problem presentation in a misleading fashion:

(11) [Breathless]

1 DOC: =hhhh So:. What’s the problem.
2 hhh[hhhhhhhhhhhhhhhh]
3 PAT: -> [Well, me breathin’s shockin’.}

In (11), the patient presents the problem as if it were new, and with no indication that she had been treated for the problem previously. However, at line 27, her physician determines from chart notes that a colleague in the same practice had treated her for this condition six months previously. It is likely that the patient has presented this problem as “new” because it is new-for-this-physician. Examples like this underscore that we need to maintain a differentiation between the way in which a problem is presented, and the problem itself as it is understood by physician and patient.

Nonetheless, it is useful to distinguish between these three main types of medical problem presentation which, at least in patients’ accounts and physicians’ responses to them, are treated as relatively distinct. First are routine acute medical conditions in which known minor and self-limiting medical problems with vernacular names are presented, often in association with an enumeration of current symptoms. Second are recurrences in which patients present symptoms in terms of their similarity to the symptoms of previously diagnosed medical conditions in a process that can often amount to self-diagnosis. Finally there are new and unknown conditions in which patients describe symptoms and their development in ways that underscore their doubt and uncertainty about their medical problems.

Accounting for the visit: the problem of legitimate doctorability

By the act of making an appointment and walking into the physician’s office, patients commit themselves to the belief that they have
a legitimate reason for attending. This can be a fraught moment for a patient. The patient has a condition which is causing concern, and may be anxious to describe it correctly and present it in an appropriate fashion. Moreover, the presentation, as Bloor and Horobin (1975) noted a quarter-century ago, can involve tensions between lay and professional judgment. Prior to visiting the physician, patients must make a judgment that they have a legitimate concern. Yet this judgment will itself be judged over the course of the visit. Under these circumstances, patients may find themselves designing their descriptions of events, experiences, and circumstances so as to communicate "good reasons" that will justify them being in the physician's office (Halkowski this volume; Heath 1992).

Thus, at the beginning of the medical visit, the patients can face the task of presenting their medical concern as "doctorable." For patients, a doctorable problem is one that is worthy of medical attention, worthy of evaluation as a potentially significant medical condition, worthy of counseling and, where necessary, medical treatment. Establishing that they have a doctorable problem is a fundamental aspect of patients' justifications for the decision to visit a physician. It is a means for patients to show that they are reasonable people, which in this context means showing that they have a problem or a concern for which seeking medical assistance is a reasonable solution. Alternatively, reasonableness can be claimed by a display of doubt, if indeed patients believe that their symptoms are only matters of marginally legitimate concern. The presentation of a complaint determined to be non-doctorable can deprive the patient of authoritative medical support for their claim to financial and other benefits from entering the "sick role" (Parsons 1951, 1975; Freidson 1970a), and engender a vulnerability to the judgment that they were misguided in seeking medical assistance, are overconcerned about their health, or in illegitimate search of "secondary gains" from the sick role itself. Patients' concerns with doctability thus center on showing that they are reasonable people, with "good reasons" to present themselves at the physician's office.

3 This term is adapted from Jay Meehan's work on calls to 911 emergency. Meehan (1989) noted callers' interests in showing that their calls were about issues that were legitimate subjects of police interest or intervention, i.e., that they were "police relevant" or "policable." Related studies by Whalen and Zimmerman (1990), Whalen et al. (1988), and Zimmerman (1992) show the complexities that can be involved in conveying the legitimacy of a call to 911.

Accounting for the visit

that reasonableness effectively converges with providing for the doctability of the concern which they present.

For example, in (12) the patient's preoccupation with justifying her medical visit effectively dominates her entire problem presentation: this patient has previously been treated for a small basal cell carcinoma on the back of her neck, and she has recently discovered a suspicious raised spot (which she refers to as a "mole" [line 7]) at, or close to, the place where she was previously treated:

(12) [Questionable Lesion]

1  PAT: I'm here on false pretenses. I think.
2  DOC: | hh
3  DOC: |
4  PAT: | eh! hii hii hii hi!
5  (Five lines omitted)
6  PAT: I asked my husband yesterday 'cause I could feel: (0.8) (cause)
7  it could feel this l'll mole coming. And: uh (0.5) (he) (.).
8  hh thought I better let etha know - uh well I asked my husband 'f
9  it was in the same place you took of this (0.5) 'thee (mm)
10  thee: ' ( )
11  DOC: | That's why you've come in because of the mole.
12  PAT: | that's why I came, but=
13  DOC: | How long 'as it been?
14  PAT: | it hasn't looked yesterday
15  he said it was in the same place but uh but it can feel it
16  nah it's down here an' the other one was up here so I don't
17  think it's the same one at all.
18  DOC: | Since when.
19  (0.8)
20  PAT: | Yh(ealthy) lhh it just felt it yesterday 'n
21  DOC: | Does it hurt?
22  PAT: | No?
23  (.)
24  PAT: | No it's just a little tiny thing but it=1 (.).
25  shhioulhild kheir yhiou kni(h) ow. hhh ihhh iihit was (on)
26  the same place, b't
27  DOC: | So when you push [on it it doesn't hurt].
28  PAT: | (Right.) | No it's
29  PAT: | just a little- little tiny skin: ittag really.
30  DOC: | (I: (.)).
31  DOC: | Yeah it's different than whatchu had before.
32  PAT: |
33  DOC: | Uh huh.
The patient is concerned to stress the exceptional nature of her cold, and again inquires if her post nasal drip is due to a cold or flu.

The patient points out that she has had a cold like this before, and asks if the medication she is on is making her feel like this.

The doctor explains that the medication she is on may cause these symptoms, but it is not likely to be the cause of her current symptoms.

The patient asks if there is anything she can do at home to help her feel better.

The doctor suggests getting plenty of rest, drinking plenty of fluids, and using a humidifier if she has a dry cough.

The patient asks if she should take any over-the-counter medication.

The doctor recommends taking an antihistamine, such as pseudoephedrine, if she is still feeling runny.

The patient asks if she should see her primary care physician if her symptoms do not improve.

The doctor suggests returning in a week if her symptoms persist.

The patient thanks the doctor and departs, feeling a little better.
A similar concern with doctorability is apparent in the following case:

John Hennessy and Jeffrey D. Robinson
Problems: can mmHg, posterior uveitis: underlying the documentation of their
in exchange for the medical gastroscopy, that's by taking the con-
the visit phase is covered with a prescription covering this treatment.
the Norman's concern is worthy of medical attention. For instance for
be a kind of medical and hospitalization. An exciting and
medical problem. Thus the first history-taking gastroscopy condenses a
medical problem. This is the physician's concern to be noted, and
exams and queries to the co-ordination of their care. In this context, they
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the patient's case notes for their chart. Our care is to bring the case for
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Diller's, when the physician asks the first history-taking gastroscopy. The
understanding about those symptoms and what are these symptoms and
understanding about those symptoms and what are these symptoms and
How long have they had this stuff in my
I have no way where I do 40 doctor. When someone we 40

Example (8) is similar to that of gastroscopy. Here's the patient's

You asked, "When do I get the doctor?" Door成型 "When are you expected in the patient's

A patient who is continent of a medical visit, whether it is in prospect

Practices for Insuring medical visits

Accounting for the visit

John Heritage and Jeffrey D. Robinson
The patient's proposal:

Physicians express it as a means of determining the likelihood of a new diagnosis. The following case is where the patient's previous experience

Part: 1

The patient: Don't know how I did it first...

Part: 2

Doctor: Is it above the mounds or below the feet?

Part: 3

Doctor: Have you had any other symptoms?

Part: 4

Doctor: Is there a history of heart disease?

Part: 5

Doctor: Have you noticed any changes in your vision?

Part: 6

Doctor: Have you had any recent changes in your diet?

Part: 7

Doctor: Have you had any recent changes in your medication?

Part: 8

Doctor: Have you had any recent changes in your work schedule?

Part: 9

Doctor: Have you had any recent changes in your personal life?

Part: 10

Doctor: Have you had any recent changes in your financial situation?

Part: 11

Doctor: Have you had any recent changes in your social life?

Part: 12

Doctor: Have you had any recent changes in your personal hygiene?

Part: 13

Doctor: Have you had any recent changes in your personal safety?

Part: 14

Doctor: Have you had any recent changes in your personal relationships?

Part: 15

Doctor: Have you had any recent changes in your personal health?

Part: 16

Doctor: Have you had any recent changes in your personal environment?

Part: 17

Doctor: Have you had any recent changes in your personal goals?

Part: 18

Doctor: Have you had any recent changes in your personal values?

Part: 19

Doctor: Have you had any recent changes in your personal beliefs?

Part: 20

Doctor: Have you had any recent changes in your personal attitudes?

Part: 21

Doctor: Have you had any recent changes in your personal behavior?

Part: 22

Doctor: Have you had any recent changes in your personal habits?

Part: 23

Doctor: Have you had any recent changes in your personal behaviors?

Part: 24

Doctor: Have you had any recent changes in your personal responses?

Part: 25

Doctor: Have you had any recent changes in your personal reactions?

Part: 26

Doctor: Have you had any recent changes in your personal responses to stress?

Part: 27

Doctor: Have you had any recent changes in your personal responses to illness?

Part: 28

Doctor: Have you had any recent changes in your personal responses to treatment?

Part: 29

Doctor: Have you had any recent changes in your personal responses to medication?

Part: 30

Doctor: Have you had any recent changes in your personal responses to lifestyle?

Part: 31

Doctor: Have you had any recent changes in your personal responses to nutrition?

Part: 32

Doctor: Have you had any recent changes in your personal responses to exercise?

Part: 33

Doctor: Have you had any recent changes in your personal responses to sleep?

Part: 34

Doctor: Have you had any recent changes in your personal responses to relaxation?

Part: 35

Doctor: Have you had any recent changes in your personal responses to social support?

Part: 36

Doctor: Have you had any recent changes in your personal responses to stress management?

Part: 37

Doctor: Have you had any recent changes in your personal responses to stress reduction?

Part: 38

Doctor: Have you had any recent changes in your personal responses to stress coping?

Part: 39

Doctor: Have you had any recent changes in your personal responses to stress avoidance?

Part: 40

Doctor: Have you had any recent changes in your personal responses to stress adaptation?

Part: 41

Doctor: Have you had any recent changes in your personal responses to stress accommodation?

Part: 42

Doctor: Have you had any recent changes in your personal responses to stress accommodation?

Part: 43

Doctor: Have you had any recent changes in your personal responses to stress accommodation?

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Doctor: Have you had any recent changes in your personal responses to stress accommodation?

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Doctor: Have you had any recent changes in your personal responses to stress accommodation?

Part: 66

Doctor: Have you had any recent changes in your personal responses to stress accommodation?

Part: 67

Doctor: Have you had any recent changes in your personal responses to stress accommodation?
A visit in which the patient's current symptoms are milde

\[\text{(continuous)}\]

17 PAT: 2
11 DOCT: OK.
11 OMA: ()

[Specify in italics if necessary]

11 DOCT: OMA:
10 DOCT: ()
6 PAT: ("")
6 DOCT: ([""])
8 DOCT: (> )
9 PAT: (> )
9 DOCT: (> )
4 PAT: ("")
4 DOCT: (> )
3 PAT: (> )
2 PAT: (> )
1 PAT: (> )

[Specify in italics if necessary]

(24) [Action Keywords]

HMO: [Specify HMO name] [years ago]

DA#: 10
DATE: 6
DOCT: ("")

I know he is cancer because it was told to me

1. PAT: 1
2. PAT: ("")
3. PAT: (> )
4. PAT: (> )
5. PAT: (> )
6. PAT: (> )
7. PAT: (> )
8. PAT: (> )

[Specify in italics if necessary]

12 PAT: 1
11 PAT: ("")
10 OMA: (> )
9 DOCT: (> )
8 PAT: (> )
7 PAT: (> )
6 PAT: (> )
5 PAT: (> )
4 PAT: (> )
3 PAT: (> )
2 PAT: (> )
1 PAT: (> )

[Specify in italics if necessary]

[CB: 29437 22234]

[CB: 29437 22234]

11 PAT: ("")
10 PAT: (> )
9 PAT: (> )
8 PAT: (> )
7 PAT: (> )
6 PAT: (> )
5 PAT: (> )
4 PAT: (> )
3 PAT: (> )
2 PAT: (> )
1 PAT: (> )

[Specify in italics if necessary]

[CB: 29437 22234]

[CB: 29437 22234]
involving that part of the brain.

Diagnosis:

The patient is able to make a connection to a medially validated zero can be overridden by doctor's decisions. Special considerations should be made when patients are considered for transcranial magnetic stimulation (TMS). One of the patients in this study was a patient with a history of depression. The treatment was effective in reducing symptoms and improving mood. The patient also reported a decrease in anxiety and an increase in energy levels.

Diagnostic evaluation

allowed her to stop smoking. The physicians suspicion "no problem"

(72) above, in which the patients experience of swallowing and breathing

than the optimum described without any basis. This contrasts with

purposes. A pertinent point is often debated, as in (79), by the fact

While these offer "bogus" trouble-reduction (see below) versions

3. (0')

9. (0')

11. (0')

10. (0')

10. (0')

3. (0')

2. (0')

1. (0')

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1. (0')

2. (0')

3. (0')

4. (0')

5. (0')

6. (0')

7. (0')

8. (0')

9. (0')

0. (0')

The talk begins with the patient's complaints of being overwhelmed by depression and anxiety. The patient has a history of depression and anxiety, and has been treated with various medications. The patient has also been diagnosed with bipolar disorder and has been on a variety of medications. The patient has been referred to a psychiatrist for further evaluation.

During the interview, the patient reports feeling fatigued and having trouble concentrating. The patient also reports feeling irritable and having trouble sleeping.

The patient has been on several medications for depression and anxiety, including Prozac and Xanax. The patient reports feeling better since starting these medications, but still experiences some symptoms.

In response to the patient's concerns, the doctor agrees to make some changes to the medication regimen. The doctor suggests reducing the dose of Xanax and adding a new medication, Cymbalta, to help with the anxiety.

The patient agrees to these changes and thanks the doctor for his help. The patient asks if there is anything else that can be done to help with the symptoms.

The doctor agrees to order some additional tests to help identify the cause of the patient's symptoms. The doctor also suggests that the patient continue to see a psychiatrist for further evaluation.

The patient agrees to these recommendations and thanks the doctor for his help. The patient asks if there is anything else that can be done to help with the symptoms.

The doctor agrees to order some additional tests to help identify the cause of the patient's symptoms. The doctor also suggests that the patient continue to see a psychiatrist for further evaluation.
You went camping and now have some difficulty breathing.

[1) Asthma-like symptoms?]

Patient: I think it’s like asthma, but I’ve never had it before.

Doctor: Let’s go through these steps.

Patient: Okay.

Doctor: (1) Have you had any trouble taking deep breaths?

Patient: Yes, I’ve been having trouble breathing lately.

Doctor: (2) Can you tell me how long you’ve been having this problem?

Patient: About a week.

Doctor: (3) Have you been exposed to any allergens recently?

Patient: I’ve been outside a lot lately.

Doctor: (4) Do you have any other symptoms, like a runny nose or coughing?

Patient: No, just the breathing issues.

Doctor: (5) Have you been using any medication for this problem?

Patient: No, I haven’t.

Doctor: (6) Have you noticed any patterns in your breathing?

Patient: Yes, it’s worse at night.

Doctor: (7) Have you been using any inhalers or other treatments?

Patient: No.

Doctor: (8) Do you have a history of asthma or any other respiratory issues?

Patient: No.

Doctor: (9) Do you smoke or have you ever smoked?

Patient: No.

Doctor: (10) Do you have any family history of asthma or respiratory issues?

Patient: No.

Doctor: (11) Have you been exposed to any irritants, like pollen or dust?

Patient: I’ve been outside a lot lately.

Doctor: (12) Have you been using any air fresheners or other household products?

Patient: No, just outdoor activities.

Doctor: (13) Have you been exposed to any mold or allergens?

Patient: No.

Doctor: (14) Have you been exposed to any medications or substances that could be causing this?

Patient: No.

Doctor: (15) Have you been exposed to any workplace hazards?

Patient: No.

Doctor: (16) Have you been exposed to any stress or other factors that could be contributing to this?

Patient: No.

Doctor: (17) Have you been exposed to any recent travel or changes in environment?

Patient: No.

Doctor: (18) Have you been using any travel pillows or other accessories?

Patient: No.

Doctor: (19) Have you been using any travel pillows or other accessories?

Patient: No.

Doctor: (20) Have you been using any travel pillows or other accessories?

Patient: No.

Doctor: (21) Have you been using any travel pillows or other accessories?

Patient: No.

Doctor: (22) Have you been using any travel pillows or other accessories?

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Doctor: (23) Have you been using any travel pillows or other accessories?

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Doctor: (24) Have you been using any travel pillows or other accessories?

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Doctor: (25) Have you been using any travel pillows or other accessories?

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Doctor: (33) Have you been using any travel pillows or other accessories?

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Doctor: (39) Have you been using any travel pillows or other accessories?

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Doctor: (40) Have you been using any travel pillows or other accessories?

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Doctor: (41) Have you been using any travel pillows or other accessories?

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Doctor: (42) Have you been using any travel pillows or other accessories?

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Doctor: (44) Have you been using any travel pillows or other accessories?

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Doctor: (45) Have you been using any travel pillows or other accessories?

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Doctor: (46) Have you been using any travel pillows or other accessories?

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Doctor: (47) Have you been using any travel pillows or other accessories?

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Doctor: (48) Have you been using any travel pillows or other accessories?

Patient: No.

Doctor: (49) Have you been using any travel pillows or other accessories?

Patient: No.

Doctor: (50) Have you been using any travel pillows or other accessories?

Patient: No.
1. Efforts by which patients show that they have (or do not have) accounted for the risk.

2. Problem-oriented presentation.

In this section we focus on two aspects of trouble resistance in patients' problem presentation: 1) the motive for patients' problem presentation (Eisenberg et al., 1981); and 2) its consistency across domains of the patient's life (Suls, 1986). We seek to understand why patients are more or less likely to present problems in certain domains of their lives, despite the fact that they may be equally concerned with these problems. We use the term "trouble resistance" to refer to the tendency of patients to present problems in a manner consistent with their current life situation. Trouble resistance is sometimes referred to as problem avoidance, or as a "negative" problem presentation (Eisenberg et al., 1981). However, we believe that this term is misleading because it implies that patients deliberately avoid presenting problems. Instead, we believe that trouble resistance is a natural consequence of the way patients present their problems.

The nature and dynamics of the physician-patient relationship

"Trouble resistance" is a concept that has been developed in the field of social psychology. It refers to the tendency of people to present problems in a manner consistent with their current life situation. This concept has been used to explain a wide range of phenomena, including the way people present their problems to physicians, the way they present their problems to their friends and family, and the way they present their problems to themselves.

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medical problems are sometimes referred to as "common sense" medical problems in the context of routine care and sometimes referred to as "uncommon" medical problems. These problems are not necessarily rare, but they may be more difficult to recognize because they are not immediately apparent. The term "rare" medical problem is often used to describe conditions that are less common or occur less frequently. However, it is important to remember that "common" medical problems can also be serious and require prompt attention.

2. Efforts to display these common and uncommon conditions and strategies for identifying patients who present with these conditions are critical. Continuous improvement of identification of patients with common medical problems can reduce the burden on healthcare providers, who must be able to quickly and accurately identify patients who have these conditions. This can be achieved through the development of algorithms and clinical pathways that can help healthcare providers identify patients with common medical problems. Additionally, healthcare providers should be aware of the potential for medication errors and work closely with pharmacists to ensure that patients receive the appropriate medications.

3. Strategies for identifying and treating patients with common medical problems are essential for improving patient outcomes. These strategies include the development of clinical pathways and algorithms, as well as the use of electronic health records to facilitate the identification of patients with common medical problems. Additionally, healthcare providers should be aware of the potential for medication errors and work closely with pharmacists to ensure that patients receive the appropriate medications.

John Herbest and Jeffery D. Robinson
When we turn to currently unknown medical problems, both ignored and experimentally discovered, we face a difficult but potentially rewarding field. These problems may provide a basis for the discovery of new therapies and the understanding of the underlying mechanisms of disease. It is essential that we continue to explore these unknown territories and not become complacent with our current knowledge. The potential for new discoveries is vast, and we must remain open to new ideas and approaches in order to make progress.

Troubles resistance in "unknown" medical problems

prouble under other circumstances.

in some instances, presentations of routine illnesses is not possible...
The patient's account also incorporates elements of the second and third points: the doctor's prescribed treatment that is intended to reduce symptoms and the patient's experience of these symptoms. The patient describes a shifting pattern of symptoms, with different intensities and durations. She mentions feelings of sadness and well-being, and the impact these experiences have on her daily life.

Here are some key points from the patient's account:

- The patient has been experiencing sadness and well-being on a daily basis.
- She has noticed changes in her mood and energy levels.
- The sadness is not always present, and she experiences periods of well-being.
- The patient feels overwhelmed by the unpredictability of her symptoms.
- She has discussed these experiences with her doctor, who has prescribed a medication to help manage her symptoms.

The patient also mentions her hope that the medication will help alleviate her symptoms and improve her overall well-being. She expresses gratitude to her doctor for the support and encouragement she has received.
2. Patients frequently have multiple concerns which can be

obtained because it can affect health outcomes;

The process of selecting and presenting concerns is impor-
tant to understand and explain responses (response and Hall
attempts to understand and explain responses) (response and Hall
attempts to understand and explain responses) in their
own terms, including the description of anxiety and concerns and
the roles they play to depict the nature of a medical problem in their
own terms. Where do you know when an area in the

The problem description phase of the medical visit has been quite

Condensing Remarks

To avoid

problem-resistant problem presentations are at

gains

Current problems resistant to the process of selecting and presenting
concerns have been described, though this does not

Lahey, A. (1992). The problem description of pain, ear, or heart-case

experience of the patient. In contrast, the problemombatant to

problems, however, the process into a more "problem-resistant

sentence in an objective and "problem-resistant" fashion is

language. In other words, the language is presented as

In this section, the term "problem-resistatant" or "problem-resistant"

to how often the patient brings a problem-resistant description of the

The language is a problem-resistant method of describing the

a. commensurate with a problem-resistant problem presentation.

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The patient's point of view is an integral manifestation of their individual experience. The information will likely be shaped by their perspective of the visit.

Four important factors that play a significant role in this context are:

1. Patient's expectations and preferences
2. Provider's communication style
3. Patient's current state of health
4. Cultural and linguistic barriers

In their decision to seek medical help, patients often develop a personal narrative of their condition, which may involve a so-called "coping mechanism.

The patient's perspective is crucial in understanding their presentation of symptoms. It is important to note that patients may not always present symptoms in the same way, which can affect the diagnostic process.

We have also discussed various features which are commonly presented as "good enough" motivational factors for medical consultations. Factors such as discomfort, uncertainty, or the desire to seek advice from a trusted individual may motivate patients to seek medical attention.

This chapter has suggested a possible reason for this discrepancy.