A Structural Analysis of Surgeon-Patient Consultations in Clinic Settings in New Zealand

A thesis submitted for the degree of Doctor of Philosophy

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Abstract

Communication in medical care is a popular topic for research and social commentary as doctors, patients, and researchers alike work to find answers as to why patients are dissatisfied and why communication and understanding break down. A multitude of studies about medical communication is published every year (Heritage & Clayman, 2010) using a range of methodologies in an attempt to understand and remedy communication problems. However, how do we know what is good and what is bad in these interactions? To gain an understanding of what goes wrong we must first understand what actually goes on in doctor-patient consultations.

There is a paucity of research into surgeon-patient consultations in the field of health communication research. As Levinson and colleagues note, “[f]urther research is needed to study patterns of communication in surgical disciplines to form a basis for education tailored for surgical specialties” (2000, p. 1026). The need for surgeon-based communication research is apparent through its notable absence in the current doctor-patient communication body of research and there is much that can and will be done to fill this void. This research fills part of that void.

Conversation analysis has been successfully used in the analysis of primary care communication research (Heritage & Maynard, 2006b). In this research, I have used what is known about the “generic orders of organization” (Schegloff, 2007, p. xiv) of conversation to analyse the turn-taking, sequence organization and turn design of 35 video-recorded surgeon-patient consultations. This research comes under the auspices of the Applied Research on Communication in Health (ARCH) group at the University of Otago, Wellington, New Zealand. ARCH researches health care communication using a variety of methodologies. All of the data was recorded in New Zealand. Of the 35 video-recorded consultations, 18 were collected in November and December 2006 and also included patient and surgeon survey data. The other 17 come from a data corpus collected in 2004. The data includes 21 general surgery consultations, while the other 14 consultations come from orthopaedics, vascular surgery, breast cancer surgery and cardiothoracic surgery.

Heritage and Maynard (2006c, p. 15) argue that “investigating the overall structural organization of a medical visit... is valuable in providing access to understandings
about the nature of the medical visit which are drawn upon by physicians and patients in their joint management of its progress”. After an examination of the literature and description of the methods and data, I focus on the activities being oriented to and performed by the participants as well as the overall structural organisation of the consultation. The first analytical chapter, chapter 4, is intended to provide an overview of how the institutional goals of the surgeon-patient consultation are achieved over the course of the interaction. The six activities of first and check-up surgeon-patient visits are interdependent and form an overall project designed to achieve the institutional goals of remedying the patient’s presenting problem. Each of these activities is explored in subsequent chapters. Activity 1, establishing mutual understanding of the referral and achieving alignment, and Activity 2, establishing the patient’s description (and perspective) of their problem, are analysed in chapter 5. Activity 3, gathering further information through verbal and/or physical examination, is examined in chapter 6, Activity 4, reformulating the problem, in chapter 7, Activity 5, proposing next steps, in chapter 8 and Activity 6, closing the consultation, in chapter 9. In each of these analyses, not only are the structures of the activities described, but also how patients have agency within their interactional constraints.
Acknowledgements

This research comes under the auspices of the Applied Research on Communication in Health (ARCH) group in the Department of Primary Health Care and General Practice at the University of Otago, Wellington. Funding was provided through a University of Otago Postgraduate Scholarship and by the New Zealand Health Research Council and Marsden fund. I am greatly indebted to the research group for making this work possible and supporting me over the past few years. The core research group includes four senior researchers Dr Maria Stubbe, Prof Tony Dowell, Ms Lindsay Macdonald and Prof Kevin Dew as well as the full-time data manager, Ms Rachel Tester. Also involved in assisting with this project were Ms George Major and several research assistants. I would also like to thank Dr Liz Dennet from the Department of Surgery for assisting me in recruiting participants and all the patients, surgeons, nurses and support persons who participated in this research.

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European Association of Communication in Healthcare Conference in 2010 and the 7th Australasian CA/MCA Symposium in 2010. I would also like to thank the Conversation Analysis in Sydney data session group and the Discourse Analysis Group at the Australian National University for their feedback on my work and the opportunity to continue my practice of the conversation analytic methodology.

I would like to thank my father, Ross White, for not only inspiring this project, but also for his love and his ongoing support in carrying out this research, providing advice, encouragement and proofreading. I would also like to thank my mother, Judy White, for her love and her emotional and practical support without which this undertaking would have proved very difficult. I would also like to thank my sister, Rachel White, for inspiring me to reach for this goal and for giving me very useful advice along the way.

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Transcription Notation

The transcription notations that are used in this research are taken from ten Have (1999, pp. 213-214) and Gardner (2001, pp. xi-xxi). These are based on the Jeffersonian transcription system.

**Sequencing**

[ A single left bracket indicates overlap onset.

] A single right bracket indicates the point at which an overlap terminates in relation to another utterance.

= Equal signs, one at the end of one line and one at the beginning of the next, indicate no gap between the two turns. This is called latching.

> A carat bracket is used within a speakers to indicate no gap between a speaker’s turn constructional units.

**Intervals**

(0.0) Numbers in parentheses indicate elapsed time in silence by tenth of seconds. This works within a turn, a turn constructional unit or between speakers. For example, (2.1) is a pause of two seconds and one tenth of a second.

( . ) A dot in parentheses indicates a tiny gap of less than 0.2 seconds within or between utterances.

**Prosodic features of utterances**

_underscore_ Underscoring a word or part thereof indicates some form of stress.

::: Colons indicate prolongation of the immediately prior sound. Multiple colons indicate a more prolonged sound.

- A dash indicates a cut-off.

_w-w-word_ Stuttering is indicated by a repetition of the stuttered sound connected by hyphens.
An asterisk around an utterance or part thereof indicates creaky voice.

A dollar symbol around an utterance or part thereof indicates smiley voice.

A period indicates a stopping fall in intonation.

A comma indicates a slightly rising, continuing intonation.

A question mark indicates a rising intonation.

A ‘Spanish question’ mark indicates stronger rise than a comma but weaker than a question mark.

An underline symbol after the word indicates a level pitch contour.

An underlined colon within a syllable indicates that the intonation within the syllable falls then rises.

An underlined second letter within a syllable followed by a non-underlined colon indicates that the intonation within the syllable rises then falls.

The absence of an utterance-final marker indicates some sort of ‘indeterminate’ contour.

An upward arrow indicates a marked shift into higher pitch in the utterance-part immediately following the arrow.

A downward arrow indicates a marked shift into lower pitch in the utterance-part immediately following the arrow.

Upper case indicates especially loud sounds relative to the surrounding talk.

Staccato talk is indicated by a bullet prior to the utterance-part.

Utterances or utterance-parts bracketed by degree signs are relatively quieter than the surrounding talk. Very quiet talk is indicated by two degrees signs on each side.

Left/right carats bracketing an utterance or part thereof indicate slowing down as compared to the surrounding talk.

Right/left carats bracketing an utterance or part thereof indicate speeding up as compared to the surrounding talk.

A dot-prefixed row of ‘h’s indicates an in breath.
Without the dot, the ‘h’s indicate an out breath.

A parenthesised h, or a row of hs within a word, indicates breathiness, such as can be hear in laughter and crying.

**Transcriber's doubts and comments**

(     ) The length of empty parentheses indicate the length of talk that the transcriber was unable to hear. Empty parentheses in the speaker designation column indicate inability to identify a speaker.

(word) Especially dubious hearings or speaker identifications are indicated by parentheses around the utterance, utterance-part or speaker designation.

((   )) Transcriber descriptions are indicated by double parentheses.
Chapter 1: Introduction

1.1 Introduction

Communication in medical care is a popular topic in research and social commentary as doctors, patients, and researchers alike work to find answers as to why patients are dissatisfied and why communication and understanding break down. A multitude of studies about medical communication is published every year (Heritage & Clayman, 2010) using a range of methodologies in an attempt to understand and remedy communication problems. However, how do we know what is good and what is bad in these interactions? To gain an understanding of what goes wrong we must first understand what actually goes on in doctor-patient consultations.

There is a paucity of research into surgeon-patient consultations in the field of health communication research. Levinson and colleagues note, “[f]urther research is needed to study patterns of communication in surgical disciplines to form a basis for education tailored for surgical specialties” (2000, p. 1026). The need for surgeon-based communication research is apparent through its notable absence in the current doctor-patient communication body of research and there is much that can and needs to be done to fill this void. This research fills part of that void.

Using the methodology of Conversation Analysis (CA), I have developed such an understanding of surgeon-patient interactions in clinic settings in New Zealand. Rather than attempting to determine what ‘bad’ communication is, I describe and analyse what occurs routinely in surgeon-patient consultations, particularly how these interactions are co-constructed by participants. Of course there is no single or standard way that a consultation plays out – every interaction is unique as it is dependent on how the participants co-construct the content and context of the interaction. That is, participants choose what they are going to say, how they are going to say it and what actions they are doing with what they say. This concept of the co-construction of the consultation is key to understanding how the activities therein are locally managed by the participants in order to achieve their goals.

The central proposition of this research is that the structure of surgeon-patient consultations is fundamentally different from that of primary care interactions and that
this is consequential both for research in this area and for the development of surgeon-specific training and education. This research challenges the assumption that surgeon-patient consultations are the same as primary care consultations. By exploring the overall structural organisation of surgeon-patient consultations, I demonstrate how several fundamental differences in participant objectives and levels of socialisation are manifested in the interactional structure of the consultation.

The aims of this research are to provide an analysis of the overall structure of surgeon-patient consultations and of the individual activities that make up that structure. This is in order to provide a basic understanding of what goes on in these consultations, an understanding that had previously not been empirically developed. While doing so, this research also demonstrates how patients participate and have agency within the various activities of the surgeon-patient consultation.

Not only is health communication researched using a variety of methodologies (Heritage & Maynard, 2006a), it is also done so from a variety of perspectives. That is, the researchers come from numerous professional backgrounds and methodological traditions. As health communication research is a multi-disciplinary space, it is important for me to clearly identify the audience of this research. My primary audience can be defined as: clinicians, social scientists, linguists and others engaged in health communication research and education, particularly those with an interest in forms of interaction and consultation analysis. Due to the diversity of the intended audience, this thesis provides background information regarding conversation analysis, thorough analysis of the data and a clear presentation of the findings.

In this chapter, I firstly review some of the issues around surgeon-patient consultations, such as their different functions and goals as compared to primary care. Secondly, I discuss the research field of communication in medical care and how conversation analysis has been used to research this field. Thirdly, I briefly describe patient participation, a theme that is explored throughout the structural analysis in this research. Finally, I provide an overview of the present research and thesis.
1.2 Surgeon-patient consultations

Good, clear communication in doctor-patient consultations can lead to improved compliance with treatment (Griffith, 1990), better health outcomes (Stewart, 1995), increased patient satisfaction (Zachariae et al., 2003), more recommendations of the surgeon to friends and family (McLafferty, Williams, Lambert, & Dunnington, 2006) and fewer malpractice claims (Ambady et al., 2002; Davidson, 2002; Mavroforou, Giannoukas, Katsamouris, & Michalodimitrakis, 2002). Communication issues are also cited as the most common cause of complaints (Taylor, Wolfe, & Cameron, 2004). The evidence is clear: good communication is essential to good care and good patient experience.

As for all doctors, good doctor-patient communication skills are widely recognised as an essential part of the competencies required by surgeons. Beyond communication training provided in medical schools (e.g. Kurtz & Silverman, 1996; Silverman, Kurtz, & Draper, 2005), the Royal Australasian College of Surgeons includes communication in its definition of surgical competence and has training and development programs aimed at promoting communication skills (Royal Australasian College of Surgeons, 2010). Undoubtedly, surgical colleges in many other countries offer such ongoing professional training programs. But on what research are these training programs based? There is such a paucity of surgeon-patient communication literature that much of this information is likely to be from primary care communication research, or arguably, not research-based at all, rather than from empirical research on actual surgeon-patient consultations.

Surgeons are confronted with unique issues and tasks in communicating with patients. Some of their tasks are similar to those of primary care physicians (though those that are similar may manifest themselves differently within the distinct objectives of the surgeon-patient consultation), while others are unique to their professional domain. Surgeons routinely break bad news, diagnose illness, manage poor surgical candidacy, negotiate treatment recommendations, disclose errors, discuss risks and benefits, ensure that patients' consent to procedures is informed. And this is to just list those interactions that are between the surgeon and the patient, let alone with colleagues.

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1 The Royal Australasian College of Surgeons includes membership from Australia and New Zealand.
within the clinic, the practice and the operating theatre as well as referrals to other doctors, and back to referring doctors.

As an experienced patient, I have had numerous interactions with doctors of different types – general practitioners, specialists and surgeons. Some of the consultations have been good and some have been bad. Inspired by my own experience, I was intrigued as to why some left me feeling disappointed while others left me feeling satisfied (as I had realised that my experience had little to with what had been diagnosed or recommended). I soon realised that for anyone to understand the issues in consultations, an understanding of the actual goings on in these consultations must first be developed in a research context that does not assign blame. As such, this became my research focus as I endeavoured to understand the structure of surgeon-patient consultations. My experience as a patient cannot be ignored as having influenced my analysis, just as it would if I were a surgeon.

This experience has led me to empirical research in order to understand the structure of surgeon-patient consultations and how patients participate in these interactions. The stereotypical surgeon is seen as “decisive, well organised, practical, hard working, but also cantankerous, dominant, arrogant, hostile, impersonal, egocentric, and a poor communicator” (Cherrington, 2008), but what actually occurs in consultations with patients? With the hypothesis that surgeon-patient consultations are different from primary care consultations, this research is aimed at answering that question, thus laying down a base level of knowledge necessary for development of surgeon-specific training and research in the future.

1.3 Communication in medical care and conversation analysis

Conversation allows the production of social actions to be both achievable and intelligible. Much of everyday sociality, both personal and institutional, is manifest through conversation (Heritage, 2004). As Silverman emphasises, “conversation is the primary medium through which social interaction takes place” (2001, p. 161). Children are socialised through conversation (Heritage, 1984a) and, following Schegloff (1987b), Clayman and Gill (2004, p. 589) note that it is “the primordial site of human sociality and a fundamental locus of social organization in its own right”. Not only is social interaction
of the mundane variety managed through conversation, but so are the institutions that make up society – government, law, health, education and so on.

Conversation is structurally organised and provides an interactional framework for action that is locally managed by participants on a turn-by-turn basis (Heritage, 1984a). The interactional practices of conversation can be described and analysed. As mentioned above, the practices of mundane conversation are modified and utilised in institutional settings. Just as practices of mundane conversation can be analysed, so too are those of institutional interaction, such as surgeon-patient communication. In studying institutional interactions the focus remains on interactions (or talk-in-interaction), “but it is examined for how specific practices of talk embody or connect with specific identities and institutional tasks” (Heritage & Clayman, 2010, p. 16).

Everyday conversation antedates institutional interaction both historically and within a human being’s lifetime. That is, mundane conversation and its interactional practices have long preceded the development of the institutions that are managed through talk and as members of society we are socialised across our lifetimes in these institutions after our socialisation in mundane conversation (Drew & Heritage, 1992b; Heritage & Clayman, 2010). Institutional interaction usually “involves a reduction in the range of interactional practices deployed by the participants, restrictions in the context they can be deployed in, and it frequently involves some specialization and respecification of the interactional relevance of the practices that remain” (Heritage & Clayman, 2010, p. 17). However, it is not possible to draw a dividing line between mundane and institutional interactions as mundane talk can occur during what would ordinarily be seen as an institutional interaction and vice versa (Heritage & Clayman, 2010).

Communication is an integral part of the delivery of medical care (Drew, Chatwin, & Collins, 2001). From clinical handover (Jorm, White, & Kaneen, 2009) and working in teams in the operating room (Yule, Flin, Paterson-Brown, & Maran, 2006) to eliciting patients’ concerns (Robinson, 2006) and delivering diagnoses (Maynard, 1992), much of medicine is performed through talk-in-interaction. It cannot be emphasised enough how central communication, particularly talk-in-interaction, is to the delivery of safe and effective medical care.
It would not be correct to imply that one methodology is better than another in researching institutional interactions, as each researcher has different motivations and different goals. The choice of methodology should be dependent on the research problem and oriented to the desired goals. There have been two major methodologies used in researching doctor-patient interactions: process analysis and the microanalysis of discourse (Heritage & Maynard, 2006b, p. 2). In the case of this research, many of the methodologies used previously by researchers into surgeon-patient communication would not be appropriate as they do not concentrate on the structure and actions of actual consultations. Conversation analysis, however, does.

Conversation analysis, which belongs to the latter group of these methodologies, has been successfully applied to primary care interactions (Heritage & Maynard, 2006c) and is increasingly being used in studying surgeon-patient interactions (e.g. Hudak, Clark, & Raymond, 2009). Conversation analysis (henceforth CA) allows the researcher to analyse the structures of interaction at a micro-analytic level. In short, CA is “centrally occupied with describing the procedures and expectations through which participants produce and understand ordinary conversational conduct” (Heritage, 1984a, p. 245). The central analytic question that drives CA research is why that now (Schegloff & Sacks, 1973). Importantly, this is not a question posed by researchers and observers alone, but is the orientation guiding the interpretation of the participants experiencing interaction-in-production.

CA has origins in the discipline of sociology and has been developed and utilised in other disciplines including linguistics, psychology, and anthropology. CA uses recorded, naturally occurring data that is transcribed in detail. The analysis begins with transcription, where repeated exposure to the data allows researchers to ‘notice’ interesting features. This is followed by a more systematic analysis of the data, which is analysed with reference to the basic structures found in everyday conversation. The benefits of using CA to study surgeon-patient consultations include creating a detailed picture of the overall structure of consultations as well as some focus on the unique intricacies of surgeon-patient consultations, where little basic research has been undertaken.
1.4 Patient participation

1.4.1 Patient-centred care and patient participation

Patient involvement in care is increasingly becoming a focus not just of research (Collins, Britten, Ruusuvuori, & Thompson, 2007b) but also of government policy (Australian Commission on Safety and Quality in Health Care, 2011; Stivers, 2006). This marks a trend away from the early conceptualisation of the doctor-patient relationship as paternalistic to one of shared-decision making and patient-centred care (Thompson, 2007). Despite the increasing interest in patient participation, “there is little consensus about what participation means” (Collins, Britten, Ruusuvuori, & Thompson, 2007a, p. 6). Peräkylä and Ruusuvuori (2007, p. 168) suggest five key components of patient participation, on which I base the definition of patient participation used in this research, due to its comprehensiveness:

1. The patient’s contribution to the direction of action.
2. The patient’s influence in the definition of the consultation’s agenda.
3. The patient’s share in the reasoning process.
4. The patient’s influence in the decision-making.
5. The emotional reciprocity between the patient and the provider of the care.

As can be seen, these components can be found across the activities of the consultation, including presenting the problem (components 1 and 2), treatment recommendation (components 3 and 4) and the overall structure (component 5). Each of these components is identifiable and analysable in the co-construction of the activities of the consultation.

As consultations are co-constructed, the communication style of the doctor can influence how much a patient participates in a consultation (Thompson, Ruusuvuori, Britten, & Collins, 2007). And, as Heritage and Maynard note (2006b, p. 20), “analyzing co-construction is a direct research embodiment of patient-centeredness, because it includes physicians and patients both within the nexus of communication through which medicine is practiced”. Therefore, using conversation analysis to study patient participation is ideal as it looks at the actual consultation (Peräkylä & Ruusuvuori, 2007) and at the individual activities that make up that consultation (Gafaranga & Britten, 2007).
1.4.2 Alignment and misalignment

Alignment and misalignment are important in considering patient participation in surgeon-patient consultations as there are very different levels of institutional socialisation between the surgeon and the patient. This is compared to primary care, where it is more likely that the patient has been socialised into the consultation structure perhaps from childhood. Many patients will not have seen a surgeon (or specialist) very often and thus will have not been adequately socialised into the interaction. For the surgeon, this may make identifying the communicative competence of their current patient difficult, as some patients have higher health literacy and may have seen many surgeons, while others may be visiting a surgeon for the first time. Because of the discrepancy in experience between the surgeon and the patient, the potential for misalignment between participants is not insignificant. As Heritage and Clayman explain (2010, p. 49): “there are very substantial discrepancies in experience, and they are associated with very extensive difference in technical knowledge, institutional know-how, and rights to express knowledge by participants. Added to this are the potentially very great differences in the emotional involvement of the participants in the topics of institutional interaction.”

Patients may orient to the structure of general practice interactions with which they are familiar, while the surgeons may be orienting to a different structure that is more suitable to the delivery of secondary care in a clinic setting. The alignment of perspectives is difficult as what is routine, ordinary and predictable for the institutional representative would ostensibly be non-routine, out-of-the-ordinary and less predictable for the lay person (Silverman, 1998). Health professionals concentrate on their institutional task and “structure the encounter according to various organizational or bureaucratic constraints” (Peräkylä & Ruusuvuori, 2007), while patients focus on their individual experience and illness. Here issues can arise when the doctor fails to acknowledge that although for them the consultation is routine, for the patient it is not (Heritage, 2004).

1.5 A Structural Analysis of Surgeon-Patient Consultations: Thesis outline

This research comes under the auspices of the Applied Research on Communication in Health (ARCH) Group at the University of Otago, Wellington, New Zealand. ARCH researches health care communication using a variety of methodologies. All of the data
was recorded in New Zealand. Of the 35 video-recorded consultations, 18 were collected in November and December 2006 and also included patient and surgeon survey data. The other 17 come from a data corpus collected in 2004 as part of an earlier study (Dowell, Macdonald, Stubbe, Plumridge, & Dew, 2007). The data includes 21 general surgery consultations, while the other 14 consultations come from orthopaedics, vascular surgery, breast cancer surgery and cardiothoracic surgery.

The literature review in Chapter 2 demonstrates that surgeon-patient communication is an understudied area, particularly in comparison to primary care interactions. The use of CA as a methodology to research doctor-patient interactions is also explored. In Chapter 3, the principal concepts of CA are described along with the methodology for data collection and analysis used in this research. Chapters 4 to 9 represent the core analytic content and findings of this research. Chapter 4 explores the overall structural organisation of surgeon-patient consultations and the following five chapters delve deeper into the activities that make up that structure: openings/referral recognition sequences/problem presentation; verbal and physical examination; diagnosis; treatment recommendation; and closings. In the final chapter, I summarise the results and conclusions of the research and also explore its possible implications for teaching and further research.

The starting point for this study was that it remains to be empirically proven whether there are structural differences between surgeon-patient consultations and primary care consultations. However, due to the different goals and orientations of the participants in surgeon-patient consultations, such differences are to be expected. This research identifies and describes the overall structure of surgeon-patient consultations, demonstrating the difference between these and primary care consultations. Through this research, I demonstrate how the goals and orientations of the participants modify the overall structure of the consultation and then how this structure influences patient participation. By doing so, this research challenges that assumption that primary care and surgical consultations are structurally organised in the same way. This is an important step in improving our understanding of surgeon-patient consultations and has implications for training, education and future research.
Chapter 2: Literature Review

2.1 Introduction

Communication training has the potential to be beneficial to the development of good communication skills of medical students and practising clinicians alike. Good communication is essential for surgeons as it allows them to "establish relationships with patients, use their surgical judgment and put technical skill into place" (Davidson, 2002). In many studies, surgeons, both trainees and consultants, give positive feedback to various types of communication training and research. Yet, research has also found that good communication skills deteriorate over time (Perkins, Sanson-Fisher, Anseline, Gillespie, & Lowe, 1998). Despite earlier calls for action to improve training in communication skills for surgeons, little has been accomplished (Herndon & Pollick, 2002). Moreover, while the more routine interaction (for patients) of visiting the general practitioner (GP) has been studied extensively (e.g. Heritage & Maynard, 2006c), research into surgeon-patient communication is still in its infancy. This is problematic as the interactions between surgeons and patients may differ greatly from those in primary care and therefore warrant detailed and independent study.

The structures of doctor-patient interactions in acute primary care settings have been described in great detail (e.g. Heritage & Maynard, 2006c). As noted in the previous chapter, these studies have used a variety of methodologies to research the structures and outcomes of doctor-patient communication. Conversation analysis (CA) is increasingly being used to study such interaction with the theory that: "It is by acting together that doctor and patient assemble each particular visit with its interactional textures, perceived features, and outcomes" (Heritage & Maynard, 2006b, p. 19). Its inclusive, teamwork-based system of analysis is well-suited to the multi-disciplinary field of health communication research and it has become an established methodology in the field (Heritage & Clayman, 2010; Heritage & Maynard, 2006c).

There is an assumption that there is a similarity between surgeon-patient and primary care consultations. Yet, surgeon communication, as noted above, has had far less analytic attention than its primary care counterparts. Therefore, this assumption of similarity (and the proposition here of dissimilarity) has yet to be evidenced through detailed interactional analysis. In the first section of this review, I
discuss research into surgeon-patient consultations in clinic settings. This review is not a systematic review of the evidence for effective communication but aims to identify the current trends in surgeon-patient communication research in the wider health communication literature and provides a view to future research directions. In the second section, I discuss how conversation analysis has been used to analyse doctor-patient consultations. Again, this is not intended to be a comprehensive review, but provides a sketch of how this methodology can be employed in studying medical communication. This chapter is intended to demonstrate, firstly, the type of research being carried out in the field of surgeon-patient consultations and, secondly, how conversation analysis is applied to medical communication research. A fuller discussion of the principles of CA can be found in chapter 3.

2.2 Surgeon-patient communication research

This section of the literature review focuses on research into surgeon-patient interaction in clinic and office situations, excluding other settings such as ward rounds or via email as these communication events are of a different type and purpose (and are not directly relevant to the present research). There is a broad range of articles that cover many areas using various methodologies, so that there is a thin spread of research covering a range of topics. This is by no means a failing of the existing research, but a typical problem for small research fields. The implications of this are that results are not duplicated by independent research, thus raising concerns about reliability.

The current literature on surgeon-patient communication can be divided into four broad categories: 1) discussions of practitioner experience, commentary on surgeon-patient communication, and instructional literature; 2) training and assessment research; 3) research into attitudes and perspectives; and 4) research into the interactional structure and activities of consultations. The final two categories form the substantive basis of this section of the review as they focus specifically on researching consultations themselves, rather than commenting upon them or providing training on how to best undertake them. Here, I briefly comment on the first two categories, before moving on to a more detailed explication of the second two.
2.2.1 Discussions of practitioner experience, commentary on surgeon-patient communication, and instructional literature

Discussion and commentary articles are based on the experiences and perspectives of surgeons, written by both trainees and consultants. Instructional articles are summaries and syntheses of research arising from observations, such as those in discussion and commentary articles. The commonality of these article types lies in their reliance on anecdotal evidence and the research of others, rather than on original research. In general, both observations and summaries suggest that there are varied problems facing surgeons (including trainees) such as stress (Rosenfield & Jones, 2004), the changing doctor-patient relationship (Herndon & Pollick, 2002), medico-legal issues (Davidson, 2002), and cross-cultural communication (Travaline, Ruchinskas, & D'Alonzo, 2005). These articles also emphasise the importance of good communication skills, describing the experiences and identifying techniques claimed by practitioners to be important to good communication.

The commentary and discussion literature identifies some problematic areas in surgeon-patient communication. By identifying key areas, such as the changing role of the patient (Herndon & Pollick, 2002), the influence of technology (Herndon & Pollick, 2002), and the impact of multiculturalism (Tongue, Epps, & Forese, 2005), these articles show both the personal and general experiences of surgeons and thereby provide a possible starting point for research. The instructional literature (e.g. Tongue et al., 2005) shows the end result of such research, providing information on what is considered by the authors to be best practice in training and in communication techniques for surgeons. However, these articles tend to appear as broad overviews rather than explaining communication techniques in detail.

Discussion and commentary articles such as those reviewed above, however, are limited as they are usually based on personal observations and opinions, and are therefore unsystematic and not generalisable. Instructional articles, as noted above, tend to be more like overviews and often provide rather generic advice. In addition, not all the research on which the instructional articles are based comes from studies specifically focussing on surgeon-patient communication. This hinders the applicability of the instructional articles as it is unknown to what extent surgeon communication experiences differ from those of the general practitioner; a fact that is rarely stated. In their defence, however, there has been little surgeon-patient communication research on which to base their recommendations and as there has been extensive research on primary interactions, authors have often called upon it
instead (such as Byrne & Long, 1976). In the next sub-section, I briefly outline the type of research being carried out into training and assessment of communication skills.

### 2.2.2 Training and assessment research

As good communication skills are essential for effective patient care (Davidson, 2002), the training and assessment of such skills form a substantial part of medical communication research. This category of research primarily focuses on the training and assessment of trainee surgeons in their postgraduate years (e.g. Brewster et al., 2005), although there has been some research on the assessment of consultant surgeons (e.g. Clever, Novack, Cohen, & Levinson, 2003). Research has also been carried out on the outcomes of structured training at medical schools (e.g. Yedidia et al., 2003). As most of the consultant surgeon assessments are volunteer-based, these studies tend to suffer from selection bias, which means that good communicators or poor communicators may be over-sampled, therefore not providing a complete picture. As training and assessment is voluntary, consultant surgeons in need of training may not participate, which limits the benefits of training techniques. However, this problem is unavoidable unless medical registration authorities enforce ongoing communication assessment requirements for continuation of registration. This means that most of the research in this category examines trainee communication only.

Training and assessment in all aspects of skill development are essential in medicine. For practising surgeons, however, there is far less opportunity to learn and practice communication skills. Here we see not only a gap in research but also a gap in practice. The research carried out on surgical trainees also suggests that over time communication skills learned in training are used less and less (Perkins et al., 1998); there is therefore no doubt of the importance of the ongoing development of communication skills for all surgeons. Practising surgeons, their colleges, medical registration authorities and medical indemnity providers need to be made aware of the benefits of training and assessment, such as improved patient outcomes (Neuwirth, 1999) and satisfaction (Williams, Weinman, & Dale, 1998). There may be some very easy and effective ways of modifying and utilising trainee assessments for practising surgeons.

There are other noteworthy articles that are independent of the above categories. Of great interest to many surgeons and other health professionals alike are the legal,
medical, and ethical aspects of informed consent. As inadequate communication between doctors and patients plays an important part in many medico-legal cases (Mavroforou, Giannoukas, Katsamouris, & Michalodimitakis, 2002), it is not surprising that concern about lawsuits is cited as a motivation in many articles for doctors to improve their communication skills (e.g. Yudkowsky, Alseidi, & Cintron, 2004). Moving from articles focussed on training and assessment, in the next subsection I discuss articles that focus on the attitudes and perspectives of the patients and surgeons regarding consultations.

2.2.3 Research into attitudes and perspectives

By far the largest area of research into surgeon-patient communication focuses on the attitudes and perspectives of both surgeons and patients. This research provides evidence that problems exist in surgeon-patient communication (though without necessarily defining what they are). This research shows that patients are, in general, satisfied with the communicative abilities of surgeons and surgeons feel that they are generally reasonably competent communicators (Sise, Sise, Sack, & Goerhing, 2006). Patient satisfaction research forms an important part in the development of guidelines as patient understanding and satisfaction is a good indicator of what patients regard as successful communication.

Surveys and questionnaires are commonly used to elicit patient attitudes towards the communication processes common in surgical consultations, including treatment option discussions and the process of informed consent. Hawley and colleagues (2007) studied the discussion of treatment options in breast cancer. Breast cancer patients with stage I, II, or III ductal carcinoma in situ generally have two treatment options – mastectomy or breast conserving surgery. Survey data was collected from 1038 patients of 270 different surgeons in Detroit and Los Angeles, USA, with the research focus both on the decision-making process and patient satisfaction. In 70% of cases, both treatment options were discussed, while in 22% of cases only breast conserving surgery was discussed. There is little discussion of these results, with the authors primarily focussing on preferred levels of patient involvement. Even though only 38% of patients reported a shared treatment decision, 66% of patients stated that their involvement in the decision-making process was the right amount. The findings did show that the desire for involvement may vary according to age or education status, with women aged between 45 and 64 more likely to perceive too little involvement and women with high school or lower education level more likely to
perceive too much involvement. These results suggest the need for surgeons to be “preference sensitive” in terms of the patient’s desire for involvement.

In another survey study, Keating and colleagues (2003) concluded that patient recall may be influenced by their preference for a particular treatment and that they may not remember discussion about other treatment options. The authors suggest that women who reported the discussion of only one treatment option may have directed the conversation toward that option, thereby not recalling the mentioning of the other. The informed consent process in cardiac surgery in the UK was studied by Howlader and colleagues (2004) using surveys administered one day before discharge to 100 patients. Although informed consent can be a contentious issue, 89% of respondents stated that they believed they had received an adequate or more than adequate amount of information in the process. Only 7% believed they were given too little information during the consent process. This research does not, however, provide an indication of how much information surgeons were actually giving and whether the level of information given was adjusted by the surgeons to suit the preferences of each patient.

Although patient recall is not reliable when analysing specific features of consultations, overall patient satisfaction may be appropriately measured using surveys as it is based on their impressions of events rather than on what objectively took place. Determinants of what older breast cancer patients regard as a helpful discussion were studied by Thind and Maly (2006). Surveys of 240 women in Los Angeles, USA, collected ratings of helpfulness, as well as demographic information about the patient and about the surgeon. This data was then analysed using multiple logistic regression modelling. Women with higher education and higher incomes were more likely to find the discussion helpful, while, overall, 44% of women found it extremely helpful. The study also found that consultation length, shared decision-making, and the level of information also impacted how helpful the patient found the discussion. The reasons behind these results are not comprehensively discussed. However the positive impact of longer consultations, shared decision-making, and more interactive information giving are noted as important factors for the development of training and for the management of consultation loads.

Interviews provide a more in-depth view into patient attitudes. In a study of 106 patients who were interviewed at home, 94 had the bad news about cancer broken
to them by a doctor, with 48 out of the 85 doctors identifiable by specialty being surgeons (Barnett, 2002). Overall, 26% of patients found the experience negative or very negative, with surgeons performing the worst out of the specialists and also scoring slightly below general practitioners.¹ Barnett (2002) accounts for this by explaining that surgeons had less contact with patients and therefore had less opportunity to build rapport with them. This study used coding to quantify interview data and no qualitative analysis of the data was undertaken. If researchers knew what in particular in the interaction resulted in positive outcomes, specific techniques could be developed for training. This research claims that patients with a very positive or very negative bad news consultation are more likely to remember it in great detail. Specific training in how to break bad news was noted by the author as essential in communication skills training.

A Canadian study (Ammerman et al., 2007) used interviews to gather information about what patients and health professionals thought was important in quality of life discussions. Semi-structured interviews were conducted with 14 surgeons, 19 other health care professionals, and 52 patients undergoing major elective surgery. These were then transcribed and themes were extracted and divided into six domains – physical well-being, emotional well-being, concern about quality of care, social well-being, cognitive preparation, and spiritual well-being. Overall, 38 of the 85 themes were discussed by a majority of health care professionals (including surgeons) and/or patients. Fifteen themes were discussed by all groups, which covered five of the six domains. The primary differences between the groups were that patients tended to rank the positive aspects of life as more important while the health care professionals ranked the negative aspects more highly. This study did not assess the actual communication abilities of surgeons, but examined the content that patients regarded as important and this may well affect patient satisfaction. Again, as with the previous study, the interview data could have been explored qualitatively to provide more specific insights into the communication process.

More innovative techniques to elicit patient and surgeon attitudes and perspectives have been utilised by Fossum and colleagues (Fossum & Arborelius, 2004; Fossum, Arborelius, & Theorell, 2002). These researchers used phenomenographical techniques in their collection and analysis of data. Consultations were recorded and

¹ Although it seems surprising that 74% of participants did not find the experience negative, it must be emphasised that this study focussed on how negatively the delivery style of the diagnosis was viewed by patients rather than the diagnosis itself.
then played back to the participants (on separate occasions). The participants then commented on the consultation, and when doing so, the consultation tape was stopped and their comments were also recorded. At the end of the consultation tape they were also asked questions about the consultation in general. All of the comments were then coded. These two Swedish studies used data collected from 18 orthopaedic surgery consultations with 18 patients and 18 surgeons participating. In the study of surgeons’ perspectives by Fossum and colleagues (2002), the comments were categorised into the type of statement made. The majority of comments focussed on the surgeons feeling as though they modified their communication to the patient's situation and then also on the way they approached the patient. In the study of the patients’ perspectives (Fossum & Arborelius, 2004), the consultations that were viewed by patients as most positive and most negative were mapped. The results showed differences in the patterns of positive and negative consultations. Positive consultations moved easily between activities, characterised by rapid changes, while in negative consultations fewer activities were covered. Both of these studies, using the same consultation data, present numerous aspects of surgeon and patient perspectives in a detailed way. It is, however, a fairly subjective methodology and coding into predetermined categories can cause limitations to the data analysis as the intricacies of the interactions can be lost through this process.

Surgeon attitudes have been studied less often than those of patients, though such research has produced interesting findings. Risk discussions are necessary when surgeons outline treatment options with patients. However, there are no specific guidelines on how in-depth the discussions should be. Pleat and colleagues (Pleet, Dunkin, Davies, Ripley, & Tyler, 2004) surveyed 60 surgeons in plastic and reconstructive surgery units in the UK to elicit the motivations for risk disclosure. Using a questionnaire, they found that with minor risks a general consensus was that if there was a 5% or more chance of occurrence, surgeons would disclose the risk. With major risks, however, there was no general consensus as to when to and when not to disclose risk. This study shows that a lack of consensus (perhaps due to inadequate guidelines) means that risk disclosure and therefore informed consent is varied. Research such as this shows gaps in training and policy, but it does not elicit patient responses to or provide an analysis of the communication skills of surgeons.
Surgeon attitudes to their communicative abilities have also been researched by Sise and colleagues (2006). A total of 351 surgeons voluntarily responded to the survey, with most rating their skills as either fairly or extremely competent. Self-reported competence in bereavement counselling and gaining consent for autopsy increased with age and surgeons in practice for fewer years generally rated themselves as less competent in the three skills related to patient death. In all groups of surgeons, training in all skills was rated as of high importance. However, although it is true that understanding surgeon attitudes is one of the initial steps in designing effective education programs (Sise et al., 2006), patient attitudes and an understanding of consultation structure are equally as important. Self-assessment of communication skills can be useful, but without comparison to patient scoring and/or objective evaluation, the validity of such self-assessment comes into question as confidence in one’s own ability may be misleading (e.g. O'Neill, Williams, & Kay, 2003).

Links between patient satisfaction and whether a surgeon liked the patient or not were uncovered by the use of exit questionnaires for both patients and surgeons (Levinson, Frankel, Roter, & Drum, 2006). The 701 participating patients in Colorado and Oregon, USA, were given a questionnaire on satisfaction, rating their satisfaction on a five-point scale. The 66 participating orthopaedic and general surgeons were given a questionnaire that included demographic questions and a 1-5 scale rating how much they liked the patient. Surgeons tended to give a higher liking score for older patients, patients with higher education and income, and patients with better health. Surgeon characteristics also affected how much they liked patients. For example, if the surgeon worked in a solo practice and if their own rating of their emotional health was high, their liking scores increased. Patients who were liked more by their surgeons were twice as likely than other patients to be satisfied with the consultation. Improved self-awareness and emotional health of surgeons could therefore improve patient satisfaction. This study does not analyse communication style, but does suggest that surgeon attitudes towards patients can have a significant effect on patient satisfaction. It would be of interest to incorporate such surveys into an analysis of consultations as interactions to explore whether liking also affects communication style or vice versa.

The major limitation of research into the attitudes and perspectives of patients and surgeons is that it does not provide insights into why these attitudes and perspectives are formed but just describes them and quantifies their prevalence.
This restricts its applicability. Ideally, research into attitudes and perspectives should also include analysis of actual consultations, thus broadening the scope to identify causal mechanisms. Attitudes and perspectives, by nature, are subjective. The empirical exploration of such data is therefore limited to an exploration of perceptions, rather than as a means to better understand actual communication behaviours. Much of the data in this type of research, whether collected in a quantitative or qualitative style, has been analysed using statistics, a quantitative analysis tool. This has resulted in a general picture of the attitudes and perspectives of patient and surgeons, but does not provide an in-depth understanding. This is particularly the case with quantified and coded interview data (e.g. Barnett, 2002). However, that is not to say that research of this kind is not useful. Understanding the perspectives of both surgeons and patients can form a basis on which to explore the effects of communication style on patient outcomes. This is particularly the case in the study where a certain aspect of actual communication (i.e. the consultation structure) was linked to a negative impression of the consultation (Fossum & Arborelius, 2004). Using both data on attitudes and perspectives as well as actual consultation data allows researchers to make links between the two. This appears to be the most insightful and comprehensive manner in which to research attitudes and perspectives.

The research in this category does improve our understanding of how both surgeons and patients react to the surgeon-patient interaction by eliciting both participants’ attitudes and perspectives towards actual consultation experiences. Patient and surgeon perspectives and attitudes are an important consideration when examining communication. However, to consider these without correlating the results with actual consultation recordings provides limited insight into communication processes, and developments in training cannot proceed without identifying either problems with or effective features of communication style. The research by Fossum and colleagues (Fossum & Arborelius, 2004; Fossum et al., 2002) is the only literature found in this category that begins to correlate these two types of data. The following describes research that considers actual consultations and the activities co-constructed by participants therein.

2.2.4 Structure and activities of consultations

Identifying the interaction structure and activities of surgeon-patient consultations is the goal of more detailed research than that described above. These (often qualitative) analyses allow researchers to provide an empirical basis for the
development of new areas of training. Consultation structure research has been carried out most extensively into primary care interactions (Heritage & Maynard, 2006a, 2006c), especially with the use of Conversation Analysis (CA), which is also the methodology used in the present study. In the research into the activities of consultations, differences and similarities between surgeon and general practitioner interactions have been examined. In this sub-section a number of different studies are described which represent different methodologies used in the analysis of audio and/or video recorded surgeon-patient consultations. I start with research that uses various coding systems and then move to more discourse-oriented research.

2.2.4.1 Research using coding systems

In research by Braddock and colleagues (2008), actual recordings of interactions were used to examine informed decision-making by patients in orthopaedic surgery consultations. These recordings were coded using a scale of nine elements of informed decision-making that are recommended for surgeons to use which focus on providing information to patients as well as encouraging patient involvement in decision-making. The results of the statistical analysis and the exemplars taken from high-scoring visits showed that those surgeons who scored higher on the informed decision-making scale (that is, they both informed and encouraged patients in decision-making), did not have significantly longer visits than those who did not score highly. The authors recommended the continued application of the informed decision-making model in surgeon-patient consultations.

Similarly, Hudak and colleagues (2008) also used recorded consultations to examine whether it was possible to correlate patient communication behaviours with their preferences for decision-making participation. In this study, 886 audio-recordings were coded for seven communication behaviours (question asking, information behaviour, initiating, statements of preference, processing, resistance, and deference) and these ratings were correlated with post-visit questionnaires regarding decision-making preferences completed by the patients. The authors found not only that there was poor interrater reliability, but also that “patient preference for decision-making cannot be easily or accurately judged on the basis of communicative exchange during routine office visits” (Hudak et al., 2008, p. 390). These findings led the authors to suggest that doctors should explicitly question patients as to their decision-making preferences rather than attempt to rely on conversational cues. While these studies are useful in understanding different
aspects of decision-making, as with other research that uses coding, sensitivity to the implications of the local sequential organisation of the consultation is lacking (Gafaranga & Britten, 2007; Heritage & Maynard, 2006b).

Levinson and Chaumeton (1999) coded 676 consultation audiotapes in an effort to understand the structure and content of surgeon-patient interactions. This US study audio recorded consultations with 394 orthopaedic surgery patients (of 37 surgeons) and 303 general surgery patients (of 29 surgeons). This is the most comprehensive research of its type into surgeon-patient communication, providing quantifiable information. This study is also the first to attempt to describe the communication between surgeons and patients during routine office visits on such a large scale. The authors found that on average a consultation lasts for 13 minutes (with general surgery consultations averaging slightly longer than orthopaedic). The phases of the consultation were then analysed. This analysis showed that during consultations, conversations about social and psychological concerns were brief, there was a narrow biomedical focus, with little empathy expressed by the surgeons. This research used a coding system validated in primary care visits, as well as using the consultation phases (i.e. history, examination, etc.) identified from primary care consultations to understand surgeon-patient consultation structure. While this study is useful in understanding most aspects of the consultation, the nuances of surgeon-patient interactions may well have been lost as the coding is based on another type of consultation. The codes used by the researchers are specific to primary care visits and do not allow for possible differences in the activities of the consultation that appear in surgeon-patient interactions (as the present research will demonstrate).

A more focused use of coding explored patient ‘clues’ to emotional and social aspects of life and the manner in which physicians responded to these (Levinson, Gorawara-Bhat, & Lamb, 2000). Patient clues are “direct or indirect comments about personal aspects of their lives or their emotions” (Levinson et al., 2000, p. 1021). This US study used recorded and transcribed data from 54 general practitioners and 62 orthopaedic and general surgeons, thereby exposing similarities and differences between the two groups. The data was coded to find clues where patients and physicians referred to lifeworld concerns. Patient-initiated clues were focussed on in terms of how physicians responded to them. Interestingly, surgeons responded positively to 38% of clues, while GPs responded positively to only 21%. A positive response was regarded by the researchers as support or encouragement for
patients to express personal, psychological, or family-related concerns. Even acknowledgement of the concern can be seen as positive and positive responses generally meant a shorter overall consultation (in surgery, for example, 12.5 minutes vs 14 minutes). This research is important in understanding how responding to patient clues can strengthen the surgeon-patient relationship without negatively affecting the length of the consultation.

The combination of patient satisfaction surveys and coded visits provided Beach and colleagues (Beach et al., 2004) with information about the relationship between physician self-disclosure and patient satisfaction in Colorado and Oregon, USA. In total, consultations from 589 primary care patients visiting 59 primary care physicians and 676 surgical patients visiting 65 general and orthopaedic surgeons were recorded. These recordings were then analysed using the Roter Interaction Analysis System (RIAS) (Roter & Larson, 2002) and patients were asked to complete a rating survey on satisfaction. The RIAS is used to code statements or complete thoughts from audiotapes (not transcripts) into one of 38 mutually exclusive categories (Levinson & Chaumeton, 1999). The results showed that when a surgeon self-discloses to a patient, patients respond with higher patient satisfaction scores. This could be viewed as the surgeon expressing personal interest and emotional support. In contrast, the results show that general practitioner self-disclosure has a negative effect on patient satisfaction. The authors suggest that this may be due to the fact that patients in primary care visits are often there for chronic illness management and may interpret GP self-disclosure as dismissive. This research is insightful as it examines a specific element of physician-patient interactions and draws well-formed, comparative conclusions. An in-depth analysis of the data, as suggested by the authors, may assist in the understanding of not just how self-disclosure occurs but in what local interactional context self-disclosures are produced. This study suggests that the use of both coding and satisfaction surveys allows a more comprehensive understanding of the relationship between specific interactional activities and patient satisfaction.

A major limitation found in this research is that the data is coded and quantified using tools developed to analyse primary care consultations. While researching a specific element, such as patient clues, a coding system, such as the RIAS, may be useful as it allows the researcher to quickly strip away the unrelated activities of the consultation. However, when one is trying to understand the various activities of the consultation, coding can be restrictive as it confines the researcher to
predetermined categories and does not allow for unique discoveries (Heritage & Maynard, 2006b). As Heritage and Clayman note (2010, p. 118), “[c]ritics identify the central weaknesses of the Roter system in its lack of sensitivity to the details of interaction and its failure to incorporate the perspectives of the participants”.

The primary advantage of coding, on the other hand, is that it allows researchers to analyse a large amount of data in a systematic and clear way that is quantifiable. Coding also allows for statistical analysis in a research field where qualitative methodologies are more common. By allowing researchers to quantify data, it is claimed that coding improves the generalisability and applicability of the research. However, in doing so, the detail and variability within the data is lost and variations from past research may be overlooked, particularly when the researcher uses a coding system that has been established in another field of research. The development of a surgeon-specific coding system would need prior basic research into surgeon-patient communication. This research would need to start from a fresh base, such as the data analysed in this thesis, and not rely on results and specific techniques used in other interaction studies.

2.2.4.2 Discourse and interactional analysis

In contrast to the coding used in the studies above, Mirivel (2007) used action-implicative discourse analysis (a type of qualitative interactional analysis) to study how plastic surgeons manage poor surgical candidacy. The author points out that in determining a patient’s candidacy for surgery, a surgeon must balance good clinical judgement with running a profitable business, reflecting that this process is “an institutional dilemma” (Mirivel, 2007, p. 329). Through the in-depth analysis of one consultation, Mirivel found that a number of communication challenges across the consultation led to the surgeon’s assessment that the patient was difficult, rather than being based upon a single moment within the consultation. While cosmetic plastic surgery differs from other surgery types (that is, it is fully elective and is conducted within for-profit, service-oriented businesses), this research demonstrates how the consultation, and any challenges therein, is managed on a moment-by-moment basis by the participants.

More recently, several studies have used conversation analysis in their research on surgeon-patient communication (Dew, Stubbe, Macdonald, Dowell, & Plumridge, 2010; Hudak, Gill, Aguinaldo, Clark, & Frankel, 2010; Maynard & Hudak, 2008). These three studies demonstrate that CA is a useful technique that can be used to
understand the way in which participants co-construct the activities of the consultation. While these studies focus on particular conversational elements and activities (decision-making, compliments and small talk), CA can also be used in analysing the overall structure of the consultation, as is evidenced in section 2.3 below.

Hudak and colleagues (Hudak et al., 2010) use conversation analysis to demonstrate that patients can use compliments to pursue their institutional agenda. The placement and design of the compliments affect the action they perform, that is, when compliments are offered prior to treatment recommendation they reflected “patients’ expectations for excellent care, not simply to offer praise” (Hudak et al., 2010, p. 788). This is in contrast to compliments produced after the treatment recommendation which do not demonstrate any such intent on the part of the patient.

Maynard and Hudak (2008) used conversation analysis to identify how ‘small talk’, that is talk that is not goal-oriented and transactional like work talk (or not the main medical business of doctor-patient consultations), is used by both doctors and patients in two forms of interactional disattentiveness in primary care and surgical visits: disattentiveness-in-simultaneity and disattentiveness-in-sequence. In the former, doctors and patients use small talk simultaneously with work-oriented, non-verbal tasks being performed during the visit, such as retrieving the patient’s file or during the examination. Disattentiveness-in-sequence, on the other hand, is achieved through small talk in order to avoid “responding to actions the other has initiated” (Maynard & Hudak, 2008, p. 673). These actions include complaints from patients and recommendations from physicians. The participants utilise small talk to transition from the action of complaining or recommending initiated by the other and thus withdraw from that action. The latter of the two was found to be more prevalent in surgeon-patient consultations.

In recent research from New Zealand, Dew and colleagues (2010) demonstrate that surgeons do not use a clinical prioritisation tool (a form that when filled in produces a score that indicates whether a patient is suitable for surgery) in their interactions with patients (that is, it is filled in post hoc). Through using CA, the authors show that due to the interactional complexity of surgeon-patient consultations, incorporating the checklist style tool would be disruptive and could affect the interactional achievements of the consultation. That is, the Clinical Priority
Assessment Criteria (CPAC) tools operate in a linear, systematic way which is incongruent with the non-linear co-construction of the surgeon-patient consultation that leads to diagnosis and treatment recommendation.

In conclusion, many of the articles above, both those using coding systems and the more discourse-oriented research, discuss the difficulties of communication, and research these areas to uncover the specifics of surgeon-patient communication. In several of the research articles, the researchers applied ideas and assumptions (sometimes even techniques) from primary care research without commenting on possible differences between these two types of interaction. An examination of the basic structure and content of surgeon-patient interactions is required to provide a firmer foundation on which to base further research and training. As this field grows, different research techniques will be applied to topics that have already been studied. This, in fact, is already happening. As reported in section 2.2.3 above, Swedish research has adopted a phenomenographical methodology to study surgeon perspectives and patient perspectives (Fossum & Arborelius, 2004; Fossum et al., 2002), while Brewster and colleagues (2005) have combined assessments of communication skills with those of surgical skills to test and teach young surgeons in a realistic, all-encompassing fashion. The following section is a discussion of conversation analysis and how it has been used in the study of particular aspects of doctor-patient consultations to exemplify the potential of CA as a tool to broaden the scope of research into surgeon-patient interactions.

2.3 Conversation analysis and doctor-patient communication

Conversation analysis has been widely used to study various types of doctor-patient interaction, particularly in the primary care setting and this growing body of literature is contributing to a substantial and empirically grounded understanding of the interactional structures and activities of primary care consultations. The large body of literature includes research on consultation openings (Heritage & Robinson, 2006a; Robinson, 1998, 2006; Robinson & Heritage, 2005, 2006), closings (Robinson, 2001; West, 2006), transitions between activities (Robinson & Stivers, 2001), prescribing (Stivers, 2002a, 2007; Stivers, Mangione-Smith, Elliott, McDonald, & Heritage, 2003), diagnosis and news delivery (Maynard, 1992, 2003; Maynard & Frankel, 2006), online commentary (Heritage, Elliott, Stivers, Richardson, & Mangione-Smith, 2010; Heritage & Stivers, 1999), patient participation (Collins, Britten, Ruusuvuori, & Thompson, 2007b), justification of and accounting for the visit (Heritage & Robinson, 2006b), and turn design (Heritage,
Robinson, Elliot, Beckett, & Wilkes, 2007), to name just a few. The present research is extending this to surgeon-patient consultations.

Conversation analysis has been used to research health communication since the early 1980s (Peräkylä, 1998) and has since developed into “an established presence in the field of medicine, where it is used to examine everything from genetic counselling to surgery” (Heritage & Clayman, 2010, p. 1). Conversation analysis can be used to study doctor-patient interaction as the conversational tools and techniques used by participants are those that are used in everyday conversation, even though they may be restricted by the institutional normative orientations of the participants. According to Heritage and Maynard (2006b, p. 13), in CA there are:

three levels through which investigators can conduct the analysis of medical conversations. These include: (1) the overall structure of the primary care visits, (2) the sequence structures through which its particular component activities and tasks are realized, and (3) the designs of the individual turns at talk that make up the sequences.

The conversation analytic research into medical communication covers all these levels, as does the present research. As there is such a large body of literature available on many aspects of doctor-patient communication, I will focus on only a few studies in this review, focusing specifically on prescribing in paediatric settings as there is a strong body of literature on this topic and it exemplifies the variety of ways in which CA can be used in understanding medical communication. Many of the other studies of doctor-patient communication that use CA are considered, and referred to as relevant, throughout the analytic chapters. For comprehensive reviews on the use of conversation analysis in medical communication research, see also Heritage and Clayman (2010), Heritage and Maynard (2006a, 2006c), Maynard and Heritage (2005), and Drew, Chatwin and Collins (2001).

In researching prescribing practices in paediatric visits, Stivers (2002b) found that there are alternative ways in which a parent can present their child’s problem, and that these express different stances towards the treatability of that problem. These are a symptoms-only problem presentation and a candidate diagnosis presentation. The use of the former conveys that parents are “seeking an evaluation of their children first and foremost” (Stivers, 2002b, p. 332), while the latter “displays a stance that the child’s illness is severe enough to require their medical visit and that
it is a treatable condition” (Stivers, 2002b, p. 332). Through using CA, Stivers was able to identify these practices and how they were responded to by physicians, demonstrating the importance of the interaction in creating physician perceptions of parent expectations.

In a follow-up study, Stivers and colleagues (2003) used a combination of conversation analysis, survey data, coding and statistical analysis. This research shows the communication practices that influence doctors’ perceptions regarding parent pressure for the prescription of antibiotics for their children. This research showed that parent pressure for antibiotics was often not overt and instead physicians perceived parent pressure through various interactional techniques used by parents. The two primary techniques resulting in physicians believing that parents expected antibiotics were presenting the problem as a candidate diagnosis and resisting a viral diagnosis (i.e. a diagnosis that would exclude antibiotics as a treatment recommendation). These two studies on prescribing show how CA can be used not only to understand the structure and activities of the doctor-patient interaction, but also how these influence the perceptions of both doctors and parents of child patients and how such activities can affect a clinical outcome, namely the rates at which doctors prescribe antibiotics.

Investigating another practice during consultations, namely doctors’ online commentary during physical examinations, Heritage and Stivers (1999) found that online commentary affects the likely level of resistance by the patient to a diagnosis. Online commentary is talk that occurs during the physical examination that “describes or evaluates what the physician is seeing hearing or feeling” (Heritage & Stivers, 1999, p. 1501). By reassuring their patients through the relatively common practice of online commentary, doctors encountered less resistance from their patients in the diagnosis and treatment recommendations commonly in those encounters where there was a ‘no problem’ diagnosis. More recently, Heritage and colleagues (2010) have demonstrated how online commentary can be used to reduce inappropriate antibiotics prescribing, thereby relating back to the earlier research by Stivers (2002a, 2002b, 2007), and demonstrating how the ‘small bits’ of CA research can, in time, build towards a powerful body of research. Specifically, those doctors who used ‘no problem’ online commentary (as opposed to that which indicates there may be a problem, even though it may be caused by viral illness) were able to reduce perceived pressure for antibiotics and reduce inappropriate prescribing.
While I have only briefly touched upon studies using CA in studying medical communication in this chapter, they exemplify the various ways in which CA can be used and the ‘real world’ significance of the outcomes of such research. Research into medical communication using CA is explored further in subsequent chapters. There are several benefits of using CA to research doctor-patient consultations. Firstly, as CA only uses naturally occurring data that is audio or video recorded, it does not rely on the recall ability of the participants. Secondly, recording preserves the sequences of talk, which allows the researcher to analyse how the interaction unfolds across the course of the consultation. Thirdly, CA is a very detailed methodology, providing an intricate picture of how the consultation is structured and how participants orient to the interactional norms of the consultation.

2.4 Conclusion

It has been argued that communication is directly linked to patient satisfaction (Mavroforou et al., 2002). This is an important consideration as patient satisfaction affects patient adherence to treatment and also biomedical outcomes (Levinson et al., 2006). It has also been well established that there are many challenges for surgeons, especially when it comes to communicating with patients. Bad news delivery, patient counselling, and treatment option discussions are all sensitive areas of which surgeons must be aware. While not all communication skills can be taught, training in how to overcome challenging situations, how to improve specific techniques, and how to manage their own emotional health can improve the surgeon-patient relationship.

There has been little research into the structure of surgeon-patient interactions. Most of the research which has been carried out is limited by the use of a coding system which is arguably inappropriate to the topic and the data. While there is clearly an interest in this area, the scope of research into the structure of surgeon-patient interactions needs to be broadened. It is argued here that an important step for surgeon-patient communication research is an in-depth examination of the consultation structure. There is a need for surgeon-based research to provide a basis of more specialised communication training and education (Levinson et al., 2000). There is a notable paucity of surgeon-patient communication research, highlighting the need for further research, particularly at a basic level so as to ensure that assumptions made are not hindered by an inappropriate reliance on primary care communication research.
An appropriate methodology for this has been successfully applied to primary care interactions – conversation analysis (CA). As a proven methodology in studying medical interaction, CA is therefore a logical choice for describing the practices and overall structure of surgeon-patient consultations. Also, to date, there has been little focus in the CA literature on surgeon-patient consultations even though it is a well-established methodology in the broader field of health communication research. In describing the overall structure, this research therefore contributes to conversation analytic research on medical interactions by providing a detailed analysis of surgeon-patient consultations, which, to date, has yet to be accomplished through CA. The research reported in this thesis also extends conversation analytic work in medical communication research, particularly in regards to surgeon-patient communication. The next chapter provides further details of this methodology as applied to the data collected for the present study of surgeon-patient consultations.
3.1 Introduction

Conversation analysis has found that institutional interactions involve “a selective reduction in the full range of conversation practices available for use in mundane interaction” and “a degree of concentration on, and specialization of, particular procedures which have their ‘home’ or base environment in ordinary talk” (Heritage, 1984a, pp. 239-240). In other words, the practices of ordinary talk are modified and specialized for “task-oriented institutional contexts” (Clayman & Gill, 2004, p. 592). As Heritage notes, institutional contexts are talked into being (1984a, p. 290):

“It is thus through the specific, detailed and local design of turns and sequences that ‘institutional’ contexts are observably and reportably – i.e. accountably – brought into being… it is within these local sequences of talk, and only there, that these institutions are ultimately and accountably talked into being”

In the previous chapter, it was noted that conversation analysis, as it is focused on detailed microanalysis of talk, is ideal for understanding the interactional structure and activities of surgeon-patient consultations. CA has become a well-established methodology in the analysis of institutional interactions (Drew & Heritage, 1992b; Heritage & Clayman, 2010), including doctor-patient consultations (Heritage & Maynard, 2006c). As “patient participation varies according to different phases, or activities, of visits” (Robinson, 2003, p. 29), using CA to understand each of these activities gives insight into patient participation across the entire consultation. For these reasons, I have chosen to use CA in this research project.

This chapter begins with a description of conversation analysis, focussing on its development, its fundamental principles and some key concepts. This chapter then provides a description of the methodological procedures of conversation, including data collection, transcription and data analysis as used in this study. Finally, the data used in the present study (the Surgeon Study) is described, including information on the demographic and ethnographic information which was also collected. As conversation analysis is a rather technical discipline, I have included information on the transcription system in the prefaces and a summary of key concepts and terminology in Appendix A.
to assist those unfamiliar with the methodology. This choice was made to ensure that valuable analytic space was not taken up by explanations of methodology, information on which can be found elsewhere and in far more detail (Clayman & Gill, 2004; Heritage, 1984a, 2004; ten Have, 1999).

### 3.2 The development of conversation analysis

Conversation analysis (CA) is the detailed microanalysis of talk-in-interaction\(^1\), examined in order to provide insight into the structures of action that are usually (or normatively) oriented to by conversational participants. The structures of conversation are tied to the actions produced by the participants and are not influenced greatly by a change in speaker or social context (Heritage, 1984a). According to Heritage, in ordinary conversation “it is assumed that both the production of conduct and its interpretation are the accountable products of a common set of methods or procedures” (1984a, p. 241). Under such an assumption, the analysis of how participants orient to and use conversational structures is possible. That is, as these structures are oriented to by participants, they are describable and analysable by researchers (Heritage, 1984a).

Conversation analysis does not focus on the why of social action, but on the what and the how (Clayman & Gill, 2004). It is directed at finding patterns in conversational structure and understanding and explaining their logic (ten Have, 1999). Conversation analysis does not try to produce rules of conversation; rather it describes existing structural patterns to which participants orient their production and understanding of talk-in-interaction. Therefore, the findings are normative procedures, not hard and fast rules\(^2\) (ten Have, 1999). Participants orient to the normative structures of conversation so as to interpret and understand action (Heritage, 1984a). Participants need not

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\(^1\) A term coined by Schegloff to cover all types of talk, regardless of its character or setting (Schegloff, 2007).

\(^2\) Often the structures in conversation are referred to as ‘rules’, such as the ‘rules of turn-taking’. The word ‘rules’, however, is an unfortunate term to use as it implies that these are unbreakable and lends CA an air of prescriptivism. A more appropriate description of these findings may be ‘normative structures’ as participants normatively orient to certain structures in conversation. However, I will continue to use the word ‘rules’ when discussing previous research that has adopted this term, otherwise I will tend towards the more neutral term ‘normative structures’ or simply ‘structures’.

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conform to the normative constraints of interaction, but such action is then accountable and sanctionable (Heritage, 1984a). That is, “the procedures that inform these activities are normative in that participants can be held morally accountable both for departures from their use and for the inferences which their use, or departures from their use, may engender” (Heritage, 2004, p. 224).

Conversation analysis (CA) was originally developed within the sociological field of ethnomethodology (Heritage, 1984a). While CA has since developed considerably in a number of fields, including linguistics and psychology (Gardner, 2004), the influence of the basic theoretical principles of ethnomethodology remain evident. Ethnomethodology developed out of sociology during the 1950s and is aimed at explaining “the ways in which members create and maintain a sense of order and intelligibility in social life” (ten Have, 2004, p. 14). This is done through the examination of daily commonplace activities, studied using empirically-based methods (ten Have, 2004). Quite innovative in comparison to the contemporary sociological thinking at the time of its development, ethnomethodology focuses on how members of society make sense of their everyday basic circumstances (Heritage, 1984a). Garfinkel’s *Studies in Ethnomethodology* (1967) is regarded as a seminal text in this methodology (Silverman, 2001) and its basic precepts are summarised most clearly by Silverman (2001, p. 123):

> ethnomethodology attempts to understand ‘folk’ (ethno) methods (methodology) for organizing the world. It locates these methods in the skills (‘artful practices’) through which people come to develop an understanding of each other and of social situations.

Conversation analysis was developed during the 1960s and 1970s, primarily by Harvey Sacks with Emanuel Scheglof and Gail Jefferson (Heritage, 1984a). Some of Sacks’ theorising about how to study everyday social life can be traced to the work of his theoretical predecessors, Goffman and Garfinkel. Yet his development of conversation analysis was new and remarkable. While not having a particular interest in language per se, Sacks found organisation in the apparent chaos of conversation, demonstrating an underlying orderliness that had previously been thought impossible to describe (Heritage, 1984a). He showed that this orderliness was both describable and analysable (Silverman, 1998). The focus of Sacks (and of conversation analysis in general) was form over content – the machinery of talk that allows participants to
produce social actions (Silverman, 1998). Sacks’s unique thinking formed a new theoretical framework, aiding in the development of a new way of understanding conversation. Unfortunately, Sacks had an early death, leaving it to others to continue the development of this field.

Schegloff has written extensively on a variety of aspects of conversational structure since the late 1960s and his work has been central in the development of CA. Schegloff’s research has included work on conversational openings (e.g. Schegloff, 1968) and closings (e.g. Schegloff & Sacks, 1973), sequence organisation (e.g. Schegloff, 1990, 2007), turn-taking (e.g. Sacks, Schegloff, & Jefferson, 1974; Schegloff, 2000b), repair (e.g. Schegloff, 1992, 1997a, 2000a), action formation (e.g. Schegloff, 1996a), and gestures (e.g. Schegloff, 1984), to name just a few. Along with writings on the theoretical environment of CA (e.g. Schegloff, 1987a, 1991; Schegloff, Koshik, Jacoby, & Oshler, 2002), Schegloff’s research and teaching has provided a strong empirical backbone for its continued development.

Jefferson contributed along with Sacks and Schegloff in their seminal paper on the rules of turn-taking (Sacks et al., 1974) and also wrote on topic transition/shift (e.g. Jefferson, 1983b), repair (e.g. Jefferson, 1987), laughter (e.g. Jefferson, 1985) and transcription (e.g. Jefferson, 1983a). One of Jefferson’s primary contributions to the conversation analytic method was through the development of the most commonly used transcription system in CA and beyond (ten Have, 1999). This system allows an analyst to notate conversation in a detailed, clear, and systematic way, while preserving the sequential flow of the talk. The transcription notations used in this research are based on Jefferson’s system (see Transcript Notation, p. ix).

Since its development, conversation analysis has had substantive and methodological influence over other disciplines (Heritage, 1984a), as the advantages of examining naturally occurring data have become apparent. While conversation analysis is congruent with other observational research methodologies (Clayman & Gill, 2004), it goes beyond such observation, as it provides researchers with the opportunity to repeatedly observe interactional phenomena. The advantage of this is the ability to discover fine details of interactions that would remain hidden without this methodology and it has been shown that such fine detail can have huge effects (e.g. Heritage,
Robinson, Elliot, Beckett, & Wilkes, 2007). In terms of its place within sociological research, it is difficult to categorize, as explained by Clayman and Gill (2004, p. 590):

Indeed, the CA approach is difficult to categorize in terms that usually dominate discussion of social science methodology. On the one hand, the enterprise has a strong qualitative dimension involving the close analysis of single instances of conduct; on the other hand, it has an informally ‘quantitative’ dimension in that practitioners typically assemble and systematically examine numerous instances of a given phenomenon. It is both an interpretive enterprise seeking to capture the understanding and orientations displayed by the participants themselves, and at the same time it enforces rigorous standards of evidence made possible by the use of recorded data. It is a predominantly data-driven or inductive enterprise, but it is guided by a well-developed conceptual foundation grounded in empirical findings from past research. Given the natural tendency to process novel stimuli in terms of familiar conceptual categories, it is perhaps not surprising that CA has in the past been incorrectly pigeonholed in relation to extant social science methods.

3.3 Fundamental assumptions of conversation analysis

In conversation analysis, conversation is analysed in terms of action not topic (Schegloff, 2007); that is, the focus is how interaction and intersubjectivity are achieved through the structures of talk. The conversational structures and practices which are described by conversation analysis are those that make social interaction and mutual understanding possible (Heritage, 2004). In studying institutional interactions, CA provides access to the normative structures and constraints to which participants orient their talk as they work towards common institutional goals. By using CA, it is possible to understand how participants modify mundane conversational practices to achieve institutional outcomes.

There are three fundamental methodological foci in conversation analysis (Silverman, 2001): the structural organisation of talk; its sequential organisation; and the empirical grounding of its analysis. These assumptions cover both the principal findings of CA and the ways in which such findings are evidenced and are described below.

3 Intersubjectivity is the production and understanding by participants of conversation, made possible through the shared procedures and rules of conversation (Heritage, 1984a; Heritage & Clayman, 2010).
3.3.1 The structural organisation of talk

Conversation analysis allows researchers to meticulously analyse conversation in order to understand the architecture of talk. This understanding also enlightens us as to “how members of society achieve everyday interactive activities” (Campion & Langdon, 2004, p. 82). The structural organisation of talk is accomplished through the turn-taking rules (Sacks et al., 1974). These rules provide a normative guide\(^4\) that participants follow so as to maintain order within conversation. These rules of turn-taking were identified by Sacks, Schegloff and Jefferson (Sacks et al., 1974). As Heritage summarises, “turns are allocated among conversationalists by reference to a set of rules which apply recursively on a local, turn-by-turn basis” (1984a, p. 263). While these are not necessarily consciously followed, they become apparent to speakers when the ‘rules’ are broken. In the case of turn-taking, this would be, for example, when a speaker is interrupted by another party. When there is a momentary ‘break down’ in the turn-taking organisation, such as an interruption, this is when participants generally become aware that the structure exists as it is not being followed. It then may (or may not) be addressed within the conversation. Analyses of ‘deviant cases’ (explored further in section 3.4), that is those that do not follow the normative structures of conversation, are often used to demonstrate the existence and architecture of the structure of the conversation in question (ten Have, 1999).

Central to turn-taking is the idea that talk consists of turn construction units (TCUs). These units, like utterances\(^5\), often appear complete when they are grammatically, semantically, and intonationally complete (Ford & Thompson, 1996). However, TCUs are, in practice, determined as complete by the participants in the conversation as they orient to what is adequate for the utterance to be understood as possibly complete. That is, they may not fit into an objectively describable set of properties (ten Have, 1999), yet they may be treated as complete by the participants.

As well as turn-taking rules, talk is also managed through a system of repair, without which intersubjectivity would not be possible. Repairs occur frequently in conversation.

\(^4\) Sacks demonstrated that conversational behaviour is guided by rules, not governed by them (Silverman, 1998).

\(^5\) Utterance is a term that attempts to encapsulate the units found in conversation. See the Appendix for more information.
Repairs are not concerned with the correction of ‘errors’ in conversation, but instead aid the progressivity of conversation when there are difficulties of speaking, hearing or understanding (Schegloff, 2007). Any turn can become a “trouble source” in need of repair, and it becomes identifiable as such if the participants initiate a repair sequence. That is, the trouble source is only identifiable when a repair initiation occurs; it is not considered to be a trouble source unless it is treated as one by the participants in the conversation. If there were no system of repair there would be no way for conversations to progress if there were any problems in speaking, hearing or understanding, thus completely halting conversation or at least making it mutually unintelligible.

3.3.2 The sequential organisation of talk

An important theoretical claim of conversation analysis is that culture and context are developed through talk, not the other way around (Silverman, 1998). Relationships, identities and ‘contexts’ are talked into being (Heritage, 1984a), rather than conversational action being performed within a fixed context (or contexts) with static relationships amongst immutable identities (ten Have, 1999). As such, analysis of relationships, identities and contexts are only acceptable in CA research if their “local procedural relevance is demonstrated” in the talk under examination (ten Have, 1999, p. 55). Heritage and Clayman (2010, p. 21) describe this as the “yellow brick road” theory of context. This further emphasises the importance of using recorded natural interaction data as “the myriad ways in which specific contexts… are talked into being and oriented to in interaction vastly exceed the comparatively limited, and overwhelmingly typified, powers of imaginative intuition” (Heritage, 1984a, p. 237).

Conversation analysis has demonstrated that context is created and maintained at a local level by the participants and that the creation of meaning is reliant on the sequential environment of the talk (Heritage, 2004). Sequential organisation forms the basis of understanding in conversation through this turn-by-turn building of context. Participants in conversation operate under the assumption that what is said relates to what has been said just prior, thus creating a contextual environment for mutual understanding and intersubjectivity (Heritage, 1984a). Heritage (1984a) regards turns as both context-shaped and context-renewing; that is, turns are delivered with reference

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6 Unless, of course, something is said to show participants that what is being said is not to be understood with reference to the prior talk (Sacks et al., 1974).
to the previous turn and they create a context for any subsequent turn. Thus when analysing conversation it is essential to have access to the surrounding talk to the utterance(s) under examination, otherwise the analysis will be limited (Silverman, 1998).

A turn projects the next relevant activity, or range of activities, to be performed by the next speaker (Heritage, 1984a). This is referred to as sequential implicativeness, which means that a turn “has sequentially organized implications” (Schegloff & Sacks, 1973, p. 296). For example, “questioners attend to the fact that their questions are framed within normative expectations which have sequential implications in obliging selected next speakers to perform a restricted form of action in the next turn, namely, at least, to respond to the question with some form of answer” (Heritage, 1984a, p. 249). Answerers are responsive to these sequential implications, as even if they do not answer the question, they overwhelmingly provide an account for their not answering (Heritage, 1984a). Regarding those responses that are relevant in that they attend to the sequential implications of the previous turn, Heritage notes that “when the relevant ‘next’ occurs, it is characteristically treated as requiring no special explanation: a relevantly produced next action is specifically non-accountable” (1984a, p. 253).

Closely linked to sequential implicativeness is the concept of conditional relevance (Schegloff, 1968). Conditional relevance refers to the observation that the way in which a first pair part is structured makes relevant, or ‘requires’, a specific type of second pair part (Schegloff, 1968). For example a question makes relevant an answer and not just any answer but one that is structurally suited to the question such as a yes/no answer to a yes/no question. Importantly, conditional relevance does not just refer to structure but also to content. That is, if the surgeon asks about the patient’s bowel the relevant response would be about the bowel. The implications for problem presentation are immense, as the way in which an opening elicitor is structured makes relevant specific types of answer. If the opening elicitor is a closed question then the patient has to work harder if they wish to answer beyond the scope and structure of the question.

In conversation, a TCU can represent more than one action (Schegloff, 2007) and “there is not an absolute one-to-one correspondence between the grammatical form of an utterance, and the action it performs” (Clayman & Heritage, 2002, p. 100). Turn
design refers to two distinct phenomena: “(a) the selection of an activity that a turn is
designed to perform; and (b) the details of the verbal construction through which the
turn’s activity is accomplished” (Drew & Heritage, 1992b, p. 32). Actions are therefore
analysable not only by what they are doing (or intended to be doing) but how they are
performed. That means turns are analysed in terms of action and composition of the
turn that the speaker has chosen from the alternatives available (Heritage, 2004).

Key to turn design is recipient design. Recipient design ensures that turns are designed
with reference to and sensitivity to the recipient of the turn (Sacks et al., 1974). As
cconversational participants, “we construct our talk by reference to how it will be heard”
(Silverman, 1998, p. 6). Participants also design turns that are context-sensitive, that is,
the talk is oriented to be appropriate to the setting in which they are speaking (Heritage,
2004) as well as the preceding talk that provides the local context for the turn.
Importantly, the action of a turn is dependant on its position and its composition
(Schegloff, 2007); that is, a turn’s sequential positioning is just as important as its
design in how the action it is performing is understood.

3.3.3 Empirical grounding of analyses

Conversation analysis, as stated above, concentrates on the minute analysis of the
structure of talk-in-interaction. To do this, a researcher records naturally occurring talk
rather than using contrived examples to explore the structure of conversation.
Silverman notes three key advantages of using recorded data (Silverman, 2001, p. 161):

1. It is a public record of ‘raw’ data: this makes the data and its analysis accessible to
other researchers.

2. The data is replayable: using recorded data allows the researcher to repeatedly view the
data, increasing the scope and the accuracy of analytic observations (Heritage, 1984a).

3. The sequences of talk are preserved: this is essential as the understanding of our talk
is created by reference to its sequential positioning (Heritage, 1984a).

Any claim in conversation analytic research must be supported by actual examples
found in natural conversation. Therefore, CA is rigorous in the collection of data and its
analyses (Clayman & Gill, 2004). This is why conversation data is audio or video recorded to ensure the empirical soundness of the analysis. Heritage notes that “it can be difficult to treat invented or recollected sequences as fully persuasive evidence for analytic claims” (1984a, p. 237). Invented examples of talk based on the intuition of researchers are not a reliable source of data (Clayman & Gill, 2004). On the other hand, recorded naturally occurring data exists independently of the researcher’s intervention and gives access to conversational practices akin to those experienced by the participants themselves (Clayman & Gill, 2004). Video recording is ideal as it allows researchers to incorporate non-verbal actions into their analyses (Clayman & Gill, 2004).

In ‘pure’ CA (see section 3.4), conversation data is collected without particular regard to the setting, whether it be a phone call, a doctor’s consultation, or talk over dinner, as the setting (what is often referred to in other disciplines as ‘context’) of the conversation is generally disregarded by the researcher unless it is made relevant by the participants themselves. The data is then transcribed in great detail and analysed with reference to previous findings on conversation as well as through ‘unmotivated looking’.

The principal findings of CA, as suggested by ten Have (1999) and Gardner (2004), form a solid foundation for research into conversational structure and have allowed more recent researchers to focus on other, more intricate, structures of conversation or on how these generic conversational structures are used within institutional settings. Understanding the various key structures of conversation is essential as “only by observing [the organisations of conversation] all together will we understand how the stuff of social life comes to be as it is. Only by understanding them one by one will we get into a position to observe them all together” (Schegloff, 2007, p. 264). The principal findings of conversation analysis have been drawn upon throughout this research and a description of these findings and other terminology used can be found in the Appendix.

**3.4 Methods and procedures of conversation analysis**

As conversation analysis uses only naturally occurring data, it only became possible with the advent of sound recording. While sound recording technology had been around for decades before CA began, the technology only became user friendly and commonly available around the 1960s. In the earliest CA research, this data was from call centres
(e.g. Sacks’ dissertation using suicide prevention centre calls (Silverman, 1998)), other phone conversations, and group therapy sessions. Mostly telephone calls were used to avoid what would have been the necessary analysis of non-verbal communication (Heritage, 1984a). This allowed early researchers to focus on the basic structures of verbal communication without the complications that non-verbal communication would inevitably entail. As the understanding of verbal communication developed, along with more affordable and user-friendly video recorders, more studies have included non-verbal data in their analyses (e.g. Goodwin, 1980).

Video recording provides other contextual information beyond that which can be elicited from audio recording alone (ten Have, 1999). Some studies have integrated the data collected from video recording into their research (e.g. Robinson & Stivers, 2001). As mentioned earlier, audio and video recording precludes the researcher from inventing and manipulating data and ensures a strong, empirical and accountable basis for any conclusions drawn from it (Schegloff, 1988). The increasing concerns around the ethical collection of data has meant that in most places anyone being recorded must be told in advance, though the various laws regarding this differ by jurisdiction. This means that the data might be affected by the consciousness of the participants that their conversation is being recorded. However the natural, unconscious structures in conversation seem to be generally unaffected. That is, the effects of using video and audio recording equipment are minimal on the conversational structures that are the focus of CA as the effects are generally limited to content rather than form (Clayman & Gill, 2004).

Data sampling in CA is usually not an issue (at least not for the researcher) as “if... the way people organize their talk-in-interaction is ‘orderly’... then it does not matter very much which particular specimens one collects to study that order” (ten Have, 1999, p. 50). That is, any episode of talk-in-interaction will elucidate something about the orderly, normative structures of conversation. Any episode is “worthy of intense and detailed examination” (ten Have, 1999, p. 51). However, in ‘applied’ CA, a researcher deliberately restricts their data sample to those from a particular institutional setting so as to concentrate on how the structures of conversation are used in that setting (Silverman, 1998).
Once the data is collected, either using sound or video recordings, the researcher then transcribes it. It is important to remember that transcriptions are not the data itself, but are used to make the original data accessible for in-depth research (ten Have, 1999). Transcripts make the recordings more accessible to repeated analysis by visualising the talk (and sometimes non-verbal action) into written text (Clayman & Gill, 2004). Ideally, researchers should do at least some transcribing of data themselves (Clayman & Gill, 2004); whether it be one or two whole transcripts from a collection or the fine-tuning of basic transcripts made by research assistants (both processes have been used in my own research). As Clayman and Gill suggest, “one practical strategy is to transcribe in varying amounts of detail, reserving the highest level of detail for segments that will receive the most analytic attention” (2004, p. 594). The number of hours of conversation, the number of interactions recorded and the time the researcher has, affects how much will be transcribed. The way a conversation is transcribed can affect the interpretation of the data as each transcriber hears and transcribes different elements of a conversation (Silverman, 2001). Through the repeated exposure to the data that is required in the very detailed transcription and by being forced to listen in much more detail than usual, one begins to notice different phenomena within the data (ten Have, 1999). This makes transcripts stand somewhere between being part of the data collection and the data analysis in their role as an analytical tool in CA.

While the methodology of CA encourages researchers to start their inquiries with ‘unmotivated looking’ (ten Have, 1999), the nature of CA nowadays means that researchers have already been exposed to the theories and findings of previous research and are thus influenced by these theoretical notions when beginning their research. Unmotivated looking is an unattainable ideal (Clayman & Gill, 2004) and, as ten Have (1999) notes, it would be impractical to ignore the conceptual apparatus already built by CA research over the past several decades. However, researcher inquiries are unmotivated insofar that they do not look for a specific feature but ‘discover’ what features are present within that particular interaction and are open to discovering new features as well. Researchers “approach data without a specific agenda in mind at the outset, and thus remain open to previously unexplored practices of interaction” (Clayman & Gill, 2004, p. 596). Overall, unmotivated looking is an open-minded and inductive approach to analysis.
Another way of analysing data within CA is systematic analysis which involves transcribing a sequence and then analysing it systematically using previous principal findings in CA to “unpack” the sequence. This assists the researcher in finding patterns in the data. Many of the more recent studies have used the principal findings of CA to help begin their research and identify patterns in conversation. Ten Have (1999, pp. 107-108) provides a neat analytic package as an example of the systematic analysis of a natural recording using a detailed transcript. To summarise ten Have’s method:

a. Analyse a selected piece of data systemically, working turn-by-turn, explicating the use of the following ‘organisations’ of conversational structure⁷:
   - Turn-taking
   - Sequence organisation
   - Repair
   - Turn construction/design

b. Formulate general observations about the specific piece of data, taking note of features of particular interest.

In this research, both methods of analysis were used. In the early stages of analysis, this included detailed description of the sequence organisation, turn-taking, repair and turn construction, however this preliminary analysis is not presented in this thesis. No matter which method of analysis (or combination of methods) is used, all analyses in CA are data-driven. Ten Have (1999, p. 103) summarises ‘three distinct elements’ from Schegloff (1996a) that are ideal in the empirical account for conversation analytic explications of actions:

1. “a formulation of what action or actions are being accomplished”;
2. “a grounding of this formulation in the ‘reality’ of the participants”;
3. an explication of how a particular practice, i.e. an utterance or conduct, can yield a particular recognizable action.

In creating a collection of a particular phenomenon, “one should include not only those that appear to be clear instances of the phenomenon in question, but also less clear boundary cases in which the phenomenon is present in a partial or imperfect form, as

⁷ Descriptions of the principal findings can be found in the Appendix.
well as negative or ‘deviant’ cases where the phenomenon simply did not occur as expected” (Clayman & Gill, 2004, p. 601). Deviant cases can often prove the ‘rule’, or systematic practice, that is under observation as participants will often orient to normative practices in deviant cases (Clayman & Gill, 2004). Such cases strengthen the analytic explication of a phenomenon by broadening its scope and clarifying its boundaries (Clayman & Gill, 2004). When the normative orientations of participants are not adhered to, participants will often account for such deviations (Heritage, 1984a). This is because this framework of normative orientations also means deviations are normatively accountable (Heritage, 1984a).

The above methods relate to what is regarded as ‘pure’ CA. ‘Applied’ CA uses the above methods but also includes other data, such as ethnographic observation, collection of written materials, and even ‘coding’ based on previous CA analyses to provide quantitative information. In applied CA “the interest is not the activity-as-such, but in specific kinds of category- or context-bound activities” (ten Have, 1999, p. 51). That is, applied CA focuses on how the features of mundane conversation that are already known, such as turn-taking rules and sequential organisation, are used by participants within particular settings. Conversation analysis is a way into the organisation of institutional interactions. It is nevertheless important to emphasise the necessity of the pure CA research that continues to inform the methodology of CA. As Clayman and Gill note (2004, p. 603), “as progress is made in these various ‘applied’ areas, it is important to keep in mind that such work would not be possible without the ‘pure’ research on which it is based”. According to Drew & Heritage (1992b, p. 22), there are three key concepts that differentiate institutional interactions from mundane conversation:

1. Institutional interaction involves an orientation by at least one of the participants to some core goal, task or identity (or set of them) conventionally associated with the institution in question. In short, institutional talk is normally informed by goal orientations of a relatively restricted conventional form.

2. Institutional interaction may involve special and particular constraints on what one or both of the participants will treat as allowable contributions to the business at hand.

3. Institutional talk may be associated with inferential frameworks and procedures that are particular to specific institutional contexts.
There have been various methodologies used in the analysis of institutional interactions. These range from coding (e.g. Roter, 1977) to conversation analysis (e.g. Drew & Heritage, 1992b; Heritage & Maynard, 2006c), with many other methods in between. Quantitative methodologies have proved useful in this area, particularly when combined with qualitative research (e.g. Heritage et al., 2007); however qualitative research gives more in depth insight into the structures of the interactions. By using CA to research institutional interactions, we can see how everyday conversational practices are employed and modified for institutional purposes (Heritage, 2004). It shows how members “invoke a particular context for their talk” (Silverman, 1998, p. 171). Because CA is a very detailed method of analysis, it provides a comprehensive examination of the interaction and as such is a useful methodology in the study of institutional interactions. Through CA, analysts can, for example, explore how the roles of the professional and the layperson are co-constructed through the interaction, and how and why participants structure their conversational turns in the way they do.

Conversation analysis uses recorded data and therefore the details of institutional interaction are not lost as they are in observations, interviews, and experimental methodologies (Heritage, 1984a). It involves the analysis of actual observable occurrences rather than invented or reported ones (ten Have, 1999). Recorded data also has the advantage that the data are “neither idealized nor constrained by a specific research design or by reference to some particular theory or hypothesis” (Heritage, 1984a, p. 238). By using CA to study institutional interaction, the identities are made relevant and observable in the aims and activities of the participants involved (Drew & Heritage, 1992b).

As noted above, this research falls under the more applied type of CA. In undertaking this research, I used both unmotivated looking and systematic analysis. I began by transcribing one consultation in full to a CA level (see section 3.7). It was chosen because the recording was particularly clear and the overall structure includes many of the activities found across the surgeon-patient consultations in this data. Using the recorded data and the base transcripts, which I had edited/transcribed to a basic level, I identified the overall structure, activities, and features of surgeon-patient consultations. Once these had been identified, I chose clear examples and transcribed extracts to CA standards. For example, when a particular opening elicitor design had been identified in
the activity of eliciting a problem presentation, I sought other examples and chose particularly clear ones to present in this thesis.

3.5 Data collection: the Surgeon Study

As mentioned in chapter 1, this particular project forms part of the work by the Applied Research on Communication in Health (ARCH) Group based in the department of Primary Health Care and General Practice at the University of Otago, Wellington. This multidisciplinary team and its research associates, who have varying backgrounds in primary health care, public health, sociolinguistics, psychology, sociology, ethnomethodology and conversation analysis, conducts research not only on surgeon-patient consultations, but on a variety of health professional communication events (ARCH website, 2010). The data collected by the team includes ethnographic observations, collection of demographic information, collection of written materials, and, most importantly, video recordings of actual communication events. Some of the data used in the present study comes from the corpus collected and archived by the research team for the Interaction Study conducted between 2003 and 2005. In addition to the Interaction Study data, a further 18 consultations with patients and surgeons were recorded (the Surgeon Study) specifically for this thesis. The data collected for the present study will also be included in the ARCH Corpus of Health Interactions (ARCH website, 2010). Ethics approval was granted by the Central Regional Ethics Committee in New Zealand.

The data from the Interaction Study used in this study was collected in 2004. Numerous primary care consultations were recorded as part of that study along with the 17 surgeon-patient consultations analysed here. Demographic information on the participants was also collected as well as some ethnographic observations of the clinics. All recordings were made in the greater Wellington area. All data was video-recorded using a digital video recorder. Separate audio recordings were also made using a mini-disk recorder. For physical examinations in the consultations the video recorder was usually turned off and the data only captured on the audio recorder. The data collection for the Interaction Study was primarily conducted by a research nurse. The research nurse approached patients in the waiting room to gain consent. This meant that the camera needed to be set up as the patient was ushered into the consulting room. Sometimes the consultation, therefore, started before the recording
did as the surgeon was already in the room; however many of the recordings capture the full consultation. This data has been used in various non-CA and CA studies (e.g. Dew, Dowell, Stubbe, Plumridge, & Macdonald, 2008; Dew, Stubbe, Macdonald, Dowell, & Plumridge, 2010; Dowell, Macdonald, Stubbe, Plumridge, & Dew, 2007).

To increase this data for the purpose of the present research, known as the Surgeon Study, I recorded a further 18 consultations in late 2006. The initial contact with possible surgeon participants for data collection for the Surgeon Study was aided by a senior academic in the Department of Surgery at the University of Otago, Wellington. A brief description of research was sent by the surgical academic to colleagues who she thought may be willing to participate. I then followed up these letters by contacting the doctors by telephone. In total, five consultants agreed to participate, one of whom had previously been involved in the Interaction Study. I then contacted the senior clinic nurse for each consultant to discuss an appropriate time to collect the data. The three registrars who participated were recruited on the day of data collection. Demographic information was collected as well as survey data on patient expectations and satisfaction and surgeon perspectives. All recordings were made in Wellington. All data was video-recorded using a high definition digital video camera. Audio recordings were also made using the mini-disk recorder. To ensure less researcher interruption, the camera was covered using the lens cap or a heavy cloth during physical examinations.

Wherever possible in the Surgeon Study data collection, the recording equipment was set up in one clinic room. Nursing staff asked patients if they might be interested in participating and those that indicated that they might be were seated in the room with the recording equipment. I then entered prior to the consultation to ask the patient if they would like to be involved. If they agreed, the recording equipment was then turned on. In the orthopaedic clinic and the cardiothoracic ward, patient permission was sought and then the recording equipment was set up in whichever room the patient was in. I asked the patient four questions about their expectations of the consultation (Table 3.1) and left the room while the consultation was in progress. All participants were made aware that they could pull out of the study at any time. After the consultation, I asked the patient four more questions (Table 3.2) and also gave the surgeon a short questionnaire (Table 3.3). The questions and survey were not based on previous research and were collected only as supplementary data to ensure that I had some
insight into the expectations and sentiments of the patients and surgeons. In hindsight, a previously utilised survey may have been useful, however this information was not key in informing this research.

Each surgeon has been assigned a code, in accordance with the conventions used in the ARCH Corpus. The first two letters refer to the study in which the surgeon first participated (i.e. IS equals Interaction Study; SS equals Surgeon Study). The second two letters, SP, indicate that they are specialists (in other ARCH studies, non-surgical specialists are also assigned this code). The third is a number showing the order of participation and this acts as an identifier between the participants. For example, IS-SP01 is a surgeon who first participated in the Interaction Study, he is a specialist, and is the first participant of his kind. Patient codes are based on surgeon codes. After the surgeon number, the patient number occurs. That is, IS-SP01-01 is the first patient for surgeon IS-SP01. Patient numbering restarts for each surgeon, meaning that the first patient for IS-SP02 is referred to as IS-SP02-01.

Table 3.1: Patient pre-consultation questions

<table>
<thead>
<tr>
<th>Patient Pre-Consultation Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are your expectations of the consultation?</td>
</tr>
<tr>
<td>Have you had a consultation like this (i.e. with a surgeon or specialist) before?</td>
</tr>
<tr>
<td>Have you had a consultation with this surgeon before?</td>
</tr>
<tr>
<td>Do you know much about why you’re here/the problem you may have?</td>
</tr>
</tbody>
</table>

The data extracts presented in this thesis are numbers as follows: In Chapter 4, the extract numbers refer to different segments from the same consultation. For example, Extract 4.3 occurs in Chapter 4 and is the third extract presented. In Chapters 5 through 9, the data extracts are taken from a number of consultations. These are numbered according to chapter, place within the chapters and consultation. For example, Extract 6.1a occurs in Chapter 6, is the first extract that occurs in that chapter and is the first occurrence of an extract from that particular consultation in that chapter. Extract 6.1b, then, occurs in Chapter 6, is from the same consultation as the first extract that occurs in that chapter and is the second occurrence of an extract from that particular consultation in that chapter and so forth. The numbering restarts for each subsequent chapter. Each of these extract numbers is also followed by the consultation code.

8 The data extracts presented in this thesis are numbers as follows: In Chapter 4, the extract numbers refer to different segments from the same consultation. For example, Extract 4.3 occurs in Chapter 4 and is the third extract presented. In Chapters 5 through 9, the data extracts are taken from a number of consultations. These are numbered according to chapter, place within the chapters and consultation. For example, Extract 6.1a occurs in Chapter 6, is the first extract that occurs in that chapter and is the first occurrence of an extract from that particular consultation in that chapter. Extract 6.1b, then, occurs in Chapter 6, is from the same consultation as the first extract that occurs in that chapter and is the second occurrence of an extract from that particular consultation in that chapter and so forth. The numbering restarts for each subsequent chapter. Each of these extract numbers is also followed by the consultation code.
### Table 3.2: Patient post-consultation questions

<table>
<thead>
<tr>
<th>Patient Post-Consultation Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were your expectations of the consultation met?</td>
</tr>
<tr>
<td>Was the information that the surgeon gave you clear?</td>
</tr>
<tr>
<td>Were all your questions answered?</td>
</tr>
<tr>
<td>Were there any questions that you didn't get an opportunity to ask?</td>
</tr>
</tbody>
</table>

### Table 3.3: Surgeon post-consultation survey

<table>
<thead>
<tr>
<th>Surgeon Post-Consultation Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you say everything that you wanted to say to the patient?</td>
</tr>
<tr>
<td>Did you feel like the patient understood you?</td>
</tr>
<tr>
<td>Do you expect to see the patient again?</td>
</tr>
</tbody>
</table>

### 3.6 Participants: the Surgeon Study

In total, there are 35 video-recorded consultations between surgeons and patients in the data for this research. Consultations were recorded over a number of clinics for both the Interaction Study and the Surgeon Study. Some recordings are missing some or all of either the video-recording or the audio-recording. Nevertheless, all 35 recordings have been considered in the analysis as the full duration of most consultations can be found on a combination of the audio and video data and only the verbal communication is analysed in detail.

Of the 35 consultations, 32 were carried out in outpatient clinic settings. Two of the remaining three were pre-operative assessments by a surgeon in a ward setting and the final one was an outpatient consultation in a ward setting (the patient had difficulty making clinic hours). In total six surgical specialties were included in the original research design: general, vascular, breast cancer, orthopaedic, cardiothoracic, and otorhinolaryngology. Data was collected in five of these six specialties, with no data collected in otorhinolaryngology or Ear, Nose and Throat (ENT) as no patients consented to be video-recorded. These specialties were not specifically chosen, but were recorded because of the willingness of surgeons and their clinic staff to participate. Clinic nurses were approached prior to data collection to ensure they were amenable to data collection (particularly if they were involved in consultations) and to confirm appropriate data collection days. Signed consent was sought from all...
participants in the recordings including surgeons, trainee interns, nurses, patients, and support people (family and/or friends of patients).

There were ten surgeons involved, two of whom were female. Three surgeons (including a female surgeon) were registrars. A details from the ENT surgeon who volunteered to participate but with whom no data were collected are not included in this research. In terms of surgeons who participated in the Interaction Study and the Surgeon Study, five surgeons were from the general clinic; two were from the breast cancer clinic; and there was one surgeon per clinic from the orthopaedic, cardiothoracic, and vascular clinics. Table 3.4 below shows this distribution.

In total there were 35 patients, 15 male and 20 female. There were 21 patients from the general clinics, 2 from vascular, 2 from orthopaedic, 3 from cardiothoracic, and 7 from the breast cancer clinic. The distribution of patients is represented in Table 3.5 below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Study</th>
<th>Specialty</th>
<th>Gender</th>
<th>Registrar/Consultant</th>
<th>Consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS-SP01</td>
<td>IS</td>
<td>General</td>
<td>Male</td>
<td>Consultant</td>
<td>6</td>
</tr>
<tr>
<td>IS-SP02</td>
<td>IS</td>
<td>Vascular</td>
<td>Male</td>
<td>Consultant</td>
<td>2</td>
</tr>
<tr>
<td>IS-SP03</td>
<td>IS &amp; SS</td>
<td>General</td>
<td>Male</td>
<td>Consultant</td>
<td>6</td>
</tr>
<tr>
<td>IS-SP04</td>
<td>IS</td>
<td>General</td>
<td>Male</td>
<td>Consultant</td>
<td>5</td>
</tr>
<tr>
<td>SS-SP07</td>
<td>SS</td>
<td>General</td>
<td>Male</td>
<td>Registrar</td>
<td>3</td>
</tr>
<tr>
<td>SS-SP08</td>
<td>SS</td>
<td>Orthopaedic</td>
<td>Male</td>
<td>Consultant</td>
<td>2</td>
</tr>
<tr>
<td>SS-SP09</td>
<td>SS</td>
<td>Cardiothoracic</td>
<td>Male</td>
<td>Consultant</td>
<td>3</td>
</tr>
<tr>
<td>SS-SP10</td>
<td>SS</td>
<td>Breast Clinic</td>
<td>Female</td>
<td>Consultant</td>
<td>6</td>
</tr>
<tr>
<td>SS-SP12</td>
<td>SS</td>
<td>Breast Clinic</td>
<td>Female</td>
<td>Registrar</td>
<td>1</td>
</tr>
<tr>
<td>SS-SP13</td>
<td>SS</td>
<td>General</td>
<td>Male</td>
<td>Registrar</td>
<td>1</td>
</tr>
</tbody>
</table>

A registrar is a doctor who has completed their postgraduate training years and has entered into specialist training.
Table 3.5: Patients per clinic type

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Female patients</th>
<th>Male patients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>12</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Vascular</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

3.7 Transcription: the Surgeon Study

CA transcription is a very detailed process. The conventions used in this study, that is the symbols and formatting style, were taken from ten Have (1999) and Gardner (2001). The conventions for CA transcription originally stem from the transcription system developed by Gail Jefferson (ten Have, 1999). The process of transcription I used is based on a system taken from Gardner’s adaptation (unpublished course notes) of Dubois and colleagues (1988). The process involves nine stages of transcription:

1. words only
2. stress, lengthened sounds
3. dysfluencies, filled pauses, minimal responses
4. pauses, latching
5. non-linguistic sounds
6. special or marked prosodic qualities
7. terminal pitch direction
8. overlaps
9. double check everything

For the Interaction Study (IS) data, words, filled pauses, non-linguistic sounds, and overlaps had all been transcribed by research assistants, however I only used the words and filled pauses and re-transcribed the remaining details to ensure consistency throughout my transcriptions. For Surgeon Study (SS) data, I transcribed three of the consultations in full while research assistants from the ARCH team transcribed the rest in the same system used for the IS data. As with the IS data, I used only the words and filled pauses then re-transcribed the rest. All consultations were transcribed to a basic level using stages 1, 3, 4, 5 and 8 of the nine stages of transcription listed above. Stages 2, 6 and 7 were used in the transcription of one entire consultation (i.e. to CA
standards) as well as in the transcription of extracts used as examples in this dissertation. All examples were double checked, stage 9, for accuracy.

Trying to figure how to render some of the data was problematic, particularly as I am an Australian English speaker and most of the participants were New Zealand English speakers and thus have ‘accents’. So, as I had had exposure to New Zealand English, I tried to use more standard orthography for standard NZ pronunciations. This problem was initially difficult to come to terms with as I aimed to be as true to the recorded data as possible while also wishing to make the transcripts intelligible. The issue was made clear to me while transcribing the word *working*. In no dialect of English that I am familiar with do speakers say *working* the way it is spelled – they say *werking*. However, to transcribe every word as it sounds would make the transcripts unreadable and I have found few transcripts that go to such extremes. So transcription decisions were made for general cases as well as for local items that appeared important to the progressing interaction. Words where using non-standard orthography was important as there were a variety of ways of pronouncing the words, like *you know*, were transcribed as such, i.e. *y’know*, and words ending in *–ing* but pronounced *–in’*, were also transcribed as such. However, most talk was transcribed in standard orthography unless the pronunciation was particularly marked.

3.8 Conclusion

Conversation analysis is increasingly being used to analyse doctor-patient interactions (Heritage & Maynard, 2006c). The strength of the methodology lies not only in its use of naturally occurring data, but also in the replayability of the data, allowing it to be viewed and re-interpreted by other researchers. While other methodologies may also use recorded data, the microanalysis of CA develops an intricate understanding of the processes of talk-in-interaction. In the research of institutional interactions, recorded data can also be used in reflexive learning10 (Antaki, Finlay, & Walton, 2009). While conversation analysis is congruent with other observational research methodologies (Clayman & Gill, 2004), it goes beyond such observation as it provides researchers with the opportunity to repeatedly observe interactional phenomena. In this research, CA is used to identify features of surgeon-patient consultations. On the one hand, it

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10 Reflexive learning is where the participants view recordings of their own interactions in order to observe, understand and improve their practice.
contributes to ‘pure CA’ as basic research on interaction and, on the other, it contributes to our understanding of doctor-patient communication that has the potential to improve the complex activity of the medical consultation.
Chapter 4: Overall Structural Organisation

4.1 Introduction: the organisation of sequences and of interaction

Sequences of talk are not organised by themes and topics but through adjacency pairs and their expansions (Schegloff, 2007). That is, they are organised with reference to the actions being performed by the participants. Sequences also build one upon another. As Schegloff states (2007, p. 263), sequence organisation “relates a series of these productions into coherent courses of action, and thereby harnesses the resources of talk-in-interaction to getting things done”. After the end of each sequence a new sequence may be launched (Schegloff, 2007). There are three ways in which sequences in a series can be related to each other: (1) a sequence of the same type occurs but with the participants reversed, such as in greetings; (2) the same sequence type occurs with the same “participatory alignment” (Schegloff, 2007, p. 213) but with a different purpose or topic, known as action-type sequence series (such as question/answers series); and (3) a sequence can be a separate structure while also continuing a particular course of action, such as making arrangements (Schegloff, 2007). As in any episode of talk, in surgeon-patient consultations all three organisations can occur.

Sequences are the smaller, local organizations of action that make up the activities of an interaction and are identifiable by the goals to which the participants observably orient their behaviours. In doctor-patient interaction, the organisation of sequences has commonly been understood in terms of ‘phases’ (cf. Byrne & Long, 1976; Heritage & Maynard, 2006c; Robinson, 2003). These phases are in part identifiable by the actions being performed within them. History taking, for example, is identifiable as history taking due to the action-type sequence series of questions and answers.

The sequential organisation of talk gives it coherence (Schegloff, 2007). The trajectory of continuing action that pervades the doctor-patient interaction not only makes it identifiable as a consultation, but also guides the participants who work together through talk to reach the common objectives and goals of the consultation (for example, diagnosing and recommending treatment for a presenting problem).
In mundane interaction, “we are dealing with local, contextual particulars, not incorporated in the general or formal organization of sequences, but requiring and getting local management” (Schegloff, 2007, p. 262). That is, there is no pre-determined structure of mundane interactions. While in some institutional settings the organisation of sequences may be pre-determined (as in courtroom settings), in doctor-patient consultations, the participants are only guided by an orientation to the goals of the interaction (though these may not necessarily align completely between the participants). The activities of consultations are identifiable by the goals of the participants and the ways in which they are oriented to and achieved, and by necessity these activities occur in a generally canonical order so as to achieve these institutional goals; however the organisation of the talk and the consultation is still locally managed by the participants in situ.

Heritage and Maynard (2006b, p. 15) argue that “investigating the overall structural organization of a medical visit... is valuable in providing access to understandings about the nature of the medical visit which are drawn upon by physicians and patients in their joint management of its progress”. The overall research proposition, as stated in the introduction, is that the structure of surgeon-patient consultations is different from primary care interactions. In this chapter, this is evidenced through the description of the differences and similarities in the overall, canonical structure of the surgeon-patient consultation as compared to primary care consultations. I focus on the activities that are oriented to and performed by the participants at a local level, as well as the overall structural organisation of the consultation. This chapter is drawn from the detailed analysis of the activities described in the subsequent chapters. It contextualises these more detailed analyses by providing an overview of how the institutional goals of the surgeon-patient consultation are achieved over the course of the whole interaction and how each activity creates a relevant local environment for the next activity. Firstly, I examine some existing theories and descriptions of consultation structure. Secondly, I discuss some of the relevant theories of patient participation. Finally, I analyse the overall structure of surgeon-patient consultations, as identified in my own analysis, using one of the visits in the present data to demonstrate the proposed structural schema.
4.2 Understanding consultation structure

Over the past 30 to 40 years there have been numerous attempts to describe the overall structure of the doctor-patient consultation. The purpose of these various descriptions of the activity structure schema of the consultation, predominantly of general practice consultations, have varied: some have been for purely descriptive purposes (Byrne & Long, 1976), while others aimed to understand patient-centred practice (Helman, 1981), and others to inform training and education (Kurtz & Silverman, 1996; Silverman, Kurtz, & Draper, 2005). Most notably in early research, Byrne and Long studied general practice consultations in order to “discover what patterns of behaviour doctors appeared to follow in their consulting rooms and the degree to which the patterns were repetitive among doctors” (1976, pp. 20-21). What they found was a sequence of events or activities to which doctors and patients routinely adhered (Byrne & Long, 1976, p. 132):

I. Greeting and relating
II. Discovering the reasons for attendance
III. Conducting a verbal or physical examination or both
IV. A consideration of the condition
V. Detailing further treatment
VI. Terminating the interview.

Byrne and Long concluded that the logical sequence of activities they discovered demonstrated that it was possible to analyse doctor-patient consultations and “from that analysis derive information which should be beneficial to the process of doctor training” (1976, p. 190). Byrne and Long were not the only researchers to describe activity structure schema of the doctor-patient consultation; there are many others that have not been described here (e.g. Cohen-Cole, 1991; Helman, 1981; Heron, 1975; Kurtz & Silverman, 1996; Neighbour, 1987; Pendleton, Schofield, Tate, & Havelock, 1984; Silverman et al., 2005; Stewart et al., 1995; Stott & Davis, 1979). Of particular note is the Calgary-Cambridge Model (Kurtz & Silverman, 1996; Silverman et al., 2005) that is now used extensively across the world in medical education, including at the University of Otago, New Zealand. This education model is less focused on phase structures and more on key tasks required in order to perform a comprehensive consultation.
It must be noted that all of these models are generalisations or ideations of what occurs in the consultation. Actual practice differs from these models as the consultation is co-constructed by the participants and is thus influenced by their individual goals, their previous knowledge of each other and of the presenting problem and other ‘contextual’ factors. In addition, most work to date has focused on acute presentations in primary care settings (Robinson, 2003); other visit types in other settings are likely to have a different canonical structure, which would be dependent on the goals of the visit type. That is, the canonical activity structure described both in textbook models and CA research does not fit other types of primary care visits, or necessarily, surgeon-patient and other secondary care consultations. It can also be said that there are similarities between the problem-solving structure in acute medical visits and those that occur in other institutions (Weatherall & Stubbe, 2010). These considerations provide a background to the following analysis. I now describe the activity structure schema that has been most influential in my analysis.

Robinson argues in these ‘activity structure schemas’1, “no one has yet demonstrated the internal validity of the proposed project or its consequences for physicians’ and patients’ communication behaviour” (Robinson, 2003, p. 32). With Robinson’s evidence (Robinson, 2003), I follow his schema (what he refers to as the ‘project’ of activities) and modify it to demonstrate the way in which the medical activities within the surgeon-patient consultation are structured in order to achieve certain goals. Models, such as that described by Byrne and Long (1976), are idealised versions of the consultation. Conversation analysis allows researchers to explore how this proposed project is co-constructed by doctors and patients.

The overall structure of the consultation is an interactional project based on a series of interdependent activities, as demonstrated by Robinson (2003). According to Collins and colleagues (2007a, p. 12), “[i]n CA research, the consultation is regarded as consisting of activities that have been located in empirical research based on video or audio recordings of actual consultations”. Consultations generally follow this structure because of the interactional accomplishments that are made relevant by the patient presenting a problem. While there may be re-visits to some activities or a transition that

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1 An ‘activity structure schema’ describes not only the overall structure of the project (here, the consultation) but also how each activity is related to all the other activities.
involves a back and forth, on the whole, the consultation follows a linear structure. In using CA to analyse the overall structure, firstly, “it must be demonstrated that participants orient to current activities as relevantly progressing toward, and being in the service of, particular next activities” and secondly, “it must be demonstrated that each activity is produced with reference to the project as a whole” (Robinson, 2003, p. 33).

Prior to continuing, I would like to note that the word ‘phase’ is not necessarily appropriate to describe the different activities of the medical consultation. The word ‘phase’ implies structure of an immovable type and does not allow for the fact that participants may move quickly or briefly into different types of talk, but instead binds the analysis to a pre-determined phase structure. The word ‘activity’, however, conveys the sense that the participants are doing something achievable through interaction and the activity is therefore identifiable by their interactional behaviour. As such, following Robinson (2003), I use the word ‘activity’.

In Robinson’s project there are four activities, listed below, that make up the “accountable progression of the project” (Robinson, 2003, p. 30):

1. Establishing a new medical problem as the reason for the encounter
2. Gathering additional information (history taking and/or physical examination)
3. Diagnosis delivery
4. Treatment recommendation

Robinson (2003) demonstrates that each of the activities of the consultation is sequentially dependant on the one that has occurred prior and makes relevant a specific context for the activity which follows. That is, a problem presentation makes relevant further information gathering (through verbal and/or physical examination), which makes relevant a diagnosis, which, in turn, makes relevant a treatment recommendation. Each of the activities described by Robinson and mentioned above also have their own interactional structure (Robinson, 2003) and are describable and analysable as such.

By coming to the doctor with a new medical problem, the participants orient to this overall structure of activities. As Robinson explains (2003, p. 47), “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”. Note that for non-new medical problems, such as follow-up or routine visits, such a structure may not necessarily be made relevant, and an overall structural schema for such primary care visits is yet to be described. However, even in new problem visits, it may become apparent that the patient’s presenting problem cannot be diagnosed or treated or even that there is no problem at all. In cases such as these, the non-occurrence of these activities is “oriented to as being accountable as a deviation from a ‘normal’ structure of activities” (Robinson, 2003, p. 31).

When a patient presents a problem and makes relevant a project of activities, these activities are based on the institutional agenda of the doctor (Robinson, 2003). However, the patient may not be aware of this agenda and this may cause misalignment between the doctor and the patient. This misalignment (or institutional asymmetry) occurs as the doctor has the insider knowledge of the institutional agenda to which the patient may not be privy through lack of experience or lack of understanding. Robinson’s approach to the doctor-patient interaction emphasises that “rather than visits embodying asymmetry, it is actions, activities, and projects of activities, and their constitutive relevancies, that account for asymmetry” (2003, p. 51).

4.3 Patient participation

As discussed in Chapter 1, the nature and extent of patient participation in the consultation can have an influence on the biomedical and psychosocial outcomes of patients as well as on patient satisfaction. As Collins and colleagues note (Collins et al., 2007a, p. 5):

Health professionals are increasingly encouraged to deliver patient-centred care, to communicate with their patients and to promote patient participation in consultations but the evidence suggests that patient-centred care and shared decision-making are not widely practised, that many health professionals lack the requisite skills and guidance, and that the context in which health care is delivered (including socio-economic influences, work pressures and resource limitations) bring their own constraints.
In researching patient participation, patients have been found to be “relatively communicatively passive” as doctors usually “initiate actions and solicit responses, whereas patients primarily respond to physicians’ initiatives” (Robinson, 2003, p. 28). That being said, there are explicit points of interactional agency for patients, such as during the problem presentation (Robinson & Heritage, 2005). Research has also shown that patient participation can be increased through interventions, both with patients and with doctors (Robinson, 2003).

Robinson explains that patient roles, patient psychology, patient resources for participation, physician communication, patient sociodemographic characteristics, visit-level variables (i.e. visit types), the length of the visits, and the presence of support persons are all “explanations for patients’ low levels of participation” (2003, pp. 28-29). Another important explanation for low patient participation is that over the course of the consultation, there are different interactional constraints placed on the participants as the various activities are accomplished (Robinson, 2003). That is, as the participants orient to the goals of each of the activities, different normative constraints may be placed upon them, such as in verbal examination where the doctor will ask questions to gather information, thus restricting the patient’s ability to have interactional initiative during that activity. However, in other activities in the consultation, the patient will have greater structural opportunity for taking the initiative, such as in the problem presentation and the treatment recommendation.

Thompson (2007) clearly describes a possible continuum of patient participation, which ranges from exclusion to informed decision-making. Figure 4.1 is reproduced from Thompson (2007, p. 47) and shows this continuum. While this could be seen as a linear progression that has developed over time, more paternalistic doctor-patient relationships may still exist and the degree of patient participation is dependant on the goals of the participants in the consultation, the doctor's consultation style and the patient’s preference for level of patient participation.
In the present research, I follow Peräkylä and Ruusuvuori’s understanding of patient participation (2007, p. 168, emphasis in original):

We suggest that there are five key components of patient participation. The five components comprise: (1) the patient’s contribution of the direction of action; (2) the patient’s influence in the definition of the consultation’s agenda; (3) the patient’s share in the reasoning process; (4) the patient’s influence in the decision-making; and (5) the emotional reciprocity between the patient and the provider of the care.

As conversation analysis looks at the various activities of the consultation, rather than only looking at the consultation overall, it is well suited to analysing patient participation (Gafaranga & Britten, 2007, p. 119). Bugge and Jones list four types of research question that conversation analysis can answer in regards to patient participation (2007, p. 25): 1) “what opportunities are made available to participants for taking part in consultations?”; 2) “in what ways do patients participate and how does this come...
about?”; 3) “in what ways do professionals take part in consultations?”; and, 4) “in what ways is participation facilitated or blocked through the use of interactional strategies?” These questions assist in understanding patient participation in each of the different activities of surgeon-patient consultations. As the concepts and models of consultation structure have now been considered, I move to an analysis of the surgeon-patient consultation data collected for this study.

4.4 Visit types and overall activity structures

To further aid analysis of the consultations, I differentiate between three different visit types. The definitions presented below are based on observations made of the 35 consultations that make up my data, including demographic and ethnographic material that were also collected. There may be different types of visit that do not occur in my data; however the types identified here appear to encompass most conceivable visit types. Robinson notes that “[i]f 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 behavioural modification” (Robinson, 2003, p. 52). As such, a distinction between visit types is made throughout the analyses in this research.

A first visit is one where the patient has not seen a surgeon in this clinic about this problem before. A check-up visit is one requested by the patient or a referring doctor where the patient has either seen the surgeon before or has had surgery for a particular problem before and has requested (or has had requested by the referring doctor) a surgeon check-up. A follow-up visit is one where the patient has been requested by the surgeon to see him/her again after a specified period of time. There are also sub-types of follow-up visit in this data, including post diagnosis, post diagnostic testing, post emergency admission, post surgery and routine follow-ups. In this data there are 20 first visits, 11 follow-up visits and four check up visits. Table 4.1 shows the distribution of visit types.

The visit types are relevant to the current analysis as there are different overall structures for first and check-up visits as compared to follow-up visits. The two different overall activity structures are described in the following section.
For first and check-up visits, I found a project\(^2\) similar to that described by Robinson (2003). The primary difference, which is not insignificant, is that in my data the project begins with the establishment of a mutual understanding of the referral and the

\(^2\) In describing the overall structure of consultations, 'project' refers to the series of activities that make up the consultation.
achievement of three-way alignment (see chapter 5). The project, therefore, for first and check-up surgeon-patient consultations is as follows:

Activity 1: Establishing mutual understanding of the referral and achieving alignment
Activity 2: Establishing the patient’s description (and perspective) of their problem
Activity 3: Gathering further information through verbal and/or physical examination
Activity 4: Reformulating the problem
Activity 5: Proposing next steps
Activity 6: Closing the consultation

Purely by virtue of being at the clinic and by being referred to the clinic, the patient and surgeon are able to orient to: (a) the fact that the patient has a problem that has been presented already; (b) an expectation that this problem will be addressed; and (c) the need for both participants to now work towards negotiating how that problem will be addressed. A series of interdependent steps (or activities) must be engaged for the participants to achieve the primary goals of the consultation; that is, in some way addressing a presented problem.

Working backwards from Activity 6, we can see how each of the activities is dependent on those that occur prior, and how they create a context for those that occur subsequently. In order to close the consultation (Activity 6), the surgeon and patient must have reached a conclusion to the reason why the patient had sought help in the first place. That conclusion is Activity 5, which not only includes treatment recommendations, but also other forms of concluding arrangements such as referring on, ordering diagnostic tests and organising follow-up visits. To make such arrangements, the surgeon must have diagnosed the problem (Activity 4) or at least discovered that, in order to make a diagnosis, more information would be required. Activity 4, which is the reformulation of the patient’s problem in light of Activities 2 and 3, can only occur once the surgeon has sufficient information to make a judgement regarding the patient’s presenting problem, which occurs through Activity 3, in which the surgeon not only gathers further information but does so in a way that aids the process of differential diagnosis. For the surgeon to know what type of information to gather, the patient must first present their problem, which is done in Activity 2. However, for the patient to present their problem (indeed, for them to be able to even attend the clinic),
they must have been referred by another doctor; through Activity 1 the participants can be observed to recognise the referral and achieve alignment regarding the occurrence of the referral (and sometimes also regarding the basic nature of the referred problem). As can be seen through this description, each activity is therefore dependent on the directly preceding activity, and also creates a local context in which the next activity is to be accomplished.

For follow-up visits, the project follows a very similar pattern, although activities 1 and 2 differ and some activities may be redundant, particularly Activities 2 and 3 in those visits where test results are being delivered.

Activity 1: Re-establishing the clinical relationship
Activity 2: Establishing the patient’s description (and perspective) of their problem since the previous appointment
Activity 3: Gathering further information through verbal and/or physical examination
Activity 4: Reformulating the problem
Activity 5: Proposing next steps
Activity 6: Closing the consultation

As explained above, in follow-up visits, the goals of the overall project vary from this basic pattern. The different sub-categories have different implications for the overall organisation of the consultation. Some activities may be made redundant as they have occurred in previous visits, such as in diagnostic test follow-up visits where problem presentation and gathering further information would have already occurred for that specific problem. However for routine follow-up visits, the surgeon may request that the patient present their experience of the problem since the previous visit. As the activities remain similar to those in the overall project of first and check-up visits, so too do dependencies between each activity that are explained above.

The following section provides a synthesis of the subsequent analysis presented in Chapters 5 through 9. It is presented in this chapter in order to provide a framework for reading and understanding the main analytical chapters in the thesis. These chapters deal with each of the activities in the overall interactional project of surgeon-patient consultations.
4.5 The overall structure of surgeon-patient consultations

Each of the following sub-sections summarises the different activities of the interaction used to illustrate the overall structure of surgeon-patient consultations. These are:

Activities 1 and 2 – Openings: Problem Presentation, Opening Elicitors and the Referral Recognition Sequence
Activity 3 – Examination: History Taking and Physical Examination
Activity 4 – Diagnosis
Activity 5 – Treatment Recommendation
Activity 6 – Closings

This information is also found in subsequent chapters regarding each activity type in much more descriptive detail. The analysis presented here is intended to provide an overview of how surgeons and patients orient to the normative structures of consultations in order to establish the problem, diagnose the problem and recommend treatment.

The consultation used to demonstrate the activity structure schema of surgeon-patient consultation is a first visit. Therefore it exemplifies the schema proposed for first and check-up visits. This consultation was chosen as it provides a particularly clear example of each of the activities that occur in surgeon-patient consultations. Due to space considerations, not all of the consultation will be reproduced here.

4.5.1 Openings:\footnote{There is much that could be said regarding greeting and introduction sequences (also known as boundary actions (cf. Schegloff, 1968)). However they are not the focus of this chapter (nor are they in any part of this research). Instead, I examine the activities that open the clinical business at the beginning of the consultation. These are the interactional sequences that involve the presentation of the patient’s primary reason for their visit.} problem presentation, opening elicitors and the referral recognition sequence

A referral letter is a particular type of clinical handover, which involves the transfer of responsibility and accountability of patient care (Australian Commission on Safety and Quality in Health Care, 2008). All the patients in this data who are there for first and
check-up visits have been referred by another doctor. The referral recognition sequence, identified and named as part of this research and explored further in chapter 5, serves to establish mutual understanding of the referral and achieve alignment, not only between the surgeon and the patient, but also with the referring doctor by means of the referral letter. In regard to the overall project of the consultation, this activity demonstrates that the participants are orienting to the reason why the patient is there; that is, not their presenting problem as such, but that they were referred by another doctor to the surgeon. In this activity, participants orient to the establishment of a mutual understanding of the referral. For example, alignment may be achieved through the surgeon not revealing what information was in the referral, but only that the patient was referred, so as to avoid disagreement as to the reason for the visit. Mutual understanding, even at this minimal level, is essential for the progressivity of the consultation as without it there would be no way forward as there would be no agreement as to the reason that the patient is there (i.e. that they were referred). Alignment between the three parties regarding the reason for the visit is less essential. Moreover, although the surgeon and patient must align before the consultation can proceed, a compromise can be made to achieve that alignment if the referral letter does not align with the patient’s understanding of why they have been referred for the visit.

In extract 4.1, the surgeon begins the consultation with a referral recognition sequence (lines 2-3, 4-5) after a boundary action to which the patient is not given an opportunity to respond.

**Ex. 4.1: IS-SP03-02**

1 SG: (how’s things.) >i got a letter from my colleague< mister samson.
2 (0.4) °and ah°
3 PT: °yes,°
4 SG: [(write to me) say you've been (0.8) having a bit of trouble
5 with: (0.7) volvulus. (0.5) or twisting of the bow:el.=
6 PT: =yeah,=
7 SG: =yep,=
8 PT: =yeah.
9 (0.6)
10 SG: if you c’d jus’ tell me a little bit about >jus’ tell me a little
11 bit about yourself.< (0.7) jason (to start). how old are you now?
12 PT: i'm twenty six now.=

In this sequence, which is analysed in further detail in chapter 5, the surgeon obtains agreement from the patient regarding the referral letter. As soon as the patient and surgeon agree as to the nature of presenting problem, mutual understanding is established. Because this mutual understanding is the same as that supposedly presented in the referral letter, as evidenced in the surgeon’s turn (lines 2-3, 4-5), alignment between all three parties is also achieved. After the alignment is achieved, the surgeon then continues with asking the patient about his age and occupation, including some social conversation in that sequence (not shown).

Opening elicitors are those utterances delivered by surgeons in order to elicit the patient’s presenting problem. Participants orient to these activities as establishing the patient’s description (and perspective) of their problem. As these typically occur near the beginning of the visit, patients orient to this sequential positioning and will respond to a variety of different opening elicitors⁴ (from how are you to tell me about your knee) as being in the service of eliciting their problem presentation. By attempting to elicit the patient's presenting problem, the surgeon is orienting to the relevance of the problem presentation not only in establishing the reason why the patient is at the clinic but also “in the service of at least the activity of diagnosis” (Robinson, 2003, p. 38).

In this particular consultation, which is a first visit, the patient has already been diagnosed by another doctor (as evidenced in referral recognition sequence). Thus, the goal of eliciting the patient’s problem (extract 4.2, lines 57-9) is likely to be in order to work towards confirming that diagnosis, while also building rapport and allowing the patient to tell their story and thus participate in this activity (which is a key point for patient agency in consultations (Heritage & Clayman, 2010)). As it is the surgeon who will ultimately recommend treatment, ensuring that he agrees with the diagnosis that has already been made is an important safety consideration because the patient has been handed over to the surgeon through the process of referral. The surgeon is therefore responsible and accountable for the diagnosis and treatment recommendation.

⁴ The different types of opening elicitor are examined in chapter 5.
In extract 4.2, the patient does not present his problem right away, instead delaying his response which prompts the surgeon in line 61 to specify how much of the patient’s problem should be presented.

**Ex. 4.2: IS-SP03-02**

57 SG: okay, (.). hhhhh (.). alright >so if you could jus’ tell me a
58 little bit abou:t<(.). what’s (.). what’s it you’ve noticed with the
59 bow:els and so on.
60 (0.4)
61 PT: si:nce (.). [i was (in ho-)]
62 SG: [jus- th- the ] whole de- (kinda) the _ whole story even
63 going back to:=
64 PT: =uh:m
65 SG: childhood ado[lescence].
66 PT: [>i know i know< it _ first happen:ed. (0.5) well
67 looking back i as- i assume this is what it was (0.2) when i _
68 in about standard four?:
69 SG: °right°

The delay in problem presentation (through an insert expansion sequence in lines 61-65) relates to the interactional norm that requires speakers not to tell listeners that which they already know (Heritage, 1984a; Maynard, 2003). That is, as the patient is cognisant that the surgeon has received a referral letter (not only as it is standard procedure to be referred to the clinic, but as it has also been discussed earlier in the consultation, see extract 4.1), he must therefore judge how much information he needs to give the surgeon. The surgeon then specifies his request (lines 62-3, 65), requesting the patient to re-tell his whole story, thereby addressing the patient’s orientation to the interactional norm that would otherwise prevent him from doing so.

After this clarification of the opening elicitor, the patient begins his problem presentation in extract 4.3 (line 79), noting that he has experienced episodic symptoms his *whole life*. The patient then continues with a description of his symptoms and historical experience of the illness, which continues in narrative form for another 63 lines.
Ex. 4.3: IS-SP03-02

79 PT: uh:m (. ) yeah there w- it was sort of same thing i jus’ (1.5)
80 pretty much my whole life i’ve remembered i’ve always had like i
81 aw- i always called the guts aches,
82 (0.2)
83 SG: [yeah
84 PT: [where i just=
85 SG: [<right>
86 PT: [=wouldn’t be able to stand up straight an’=
87 SG: =right
88 (0.4)
89 PT: °an’° (. ) but it it would never be too: bad.
90 SG: [yeah
91 PT: [i just sort ev have tuh
92 (1.2)
93 PT: °um° (. ) i w’dn’t be able to do much for a whi:le but
94 SG: y[eh
95 PT: [it was never like intense pain or anything, it was ju[s’=
96 SG: [yeh
97 PT: =really (0.2) uncomfortable.
98 SG: yep
99 (0.5)

By presenting his problem, in the way requested by the surgeon, the patient and the
surgeon are co-constructing the problem presentation. This demonstrates their
orientation to the activity at hand, that is to establish the patient’s description (and perspective) of their problem, as well as to the overall project, as patients present their problems “in the service of having them remedied, and this remedy is implicated by their production” (Robinson, 2003, p. 34, emphasis in original).

4.5.2 Examination: history taking and physical examination

The transition from problem presentation to history taking is managed primarily through
the doctor identifying the zone of transition in which he can ask the first history taking
question (Heritage & Clayman, 2010; Robinson & Heritage, 2005). This zone is often
identifiable by the presentation of current symptoms, though the doctor may wait until
the patient uses an exit device, stating in some way that they have finished their
problem presentation (Heritage & Clayman, 2010; Robinson & Heritage, 2005). In
extract 4.4, the surgeon begins history taking in line 163. Note that he does so, not after the presentation of a current symptom, but after the patient presents an occurrence of the problem, which is an episodic illness rather than an ongoing symptom, and then does not continue after line 161.

**Ex. 4.4: IS-SP03-02**

147 PT: <an’ the second ti:me was uh::m (0.7) “ah::: what was it” (0.8) second start a- second university?> i [was um
148     (0.6)
149 SG:                        [yes
150     (0.6)
151 PT: <twentyish?>=
152 SG: =right
153     (1.0)
154 PT: uh::m (1.3) tch (0.6) an’ it was jus’ one night i’d actually gone
to sleep an’ then i woke up in the middle of the night (0.2) <an’
156     it was just unbelievable.>
157 SG: °yeh°
158 SG: [whe-
159 PT: [i was like=
160 PT: [rolling out of bed.]
161 SG: [(                ).] mm
162     (.)
163 SG: whereabouts do you feel the pain.
164     (0.5)
165 PT: ↑uh::m (0.8) aw jus’ generally,=
166 SG: =jus’ across the middle?
167 PT: yeh.
168 SG: yeh?
169 PT: basically=
170 SG: =[okay]
171 PT: =[ i: ] (.) i c’dn’t really (0.7) s- (0.2) c’ldn’t say it with a
172     whole lot of [clarity=
173 SG:                         [<right>
174 PT: =exa[cly where=
175 SG:     [e hhhhh
176 PT: =i felt it but at the=
177 SG: =[<right>]
178 PT: =[at the ] [time=
Due to the episodic nature of the illness, the surgeon would be unable able to rely on waiting for the patient to present a current symptom and instead must judge the zone of transition based on what could be considered the most recent episode. At first, it appears that the patient has indeed finished presenting his problem as he responds to the surgeon’s questioning (starting at line 165). As he continues to answer the question at line 183, however, he cuts off the start of his utterance and returns to his problem presentation. The patient, nevertheless, does not describe the third episode until after the surgeon has confirmed the number of episodes, which allows the surgeon to best judge when to re-start taking the patient’s history. Here we can see how the surgeon and the patient “negotiate the boundaries of each of the main activity components” (Heritage & Maynard, 2006b, p. 15), and by doing so demonstrate their orientation to the overall interactional project.
History taking, or verbal examination, is characterised by question and answer sequences. This activity involves gathering further information through verbal and/or physical examination, which Robinson argues is oriented to by the participants “as being in the service of diagnosis” (Robinson, 2003, p. 39). The activities of verbal examination and physical examination can be ordered either way and are more often than not intertwined. One or other can also be omitted, depending on the information needs of the surgeon. Through examination, the participants can be seen to be orienting to the necessity of further information for two distinct purposes: 1) to aid diagnosis, including the process of differential diagnosis; and 2) to assist the surgeon in assessing the patient’s eligibility for treatment, particularly for surgery, as certain existing conditions may preclude the patient from being recommended for surgical treatment. Thus, examination is not only conducted in the service of diagnosis, but also in the service of treatment recommendation. In extract 4.5, the surgeon begins history taking (again) in lines 201-2.

**Ex. 4.5: IS-SP03-02**

201 SG: .hhhhhh (0.6) what are yuh bowels like between attacks, are they
202 are they kind of
203 (.)
204 PT: yeah: i wouldn't i wouldn't say they're classic.
205 SG: n[o
206 PT: [ah:: yih know like standard? (0.8) like >quite often< (0.2)
207 "uh" (0.5) sort of sittin’ there for a while and not much is
208 goin’ on but i jus’ FELT like (um)
209 (0.6)
210 SG: "right"
211 (0.9)
212 SG: would you how often would you go to the toilet (during the day)
213 how many times a week (0.2) for example w’ld you
214 (1.1)
215 PT: "(mm::)"
216 (2.7)
217 PT: "aw jeez i don't know?" (1.4) *uh::m* a- i- i- i try an’ go once
218 a day but uh:m (2.4) yea:h it's NOT (1.0) yeah there's no real

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5 For more information regarding question and answer sequences in medical settings, see Heritage and Clayman (2010).
In this extract, the surgeon starts with a question that invites the patient to complete his sentence, ending his turn with the word of. The patient responds in line 204 with his assessment. The surgeon continues with this problem-specific history taking, asking about regularity (line 212) and then re-specifying the question before the patient can respond (line 213), and summarising the patient's response to confirm his understanding (line 223). This problem specific question and answer sequence continues for another 16 lines (not all shown).

In extract 4.6, the surgeon begins the transition from problem-specific history taking to comprehensive history taking by using a bridging question in lines 242-3.

Ex. 4.6: IS-SP03-02

242 SG: okay (.). hhh anybody else in yuh family suffer from (.). similar
243 sort of problems?
244 (1.2)
245 PT: not that i've heard of,
246 SG: no
247 PT: [uh::m
248 (1.1)
249 PT: "yeah"
250 (1.4)
251 SG: okay (.). hhhh y- your general health otherwise.
252 (1.5)
253 SG: >pretty good<?
254 PT: [y:eah:?  
255 (0.2)
256 SG: [(pretty healthy)?
257 PT: [no complaints?
The question in lines 242-3 can be categorised as both problem-specific, as it is in regards to the problem, and as comprehensive as it is not about the patient’s own experience, but rather his family history. In line 251, the surgeon continues with another comprehensive history taking question, which is a non-specific enquiry after the patient’s general health. The questions then increase in granularity as the surgeon not only establishes the status of the patient’s health generally, but also gathers information that will allow him to assess the patient’s suitability as a surgical candidate. The verbal examination then moves into the physical examination, as seen in extract 4.7.
Chapter 4 – Overall Structural Organisation

Ex. 4.7: IS-SP03-02

321 SG: =so yih know (0.6) a- th- at this stage we would t- if y’know
322 we're talking about surgery we would be talking about doing a
323 limited op operation to deal with the bit of bowel that’s
324 causing the trouble,
325 PT: yeah.=
326 SG: =that's twisting it an’ (i'll just strai-) take out that s- that
327 extra [length that's twisting]=
328 PT: [/yeah sure<
329 ((16 lines omitted))
330 SG: =but at this stage (0.5) (y’know) in a young person like yourself
331 (w- would) i think one would deal with the (0.5) th- th- problems
332 that's really: "e- y- y-" [yih know=
333 PT: [*yeah*
334 SG: =causing this twisting.
335 349 (0.2)
336 PT: ["mm"]
337 SG: [an- then j’st (0.3) take it from there okay?
338 (0.8)
340 SG: uh::m tch what i might do >is jus’ pop you up on the couch jus’
341 have a little (look) at yuh tu::m::< ah: then we can jus’ talk
342 through (1.0) y- the operation that's involved with taking out
343 this bit that’s twisting.=and ah:
344 PT: "mm"
345 SG: how it's done, (0.9) <the um> the risks an’ benefits and so
346 on.=okay?=so (1.8) we'll ask these folks here to (. ) turn off
347 their recorde an’ we'll .hh huh huh huh .hh we’ll examine you
348 okay?
349 (0.3)
350 SG: alright?
351 (1.5)
352 SG: now "mm ↑mm"
353 (0.7)

Here the surgeon indicates the probable treatment recommendation (lines 321-4, 326-7, 344-6, 348, 354-6, 358-9). The surgeon begins by stating that surgery is only a possibility at this stage, using the word if in line 321. After positive uptake from the patient in lines 325 and 328, the surgeon then becomes more persuasive in his
treatment talk, by arguing for surgery in lines 344-6 and 348, using the age of the patient to support his argument. All of this occurs prior to the examination, though after some diagnostic talk (see extract 4.10, below). The surgeon then requests the patient to move (lines 353-4). The examination begins around line 398 (extract 4.8).

**Ex. 4.8: IS-SP03-02**

398 SG: r:ight (jus’ sit) (. ) that’s okay.
399          (0.7)  
400 SG: jus’ loosen you top (there)?
401          (3.8)  
402 SG: .hhh
403          (0.9)  
404 SG: (“that’s obviously t- (. ) let’s have a look.”)
405          (1.0)  
406 SG: o:kay? just relax (   )?
407          (0.9)  
408 SG: so have you had any other x rays of the bow:el apart from.
409          (0.9)  
410 PT: the one when i w’s
411 SG: you: had plain x rays, they put that tube up last time didn’t
412          they,=
413 PT: =hyeah
414 SG: did that get rid of tha- did that relieve the pressure?
415 PT: oh h yeah [hhh
416 SG:       [yeah
417          (0.3)  
418 PT: [instantaneously.
419 SG: [the whole (. ) (the j’st all the gas ‘n’)
420          (. )
421 PT: [(oh my god it was)
422 SG: [(( ) explosion.
423 PT: it [was fantastic apart from the whole uh:m=
424 SG:    [yeah
425 SG: =yeah the tube [thing
426 PT:     [(them having) to go up my=
427 PT: =[“bottom.”
428 SG: =[yeah ¡yeah yeah
429          (1.2)
In this consultation the video was switched off for the examination and the audio was captured on a separate audio recorder, thereby making it possible only to estimate the non-verbal actions of the participants. The surgeon gives the patient a number of instructions (lines 398, 400, 406) and then continues the verbal examination while conducting the physical examination, starting in line 408. This continues for another 44 lines.

Physical examinations can also include talk that is purely directive to aid the process of examination, as in extract 4.9.

Ex. 4.9: IS-SP03-02
455 SG: “jus- take a big breath for me?”
456 (1.1)
As can be seen here, the surgeon asks the patient to breathe in lines 455, 457, 461 and 464 (and this continues but is not shown). The relevant response is to perform the requested action, which the patient does (although we cannot see this, it is presumed as the consultation progresses smoothly and the action is sometimes audible, as in lines 459 and 463).

4.5.3 Diagnosis

As patients present their problems in order for them to be remedied and doctors need to diagnose such problems in order to recommend a remedy, diagnosis not only builds on the problem presentation and examinations that have preceded it, but also projects a treatment recommendation (Robinson, 2003). The activity of reformulating the problem is therefore key to the progressivity of the overall project of the consultation. It is important to note, in some surgeon-patient consultations such as this one, a diagnosis may already exist prior to the visit. This may alter the sequential progression of the activities in the overall project as the diagnosis is not dependent on the previous activities. Thus, the processes of hearing the patient’s story and gathering further information may also be in service of building rapport and confirming the diagnosis and developing treatment recommendations, as mentioned previously. In this consultation, the surgeon re-iterates the diagnosis (extract 4.10, lines 283-4) that had previously been stated during the referral recognition sequence (see extract 4.1).

Ex. 4.10: IS-SP03-02

283 SG: so (. ) mister samson's explained to you you've got this (0.2)
284 you've got a very lo:ng bowel (and it) seems to [be twisting.
285 PT: [yeah:.  
286 (0.5)
287 PT: he said it was some (. ) bottom (. ) heh: (0.2) >he sort of kept
In this extract, which occurs prior to the examination, the surgeon uses the referring doctor (line 283) to support his diagnosis, which in turn will support and justify his treatment recommendation. The patient uses this opportunity to demonstrate his lack of understanding of the diagnosis (lines 287-8, 291). The surgeon responds to this by providing an explanation of the diagnosis that includes information about how the problem occurs (lines 292-320, not all shown). The surgeon then indicates what the likely treatment will be (see extract 4.7).

Robinson notes (2003, p. 43), “[p]hysicians 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 diagnoses. In these ways, physicians display that treatment recommendations relevantly and accountably follow diagnoses.” Extract 4.11 occurs directly after the examination and prior to the treatment recommendation.

Ex. 4.11: IS-SP03-02

529 SG: now yuh x rays ar- i've got the report here (.) "which shows
530 (there was a obviously a sigmoid volvulus,"
531 (1.4)
532 SG: uh::m
The sequential positioning is important because this diagnosis, although it has already been stated previously, creates a local context for recommending treatment. As with the reference to the referring doctor in extract 4.10, the surgeon uses a report in lines 529-531 (from an investigation of the problem) along with medical terminology as evidence to strengthen his diagnosis and to support his treatment recommendation.

4.5.4 Treatment recommendation

Another way surgeons orient to the overall project of the consultation is by initiating the activity of proposing next steps following the delivery of the diagnosis. The relevant next activity after diagnosis is treatment recommendation (Robinson, 2003). In this way, both surgeons and patients orient to the overall project as moving towards remedying the presenting problem, which is done through an interrelated series of activities. In order to propose the next steps, even if it may be further diagnostic testing or referring back to the doctor who referred the patient, the surgeon must first develop an understanding and formulate a diagnosis of the problem through the activities of establishing mutual understanding of the referral and achieving alignment, establishing the patient’s description (and perspective) of their problem and gathering further information through verbal and/or physical examination and then must share that ‘diagnosis’ with the patient through the activity of reformulating the problem. In extract 4.12, the surgeon describes what is involved in the surgical treatment of this problem.

Ex. 4.12: IS-SP03-02

550 SG: .hhhh (0.4) alright okay (0.6) *so* (0.3) ((clears throat))
551 (0.3) so essentially what's involved (0.9) (*seems that*) if i
552 jus’ sort ev (2.2) wh- with when you've got this condition with
553 this vovulvus th- the bowel's very (.) floppy and easily
554 accessible so we can do this through a fairly small hole. okay?
555 PT: mm
556 (0.4)
557 SG: right
558 (0.2)
559 SG: we we could sort of do it pa:rtly through the keyhole technique
using a: (. ) yih know jus' little (0.5) camera we put inside your
_tum? (0.7) uh:mm: (0.7) to be honest (0.3) ((coughs)) normally =
the bowel is so: floppy and so: mobile .hhh we can do it through
a tiny little hole anyway so (0.3) i think probably on balance we
can j'st we'll j'st do a little conventional (one) (0.6) jus' a
little cut down here on the left hand side.

PT: mm
(0.3)

SG: uh:mm (1.7) i- it does remo:ve (0.2) so y- y- yih know we're
gonna take out (a a big) a long length of bowel that we're going
to take out an’ then (0.5) straighten it out and then join the
two (0.4) en- ends together. (at [that])=

PT: [yeah

As has been mentioned previously, this is not the first occasion where the surgeon has
identified surgery as the possible treatment in the consultation (see extract 4.8). On
these previous occasions, the patient has not resisted the treatment recommendation,
and thus the surgeon is at liberty to progress the consultation by describing
the treatment rather than needing to pursue agreement from the patient. Throughout the
description the patient offers minimal feedback in lines 555 and 566 and at the end of
the description provides the affirmative response of yeah (line 572). One discussion that
can occur during the treatment recommendation activity is that of informing the patient
of the risks associated with the treatment. Extract 4.13 follows directly from 4.12, with
the surgeon moving from describing the treatment, which had received positive uptake
from the patient to describing the risks associated with surgery.

Ex. 4.13: IS-SP03-02

SG: =right so .hh it's it's a fAIrly straight forward operation?
(0.5) like (0.4) like every operation ;there are (sort of)
risks, (0.3) er which one has to take in= so the expected
outcome is that you be in hospital for ab- maybe abou- ter (0.5)
>i w’d think about< (0.3) four or five Days:
(0.3)
PT: yep=

SG: =ah: you be k- (0.2) you c’d go ho:me basically on a normal diet
with yih bowels working,(.) "okay" (0.4) "*alright,** (0.7)
with- (.) with any:: ( . ) bowel surgery when we're sort of joi:n
two ends of the bowel together there's th- (0.3) (th-) the most
important thing risk of things that (uh) () could ().
potentially go wrong is >that the< two ends don't heal, (0.3)
"kay" (0.3) "alright" (0.5) now that would happen in may:be:
(0.5) something in the order of one percent of people? (0.3)
>undergoing this surg-=a one in a hun[dred,<
[yeah, (0.6)
the bow:el WOUldn't heal (0.4) absolutely perfectly, an you get
what's called a leak, so there'd be some bowel contents w'd come
outs:ide, (0.6) er that's obviously a serious complication:. (.)

The shift to describing the risks of surgery, marked by the shift implicative *right* at line
573, begins with a noting of the occurrence of risks in line 574-5 followed by a
contrasting statement regarding the normal, expected outcomes of the surgery. The
surgeon then returns to the description of risks, starting at line 582. As this activity is
primarily about informing the patient, there is minimal talk from the patient, although he
does mark his attentiveness through the use of minimal feedback in lines 579 and 589.
This risks informing activity continues for another 33 lines (not shown). Patients also
ask questions during the activity of treatment recommendation, as in extract 4.14.

**Ex. 4.14: IS-SP03-02**
628 PT: someone told me like uh:: (0.3) >doctor samson told me< it was
629 like a MONTH OFF: is that?
630 (0.5)
631 SG: yeh in terms of (0.4) ah recov:y: uh:m (1.0) is very variable
from patient to patient? okay; so. (0.4) "it's ay" everybody
ah:f an anaesthetic has what we call post operative fati:gue
syndrome where you feel j’st ti:red y’know it's not just (0.5)
not jus’ the wound healing jus’ generally in yourself, th’ energy
levels (of) () are dow:n and they do: take a while tuh (0.3)
rtuh- (0.2) to pull back up;

In this extract, the patient asks for information about how recovery from the surgery will
affect his work life (lines 628-8). The surgeon then informs the patient of what is
expected to occur after surgery (starting in line 631). After describing the recommended
treatment, the associated risks and answering the patient’s question, all of which
receive agreeing responses from the patient, the surgeon moves to close the activity of
treatment recommendation by offering to organise the recommended treatment of
surgery (extract 4.15, lines 654-5).

Ex. 4.15: IS-SP03-02
654 SG: uh::m (.) so what i might do then is (.) is (0.4) or:ganise to:
655   (.) to do that. (.) uh::m,
656   (0.5)
657 PT: it was _actual- i've (.). i've got i'm working up until the: (.) i
think it's the _fourth of july?_
658   (0.4)
659 SG: ri:ght.
660 PT: ('*was on ↑the[re*])
661 SG: [fourth of _july okay, (0.5) cos tyler said ju:ne
662   so¿
663 PT: yeah
664 SG: (>so we do it<) so :'a:fter the fourth of _july:,
665   ((39 lines omitted))
705 SG: so n- not before the _fourth of july. okay? (0.4) (>i mean< (1.0)
706   in _terms ev (0.6) y’know i _think if we uh _still work fur *>'mm
707   _sort ev< (0.5) >middle or _end uh _july?:< (0.5) >would that
708   sound rea’s’nable?<
709   (0.3)
710 PT: yeah
711 SG: yep
712   (0.4)
713 SG: okay.
714   (0.4)

This triggers a negotiation sequence between the surgeon and the patient, not as to the
treatment type, but as to when it might occur because the patient hopes to fit in the
surgery around his work schedule (lines 657-8). The participants reach an agreement
and the sequence concludes at line 713. The surgeon returns again to the bureaucratic
aspects of organising surgery in lines 715-8 in extract 4.16.
This receives no uptake from the patient and so the surgeon re-iterates the necessity of the treatment, stating not that it is likely that another episode might occur but that another episode is destined to occur (line 720). After this, the surgeon receives explicit uptake from the patient, which is produced in overlap with his own extension of line 720 that emphasises the need for treatment (line 723).

4.5.5 Closings

Closing the consultation is an important activity as it demonstrates the participants’ orientation to the completion of the overall project. In finishing the activity of treatment recommendation, the relevant next activity is the closing as the presenting problem has in some way been remedied. In this consultation, the activity of treatment recommendation has been completed with the necessary agreement from the patient and so the surgeon moves to close the encounter (extract 4.17).

Ex. 4.17: IS-SP03-02
729 SG: >have you got any:<(questions or concerns about (0.7) y’ know
730 what we're proposing to do: or
731 (1.3)
732 PT: *uh:m* (2.8) not especially,=
733 SG: =yeh- you probably won’t know until a:fter the operation [(what)=
734 PT: [yeah:
This final activity is initiated in extract 4.17, where in lines 729-730 the surgeon offers the patient the opportunity to ask further questions regarding the agreed treatment (although it is noteworthy that he does so using the negative polarity item any which interactionally inhibits the patient from responding with a yes answer (Heritage, Robinson, Elliot, Beckett, & Wilkes, 2007)). The patient delays his response, hesitates, pauses and then states that he does not have any questions (line 732). Instead of closing the encounter, however, the surgeon restates the risks and then describes pain management directly following the procedure. The activity of closing is again made relevant in extract 4.18, line 774, as the surgeon returns to the necessity of paperwork.

**Ex. 4.18: IS-SP03-02**

774 SG: aw:llright so if that's: okay we'll (.) we'll get the paperwork organised,
775   (0.3)
776   (0.3)
777 SG: o[kay?
778 PT: [excellent.=
779 SG: =alrigh?
780   (0.4)
In line 774, the surgeon also seeks further confirmation from the patient as to his agreement with the treatment recommendation, by stating that if that’s okay then that the bureaucratic procedures to book the surgery will be organised (line 774). This, however, is not responded to by the patient and the surgeon pursues agreement in line 777 using an upward intoned (or try-marked) okay. The patient then agrees using a very positive assessment, excellent. The closure of the consultation is then delayed again as the patient requests more information regarding the booking of the surgery (line 781). The surgeon not only answers the patient’s enquiry but also explains other pre-operative procedures that will occur. Agreement is pursued (line 787) and received (line 789) and then re-pursued (line 790) and then re-received (line 792). Finally, the consultation closes as the surgeon asks the patient to wait as the paperwork is organised and then leaves the room.

4.6 Conclusion
This research shows that surgeon-patient consultations follow a similar overall structural organization to those described by Robinson (2003) and by others (Byrne & Long, 1976; Cohen-Cole, 1991; Helman, 1981; Heron, 1975; Kurtz & Silverman, 1996; Neighbour, 1987; Pendleton et al., 1984; Silverman et al., 2005; Stewart et al., 1995). There is a logical progression of activities that is generally undertaken when a problem is to be addressed and this is reaffirmed by the findings of this research. There are,
however, some key differences. As the patient is referred for first and check-up visits, the first activity of the consultation is performed in service of establishing a mutual understanding of the referral letter and achieving alignment between the surgeon, patient and the referring doctor. Such a sequence does not usually occur in primary care consultations as patients self-refer, thus the doctor is unaware of the precise problem that the patient might present. In primary care, there are also more likely to be multiple problems presented, as patients that are referred to surgeons are usually referred for a specific problem while general practitioners provide more holistic, ongoing care. The referral permeates through the other activities in the consultation, particularly if the patient has previously been diagnosed or even had particular treatment recommended, as we saw in the consultation analysed in this chapter. In follow-up visits, the patient and surgeon must re-establish the clinical relationship. While this is somewhat reflective of actions that might occur in primary care, often the surgeon and the patient have had few prior meetings (or perhaps none as another surgeon in the clinic has previously seen the patient) and thus pursuing this activity is important in engaging with the patient and building rapport.

Agency in each of the activities varies due to the interactional constraints directed by institutional identities and goals (Robinson, 2003). Participants are oriented to the institutional goals which affect the relative passivity or interactional activity of the patient. Within this project of activities, there are points where the patient can more easily display greater agency, predictable by the purpose of the activity (Robinson, 2003). In the activity of history taking, for example, the surgeon is directing the course of action through a series of questions and answers, restricting the type of response the patient can give. However, as was seen in the consultation analysed above, the patient was able to answer outside of the constraints of the question in order to continue his problem presentation.

In the activity of diagnosis, the surgeon informs the patient of his or her problem and such descriptions do not necessarily require responses. In other activities, there is more scope for patient involvement. Due to the overall structure of the activities described, surgeons routinely allow patients points of interactional agency in the two activities that are most important for patient participation – defining the problem (through the referral recognition sequence and problem presentation) and deciding on treatment. These
points of interactional agency are achieved through the requirement of the achievement of alignment in the referral recognition sequence, eliciting the patient’s problem presentation and requiring the patient’s agreement to the treatment recommendation.

The six activities of first and check-up visits are interdependent and form an overall project designed to achieve the institutional goals of remedying the patient’s presenting problem. As can be seen from the consultation analysed above, the various contingencies of the consultation (e.g. the referral may include symptoms, a tentative diagnosis or a confirmed diagnosis) can affect the ordering of these activities. However, as each activity is dependent on the occurrence of the activities that preceded it, the overall sequential organisation of the overall project generally remains the same.

In the following chapters, each of these activities is explored in far more detail than has been given here. These descriptions not only provide a detailed picture of each of the activities in the surgeon-patient consultation, but also demonstrate how patients have agency within these activities. Activity 1, *establishing mutual understanding of the referral and achieving alignment*, and Activity 2, *establishing the patient’s description (and perspective) of their problem*, are analysed together in chapter 5. Activity 3 *gathering further information through verbal and/or physical examination* is explained in chapter 6, Activity 4 *reformulating the problem* in chapter 7, Activity 5 *proposing next steps* in chapter 8 and Activity 6 *closing the consultation* in chapter 9.
Chapter 5: Openings: Opening Elicitors, the Referral Recognition Sequence and Problem Presentation

First and Check-Up Visits:
ACTIVITY 1: Establishing mutual understanding of the referral and achieving alignment

ACTIVITY 2: Establishing the patient’s description (and perspective) of their problem

Follow-Up Visits:
ACTIVITY 1: Re-establishing the clinical relationship

ACTIVITY 2: Establishing the patient’s description (and perspective) of their problem since the previous appointment

5.1 Introduction

Previous research has clearly established that patients orient to the sequential relevance of providing a problem presentation at the beginning of a consultation (Heritage & Robinson, 2006a; Robinson & Heritage, 2005). Robinson and Heritage note, in regards to acute primary care consultations, “the activity of presenting acute problems is part of a medically institutionalised project of phased activities… the ordering and functions of which are jointly and independently understood by physicians and patients” (2005, p. 482). As patients are primarily socialised through these primary care interactions, it is therefore conceivable that the surgeon and the patient could orient to different medically institutionalised activities of the consultation. The current project shows differences in the inclusion, design, and function of some surgical consultation activities between patients and doctors. This means that there could be a misalignment between a surgeon and an inexperienced surgical patient (i.e. one that
has not been to a surgeon before). An important task of the opening activities of these consultations is therefore for the surgeon and the patient to develop a shared understanding and a shared orientation to the sequential relevance (or not) of particular activities at the beginning of the consultation.

In this chapter, I first briefly discuss the methods and data used for this particular analysis. While these do not vary significantly from the discussion in chapter 3, I outline which consultations form the data for this analysis (that is, of the opening activities of consultations). I then describe the three components involved in the opening activities – opening elicitors, the referral recognition sequence and problem presentation. These activities are interdependent as they involve the development of understanding of the reason for the visit. Two key questions will be addressed. First, if the problem presentation activity is the only point in primary care interactions at which patients are “systematically given institutional license to describe their illness in their own terms and in pursuit of their own agenda” (Robinson & Heritage, 2006), how does the minimised epistemic distance¹ between the surgeon and the patient created through the referral letter affect the problem presentation? Second, how do the opening activities of a surgeon-patient consultation provide the interactional space for patients to promote their own agendas?

5.2 Data analysis

To analyse the activities of the opening of the consultation, I examined the opening sequences of 30 recorded consultations up to the point where the history taking activity commenced. Only 33 out of the 35 consultations were recorded from the beginning of the consultation due to some early issues in the recording of these consultations.² The recording of another consultation was interrupted during the opening activities. A further two were pre-operative consultations, which were functionally and structurally distinct from the others as the patients were being prepared for surgery the following day. As the patient’s presenting problem had previously been diagnosed and treatment decided upon, I excluded these from this analysis. The 30 remaining consultations were

¹ Epistemic distance refers to the difference in background knowledge between the participants in the conversation. As compared to primary care visits with no referral letter, there is a smaller epistemic distance between the doctor and the patient in surgical consultations.

² As described in chapter 3.
analysed in full to ensure, firstly, that any referral and presenting problem talk was identified no matter where it occurred in the consultation and, secondly, to understand the sequential and structural/organisational implications of such sequences. The overall structure of surgeon-patient consultations has been described in chapter 4. The analytic methods used for this chapter were unmotivated looking and systematic analysis, as described in chapter 3. These methods provided a starting point for this analysis, along with a basis in the conversation analytic literature that discusses opening sequences in medical consultations.

In the clinics used in this research, patients start in a common waiting room. Clinic nurses then usher them into one of several consulting rooms, where the patient waits for the surgeon to enter. This waiting period can vary from almost immediately to over half an hour, though in general it is not longer than around five minutes. Many consultations opened with greetings and/or introductions, known as boundary actions, though these are not discussed in this research.$^3$

$^3$ Although boundary actions are not a focus of the analysis, here is a brief glance at a greeting sequence, extract A. In this sequence there are three adjacency pairs – lines 1 and 2, lines 3 and 4, and lines 5 and 6. The first adjacency pair consists of the greeting morning, a shortened version of good morning and this is reciprocated. Notice that the patient does not reciprocate with a how are you sequence in the second adjacency pair, he only responds to the how are you in line 3. The surgeon continues directly with a greeting sequence with the patient’s wife who is also in the room. The greeting sequence with the patient’s wife does not include a how are you sequence, perhaps indicative of the surgeon’s primary interest in the patient. The patient also does not respond to line 3 as directly enquiring after his physical health, as he replies to the how are you question as asking part of the greeting sequence. The patient responds with very good, which is an upgraded version of good or fine, which are common responses to how are you. This could indicate that he is attempting to portray his good health to the surgeon as well as responding to his greeting.

**Ex. A: SS-SP07-03**
1 SG: morning?
2 PT: morning.
3 SG: how are you today.
4 PT: very good,
5 SG: hi,
6 WI: hi,
5.3 Opening the consultation: interrelated and interdependent activities

The start of the consultation can impact upon the biomedical and psychosocial outcomes for a patient including diagnosis, treatment options, patient satisfaction, and patient adherence to treatment regimens (Robinson, 1998; Robinson & Heritage, 2006). With this in mind, it is important to understand how surgeon-patient consultations begin – how the patient’s view of their primary concern is elicited and how patients maintain agency in the referred visit environment. The way in which a consultation opens has particular implications for how a patient presents their problem (Robinson, 2006) and, therefore, on how the rest of the consultation progresses.

In the New Zealand public health system, patients are only able to see surgeons if they are referred either from a general practitioner (GP), a specialist or another surgeon. A referral letter is sent from the referring doctor directly to the chosen surgical clinic and the patient is then contacted with a date and time when he or she will see the surgeon. Referral letters set up an agenda for the interaction as they pre-empt the problem presentation by the patient with a representation of it made by the referring doctor. As such, they change the local environment in which a patient is able to present his or her problem.

Referral letters are a form of clinical handover (Loh, 2007) as information, accountability and responsibility regarding a patient are transferred between care providers (Wong, Yee, & Turner, 2008). Unlike other forms of clinical handover, in the case of a referral letter to a surgeon, this information is partial and the transfer temporary as the surgeon has been asked to care for the patient only in relation to a particular problem (although other issues are taken into consideration if relevant) and the patient will eventually be referred back to the referring doctor. The information in a referral letter can vary greatly – it may be very sparse or very detailed: it may include symptoms only, a candidate diagnosis or even a confirmed diagnosis. A good, clear referral letter is essential in ensuring that the patient is seen for the right problem and is cared for in the most appropriate way.

In this data, the significance of a referral letter is demonstrated by its use as a point of reference to begin consultations. The surgeon confirms with the patient that the information is correct and ensures that the patient knows why they are there. If there is
any contention, it must be resolved before the consultation progresses. Specifically, it is ideal for the progressivity of the consultation that there be alignment between all three parties – the referring doctor, as embodied in the letter, the consulting surgeon and the patient. This may explain my observation that the first turn of the referral recognition sequence may be designed by the surgeon not to include mention of patient’s problem, presumably so as to avoid any contention between what has been said in the referral letter and the patient’s understanding of why they are there. It may also be designed in this way to ensure that patients explain their symptoms in their own way.

As noted in chapter 4, there are two activities that occur during the openings of first and check-up surgeon-patient consultations: 1) establishing mutual understanding of the referral and achieving alignment; and, 2) establishing the patient’s description (and perspective) of their problem. These activities are achieved through the referral recognition sequence, the opening elicitor and the problem presentation. The referral recognition sequence is a superordinate sequence that occurs in first and check-up surgical consultations. In this sequence, discussed further in section 5.5, patients and surgeons orient to the relevance of the referral. This sequence can either occur as an independent sequence or can occur as part of the opening elicitor for the problem presentation.

The referral recognition sequence is geared towards developing a mutual understanding and recognition of what is in the referral letter. The referral letter provides the surgeon with a guided view of the presenting problem, thus narrowing the scope of the problem that is being presented and the range of questions that may be asked. The agenda is therefore set by the referral letter, which was written by the referring physician based on the story the patient told the referring physician as well as information from any verbal and/or physical examinations. A clear and informative referral letter that is aligned with the patient’s understanding of their problem is therefore essential to ensuring a worthwhile and helpful consultation. The content of the referral letter, and its subsequent acceptance or non-acceptance, frames the trajectory for the interaction and, though perhaps only initially, restricts both the patient and the surgeon to the particular topic.
In this chapter, I begin with a discussion of the intertwined activity components of the opening elicitor and the referral recognition sequence, the I discuss problem presentations in surgeon-patient consultations.

### 5.4 Opening elicitors

In understanding the opening activities of a medical visit, it is important to consider that questions (and other types of first pair parts) set agendas (Heritage & Robinson, 2006a); that is, they create a conditionally relevant context for a response (Schegloff, 1968), a concept discussed previously in chapter 3. Rather than call these opening activities “first concern elicitors”, after Gafaranga and Britten (2007), or “opening questions”, after Heritage and Robinson (2006a), I have instead chosen to call them “opening elicitors” for two reasons. Firstly, this is because in surgeon-patient consultations the patient is usually referred to the surgeon regarding a particular health issue rather than several issues. While the patient may on occasion present more than one concern, this is uncommon so to call them “first concern elicitors” may be misleading in the secondary care context. Secondly, “opening questions” may be a misnomer as in many cases where there is no opening question as such, for instance in cases where statements or directives are used to elicit the problem presentation from the patient. The term “opening elicitor” encapsulates both the ‘firstness’ of the elicitor in relation to the problem presentation (though it is not always the first activity of the consultation, see section 5.5), and the action which it performs, that is, the elicitation of a problem presentation.

The opening elicitor marks the point at which the participants ‘get down to business’ in the consultation, thus invoking the institutional context of the medical consultation through their talk. An opening elicitor can be designed to allow the patient to present their problem in their own way. Alternatively, it can restrict the patient to a particular issue or it can be a purely history taking question, thus removing the patient’s ability to tell their story in their own words (Heritage & Robinson, 2006a). Patients are not powerless, however, and have mechanisms to regain agency in the consultation (Heritage & Robinson, 2006a).

In surgeon-patient consultations, or any referred visit for that matter, the epistemic distance between the patient and the surgeon is much smaller than it would have been
if a referral letter had not been sent to the surgeon. There is evidence that participants are mindful of the surgeon’s prior knowledge of the patient’s presenting problem. As demonstrated in extract 5.1a, the doctor attempts to use an open question to elicit a problem presentation (line 62).

**Ex 5.1a: IS-SP01-02**

62 SG: .hhh and uh (2.1) an’ why: is that yuhr’ve come today:h.  
63 (.).
64 PT: because of the le- letter,  
65 SG: #ye::s?#  
66 (1.1)  
67 PT: >got a letter in the mail to come?<  
68 (3.5)

However, the patient’s response to the surgeon’s question in a way ‘challenges’ the use of a general inquiry question as he was told to come, and therefore the surgeon should know why he is there. The surgeon pursues a more elaborate response in line 65, but the patient responds, after a delay, with what is basically a re-iteration of the answer in line 64. The surgeon displays an unknowing stance in relation to the patient’s problem, but the patient is orienting to the epistemic advantage that the surgeon should have because of the referral process.

**Ex. 5.2a: SS-SP08-02**

37 SG: alright no:::w_ (.) >how can i help you.<  
38 PT: well i hope to get my hip fixed. [huh .hh  
39 SG: [do you.  
40 PT: y(h)es heh .hh

In extract 5.2a, the surgeon uses a general inquiry question (line 37) and receives an abrupt answer, with the patient perhaps being cautious, so as not to tell the surgeon something he already knows. The well preface in line 38 suggests some problem with the question (Schegloff & Lerner, 2009). This extract is discussed further in section 5.4.1.3.
As in all talk, opening elicitors are produced in accordance with the principle of recipient design (as discussed in chapter 3). As these are referred visits, asking why a patient is there without acknowledgement of the referral or referred problem is inapposite, as illustrated in extracts 5.1a and 5.2a. In addition, as shown previously by Gafaranga and Britten (2007), physicians’ design opening elicitors based on an assumption of the type of visit for which the patient is there, as a doctor usually would not ask a patient coming for a follow-up visit, for example, to present their problem in full all over again.

Ex. 5.3a: SS-SP07-02

10 SG: right_ (.) how’s the (0.2) belly been.
11 PT: belly ah: not too ba:d uh:m (.). actually today and yesterday
12 [pretty good days; uh:m: but i’ve still had a little
13 SG: [mm
14 PT: =irritation off and on=
15 SG: =f°okay°

For example, in extract 5.3a, the surgeon asks the patient how the problem has been since the last consultation, in line 10. This is appropriate as this is a follow-up visit and the patient answers accordingly.

Ex. 5.4: IS-SP01-03

10 SG: now (2.1) y- you've noticed a small hernia on the right; is that
11 PT: no we've had that- (0.2) we've had the operation;
12 [ (              )]
13 SG: [we've had the operation for that; okay there must be another
14 letter; (7.0) so is it j’st a- j’st a follow up after the
15 operation is it or it [ a- ]
16 PT: [nah?] uh:m (.). what's actually happening
17 is: i went back to the g p,
18 SG: oh i [see here's another letter,] yep
19 PT: [ <um quite recently, > ]
20 PT: uh:m (0.9) like it's: (.). i'm gettin quite numb feelings down
21 the leg;
22 SG: ri_ght?
In extract 5.4, the doctor opens with an incorrect assumption in line 10 with *you've noticed a small hernia on the right is that* as he had read an older referral letter (evidenced by his turn in lines 13-15). The patient then corrects the surgeon and presents his problem without further solicitation, starting at line 16.

5.4.1 Types of opening elicitor

There are several different types of opening elicitor used by the surgeons in this data and, while I reference the opening question types described in Heritage and Robinson (2006), I have chosen not to limit the data analysis to those definitions. The conceptual categories are referenced as applicable, but I have deviated from their work as I use different terminology (*opening elicitor* instead of *opening question*) and have added and deleted categories. I have done this as I did not find some kinds of ‘opening questions’ that are described by Heritage and Robinson (2006), and found others that they had not described. In this section, I describe the five distinct types of opening elicitor I have found and provide an analysis of at least one example of each type. These are:

1. ‘In your own words’ elicitors
2. Referral-based elicitors
3. Open problem presentation elicitors
4. ‘How are you’ elicitors
5. Follow-up elicitors

The most common elicitor type was the referral-based elicitor (type 2), which occurred eight times. This elicitor type was very closely followed by the ‘in your own words’ elicitor (type 1) with seven occurrences overall. Open problem presentation elicitors (type 3) occurred three times, how are you elicitors (type 4) also occurred twice and follow-up elicitors (type 5) occurred five times. Five consultations had no opening elicitor.

5.4.1.1 ‘In your own words’ elicitors

‘In your own words’ elicitors are problem presentation elicitors that occur after the referral recognition sequence (a sequence in which the referral process or letter, referring doctor or referred problem are discussed, as explained in section 5.5), as in extract 5.5a. As they occur in the environment after the referral recognition sequence (RRS), the elicitor is bound by the local context created by the previous activity, that is
the RRS, and therefore limits the patient to respond within that sequential context. There are seven of these questions in this data. In these consultations, the surgeon could have continued with a history taking question regarding the referred problem, but chose instead to prompt a problem presentation from the patient.

Ex. 5.5a: IS-SP01-04
10 SG: now you've (.) seen some of my colleagues here haven't you;
11 >you've seen mister hopkins and mister ( ).
12 (1.8)
13 PT: *uh::m*
14 SG: i gather
15 PT: *eh (.) uh yeah ( ) must’ve yep*
16 (P)
17 SG: s- so just uh explain the problem: (0.2) as far as you're concerned. what (.) what is troubling you.
18 PT: well to be honest not a lot at the moment; cos thee uh pain
19 has subsided for about three weeks now,
20 SG: oh that's good.

In extract 5.5a, the surgeon follows the patient’s weak response to the referral recognition in line 15 with a problem presentation question in lines 17-18, s- so just uh explain the problem: (0.2) as far as you're concerned. Before the patient can respond, the surgeon re-structures his question to be even more open with what is troubling you, in line 18. In this case, the question is not inapposite as the participants have already established the surgeon’s prior knowledge of the patient’s presenting problem, albeit non-specifically.

The ‘in your own words’ elicitor type can also be embedded in the referral recognition sequence itself, thus specifying the context of the problem presentation, and at the same time demonstrating both the surgeon’s knowledge of the problem and their desire to hear the problem presentation from the patient. This is clearly exemplified in extract 5.6.

Ex. 5.6: SS-SP13-01
1 SG: hello=
2 PT: =hi
The surgeon demonstrates a high level of knowledge about the patient as she explicitly refers to the referral in line 6 and also notes that she has read the report (line 4) and seen the scans (line 6). Despite this, she does not move on to history taking or mention the problem in particular and instead asks the patient to present the problem in line 8. This extract is also interesting as it demonstrates an apparent textbook structure (Byrne & Long, 1976; Kurtz & Silverman, 1996) of how to open a consultation. The surgeon here is a less experienced doctor than most of those in the data as she is a registrar, and more recently out of medical school, and this may explain her use of textbook structure.

This elicitor type attends to the two different pressures on the surgeon: 1) the desire to give the patient an opportunity to present their problem in their own words; and 2) the epistemic advantage that the surgeon has already gained from the referral letter that may influence the amount and type of information presented by the patient. It promotes patient participation and agency within the consultation, maintaining an interactional space for the patient to present their problem.

5.4.1.2 Referral-based elicitors

Referral-based elicitors are those that begin with an allusion to the referral (whether implicitly or explicitly) and are responded to by patients as eliciting a problem presentation. Patients treat these elicitors as a solicitation of their presenting concerns. After these elicitors, the patient tacitly displays agreement with an understanding of the referral by continuing with the problem presentation without further solicitation such as that which occurs in the in your own words elicitors. There are two sub-types of referral-based elicitors: explicit and implicit. In all there are eight referral-based elicitors in this data.
In explicit referral-based elicitors, surgeons explicitly mention the referral letter, the referral process and/or the referring doctor. In extract 5.7, the surgeon explicitly refers to the letter written by the referring doctor (line 4), in this case, the patient’s general practitioner (GP).

**Ex. 5.7: SS-SP10-04**

1 SG: "i’m doctor jess abbott i’m [(one of the breast surgeons?)]”
2 PT: [ < hi i’m stacy > ]
3 SG: "i’ll just flip that round so i can sit and talk to you” (0.9) ↑ now your g p’s written us a letter to say you’ve noticed a problem with yuh breast.
4 PT: · oh · yeah · the · uhm: (0.2) right breast’s uh (.) nipple’s inverted
5
6 SG: mhm

The surgeon starts this by using the shift-implicative *now* as it follows the greeting/introduction sequence and an adjustment of the setting. The surgeon here refers to the doctor who referred the patient, the mode of the referral and the problem described in it. However, in other instances of this elicitor type, not all of this information is included in the opening elicitor. In this example, the patient confirms the correctness of the referral with *yeah* and then continues, without further prompting, with an explanation of what the problem with her breast is. That is, she launches into a narrative problem presentation for 10 lines while the surgeon gives minimal response feedback (not shown).

In contrast, by using implicit referral-based elicitors, a surgeon demonstrates knowledge of the patient’s presenting problem without explicitly mentioning the referring doctor, the referral letter or the referral process. As with explicit referral-based elicitors, patients also treat this question as soliciting a problem presentation. The implicit referral-based elicitor type is exemplified in extract 5.8.

**Ex. 5.8: SS-SP08-01**

58 SG: [so tell me about yuh knee.
59 (2.4)
60 PT: tlk (.) it’s bloody awful. nhh
61 SG: mhm

After introductory talk between the surgeon and patient regarding the recording of the consultation, the surgeon (who has previously operated on the patient's hip) uses the shift-implicative so, and begins with his opening elicitor in line 58. Prior to this, there is no talk regarding the referral process. This elicitor is formatted as a directive, telling the patient to give his story. In structuring the elicitor this way, the surgeon demonstrates his knowledge about the patient's problem conveyed to him through a referral letter, yet still requests that the patient present his problem, which he does after line 61 (not shown).

5.4.1.3 Open problem presentation elicitors

Open problem presentation elicitors are reflective of the Type 1 (general inquiry) questions identified by Heritage and Robinson (2006a). As these elicitors are broad and non-specific, they allow the patient to articulate their concerns in their own terms. However, this elicitor type occurs only three times in this data. As discussed earlier, this is most likely explained by the nature of surgeon-patient interactions in New Zealand as the surgeon has prior knowledge of the patient's presenting problem via the referral letter. Therefore it would generally be inapposite to the type of visit (i.e. a referred visit) for a surgeon to essentially ask how they can help or why the patient is there. A clear example of this elicitor type is found in extract 5.2b.

Ex. 5.2b: SS-SP08-02

37 SG: alright no:::w_ (.) >how can i help you.<
38 PT: well i hoppe to get my hip fixed. [huh .hh
39 SGP: [do you.
40 PT: y(h)es heh .hh

After boundary actions, including introductions and greetings (a trainee is also present), the surgeon begins the consultation proper in line 37 with the shift-implicative (Jefferson, 1981) alright now. He then delivers his opening elicitor how can i help you. This is a first visit and therefore the patient has been referred and would be cognisant that the surgeon has read the referral letter from her referring doctor. Notice that the patient does not immediately launch into a problem presentation, but instead presents
her desire for treatment; namely that her problem, in this case her hip, should be fixed. There is some evidence here that this kind of opening elicitor is inapposite, both through the ‘obviousness’ of the patient’s answer and through her little laugh particle at the end of line 38. It is likely that the patient is orienting to the surgeon’s prior knowledge of her presenting problem (and/or the assumption that he should have this) and is adhering to the conversational norm of not telling someone something they already know (Heritage, 2010).

5.4.1.4 ‘How are you’ elicitors

These elicitors are ambiguous and could either refer to the patient’s presenting problem or could be part of the greeting sequence. As Heritage and Robinson (2006a, p. 96) note, “there is a potential for ambiguity between the overt question agenda, which invites an evaluation, and the sequential position of the question relative to the opening of the visit, which provides the relevance for problem presentation”. In responding to this question type, the patient may lose the opportunity to present their problem as they may not respond to it as eliciting a problem presentation and the surgeon may then move on. There are two how are you elicitors in this data.

Ex. 5.9: IS-SP02-01
1 SG: um (1.5) an how’ve yuh been,
2 (1.3)
3 PT: yeah not too bad i haven’t uh (.) any pain or anything¿
4 SG: mm

In extract 5.9, the surgeon’s opening elicitor is how have you been in line 1. The patient responds to this in line 3 as eliciting a problem presentation rather than as a social question. This may be because it is not a canonical ‘how are you’, specifically referring to the past and not the present.

5.4.1.5 Follow-up elicitors

Follow-up visits present surgeons with a different epistemic advantage to first and check-up visits. Here the surgeon is orienting to a source of knowledge, but the source of knowledge is either their own memory and notes or notes written by another surgeon within the clinic. There is no referral from an external source. Therefore, it is the same formulation as the referral-based elicitors but with a different context of knowledge. In
these opening elicitors, there is an observable orientation to a previous interaction between the patient and surgeon (or the patient and the surgeon’s colleague). Follow-up questions allow the surgeon to re-establish a clinical relationship with the patient. Unsurprisingly, when there was a follow-up after diagnostic testing, there was not always a problem presentation as the surgeon explained the results of the test. There are five examples of this question type in this data, exemplified in extract 5.3b.

**Ex. 5.3b: SS-SP07-02**

10 SG: right_ (.) how’s the (0.2) belly been.
11 PT: belly ah: not too ba:d uh:m (.) actually today and yesterday
12 [pretty good days; uh:m: but i’ve still had a little
13 SG: [mm
14 PT: = irritation off and on=
15 SG: =[^okay^]

After the greetings and a re-establishment of the clinical relationship, the opening elicitor comes in line 10, where the surgeon asks the patient how he has been experiencing his original presenting problem since the last consultation (in this case it was an emergency department presentation). This referencing to his prior problem and visit is done through the problem identifying term *belly* and the temporal marker *been*. This is followed by a problem presentation by the patient.

**5.4.2 No opening elicitor**

In five of the 30 consultations, there was no opening elicitor. That is, there was no direct or indirect solicitation of a problem presentation. Four of these consultations were post-diagnostic testing follow-ups, so the surgeon will have already been presented with the patient’s problem (in one case through notes; the other three through previous appointments). Extracts 5.11 and 5.12 clearly show this visit structure. Interestingly, one first consultation also did not have an opening elicitor, seen here in extract 5.10a. This is because the patient pre-empts the surgeon and presents her problem (lines 35, 37, 41).

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4 I use the term ‘clinical relationship’ as sometimes a follow-up consultation is actually provided by a surgeon who has not treated the patient before, however the consultation serves the same purpose as either a follow-up from a previous appointment, after surgery (some of which are routine for several years after surgery) or after diagnostic testing. This occurs due to the collaborative nature of public hospital clinics and when surgeons leave the clinic or retire.
39 and 41) before it can be solicited (this extract is discussed further in section 5.5.3 below).

**Ex. 5.10a: SS-SP03-06**

20 SG: >so i got a letter frm:< uh:m (.) doctor stephen winter
21 about your bowel [and your bowel symptoms and uh
22 HS: ((clears throat))
23 (1.0)
24 SG: uh:m it’s a question uh i think he (.) he was asking really
25 if there was any surgical solution t- to help your problems.
26 °and so° .hhh you could just tell me a little bit about things
27 h- how old are you now (tracy); >you’re twenty ei[ght?
28 PT: [twenny eight.
29 SG: yep (0.2) okay you working or_
30 PT: no; [i can’t work,
31 SG: [(yep)
32 SG: you can’t work,
33 PT: °no°
34 SG: because of;
35 PT: uh:m the pain and swelling_
36 SG: o[kay.
37 PT: [i throw up_
38 SG: so (.) a- and vomiting?
39 PT: yeah i get vomiting as well >i get dizzy; i [get yeah i’m (.)=
40 SG: [*mm°
41 PT: =when i’m (.) really sick i can hardly move;
42 SG: <ri:ght okay,>
43 PT: >it’s too much,<

In follow-up visits, an opening elicitor may not be necessary, depending on the type of follow-up and whether or not a problem presentation is necessary. After the greeting sequence in extract 5.11, the surgeon makes a general comment in lines 26-27 about the patient’s recent busy time.

**Ex. 5.11: SS-SP10-03**

26 SG: n:ow hh (0.8) you’ve had a bit of a busy time since i last saw
27 you;=
The patient agrees but does not produce anything further, such as a problem presentation, as is to be expected because a problem presentation is not relevant in this type of consultation. The patient has previously seen the surgeon and presented her problem. In the previous consultation it appears that a biopsy was performed. As such, the surgeon relays the good news for the patient that the diagnostic tests performed in the previous visit have returned as normal (lines 31, 33-34, 36), rather than asking the patient to present or re-present her problem. In contrast, in some other follow-up visit types, such as post-surgery visits, the patient might be asked to present their experience regarding their problem from the previous visit.

In lines 22-23 of extract 5.12, the surgeon asks the patient\(^5\) (and his wife and daughter) to wait while he reads the notes from the patient’s file, including the diagnostic test results.

\textbf{Ex. 5.12: IS-SP02-02}

19 SG: tlk okay so uh:m .hh you’ve recently had a c t scan to look at 
20 the aneurysm? 
21 WI: °yep° 
22 SG: yep kay .hh a:nd (.) let's jus have a (little look) at that, (.) 
23 one moment? 
24 (21.2) ((SG shuffling papers)) 
25 SG: °mhm°

\footnote{The patient in this consultation has suffered a stroke and has impaired communicative abilities. Along with the surgeon, the patient’s wife is the primary participant in this consultation, acting on behalf of the patient.}
Chapter 5 – Openings: Opening Elicitors, the Referral Recognition Sequence and Problem Presentation

At line 27, he begins with an explanation of what he will do, which he does as at line 45, explaining the results of the scan. In this extract there is no attempt to elicit a problem presentation from the patient. This is likely to be the case because this is a post diagnostic testing follow-up and a problem presentation is not normatively required (and probably unnecessary).
5.4.3 Opening elicitors and problem presentations

While the referral recognition sequence plays a key role in creating a local context for the problem presentation, as discussed below in section 5.5, the opening elicitor type used by the surgeon appears to be more influential in determining how and when a patient presents their problem. As discussed in chapter 3, the grammatical design of a question or other elicitor can impose constraints on the type of response that is produced (Raymond, 2003) and answerers can choose whether or not to conform to the agenda set by the question. This is where patients can express agency within the opening activities of a consultation, as they have the opportunity not to conform to the agenda of an opening elicitor. Patients may also choose how to respond to different types of opening elicitors in different ways, for example, whether they begin their problem presentation after a referral-based elicitor (extracts 5.7 and 5.8) or wait for further solicitation (extract 5.5a). Alternatively, patients can respond to a how are you elicitor either as part of a greeting sequence or as a solicitation of their presenting problem (extract 5.9). An explicit elicitor, that is one that directly asks (or tells) the patient to tell their story, disambiguates how the patient is to respond, inviting them to present their problem (extract 5.6).

The opening elicitors, as mentioned above, are not necessarily questions. Looking at the grammatical properties of the opening elicitors (rather than their actions, as all are acting as opening elicitors), we can see that opening elicitors can be statements, directives, open questions or closed questions. Interestingly, some patterns emerge in the relationship between the elicitor structure and elicitor type. In this data, all the referral-based elicitors are statements or directives and all the in your own words elicitors are open questions.

Problem presentation is a key point of patient agency in surgeon-patient consultations and this data shows that patients are capable of creating their own interactional space to tell their story. Patients who present their problem directly after a referral-based elicitor, which are all statements, are demonstrating agency by presenting their problem without direct solicitation. Patients who do this also appear to be orienting to the medically institutionalised sequential norms of problem presentation at the start of the medical visit and are using this as an interactional resource.
There are four consultations that differ from others of the same visit type. In extract 5.1b, the surgeon starts with an inapposite elicitor for the visit type (check up visit) in line 62.

**Ex. 5.1b: IS-SP01-02**

62 SG: .hhh and uh (2.1) an’ why: is that yuhr’ve come today:h.
63 (.)
64 PT: because of thuh le- letter,
65 SG: #ye::s?#
66 (1.1)
67 PT: >got a letter in the mail to come?<
   (41 lines omitted)
109 SG: ri:ght. so i jus- (.) not quite sure why you're hh- seeing
110 me toda::y? ah it's jus jus for a bowel check-up;is it?
111 WI: w'll that's what he told u:s,
112 SG: ri:ght. okay, (.) so (2.1) um have your____
113 alri:ght?
114 PT: yeah::.

The surgeon eventually begins addressing the presenting problem after the complex referral recognition sequence but does so with a history taking question in line 112. There is therefore no problem presentation. This is an important deviant case that is discussed in more detail in section 5.5. In both extracts 5.15 and 5.16a, there is an opening elicitor with an open question structure, however in neither extract is there a problem presentation.

**Ex. 5.15: SS-SP09-02**

6 SG: um: (.) how’re you doing.
7 PT: i’m alright¿
8 SG: good (0.8) what date was the accident?
9 PT: ah:: (it) w’s: (.) about eight weeks ago now¿=
10 SG: =right
11 MO: "mm"

In extract 5.15 the surgeon begins with a history taking question in line 8. The closest turn resembling an opening elicitor is line 6, although this is treated as part of the
greeting sequence by the patient, highlighting the inherent ambiguity in such questions (Heritage & Robinson, 2006a). The surgeon does not elicit or solicit a problem presentation from the patient.

**Ex. 5.16a: IS-SP03-01**

1 SG: ri:ght (2.2) hh so since i last saw you how ha- how have things been.
2 PT: <i>i've been fine.>
3 SG: yeah?
4 PT: [yes:?]
5 SG: [great (.). okay?]
6 PT: "no problem?"
7 SG: i've got your blood test from: (1.0) january which (0.4) was
8  good;

Extract 5.16a is part of a follow-up visit, so a problem presentation is not necessarily clinically relevant, particularly as in this consultation the patient is to receive the results of diagnostic tests. The surgeon does give the patient the opportunity to present his problem with his open question in line 1 and also with the post-expansion yeah in line 4. The patient declines to present a problem, giving a ‘no problem’ response and the consultation moves forward.

In contrast to the previous example, in extract 5.10b there is no opening elicitor but there is a problem presentation. Here the patient pre-empts an opening elicitor. This problem presentation pre-empts an opening elicitor and instead comes from a general information sequence question. In other consultations the same surgeon demonstrates an overall visit structure where he begins with a referral recognition sequence and then continues with questions regarding the patient’s social situation, such as work life and age, prior to eliciting a problem presentation.

**Ex. 5.10b: SS-SP03-06**

20 SG: >so i got a letter frm:< uh:m (.). doctor stephen winter
21 about your bowel [and your bowel symptoms and uh
22 HS: [((clears throat))
23  (1.0)
24 SG: uh:m it’s a question uh i think he (.). he was asking really
if there was any surgical solution to help your problems.
"and so" hhh you could just tell me a little bit about things
how old are you now (tracy); you’re twenty eight?
PT: [twenty eight.
SG: yep (0.2) okay you working or_
PT: no; i can’t work,
SG: [yep)
SG: you can’t work,
PT: "no"
SG: because of;
PT: uh:m the pain and swelling_
SG: okay.
PT: [i throw up_
SG: so (.) a- and vomiting?
PT: yeah i get vomiting as well i get dizzy; i [get yeah i’m (.)=
SG: ["mm"
PT: =when i’m (.) really sick i can hardly move;
SG: <right okay,>
PT: >it’s too much,<

In this consultation, the surgeon discusses the referral in lines 20-21 and 24-25, but then asks a question regarding the patient’s age rather than soliciting the patient’s problem. The patient begins to conform to this line of questioning. However, when prompted by the doctor for an explanation regarding why she does not work in line 34, the patient begins to present her problem in line 35. Through this the patient redefines the general information question delivered by the surgeon. In line 44 (not shown) the surgeon does not continue with general information questions but instead moves on to history taking.

This data shows that problem presentation is normatively required in first and check-up surgeon-patient consultations. Without a problem presentation, the surgeon would be relying on the referral letter, which may not align with the patient’s understanding of their problem and why they have been sent to the surgeon. In the one check-up consultation in which a problem presentation did not occur (extract 5.1), the local context of the opening activities is complicated by problems that occur in the referral recognition sequence. This extract is discussed in the next section.
5.5 Referral recognition sequences

While examining openings in surgeon-patient consultation data, I noticed a distinctive feature of many of these interactions. This is a sequence within the consultation where the participants observably orient to the referral from another physician (GP or specialist/surgeon) through which the patient has been ‘handed over’ to the consulting surgeon. As such, I have termed these sequences Referral Recognition Sequences (RRS). In these sequences, patients are required to confirm the correctness of the information in the referral letter or at least that they were referred by another physician. This may be done tacitly through the patient’s presentation of their problem or overtly in confirming the correctness of the information provided. It may also be contested by the patient and any such disagreement must be resolved before the consultation can progress to problem presentation or history taking. That is, instead of agreeing (tacitly or overtly), the patient can contest the assumptions made through the referral letter. The RRS therefore provides an interactional opportunity for the patient to have agency in the opening activities of the consultation.

This data shows that in first and check-up visits, referral recognition sequences are normatively required for the progressivity of the interaction, whether they occur as independent sequences (as those prior to *in your own words* elicitors do) or embedded within the beginning of the activity of problem presentation (as those in referral-based elicitors do).

5.5.1 Implicit versus explicit referral recognition sequences

As discussed in regard to opening elicitor types, referral recognition sequences may begin with an implicit or explicit reference to the referral. An explicit RRS includes explicit reference to either the referring doctor and/or the referral letter. A reference to the presenting problem may also be included along with reference to the referral

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6 This is a distinctive feature in comparison to primary care visits (Maynard and Heritage, 2006). It could be imagined that a referral recognition sequence might occur in a GP visit if the patient is referred back from a specialist/surgeon or if the patient has changed clinics. This would be different from the surgical RRS as referring back means the GP is already aware of the problem and clinic changes often include more than one problem and the patient records.

7 Although I have studied only surgeon-patient interactions here, it is likely that these sequences would also occur in other referred consultations, such as non-surgical specialist consultations and allied health interactions.
process. An explicit reference may also be shown physically by the surgeon reading the letter in front of the patient with reference to that action. An example of an explicit RRS is found in extract 5.5b.

**Ex. 5.5b: IS-SP01-04**

10 SG: now you've (.) seen some of my colleagues here haven't you;
11   >you've seen mister hopkins and mister ( )
12     (1.8)
13 PT: *uh::m*
14 SG: i gather
15 PT: *eh (.) uh yeah ( ) must’ve yep*
16     (P)
17 SG: s- so just uh explain the problem: (0.2) as far as you're concerned. what (.) what is troubling you.
18 PT: well to be honest not a lot at the moment; cos thee uh pain
19     has subsided for about three weeks now,
20 SG: oh that's good.

In this example the surgeon refers to the other surgeons/specialists that the patient has visited regarding his presenting problem and seeks epistemic alignment from the patient. A referral would have come from one of these doctors. The patient, however, does not appear to recognise the names of these doctors, as evidenced by his delayed *um* produced in line 13. The surgeon then justifies his claim in line 14 by saying *i gather*, through which he shows that his information was gleaned through another source. The patient gives hedged agreement in line 15 which is sufficient for the surgeon to continue with an opening elicitor in lines 17-18.

An implicit RRS includes a reference to the patient’s presenting problem, which implies shared knowledge, without explicit reference to the referral process. This is clearly demonstrated in extract 5.15.

**Ex. 5.15: SS-SP10-05**

10 SG: ↑mm ok from what i understand i:s that you’ve had a lumpy
11   area in your breast and you have a previous sca:
12     (0.6)
13 PT: yes,
Chapter 5 – Openings: Opening Elicitors, the Referral Recognition Sequence and Problem Presentation

14 SG: and we were investigating that.=
15 PT: =aha i’ve had two lumps;
16 SG: and you’ve had [two lumps–]
17 PT: [( )]
18 (0.2)
19 PT: yeah
20 SG: and you’ve had a needle test on each side [is that right?=  
21 PT: [uhh  
22 PT: =no i’ve just had [one aspir ]ated on the le:ft?  
23 SG: [just (one okay)]  
24 SG: mhmb  
25 (.)  
26 PT: tlk .hh but not on the right.  
27 SG: not on the right. (.) oh:okay:. *(lemme just)* check the date
28 i’ve got a result he:re? (4.0) check i’ve got the right one;  
29 >which was done i:n oh five have you had a needle test since  
30 then.=  
31 PT: =no  
32 SG: no the only needle test you had was in oh five.  
33 PT: that was in ho- at the ryde hospital.  
34 SG: at ryde hos[pital.  
35 PT: [yes  
36 SG: °okay° and that didn’t show anything nasty which is good.  
37 PT: °nah°  
38: (1.0)  
39 SG: tlk alright (0.2) so today we’re just checking up how things
40 are; is that right?
41 PT: yes (.) °yes°

In this example, the surgeon begins by stating what she understands to be the patient’s presenting problem. The patient confirms this in line 13. The surgeon then continues with more information regarding what the patient wants and what tests have been performed. By confirming this information, the surgeon ensures that the referral letter is correct and that she understands it. The patient is also given an opportunity to correct any information, which she does in lines 15 and 22. Through this process, the patient is given agency and alignment is achieved between the surgeon, the patient and referring
doctor. This is quite an extended RRS and it concludes with the patient’s acceptance in line 41 of the surgeon’s summary of the goal of the visit (line 39-40).

5.5.2 Visit types and the RRS

The visit type correlates with the occurrence of RRS as it also does with the type of opening elicitor produced by the surgeon. I found that in 19 out of 30 consultations there was a referral recognition sequence. For each consultation the visit type and whether an RRS occurred is listed in Table 5.1. This table shows that in all but one of the first and check-up visits there was a RRS. This is presumably because in order to access the surgical clinic the patient must have been referred from another doctor, thus giving the surgeon access to information regarding the patient, and changing the epistemic distance between the two participants (as discussed above). On the other hand, no RRS occurred in any of the follow-up visits, which is not surprising, as the attending surgeon or another surgeon from the same clinic (in these cases the attending surgeon reads from the patient notes) has requested the visit and therefore is in an epistemic position similar to that of a referring doctor in that the patient was requested to return for another consultation. Extract 5.16 is a first visit in which a RRS occurs.

Ex. 5.16: IS-SP03-04
9  SG: right now kimberley i've got a letter from
10 (1.0)
11 PT: doc[tor ling.
12 SG:  [(yuh)
13 SG: s:::-- mm:
14 (2.0)
15 SG: oh tommy ling. [yep,
16 PT:  [tommy ling.
17  (25 lines omitted))
42 SG: okay (. ) now if you can just tell me a little bit in your
43 own words what you've noticed has been wrong an;
44 (2.8)
45 PT: ah: (0.8) why doctor ling sent me [to yuh,
46 SG:  [yeah what brought you to
47  doctor ling in the
PT: <i>was having bowel problems</i>

SG: yeah:

Here the surgeon begins (after the greeting sequence) with a RRS, which is completed by the patient in line 11, after he pauses in line 10. The patient confirms the referring doctor’s name and the consultation progresses into talk about where the doctor practices and also general information about the patient (not shown). In line 42, the surgeon then delivers the opening elicitor to solicit a problem presentation from the patient. As this is a first visit, both sequences might be expected to occur as the surgeon and patient are not acquainted and this is a referral for a new problem.

### Table 5.1: Visit type and the occurrence of RRS in 30 consultations

<table>
<thead>
<tr>
<th>Consultation Code</th>
<th>Visit Type</th>
<th>RRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS-SP01-02</td>
<td>Check-up</td>
<td>Yes</td>
</tr>
<tr>
<td>IS-SP01-03</td>
<td>Check-up</td>
<td>Yes</td>
</tr>
<tr>
<td>IS-SP01-05</td>
<td>Check-up</td>
<td>Yes</td>
</tr>
<tr>
<td>IS-SP02-01</td>
<td>Check-up</td>
<td>Yes</td>
</tr>
<tr>
<td>SS-SP08-02</td>
<td>First</td>
<td>No</td>
</tr>
<tr>
<td>IS-SP01-04</td>
<td>First</td>
<td>Yes</td>
</tr>
<tr>
<td>IS-SP03-02</td>
<td>First</td>
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<tr>
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<td>IS-SP04-05</td>
<td>First</td>
<td>Yes</td>
</tr>
<tr>
<td>SS-SP03-06</td>
<td>First</td>
<td>Yes</td>
</tr>
<tr>
<td>SS-SP07-01</td>
<td>First</td>
<td>Yes</td>
</tr>
<tr>
<td>SS-SP08-01</td>
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<td>Yes</td>
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<td>SS-SP13-01</td>
<td>First</td>
<td>Yes</td>
</tr>
<tr>
<td>IS-SP01-06</td>
<td>Follow-up</td>
<td>No</td>
</tr>
<tr>
<td>IS-SP02-02</td>
<td>Follow-up</td>
<td>No</td>
</tr>
<tr>
<td>IS-SP03-01</td>
<td>Follow-up</td>
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<tr>
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<td>Follow-up</td>
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<td>SS-SP07-02</td>
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<td>SS-SP07-03</td>
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<tr>
<td>SS-SP09-02</td>
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<td>SS-SP10-01</td>
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<tr>
<td>SS-SP10-03</td>
<td>Follow-up</td>
<td>No</td>
</tr>
<tr>
<td>SS-SP10-05</td>
<td>Follow-up</td>
<td>No</td>
</tr>
</tbody>
</table>
In contrast to extract 5.16, extract 5.2c shows how more work is required on behalf of the surgeon to solicit a problem presentation from the patient.

**Ex. 5.2c: SS-SP08-02**

37 SG: alright no:::w_ (. ) >how can i help you.<
38 PT: well i hope to get my hip fixed. [huh .hh
39 SG: [do you.
40 PT: y(h)es heh .hh

In this extract, the surgeon does not first attend to the epistemic advantage he has gained through the referral letter. Therefore the patient does not respond with a problem presentation in line 38, instead only requesting treatment. The surgeon pursues more information with his question *do you* in line 39, but is again unsuccessful. The patient continues with a description of the diagnostic test that has been performed and the doctor begins history taking (not shown). A problem presentation does not occur until the patient responds with an extended narrative response to a history taking question (not shown).

Extract 5.14b is a follow-up visit and has no RRS, as observed in all other follow-up visits.

**Ex. 5.14b: IS-SP03-01**

1 SG: ri:ght (2.2) hh so since i last saw you how ha- how have things
2 been.
3 PT: <i: 've been fine.>
4 SG: yeah?
5 PT: [yes:?
6 SG: [great (. ) okay;`
7 PT: "no problem?"
8 SG: i've got your blood test from: (1.0) january which (0.4) was
9 good;`

The surgeon begins with an opening elicitor which solicits information about how the patient has been since the last visit. This serves to re-establish the pre-existing clinical relationship, with the surgeon designing his turn to show that he recalls the patient and
the patient's presenting problem. The consultation then continues with diagnostic results delivery in lines 8-9.

5.5.3 Simple and complex referral recognition sequences

In examining the 19 RRSs that occurred in this data, I noticed that some sequences were more complex than others. I classed the RRS as simple if there was no disagreement from any participant as to the correctness of the assertion about the referral made by the physician – that is, alignment regarding the accuracy of the surgeon's understanding of the referral was achieved between all three parties without contention about the accuracy of the referral from any participant. I classed the RRS as complex if there was some contention as to the correctness of the referral letter. The distinction between the two is not black and white but rather could be placed upon a continuum of complexity. Extract 5.17 is an example of a simple RRS.

**Ex. 5.17: IS-SP03-02**

1 SG: (how’s things.) >i got a letter from my colleague< mister samson. (0.4) "and ah"
2 PT: "ye[rs,"
3 SG: [(write to me) say you've been (0.8) having a bit of trouble with: (0.7) volvulus.
4 (0.5)
5 SG: or twisting of the bowel.=
6 PT: =yeah,=
7 SG: =yep,=
8 PT: =yeah.

The surgeon begins by noting from whom he received the referral, which the patient confirms in line 2. In lines 4-6, the surgeon then describes the problem for which the patient was referred. Interestingly, the first point of possible completion occurs in line 5 after the word *volvulus*. The patient does not at this point confirm this as the correct problem presentation despite having five tenths of a second in which to do so. The surgeon then adds a more simple explanation to his previous turn, to which he receives
a latched confirming response. Despite the transition space repair in line 7, this is classified a simple RRS as there is no contention as to the accuracy of the referral.

In extract 5.1c, the RRS does not occur until there is a difficulty in the patient’s problem presentation because the reason for the visit is unknown, so the referral letter must be examined by the participants.

**Ex 5.1c: IS-SP01-02**

62 SG: .hhh and uh (2.1) an’ why: is that you’ve come today.:
63 (.)
64 PT: because of thuh le- letter,
65 SG: #ye::s?#
66 (1.1)
67 PT: >got a letter in the mail to come?<
68 (3.5)
69 WI: “uh” we went to see: (. ) mister atk- uh doctor atkinson and
70 he suggested that he should have a-
71 PT: =hhhh=
72 WI: =check-up,
73 (0.2)
74 WI: a bowel check-up,
75 (0.4)
76 SG: a bowel check [up. ri::ght?
77 WI: ["mm"
78 SG: .hh what’s this about vei::ns sticking ou:t.(do i n- ) he’s
79 got that in the letter i wasn’t sure what he mea:nt by that.
80 WI: vei::ns,
81 (.)
82 PT: a what? (duh- do- [duh-)
83 SG: [he said- uh hh (3.8)>did you go and
84 see the doctor about varicose vei::ns or something.did you:?<
85 PT: [no
86 WI: [no[:?
87 SG: [n- no he says here he presented today with the

---

8 Although this repair is not pre- or post-framed, it is addressing a possible point of trouble in understanding by the patient, as he does not confirm the problem formulation of *volvulus*. The surgeon’s turn then gives the definition, thereby addressing the possible point of trouble in understanding, which then allows the patient to continue.
there is no overt reference to the referral letter prior to line 62, but it is very likely to be in front of the doctor, evidenced later in the sequence as he reads aloud from it. in line 62, the doctor attempts a solicitation of problem presentation from the patient. even though it is usual in first and check-up visits for the surgeon to produce a RRS prior to the problem presentation, here the RRS is initially avoided by the surgeon. this is most likely to be because the referral letter is unclear, which becomes apparent when he reads aloud from it in lines 87-8. the surgeon is forced into a RRS after he attempts to use an open problem presentation elicitor type without reference to the referral. there is no prior mention of the referral or the presenting problem before line 69, where the
patient’s wife refers to the referring doctor. It is important to note that had the consultation proceeded smoothly with no RRS, it would have been ‘noticeably absent’ for us as analysts as compared to the other instances of check-up visits in this data. This is a deviant case that shows that the RRS is normatively required.9

In extract 5.1c, the RRS could have ended at line 77, but the letter is now relevant and is not consistent with the problem being presented by the patient and his wife. This inconsistency is remarked upon by the surgeon in lines 109-110, who aligns with the patient and his wife’s understanding of the reason for his referral rather than that of the referring doctor. The inconsistency is not resolved, rather a compromise is made in order to take the consultation forward. However a problem presentation does not occur and history taking is started at line 112-113 (the patient complies with this line of questioning in line 114). This is also a deviant case in terms of problem presentation.

The local context of the problem presentation is developed by the opening elicitor and the referral recognition sequence, as we have seen in the examples that have been described above. The following section focuses on problem presentations in surgeon-patient consultations.

**5.6 Problem presentations**

Much is already known about patients’ problem presentations in primary care visits. Importantly, problem presentations vary greatly in their structure, content and goals (Heritage & Clayman, 2010; Heritage & Robinson, 2006b). Problem presentations are regarded as a key point of patient agency in which patients can describe their problems in their own words; nonetheless they are co-constructed by both physicians and patients (Heritage & Clayman, 2010; Heritage & Robinson, 2006b). That is, how the patient presents their problem is influenced by how it is elicited and how the problem presentation ends is determined by how the participants together negotiate the transition to history taking.

---

9 No RRS occurs in SS-SP08-02 even though this is a first visit. The surgeon uses an open problem presentation elicitor type without reference to the referral. In this consultation, the patient does not produce a problem presentation until the activity of history taking. This deviant case shows how the absence of a referral recognition sequence affects the progressivity of the consultation.
The present data suggests that, despite their diversity in both settings, problem presentations in surgeon-patient consultations share many common features with those in primary care, as Heritage and Clayman explain (2010, p. 117):

Problem presentation is shaped by the doctor’s opening question and, immediately afterwards, its extent and structure are projected by the patient from the very first unit of talk. Thereafter its extension is an object of negotiation organized by the practices through which patients design, and doctors acknowledge, each new element of the presentation. At length, the participants enter a zone of transition into history taking. This zone of transition is effectively entered once the patient has described at least one current symptom in concrete detail. These “current symptom” parameters are clearly oriented to by both physicians and patients as indexing the zone of transition, regardless of whether current symptoms are entered into at the very beginning of the problem presentation or only after an extended narrative.

5.6.1 Visit types and problem presentations

In this data, problem presentations occurred across all three types of visit, whether overtly solicited or not by the surgeon, though the occurrence of problem presentation is related most strongly to visit type. There were three consultations with no opening elicitor where there was also no problem presentation, but there was a problem presentation in one of the visits that had no opening elicitor (see extract 5.10a). As shown in Table 5.2, there were eight consultations in which there was no problem presentation. Seven of these were follow-up visits and one was a check-up visit.

Table 5.2: Visit types and problem presentation in 30 consultations

<table>
<thead>
<tr>
<th>Consultation Code</th>
<th>Visit Type</th>
<th>Problem Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS-SP01-02</td>
<td>Check-up</td>
<td>No</td>
</tr>
<tr>
<td>IS-SP01-03</td>
<td>Check-up</td>
<td>Yes</td>
</tr>
<tr>
<td>IS-SP01-05</td>
<td>Check-up</td>
<td>Yes</td>
</tr>
<tr>
<td>IS-SP02-01</td>
<td>Check-up</td>
<td>Yes</td>
</tr>
<tr>
<td>IS-SP01-04</td>
<td>First</td>
<td>Yes</td>
</tr>
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<td>Yes</td>
</tr>
<tr>
<td>SS-SP03-06</td>
<td>First</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Problem presentations occurred in all first visits and in the majority of the check up visits in this data. The one check-up visit without a problem presentation is a deviant case as this data suggests that problem presentations are normatively required in first and check-up visits in surgeon-patient consultations. In the one check-up visit in which a problem presentation might have been but did not occur (analysed above in section 5.5 as extracts 5.1a, b and c) its non-occurrence is most likely due to the complexity of the referral recognition sequence because the problem for which the patient was referred was uncertain. It may be speculated that attempting to solicit a problem presentation could have been a difficult task for the surgeon given the communication difficulties already experienced. The surgeon thus begins with the bowel check-up with a history taking question.

Problem presentations are less likely to occur in follow-up visits as the surgeon may, for example, be delivering diagnostic news, thus making a problem presentation unnecessary. While this data may indicate that in post diagnosis and post emergency admissions there is more likely to be a problem presentation, there are too few examples of each follow-up type to show any systematicity in this finding. Follow-up visits may also occur periodically for several years after surgery, as is standard practice for patients who have undergone surgery for cancer, as seen in extract 5.18.
Ex. 5.18: IS-SP01-06
15 SG: [be- been ___keeping well?]
16 PT: yes; thank you, (0.8) i've got diabetes in no;w [uh huh huh huh
17 SG: [ah:: i see,
18 SG: oka:y so that's a bit of a headache;
19 PT: hyeh huh huh huh .hhh [oh::.
20 SG: ["mm:"
21 PT: mm:=
22 SG: =so no: (. problems with re- the operation?
23 PT: no (.") nah"
24 SG: and the other breast alri:ght?
25 PT: yes mm

In line 15 the surgeon asks about the patient’s health. The patient interprets this as a
genral health question and answers with a positive answer and an appreciation and
expands with information about other, unrelated problems. This is not a problem
presentation as it would usually be defined because the patient only states rather than
describes her problem and it is not a problem for which she would usually see this
type of doctor. In line 22 the surgeon then asks about the operation he performed a number
years ago removing a lump from the patient’s breast. The patient’s response is limited
to the grammatical constraints set by the question – namely, that it was designed to
receive a ‘no’ answer from the patient.

5.6.2 Presenting the problem in surgeon-patient consultations
Patients are able to present their problems even without having them overtly solicited
by the surgeon and are able to do so in all the different types of visits. The current data
includes 22 problem presentations in total. As already noted, these problem
presentations appear similar in structure to those described in primary care interactions
(Heritage & Robinson, 2006a; Robinson, 2006; Robinson & Heritage, 2005). One key
difference relates to accounting for or justifying the visit. Justifying the visit is not a
unique part of surgeon-patient consultations and is in fact more typical in primary care
consultations. In surgeon-patient consultations, justification is often achieved via the
use of the referral from the physician, which already justifies the doctorability of the
problem in and of itself as the patient has been sent by another doctor. Patients
however can be observed to use the referral process in different activities of the visit to
strengthen their account for why they are there. Surgeons can also use it to affirm the
justification of the visit on behalf of the patient. In follow-up visits, patients have been asked to come in by the surgeon (or another surgeon in the clinic) so there is also no need for them to justify their visit as they were asked to be there. To exemplify the similarities between primary care and surgical problem presentations, a full problem presentation is analysed in extract 5.19.

Ex. 5.19: SS-SP12-01
13 SG: good (..) um (..) tlk got a brief referral letter here from your g
14     p telling us [a bit about $uhh$ (..) some]thing (..) a c- a cyst=
15 PT: [yehuh  huh huh huh huh huhh]
16 SG: =or something is [that] right?
17 PT: [yeah]
18 PT: yep. tlk [.hh now] normally you wouldn’t (..) see such things=
19 SG: [what’s-]
20 PT: =and he: was bit s’prised you wuh willing to. >.hh what’s
21 happened was i had a (..) sebaceous cyst [a little] (0.2) >and=
22 SG: [ yeh]
23 PT: =it was just sitting under the skin for about< two years
24 PT: [three] years .hh and it got infected earlier this yea:r and=
25 SG: [mhm]
26 turned into sort of the $size of a huh .hh [s(h)ort (h)of]=
27 SG: [ nfhhhh nfhh ]
28 PT: (=h)of(h)an kind of$ two dollar coin, >[that] sorta size it=
29 SG: [yeh ]
30 PT: =got quite big; .hh so he tried to remove it, .nhh but the
31 problem was that it- he put a probe in and it went way in he
32 can’t it he can’t get under it [basic]ally. [.hh ] >now the=
33 SG: [right] [okay]
34 PT: =other problem is i have really low platelets coz i had an
35 allergic reaction to a drug last yea:r<
36 SG: ri[gh:t, ]
37 PT: [.hh tlk] a:nd it bleeds a lot (h)i(h) bleed a lot (h)i
38 d(h)on’t clot very well .hh [so he couldn’t get under and he
39 SG: [okay]
40 PT: =said he’s just not skilled enough it [needs] (0.4) .hh=
41 SG: [ mhm ]
42 PT: =↑somebody skilled at being able to cut these things ou:t [.hh
43 SG: [in order to solve the problem.]
44 PT: [and to actually] get it out and he feels that it
45 needs to be someone who has experience because of the bleeding
46 that it could be a bit of ah um
47 SG: yeah that’s interesting i didn’t know about the bleeding; that
48 uh (0.4) adds a new dimension to [things.]
49 PT: [uh huh ] huh huh huh it’s
50 [(another thing)<]
51 SG: [ (you’ve be- ) ] is this the [ first ] () time its been=
52 PT: ["anyway"]
53 SG: =infected=?
54 PT: uh::m s- well it’s been infected twice no::w=
55 SG: ="okay"=
56 PT: =it’s actually been infected again since then and he feels it’s
57 gonna keep on: going,
58 SG: tik and are you diabetic?
59 PT: no

This extract involves a competent and experienced patient (as displayed in both the pre-consultation interview and the consultation itself) and I have chosen it because it shows a wide range of features and is a rich example of possible trajectories. The surgeon begins with a referral-based opening elicitor in line 18 as part of the referral recognition sequence from lines 13-17. The patient begins by justifying her visit (Heritage & Robinson, 2006b), using the referring doctor to strengthen her reason for being there even though, according to the patient, general surgeons would not normally see such cases. Through her use of what’s happened in lines 20-1, the patient projects that her problem presentation will be an extended turn. As in primary care settings, patients often project the design of their problem presentation (e.g., narrative versus symptoms-only) in their initial units of talk (Heritage & Clayman, 2010). The surgeon is then interactionally restricted to producing minimal feedback until the patient presents current symptoms described in the present tense, as in primary care consultations (Heritage & Clayman, 2010; Robinson & Heritage, 2005). Through the use of various types of feedback, the surgeon can influence the way in which a problem is presented, particularly as some acknowledgements encourage continuation (e.g. through continuers such as ‘uh huh’), while others demonstrate the preparedness of the listener.
to shift the talk (Heritage & Clayman, 2010; Robinson & Heritage, 2005). The surgeon does give minimal feedback which becomes shift-implicative around line 29 after the patient presents the current problem, which is that her GP can’t get under it in line 32. This shift to a new phase is indicated by the activity shift tokens right and okay (Gardner, 2001), produced by the surgeon line 33. However, the patient continues in line 32 with a related problem that affects how the problem can be treated. Again she begins in past tense and the surgeon continues giving minimal feedback. This means the patient and surgeon retreat from the ‘zone of transition’, which is identifiable when the patient presents their first current symptom (Heritage & Clayman, 2010; Robinson & Heritage, 2005), and they return to the narrative. The surgeon’s feedback changes from being strongly shift-implicative in line 36 with right to mildly shift-implicative in line 39 with okay to a continuer with mhm in line 41 (Gardner, 2001). The surgeon recompletes the patient’s turn (line 42) in lines 43-4 with a summary of why the patient is there – to solve the problem. The patient again justifies her visit in lines 45-47, citing the GP to reinforce the necessity for her to see a surgeon in the clinic. The surgeon gives an agreeing assessment and then delivers the first history taking question in lines 52 and 54.

As seen in the extract above, there are similarities shared between problem presentations in general practice and surgical consultations. However, there are two key points of difference for the surgical patients in this data (as compared to primary care patients) that influence problem presentation. Firstly, the legitimacy of the visit is not oriented to as frequently by the patients as the patient has been referred by another doctor (first and check-up visits) or has been asked to return by a doctor in the clinic (follow-up visits). The claims of legitimacy made in the primary care interaction (Heritage & Clayman, 2010; Heritage & Robinson, 2006b) are ratified by the referring doctor and transferred in the process of referral, thus making legitimate the patient’s presenting problem without this requiring further interactional work by the patient. Secondly, in the majority of surgeon-patient consultations, the patient has often been referred for a single complaint, which differs from the multiple concerns that frequently occur in primary care (Heritage & Robinson, 2006b).

In summary, the data suggests that in surgeon-patient consultations problem presentations are by and large designed similarly to those in primary care, although
they may have a different sequential environment due to the participants' orientation to the development of a shared epistemic understanding.

5.7 Conclusion

In this chapter I have described the opening activities of surgeon-patient consultations, demonstrating the unique structure of these interactions. The opening activities of referred visits (that is, first and check-up visits) are different not only from follow-up visits but also from the primary care environment where patients usually self-refer for consultations. The larger task of the opening activities in surgical consultations is for the participants to establish a shared epistemic understanding of the reason for the visit, incorporating not only their own understanding but also that of the referring doctor or of other doctors in the clinic. In first and check-up visits, this is achieved through the referral recognition sequence, while in follow-up visits this may be achieved through the use of a follow-up elicitor.

The referral letter in first and check up visits provides a pre-determined direction for the consultation. By using the letter the surgeon can control the focus of the consultation, limiting it to that which is described in the letter. Patients use conversational resources to ensure that they can present their problem in their own way and sometimes this also occurs after the opening activities, embedded in the examination activities, for example.10 As far as problem presentations during the opening activities of the consultation are concerned, they occur in a similar way to those in primary care, as described by Halkowksi (2006), Robinson (2006), and Heritage and Robinson (2006a, 2006b) for example, even though their solicitation differs. They occur in a similar way because participants utilise the norms of story-telling for ordinary conversation (Jefferson, 1978; Schegloff, 1997b) to present their problems in medical consultations, although in a somewhat different sequential environment.

In the referred visit environment, it is essential for the progressivity of the interaction for there to be alignment regarding the reason for the visit between the surgeon and the patient, and preferably the referring doctor (as embodied in the letter). If this alignment is not achieved either through the tacit confirmation after a referral-based opening

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10 The occurrence of these later problem presentations and how they arise and are structured will be addressed in subsequent chapters.
elicitor (that is, a problem presentation) or the explicit confirmation as part of the referral recognition sequence, the consultation cannot progress smoothly or at all as there is disagreement as to why the patient is seeing the surgeon. This may result in a compromise, as described above. This disagreement and any subsequent misalignment can be caused by a poorly written referral letter, a missing referral letter or the surgeon’s or patient’s misunderstanding of why the patient has been sent to the surgeon in the first place. This emphasises the necessity for a clear referral letter.
Chapter 6: Examination: History Taking and Physical Examination

ACTIVITY 3: Gathering further information through verbal and/or physical examination

6.1 Introduction

Examination, both verbal and physical, helps doctors to build a more comprehensive picture of the patient’s problem, beyond that which is delivered in the problem presentation. Examination also assists doctors to undertake a process of differential diagnosis to rule in or rule out the possibility of a particular condition or disease. History taking (or verbal examination) and physical examination usually occur after the patient presents their problem and prior to the diagnosis delivery and treatment recommendation by the doctor. This is a logical sequence of events as the examinations ‘fill in the gaps’ (that is, uncover the objective information needed to complement the patient’s subjective expression of their problem) remaining from the problem presentation and are fundamental to the process of medical diagnosis (Boyd & Heritage, 2006).

The transition between problem presentation and history taking is managed locally by the participants (Heritage & Clayman, 2010; Robinson & Heritage, 2005). The patient will often finish their story with the presentation of current symptoms which “constitutes a place where patients indicate their willingness to relinquish the interactional floor and physicians tend to take it” (Robinson & Heritage, 2005, p. 482). As noted in the previous chapter, for the purpose of this research the problem presentation was regarded as complete with the first full history taking question.

The local context of history taking is considerably different to that of problem presentation as the doctor has the ability to direct the course of the interaction through a question-answer structure. As Collins and colleagues note: “while the problem presentation is described as the prime opportunity for a patient to voice concerns, the history-taking activity which follows it has repeatedly been shown to be a relatively
restricted environment for patient initiated actions” (2007a, p. 13). That is not to say, however, that patients are unable to modify the local context by responding to questions beyond their action and/or topical agenda (Collins et al., 2007a), as demonstrated in Stivers and Heritage (2001) and below in my data. Patients can still have agency in this locally restricted context (Frankel, 1990); however they are forced to do extra work in order to gain it.

In this chapter, I begin with a brief description of the data used for the analysis of examinations then discuss the different types of history taking found in surgeon-patient consultations: problem-specific history taking and comprehensive history taking. This is followed by an examination of question design in the history taking activity, because “when considering the impact of context on action, the most primary aspect of this context is the immediately prior action to which the action responds” (Heritage, 2010, p. 28). As noted above, patients are able to respond to questions outside the questions’ agendas. The occurrence of the different types of responses and how they are achieved is therefore analysed below prior to a brief examination of the transition from history taking to physical examination.

6.2 Data analysis

Sometimes verbal and/or physical examination is not necessary depending on visit type, or the quality and quantity of detail in the problem presentation, the referral letter or the patient notes. While there were several consultations in which neither a verbal nor a physical examination of the patient occurred, these have been included in the analysis to demonstrate the context in which such activities do not occur. As such, all 35 consultations were considered in the analysis of examination. As previously described in chapter 3, the data was analysed systematically using conversation analytic techniques. Firstly, the history taking and physical examination sequences were identified. Secondly, these sequences were analysed in more detail with reference to previous research on the structure of history taking in primary care (e.g. Boyd & Heritage, 2006; Heritage, 2010; Stivers & Heritage, 2001). It is essential to note that as the physical examination often involved the camera being switched off (Interaction Study data) or covered (Surgeon Study data), the non-verbal transition to and action of physical examination has not been considered in this analysis due to the limitations of the data.
6.3 Types of history taking

In surgeon-patient consultations, and in other doctor-patient consultations, two different types of history taking typically occur: problem-specific\(^1\) and comprehensive. Both types are important in forming a more complete picture of the patient’s presenting problem and aid the formulation of diagnosis as well as deciding which treatment is most appropriate for the patient. Mixed history taking can also occur as does history taking during the physical examination.

6.3.1 Problem-specific history taking

In problem-specific history taking, as shown in extract 6.1a, the surgeon focuses on the presenting problem, asking the patient questions such as when the problem started, the type of pain experienced and other relevant symptomatic information.

**Ex. 6.1a: IS-SP03-02**

207 SG: .hhhhhh (0.6) what are yuh bowels like between attacks, are 208 they are they kind of 209 (.)
210 PT: yeah: i wouldn't i wouldn't say they're classic.
211 SG: n[o 212 PT: [ah:: yih know like standard? (0.8) like >quite often< (0.2) 213 “uh” (0.5) sort of sittin’ there for a while and not much is 214 goin’ on but i jus’ FELT like (um) 215 (0.6)
216 SG: "right"
217 (0.9)
218 SG: would you how often would you go to the toilet (during the 219 day) how many times a week (0.2) for example w’ld you 220 (1.1)
221 PT: "(mm::)"
222 (2.7)
223 PT: "aw jeez i don't know?" (1.4) *uh::m* a- i- i- i try an’ go

\(^1\) Sometimes referred to as “differential diagnostic history taking” (Stivers & Heritage, 2001), however that terminology could be inappropriate for surgeon-patient consultations where the diagnosis may already be known and the questions are asked for other reasons. Although in many consultations a process of differential diagnosis will occur, this is not always the case. As such, I have chosen the term ‘problem-specific history taking’.
once a day but uh:m (2.4) yea:h it's NOT (1.0) yeah there's no
real (. ) real pattern to it.=

SG: =right [okay¿
PT: °(>i'd say?<)°
(0.5)

SG: so yuh not a regular
PT: [nah: not=
SG: [a regular
PT: =not really
SG: >what a- what about< consistency of the bowel motions,
PT: *er:: not really*
SG: what- are they soft or they ha:[rd,
PT: [*awh uh:m*
(2.3)

PT: yeah (. ) soft
SG: ah soft
PT: °mm°
SG: okay?
(2.5)

SG: do you have to push and strain to go? when you need to ;go or,
PT: uh:m (0.9) yeh (. ) ah w- well not all the time but >a lot of
the time.<=
SG: =hmm okay,

After the problem presentation and some problem-specific history taking, the surgeon in extract 6.1a asks another problem-specific history taking question in lines 207-8. This is not a grammatically complete sentence, prompting the patient to respond to the surgeon’s turn after are they kind of. As can be seen across the history taking data here, incomplete sentences are a commonly used elicitation strategy for surgeons. The patient responds with a less than transparent answer, categorising his bowels as not classic. The surgeon begins to say no and is overlapped with a more detailed explanation by the patient in lines 212-214. The surgeon continues asking problem-specific questions in lines 218-219, line 229, line 233, line 235 (as a clarification of line
233) and line 243. All of these questions relate topically to the bowel habits of the patient and provide the surgeon with more biomedical information on which to form a diagnosis and treatment recommendation.

6.3.2 Comprehensive history taking

Comprehensive history taking, shown in extract 6.2a, revolves around the patient's health in general, with the surgeon asking questions about lifestyle (e.g. smoking), past surgeries and pre-existing medical conditions, current unrelated medical conditions (e.g. diabetes) and the health status of immediate family members (Stivers & Heritage, 2001).

Ex. 6.2a: SS–SP08–02

153 SG: so liver complaint >problem with your eyes: s, (0.8) tell us
154 about your heart, do you have any problems [with= 155 PT: (no,
156 SG: =with blood pressure¿
157 PT: no,
158 (0.8)
159 SG: do you get chest pains or [shortness of breath [or
160 PT: [no
161 (0.8)
162 SG: palpitations [do you feel your heart beatin irregularly?
163 PT: (no
164 PT: no:.
165 (1.0)
166 SG: any uh asthma or bronchitis?
167 PT: no
168 SG: did you have rheumatic fever when you were young?
169 PT: no
170 (1.0)
171 SG: uh you diabetic?
172 PT: $n(h)o(h)$
173 SG: (no) any allergies to drugs you know of?
174 PT: no
175 (1.0)
176 SG: uh: m h‘v you ever had a blood clot in your legs or a blood
177 [clot in your lungs¿
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178 PT: [°no°
179 SG: no. (0.2) do you- do you take any other medicines regularly
180 except for the: (0.8) ibuprofen?=  
181 PT: =i take um ah- am- (ampatripaline)¿  
182 SG: amitriptyline yes¿  
183 PT: =yes cos i’ve got shingles.  
184 SG: oh have you.  
185 PT: hyeah  
186 SG: and does that help the shingles [pain¿]  
187 PT: [ huh ] yes it does.  
188 SG: does it?  
189 PT: yes  
190 SG: [what-  
191 PT: [i wi- i wish it to stop the itch¿ [hh huh hh huh .hh  
192 SG: [yeah  
193 SG: how much amitriptyline >do you jus’ take some at night?  
194 PT: uh one at night.  
195 SG: one at night. ((mumbles to TI)) (  
196 and does that help?  
197 PT: mm.  
198 SG: does it¿ oh that’s good. (1.0) alright, well look i wonder if  
199 we could just get you to have a wee walk.  
200 PT: m:\m,

In extract 6.2a, from a consultation with a different patient and surgeon, the surgeon continues with comprehensive history taking after an extended response by asking the patient a series of checklist type questions. These questions occur in lines 153-4, 156, 159, 162, 166, 168, 171, 173, 176-7, and 179-180. Several of these questions are designed to elicit a ‘no problem’ response by the patient due to the inclusion of negative polarity markers (Heritage, 2010; Schegloff, 2007) in their structure. As such, these questions predominantly elicit one word preferred responses, besides the question in lines 179-180. Only when the patient gives a dispreferred response in line 181 does she need to provide further information, including information that is elicited by further (contingent) questions from the surgeon.

4 Note the first question in lines 153-4 actually begins with a directive, tell us about your heart, followed by a specific question, do you have any problems with blood pressure.
Comprehensive history taking is particularly important when surgeons consider treatment options for patients as it can disclose information that precludes the patient from certain treatment types, such as surgery, or can reveal other information important to the diagnosis. As it involves “the deployment of questions that recover baseline data from the patient” (Boyd & Heritage, 2006, p. 169), comprehensive history taking is particularly important in surgeon-patient interactions as the surgeon is less likely to be acquainted with the patient and this information is less likely to be in the referral letter.

6.3.3 Mixed history taking

The distinction between the two types of history taking is not always clear in practice as some questions seem to facilitate information gathering for both types. Questions such as “is there a history of breast cancer in your family” or “has anyone in your family suffered from bowel problems” are examples of this type of question. This is baseline information regarding the patient’s general health but can also provide problem-specific information for the surgeon regarding the likelihood of certain illnesses, such as cancer.

Ex. 6.3: SS-SP10-04

53 SG: any family history of breast or ovarian disease.
54 PT: tlk uh:m (“trying to think”) i think my sisters’ had uh:m (.) um
55 i know (.) two of my sisters have had hysterectomies?
56 SG: mh:m,
57 PT: and i’m sure: (1.0) but i’m not exactly sure what the reasons
58 were.
59 SG: mh[m:]
60 PT: [so ] i’m assuming it’s something.
61 SG: did they have to have chemotherapy or anything like that
62 afterwards?= 63 PT: =no (i’m n-) no,
64 SG: (right).

For example, in extract 6.3, the surgeon asks the patient (who has presented with lumps in her breasts) whether there is a history of breast or ovarian disease⁵ in her

⁵ Note the use of the word disease instead of cancer. This interesting word choice is presumably made in order to avoid unnecessary anxiety that the suggestion of cancer might cause.
family (line 53). While this question is specifically related to the presenting problem, it also reveals other comprehensive health information regarding the patient’s family. The question is also asked in a checklist style and is optimised (that is, preferring a response that is the positive health outcome) with the negative polarity marker any, thus preferring and presupposing a ‘no problem’ response from the patient (Heritage, 2010), which is typical of comprehensive history taking questions (Boyd & Heritage, 2006). (Question design is discussed further in section 6.4).

History taking, as with other consultation activities, does not necessarily happen in a specified order, such as comprehensive history taking being followed by problem-specific history taking or vice versa (Robinson, 2003). In many of the consultations with comprehensive history taking in this data, the surgeon begins with a general, open-ended question, such as “how is your health otherwise”, which acknowledges the existence of the presenting problem through the use of a word such as otherwise, but also makes relevant the patient’s other medical problems. Patients either respond with a short assessment or pre-empt the types of questions that surgeons may ask regarding family history, medications, and lifestyle choices. Extract 6.4a shows how the surgeon and patient can alternate between the two as the surgeon builds a picture of the patient’s presenting problem and the health context in which the problem exists.

**Ex. 6.4a: SS-SP13-01**

62  SG: um t- how is your health otherwise.
63  PT: tlk good i mean i (0.8) can’t really tell you of any really
64      ba:d things um i had three children? [.hh ] uh:m eighteen to=
65  SG: [mh:m]
66  PT: =eight years old? uh:m (. ) forty six years old? and this is
67      probably the first time that i’ve been referred to surgery? >i
68      haven’t had any broken bo:nes? .hh probably the worst thing
69      i’ve ever had is hay fever [hhh hah] .hh uh:m i think i=
70  SG: [ mm: ]
71  PT: =<keep (. ) pretty fit;> i mean i do um rock n roll dancing and
72      i walk to work and things like that,
73  SG: okay,
74  ((15 lines omitted))
75  SG: and you’ve never noticed any other lumps in your
76  PT: ↑n[o: n]o my sister, uh probably about three years ago w’s:=

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91 SG: [breasts]
92 PT: =referred for the same thing and she had cysts but they didn’t do anything about them?
93 SG: (right),
94 PT: mm
95 SG: and there’s no history of any [other breast problems.]
96 PT: [not of breast cancer. ] no.
97 SG: and how about any other types of cancer apart from your father’s?
98 PT: ↑uh:m (1.2) no i can’t think of anyone really dying of- but my
grandparents;
((19 lines omitted))
99 SP: and (.) you don’t have fevers or anything like (.) night
100 sweats?
101 PT: no:? no:¿ >i mean< (0.6) apart from just having this bit of
dis:comfort >it felt at first a little bit as though it was a
little bit war:¿ and i thought aw: (y’kn-) it felt like you
102 how you get an infection when you’re breast feeding.
103 SP: mhm.
104 (1.2)
105 PT: like that. [a bit] sore and warm.
106 SP: [okay.]
107 PT: tlk yes; um i probably in my forties i may have gained a
108 qu- little bit [hh ] hah hah hah [hah ] .hh ro-
109 SP: [ yeah] [okay]
((25 lines omitted))
110 SP: .hh and do you know whether you’re allergic to any
111 medications?
112 (1.0)
113 PT: uhm (1.0) i’ve had penicillin shot in the bottom for
tonsillitis and that was alright? >um i have been put under by
general tuh have ton- um teeth out and that was okay;
114 SP: °okay°
115 (1.0)
116 PT: that’s about it really;
The surgeon begins in line 62 with a very general and open-ended comprehensive history taking question. The patient delivers a long answer that includes some pre-emption of the kinds of questions the surgeon might ask, such as previous surgery, exercise levels, family history of cancer. The surgeon then asks a problem-specific question in line 89, with the patient answering the question as both problem-specific with a no and also as comprehensive by giving more of her family history. How the patient responds is relevant to how the question is categorised and interpreted by the patient, demonstrating that history taking is also a co-constructed activity. The surgeon then asks a history taking question in line 96 that could be considered both problem-specific and comprehensive. Using such a question as a ‘bridge’ allows the surgeon to redirect the consultation back to comprehensive history taking, which is done with a comprehensive history taking question in lines 98-99. This is followed by more comprehensive history taking for another 65 lines. While there are only two shifts between history taking types in this extract, it is important to note that these shifts are managed locally by both participants, demonstrating the agency that both can have within the history taking activity.

6.3.4 History taking conducted in parallel with physical examination

While history taking predominantly occurs prior to physical examination (Frankel, 1983; Heath, 1992; Robinson, 2003), in some cases the history taking, particularly problem-specific history taking, continues in parallel with physical examination, as the surgeon asks more questions regarding the patient’s experience of illness.

Ex. 6.5: SS-SP10-06

88  SG: =o:Kay:. lovely; now (. ) if i get you to slip your top things
89      off? (1.0) pull that curtain around? (0.6) that way nobody can
90      come marching in the doors? there’s a little cape to put on
91      your shoulders? (1.0) keeps you a little bit modest;
      ((21 lines omitted))
112 SG: okay:. now where’s the trouble.
113      (1.0)
114 SG: where do you feel a sore area_

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6 Other forms of talk also occur during the examination, such as procedural talk (describing what is occurring or asking the patient to move), online commentary (describing what the doctor is seeing) (Heritage & Stivers, 1999), social talk etc.
In extract 6.5, for instance, the surgeon asks the patient to change for examination and then asks the patient to show her where she experiences the pain in line 112 (during the examination). The surgeon then continues with asking about the patient’s previous diagnostic test in lines 117-8. In line 136, the surgeon asks another problem-specific history taking question. Throughout this sequence there is also procedural talk and online commentary (not shown).

6.4 Question design

The responses to the two types of history taking differ as the design of comprehensive history taking often promotes minimal, ‘no problem’ responses (Stivers & Heritage, 2001) in an effort to rule out “domains of medical problems” (Heritage, 2010, p. 21). In contrast, problem-specific history taking allows patients the opportunity to expand with extended or even narrative responses. The differences between the two types of history taking go beyond their topics and goals as there are structural variations as well. As Stivers and Heritage explain (2001, p. 181 note 2):

Comprehensive history taking can occur in the same consultation as history taking that is directed at diagnosing a specific problem and informed by the principles of differential diagnosis. However the two types of questioning are clearly distinct in terms of the organization and design, and the types of responses they mandate. By comparison with the question designs in comprehensive history taking, which are optimised for ‘no problem’ response, differential diagnostic questioning commonly incorporates questions designed for the affirmative acknowledgement of problematic symptoms.

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7 The video camera is covered for the examination.
The design of the questions used by surgeons is important in the type of response they elicit and this is discussed in this section.

The role of questions in history taking is to elicit further information regarding the patient’s experience of illness in order to move towards a diagnosis and treatment recommendation. In designing questions, surgeons must be cognisant of a variety of factors before choosing how to structure their question. As Boyd and Heritage explain, “physicians, in designing questions for patients are continually faced with selecting between alternative forms of the “same” question” (2006, p. 183). As discussed in the previous chapter, question design is key to understanding what the speaker is communicating – why did the speaker choose that topical agenda, that action agenda, that presupposition and that preference (Heritage, 2010)?

According to Boyd and Heritage, doctors’ questions, at the minimum, have three features: “first, they establish particular agendas for patient response; second, they embody presuppositions about various aspects of the patient’s health, bodily awareness and background knowledge of medicine, and third they incorporate ‘preferences’” (2006, p. 154). First, questions set topical agendas and action agendas (Boyd & Heritage, 2006). A topical agenda is one that directs the topical content of the response; that is, the patient is accountable to answer within the topical field of the question. An action agenda is the type of response or action that is normatively required by the question, such as a yes or no answer to a yes/no (or polar) question. Such agenda setting is crucial to understanding the interactionally restrictive context in which a surgeon often places the patient in the history taking activity.

Second, through the design of questions, the surgeon communicates their knowledge and presuppositions about the patient, information which is understood and interpreted by the patient in their response (Heritage, 2010). These presuppositions can be about the patient’s lifestyle choices, social situation, or presenting problem.

Ex. 6.6: SS-SP09-02
27 SG: and um what sort of work do you do;
28 PT: uh don’t work at all;
29 SG: um so: (. ) wha- what- (. ) um so there’s not (0.2) a need for
For example, in line 27 of extract 6.6, the surgeon asks about the kind of work the patient does rather than whether he does actually work. By doing so the surgeon presupposes that the patient is currently employed. In line 28, we can see that the surgeon was mistaken as the patient does not work at all.

Finally, understanding preference is key when considering question design in medical history taking. In conversation analysis, as Heritage explains, “‘preference’ is used to describe the bias or tilt of questions that are designed for, favor, or suggest an expectation for, an answer of a particular type” (2010, p. 13). Through various grammatical techniques, a surgeon can build a preference for a ‘yes’ response or for a ‘no’ response. Patients can then design their responses to be preferred (aligning with the preference in the question) or dispreferred (not aligning with the preference in the question) (Boyd & Heritage, 2006). By designing questions with a certain preference, a surgeon can influence the kind of response that the patient might give while also embodying the surgeon’s presuppositions in its design.

There are various other principles that guide question design in history taking, including optimisation, recipient design and problem attentiveness (each of which is touched upon below). Optimisation of questions involves designing questions that presuppose (and are designed to elicit) the best case scenario for the patient. In comprehensive history taking, optimisation is the default principle in designing questions (Boyd & Heritage, 2006; Heritage, 2010). In extract 6.7, the surgeon asks three optimised comprehensive history taking questions (lines 114, 116, and 123-4).

**Ex. 6.7: IS-SP03-04**

114 SG: any any other medical (0.2) [prob]lems; [no.] okay?
115 PT: [no. ] [no. ]
116 SG: you _ on medications for anything_?
117 PT: ah::: yes. i'm on: (0.8) "filip (.) what is it?"
118 DA: floocl[u]co? ]
119 SG: [flu-] fluoxetine?
120 PT: ye:s, for depression, (0.8) and losec.
121 SG: okay. fo- for what reflux;
In all three instances he uses the negative polarity marker *any* (Schegloff, 2007), which creates a negative preference. That is, all three questions are designed to elicit a *no* response from the patient, thus optimising the questions for the best case scenario (that the patient has no other medical problems, is not on medication and has no allergies to medications, respectively). Also, none of these questions is designed as a full question which foregrounds the routine, agenda-driven nature of these questions. As we can see, the patient gives a *yes* answer to the second question, using *ah* to delay the dispreferred response (Schegloff, 2007).

As comprehensive history taking is generally designed for ‘no problem’ responses through the principle of optimisation, this type of history taking often appears as a series of checklist style questions (Boyd & Heritage, 2006). For example, in extract 6.1b, after a question regarding the patient’s general health, the surgeon begins a series of closed, optimised history taking questions in line 279.

**Ex. 6.1b: IS-SP03-02**

279 SG: no serious illnesses or operations,
280 PT: "mm" ((shakes head))
281     (1.3)
282 SG: you on medications for anything?
283     (0.7)
284 PT: "nah"
285     (1.3)
286 SG: any allergies to medicines you've had previously;
287     (0.5)
288 SG: "no"
289     (2.6)
290 SG: "kay"

The three questions asked by the surgeon are all no-preferring questions (although the first question in line 279 is grammatically a statement, its action is a question, as
evidenced by the patient’s response in line 280). These are also in the epistemic domain of the patient. That is, it is about something about which the recipient (the patient) has the knowledge, not the questioner (the surgeon). The patient produces preferred responses to all the questions, though they are delayed in their delivery.

Recipient design is about how the surgeon designs a question with reference to what they already know or presuppose about the patient, their medical history, their lifestyle and their presenting problem and about fitting the question to the surgeon’s expectations of what the recipient knows. The principles of optimisation and recipient design may align or they may be cross-cutting, in which case the surgeon is less likely to optimise a question as it would be unrealistic (and possibly redundant) to do so (Boyd & Heritage, 2006). In the 35 consultations in this data, most of the comprehensive history taking questions are optimised. This is most likely because few of the surgeons and patients have previously been acquainted and therefore the surgeon would have less knowledge about the patient and would be able to make fewer presuppositions about the patient’s general medical history. In extract 6.8 the surgeon first states that the patient has been a smoker and then asks when he stopped in line 203.

Ex. 6.8: SS–SP09–03

203 SG: you have been a smoker? when did you stop?
204 (0.2)
205 PT: twenty. >twenty one years ago.<=
206 SP: =okay;:

Knowing that the patient had previously been a smoker (likely from the referral letter or patient notes as the participants were previously unacquainted), it would have been inapposite for the surgeon to ask the patient whether or not he smoked.

The principle of problem attentiveness is closely related to optimisation and recipient design (Heritage, 2010). As optimised questions presuppose a best case scenario, optimisation is not always appropriate in problem-specific history taking as it would

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8 This extract is taken from a pre-surgery consultation and this history taking sequence occurs within a diagnostic education activity where the surgeon is explaining the reasons for a particular diagnosis.
display an inattentiveness to the patient’s presenting problem. Problem attentive questions, therefore, are designed for acknowledgement of problematic symptoms and thus are usually not optimised for best case responses (Stivers & Heritage, 2001). Problem-specific history taking is therefore more likely to be guided by this principle (Heritage, 2010), as in extract 6.1c.

**Ex. 6.1c: IS-SP03-02**

169 SG: whereabouts do you feel the pain.
170 (0.5)
171 PT: uh:m (0.8) aw jus’ generally,=
172 SG: =jus’ across the middle?
173 PT: yeh.
174 SG: yeh?
175 PT: basically=
176 SG: =okay
177 PT: [= i ] (.) i c’dn’t really (0.7) s- (0.2) c’ldn’t say it with
178 a whole lot of [clarity=]
179 SG: =<right>
180 PT: =exact[ly where=
181 SG: =e hhhhh
182 PT: =i felt it but at thuh=
183 SG: =<right>]
184 PT: =at thuh] [time=
185 SG: =.hhh
186 PT: =it w’s

In this extract, the surgeon asks the patient (line 169) where he feels the pain rather than asking if he feels pain. The surgeon is attentive to the patient’s experience of his problem, which in this case is pain. Nevertheless, problem-specific history taking questions are sometimes optimised and several cases of this occur in my data, as in extract 6.9.

**Ex. 6.9: IS-SP01-05**

85 SG: a- are you off your foo:d?
86 PT: i don’t really care (h)ab(h)out it too much but i do
87 e:t, (0.6) [mm,
88 SG: [any vomiting?

146
In this extract, the surgeon asks the patient about vomiting in line 88, preferring a no problem response by using the negative polarity marker any. Here, the surgeon is not only optimising the question for the best case scenario but is doing so as he shifts from problem-specific to comprehensive history taking. That is, the optimised design of the question in line 88 is the same as that of the question in lines 93-4, which is a comprehensive history taking question, albeit related to the area of the body in question. The surgeon uses question design to aid the transition between the two types of history taking.

Optimised, checklist questions can also occur in problem-specific history taking during follow-up visits. This type of questioning clearly has a different purpose to problem-specific history taking in first and check-up visits, where a problem is presumed by virtue of the patient being there. As some follow-up visits are scheduled in order to ensure that a patient has not experienced a recurrence of symptoms some time after surgery, the surgeon can use optimised questions, presupposing the best case response from the patient, as in extract 6.10a.

Ex. 6.10a: IS-SP01-06
22 SG: so no (0.4) problems with re- the operation?
23 PT: no no
24 SG: and the other breast alri:ght?
25 PT: yes *mm*
26 (0.2)
27 SG: good. and no (0.8) particular pains anywhere un-
28 PT: aw: f- get a few stabbing pains someti:mes, (1.4) in th-
29 [this] (at night) yeah?
Here the surgeon begins in line 22 by using a ‘no problem’ statement to ascertain whether there have been problems since the operation. There are subsequent checklist questions, including a contingent question (as explained below) in line 32 that is prompted by the patient’s dispreferred response in lines 28-29. Each of the checklist questions (lines 22, 24, 27, and 36) is optimised for the best case response even though this is problem-specific history taking.

Another type of question not yet described here in any detail but which occurs frequently in this data is the contingent question. These questions are designed to elicit more information or specification of the patient’s previous answer (Boyd & Heritage, 2006). They are found in both comprehensive and problem-specific history taking and, as in extract 6.4b, demonstrate the surgeon’s attentiveness to the patient’s answers (rather than continuing on a checklist, for example).

Ex. 6.4b: SS-SP13-01
142 SG: .hh and do: you take any medications: of any type.
143 PT: uh don’t: uh:m i have an i u d: i’ve had it fuh (. ) bout four
144 five years now:
145 SG: ri:ght;
146 PT: and tlk yeah and i was on the pill before that,
147 SG: [(yeah) ]
148 PT: [mainly,] my i u d fitted in my forties?
149 SG: okay what type of i u d is it,
150 (1.6)
In this extract, the surgeon is asking checklist style comprehensive history taking questions. The patient delivers a dispreferred response across lines 143-4, 146 and 148. In line 149 the surgeon asks a contingent question, seeking specification of the type of contraceptive. The patient, however, is unable to provide specification.

Question-answer sequences are normative procedures used to achieve the goals of history taking (Heritage, 1984a). As such, their use locally (re-)creates the institutional context of surgeon-patient interactions. However, while comprehensive history taking may be restrictive through the optimisation of questions and checklist design, thus constraining the patient’s answers (Stivers & Heritage, 2001), problem-specific history taking often does include open questions that allow patients a structural opportunity to provide further detail about their presenting problem, albeit within the topical agenda set by the question. This phenomenon is explained further in the next section.

### 6.5 Patient expansions

Through the principle of optimisation, surgeon questions are designed to elicit ‘no problem’ responses and therefore discourage further elaboration beyond the agenda of the question (Stivers & Heritage, 2001). Although history taking is considered a restrictive interactional environment for patients (Collins et al., 2007a), patients frequently make use of conversational techniques in order to respond beyond the topical and action agendas set by the question. Stivers and Heritage (2001) have shown that patients can make expansions to their answers, either in the form of expanded answers or narrative expansions. Both expansion types also occur in surgeon-patient interactions and, as demonstrated by the extracts below, can occur within both comprehensive history taking and problem-specific history taking.
Expanded answers are, just as their name suggests, answers that not only respond to the questions but that are also elaborated (Stivers & Heritage, 2001). These expansions include those that (Stivers & Heritage, 2001, p. 154):

i. address the patient’s difficulties in giving definite answers to some questions;

ii. support answers by adding details; or

iii. pre-empt negative inferences which might otherwise arise from unelaborated answers.

In comprehensive history taking, “patient expansions are accountable in various ways” (Stivers & Heritage, 2001, p. 151). That is, as in mundane conversation, deviation from the topical and/or action agenda of the question is normatively accountable. A patient may be unable to answer a question for which they should be able to have access to answer. In such a case they are accountable for not knowing and provide an expanded answer. Extract 6.4c is a clear example of an expanded answer.

**Ex. 6.4c: SS-SP13-01**

149 SG: okay what type of i u d is it,
150 (1.6)
151 PT: °i don’t kn© i [know] it’s a [tee] thing [HH HUH huh huh ]
152 SG: [oh ] [no ] [no- not the one]
153 with progesterone; uh
154 PT: i don’t kno- i have the i have it um you know the formal
155 information at ho:me,
156 SG: okay; no that’s o[kay.]

In line 149, the surgeon asks for specification regarding the patient’s contraceptive. Unable to deliver it, the patient says she does not know but then continues with a possible explanation that is overlapped with the surgeon’s positing of a possible answer in lines 152-3. The patient again denies knowing the information, but accounts for this by stating that she has the information at home. The patient uses an expanded answer to account for her inability to answer the surgeon’s question.

Expanded answers can also be used to pre-empt negative inferences that could be made by the surgeon if the answer were to be left unexpanded (Stivers & Heritage, 2001). The participants in extract 6.11 are discussing the patient’s blood pressure.
The patient responds to the surgeon’s question with an expanded answer, through which the patient accounts for the high blood pressure reading (which she never tells the surgeon in full) by stating that she was running around and feeling unwell the day her blood pressure was taken. By using these accounts, the patient is pre-empting the possible negative inference that the surgeon might make regarding her high blood pressure.

In the surgeon-patient consultations analysed here, expansions are used for the above purposes but also to account for the visit, to express theories of illness, and to integrate lifeworld concerns into the history taking activities. In addition, in surgeon-patient interactions, patients are able to justify their visits by invoking a third party (Heritage & Robinson, 2006b), that is, their referring doctor, in their answers to history taking questions. As patients are referred and the referral is in itself a justification for their visit, many of the visits do not include any such justification. However, when a third party is invoked, more often than not it is the referring doctor. The patient in extract 6.12 uses such an account in lines 46-7 to support her claim of being a legitimate patient with a doctorable problem (Heritage & Robinson, 2006b; Stivers & Heritage, 2001).

Ex. 6.12: SS-SP12-01

37 PT: [.hh tlk] a:nd it bleeds a lot (h)i(h) bleed a lot (h)i
38   d(h)on’t clot very well .hh [so he couldn’t get under and he
39 SG: [okay

---

9 Such referencing also occurs in problem presentations.
In line 52, the surgeon presupposes that this is the first time the patient has had an infected cyst. She delivers a dispreferred response (without saying no) in lines 54. By stating he feels it's gonna keep on going (lines 56-7), she is again invoking the referring doctor's reasoning for his referral to the surgeon, thus justifying or accounting for her visit.

Expanded answers can also be used by patients to tell the surgeon their theory of illness or to inform the doctor of other symptoms that may not be within the topical agenda of the line of questioning, as in extract 6.13.

Ex. 6.13: IS-SP01-01

27 SG: did it have any side effects:?  
28 (1.2)  
29 PT: no: i thoug:ht i had rash which was related to it but it wasn't.  
30 (0.6)  
31 SG: ri:ght.
In this extract, the patient initially responds with a *no* answer to the surgeon's question regarding side effects of medication in line 29. However, she expands on this (lines 29 and 32-3) by telling the doctor about a problem she thought she may have had.

Patients also expand their answers in order to tell the surgeon their lifeworld or psychosocial concerns. As patients' lifeworld concerns are often dismissed by doctors (Mishler, 1984), including them in an expanded answer allows the patient to link their concern to their presenting problem and to the questions being asked by the surgeon, as in extract 6.14.

**Ex. 6.14: IS-SP04-01**

23 SG: ah yea:h. (0.2) so um with the infections with the >u- u- u- u-<
24 _urine infections has the um: .hh >d- d- d-< doctor a- um (. ) had
25 you on and off treatment for that? [or ]
26 PT: [yeah] yeah she gives me
27 _antibiotics then and that's the trouble i have to have thrush_
28 treatment (h)aft(h)er that [because i i keep getting thrush= 29 SG: [oh yeah.
30 PT: =then as well, [so ]
31 SG: [oh yeah.]
32 PT: it just seems to be continually (0.2) kind of going to the
33 _doctor all the ti:me. an
34 SG: yea:h=
35 PT: =you know=
36 SG: =yea:h.
37 PT: an it's starting to get me down a little bit no:wiz=
38 SG: =yea:h. uh (that um) (. ) sorry i i thought we'd all organised
39 _>a- a- a-< another .hh >ap- p- p- p-< appointments [{(that were)}]
40 PT: [ ( oh oh ) ]
41 SG: =to try and sort it out there [$f(h)or] (h)you$.  
42 PT: [ ah ]
In this extract, the patient expands her response to the surgeon’s question in lines 23-5 regarding treatment. The patient begins by answering the question, but then expands in line 26-8, stating that she needs other treatment as well. The surgeon responds with the change-of-state token oh (Heritage, 1984b) in line 29, indicating that this is news. The patient continues with her expanded answer, concluding with the lifeworld concern that it’s starting to get me down a little bit now. All the talk in this turn prior to this statement is geared towards justifying that concern, saying that the treatment is causing trouble and that she is continually going to the doctor. By placing the lifeworld concern within the question-answer sequence the patient takes the risk that the surgeon might continue with another question, as he has the structural imperative to do so. However, the surgeon here addresses her concerns in lines 38-9 and 41 before moving on with further history taking questions.

Narrative expansions are more extensive than expanded answers and change the structure of the history taking from question-answer sequences (Stivers & Heritage, 2001). As Stivers and Heritage (2001, p. 167) explain,

narratives embody a shift in the interactional organisation of history taking, from one in which patients respond to physician questions to one in which physicians are unambiguously placed in the role of story recipient. In this role, physicians are unassured of a next slot in which to resume history taking and, in this sense, lose part of the interactional initiative associated with history taking as an activity.

Expansions do not only occur after closed questions, as patients respond to open-ended questions beyond their action agenda in order to have more agency within an interaction. Through the use of narratives, patients regain their agency within the consultation and are able to tell their story and experience of illness on their own terms beyond the agendas set by surgeon questions. As can be seen in extract 6.2b, there is a narrative expansion after a wh- open-ended question in line 31. This is a narrative regarding symptom discovery, as described by Halkowski (2006).

Ex. 6.19: SS-SP08-02
26 SG: and where do you feel the pain most of the time is it in the
27 hip itself [and ] the [ knee ]?
28 PT: [(my)] [(my kne-)] yes, mostly my knee,
29 SG: mostly your knee;
30 PT: yeah.
31 SG: mm: alright (1.0) and how long have you had the pain for.
32 PT: well i’ve i’ve got arthritis and i just thought it was that
33 because the southerly (0.2) wind affects me more,
34 SG: [yeah
35 (.)
36 PT: and >i’ve always (known) when there’s a southerly coming and i
37 naturally thought it was just< (.) that, (1.2) so i went and saw
38 my doctor for my check up and she said what are you limping for.
39 (1.0) i said w(h)ell (h)i huh i said i’m s- i’m sore; (you kn-)
40 SG: mm [mm]
41 PT: [mm] “mm”
42 (1.0)
43 PT: (“um”)
44 SG: “alright” (0.8) and um (.) how long has it been sore for do you
45 think.
46 (1.1)
46 PT: mm:. (2.0) been getting worse over the last year,

The patient prefaces her response with well, which indicates a departure from the restricted agenda set by the question, thus indicating that the answer will not be straightforward (Schegloff & Lerner, 2009). She then continues with talk that does not directly respond to the question, precluding the surgeon from continuing with another question until she has answered it (or relinquished the floor). Her narrative response starts in line 32, where she explains what her previous theory of illness was, reiterated in lines 36-7. The patient then begins her story regarding seeing her doctor in line 37 and concludes the story without answering the question. The surgeon then re-asks the question in lines 43-4, to which he gets a straightforward response. The patient had previously given a very short problem presentation with no information regarding what led her to see her referring doctor. She used this opportunity to break the sequential mould in order to tell her story (Stivers & Heritage, 2001).

Through expansions, both expanded answers and narratives, as in the extract above, patients can make the most of the local context in order to regain agency within the
restrictive environment of history taking and let their concerns, accounts and theories be heard (Stivers & Heritage, 2001).

6.6 Physical examination

Physical examination, as with history taking, is central to developing a diagnosis and treatment recommendation for a patient (Boyd & Heritage, 2006). However, physical examinations do not always occur in surgeon-patient consultations (in this data they take place in 23 out of 35 visits). For the purpose of this research, the physical examination activity begins when the surgeon verbally transitions to an examination (e.g. ‘let’s have a look at that’) and ends when the patient is asked to get dressed. As already discussed, sometimes other activities occur within the physical examinations, such as problem presentations, history taking and even talk regarding diagnosis and treatment.

Although history taking and physical examination are not usually independent activities (see extract 6.5), there is always a transition point either during or after the history taking where the patient and surgeon move to physical examination. In research by Robinson and Stivers (2001, p. 259) “physicians produced transition-relevant nonverbal behaviours in the accomplishment of 39 out of 40 transitions (98%). Furthermore, 24 out of 40 transitions (60%) were accomplished without physicians’ overt verbal references to physical examination.” These non-verbal behaviours included putting down pens and medical records, altering gaze and standing up. Robinson and Stivers (2001) also show that both participants work together in the local context and use verbal and non-verbal resources to achieve this transition, with one modality alone insufficient to do so. The participants also rely on their knowledge of activity structure, that generally the physical examination is subsequent to the problem presentation and history taking (Robinson & Stivers, 2001).

In most of the data in this research, the physical examination has not been captured as the camera has been switched off or covered for the examination. What can be heard, however, is that in every consultation where there is a physical examination, the surgeon explicitly verbalises the transition to that activity. During the examinations, as mentioned earlier, we can also hear that several different kinds of talk occur, such as procedural talk (describing what is occurring or asking the patient to move or breath in a
specific way), online commentary (describing what the doctor is seeing) (Heritage & Stivers, 1999), and social talk.

6.6.1 Procedural talk

In extract 6.1d, the surgeon begins the examination sequence in lines 374-5 as he outlines his plan for how the consultation will progress.

Ex. 6.1d: IS-SP03-02
374 SG: _uh::m tch what i might do >is jus’ pop you up on the couch jus’
375 _have a little (look) at yuh tu::m:< ah: then we can jus’ talk
376 through (1.0) y- thee operation that's involved with taking
377 out this bit _that's twisting._and ah:
378 PT: °mn°
        (( 51 lines omitted))
420 SG: r:ight (jus’ sit) (. ) that's okay.
421 (0.7)
422 SG: jus’ _loosen you top (there)¿
423 (3.8)
424 SG: .hhh
425 (0.9)
426 SG: ("that's obviously t- (. ) let’s have a look.")
427 (1.0)
428 SG: o:kay? just relax ( )?
429 (0.9)

After some intermediary talk regarding switching the camera off (however the separate audio recording continued), it appears that the surgeon begins the examination proper in line 420, instructing the patient how to prepare for the examination. Some history taking then occurs, which could have been while the surgeon examined the patient, though we cannot see it as the camera is off. In extract 6.1e, which follows on 48 lines after extract 6.1d, the surgeon gives the patient direction as to how and when he should breathe for the purposes of examination.

Ex. 6.1e: IS-SP03-02
477 SG: °jus- take a big breath for me?°
478 (1.1)
479 SG: °and right out.°
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480 (0.7)
481 PT: hhh
482 (1.6)
483 SG: "and again?"
484 (0.5)
485 PT: hhhhh
486 SG: "an’ right out."
487 (0.4)
488 PT: hhh
489 (2.3)
490 SG: ">and again,<"
491 (0.6)
492 PT: hhhhh
493 SG: "and right out."
494 (0.3)
495 PT: HHHH
496 (1.1)
497 SG: "and again?"
498 PT: hhhhh
499 (0.6)
500 SG: "an’ right [out."
501 PT: [HHH
502 (0.6)
503 SG: "big breath," 
504 (0.4)
505 PT: hhh
506 SG: "an’ right out,"
507 (0.4)
508 PT: HHHH
509 (2.2)
510 SG: "big breath,"
511 (0.3)
512 PT: hhh
513 (0.4)
514 SG: "an’ right out."
515 PT: HHHH
516 SG: okay;
517 (1.6)
In line 477 of extract 6.1e, the surgeon begins an instruction sequence which involves the patient breathing in and out. For each adjacency pair, the first pair part is the instruction and the second pair part is the action of breathing by the patient (audible on the audio recording). The surgeon then instructs the patient to get dressed, thus ending the examination.

This examination has several types of procedural talk – instructing the patient how to prepare for examination, instructing the patient what to do within the examination and instructing the patient to get dressed (line 520) so as to continue with the next activity of the consultation. Such talk is important in guiding patients through the process of physical examination.

6.6.2 Online commentary

During examinations, doctors can use online commentary, that is providing comment (often positive) about the patient’s problem during the examination, often in order to minimize patient resistance during the diagnosis and treatment activities (Heritage & Stivers, 1999). This occurs to varying degrees in several of the examination activities in my data. In extract 6.10b, the surgeon is examining the patient’s breasts eight years after performing breast cancer surgery on her.

Ex. 6.10b: IS-SP01-06

105 SG: that all feels pretty good? (1.0) and nothing untoward to
106 see there or to fee:1;
107 (5.6)
108 SG: big breath in,
109 PT: *.hhhh*
110 SG: out;
111 PT: "hhhh" 
112 SG: alright well you've done very well.
113 PT: huh huh [thank you.
114 SG: [that's good. alright then_
When he starts the examination he is teaching a trainee (not shown). In lines 105-6, the surgeon delivers his online commentary, stating that there have been no problems found during the physical examination. The surgeon continues to examine the patient, instructing her to breathe, finishing the physical examination in line 112 using the shift implicative *alright* followed by an assessment of the patient’s ‘performance’ during the examination and/or since the surgery.

6.6.3 Social talk

A surgeon and patient may also engage in social talk during the examination activity. In extract 6.15, the patient begins by thanking the surgeon for seeing her (which may imply that the surgeon is seeing the patient at short notice).

**Ex. 6.15: SS-SP03-05**

193 PT: [i do] appreciate you
194 SG: that’s alright?
195 PT: doing this [ because ] it’s um
196 SG: [(that’s okay.)]
197 SG: (y’know)=
198 PT: =we’re going on holiday. (. ) and (0.4) couple of days and we’ve been putting it [off] thinking [oh ] let’s get this=
200 SG: [yep] [yep]
201 =tidied up,
202 SG: yeah where are you off to.=
203 PT: =i know it’s m- a mi:or thing compared to what gosh some people fa:ce, gisborne.
205 SG: okay that’s nice,
206 PT: hhh
207 (1.0)
208 SG: you got rela[tives there? or friends (you] know)?=oh [that’s]=
209 PT: [i have a twin sister there. ] [yeah ]
210 SG: nice. o[kay.]
211 PT: [yeah]
212 (1.2)
213 SG: >hopefully the weather’ll be< “nghh” (0.2) [ah: ] little $bit
214 PT: [ahhh]
215 SG: more warmer;$ [mind] you that cold front yesterday wasn’t (. )=
216 PT: [do- ]
The surgeon picks up on her mention of a holiday and pursues a social line of questioning, starting at line 202. The patient continues with her previous agenda in lines 203-4; however she answers the surgeon’s question at the end of her turn. The surgeon attends verbally to examination momentarily prior to continuing the conversation regarding the holiday destination of the patient. The surgeon then continues the social nature of the talk but asks the patient about where she lives and they talk about the weather. This social talk occurs during a rectal examination of the patient (which is invasive) and may be a technique used by both participants to distract from the unpleasant nature of and physical discomfort caused by the examination.

As can be seen from the data above, examination is usually not a stand alone sequence as the surgeon multitasks by continuing history taking, instructing the patient through the examination process, providing online commentary and engaging in social chit chat. A linear view of these activities is therefore inappropriate as they often occur at the same time.

6.7 Conclusion: occurrence of sequences

Not all of the sequences described above occur in every consultation, a finding that is consistent with other research on history taking and physical examination (Robinson, 2003). The occurrence of the types of history taking and physical examination varies across the 35 consultations. There are seven possible combinations of occurrence as
well as complete non-occurrence, as depicted in Table 6.1 below. There are several factors that influence the occurrence of the different types of examination. A surgeon may find a patient’s problem presentation sufficient or the problem self-evident (Robinson, 2003) or may have previously encountered the patient, rendering one or more of the sequences redundant.

Table 6.1: Occurrence of examination sequences

<table>
<thead>
<tr>
<th>Occurrence Combination</th>
<th>Comprehensive History Taking</th>
<th>Problem-specific History Taking</th>
<th>Physical Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
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<tr>
<td>3</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>4</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>✗</td>
<td>✗</td>
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<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>7</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>

No single factor correlated with the occurrence or non-occurrence of any of the sequences in the 35 consultations. Occurrence does not appear to be influenced by visit type, except that all check-up visits included a physical examination. Not all first and follow-up visits included a physical examination.

Through the use of various interactional tools, such as expanding beyond the agenda set by the question, the patients in this data frequently promote their own agendas through the restrictive context of history taking, as summarised by Boyd and Heritage (2006, p. 184):

Even during history-taking – perhaps the activity of the doctor-patient consultation that is most completely under the doctor’s control – question-answer sequences remain co-constructions in which the doctors’ question, although constraining, are not determinative of patient response. Indeed, the construction of history-taking as a routine matter necessarily involves complementary actions of doctors and patients which convey just that.
Surgeon-patient consultations do not appear to differ significantly from primary care interactions in terms of the structure of history taking and physical examination. These sequences display many of the same interactional features as found in primary care research. While their occurrence is not divisible by visit or surgeon type, these activities play an essential role in building a comprehensive picture of the patient’s presenting problem in order to facilitate diagnosis; a role that is oriented to by both surgeons and patients (Robinson, 2003).
Chapter 7: Diagnosis

ACTIVITY 4: Reformulating the problem

7.1 Introduction

While other activities of medical consultations are comparatively well researched, there remains a paucity of research into diagnostic delivery\(^1\), and, in the research that does exist, there is particular emphasis on the delivery of ‘bad news’ and little consideration of the delivery of ‘good news’ and ‘no news’ (Maynard & Frankel, 2006). It may appear that patients have minimal engagement in the diagnostic activity of the consultation. But in fact patients do have agency within this activity of the consultation (Peräkylä, 2006), though it is assumed within the confines of maintaining the medical authority of the doctor. For instance, Heath (1992, p. 242) notes that “doctors recurrently provide an opportunity for patients (or guardians) to reply to the diagnosis or medical assessment”. For example, doctors orient to the evidential basis of their diagnostic decision rather than just pronouncing a diagnosis without evidence. This reflects “a broader change in the doctor-patient relationship in our societies” (Peräkylä, 1998, p. 318).

Diagnosis in surgeon-patient consultations appears to be different from that in primary care (e.g. Heritage & Maynard, 2006c; Peräkylä, 2006). Most significantly, as evidenced in this data, there are additional sources to inform diagnostic reasoning available to the surgeon. As in primary care interactions, the surgeon has available to him information from the problem presentation, the verbal and physical examinations, and perhaps also any diagnostic tests that have previously been undertaken. However, the surgeon also has specialist knowledge and experience, as well as information provided by the referring doctor through the referral letter, which may include a description of symptoms alone, a provisional diagnosis or a confirmed diagnosis. In delivering the diagnosis, the surgeon must therefore be cognisant of the opinions of both the patient and the referring doctor, which may align or not with his diagnosis. That is, the surgeon is not

\(^{1}\) While the activity being discussed has been called ‘reformulating the problem’, I have chosen to use the word ‘diagnosis’ throughout to cover all types of problem reformulations described here.
only accountable for his diagnostic reasoning but must also consider the medical authority of the referring doctor and the subjective experience of the patient.

The environment of the interaction is therefore different to that of the general practice consultation. The data examined here suggest that this affects the way in which diagnosis is delivered and the responses to that delivery. Through the analysis presented in this chapter, we can see how diagnosis delivery in surgeon-patient consultations differs from primary care consultations. In this chapter, I first describe the six different ways in which surgeons deliver diagnoses in the consultations in this data. Secondly, I explain the various news types in surgeon-patient consultations, demonstrating how they extend beyond those found in primary care and how they are influenced by the unique environment of the interaction. Finally, I discuss how patient agency is talked into being through patient responses to diagnosis and their participation within the diagnostic activity of the consultation.

7.2 Data analysis

Using all 35 consultations as a starting point for this analysis, I eliminated those that did not have any diagnostic activity. This left 26 consultations in which diagnostic activity occurred. As in the previous chapters, I used conversation analysis and an understanding of the literature around the structures and actions of diagnosis to inform my analysis. Following Peräkylä (2006), I identified diagnostic activity as any sequence involving diagnostic statements and explanations, including assertions of non-existence of disease or problem and excluding pre-diagnostic commentary.

In some instances, the surgeon reveals the diagnosis during a referral recognition sequence (RRS; see chapter 5), presumably based on information from the referral letter. In these cases, the surgeon appears to be confirming the patient’s understanding of their diagnosis and that it has been revealed and explained to them previously. Although the RRS is generally designed to seek alignment between the three parties, the patient, the surgeon and the referring doctor (see chapter 5), by explicitly stating the diagnosis given by the referring doctor, it also functions as a pre-diagnostic comment, as seen in extract 7.1a.
Ex. 7.1a: IS-SP03-02
1 SG: (how’s things.) >i got a letter from my colleague< mister samson. (0.4) °and ah°
2 PT: “ye[s,]
3 SG: [(write to me) say you’ve been (0.8) having a bit of trouble with: (0.7) volvulus. (0.5) or twisting of the bow:el.=
4 PT: =yeah,=
5 SG: =yep,=
6 PT: =yeah.

In this extract, the surgeon begins the consultation by confirming the patient’s presenting problem (lines 4-6), which he does supported by the evidence of the referring doctor and the referral letter (lines 1-2). Only one non-RRS pre-diagnostic comment occurred in this data, extract 7.2a.

Ex. 7.2a: SS-SP13-01
160 SG: i’m going to get the surgeon to come in: (. ) [an examine you],
161 PT: [mhm]
162 PT: [mhm]
163 SG: [but .hh from the scans they: look like nice uncomplicated cysts. [um
164 PT: [right,
165 SG: that don’t show any (. ) [nasty signs, so,
166 PT: [mm
167 PT: good,=
168 SG: =>she’ll come out and have a look at you,< [“bt” ]
169 PT: [okay;]
170 PT: good
171 SG: uh we won’t be a moment,
172 PT: good

In this case, extract 7.2a, the patient is initially seen by a surgical registrar in the clinic. After the problem presentation and history taking, the surgical registrar asks if the patient has any questions and then delivers a pre-diagnostic comment (lines 163-4 and 166). The surgical registrar then fetches the consultant surgeon to examine the patient. Rather than leave the patient with no sense of diagnostic probability, which may
unsettle the patient and cause unnecessary anxiety, the pre-diagnostic comment here relieves stress on the patient and concludes the registrar’s information gathering role in the consultation. In addition, the use of the pre-diagnostic comment also allows the registrar to maintain her medical authority while she also defers to a more senior colleague for her opinion.

The diagnostic activity not only includes a diagnostic statement, but also includes medical information, such as naming the disease, assessing the patient’s condition and giving background information about the disease (Peräkylä, 1998, p. 304). All of these features occur in this dataset, although not in every consultation. In 11 out of the 26 consultations with diagnostic activities, the surgeon explains what the diagnosis means, however only in three consultations does the surgeon provide an assessment of the diagnosis. Not all the consultations had diagnostic activities. The nine consultations in which there is no diagnosis include the two pre-surgical consultations (for which a diagnosis and treatment decision has already been made), three visits where no diagnosis or provisional diagnosis is made (although diagnostic testing is ordered), two post-surgery follow-up visits, one visit where the referring doctor appears to have made a diagnosis (however the start of consultation was not recorded), and one follow-up visit where the patient was diagnosed during the previous visit and a treatment decision needs to be made.

7.3 Delivering the diagnosis

The delivery of a diagnosis can occur in different sequential locations (Peräkylä, 1998), something which in surgeon-patient consultations is related to the purpose and type of visit. In visits that involve the delivery of diagnostic information, for example, the diagnostic delivery usually occurs close to the beginning of the consultation. This is expected as the patient would have already given their problem presentation and had their history taken in a previous visit in which diagnostic testing was ordered. In first visits, however, it might be premature for a surgeon to diagnose the patient prior to verbal and physical examinations (unless the referring doctor provided a confirmed diagnosis in her referral letter).
In primary care, there are three ways in which the doctor can establish the connection between the diagnosis and its evidential basis (Peräkylä, 2006). These three different ways are (Peräkylä, 2006, pp. 218-219):

- Plain assertions
- Diagnoses indexing inexplicit references to the evidence
- Explicating the evidence of the diagnostic conclusion

As Peräkylä explains (2006), in primary care consultations, if the diagnosis is delivered directly following the examination, the doctor maintains an observable link between the examination and the diagnosis. In this case, a plain assertion is often used. If the link is not observable, due to an inferential distance created by opacity of the examination or by time between examination and diagnosis, the doctor may use a diagnostic statement that implicitly indexes references to the evidence. Finally, a doctor may choose to explicate the evidence for the diagnosis as there may be some contention regarding the diagnosis, so as to pre-empt any difficulties the doctor may encounter after its delivery. These different ways of diagnostic delivery demonstrate that doctors are accountable (and orient to being so) for the evidence used in making their diagnostic conclusions (Peräkylä, 2006). The use of different diagnostic statements assists the doctor in maintaining a balance between medical authority and diagnostic accountability (Peräkylä, 2006).

In describing the different diagnostic statement types in primary care consultations, Peräkylä concedes that the “practices of referring to evidence may be different in other medical contexts such as specialized or hospital medicine” (1998, p. 304). This is certainly the case for surgeon-patient interactions. While inferential distance (Peräkylä, 2006) may have been a contributing factor in the general lack of plain assertions used by surgeons in this data, I would argue that the more complex evidential basis on which the diagnosis based is key. This evidential basis, as noted above, includes the incorporation of the referring doctor’s opinion, the patient’s theory of illness, information from the problem presentation and information from the verbal and physical examinations. Given the variety of sources from which the surgeon could draw his conclusion and the importance of aligning with the referring doctor (as embodied in the referral letter) in particular, a plain assertion may be inadequate in encapsulating the evidence apparently used in the decision making process. On the other hand, the
surgeon may use the referring doctor embodied in the referral letter as the justification of his or her diagnosis, thus negating the need to demonstrate other forms of evidence and medical authority.

In developing a typology of the actions of diagnostic statements from my data, I found that there are a number of types of diagnostic activities all designed to accomplish different actions as evidenced in the detailed descriptions below. These types are linked both to the type of visit and to the structural design of the diagnosis as shown in Table 7.1. Six different action types were found in the 26 consultations that included a diagnostic activity:

1. No problem diagnosis
2. Delivery of diagnostic test results
3. Diagnosis with explicit reference to diagnostic testing
4. Pre-diagnostic testing hypothesis or provisional diagnosis
5. Re-stating diagnosis from referring doctor
6. Diagnostic statement

Each of these diagnostic activity types are described and exemplified below, with particular reference to the environment in which they are likely to occur and how they are structured in this data.

**Table 7.1: Occurrence of diagnostic activity types in 26 surgeon-patient consultations**

<table>
<thead>
<tr>
<th>Code</th>
<th>Action type</th>
<th>Structure</th>
<th>Visit Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS-SP09-02</td>
<td>No problem</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>Follow-up</td>
</tr>
<tr>
<td>IS-SP01-02</td>
<td>No problem</td>
<td>Plain assertion</td>
<td>Check-up</td>
</tr>
<tr>
<td>SS-SP10-06</td>
<td>No problem</td>
<td>Diagnoses indexing inexplicit references to the evidence</td>
<td>First</td>
</tr>
<tr>
<td>IS-SP01-03</td>
<td>No problem</td>
<td>Diagnoses indexing inexplicit references to the evidence</td>
<td>Check-up</td>
</tr>
<tr>
<td>IS-SP01-04</td>
<td>No problem</td>
<td>Diagnoses indexing inexplicit references to the evidence</td>
<td>First</td>
</tr>
<tr>
<td>IS-SP03-01</td>
<td>Delivery of diagnostic test results</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>Follow-up</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Details</td>
<td>Stage</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>SS-SP10-03</td>
<td>Delivery of diagnostic test results</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>Follow-up</td>
</tr>
<tr>
<td>SS-SP07-02</td>
<td>Delivery of diagnostic test results</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>Follow-up</td>
</tr>
<tr>
<td>IS-SP02-02</td>
<td>Delivery of diagnostic test results</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>Follow-up</td>
</tr>
<tr>
<td>IS-SP04-02</td>
<td>Diagnosis with explicit reference to diagnostic testing</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>First</td>
</tr>
<tr>
<td>SS-SP08-02</td>
<td>Diagnosis with explicit reference to diagnostic testing</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>First</td>
</tr>
<tr>
<td>SS-SP08-01</td>
<td>Diagnosis with explicit reference to diagnostic testing</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>First</td>
</tr>
<tr>
<td>IS-SP03-04</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Diagnoses indexing inexplicit references to the evidence</td>
<td>First</td>
</tr>
<tr>
<td>SS-SP13-01</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Diagnoses indexing inexplicit references to the evidence</td>
<td>First</td>
</tr>
<tr>
<td>SS-SP07-01</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Plain assertion</td>
<td>First</td>
</tr>
<tr>
<td>SS-SP10-05</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Plain assertion</td>
<td>Follow-up</td>
</tr>
<tr>
<td>SS-SP07-03</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Plain assertion</td>
<td>Follow-up</td>
</tr>
<tr>
<td>SS-SP10-04</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Plain assertion</td>
<td>First</td>
</tr>
<tr>
<td>SS-SP03-05</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Plain assertion ?</td>
<td>Follow-up</td>
</tr>
<tr>
<td>IS-SP04-04</td>
<td>Re-stating diagnosis from referring doctor</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>First</td>
</tr>
<tr>
<td>IS-SP03-02</td>
<td>Re-stating diagnosis from referring doctor</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>First</td>
</tr>
<tr>
<td>IS-SP03-03</td>
<td>Re-stating diagnosis from referring doctor (RRS only)</td>
<td>Explicating the evidence of the diagnostic conclusion</td>
<td>First</td>
</tr>
</tbody>
</table>
7.3.1 No problem diagnosis

No problem diagnostic activities are those in which the surgeon discharges the patient from his care with a ‘no problem’ diagnosis (five out of 26). Importantly, the surgeon may acknowledge that there is a problem, but that it is not a problem that is within his realm of medicine, as in extract 7.3a. This diagnosis type is often followed by a referral back to the referring doctor.

Ex. 7.3a: SS-SP09-02

172 SG: yep °one oh six (.).
seven(ty).° (0.2)(rips off arm cuff) your
173 blood pressure’s perfect; (0.6) uh:m: the: the lungs sound good
174 the heart sounds good (0.4) uh:m: you didn’t need any surgery;
175 so from my side as a chest surgeon, (.)(uh:m i don’t need to
176 PT: [mm]
177 SG: =see you again, we’ve given you a clean bill of health there,
178 (0.4) i’m not gonna get involved in this [because] (it’s out=
179 PT: [nah nah]
180 SG: =of) (.). my realm,

In this follow-up visit, the surgeon precedes his discharge statement (lines 174-5 and 177) with evidence, noting that the physical examinations he has performed show that the patient is well. The surgeon chooses to explicate the evidence of the diagnostic conclusion, utilising his specialty as the reasoning for the discharge and ‘all clear’ diagnosis from his perspective. In extract 7.4a, the surgeon chooses to reference the evidence for his diagnostic conclusion.
Ex. 7.4a: IS-SP01-04

137 SG: alright wally; um (0.2) well there's nothing abnormal i can
  feel there?
139 PT: yep,
140 (1.0)
141 SG: you've had quite a few investigations of the [gall bladder; _]
142 PT: [*uh heaps*
143 PT: [(okay)
144 SG: [so i'm sure it's nothing related to the gall bladder.]
145 PT: *yep* nhh
146 (0.4)
147 SG: i suspect that this is a pain which is originating in your
  back,
149 (0.6)
150 PT: yep,
151 (0.4)
152 SG: you can get (0.4) pain from the back (0.2) presenting (0.2) in
  the abdomen.
154 PT: yeah,
155 SG: and (0.2) i- i think that that's: (.) the most likely cause in
  you:.
157 (0.4)
158 PT: *eah*,
159 (1.2)
160 SG: so (0.4) i think that you could help this by losing some
  weight:;
162 PT: yeah,
163 (1.0)
164 SG: and you just might have to modify a little bit $how you sit$;
165 (0.8)
166 PT: [yeah]
167 SG: [bt  ] (.) but i think (0.4) uh:m with your weight and you
  probably do a lot of sitting with yuh work, (0.4) [it a]ll=
169 PT: [yeah]
170 SG: =sort of uh:m (0.6) s- probably aggravating something that's
  going on in your back,
172 (2.0)
173 PT: *mm hm*
In lines 137-8, the surgeon uses the word *feel* to implicitly reference the physical examination performed earlier in the consultation. Beyond that, however, the surgeon also explains the other source of evidence, a number of previous investigations (line 141), used in his diagnostic reasoning. The 'no problem' diagnosis is delivered in line 144 (with uptake from the patient) followed by a possible explanation of why the patient is experiencing pain. This explanation continues over a number of lines and includes suggestions for treatment (lines 160-1 and 164). After more diagnostic explanation, the surgeon concludes the diagnosis activity by stating that, as far as his field of medicine is concerned (that is, the abdomen), there is nothing wrong with the patient (lines 175-7). The patient is then discharged with a statement in line 179.

The use of diagnoses that include either implicit or explicit reference to evidence may be because a 'no problem' diagnosis not only leaves a symptom residue (that is, unexplained symptoms) (Maynard & Frankel, 2006) but also may challenge the view of the patient if the patient believes that there is a particular cause for their symptoms (Peräkylä, 2006) and, in these interactions, even the view of the referring doctor. By referencing the evidence, the surgeon mitigates the possibility of defensiveness or resistance by the patient.

**7.3.2 Delivery of diagnostic test results**

As mentioned previously, some visits are focused on the delivery of diagnostic test results (four out of 26). In these consultations, which can be categorised as post-diagnostic testing follow-up visits, the surgeon delivers test results to the patient. In all four cases, the surgeon explicates the evidence, either through prefacing the news delivery with a reminder about the test (as in extract 7.5a) or by referencing the scans (as in extract 7.6).
Ex. 7.5a: SS-SP10-03
31 SG: .hh _okay_ i’ve got some good news for you._
32 PT: oh good.
33 SG: .hh the _two_ areas >that we put the needle into,< (0.2) .hh the
34 one that _i_ did (.) [that’s] come back and shown _normal_ breast=
35 PT: [*mm* ]
36 SG: =tissue? (.) which is what i thought it would;
37 PT: yeah
38 SP: .hh a:nd the _other_ area has _also_ come back as showing the _normal
39 breast tissue¿ (0.4) which is also good;
40 PT: yeah

In extract 7.5a, the surgeon prefaces the news in line 31 by categorizing it as _good_. In line 33, she then references the diagnostic procedure on which the news is based followed by the diagnostic news delivery (line 34 and 38-9). Each of these diagnostic statements is followed by assessments (lines 36 and 39). As can be seen by the line numbering, this activity occurs early in the consultation and there is no problem presentation or history taking prior to its delivery.

Ex. 7.6a: SS-SP07-02
34 SG: and you’re still on the fosamax aren’t [you.
35 PT: _[.hhh now i haven’t_ 
36 bothered to take it since (.) i l- came [into=
37 SG: _[okay_ 
38 PT: =the [hospital. ah: >the week before i came into=
39 SG: _[yep_ 
40 PT: =[hospital< b’coz i was (.) w-wondering if that would=
41 SG: =[yeah_ 
42 PT: =aggravate, (.) anything, or: [{( )}]
43 SG: _[coz ] that’s the only explanation
44 so far; >although it’s a _very_ rare side effect,
45 PT: yes
46 SG: but it exists¿
47 PT: ri[ght “right ”]
48 SG: [an- and we’]ve excluded i mean you had a c t a few _days_ ago¿;
49 PT: yes
50 SG: there’s no formal report but you looked at the films and it
51 looks fine ths- the head of the pancreas doesn’t look (.)
52 normal; (. ) uh: m in terms of like there’s a bit of swelling
53 around it?
54 PT: ye[s:

In extract 7.6a, the diagnostic activity is touched off by a history taking question in line 34. The patient delivers a delayed, dispreferred response (Schegloff, 2007) (lines 35-36, 38, 40, 42), giving his reasoning for not taking his medication. The action of this response poses a question (though not grammatically) to the surgeon in lines 40 and 42, as the patient was wondering about the side effects of the medication. The surgeon interprets this as a solicitation of information, thus moving the consultation into the diagnostic activity in line 43. The surgeon asks the patient to recall the CT scan (line 48) that forms the basis of the fine diagnosis he delivers, though he concedes it is not entirely normal (lines 50-3). The diagnostic activity continues with further explanation of the scans and a naming of the diagnosis as idiopathic pancreatitis (not shown).

7.3.3 Diagnosis with explicit reference to diagnostic testing

A surgeon can make a diagnosis with explicit reference to diagnostic testing, using that reference as the evidential basis for diagnosis. Interestingly, this occurs only in first visits in this data. As such the diagnostic tests must have been ordered by the referring doctor prior to the surgical consultation. This occurs three times in the data, as exemplified in extract 7.7a.

Ex. 7.7a: SS-SP08-02
284 SG: you could just go and sit down again there and we’ll just carry
285 on with this e- sarah and i have looked at your x
286 rays already? .nhh m- sarah’s written me a report?
287 TI: teh “heh heh”
288 (2.2)
289 SG: ’HH
290 (1.8)
291 PT: “uhh”
292 SG: so the x rays basically show that you’ve got arthritis in both
293 of yuh hips but much m-worse on the r- the left than the
294 right,= 
295 PT: =oh yeah.
296 SG: the right one looks like it’s (. ) reasonably good [but the r--
297 PT: \[mm
298 SG: =left one’s: (. ) basically had it.
299 PT: ‘hhh

In this extract, the surgeon precedes his diagnosis delivery by referencing the evidence, the x-rays and the trainee intern’s report (lines 285-6). In the diagnostic statement, starting in line 292, the surgeon explicitly states that the x-rays show that the patient has arthritis. By using the evidence from the tests, the surgeon is supporting his diagnosis with objective evidence that is observable by persons other than himself.

7.3.4 Pre-diagnostic testing hypothesis or provisional diagnosis

In some consultations a firm diagnosis cannot be made (seven out of 26), however the surgeon may provide a pre-diagnostic testing hypothesis or provisional diagnosis. In these diagnostic activities the surgeon delivers a possible diagnosis, sometimes with an explanation of what that diagnosis means. As Peräkylä (2006, p. 229) notes, “uncertainty undermines the doctor’s authority as an expert; thus when delivering an uncertain diagnosis, the doctor cannot rest on authority alone. By displaying evidence, the doctor earns his or her claim to knowledge”. These diagnoses occur in both first and follow-up visits and can be plain assertions or may include an inexplicit reference to the evidence. Importantly, most of these provisional diagnoses are ‘no problem’ diagnoses that are mitigated to emphasise their unconfirmed status, as in extract 7.8a.

Ex. 7.8a: SS-SP07-01

433 SG: [i don’t think there’s anythingk (. ) serious with your
434 guts.
435 PT: oh- (. ) thank you darling.

In this extract, after organising for the patient to have a colonoscopy (not shown) the surgeon states that he does not think there is anything wrong with the patient (lines 433-4). This diagnostic statement is mitigated by the words i don’t think, which introduce uncertainty.

In two consultations, the surgeon describes what had been found in the examination and then delivers a provisional diagnosis. That is, the surgeon implicitly references what
was felt during the physical examination and gives a provisional diagnosis requiring further testing. These both occurred in first visits and the patient was referred for further testing. Although only a provisional diagnosis is made, the surgeon produces a diagnosis that includes inexplicit references to the evidence, invoking the examination, through which “they re-establish the mutual intelligibility of the evidential basis of the diagnosis” (Peräkylä, 2006, pp. 227-228).

Ex. 7.9: IS-SP03-04

333 SG: .nhhh so (1.0) th- there's a little there's a little sortev
334 (0.2) second nodule i can feel sortev in the pelvis >it's
335 [not actually in the rectum i think it’s just outside=
336 PT: [ri:ght;
337 SG: =i'm feeling it through the wa:ll.<
338 PT: =[si:de
340 PT: mm hm:?  
341 SG: an you've got some haemorrhoids down there which i think is
342 where that blood's been coming [from; >but
343 PT: [yeah: i thought so.

In extract 7.9, the surgeon describes what he could feel during the physical examination, including a firmer diagnosis of haemorrhoids (line 341). However, he mitigates his diagnostic statement with i think, showing that it is a probable cause for the patient’s symptoms rather than a definite one. The patient is later referred for further testing (not shown).

7.3.5 Re-stating diagnosis from referring doctor

The referral letter can sometimes present the surgeon with a confirmed diagnosis, with the surgeon usually deciding whether the patient is an appropriate surgical candidate through verbal and physical examination. In such consultations, the surgeon re-states the diagnosis from the referring doctor. In these diagnostic activities, the surgeon references the diagnosis presented in the referral letter as the basis for diagnostic statement and this requires uptake from the patient before the surgeon can move on. It only occurred in first visits in this data (six out of 26 consultations). In three of these instances it occurred during the referral recognition sequence (RRS) alone. While previously it was noted that the RRS may also be used as a pre-diagnostic comment, in some cases the only reference to the diagnosis is through the RRS. In all re-statements
of diagnoses, the surgeon uses the referring doctor as evidence of the diagnostic conclusion, as in extract 7.1b.

**Ex. 7.1b: IS-SP03-02**

294 SG: so (. ) mister samson's explained to you you've got this (0.2)  
295 you've got a very long bowel (and it) seems to [be twisting.  
296 PT: [yeah:.  
297 (0.5)  
298 PT: he said it was some (. ) bottom (. ) heh: (0.2) >he sort of kept  
299 going like that,< there's like a bottom thing that  
300 (0.8)  
301 SG: twisting  
302 PT: [*AH:: yeah? _people_ giving me all sorts of hand signals.*]  
303 SG: yeah hh heh "kay" it's basically like a .hha the large bowel's  
304 like a is a sort of like an _inverted_ u shape tu:be. but (. ) in  
305 some people i- it sort of looks (0.4) part of it's very  
306 _e:longated;_ (0.5) an' it's one quite a NARROW: (0.7) ( _ )  
307 >an’ th-< an’ that allows the whole thing to twist around=  
308 PT: ="yeah"=  
309 SG: =so it blocks off when it twists it, (0.4) the _tube_ gets  
310 _blocked off at two_ points "(and they sort of gotten a)" _closed  
311 system? (0.9) ah:: an’ that's _obviously_ when yuh getting the  
312 pain an’ so on. (*kay*)  
313 (.)  
314 SG: .hha now (0.5) in in _some people:_ (0.7) >particularly in people  
315 yih know l- like yourself who have had it from an early age it  
316 bt s-< (. ) ("er th-") (0.3) they have a (0.3) a motility  
317 problem with the _bowel._ (.) generally. (.) >in other words<  
318 (.) although (1.4) it's the sigmoid colon which is the  
319 _commonest place_ for this to happen the _whole_ bowel may: be a  
320 little bit sluggish.

In this extract, the surgeon explicitly names the referring doctor in his re-statement of the diagnosis (lines 294-5). The patient confirms this (line 296) and then takes the opportunity of the gap in line 297 to demonstrate his understanding of the diagnosis. Although the patient has confirmed that the diagnosis has been explained to him, the surgeon explains the diagnosis in further detail from line 302.
During the referral recognition sequence in extract 7.10a, the surgeon explicitly references the referring doctor (line 8) and the diagnosis, including the treatment preference of the patient (line 13) and the ‘no problem’ diagnosis given by the referring doctor (lines 15-6).

**Ex. 7.10a: SS-SP10-02**

6  SG: he[llo.] kay i’m doctor jess abbott one of the breast surgeons
7  PT:   [hi: ]
8  SG: n:ow i got a letter from: mr smi:th;
9  PT: yes,
10  (0.8)
11  SG: which say:s that you’ve got a little breast nodule?
12  PT: yes,
13  SG: an tht you want it removed;
14  PT: that’s right?
15  SG: and he stuck a needle in it and it said it was (0.2) not a
16       cancer.
17  PT: that’s right. yep. that’s but it has changed he said and it is
18       getting bigger and it is starting to hurt more?
19  SG: mhm?
20  PT: it catches right on my $bra$?
21  SG: okay;
22  PT: $hh$ so:;
23  SG: (‘ah) ( ) (‘one of breast nurses.’)‘that sounds like a
24       jolly nuisance‘
25  PT: so yea:h he said it was better to be taken out__
26  SG: yep
27  PT: um partly coz it shoots pain up underneath my arm as well;
28  SG: ‘mm:.’
29  PT: so THAt’s a really good one hh huh
30  SG: fair enough? (0.4) tlk okay. (0.4) s:o what we can do is put you
31       on an operating list?
32  PT: mhm?

The patient confirms each of these references, however after the ‘no problem’ diagnosis re-statement, she uses the referring doctor to justify her visit and treatment preference, using the words *he said* as evidence. The patient re-asserts this by invoking the
referring doctor again in line 25 as not only agreeing with but also recommending her treatment preference. By using the same evidence as the surgeon, she is countering any possible inferences that her treatment preference is unjustified as she has been given a ‘no problem’ diagnosis. The patient is not relying on her own understanding of the diagnosis, but on one that has already been invoked by the surgeon as evidence.

7.3.6 Diagnostic statement

In one consultation (extract 7.11a), the surgeon makes a bald diagnostic statement which involves no reference to any evidence source used in diagnostic reasoning (lines 119-120, 122-3). This is a bad news diagnostic delivery, and the patient replies with an oh-prefaced response (Heritage, 1998) (news types and patient responses are discussed further below).

Ex. 7.11a: IS-SP04-01

119 SG: no (. ) um it seems::: f:airly clear that you know th- the
120 inflammation in the bowel the diverticulitis has [got= [mm
121 PT: [mm
122 SG: =itself attached to the (. ) b-b-b-bladder there:; and
123 [that]'s the reason for the infection
124 PT: [oh ]
125 PT: oh i s- [oh
126 SG: [c-c-coming through.
127 PT: oh o[kay;,
128 SG: [and um th- that would seem the most likely
129 PT: mm
130 SG: thing there:,

Between lines 124 and 127 the patient produces four ohs, in somewhat rapid succession, which show that the diagnosis delivery was in fact news, rather than just a re-statement or confirmation of her presenting problem. This manner of delivery may be surprising due to its frankness, however it appears to be designed by the surgeon for a patient who already had prior knowledge of this problem (i.e. that it is not news to the patient). This is evidenced by a subsequent diagnosis delivery by the same surgeon (extract 7.12a, lines 28-34), which is similar however it is prefaced by reference to evidence (lines 28-9).
Ex. 7.12a: IS-SP04-02
28 SG: okay well um (.) it it seems (.) pretty clear from the x rays
29 that you know the there are still some stô:nes (.) in there
30 you know in the (. ) the duct that leads from the gall bladder
31 to the main duct is still got some stones in it=is probably
32 slightly abnormal of itself um (0.2) i don't (0.2) th:ink
33 there’ll be m-m-m-much option but to do a further operation and
34 take that part ou:t.=
35 PT: =aw [yeah,
36 WI: [mm.

This consultation occurs on the same day directly after the one in which he delivers the
diagnosis with no evidence, possibly demonstrating the 'wind-tunnel effect' (Heritage,
2004) that can occur in institutional interactions as the institutional representative
refines their talk based on previous experience.

As can be seen, in all but one of the diagnostic activities in this data, the surgeons by
virtue of close inferential distance or implicitly or explicitly referenced evidence from
examinations, diagnostic tests and referrals, orient to their accountability in delivering
the diagnosis. They are unable to rely on their medical authority alone and display their
accountability through the provision of an evidential basis of their diagnoses.

7.4 Bad news, good news and no news

Diagnostic delivery in primary care consultations parallels that in ordinary conversation,
where bad news is delayed, hedged and opaque and good news is delivered
straightforwardly (Maynard & Frankel, 2006). In surgeon-patient consultations, news
type is linked closely with the type of diagnostic delivery used by the surgeon, as can be
seen in Table 7.2. That is, previously known bad news, for example, is consistently
delivered as a re-statement of the referring doctor's diagnosis. Out of the 26
consultations, only five included bad news that was previously unknown to the patient,
while six patients were required to confirm bad news of which they were already aware.
Table 7.2: Occurrence of diagnostic news types in 26 surgeon-patient consultations

<table>
<thead>
<tr>
<th>Code</th>
<th>Visit Type</th>
<th>Action type</th>
<th>News Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS-SP02-02</td>
<td>Follow-up</td>
<td>Delivery of diagnostic test results</td>
<td>Bad news</td>
</tr>
<tr>
<td>IS-SP04-02</td>
<td>First</td>
<td>Diagnosis with explicit reference to diagnostic testing</td>
<td>Bad news</td>
</tr>
<tr>
<td>SS-SP08-02</td>
<td>First</td>
<td>Diagnosis with explicit reference to diagnostic testing</td>
<td>Bad news</td>
</tr>
<tr>
<td>SS-SP08-01</td>
<td>First</td>
<td>Diagnosis with explicit reference to diagnostic testing</td>
<td>Bad news</td>
</tr>
<tr>
<td>IS-SP04-01</td>
<td>First</td>
<td>Diagnostic statement</td>
<td>Bad news</td>
</tr>
<tr>
<td>IS-SP04-04</td>
<td>First</td>
<td>Re-stating diagnosis from referring doctor</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>IS-SP03-02</td>
<td>First</td>
<td>Re-stating diagnosis from referring doctor</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>IS-SP03-03</td>
<td>First</td>
<td>Re-stating diagnosis from referring doctor (RRS only)</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>SS-SP12-01</td>
<td>First</td>
<td>Re-stating diagnosis from referring doctor (RRS only)</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>SS-SP10-02</td>
<td>First</td>
<td>Re-stating diagnosis from referring doctor (RRS only)</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>IS-SP04-05</td>
<td>First</td>
<td>Re-stating diagnosis from referring doctor (RRS only)</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>IS-SP03-01</td>
<td>Follow-up</td>
<td>Delivery of diagnostic test results</td>
<td>Good news</td>
</tr>
<tr>
<td>SS-SP10-03</td>
<td>Follow-up</td>
<td>Delivery of diagnostic test results</td>
<td>Good news</td>
</tr>
<tr>
<td>SS-SP07-02</td>
<td>Follow-up</td>
<td>Delivery of diagnostic test results</td>
<td>Good news</td>
</tr>
<tr>
<td>SS-SP10-06</td>
<td>First</td>
<td>No problem</td>
<td>No news</td>
</tr>
<tr>
<td>SS-SP09-02</td>
<td>Follow-up</td>
<td>No problem</td>
<td>No news</td>
</tr>
<tr>
<td>IS-SP01-03</td>
<td>Check-up</td>
<td>No problem</td>
<td>No news</td>
</tr>
<tr>
<td>IS-SP01-04</td>
<td>First</td>
<td>No problem</td>
<td>No news</td>
</tr>
</tbody>
</table>
As there were so few genuine bad news deliveries, it is difficult to compare the news delivery format to that in primary care and ordinary conversation. In the 26 consultations with diagnostic activities, there are five different news types:

1. Bad news
2. Previously known bad news
3. Good news
4. Uncertain news
5. No news

7.4.1 Bad news

There are five instances of bad news delivery which are delivered in three different ways. While the other types of news display homogeneity in their delivery (sections 7.4.2-7.4.5 below), the bad news has no discernable pattern in regards to delivery type. In extract 7.13 we can see that because the visit is delivering test results, the bad news is embedded within that activity.

Ex. 7.13: IS-SP02-02

32 SG: okay (. ) s- stand up and have a little look at this and th- this
34 [may help to=
35 WI: [°(do you want to)]°
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36 DA: =yep
37 SG: explain the [situation, (0.8) uh:m
38 DA: (((coughs)))
39 (1.2)
40 PT: ("i can get up")
41 SG: (i just might)
42 (7.8)
43 ??: ("okay")
44 (1.8)
45 SG: 'um 'thee (2.1) the aneurysm that mister parkinson fixed =
46 W: =mm=
47 SG: =um (.) tlk .hh re- really what he did w’s: uh:m (0.2) .hhh uh:
48 he (1.0) >he he< did ay (0.8) a repair of the aneurysm in [this= 49 WI:
50 SG: =area [he:re]?
51 WI: [mm
52 WI: [yeah
53 DA: ["yeah"
54 SG: and what's happened is a further aneurysm has developed above
55 that;
56 WI: "mm hm" 57 SG: .hh and wha- well these are his kidneys;
58 WI: mm:, 59 SG: there and there,
60 WI: yeah 61 SG: okay belly button's about there:, 62 WI: right;
63 SG: so a- (. ) above the area where mister parkinson did the
64 WI: mhm 65 SG: the operation another aneurysm has grown
66 WI: "yeah"
67 SG: and that's grown to (0.6) a la:rg e si:ze and it's it measures
68 (0.4) six centimetres [from] side to side so it's width is six=
69 WI: [mm ]
70 SG: =centimetres [which is quite la:rg e. 
71 WI: [mm
72 WI: i know mm
73 SG: now (. ) um (. ) at at present (. ) um (0.4) the (0.2) um (. ) the
arteries that go out to the kidneys are very very close to this aneurysm.

WI: *mm*

SG: and um it it's a little bit (.) difficult to see bt (0.6) this is the aneurysm here this round thing (.) and that's one of the kidney arteries there so it's really just at at the aneurysm (0.4) um and there's another one there;

WI: *mm.*

SG: so it's all very close_

WI: *mm*

Using the scans, the surgeon explains what treatment the patient has had previously (lines 45, 47-8, 50) and then delivers the bad news in lines 54-5. The bad news is expanded after the surgeon explains how to read the scans with details regarding the nature and severity of the problem (lines 73-4, 77-80, 82). In this consultation the bad news is delayed and presented with strong reference to diagnostic evidence through the use of the scans. In extract 7.7b, the surgeon references the x-rays as evidence for the patient’s problem.

Ex. 7.7b: SS-SP08-02

SG: you could just go and sit down again there and we’ll just carry on with this e- sarah and i have looked at your x rays already? m- sarah’s written me a report?

TI: teh *heh heh* (2.2)

SG: ‘HH (1.8)

PT: *uhh*

SG: so the x rays basically show that you’ve got arthritis in both of yuh hips but MUch m-worse on the r- the left than the right,= 

PT: =oh yeah.

SG: the right one looks like it’s (..) reasonably good [but the r-=

PT: [mm

SG: =left one’s: (..) basically had it.

PT: ·hhh
This diagnosis delivery occurs directly after the surgeon physically examines the patient. The bad news delivery itself (lines 292-4) is preceded by this evidence. Early in the consultation the patient expressed a desire to have her hip fixed (not shown), displaying that she is already aware of the existence and perhaps severity of her problem. This may explain why the surgeon does not mitigate the diagnosis or co-implicate the patient in its delivery, as is common in primary care interactions (Maynard, 1992). As the surgeon’s diagnosis aligns with the patient’s problem presentation, particularly the statement in line 298 that the left one’s basically had it, there is no need to shroud the bad news delivery, as is usual practice in both ordinary conversation and in primary care interactions (Maynard & Frankel, 2006).

In extract 7.11b, as discussed above, the surgeon delivers the bad news as a bald diagnostic statement (lines 119-120, 122-3 and 126).

Ex. 7.11b: IS-SP04-01
119 SG: no (.) um it seems::: f:airly clear that you know th- the
120 inflammation in the bowel the diverticulitis has [got=
121 PT: [mm
122 SG: =itself attached to the (..) b-b-b-bladder there:¿ and
123 [that]'s the reason for the inflection
124 PT: [oh]
125 PT: oh i s- [oh
126 SG: [c-c-coming through.
127 PT: oh o[kay¿,
128 SG: [and um th- that would seem the most likely
129 PT: mm
130 SG: thing there:¿,

As there are so few instances of bad news delivery, it is difficult to identify strong patterns of delivery structure, such as perspective-display series that are described as occurring in primary care interactions (Maynard, 1992). However, it can be noted that there was no homogeneity in delivery as there was in all the other news types, which may suggest a level of discomfort, unease and uncertainty in bad news delivery. On the other hand, the lack of homogeneity may suggest that the resources available to
surgeons allow for more diverse responses. More data is needed to explore bad news delivery in surgeon-patient consultations further.

7.4.2 Previously known bad news

As six patients in this data were already aware of their diagnoses, the ‘news’ delivery was rather a confirmation of the patient’s knowledge rather than introducing new knowledge to the patient. That is, the diagnoses were not news to the patient and it would have been inapposite to deliver them as such due to the constraints of recipient design (Sacks, Schegloff, & Jefferson, 1974). In all five consultations, the ‘news’ is delivered as a re-statement of the diagnosis from referring doctor, as in extract 7.14 (lines 14-5).

Ex. 7.14: IS-SP03-03

14 SG: okay so ((clears throat)) (1.2) th- these haemorrhoids giving
15 you a bit of trouble are they;
16 PT: mhm,

In extract 7.1c, the surgeon re-states the patient’s already diagnosed problem, using the referring doctor as evidence in its support.

Ex. 7.1c: IS-SP03-02

294 SG: so (. ) mister samson's explained to you you've got this (0.2)
295 you've got a very long bowel (and it) seems to [be twisting.
296 PT: [yeah:.
297 (0.5)
298 PT: he said it was some (. ) bottom (. ) heh: (0.2) >he sort of kept
299 going like that, < there's like a bottom thing that
300 (0.8)
301 SG: twis[ting
302 PT: [*AH:: yeah? people giving me all sorts of hand signals.*
303 SG: yeah hh heh "kay" it's basically like a .hhh thuh large bowel's
304 like a is a sort of like an inverted u shape tu:be. but (. ) in
305 some people i- it it sort of looks (0.4) part of it's very
306 elongated: (0.5) an’ it's one quite a NARROW: (0.7) (     )
307 >an’ th-< an’ that allows the whole thing to twist around=
308 PT: ="yeah"=

188
As the bad news is already known to the patient, there is no need to shroud it or mitigate it and the response from the patient (lines 296 and 298-9) is evidence that he is aware of the problem.

### 7.4.3 Good news

Three consultations involved the delivery of good news, all of which were diagnostic test results. In extract 7.5b the surgeon prefaces her news delivery by marking what type of news it is then delivers two separate diagnostic statements (lines 33-4, 36 and 38-9).

**Ex. 7.5b: SS-SP10-03**

31 SG: .hh okay i’ve got some good news for you.  
32 PT: oh good.  
33 SG: .hh the two areas >that we put the needle into,< (0.2) .hh the  
34 one that i did (.) [that’s] come back and shown normal breast=  
35 PT: [*mm* ]  
36 SG: =tissue? (.) which is what i thought it would;  
37 PT: yeah  
38 SP: .hh a:nd the other area has also come back as showing the normal  
39 breast tissue; (0.4) which is also good;  
40 PT: yeah

The good news delivery is not straightforward as the surgeon prefaces the statements and also assesses them. This may be because the surgeon subsequently offers the patient surgery to remove the lumps as a precautionary measure (not shown), even though there is no sign of cancer.

In extract 7.6b the surgeon delivers the news after talking about the problem the patient has. That is, he does not deny the existence of a problem, however he delivers the good news that the scan *looks fine* (line 51).

**Ex. 7.6b: SS-SP07-02**

34 SG: and you’re still on the f osamax aren’t [you.  
35 PT: [.hhh now i haven’t  
36 bothered to take it since (.) i l- came [into=  
37 SG: [okay
Again the good news delivery is not straightforward and the surgeon explains the results of the scan and the meaning of the provisional diagnosis (that had been made on a previous occasion). In all three consultations, the patients do not display any problems with the indeterminacy and uncertainty that good news can induce (Maynard & Frankel, 2006). That is, “when some disease is ruled out, it can be “good news” from a clinical point of view. That point of view may or may not be one that the patient shares...especially when the patient does have some residue of pain or other symptoms” (Maynard & Frankel, 2006, p. 275).

7.4.4 Uncertain news

Uncertainty of a different kind is a feature of this news type as the surgeon gives the patient a provisional diagnosis and refers the patient for further diagnostic testing. Uncertain news is delivered in seven consultations, all in this same manner as a pre-diagnostic testing hypothesis. Five of these provisional diagnoses have no reference to any evidence (because there may be none, as is extract 7.8b), while two involve implicit references to evidence (as in extract 7.15a).
**Ex. 7.8b: SS-SP07-01**

433 SG: [i don’t think there’s anythingk (. ) serious with your
guts.
435 PT: oh- (. ) thank you darling.

In extract 7.8b, the surgeon was unable to perform an examination during the consultation and has referred the patient for a colonoscopy (not shown), followed by a provisional ‘no problem’ diagnosis in lines 433-4. This is similar to the ‘good news’ diagnoses in primary care as it is straightforward and unmitigated (Maynard & Frankel, 2006).

**Ex. 7.15a: SS-SP03-05**

26 SG: okay now when you had then colonoscopy they they said they took
a tiny little biopsy of a of a polyp that was about four millimetres in size but they (. ) there’s nothing on the computer
so (. ) i suspect [it didn’t actually it ] >hasn’t gone=
30 PT: [it hasn’t come through yet]
31 SG: =through to the lab< we[ll ] it should’ve;
32 PT: [no: ]
33 PT: said two to three weeks [but (of course they might have to say)
34 SG: </yeah it would’ve gone> it’s:: oh:kay
35 no actually it’s only the twenty third of november so it’s
36 probably not been processed yet. yep yep .hh it was a tiny
37 thing about four millimetres in size. >so look it’s [not th-
38 PT: [how much is
39 four [mil- about that "is it?"
40 SG: [oh yeah] smaller smaller smaller so it’s kind of
((21 lines omitted))
62 PT: and it look innocent.
63 SG: aw bt they thought it was >w- wha we call< hyper plastic polyp,
64 which has no cancer potential.
65 PT: oh [so that’s ] good to know;
66 SG: [(so yeah yeah]
67 SG: =mm it [is
68 PT: [thank you for [that?
69 SG: [heh heh (h)o(h)kay .hh so=
70 PT: =that’s what i’ve been [w- not] wor- [i’ve] been just interested
71 SG: [yeah ] [yeah]
In extract 7.15a, the information after a diagnostic test is not yet available\(^2\) despite the test already having been carried out. The diagnosis is therefore uncertain, however the surgeon is able to let the patient know the provisional diagnosis given by those who performed the test, that there is no cancer potential in what was found (lines 63-4). This diagnostic sequence is far longer as the surgeon is concurrently reading the report from the doctor who carried out the colonoscopy. As this consultation appears to be a follow-up after diagnostic testing, the surgeon would normally be able to deliver a firm diagnosis; however the delay in receiving test results makes the consultation more complex and the surgeon delivers a provisional diagnosis.

7.4.5 No news

Surgery and specialisation is vastly different from general practice as the surgeon only has clinical expertise in and responsibility for specific parts of the patient’s body. In five consultations, the surgeon has no news for the patient, in three of these cases claiming that the presenting problem is out of their realm of clinical expertise (as discussed above). It does not appear to be unusual for a surgeon to explicitly state that a presented problem is out of their realm.\(^3\) In extract 7.16, the surgeon both delivers a ‘no problem’ diagnosis and refers the patient back to find a more appropriate person (the patient presented with two problems that he believed to be related to his recent surgery).

\(^2\) There was a major pathology laboratory strike around the time this data was collected and there was discussion about it in a number of consultations.

\(^3\) This also occurs in consultations (with other diagnosis delivery types or no diagnosis delivery) where the patient later in the consultation brings up another presenting problem, as in IS-SP01-06 and SS-SP07-02.
Ex. 7.16: IS-SP01-03

124 SG: well there's nothing obvious to see there;
125 PT: yep,
126 SG: i mean it feels normal, (0.6) uh:m (0.4) it's not unknown for:
127 people to get problems with nerves (0.2) after a hernia
128 [operation;]
129 PT: [yeah,
130 (0.8)
131 SG: and that (0.2) c’n be manifest as (.) as pain? (0.2) [which=
132 PT: [mhm
133 SG: =doesn't seem to be a major feature with you;]
134 PT: no [i've coz i've been relaxing for quite a few days lately?
135 SG: [or or
136 SG: right? (0.4) [or alternatively you can get numbness?
137 PT: [(yeah)
138 PT: yep
139 SG: *uh:m* (2.0) in my experience these symptoms gradually
140 improve over time particularly numbness,
141 PT: yea[h
142 SG: [norm- coz s- nerves form surrounding areas grow into (0.4)
143 take over that area that might have been (0.2) interrupted when
144 the operation was done for the hernia,
145 PT: oh:kay,
146 (1.2)
147 SG: uh:m a sar- as far as the sexual function goes,
148 PT: mm
149 SG: th- that can't be attributed in any way to the hernia,
150 PT: oh:kay,
151 SG: i mean er (0.8) operating on a hernia (1.2) doesn't in any way
152 affect (1.2) sort of sexual function;
153 PT: okay,
154 (1.0)
155 SG: so i'm (0.4) i'm not sure what problem is there: (0.6) so
156 maybe you'll need to see it's doctor ( )
157 isn't it; maybe you'll need to see doctor ( ) and
158 (0.6)
159 PT: and see what {(he reckons)?
160 SG: [s- see (0.6) if there's someone $more appropriate
In lines 126-8, the surgeon generalises and normalises the patient’s problem, followed by the prognosis in lines 139-140, that it will resolve over time. The surgeon then explains the diagnosis and prognosis. The surgeon uses normalisation (lines 126-7) and his experience (line 139) as evidence for the ‘no problem’ diagnosis. After establishing his medical authority in regards the first problem, the surgeon then goes on to state that the other problem presented is, firstly, not related to the surgery (lines 151-2), secondly that he is unsure of what has caused the problem (lines 155-6) and thirdly that there may be another clinician more appropriate for the patient to see for the problem (lines 160-1). By establishing his medical authority prior to these statements in regards to the first problem, the surgeon demonstrates that he has no expertise in regards to the sexual function problem with which the patient has presented. Therefore he can dispense with that problem by referring the patient back to the referring doctor (or he could also have referred the patient on to another doctor).

The five news types found in surgeon-patient interactions demonstrate the diversity in these interactions. Although previous research has primarily focused on bad news delivery, Maynard and Frankel (2006) argue that both uncertainty and good news deserve similar attention. To go further, in surgeon-patient interactions, all five news delivery types should be examined.

In the previous two sections, we have examined the way in which surgeons structure their diagnostic deliveries and the different news types they deliver. As consultations, just like conversation, are co-constructed by the participants, the way in which patients respond to diagnosis delivery is a key consideration when developing an understanding of the structure and action of the diagnostic activity. The next section provides an analysis of patient responses to diagnosis.
7.5 Responses to diagnosis

7.5.1 Types of responses

Patients responded in a number of different ways to the diagnostic deliveries of surgeons. Earlier research suggests that patients characteristically respond with minimal response tokens such as er and yeh and that responses beyond that demonstrate misalignment or incongruence between the doctor and the patient (Heath, 1992). However, only 11 out of the 26 responses to diagnosis in this data were minimal. Thirteen of the other responses were extended and two elicited no response from the patient whatsoever. Of the extended responses, there were several different types, including justifying the visit and requests for treatment recommendations and these were not necessarily indicative of misalignment or incongruence. The occurrence of responses in the 26 surgeon-patient consultations is shown in Table 7.3. The type of response to diagnosis does not appear to be linked to news type, particularly considering that, in this data at least, minimal responses occur after all five news type deliveries. As news type is linked so closely to delivery type, there is also no apparent correlation between how the news is delivered and the patient responses. In this section I discuss both minimal and extended patient responses.

Table 7.3: Occurrence of responses to diagnosis in 26 surgeon-patient consultations

<table>
<thead>
<tr>
<th>Consultation Code</th>
<th>Visit Type</th>
<th>Response to Diagnosis</th>
<th>Action type</th>
<th>News Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS-SP04-02</td>
<td>First</td>
<td>Asking about the diagnosis</td>
<td>Diagnosis with explicit reference to diagnostic testing</td>
<td>Bad news</td>
</tr>
<tr>
<td>SS-SP03-05</td>
<td>Follow-up</td>
<td>Asking about the diagnostic procedure</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Uncertain news, testable</td>
</tr>
<tr>
<td>SS-SP07-02</td>
<td>Follow-up</td>
<td>Demonstrating knowledge</td>
<td>Delivery of diagnostic test results</td>
<td>Good news</td>
</tr>
<tr>
<td>IS-SP04-04</td>
<td>First</td>
<td>Demonstrating knowledge</td>
<td>Re-stating diagnosis from referring doctor</td>
<td>Bad news</td>
</tr>
<tr>
<td>IS-SP03-02</td>
<td>First</td>
<td>Demonstrating knowledge</td>
<td>Re-stating diagnosis from referring doctor</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>IS-SP04-05</td>
<td>First</td>
<td>Demonstrating knowledge</td>
<td>Re-stating diagnosis from referring doctor</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>SS-SP10-02</td>
<td>First</td>
<td>Justifying the visit</td>
<td>Re-stating diagnosis from referring doctor (RRS only)</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>IS-SP02-02</td>
<td>Follow-up</td>
<td>Minimal</td>
<td>Delivery of diagnostic test results</td>
<td>Bad news</td>
</tr>
<tr>
<td>SS-SP10-03</td>
<td>Follow-up</td>
<td>Minimal</td>
<td>Delivery of diagnostic test results</td>
<td>Good news</td>
</tr>
<tr>
<td>SS-SP08-02</td>
<td>First</td>
<td>Minimal</td>
<td>Diagnosis with explicit reference to diagnostic testing</td>
<td>Bad news</td>
</tr>
<tr>
<td>SS-SP09-02</td>
<td>Follow-up</td>
<td>Minimal</td>
<td>No problem</td>
<td>Good news</td>
</tr>
<tr>
<td>IS-SP01-03</td>
<td>Check-up</td>
<td>Minimal</td>
<td>No problem</td>
<td>No news</td>
</tr>
<tr>
<td>IS-SP01-04</td>
<td>First</td>
<td>Minimal</td>
<td>No problem</td>
<td>No news</td>
</tr>
<tr>
<td>IS-SP03-04</td>
<td>First</td>
<td>Minimal</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Uncertain news, testable</td>
</tr>
<tr>
<td>SS-SP10-05</td>
<td>Follow-up</td>
<td>Minimal</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Uncertain news, testable</td>
</tr>
<tr>
<td>SS-SP07-01</td>
<td>First</td>
<td>Minimal</td>
<td>Pre-diagnostic testing hypothesis</td>
<td>Uncertain news, testable</td>
</tr>
<tr>
<td>IS-SP03-03</td>
<td>First</td>
<td>Minimal</td>
<td>Re-stating diagnosis from referring doctor (RRS only)</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>SS-SP12-01</td>
<td>First</td>
<td>Minimal</td>
<td>Re-stating diagnosis from referring doctor (RRS only)</td>
<td>Bad news, known</td>
</tr>
<tr>
<td>IS-SP03-01</td>
<td>Follow-up</td>
<td>None</td>
<td>Delivery of diagnostic test results</td>
<td>Good news</td>
</tr>
<tr>
<td>SS-SP08-01</td>
<td>First</td>
<td>None</td>
<td>Diagnosis with explicit reference to diagnostic testing</td>
<td>Bad news</td>
</tr>
<tr>
<td>SS-SP10-06</td>
<td>First</td>
<td>Questioning a 'no problem' diagnosis</td>
<td>No problem</td>
<td>No news</td>
</tr>
<tr>
<td>IS-SP01-02</td>
<td>Check-up</td>
<td>Questioning the evidence for a 'no problem' diagnosis</td>
<td>No problem</td>
<td>No news</td>
</tr>
</tbody>
</table>
7.5.1.1 Minimal patient responses

A response to diagnosis was considered minimal if they were part of the collection of continuers and acknowledgement tokens such as *mm, mm hm, yes, yep, yeah* and *right* (cf. Gardner, 2007) without further talk after the conclusion of the diagnosis delivery by the surgeon.\(^4\) Extract 7.3b clearly demonstrates how minimal such a response can be.

**Ex. 7.3b: SS-SP09-02**

172 SG: yep "one oh six (. seven(ty))." (0.2)((rips off arm cuff)) your
173 blood pressure’s perfect; (0.6) uh:m: the: the lungs sound good
174 the heart sounds good (0.4) uh:m: you didn’t need any surgery;
175 so from my side as a chest surgeon, (.) [uh:m i don’t need to
176 PT: ]
177 SG: =see you again, we’ve given you a clean bill of health there,
178 (0.4) i’m not gonna get involved in this [because] (it’s out= 179 PT: [nah nah]
180 SG: =of) (. my realm,

In line 176, the patient pre-empts the final diagnostic ‘no problem’ statement with the continuers *mm* and then does not deliver any further response. The surgeon then continues with a disclaimer of his responsibility over the patient’s other problem that has been presented. Notice that this is a ‘no problem’ diagnosis. However neither the patient nor the patient’s mother resists it or attempts to justify the visit. As patients in surgeon-patient interactions have either been sent by a referring doctor or, as in this consultation, the patient has been requested by the surgeon to come for a follow-up

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\(^4\) Minimal responses may also occur in extended responses, however in the 11 consultations where minimal responses have been identified there was nothing more than the minimal response before the surgeon moved on either to treatment recommendations or towards closing the consultation.
visit, there is less impetus for the patient to justify a visit in which there is a ‘no problem’
diagnosis. These minimal responses might occur several times across the course of
diagnosis, particularly as many of the diagnostic activities include references to the
evidence of diagnostic reasoning and an explanation of the diagnosis, as in extract
7.4b.

Ex. 7.4b: IS-SP01-04

137 SG: alright well there's nothing abnormal i can feel there?
138 PT: yep,
140 (1.0)
141 SG: you've had quite a few investigations of the [gall bladder;]
142 PT: [*uh heaps*]
143 PT: [(okay)
144 SG: [so i'm sure it's nothing related to the gall bladder.
145 PT: *yep* nhh
146 (0.4)
147 SG: i suspect that this is a pain which is originating in your
148 back,
149 (0.6)
150 PT: yep,
151 (0.4)
152 SG: you can get pain from the back presenting in the abdomen.
154 PT: yeah,
155 SG: and i think that that's: (. .) the most likely cause in
156 you:
157 (0.4)
158 PT: *eah*,
159 (1.2)
160 SG: so i think that you could help this by losing some
161 weight;
162 PT: yeah,
163 (1.0)
164 SG: and you just have to modify a little bit $how you sit$;
165 (0.8)
166 PT: [yeah]
In this consultation the patient responds a number of times with different response tokens (lines 139, 143, 145, 150, 154, 158, 162, 166, 169, 173, 178, 180). Only when confronted with a strong statement in line 141 does he give a more than minimal response. By asking the patient about the investigations he has had regarding the problem, the surgeon is co-implicating the patient in the diagnosis by eliciting agreement regarding the diagnostic procedures already undertaken (Maynard, 1992).

Minimal responses are not necessarily an indication that the patient is unable or unwilling to respond to the diagnosis, but instead show that the patient is orienting towards the relevant next activity to be produced by the surgeon and therefore the minimal response is used to pass their turn at talk (Gardner, 2007). As Peräkylä (2006, p. 245) notes, “by remaining passive the patients can simply show their recipiency, and/or they can indicate their expectation that discussion on treatment or other future action will ensue”. After each of these diagnostic activities, the surgeon proceeds to recommend treatment or in some other way move towards the final activities of the consultation.

7.5.1.2 Extended patient responses

Half of the patient responses were ‘extended’ and encompassed a variety of different actions, including justifying the visit, requesting treatment recommendations, asking about the diagnosis, displaying knowledge about the diagnosis, questioning the
diagnosis, asking for information about the diagnostic procedure, and resisting the diagnosis, as shown in Table 7.3. As there is such a range of responses, it is difficult to categorise them any further than being extended responses. What this does show is that surgeons routinely allow space for patients to respond to diagnoses (Heath, 1992) and that patients give extended responses to diagnoses for a variety of reasons that are based within the local context of the interaction and on the patients’ desired level of participation in the consultation. In extract 7.10b, the surgeon uses the referral recognition sequence to introduce the patient’s diagnosis that had been made by another surgeon (lines 8, 11 and 13).

Ex. 7.10b: SS-SP10-02

6 SG: hel[llo.] kay i’m doctor jess abbott one of the breast surgeons_
7 PT: [hi: ]
8 SG: now i got a letter from: mr smi:th;
9 PT: yes,
10 (0.8)
11 SG: which say:s that you’ve got a little breast nodule?
12 PT: yes,
13 SG: an tht you want it removed;
14 PT: that’s right?
15 SG: and he stuck a needle in it and it said it was (0.2) not a
16 cancer.
17 PT: that’s right. yep. that’s but it has changed he said and it is
18 getting bigger and it is starting to hurt more?
19 SG: mhm?
20 PT: it catches right on my $bra$?
21 SG: okay;
22 PT: $hh$ so:;
23 SG: ("ah") ( "one of breast nurses.") "that sounds like a
24 jolly nuisance"
25 PT: so yea:h he said it was better to be taken out.
26 SG: yep
27 PT: um partly coz it shoots pain up underneath my arm as well;
28 SG: ":"
29 PT: so THAT’s a really good one hh huh
30 SG: fair enough; (0.4) tlk okay. (0.4) s:o what we can do is put you
When the surgeon states that the diagnosis was not cancer (lines 156), the patient uses the referring doctor as a justification not only for the visit but for her choice of treatment, which is surgery. By invoking the referring doctor, the patient is strengthening her position through the expertise of another surgeon. As noted in chapter 5, in order for the consultation to progress, there should ideally be alignment between all three participants – the patient, the surgeon and the referring doctor as embodied in the referral letter. Through the reference to the referring doctor, the patient is also questioning the perceived alignment between the referring doctor and the consulting surgeon. The surgeon does not resist this and offers the patient the treatment she has requested (lines 30-1). Rather than relying solely her subjective experience of illness to justify her visit (Heath, 1992), the patient’s justification is also based on the external judgement of an expert. This technique is available (and is used) in surgeon-patient interactions as the act of being referred automatically justifies the patient’s presence in the consultation.

After a diagnosis, a patient may request a treatment recommendation, for example ‘what can be done about this’, showing an orientation to the solution for the diagnosis and pre-empting the next relevant activity of the consultation, as in extract 7.2b.

Ex. 7.2b: SS-SP13-01
221 SG10: oh:kay so (now what i’ve just done shows you’ve developed
222 some cysts)
224 PT: mm:
225 SG10: cysts are a little part of what breasts do.
226 PT: oh right.
227 ((20 lines omitted))
228 PT: so what do you do about these cysts.
229 SG10: oh:kay; well first thing i want to do is prove that that’s
230 all there is to it; hh and what i recommend for that is
231 we put a very fine needle into the bottom of it and we just
232 simply remove the fluid from the inside of it;
233 PT: (mhm?)
In this extract, the surgeon delivers the diagnosis, referencing the examination as evidence while also normalising the problem (which receives an oh-prefaced response in line 226). After the surgeon explains the cause of the problem, the patient responds in line 246 with a question about how the problem might be treated. This propels the consultation forward into the treatment activity, initiated here by the patient rather than the surgeon. While extended responses in primary care interactions “entail that the progression of talk from diagnosis to other business (usually treatment) be postponed, at least for the time that the patient produces his or her response” (Peräkylä, 2006, p. 234), in surgeon-patient consultations this may not be the case if the talk is regarding treatment, and the patient may guide the consultation towards the treatment activity.

In some consultations, the patient may ask for more information regarding the diagnosis, as in extract 7.12b (in this case the patient’s wife asks the question).

Ex. 7.12b: IS-SP04-02
28 SG: okay well um (. ) it it seems (. ) pretty clear from the x rays
29 that you know the there are still some st0:nes (. ) in there
30 you know in the (. ) the duct that leads from the gall bladder
31 to the main duct is still got some st0:nes in it=is probably
32 slightly abnormal of itself um (0.2) i don't (0.2) th:ink
33 there’ll be m-m-m-much option but to do a further operation and
34 take that part ou:t=.
35 PT: =aw [yeah,
36 WI: [mm.
37 SG: [y-y-y-you know w- which would have to be an open operation you
38 know the not the n-n-n-not the [keyhole not .hh the keyhole one=
39 WI: [oh yeah yea:h
40 SG: =because um (. ) .hh you know it's not (1.2) w-wouldn't you
41 know it wouldn't be straight forward enough to sort of keyhole
42 WI: no:
43 SG: way_ >but um (0.2) there are still some stones there hh yeah-
44 WI: the- they've left behind when the gall bladder was first taken
45 ou:t, (0.2) would they? coz you [don't keep making them;
46 SG: [yes.
47 SG: n[o.]
48 WI: [that] quick [do you.]
After the surgeon delivers the bad news diagnosis that requires surgery, he continues to inform the patient about what the surgery entails. However, the patient’s wife brings the consultation back to the diagnosis activity by asking about why the patient would be having such problems after having surgery previously (lines 44-5, 48). The patient (or their support person) can exert agency in the diagnostic activity of a consultation by requesting for further information regarding the diagnosis. This may occur because the diagnosis was opaque or because there is some misalignment between what the patient believes is the problem and the diagnosis delivered by the surgeon.

When a patient has previously been diagnosed or even provisionally diagnosed, they may display knowledge about the diagnosis. This knowledge may have been gleaned from the referring doctor, written information given to them by that doctor, or from other sources such as the internet. In extract 7.6c, the patient references unspecified written information as the source of his displayed knowledge.

**Ex. 7.6c: SS-SP07-02**

68 PT: right yeah ye- [i mean i think i read something where= 69 SG:        [yeah: 70 PT: =or ah there was nine cases or something on= 71 PT: =[(one of the) rePORts said nine cases.] 72 SG: =[yeah there’s lots of (. ) case reports] yeah. 73 PT: uh:m (. ) yeah we- i mean ah (. ) see when i first started taking 74 fosamax ah: five six years ago; ah: it did aggravate 75 [uh:m yih know my upper diges[tive yih know= 76 SG: [(sniffs)] [mm 77 PT: =sys’m so uh:m (. ) and the doctor told me to take it on a full 78 stomach; [yih] know [ah: normally you take it with jus= 79 SG:        [yeh] [yeh 80 PT: =wa[ter for half an hour blah blah_ .hh an’ then they= 81 SG:        [yeah: 82 PT: =switched me on to actonel i think i might have told you
you that [which is a different product an’ that was fine]

SG: [mm]

PT: but when i got back to new zealand ah: four months ago:

uh:m new zealand doesn’t carry actonel;

SG: no=

PT: =and (foss wa-) i was jus wondering may:be: it was a reaction

tuh=

SG: =could be=

PT: =going back [on the

In line 68, the patient begins his knowledge display by citing a written document about the provisional diagnosis he was given when he was discharged from hospital. While he has the floor, he begins a narrative problem presentation in line 73, which acts as an evidential preface to his theory of illness in lines 88-9 (in the guise of a question in order to maintain the medical authority of the surgeon and the patient’s role as a layperson). Alternatively, by displaying knowledge the patient may be able to ask more complex questions or express a theory of illness, as in this extract, or they may also show that they have less of a grasp on their diagnosis than presumed which may prompt further explanation by the surgeon. A patient may also question the diagnosis given by the surgeon, as in extract 7.17.

Ex. 7.17: SS-SP10-06

172 PT: so what would it be.

173 SG: oh:kay: well lets cover you up; (. ) tlk when put the did the

174 needle test: what he showed is that you had a cyst; (0.2)

175 okay; a cyst is a nor: mal thing that womens’ breasts make, most

176 common between the ages of about thirty five and going through

177 the menopause?

178 PT: (uh huh.)

((8 lines omitted))

187 PT: sometimes you know i mean even if i’m (. ) lying down it you

188 know sort of very

189 SG: it’s really sore,

190 PT: .hh very sore.

191 SG: yeah.

192 PT: so that’s normal.

193 SG: well (1.2) it’s nor: mal but it’s a nuisance. (. ) and any area
that you’ve got feels like a lump and is sore like that that’s
it’s not normal and it needs to be sorted out but the good news
is that there’s nothing nasty that we can feel or see there.

PT: “ah okay”

SG: yeah which is good; cos you don’t need anything like that.=

PT: =NO: mhh mhh mhh mhh

SG: *yeah* .hh and there’s nothing there that i need to put needles
in today?

PT: oh (. ) oh wow

SG: well that’s pretty good too isn’t it;

PT: mm::.

SG: coz i’d have to be able to feel something to be able to put a

PT: okay that’s great.

In this extract, the patient questions the ‘no problem’ diagnosis delivered by the surgeon by asking what the cause of her pain would be (line 172). By doing this she challenges the surgeon’s assertion that there is nothing wrong and prompts the surgeon to further explain the diagnosis. The patient also reiterates the severity of the pain she is suffering (lines 187-8, 190), through which, as Heath states, “patients not only encourage the doctor to reconsider his opinion of the condition and its management, but also bolster their grounds for seeking professional help in the face of a diagnosis which implies that their difficulties are familiar and relatively unproblematic” (Heath, 1992, p. 255). The surgeon then seeks alignment from the patient in line 203 by assessing the diagnosis and adding a tag question that prompts the patient to agree with the positive assessment (which the patient does in line 207). In this consultation, the patient seeks to align her subjective experience of the problem with the objective diagnosis by the surgeon and in the process of doing so questions the surgeon’s diagnostic statement. A patient might also respond with questions about the diagnostic procedure that led to the diagnosis. In extract 7.15b, the surgeon provides a description of what was found during a colonoscopy without any diagnostic information as the test information is yet to come back from the pathology laboratory.

Ex. 7.15b: SS-SP03-05

SG: okay now when you had then colonoscopy they they said they took

tiny little biopsy of a of a polyp that was about four ml-
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28 millimetres in size but they (.) there’s nothing on the computer—
29 so (.) i suspect [it didn’t actually it ] >hasn’t gone=
30 PT: [it hasn’t come through yet]
31 SG: =through to the lab< we[ll ] it should’ve;
32 PT: [no:.]
33 PT: said two to three weeks [but (of course they might have to say)
34 SG: [<yeah it would’ve go:ne> it’s:: oh:kay
35 no actually it’s only the twenty third of november so it’s
36 probably not been processed yet. yep yep .hh it was a ti:ny
37 thing about four millimetres in size. >so look it’s [not th-
38 PT: [how much is
39 four [mil- about that °is it¿°
40 SG: [(oh yeah) smaller smaller smaller so it’s kind of
41 ((21 lines omitted))
62 PT: and it looked innocent.
63 SG: aw bt they thought it was >w- wha we call< hyper plastic polyp,
64 which has _no cancer potential.
65 PT: oh [so _that’s ] good to know¿=
66 SG: [(so yeah yeah]
67 SG: =mm it [is
68 PT: [thank you for [that?
69 SG: [heh heh (h)o(h)kay .hh so=
70 PT: =that’s what i’ve been [w- not] wor- [i’ve] been just_interested
71 SG: [yeah ] [yeah]
72 PT: =to hea:r,
73 SG: yep
74 PT: yeah:
75 SG: okay so no so [from that point of vie-
76 PT: [and where was it did they [say that?]
77 SG: [it was in
78 the sigmoid colon? [($)on the] left side? sort [(h)of] rather low=
79 PT: [oh yes] [yes ]
80 SG: =down;$ .hh on the [left] hand side.
81 PT: [yeah]

In lines 63-4 the surgeon then reassures the patient that there is no cancer potential, which is the only provisional diagnosis given here. This is receipted by the patient with an _oh_, demonstrating that it is news (Heritage, 1984b). In this consultation the patient is
not challenging the evidence used by the surgeon as no firm diagnosis is made. The patient is instead increasing her understanding of her problem as demonstrated later when she also asks how she might identify any further polyps in the future (not shown).

Patients can also resist the diagnosis delivered by the surgeon by presenting evidence and accounting for their alternate theories. As Heath (1992, p. 258) notes that "by providing hitherto unmentioned details, asserting the severity of their symptoms and/or their reasons for concern, patients attend to and account for the incongruence between their own conception of the condition and the doctors’ professional, medical assessment”. This is most clear in extract 7.18a. In this consultation the surgeon cites the patient’s smoking for the cause of her presenting problem, however the patient posits four other possible causes for the problem during the consultation, thus resisting the diagnosis that implicates her own behaviour as being at fault.

**Ex. 7.18a: SS-SP10-04**

107 SG: the most common cause for nipple inversion is unfortunately
108 (the) smoking.
109 PT: oh okay;
110 SG: uh: in same way that smoking damages (a lot of the) little
111 bronchials in your lungs;
112 PT: yep
113 SG: also paralyses the muscles around the milk ducts.
114 PT: oh okay
115 SG: and they tend to get shorter (0.4) and flabbier an’ (. ) to
116 infection.
117 (0.2)
118 PT: coz before i had my daughter i had much smaller breasts;
119 SG: mh[m ,]
120 PT: [and] um (1.2) they seemed to of um (. ) stayed [even] like=
121 SG: [mh m]
122 PT: =even with the weight that i lost they (. ) haven’t shrunk as
123 much as i would like them to eh heh
124 (2.4)
125 SG: okay: (1.2) (i can’t feel any lumps or anything nasty) so
126 that’s good;
127 (2.8)
128 PT: my sister’s got inverted nipples?
129 SG: mhm¿
130 PT: (but um)
131 (2.0)
131 SG: has she always had those?
132 PT: (mm.)

The surgeon begins with a generalised comment regarding the most common cause for the presenting problem (lines 107-8, 110-111, 113 and 114-5), which, while it implicates the patient’s smoking as the cause, does not overtly lay blame or label the patient’s actions. The patient delivers a number of minimal turns, including two oh-prefaced turns⁵ (lines 109 and 114), during the diagnosis delivery. In response after diagnosis has been completed, the patient presents new information regarding her breasts, the area of her body where the problem is found. Directly after the first possible cause (lines 122-3), which is not responded to by the surgeon, the patient adds further information in line 128 regarding her family history. This possible cause is challenged by the surgeon who questions the validity of the comparison between the patient and her sister by asking about the patient’s sister’s problem presentation (line 131), which contrasts that of the patient.

The third assertion of a possible cause occurs during the fine needle biopsy that the surgeon conducts as a diagnostic test.

Ex. 7.18b: SS-SP10-04
182 PT: so the other thing is is that like with (it wouldn’t’ve been)
183 something to do with hormone.
184 SG: ↑um::: well certainly with th- like with the closer you get to
185 the [menopause]
186 PT: [menopause] and things like that.
187 SG: (th- the the normal) strange hormonal things that go on, b’t
188 ( )
189 (2.2)

⁵ While oh-prefaced responses (as well as stand alone oh responses) may be uncharacteristic in question-answer sequences in the medical interview (Heritage, 1984b), they occur seven times within this data as a response to diagnostic informing.
190 PT: I had fertility treatments with my daughter and [my] so my= [mhm]  
191 SG:  
192 PT: estrogen levels were quite you know [yes ]  
193 SG: all over the place [yes ]  
194 PT: [yeah] well they were pretty high. [like]= [mhm ]  
195 SG:  
196 PT: the um (. ) talk these levels were very high? [yep ]  
197 SG:  
198 PT: so I figured that I’ll most probably go through a slightly earlier menopause¿  
199 SG: could do. [1.6]  
200 SG: you: any idea: when your mum went through menopause?  
201 PT: well I’m assuming she started—she went through when she was forty six coz that was when (she had her last child.) [pft hah]  
202 SG: [ah hah ]  
203 PT: (so yeah)  
235 PT: coz the other thing is that when I was feeding Heidi I was prone to cystitis? [1.2]  
236 PT: ye–  
237 SG: problem with your bladder?  
238 PT: pardon [oh] I mean not cysti– um sorry um talk mastitis. [( )]  
239 SG:  
240 PT: (and uh)  
241 SG:  
242 SG: mhm?  
243 PT: (and uh)
The surgeon finally acknowledges the possibility that the patient has mastitis and that it has caused her problem, although she does so very weakly (line 246). While the patient continues giving more information about her previous mastitis infection, the surgeon continues with the diagnostic test. No more patient theories are expressed. While the patient does not explicitly posit any of these statements as alternative diagnoses or possible causes, their reference to the presenting problem and their sequential positioning directly after the diagnosis delivery and during the diagnostic test clearly link them to the diagnosis made by the surgeon. This implicit resistance is challenged (also implicitly) or ignored by the surgeon three times, thereby retaining the surgeon’s diagnosis as the correct one. Only after the patient’s last diagnostic theory does the surgeon acknowledge that there may be another cause for the problem. The balance between medical authority and patient agency is maintained here through the patient’s implicit delivery of the assertion and through the surgeon’s final acknowledgement of another possible cause. The surgeon is also careful not to blame the patient in the initial diagnosis delivery by generalising the diagnostic statement (lines 107-8 in Extract 7.18a).

7.5.1.3 No response to diagnosis

In two consultations the patients did not reply to the diagnostic statements. In one consultation, the diagnostic statement was the delivery of test results near the end of the consultation as the correct results were unable to be found at the beginning. After delivering the good news, the surgeon leaves a short pause and then continues to talk
about future diagnostic testing as a check up for the patient. In extract 7.19, the surgeon delivers the diagnosis after the patient rolls up his trousers to show the surgeon the swelling around his knee.

Ex. 7.19: SS-SP08-01
310 PT: well i’d say you can you can see the size of
311 [(it there) and you’ve you’ve seen [the ] you know look at it
312 SG: [yeah well i have a look at that [yeah]
313 PT: =you know [it’s] (. it’s p- pretty obvious and it’s
314 SG: [yeah]
315 SG: yeah
316 PT: n- not very [useful. not very] useful.>you’ve s--
317 SG: ['n the x rays:: ]
318 PT: =[you’ve seen _them] have you;
319 SG: [certainly conf- ]
318 SG: i have yes [confir]ming you’ve got pretty advanced arthritis=
319 PT: [yeah ]
320 SG: =the:re, .hh other than the prostate problem that you _mentioned
321 um (0.4) tell me about your _general health.
322 PT: oh it’s good,

In this consultation, the diagnosis was delivered as a response to the patient’s question regarding the x-ray in line 318. Therefore, the adjacency pair was complete and the response was not treated as officially or noticeably absent. In both these consultations the patients withheld responses allowing the surgeon to progress the consultation. There is no indication that the patients were unable to participate in the diagnostic activity as in the first consultation the surgeon left a pause and in the second the diagnosis was delivered as a reply (or second pair part) to the patient’s question.

7.6 Conclusion

Instead of viewing the diagnostic activity of the consultation as one-sided, it is clear from this data that patients and surgeons co-construct each activity within the consultation despite the asymmetries in the expertise of the surgeon and the experience of the patient (Heath, 1992). Heath (1992) focuses on asymmetry rather than agency, which may be unwarranted, as patients can assume agency even with an environment that appears to be restricted. This focus on asymmetry also leads Heath
(1992) to infer that extended responses indicate disagreement between the parties. However this does not appear to be the case in surgeon-patient consultations. Although extended responses occur regularly in this data, there is not necessarily greater misalignment between the participants than in those with minimal responses. What this data does demonstrate, is that, as in primary care interactions, patients have interactional means through which they can assume agency within the diagnostic activity of the consultation (Peräkylä, 2006).

A greater understanding of diagnostic activities is necessary prior to making recommendations for surgeons to change their behaviour, as patients who deliver minimal responses may do so, not necessarily because they are unable to ask questions, but perhaps because they are orienting to the next activity (usually treatment) and are thereby passing the opportunity to talk further (Gardner, 2007). The number and variety of extended responses in the surgeon-patient consultations analysed here demonstrate that patients can and do assume agency within the diagnostic activity of the consultation, but, as Peräkylä (2006, p. 246) notes, “their agency and knowledgeability are intertwined and also overshadowed by the patients’ and doctors’ orientation to the doctor’s authority in the domain of medical reasoning”.

Chapter 8: Treatment

ACTIVITY 5: Proposing next steps

8.1 Introduction

Proposing the next steps in addressing the patient’s presenting problem, often referred to as ‘treatment’ or ‘treatment recommendation’\(^1\), involves explicit work in decision making by both the patient and the doctor. There are various models for decision making in medical interactions, prominent among which are the paternalistic model, the informed model, the professional-as-agent model and the shared model (Charles, Gafni, & Whelan, 1997). Shared decision making is promoted as a way of ensuring patient participation, as not only is it a patient’s right to be involved in making decisions about their care but it also improves the outcomes of care (Stivers, 2006). Yet the best way to determine what level of participation patients want in decision making has not yet been established (Collins, Britten, Ruusuvuori, & Thompson, 2007b; Hudak et al., 2008). As decision making in medicine, particularly shared decision making, continues to be a focus of policy makers, researchers, and clinicians, there is comparatively little research into actual interactional behaviours of the participants in the treatment activity in either primary care or surgical consultations, the point at which the process of decision making occurs.

Charles and colleagues (1997) argue that while shared decision making in primary care involves at least two parties, in surgeon-patient consultations there are at least three: the surgeon, the patient and the referring doctor (a point to which they also allude). This triad is then added to with support persons (family and friends) who may be present; interns, surgical house officers and registrars who consult more senior clinicians, and other staff such as nurses and other specialists who may be involved in the consultation. With additional participants in the consultation “the range and complexity of the interactional dynamics is automatically increased” (Charles et al., 1997, p. 685).

\(^1\) While the activity being discussed has been called ‘proposing next steps’, I have chosen to use the word ‘treatment’ throughout to cover all types of next steps described here. This is primarily for ease of reading and for consistency with the majority of the literature on medical communication.
While many of the other activities of doctor-patient consultations have been subject to conversation analytic research, there appears to be a paucity of research regarding the activity of proposing next steps (or ‘treatment recommendation’). Stivers (2005, 2006) has provided a in-depth picture of this activity with a particular focus on encounters with children as patients, although there is little research beyond this that describes interactions involving adults. What Stivers has described is crucial to understanding how patients/parents participate in the treatment activity: through the “acceptance or resistance to physicians’ treatment recommendations” (Stivers, 2005, p. 67). This acceptance or resistance demonstrates that there is a structural opportunity for patients to participate in the interaction to the point where acceptance of the treatment recommendation must be elicited prior to the closure of the consultation.

All 35 consultations were considered in the analysis of treatment recommendations. This revealed a variety of recommended treatments as well as consultations in which no treatment activity occurred. The treatment recommendation activity can include a description of treatment options, an explanation of risks, a description of how to prepare for treatment, a description of the procedure and recovery and a description of the administrative processes involved in the treatment. Not all treatments require all of this information and not all surgeons provide it. In this chapter, I demonstrate the ways in which different treatment recommendations are delivered by surgeons and responded to by patients. I then describe how surgeons and patients talk about treatment options and the risks and benefits of treatment. Finally, I analyse two interactions – one in which the surgeon reverses his treatment recommendation and another in which the surgeon resists patient pressure for unsuitable surgery.

8.2 Treatment recommendations and responses

In the consultations considered in this data, the treatment recommendation may not be a treatment in the traditional sense of a procedure undertaken or medication prescribed in order to cure or ameliorate a problem. Instead, it may be diagnostic testing that can assist the surgeon in confirming a diagnosis (or ruling out a diagnosis) in order to move forward in the journey towards treatment, whether it be a lifestyle change, surgery, or no treatment whatsoever. A treatment recommendation may also be a proposal to continue follow-up visits for a specific period of time (which may or may not include
diagnostic testing), which is often the case after surgery for cancer. There can also be more than one treatment recommendation for the patient, such as both a lifestyle change and diagnostic testing.

As opposed to most other activities in doctor-patient consultations in which acknowledgement is sufficient for the consultation to progress, treatment recommendations normatively require acceptance from the patient to ensure ‘progressivity’\(^2\) (Lerner, 1996; Schegloff, 2007; Stivers, 2005). This normative constraint on this activity not only allows patients to resist treatment recommendations but also influences the way in which doctors structure their talk in order to avoid resistance and to encourage acceptance.

According to Stivers (2006, p. 300), in acute primary care settings, “physicians tend to offer their treatment recommendations in one of two main ways: either as a recommendation for or against a particular treatment”. As the acceptance or non-acceptance of recommendations have been found to place normative constraints on the participants (Stivers, 2005), the way in which the recommendation is structured has consequences for the progressivity of the consultation. In primary care interactions, Stivers found that patients offer less resistance to recommendations that are for a treatment rather than for those that are against a treatment. In this section, I analyse the ways in which surgeons recommend various types of treatment and how patients respond to those recommendations.

8.2.1 Pre-treatment recommendation commentary

Some surgeons in this data deliver what I have termed pre-treatment recommendation commentary at an earlier point in the consultation. This commentary flags a probable treatment option prior to the diagnosis and often prior to the examination. It can be a brief statement, as in extract 8.1 or it can include details of the probable treatment, as in extract 8.2a. This type of commentary occurred in five of the 35 consultations in this data, four of which involved the same surgeon. This practice may therefore be idiosyncratic to particular surgeons.

\(^2\) Progressivity refers to the ongoing progress of an interaction as participants orient to the principles of sequential implicativeness and conditional relevance and is achieved through sequence organisation, repair and preference organisation (Stivers & Robinson, 2006).
Ex. 8.1 IS-SP01-06
39 SG: we'll have a check on you today: and uh:m (2.0) we'll organise
40 another mammogram?
41 (1.0)
42 PT: oh right,
43 SG: and then uh:m i shouldn't need to see you after that.
44 PT: (h)oh .hh r(h)igh(h)t

The pre-treatment recommendation commentary occurs directly after the activity of history taking in extract 8.1. This consultation is a routine follow-up a number of years after the patient has had breast surgery. Prior to an examination and diagnosis, the surgeon proposes the probable treatment recommendation that will be made (lines 39-40). The patient responds favourably to this suggestion, presumably as a 'no problem' diagnosis would be preferred for a patient who has previously had breast cancer.

Ex. 8.2a IS-SP03-02
338 SG: =so yih know (0.6) a- th- at this stage we would t- if y’know
339 we're talking about surgery we would be talking about doing a
340 limited op- operation to deal with the bit of bowel that's
341 causing the trouble,
342 PT: yeah.=
343 SG: =that's twisting it an’ (i'll just strai-) take out that s-
344 that extra [length=
345 PT: >yeah sure<
346 SG: =that's twisting?

In extract 8.2a, the commentary occurs after the surgeon describes the diagnosis that the referring doctor has made; however it is prior to this surgeon’s examination and final diagnosis delivery. As the diagnosis has previously been made (as evidenced throughout the interaction), the surgeon is able to describe the probable treatment in some detail prior to examining and formally re-diagnosing the patient. It is still framed as probable treatment by the surgeon, who uses the word if in reference to the treatment in line 338, highlighting the need for a choice to be made. The patient agrees with this choice in line 342. Later in the consultation, the treatment recommendation is described in some detail and is again readily accepted by the patient.
8.2.2 Surgery

Surgery is the recommended treatment in 13 out of 35 consultations in this data. In four of these the decision to have surgery has been made in a previous consultation. In this data, when surgery is the recommended treatment, there are no other treatment recommendations suggested by the surgeon in addition to the surgery. That is, no other treatment such as lifestyle changes or diagnostic testing are suggested. Surgery was framed as a preferred treatment option in all 13 cases, which bears similarity to research by Hudak and colleagues (2009). The surgeon delivered the recommendation directly and simply without hedging or delay. Only in one consultation did the surgeon present any other option without prompting. In two consultations, the patients’ support persons raised the possibility of other treatment options other than surgery. Treatment options (or alternatives) are discussed further in section 8.3. In one consultation, the surgeon provided details of a treatment option other than surgery (extract 8.3a).

Ex. 8.3a: SS-SP08-02

292 SG: so the x rays basically show that you’ve got arthritis in both
293     of yuh hips but much more on the right than the
294     left,=
295 PT: =oh yeah.
296 SG: the right one looks like it’s (...) reasonably good [but the r--
297 PT: [mm
298 SG: =left one’s: (...) basically had it.
299 PT: hhh
300 SG: talk and ah: (0.2) [so (...) <the treatment options here> (0.8)
301 PT: [hh
302     uhm (...) a are obviously some of the things you’re already
303     doing; you’re on anti you’re on
304 PT: "mm"
305 SG: some pantadol which is a f- ah simple analgesic works very well,
306     nhh you’re on (...) ibuprofen which uh: (0.4) can help, (0.6)
307     talk uh (...) physiotherapy is no use for this type [of ] hip=
308 PT: ["mm"]
309 SG: doesn’t work (1.0) uh there are many (0.6) homeopathic
310     remedies which (0.6) most of my patients try:; [but
311 PT: [mm
312 SG: generally don’t help a great deal, nhh uh:mm there are all
In lines 305-7, 309-10, 312-14, 316-17 (as discussed further in section 8.3.1). In two of the consultations the patients (or their support persons) resist the recommendation for surgery, as in extract 8.4a.

**Ex. 8.4a: IS-SP02-02**

73 SG: so any treatment to: um (.) tlk to fix this an- any sur:gi- cal  
74 treatment to fix this aneurysm .hh uh would invo:1ve (.l)  
75 operating arou:nd or on the kidney _ 
76 WI: mm hm  
77 SG: okay?  
78 WI: "mm"  
79 SG: .hh now that adds a whole new (0.4) e- complexi-ty to the  
80 surgery because there's a risk that the kidneys won't work=  
81 WI: ="mm"=  
82 SG: =after the operation. (1.0) a:nd  
83 WI: {"don't worry dear"}  
84 SG: you know so there's always a risk of kidney failure an' (.l) the  
85 need for dialysis and all of that sort of thing.
In extract 8.4a, the patient has previously had a stroke and his wife consults with the surgeon as the patient has reduced capacity for interaction. The surgeon here is more tentative in his recommendation for surgery than the one in extract 8.3a above. Early in his recommendation he cites the risks of an unspecified ‘traditional’ type of surgery (lines 79-80, 82, 84-5), however he does go on to present a preferred type of surgery
starting in line 88. The surgeon presents this far less invasive surgical alternative\(^3\) as the only option for addressing the patient’s problem, however this is both passively and actively resisted by the patient, the patient’s wife and the patient’s daughter. The wife’s passive resistance occurs across the first part of the treatment recommendation as she produces minimal, continuing responses (lines 76, 78, 81, 87, 92, 94, 98, 101, 106, 108, 113, 115). When the surgeon finishes describing the treatment in line 117, the patient’s wife responds with a delaying *um* which is followed by a two second pause.

**Ex. 8.4b: IS-SP02-02**

119 SG: [a- a-
120 WI: [big decision isn't it.
121 SG: it is a big decision; [uh:m-
122 WI: [*mm.*

(98 lines omitted)

220 SG: but i- (.). but it if we are: thinking about [fixing it; [then
221 WI: 
222 (.).
223 SG: talk you know it we should really get on and do it; (P) [er
224 WI: ]*yeah
225 SG: =if that if that is (.). that is the decision.
226 WI: yeah
227 SG: [the the reason t-
228 WI: [i- it's mark's decision
229 SG: oh of course.
230 WI: [and
231 DA: [mm
232 SG: absolutely.
233 WI: "i don't [think] he's" (**"going to be [prepared to [have]"**)=
234 SG: [yeah ]
235 WI: (**"an [operation]"**) he's been [through] a [great] deal.
236 WI: [*yeah]
237 SG: [yeah ]
238 DA: okay.

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\(^3\) While a stent is called an ‘intervention’, it might still be considered a surgical intervention, though it is minimally invasive. It is often performed by vascular surgeons because if there is a problem during the intervention, more extensive surgery might be required (White, personal communication).
The patient’s wife then offers an assessment of the process of decision making rather than an acceptance or non-acceptance of the recommendation itself. The discussion continues around what the diagnosis means until the surgeon once again pursues the surgical option in line 220. The patient’s wife begins her active resistance here in line 228 as she reminds the doctor that it is the patient’s decision and continues on to state that he is unlikely to be prepared to undergo such treatment. The surgeon does not continue to pursue surgery in light of this resistance, which is a clear example of how the treatment recommendation activity involves negotiation of the treatment between the parties. Patients are by no means helpless recipients of advice but are able to negotiate the treatment recommended to them.

**Ex. 8.4c: IS-SP02-02**

284 DA: dad dad has said to us no:.
285 SG: yeah [yeah]
286 WI: [yeah] he has mm
287 SG: .hh and and and that's a very reasonable (. ) [thing ]
288 WI: [yeah i] think it
289 [is too]
290 SG: [yeah ] i mean you know .hhh [um hh] you know the the =
291 WI: [yeah ]
292 SG: =decision is very much a joint decision;=
293 WI: =yeah=
294 SG: =between [you know] what would what =
295 WI: [(right) ]
296 SG: =[you know
297 WI: [would you have the operation mark?
298 PT: awHHHHH (1.8) no- (not another one) (0.4) .hh [aw]HHHHHHH not=
299 SG: [mm]
300 PT: =again;=
301 SG: =.hh yeah=
302 PT: =surely.=
303 WI: =°no he's been s- through so much°
304 SG: but what i think would be a reasonable [thing is s= 305 PT: [awHHHHH
This is evidenced later in this same consultation as the surgeon proposes that the problem be monitored rather than operated on (line 303), after both the patient and his daughter also actively resist surgery. The surgeon, however, does not completely eliminate the offer of surgery as a treatment option, stating that in the future it may be necessary if the patient’s condition worsens (lines 309-10, 312-3, 315, 317, 321).

8.2.3 Diagnostic testing

In 13 consultations the recommended ‘treatment’ is diagnostic testing that will assist in the process of diagnosis. In two consultations, routine diagnostic testing is also recommended as treatment (including one in which a specific diagnostic test is ordered). Out of these 13 consultations, there is only one in which the patient resists the recommendation for diagnostic testing as she has previously had bad experiences with the procedure recommended. All other recommendations are readily accepted by
patients, although several patients raise other potential treatments that could be
considered after the tests. Most diagnostic testing would be followed by an appointment
either with a surgeon in the clinic or with the patient’s general practitioner. In extract 8.5
the surgeon suggests a diagnostic test to rule out a cancer diagnosis.

Ex. 8.5: SS-SP10-05
152 SG: what i think would be useful to do to prove what they are once
153 and for all, .hh is to put a very fine needle in,
154 PT: mh[m
155 SG: [with some local anaesthetic to make ( ) not too nippy?
156 PT: mhm?
157 SG: .hh to prove what’s going on.
158 PT: okay [yeah] yep
159 SG: [okay]
160 SG: i don’t think this is anything to do with cancer, i don’t think
161 this is anything that’s danger[ous
162 PT: [it’s been the breast reduction
163 ‘as it?
164 SG: i suspect tht (. ) th- the nature of a breast reduction is
165 you’re mo:ving lots of tissue around,
166 PT: “oh i [see”].
167 SG: [and ] any little bits that lose their blood supply:
168 (0.4) end up as little lumps.
169 PT: “oh i see. yeah;”
170 ((14 lines omitted))
183 SG: oh:kay .hh so what i’ll do put local in make the area numb; mm
184 “and then we’ll (put a needle into [the area)” ok[ay?
185 PT: [okay [thank you.
186 SG: great.

The patient accepts the proposed diagnostic test without any resistance in line 158. The
surgeon is careful to reassure the patient that the test is being carried out to ensure that
there is no cancer even though a cancer diagnosis is unlikely. This is one of the three
consultations in which the diagnostic testing occurs during the consultation4, with the

4 During three consultations, the surgeon performs a fine needle biopsy in order to diagnose the cause of
breast lumps. The fluid collected from the procedure is then sent to a pathology laboratory.
patient accepting that it occur at the time in line 185. It is unsurprising that a patient is less likely to resist diagnostic testing as they orient to the need for further information to inform the final diagnosis and this treatment not necessarily the final treatment for the presenting problem. This treatment recommendation is not being proposed to solve the presenting problem or alleviate symptoms but instead to find more information in order for the surgeon or a general practitioner to recommend further treatment.

8.2.4 Lifestyle changes

Lifestyle changes are the recommended treatment in three of the consultations and in two of those the surgeon also recommends further testing. In extract 8.6, after the surgeon delivers his diagnosis (not shown), he recommends that the patient lose weight (lines 160-1) and modify how he sits (line 164).

Ex. 8.6: IS-SP01-04
160 SG: so (0.4) i think that you could help this by losing some __weight __
161  
162 PT: yeah,
163 (1.0)
164 SG: and you just might have to modify a little bit how you sit __
165 (0.8)
166 PT: [yeah
167 SG: [but (.) but i think (0.4) uh:m with your weight and you probably do a lot of sitting with yuh work, (0.4) [it a]ll=
169 PT: [yeah]
170 SG: =sort of uh:m (0.6) s- probably aggravating something that's going on in your back,
172 (2.0)
173 PT: *mm hm*
174 (1.0)
175 SG: so i- i don't think (0.6) from my point of view >there's anything to suggest there's anything going o-< (. ) going on in the abdomen.
178 PT: *yeah*  
179 SG: alright? (0.2) [i think we'll just leave that _
180 PT: [*yep*
While this recommendation is delivered in a fairly straightforward manner, the surgeon explains his reasoning for his diagnosis and treatment (lines 167-8, 170-1), with the patient producing two continuing yea hs and an mm hm in response to the two lifestyle changes suggested. By explaining his reasoning, the surgeon pre-empts possible resistance prior to the closure of the consultation. The surgeon states that in terms of his specialty as a general surgeon, there is no problem and thus no surgical treatment is called for. The surgeon then pursues further acceptance (line 179) which is delivered by the patient (line 180). Previous research has shown that patients are less likely to resist recommendations for a particular treatment than those recommendations that are against a particular treatment (Stivers, 2006) and here the surgeon offers the patient affirmative action as treatment prior to any indication that surgery is not an option, thus minimising the possible resistance from the patient. In this consultation, the treatment is accepted with a minimal response token. The issue then is that the surgeon has little to go on apart from these rather passive acknowledgements as to whether patient really understands the recommendation and what, if any, plans he has of how the lifestyle change might be accomplished.

8.2.5 No treatment, follow-ups and referrals

In this data, there are no consultations in which a surgeon recommends against treatment without also offering a follow-up visit and/or referring the patient back to the referring doctor or referring on to another doctor. This could be a method used by these surgeons to minimise resistance from patients, which is successful as in the six consultations in which no treatment is recommended, there is no overt resistance from patients. In extract 8.7, the surgeon explains to the patient why he might be experiencing these post-operative symptoms (i.e. they are normal) and in lines 139-40 he explains that these symptoms improve with time, which implies that there is no particular treatment that the surgeon can provide for the patient.

Ex. 8.7: IS-SP01-03

124 SG: well there's nothing obvious to see the:re;
125 PT: yep,
126 SG: i mean it feels normal, (0.6) uh:m (0.4) it's not unknown for:
127 people to get problems with nerves (0.2) after a hernia
128 operation;
129 PT: [yeah,
Here the surgeon has not yet provided any other recommendation and the patient proposes a possible explanation for his apparent good health, that he has been relaxing for quite a few days lately (line 134). The surgeon discusses another problem the patient has presented (not shown) and then reiterates that there is no treatment. Note, however, that the surgeon offers a follow-up visit to the patient. By offering a follow-up visit, the surgeon is providing the patient with an affirmative treatment recommendation and also demonstrates his concern regarding the post-operative symptoms that the patient is experiencing. In doing so, he minimizes the resistance that can often follow no treatment recommendations (Stivers, 2006).
As a secondary care doctor, the surgeon can also refer back to the referring doctor who has handed over the patient and their presenting problem. Through this, the surgeon is at least partially withdrawing his responsibility for the treatment of the patient. In extract 8.8 the surgeon lets the patient know that he will write to the patient’s GP informing her of their discussion (line 451).

**Ex. 8.8: SS-SP08-01**

451 SP: uh what’s say i drop a note to doctor gibson is she uh
452 still [your] g p [yep ]
453 PT: [yep ] [yeah] she is
((6 lines omitted))
460 SG: what i would [s:a:y graham is that we’re always= 461 PT: [six months ago.]
462 SG: =he:re, (.) if over the summer you say god this knee’s really
463 getting [on top ] of me;
464 PT: [right,]
465 PT: yeah?
466 SG: you sh:ould call the clinic?
467 PT: yep
468 SG: and say: i’m coming back to discuss getting in my e- knee
469 fixed.
470 PT: .hh
471 SG: and you can feel free to do that (.) thee clinic uh
470 just call the orthopaedic clinic a- coz you’re on the books as
471 a [patient?]
471 PT: [>yes yes yes.<
472 SG: and then you can pop back and whenever; when you decided this
473 is i- i think that (0.8) uh i like to think sometimes that
474 the:se (.) eh (.). decisions will become (0.6) easier to make
475 (.). if things deteriorate.

This surgeon also offers the patient the opportunity to return of his own volition (i.e. without a referral) if his condition worsens, an offer which is done over several turns and in considerable detail. Again, by not limiting the recommendation to no treatment, the surgeon provides the patient with positive action and thereby continues the process of treatment.
In extract 8.9, the surgeon offers diagnostic testing for one problem and to refer the patient on for another.

**Ex. 8.9: SS-SP07-02**

102 SG: what i’ll what i’ll do is i want you to have some fasting
103 lipid studies? you know your lipid profile cholesterol and triglycerides.
105 PT: mm hm:
106 SG: and they have to be fasting. i think twelve or sixteen hours?
107 PT: i’ve had those before yeah_
108 SG: ye[ah
109 PT: [yeah
110 SG: and we’ll check your calcium and repeat all your blood test
111 >i’ll also write a letter to paul worthington¿ who’s a endocrinologist¿ here in this hospital?
113 PT: mhm
114 SG: to see you about the osteoporosis. if you want;

Although here the patient has been offered treatment in the form of diagnostic testing (lines 102-4), the surgeon is attentive to the patient’s secondary problem (the medication for which caused the primary presenting problem) and offers assistance through the referral to an endocrinologist (lines 110-2). Referring on not only demonstrates mindfulness in regards to the patient’s secondary problem but also addresses possible resistance that the surgeon may face by not addressing it, particularly as it relates directly to the presenting problem.

Overall in this data there was little resistance to treatment recommendations – in only six out of 35 consultations was there resistance and in two cases this resistance was not to the primary treatment recommendation but instead in one to a lifestyle change and in the other to the no-surgery stance presented by the surgeon after he has recommended diagnostic testing (extract 8.10a and 8.12a, both of which are discussed below). By offering patients affirmative treatment recommendations, as described by Stivers (2006), offering the prospect of follow-up visits and by including referrals back to the referring doctor or on to another specialist, surgeons are able to minimise the resistance to treatment recommendations that they might otherwise encounter without such devices. Alternatively, surgeons may feel compelled to offer something with ‘face
validity’ if surgery is not indicated as the appropriate treatment. The important thing is how this alternative is formulated and possibly where it occurs in the activity of proposing next steps.

8.3 Treatment options, procedures, risks, benefits and recovery

In advice to surgeons on communication, they are encouraged to provide the patient with treatment options including discussions of benefits and risks (Tongue, Epps, & Forese, 2005). However patients report that such discussions do not always occur (Keating, Weeks, Borbas, & Guadagnoli, 2003). From the current data, we can also see that these discussions do not always occur. Treatment options (or alternatives) are only presented to one patient without prompting and risks are not discussed in all consultations in which surgery is the recommended treatment. Surgeons in this data tend to focus on the practical implications of the recommended treatment such as what is involved in the procedure, negotiating the date of the procedure and describing the possible recovery time for the patient.

8.3.1 Treatment options introduced by the surgeon

As mentioned above, in only one consultation did a surgeon unilaterally provide the patient with more than one treatment option in the consultation (that is, without further prompting from another participant). However, if the data is examined more closely, in only ten consultations would different treatment options have been a relevant point of discussion for the participants. In the 13 consultations in which the patient was referred for diagnostic testing and the six in which no treatment was recommended, different treatment options are not necessarily appropriate nor would they be expected by patients. In two other consultations there was no treatment sequence as the visits were post-surgical follow-ups and treatment was not broached by the patient or the surgeon. In four consultations, surgery had already been decided upon by the participants as the most appropriate treatment prior to the interaction.

The non-occurrence of options in the remaining ten consultations may result from a variety of influences, such as treatment already being recommended by the referring doctor, the patient readily accepting the first treatment option or no other treatment seen as appropriate by the surgeon. Unfortunately, with the data available, it is difficult to analyse why these surgeons did not present a variety of options to their patients.
(although few patients were dissatisfied with their consultation according to post-visit surveys collected as part of the Surgeon Study). In extract 8.3b, we can see how one surgeon presented treatment options to his patient.

Ex. 8.3b: SS-SP08-02

292 SG: so the x rays basically show that you’ve got arthritis in both
293     of yuh hips but much much worse on the r- the left than the
294     right,=
295 PT: =oh yeah.
296 SG: the right one looks like it’s (. ) reasonably good [but the r==
297     [mm
298 SG: =left one’s ( . ) basically had it.
299 PT: hhh
300 SG: talk and ah: (0.2) [so (. ) <the treatment options here> (0.8)
301 PT: [hh
302     uhm (. ) a- are obviously some of the things you’re already
303     doing; you’re on anti you’re on
304 PT: *mm*
305 SG: some paracetamol which is a f- ah simple analgesic works very well,
306     nhh you’re on (. ) ibuprofen which uh: (0.4) can help, (0.6)
307     talk uh (. ) physiotherapy is no use for this type [of ] hip=
308 PT: ["mm"]
309 SG: doesn’t work (1.0) uh there are many (0.6) homeopathic
310     remedies which (0.6) most of my patients try:¿ [but
311     [mm
312 SG: generally don’t help a great deal, nhh uh:m there are all
313     sorts of other alternative medicines (0.4) acupuncture
314     homeopathy (0.4) osteopathy if you’re into that sort of thing¿
315 PT: mm
316 SP: uh all those interventions are designed to be to relieve pain.
317     (0.4) they don’t improve function very much (1.0) and the final
318     thing is to put a new hip in. (1.4) now (0.4) e- >the choice of
319     course is ultimately you:rs:¿< [hhh] uh:m
320 PT: [mm ]
321 (0.8)
322 SP: but if you want to make a big leap in your mobility (0.4) the
323 only way you’re going to do that in MY opinion is to have a new
324 hip put in.
In this interaction the patient has presented with a problematic hip. After the diagnosis (lines 292-4, 296, 298), the surgeon explicitly prefaces the upcoming talk as *treatment options*. While he does present options, he does so in a way that heavily preferences surgery. In line 307 the surgeon states that physiotherapy will not help and neither will homeopathic remedies (line 312) and then he continues naming other treatments that do not improve function (line 317). By framing these options negatively saying they will not help in the way in which the patient wants them to, the surgeon sets up the next treatment option as the best option available (even though he emphasises that the choice is the patient’s in lines 318-9). The surgeon then delivers the treatment option of surgery, using the words *only* to single out the treatment and *in my opinion*, thereby using his clinical expertise to further promote the surgical option. The patient gives a minimal, continuing response (line 325) yet the surgeon does not pursue a more explicit acceptance of the treatment recommendation. The patient accepts his recommendation without reference to the other options in line 327. By juxtaposing the ineffective options with what is, in the surgeon’s opinion, the only effective treatment option, the surgeon is using turn design and sequence organisation to influence the patient’s decision making while giving the appearance of giving the patient options.

8.3.2 Treatment options introduced by the patient

Although treatment options might not be introduced by the surgeon, they may be introduced or prompted by the patient or their support person. In extract 8.10a we can see a clear example of this near the end of the consultation after diagnostic testing and a lifestyle change have been the recommended treatments.

**Ex. 8.10a: IS-SP02-01**

361 PT: “uh:m no i don't think i had any other _questions_.” (3.4) what
362 (0.4) so you got any more _thoughts_ on whether that first _rib_ 
363 _needs_ to come out or;
364 SG: .hh uh:m (0.8) yeah i mean that- th- th- (. ) the the _situation_
with taking the first rib out it's a very sort of controversial area in you know in in this particular problem.

((60 lines omitted - surgeon describes risks of surgery))

SG: My personal philosophy is that if you're getting better on the current treatment then that's great we just keep on going as is and you don't subject yourself to any further risk so that's the way I feel about it.

(1.6)

PT: yeah there's [uh my mum works at nelson hill and the] doctor

SG: [°mm°][°mm°]

there s- she was talking to him about it and he goes [awh ]

SG: [°mm°]

(0.4) the rib's gotta come out, [yeah but yeah I suppose as=]

SG: [°mm°]

PT: =yih [say people are different;]

SG: [°mm°]

you know (.). more than happy to send you for a second opinion, .hmm you can talk about those sorts of things,

(0.6)

PT: awh i don't thi- (.). (it doesn't looks like it's at that stage)

SG: so let's do an ultrasound and see what's happening .hh and then we'll talk about it some more;

PT: *yeah*

SG: *yeah*

PT: *yeah*

SG: tlk okay?

PT: yep
Here the patient asks the surgeon’s opinion regarding surgical treatment (lines 362-3). The patient does this using the negative polarity item *any*, which would allow the surgeon to easily answer *no* to the question. The surgeon does however, take up the question and describes all the risks involved with surgery (not shown), prefacing those risks with a comment that the surgery itself is *controversial* (line 366). By spending time describing the risks and characterising the surgery as controversial, the surgeon is attempting to dissuade the patient from this option. In response, the patient justifies his question, citing other medical expertise as having originally suggested the surgery in lines 433-5, which is framed as an only option (line 437). This receives delayed, minimal uptake from the surgeon and the patient softens his response by adding an assessment to his statement that agrees with the surgeon (lines 437 and 439). The surgeon uses the ideas of experience (line 442) and evidence (line 443) to support his no-surgery stance. He then offers the patient to be sent for a second opinion on the matter (line 447-9), thereby attending to the patient’s preferences in regards to treatment. The patient declines the offer and the original treatment plan of diagnostic testing is re-accepted and the sequence is closed. Using evidence in the form of a risks discussion, as well as relying on his expertise and experience, the surgeon successfully dissuades the patient from surgery while also leaving the option on the table for future discussion (line 454).^5^

8.3.3 Discussing procedures, risks, benefits and recovery

In five of the 13 consultations in which surgery is the recommended treatment, risks are not discussed at all. Risks are, however, discussed as the surgeon addresses patient pressure for surgery that is not the recommended treatment in two consultations (one of which is analysed in section 8.4.1). Often the focus of discussion is around how the procedure is undertaken and how long it will take for the patient to recover. These issues, along with administrative concerns involving scheduling and waiting lists are discussed in many of the consultations that involve surgery. In this data, it is by no means standard procedure for a surgeon to discuss the risks of surgery. This may be influenced by a variety of factors, including that some clinics employ specially trained nurses to educate patients, so consultations are pre-cursors to consultations in which

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^5^ In another consultation with the same surgeon, the patient’s wife prompts discussion of a no-surgery treatment option, which is negotiated as the preferred treatment even though the original recommended treatment was surgery (see extract 8.4).
the decision is made, the risks may be discussed directly prior to surgery and/or the risks may have been discussed previously. This is not to excuse the non-disclosure of risks, but the individual circumstances of the consultation must be taken into account prior to any judgement of the surgeon as inappropriately neglecting to impart information necessary for the patient to make an informed decision. As there is not enough data regarding the circumstances of each interaction, no such attempt to explain this absent information will be attempted. The following section describes how risks are discussed in those consultations in which risks discussions did occur.

8.3.4 Discussing treatment that has already been decided

When surgery is already the recommended treatment, surgeons may focus on discussing the procedure, the risks and the recovery process. This is the case in four of the consultations. Two other consultations also include similar procedures discussions although treatment is decided within the consultation. However the settings of these interactions differ – in two the patient is scheduled for surgery the next day and is meeting the surgeon for the first time and in the other two the patient has previously been diagnosed and recommended to have surgery at the clinic and is returning to discuss their treatment. The procedures of treatment are also discussed in three consultations as diagnostic tests are carried out during the consultations. Extracts 8.11 and 8.2b are clear examples of this process.

Ex. 8.11: SS-SP10-01
58  SG: .hh okay:; uh:m i’ve got a surgery an’ date, (0.2) that i’m
59    looking at:; (1.6) thee: seventh of december. (0.6) how’s that
60    [suit you;]
61  PT: [what day ] of the week is that.
62  SG: that’s a thursday. that’s the day i operate.
63  PT: ri:ght:_. (.) um .hh yep, (. ) okay,
64  SG: so the plan would be bringing you in to hospital?
65  PT: mhm
66  SG: on the day?:
67  PT: mhm
68  SG: .hh because this area was so sma:ll?
69  PT: yeah
70  SG: we would need to put a: fine wire [into the] area so that we=
71  PT:                                     [mm mm ]
In extract 8.11, the surgeon begins the discussion of the procedure by proposing a date for surgery (line 59), which is accepted by the patient (line 63) after an insertion sequence (Schegloff, 2007). The surgeon then describes the procedure from the point where the patient would be brought into hospital (line 64) to discharge, pain management (not shown) and a follow-up visit (lines 154-5). The patient primarily responds with continuers except in lines 73-4, where she expresses disinterest (perhaps discomfort) in hearing about the process. However the surgeon continues with the description, which may be protocol in this circumstance. The surgeon twice pursues a response from the patient. In line 87 she produces a try-marked\(^6\) okay (Sacks & Schegloff, 1979) after describing the procedure up until the actual surgery. After receiving a minimal response, she continues the description. At the very end of this sequence the surgeon pursues acceptance of the timing of the follow-up visit (line 159),

\(^6\) That is, marked with a questioning intonation.
which she readily receives from the patient. This procedure description sequence is an
example of how a surgeon might explain the surgery to the patient in a chronological
order.

Ex. 8.2b: IS-SP03-02
601 SG: =right so .hh it's it's a fAIRly straightforward operation?
602 (0.5) l:ike (0.4) like every operation ;there are (sort of)
603 risks, (0.3) er which one has to take in= so the \expected
604 outcome is that you be in hospital for ab- maybe abou- ter
605 (0.5) >i w’d think about<(0.3) four or five Day:s.
606 (0.3)
607 PT: yep=
608 SG: =ah: you be k- (0.2) you c’d go ho:me basically on a normal
609 diet with yih bowels working, (.). "okay" (0.4) "*alright,*" (0.4)
610 (0.7) with- (.). with any:: (.). bowel surgery when we’re sort
611 of jo:n two ends of the bowel together there's th- (0.3)
612 (th-) the most important thing risk of things that (uh) (.)
613 could (.). potentially go wrong is >that the< two ends don't
614 heal, (0.3) "okay" (0.3) "*alright," (0.5) now that would happen
615 in maybe: (0.5) something in the order of one percent of
616 people? (0.3) >undergoing this surg=<(a) one in a hun[dred,<
617 PT:                                                                                          [yeah,
618 (0.6)
619 SG: the bowel WOULDn't heal (0.4) absolutely perfectly an you get
620 what's called a leak, so there'd be some bowel contents w’d
621 come outs:ide, (0.6) er that's obviously a serious
622 complication:. (.). you w’d (.). need to go back to the \operating
623 theatre an’ have it all cleaned out,
624 PT: >"mm sure"<=
625 SG: *=uh:* probably with a temporary ba:ga: >have to go to the<
626 intensive ca:re unit. so (0.4) i jus’ have to war:n you about
627 >that that's< the mo:st im:portant complication (that sort can
628 s-) i- in this situation it (0.3) it's (0.4) uncommon to::
629 (0.2) yeh
630 (0.4)
631 PT: do yuh find out like (0.3) like a:fter i've left hospital?=
632 SG: =no (it= da- w’d be w’d)=
633 SG: =\[while you’re in hospital generally \] speaking
In extract 8.2b the surgeon discusses the risks involved in surgery, beginning the sequence, however, with a characterisation that the surgery is fairly straightforward (line 601). The surgeon then starts the risk discussion by briefly describing the normal situation of going home and recovering (lines 603-5, 608-9). He then details a variety of risks, that all receive agreeing responses from the patient. The surgeon uses a variety of characterisations of the risks that can seem juxtaposed to one another. The first risk is the most important risk (line 612) yet the best case scenario is characterised as healing absolutely perfectly (line 619), which re-frames the risk as less than perfect but not catastrophic, only less than perfect. Then again it is re-characterised as a serious complication (lines 621-2). By using these different, opposing characterisations the surgeon utilises turn design to attempt to minimise the potential concern or even panic that a risks discussion may invoke while at the same time not diminishing the seriousness of the risks involved. The surgeon ends his explanation of the risks by
restating the likely ‘no problem’ outcome of the surgery. This risks discussion is an example of how a surgeon might present the risks involved in surgery in a way that attends to both the potential fear that such a discussion might cause and the importance of relaying this information to the patient.

8.4 Resisting the treatment recommendation

In this section I focus on two examples: one in which a patient pursues unsuitable treatment which is resisted by the surgeon and another where a surgeon reverses his treatment recommendation. In primary care acute visits, there is a normative constraint on physicians to secure the acceptance of the treatment recommendation prior to closing the activity (Heritage & Sefi, 1992; Stivers, 2005). This normative constraint also seems to hold true for surgeon-patient consultations. Patient resistance to a treatment recommendation invites negotiation of that recommendation between the participants (Heritage & Sefi, 1992; Stivers, 2005) and is evidence that patients have agency within consultations.

Resistance to treatment recommendations can be passive or active. Patients who use silences or continuers can be seen as offering passive resistance as they are not accepting the treatment recommendation (Stivers, 2006). Patients can also overtly contest the recommendation, which is active resistance (Stivers, 2006). As Stivers notes, “active resistance is stronger than passive resistance because it initiates new sequences and thus makes a response from the physician conditionally relevant” (Stivers, 2006, p. 298). As acceptance of the treatment recommendation is necessary for the progressivity of the consultation, a doctor pursues acceptance through a variety of means. Surgeons in this data, similar to those in primary care research (Stivers, 2005), pursue acceptance through modifying the treatment recommendation, reiterating their evidence for the proposed treatment, restating their recommendation or using devices such as tag questions to encourage an aligning response. Responses to resistance can include concessions, alternative treatment or reversals of recommendations, all of which could potentially have problematic medical outcomes if the accepted recommendation is unsuitable or inappropriate (Stivers, 2006).

By initially offering more than ‘no treatment’ to those patients for whom a diagnostic or surgical treatment cannot be recommended (that is, by recommending referrals and
follow-up visits), surgeons in this data generally avoided patient resistance to treatment recommendations. Yet in six consultations, even though the surgeon recommended a particular treatment, patients resisted the recommendation, either passively or actively. The two consultations analysed below demonstrate the different ways that surgeons manage resistance and how patients can influence the treatment recommendation being made by the surgeon.

8.4.1 Resisting patient pressure for unsuitable or inappropriate treatment

In extracts 8.12a – 8.12h, the patient is pursuing surgery as treatment for her chronic constipation, nausea and bloating. This sequence is examined in detail here as it shows what happens when the patient persists in resisting the surgeon’s recommendation over several minutes (the consultation lasts for around 45 minutes in total). However, the surgeon is reluctant to perform surgery on the patient as it could potentially make her quality of life poorer than it is now (though the patient remarks a number of times how poor her quality of life currently is). The surgeon attempts to dissuade the patient from surgery as the patient pressures the surgeon for treatment.

Ex. 8.12a: SS-SP03-06

651 PT: i mean i would like the surgery if i can have it i wanna be
652 normal. an’ [ehhh hah]
653 SG: [yeah but] but [that’s the thing it’s it’s not]=
654 PT: [i know a bag’s not normal. but]
655 SG: =gonna (0.2) [y’know an uh all your symptoms dizziness (.]=
656 PT: [i’m
657 SG: =an’ nausea an’ stuff like that it’s not gonna help you with
658 that it might help with the constipation but
659 PT: mm
660 SG: and the bloating but it’s not going to help with .hh all those
661 other things. [i’m pretty sure.
662 PT: [i mean i’m i’m i’m attributing all that to the
663 constipation. uh that’s all i can think that [would be]=
664 SG: [well i i]
665 couldn’t i couldn’t ge- you know i think it’s important to say
666 i couldn’t give you a guarantee about that;
667 PT: mm
668 (2.2)
669 SG: and even (yeah:) i think we haven’t there are lots of issues
670 we have to discuss here i don’t want to s- y’know to think
671 s- surgery’s you know quick (.) quick operation’s going to
672 fix everything up and you’re going to be (0.6) you know;
673 PT: mm

The patient first raises surgery as a possible treatment in line 651. Treatment at this stage has not been discussed and at this point the surgeon is part way through the physical examination of the patient. Treatment negotiation now takes up much of the rest of the consultation. The patient presents quality of life as the reason for desiring surgery, saying *i want to be normal*. She also orients to the delicacy of directly requesting treatment, particularly in a sequential environment where treatment recommendation is not yet expected, using the interactional resource of laughter, *ehh hah* in line 652, to signal this (Jefferson, 1985). The surgeon challenges this by noting that surgery would only treat one of the patient’s presenting problems not all of them (lines 653, 655, 657-8, 660-1). This is countered by the patient as she posits a candidate diagnosis of her problems, namely that they are all related to chronic constipation (lines 662-3). The surgeon re-iterates that surgery is not likely to be the solution (lines 669-72) and returns to the examination without acceptance from the patient that surgery is not the recommended treatment.

**Ex. 8.12b: SS-SP03-06**

682 PT: when i go to the toilet it’s only at very short notice?
683 SG: yeah i [mean] that’s that’s the other thing i mean if we do an=
684 PT: [i’m ]
685 SG: =operation an’ an’ you’re incontinent it could be .hhh=
686 PT: =mm
687 SG: still have all your symptoms and just but but no control and
688 that would be a disaster. >so i think you need we all need to
689 think it [thr]ough very c(h)are(h)fully before_
690 PT: [mm ]
691 (1.0)
692 SG: =yeah (1.4) so that problem of having to like urgenc- having to
693 rush to the toilet i mean (.) do you [(do you f:-)]
694 PT: [i get about ] if i need
695 to i can hold o:n? i i can¿ .hh but (1.0) generally if i need
to i just do it right there and then as though i got th- three minutes maybe ay .hh hah hah [i’l kick some]one else out =

SG: [yeah (       )]

PT: =of the toilet [so i can go but]

SG: =see the problem] is with any surgery it’s gonna make that worse;  

PT: mm

In extract 8.12b, the patient presents another symptom within the examination. The surgeon uses this symptom to further his argument that surgery would be an inappropriate treatment (line 683, 685, 687-9). In response to this, the patient retreats from her initial statement saying that if she needs to she would be able to hold on. The surgeon continues his explanation, but just as in extract 8.12a, there is no resolution to the sequence as the patient does not accept the no-surgery recommendation, instead giving weak acknowledgements.

Ex. 8.12c: SS-SP03-06

SG: .hh i mean in terms of the s’rtev you know the surgical options the sort of things we give s- people with severe: (0.2) severe constipation; .hhh we tend to do it on people w- who who’s main problem is is just the constipation without pain; >[coz]=

PT: [°mm°]

SG: =people with pain the pain seems to persist afterwards; >an’ .hhh thee th- th- also the (1.6) a lot of your other symptoms like the nausea and dizziness

PT: “mm”

SG: you know i’m not i’m not sure how they whether they would improve or not with .hh >but but< but certainly the concern about ha- you know having urgency and and and having a leakage i- if we were to shorten the bowel which is one of the options for people with s- what we call slow transit where things taking an awfully long time to get thr[ough;,,] .hhh uh:m you=

PT: [“mm” ]

SG: =know i- i- that that problem with having to to run to the toilet that that’s going to be made significantly worse coz your bowel’s actually going to be on the loose side; [yeah]

PT: [°mm°]
Following further discussion regarding the symptom (not shown), the surgeon returns to the discussion regarding surgery. In this sequence he begins with a different tactic, this time using what clinical indications make surgery a recommendable option not just for him but for his colleagues as well. He uses the word we several times, thus aligning himself and his viewpoint with those in his field of expertise. Again, the patient responds with continuers until line 753 where she refers back to her lifeworld concern of the lack of normalcy in her life, which she attributes to this problem. This is followed by laughter, highlighting again the delicateness of what is being said (Jefferson, 1985). The laughter is not interspersed through the talk; as it is positioned directly after the presentation of a lifeworld concern as a motivation for surgery, the laughter acts upon the directly preceding talk.

Ex. 8.12d: SS-SP03-06

753 mm (2.0) would i have like a chance at a normal life th(h)ough
754 huh huh huh .hh huh huh.=
755 SG: =well not if you’re leaking [you won’t you won’t $thank me=
756 PT: [huh huh i mean
757 SG: =f(h) (h)if(h) i do an operation$ an’ you can’t hold on you’re
gonna be in a y’know (yih gonna be) that’s not gonna be [good]
758

Ex. 8.12d: SS-SP03-06

755 SG: =well not if you’re leaking [you won’t you won’t $thank me=
756 PT: [huh huh i mean
757 SG: =f(h) (h)if(h) i do an operation$ an’ you can’t hold on you’re
gonna be in a y’know (yih gonna be) that’s not gonna be [good]
758
759 PT: [what]
760 about colostomy as an option is that an option for me?
761 SG: .hh (1.0) hhhh a colostomy is not gonn- if you just had a
762 colostomy i still think you’re gonna be: constipated.
763 PT: mm (0.6) or ileostomy? or someth(h)ing .hh huh it’s coz um
764 doctor malcom did say that that would pro- probably be the most
765 likely option; .hh um (1.4) surgery-wise but=
766 SG: =hhh
767 PT: >i mean i’m not i’m not a surgeon i don’t know anything about
768 it i’m just< grasping [at straws here >huh huh huh .hh huh<]
769 SG: [the problem the problem the problem] the
770 prob- th- the these these sort of operations they for
771 functional bowel disorder; so it’s not [like] we’re taking=
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772 PT: [mm.]
773 SG: =out there’s a tumour or something we’re taking out and we’d
774 just (join it all together) in everything’s gonna be fine;
775 PT: mm.
776 SG: the they’re very: (.) the outcomes are (0.4) not always
777 predictable.
778 (1.4)
779 PT: *mhm*
780 ((21 lines omitted))
781 PT: tlk i mean i have put up with a lot so far; (.) and i can put
782 up with other things i know that_ (0.8) um (0.2) but i’m gettin
783 to the point where (2.0) it’s getting difficult it really is
784 getting difficult i’m gettin depressed i’m gettin
785 SG: mm:=
786 PT: =this poor [thing] has to live with me an’=
787 SG: [mm]
788 PT: =i know [i i guess it’s it’s ] trying to work out what .hh w:=
789 SG: =my poor daughter an’]
790 PT: =what is the problem is is it just it’s it’s i- trying to
791 work out what the underlying problem is [is] is it is the
792 SG: [mm]
793 PT: =constipation (1.8) really causing these other s:ymp- are they
794 secondary symptoms¿ >in which case they might improve if you
795 sort out this constipation? o[r]

Continuing directly from extract 8.12c, in extract 8.12d the patient suggests a particular type of surgery as possibility for treatment, which receives a delayed, disagreeing response (line 761-2). The patient uses her referring doctor to strengthen her position, stating that it would be the most likely option adding on after a pause surgery-wise. She receives no uptake from the surgeon and so retreats from a position where she demonstrated knowledge to one where the epistemic difference between the two participants (as expert and layperson) is maintained (lines 767-8). The patient returns for a third time in this consultation to her lifeworld concerns, stating that it not only affects her (lines 799-802), but also her partner (line 804) and her daughter (line 807). In response, the surgeon does not focus on the patient’s lifeworld concerns but instead relies on fact that the process of diagnosis is not yet complete, as another reason not to have surgery.
Ex. 8.12e: SS-SP03-06

845 SG: there are lots of yeah i mean i think hhh i think that before
846 we contemplate any major s(h)urgical (h)intervention we
847 kinda need to kn- know a bit more about .hh i mean you we need
848 to have a look down and make sure you (just) you haven’t got
849 any .hh bugs in your stomach, it that you’ve got no stomach
850 ulcers, i mean i think a few things we need tuh .hh [kinda do=
851 PT: [(alright)
852 SG: =before any [kind] of surgical intervention; you know i mean=
853 PT: [yep ]
854 SG: =we need to know more about what what’s going on you’ve got so
855 many symptoms .hh i don’t think (..) you know just ay ay quick
856 operation’s gonna fix you up [really? i think it’d=
857 PT: [(okay
858 SG: =[be too simplistic] you [know?]
859 PT: [hhhhuh huh .hh] [yep ]
860 (0.8)
861 PT: **"mm**
862 SG: i think clearly the bowel (.) motility’s abnormal¿

In extract 8.12e, which is preceded by a discussion of the patient’s symptoms and of
the possible diagnosis, the surgeon returns to the topic of surgery as the patient has yet
to accept the no-surgery recommendation. The surgeon is pursuing acceptance by
educating the patient about his diagnostic reasoning. He nominates several other
possible causes for the patient’s symptoms (lines 849-50), which further weakens her
argument for surgery. This proposal implies further diagnostic testing, which is finally
accepted by the patient (lines 851, 853). The surgeon also acknowledges that the
patient has a problem (line 862) and continues to explore the diagnostic uncertainty and
multiplicity of presenting symptoms that makes surgery, at present, an inappropriate
option (not shown).

Ex. 8.12f: SS-SP03-06

880 SG: and whether you’re gonna be incontinent >and if you are
881 incontinent the options then are fairly limited coz you’ve
882 taken your colon out; [.hh]=
883 PT: [mm ]
884 SG: =you know you (..) one of the options then you’re gonna live
with a bag for the rest of your life; you know and that’s a pretty (.) big (.) thing for sort of a=

[“mm”]

twenty eight year old to have to contemplate.

PT: mm (. ) i am prepared to do it though,

SG: ye(h)ah huh huh (h)yea(h)h .hh $you are at the moment; but$

yeah .hh you know (      ) yeah when it you’ve obviously given

it some thought but i [i] i don’t i don’t think we should=

[“mm”]

oversell surgery until we know (0.4) really that it is the

last option because it’s a [once] you’ve taken that step you=

[mm    ]

SG: =can’t there’s no going back; [you know]

PT: [yeah no ] yeah no i

understand that;

Extract 8.12f follows soon after the previous extract. Here the surgeon focuses more on the patient’s lifeworld concerns; that is, that surgery may in fact worsen the problem and could result in lifelong complications. Using the patient’s age, the surgeon attempts to highlight the gravity of the decision. However the patient counters this in line 889, stating that she is prepared for the risks. Confronted by the patient’s determination, the surgeon acknowledges the patient’s role in the decision making process (lines 891-2), but goes on to emphasise that surgery is irreversible. Here we see an acceptance from the patient, although it is responsive to the statement regarding the irreversibility of surgery rather than the no-surgery treatment recommendation.

Ex. 8.12g: SS-SP03-06

i- i’m not ent-t-i-rely clear in my own mind whether all

symptoms are i- it’s

mm

due to bowel or not; >i think .hh that it that there’s

a few things i’d like(h) (t- tanya) to look at. you know i

think we need to be we need to be we need to do an upper g i

endoscopy?

mm

and check you up making the helicobacter which is a bug you

can carry in the stomach an’ an’ an’ that needs to be sorted
The surgeon and patient then discuss other treatment options for the patient to try in order to alleviate her symptoms. The focus then returns to the incomplete diagnosis, with the surgeon recommending diagnostic testing as the next step for the patient (lines 974, 976-9). With no uptake from the patient, the surgeon pursues it by raising the possibility that surgery could be discussed again after the testing (lines 981-3). This concession by the surgeon is unsuccessful at eliciting acceptance from the patient. Instead of further concessions, the surgeon instead reverts back to discussing the risks of performing unsuitable surgery and the effect that would have on the patient’s quality of life. Again, the surgeon’s explanations are met with silence or minimal responses. The surgeon then continues to re-iterate the importance of confirming a diagnosis and viewing surgery only as a last resort option (not shown).

Ex. 8.12h: SS-SP03-06

1056 SG: .hh kay can i er w- i- i’ll need to bu- d- we don’t we don’t want to rush into this i think you know i know it’s it’s it’s a terrible to have to to "you know" to deal with but i’d reg
1059 PT: mm
1060 SG: i don’t want to be sort of cornered in saying you know you’ve gotta do something and >(then forced to do s- that)< then re-
1062 actually do we a:ll regret it later on; [so] i think it’s=
1063 PT: [mm]
In extract 8.12h, which occurs after more talk regarding symptoms, the surgeon co-implicates the patient in the desire not to rush, by using we (line 1056) and then also expresses sympathy for the patient (line 1057). The patient delivers another continuer (line 1059), thus not aligning with the surgeon’s attempting at co-implication. The surgeon then expresses his reluctance to perform unsuitable surgery, using the general you, so as not to directly accuse the patient of pressuring him (lines 1060-2). The
patient does not accept the no-surgery treatment here, but instead states that she understands the surgeon’s perspective (line 1073). The surgeon pursues acceptance again by emphasizing that they (the doctors) want to help (line 1075), but that surgery may be something they (the doctor and the patient) might regret (line 1078). This receives uptake from the patient who acknowledges the surgeon’s concern (line 1084), but still does not accept the no-surgery recommendation. This is the final sequence in which the inappropriateness of treatment is discussed yet still the surgeon does not receive acceptance of the no-surgery recommendation. There is no alignment in regard to surgery as treatment. Despite this, the surgeon continues on to arrangement making and closing all the same, perhaps because the normative constraint had been addressed by the acceptance received for the treatment recommendation of diagnostic testing.

In the face of ongoing pressure for inappropriate treatment, the surgeon employs a variety of strategies, such as recommending other testing and noting that the diagnostic process is incomplete, to obtain the patient’s acceptance of the no-surgery recommendation. Although this plays out across much of the second half of the consultation, the surgeon finally moves towards closing after line 1094 (not shown).

8.4.2 Reversal of a treatment recommendation

Stivers found that “complete reversals in treatment recommendations are rare” (2006, p. 292), and even in extracts 8.10b – 8.10e, the surgeon modifies his recommendation significantly without reversing it completely. That is, across the consultation analysed below, the surgeon and patient renegotiate the strength of treatment recommendation. In this consultation the patient asks the surgeon for a second opinion regarding a treatment recommendation he received from another doctor (lines 55-6).

Ex. 8.10b: IS–SP02–01

55 PT: one thing that he did say (0.6) was that i should _ _ never do upper _ _ body weights again in my life?
56     SG: *mm mm*
57 PT: is that something you agree with?
58 SG: uh:mm nhh well it it (0.6) i mean that that that would just be: (0.4) commonsense (. ) advice; >i mean .hh we think that it's thee (. ) thee the weights and the upper body development that's
caused this problem.

PT: mm hm

((17 lines omitted))

SG: and s- you know so commonsense would would tell you not to

do (.). not to do it anymore; s- and you know to sort of develop

.hh some other (.). area of interest [(than i mean) that sort of=

PT: [yeah i mean

SG: =thing you know um .hh e- e- (.). basically you've got a tendency

(1.0) um to f- to have that problem it may happen on the other

side for example? (0.2) if the vein on the right side clears

(0.2) again it may well happen again [on that side;

PT: [yeah

There is initially no uptake from the surgeon until the patient directly asks for his opinion
(line 58). The surgeon educates the patient regarding the diagnosis, citing commonsense twice as the source of such a recommendation (lines 60, 80). This
implies that he agrees with the original recommendation. He does not, however, overtly state that the patient should never lift weights again or that he agrees with the other
doctor. While the patient gives an affirming response (line 88), sequentially it occurs
during patient education regarding the diagnosis rather than the treatment recommendation.

Ex. 8.10c: IS-SP02-01

PT: so i mean o' course everything you read these days is

SG: mm

PT: like you always hear oh you know your muscles degrade so it's=

SG: =mm=

PT: =good to some resistance [so that you got some muscle=

SG: [yeah

PT: =there to [help your metabolism and all that sort=

SG: [mhm

PT: =[of thing?

SG: [yeah sure sure_

PT: = so with the ah: i mean it (0.4) you know that (0.4) sort of

thing out of the [question;_

SG: [mm yep

PT: what i mean what *(will you (.). do)*
Further discussion regarding the diagnosis ensues and the participants move to the physical examination, at which point extract 8.10c occurs. In this sequence, the patient pursues a modification of the no-weightlifting recommendation through the use of evidence. This evidence is everything you read (line 172). The surgeon agrees with the patient that resistance training is important (line 181), but does not offer a modification on the original recommendation. Again the patient pursues this with a direct question asking for advice (line 185 and 187). There is a significant delay before the surgeon requests clarification, which is delivered by the patient in line 191. Instead of answering the patient’s question from line 185, the surgeon instead asks more about the injury, which is followed by further diagnostic talk and a description of what the surgeon is seeing in the examination (not shown). The second pair part to the patient’s question in line 185 is noticeably absent.

Ex. 8.10d: IS-SP02-01

217 SG: _basically what i'd like to do now is to do a um an ultrasound=
218 PT: =mhm=
219 SG: =scan of your vein just to see where we're at in terms of (.).
220 uh:m the vein being blocked or (0.4) being cleared or (0.2)
221 jst just exactly what's happening in that area that jst jst
222 gives us a bit more information.
223 PT: mhm?
224 SG: tlk uh:m .hh and i'll catch up with you: (.) after you've had
225 that done .hh (1.6) the reason i'd say that (0.8) you should
226 uh:m you know (..) do much less (0.2) upper body body building
227 is because of a a _fear that you may get the same problem on the
228 other si:de. (1.0) the right side vein is blocked (0.6) and it
229 stays blocked (..) and probably there's no _reason .hhh why you
230 can't resume body building (..) on that side because (1.2) if
231 it's block _there's no (..) vein to block off in the future;
232 (0.4) but i i would have _fears for the other side that the same
process may occur; and it and it may be that the fractured (.)
clavicle sort of contributed to the whole thing. [and that= 
PT: [mm hm
SG: =that you know y- you’re not going to get it on that left side
anyway. .hhh uh but we don’t know that.
PT: "you don't know {} 
SG: [you know and the thing is yeah you jus- it's
just commonsense you don't want the same thing happening
again. and uh:m (1.0) you know so:
PT: hhh
SG: it it would seem sensible to think of something else to do,
you know some other .hh uhm nhh [<exercise.> [yeah]
PT: [yeah that's fine. [yeah] but
what about just maintaining muscle to y’know (.) as you get
older [t-
SG: [yep sure i mean you know e- anything in moderation's
fine. yeah yeah you know so .hh but in in terms of really
beefing up the weights it's [probly probly sure "yeah yeah"
PT: [(an’ i was never really doing that
anyway,)  
SG: "yeah .hh yeah° i mean th- th- there are there are no: (.).hh
uh:m .HH tlk you know th- it- it's not black and white
situation. th- there are- you know i can’t (.) tell you just
(.). don't ever lifts weights, y’know because that's not the
case, you can do (.). prob- you can probably do some, .HH uh::m
but probably le- y’know less than what yuh did;
PT: "*(right)°°
SG: so whatever that is;

In extract 8.10d, the surgeon recommends diagnostic testing as the next step in the
treatment process (lines 217, 219-222). The patient receives this with a continuer and
the surgeon continues his recommendation with an offer of a follow-up visit (lines 224-
5). Significantly, this is followed by a 1.6 second pause, through which the patient
passively resists the treatment recommendation (Stivers, 2005). The surgeon then
returns to the original treatment recommendation discussed in this consultation,
perhaps acknowledging the incompleteness of the sequence by doing so. Notice how
the surgeon here uses slightly more technical language than previously. Earlier in the
consultation, the surgeon used the word *collarbone* (not shown) but in line 233 here he uses *clavicle*. By choosing to use more medical terms and ways of describing the diagnosis, the surgeon is emphasizing his role as the expert and his epistemic advantage over a patient who has already demonstrated some health literacy in extract 8.10c.

In lines 245-6 the patient modifies the treatment recommendation – instead of weightlifting or body building, the patient would like to maintain muscle mass. This refocuses the recommendation away from a sport-oriented pastime to a health-oriented concern. The surgeon agrees with this modification of the treatment recommendation, though emphasizes that it must be in moderation (line 248). Interestingly he also maintains his role as expert in the consultation by stating that the situation is never black and white (line 252). It appears that the participants have interactionally aligned regarding the recommended treatment.

**Ex. 8.10e: IS-SP02-01**

291 SG: you know so it's it's a it's a (.). complex sort of anatomical
292   area that it's all going through .hh and (.). as i
293   say there's no absolutely right or wrong answer. (1.0) uh:mm but
294   commonsense will tell you [that if somethi- y'know (0.8) if=
295   PT:                   [mm
296 SG: =doing the weights: (0.6) probably a combination of the
297   clavicle fracture has brought this on (.). then (0.6) don't do
298   as much (0.4) in the future mm
299 PT: ["alright."
300 SG: [but obviously you'd y- you know you'd need to maintain muscle
301   be bulk and exercise and do all that sort of [stuff and .hh
302   PT:                                      [oh yeah i'm back
303   to running [and things like that. ]
304 SG:                                               [yeah yeah exactly yeah] .hh yeah and you know
305   you're going to run y- you perhaps you want to run with weights
306   or wh- whatever whatever .hhh you know suits basically, mm
307 PT: and uh:mm (0.6) tlk so from here to the ultrasound and then
308   [(back to) see you again.
309 SG: [mm

252
The surgeon soon reiterates the ambiguity in regards to this type of recommendation (line 293), but then supports the patient’s previous statements by encouraging a return to physical activity (lines 300-1). The patient then implicitly accepts both treatment recommendations, the modified lifestyle change and the diagnostic testing, by moving towards a confirmation of the treatment recommendation that he earlier failed to accept (lines 307-8).

The careful negotiation between the two parties was managed as each participant moved from the polar opposites of treatment recommendation to a compromise. Although this is not a complete reversal of treatment recommendations, it shows how patients are able to have agency within the treatment recommendation activity of consultations and how the participants work together to interactionally align on a treatment recommendation.

8.5 Conclusion

Charles and colleagues argue that “the patient preferences literature provides only a partial answer to the question of what role patients want to play in treatment decision-making because it fails to consider that preferences may be situationally determined, and hence, subject to change” (1997, p. 687). To extend this premise, I argue that the role of both patient and surgeon (as well as the roles of other participants present) in the decision making process are sequentially determined through the course of the treatment activity and the overall interaction. Patients and doctors orient to the sequential structure and relevance within the consultations in order to negotiate the treatment recommendation. This is evidenced by the normative constraint of patient acceptance of treatment recommendation prior to advancement to the closing of the consultation found in primary care interactions (Stivers, 2005), which has also been found in surgeon-patient interactions in the present data. Patients are not usually overtly offered participation in this sequence; however they are given agency through the normative constraint that requires doctors to gain acceptance of their treatment recommendation prior to closure of the sequence (Heritage & Sefi, 1992; Stivers, 2005). This can lead to a modification of the treatment recommendation or at least the offer of further discussion on the topic.
Chapter 9: Closings

ACTIVITY 6: Closing the consultation

9.1 Introduction

Closing an encounter is a co-constructed activity through which participants terminate verbal and non-verbal action in a way that allows each to raise any matters they wish prior to the termination of the encounter (West, 2006). Although medical encounters are often time restricted, the scheduled length of the appointment “does not determine just when or how such a visit will be brought to a close” (West, 2006, p. 379). There are, however, points within the consultation where closing becomes a relevant activity. That is, as surgical visits are generally monotopical (Schegloff & Sacks, 1973), we can therefore expect closing to become the next relevant activity after the presented problem has been resolved in some way (even if there is no treatment).

In primary care, the transition between the treatment recommendation (or proposing next steps) and the closing of the consultation is a point at which patients can raise additional concerns either about the current diagnosis and proposed treatment or an altogether different health concern (Robinson, 2001). In surgeon-patient consultations in New Zealand, however, a patient is often referred for a single problem within the realm of the surgeon’s expertise, rather than having self-referred with a possible multitude of problems. Also in contrast to primary care closings, such as those described by West (2006), surgeons and patients usually do not have a standing relationship, particularly in public hospital clinic settings. These differences alter the way in which surgeon-patient consultations close when compared to how they are closed in primary care consultations. As in primary care, the way in which surgeon-patient consultations are closed is also influenced by the recommended treatment, including whether the patient is expected back for a follow-up visit or will be referred back to the referring doctor or on to another doctor.

Even in primary care consultations, there have been few studies of the closings of doctor-patient consultations (West, 2006). Those studies that do exist have found that
in closing consultations, the participants utilise the techniques used in mundane conversation, specifically the pre-closing sequence. These techniques include arrangement making, which is also often used in clinical settings. In contrast to mundane conversation, however, it is most often one participant, namely the doctor, who initiates the move towards closing the consultation. In this chapter, I begin with a description of pre-closings in both mundane and medical interactions. I then examine the various ways in which pre-closings are achieved by the participants in this data, followed by a consideration of the responses made by patients to pre-closing activities.

9.2 Data analysis

The closings of all 35 consultations were analysed in this chapter. The shift to ‘closing’ was determined by either the occurrence of pre-closing activities or by the end of the activity of treatment recommendation (at which point closure is the next relevant activity (Robinson, 2001)). The methods of data collection may have affected the closings. In the data collected as part of the Interaction Study, the research nurse was sometimes asked by the surgeon to come in to switch off the recording equipment. In the data collected specifically for this study, I had requested to speak to patients directly after their appointment, which meant they always stayed in the clinic room so they could talk to me. This was sometimes discussed during the closing of the consultation. However, any differences appear to be limited to content of the closings and whether the patient stays in the room or not, rather than the techniques used by the participants to close the consultation.

9.3 Closing interactions

The problem of closing an interaction is that the participants together must in some way suspend the ongoing relevance of turn-taking rules (Schegloff & Sacks, 1973). The co-participants in the interaction do not merely say goodbye or some other form of farewell exchange, but instead work together to suspend the turn taking rules through what is known as pre-closing (Schegloff & Sacks, 1973). Possible pre-closings (‘possible’ as they may not in fact lead to the closing of the interaction) allow the participants to build towards closure. That an interaction can be extended beyond a possible pre-closing demonstrates how this adjacency pair sequence allows for co-participants to raise
previously ‘unmentioned mentionables’\footnote{A previously ‘unmentioned mentionable’ refers to something which a participant may wish to bring up in a conversation but has not had the chance to do so. The pre-closing allows an interactional space for such talk to occur should a participant wish to bring it up (Schegloff & Sacks, 1973)} prior to closure (Schegloff & Sacks, 1973). Without this pre-closing sequence, the participant who produces a goodbye may not be understood as doing so in the service of closing the interaction (Robinson, 2001). When a pre-closing sequence has been successfully co-constructed by the participants, then the consultation is possibly complete (West, 2006).

There are different techniques for initiating a possible pre-closing sequence, some of which are specific to the participants’ roles in the interactions (e.g. the caller versus the called in telephone calls) (Schegloff & Sacks, 1973). According to Robinson, “it has been widely documented that, in both mundane and institutional contexts, the general action of arrangement making – especially when the arrangements invoke actions that will be accomplished after the current interaction is terminated – is socially understood as a last topic” (Robinson, 2001, p. 642). In medical interactions, arrangement making is often the re-iteration of treatment recommendations which are now presented in the possible pre-closing as plans rather than proposals (West, 2006).

Robinson (2001) identified two practices of pre-closing in primary care: final-concern sequences, such as any questions or anything else, and arrangement making sequences, as described above. The former, although often designed to elicit no-type responses (Heritage, Robinson, Elliot, Beckett, & Wilkes, 2007), directly allows the patient to raise new concerns (Robinson, 2001). The production of the latter, that is arrangement making, unlike final-concern sequences, “does not provide patients with a formal opportunity to topicalize new concerns” (Robinson, 2001, pp. 651-652). While the two different types of pre-closings have different sequential implications for patients, they are not mutually exclusive and can easily both occur in the same consultation (Robinson, 2001).

By producing either type of possible pre-closing, the doctor provides the patient with an interactional opportunity, even if not formally, to raise previously unmentioned issues, whether they are questions regarding treatment or diagnosis or even new problems. In studies of primary care consultations (White, Levinson, & Roter, 1994; White, Rosson,
Christensen, Hart, & Levinson, 1997), patients raised new problems at the end of between 21% and 23% of consultations. However, as noted above, the raising of new problems by patients at the end of consultations is less common in surgeon-patient consultations and in fact does not occur in any of the consultations in this data. This data also demonstrated that surgeons can also add more after pre-closing, something which also occurs in primary care (West, 2006). Having briefly described the way in which both mundane and medical interactions are generally closed, I now move on to describe specifically how they are closed in surgeon-patient consultations, focussing particularly on the different types of pre-closing.

9.4 Pre-closings in surgeon-patient consultations

Arrangement making can assist continuity of care in surgeon-patient visits but in a different way to that which has been described for primary care (West, 2006). That is, through arrangement making the surgeon may re-iterate the treatment plan but may also let the patient know where the next point of treatment is – either back to the surgeon for a follow-up visit, on to the referring doctor or general practitioner as the surgeon refers back, or to another surgeon or specialist as the patient is referred on. In the surgeon-patient consultations in this data, there were a number of ways in which pre-closing was initiated. As noted earlier, the different types of pre-closings in surgeon-patient consultations, primarily involving arrangement making of various types, are not mutually exclusive, with often more than one occurring during the pre-closing sequence. These pre-closings do not differ significantly in structure from those in primary care consultations, only in the types of arrangements that might be made. The likelihood of referring to the next point of treatment for the patient is also increased compared to primary care consultations as part of the process of clinical handover and discharge.

There are seven types of surgeon-initiated pre-closings found in the present data. These are: final-concern sequences; arranging surgery; referring back; referring on; arranging diagnostic testing; organising a follow-up; and instructions regarding front desk paperwork. There is also one instance of patient-initiated possible pre-closing, which is also described below. In the next sections, I discuss the types of pre-closings used by surgeons and patient, followed by an analysis of the types of non-minimal responses that can be produced by patients.
9.4.1 Final-concern sequences

Final-concern sequences in surgeon-patient consultations differ from those described in primary care (West, 2006). These sequences are not about other presenting problems, as an anything else question sequence might be, but instead these sequences are produced in regards to the presenting problem, its diagnosis and treatment, as seen in extract 9.1. This is due to the generally monoptical nature of surgeon-patient consultations.

Ex. 9.1: SS-SP-08-02
364 PT: thank you,=
365 SG: =alri_ght? do you have any __questions. or worries.
366 PT: ↑ no
367 SG: no (1.6) tlk alright¿ .hh you’ll be (.) uh in hospital for
368     about four days?
369 PT: mm

In extract 9.1, immediately after the activity of treatment recommendation is complete, the surgeon asks if the patient has questions in line 365. Although the patient says no, the surgeon then talks about recovery from line 367 (not all shown). In this consultation the possible pre-closing does not move to closing as the surgeon returns to talk regarding the treatment recommendation. The placement of the surgeon’s question after the initial activity of treatment recommendation, and the no-preferring design of the question with the use of the negative polarity item any, indicates that the surgeon’s turn was designed in the service of pre-closing. This type of pre-closing technique is often used in conjunction with other techniques, such as arranging surgery, arranging diagnostic testing and terminal exchanges, whether there be intervening non-pre-closing talk or not.

9.4.2 Arranging surgery

Arranging surgery is a form of pre-closing that is a re-iteration of the treatment recommendation; however it is formulated as a plan in pre-closing rather than as a proposal as is done in treatment recommendation (West, 2006). Arrangement making differs from treatment recommendations as this type of pre-closing involves re-invocations of arrangements already made and agreed upon during the treatment recommendation activity (West, 2006). Often in the (possible) pre-closing the doctor will
upgrade the treatment proposal made in the activity of proposing next steps to a treatment plan (West, 2006), as seen in extract 9.2a.

Ex. 9.2a: SS-SP-12-01
144 SG: any questions you’d [like to ask me about?
145 PT: [can’t get any worse than what it looked like [when it was all pus-y reh heh heh=
146    SG: [oh:kay
148 PT: =[heh hh
149 SG: [$good stuff$ .hh well i’ll uh (..) get your details on
150 the on the list and i think the nurses may come back with a
151 form for you to fill in;
152 PT: mm [hm
153 SG: [and then we’ll let you on your way today? okay?
154 PT: oh:kay=]
155 SG: =and i’ll bring you a _form for those blood tests, [alright?]
156 PT: [mm hm=]
157 SG: okay. [((voc))
158 PT: [thanks.

In this extract, the surgeon begins the pre-closing with a final-concern sequence in line 144, which receives an extended, although joking response. The next part of the pre-closing sequence occurs in lines 149-151 and is arrangement making regarding surgery, followed by arrangement making regarding diagnostic testing (line 155). This extract, which is analysed further in section 9.5.1, shows that more than one type of pre-closing can occur during the sequence, even when there is possible uptake by the patient (line 154) that would make closure (that is, some kind of terminal exchange sequence\(^2\)) the next relevant action.

9.4.3 Referring back

Referring back is a type of pre-closing technique uniquely available to surgeons (and most likely to other specialists to whom a patient might be referred). This involves an overt statement regarding the patient’s referring doctor, often the general practitioner,

\(^2\) A terminal exchange sequence is where participants conclude a conversation with a sequence that signifies the termination of the interaction, usually with words such as “goodbye”, “bye” or “see you later”.

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and that the surgeon will write him a letter. Extract 9.3 is an example of this type of pre-closing.

**Ex. 9.3: IS-SP01-04**

179 SG: alright? (0.2) [i think we'll just leave that_  
180 PT: [*yep*  
181 (2.0)  
182 PT: *it's good* (while i’ve) been in here anyway_  
183 SG: good (0.6) okay then?  
184 PT: alright?  
185 SG: [all the best,]  
186 PT: [(thank you) ]  
187 SG: [thank you?]  
188 PT: [cheers? ]  
189 (1.8)  
190 TI: good to meet you?  
191 PT: [(thank you?)  
192 SG: [ah i'll give you this to hand in?  
193 (2.8)  
194 SG: and i'll write to ah:: (. ) patrick [mathews. ]  
195 PT: [(reception] is it_  
196 SG: yeah [you ] give it to reception_  
197 PT: [okay]  
198 (0.4)  
199 PT: alright_ (.) [(thank you] doctor)  
200 SG: [(see you) ]

The surgeon begins pre-closing by saying that we’ll just leave that (line 179) as there is no treatment recommended for the patient. This is accepted by the patient and they move towards closure with an exchange of thank you, which can be a type of terminal exchange in service-delivery environments (West, 2006). The surgeon briefly re-opens the consultation as he hands the patient paperwork for the staff at the front desk. This is followed by the surgeon stating that he will write to the referring doctor (line 194). By doing so, the surgeon is informing the patient of the next step in his care, thus, in a small way, contributing to the patient’s continuity of care as well as making closure once again the next relevant activity.
9.4.4 Referring on

Like general practitioners, surgeons are also able to refer their patients on. While in this data this is not done without other arrangement making, it still forms a key part of several pre-closing sequences. In extract 9.4a, the surgeon uses arranging diagnostic testing (lines 310-11), referring on (lines 313-4), and reiteration of treatment advice (lines 316-7) in the possible pre-closing sequence.

Ex. 9.4a SS-SP07-02
310 SG: uh::m so i’ll i’ll give you a form for those blood tests
311 fasting lipids and everythi:ng?
312 PT: mm hm,=
313 SG: =uh:m i’ll (. ) get an appointment with paul wellington? our
314 endocrinologist?
315 PT: mm: [hm,
316 SG: [and if you’re alright off the: fos’max jus stay off it
317 until you see him;
318 PT: ok[ay
319 SG: [he may wanna do th- repeat the bone density scan,
320 PT: mm [hm
321 SG: [and consider something else if needed;
322 PT: [right,
323 SG: [uhm (. ) yih know

In referring on, the surgeon is recognizing the limitations of his expertise and the necessity for the patient to be seen by another doctor (in this case for a secondary problem rather than for the presenting problem, though they are closely related). Again, by informing the patient of the referring on, the surgeon is also involving the patient in his own continuity of care. This is only a possible pre-closing as further talk between the participants ensues. This extract and other possible pre-closings from the same consultation are analysed further in section 9.5.2.

9.4.5 Arranging diagnostic testing

As discussed in the previous chapter, diagnostic testing is a common form of ‘treatment’ recommendation or ‘next step’. Arranging such testing is another type of possible pre-closing. While the treatment recommendation has already been made and accepted, as
with other arrangement making discussed above, this is a reiteration of that recommendation, as seen in extract 9.5.

**Ex. 9.5: SS-SP07-01**

423 SG: so we’ll get this organised; you’ll get it in the mail.
424 PT: oh thank you [darling.]

In this extract, the surgeon uses arranging diagnostic testing as a possible pre-closing (line 423), doing so with an upgrade from an earlier treatment proposal during the activity of proposing next steps (not shown) to a treatment plan as part of the pre-closing.

**9.4.6 Organising a follow-up**

Follow-up visits can be scheduled for a variety of reasons, such as post-diagnostic testing, post-surgery, and post-diagnosis (e.g. a cancer diagnosis for which treatment options must be considered). The patient in extract 9.6 has routine follow-up visits, having had surgery for cancer several years prior.

**Ex. 9.6: IS-SP03-01**

184 SG: so i'll just (keep) that appointment for six months then;
185 (.) and the forms. okay;
186 (0.6)
187 PT: if i: um wandered up to ward twenty nine to visit someone;
188 would they (.)(bring me up) ( )?
(14 lines omitted)
202 SG: okay so i'll just give those forms for [six (months)]
203 PT: [thank you?]

In extract 9.6, the surgeon uses the follow-up appointment as a possible pre-closing sequence in lines 184-5. This is for a regular post-surgery follow-up. There is no uptake from the patient following the surgeon’s turn. This is likely to be because the patient recognises that this arrangement making sequence is closure relevant. As such, he uses this space to mention a previously unmentioned mentionable (Scheglof & Sacks, 1973) in lines 187-8, even though it is an unrelated question regarding visiting a patient who is in the hospital. After that sequence is closed, the surgeon re-starts the pre-
closing (line 202), this time using forms regarding the follow-up in pursuit of agreement and closure, which is successful.

9.4.7 Instructions regarding front desk paperwork

In public hospital clinics there are several forms that can be and are used by surgeons. Often these are for making follow-up appointments or other arrangements. In some consultations, as in extract 9.7, the surgeon uses reference to this paperwork in the pre-closing sequence, instructing the patient to take the paperwork to the front desk, thus demonstrating their intention to close the consultation as the action of taking the paperwork to the front desk requires that the patient leave the consultation room.

Ex. 9.7: IS-SP01-03

165 SG: uh:m (2.2) but i i don't think there's anything further i can
doiatthistage (0.6) maybe i'll plan to check you in about
167 four months. how would that be;
168 PT: yeah,
169 SG: alright? .hh so i'll give you an appointment for four months_
170 (2.8) talk alright? thank you [ed? (       )]
171 PT: [yep thank you]
172 SG: hand that in.
173 PT: [okay]
174 SG: [alright good.

In extract 9.7, the surgeon re-formulates the treatment proposal made in lines 166-7 as a treatment plan in line 169. This is the start of the pre-closing sequence. In line 172, the surgeon hands a form to the patient, telling him to hand that in. The patient stands and then leaves the room as the final talk occurs.

9.4.8 Patient-initiated pre-closing

As surgeons have the institutional epistemic advantage over the patient, they most often also initiate the pre-closing. However, in one of the 35 consultations in this data, the patient initiates two possible pre-closing sequences.

Ex. 9.8: IS-SP02-01

307 PT: and uh:mm (0.6) talk so from here to the ultrasound and then
308 [(back to) see you again.
In extract 9.8, the patient initiates pre-closing (lines 307-8) by re-confirming the next steps previously proposed by the surgeon. This is only a possible pre-closing as the patient and surgeon then go on to discuss the diagnostic testing in further detail (not shown). The surgeon and the patient then move back into a treatment discussion as the patient states that he has no further questions (line 361) though he is not in fact asked by the surgeon if he has any. The patient then does ask a “question” (lines 361-3), though this question also acts as a way of re-opening the discussion of the treatment plan, thus moving away from pre-closing. While this is, again, only a possible pre-closing rather than an actual pre-closing, the patient is orienting to the end of the consultation as a point where any other questions might be appropriate. Another possible pre-closing begins again, this time initiated by the surgeon returning to the arrangement making for the diagnostic testing (lines 453-4) introduced earlier (line 307).

9.5 Responses to pre-closings in surgeon patient consultations

The number of possible pre-closings that occurred during each consultation varied as participants ‘opened up’ the activity of closing (Schegloff & Sacks, 1973). There were between one and four possible pre-closings that occurred in each consultation in this
data. In one consultation there were two surgeons present, so there were separate pre-
closings with each surgeon. Whether or not the acceptance of the pre-closing occurred
during the first possible pre-closing or after a number of attempts, these “responses
simultaneously accept physicians’ arrangements, close the future-arrangement
sequence, and collaborate in the creation of a closing-relevant environment” (Robinson,

In this data, many of the pre-closing initiators were responded to minimally, however
these are not discussed here. There were also two types of non-minimal responses to
possible pre-closings. The first is a response that accepts the possible pre-closing in a
non-minimal way and the second is a response that resists the possible pre-closing. It is
also noteworthy that even after a successful pre-closing sequence is co-constructed by
the participants, this does not mean the consultation is about to close as more non-
closure talk may be started by any of the participants.

9.5.1 Non-minimal acceptance of possible pre-closing

Patients can accept the possible pre-closing in a non-minimal way. In extract 9.2b, the
patient makes a comment regarding her presenting problem in lines 145-6 (which
appears to be a joke as evidenced by her laughter in line 148).

**Ex. 9.2b: SS-SP-12-01**

144 SG: any questions you’d [like to ask me about?]
145 PT: [can’t get any worse ] than what it looked
146 like [when it was all pus-y reh heh heh=  
147 SG: [oh:kay  
148 PT: =[heh hh 149 SG: @$good stuff$ .hh well i’ll uh (. ) get your details on
150 the on the list and i think the nurses may come back with a  
151 form for you to fill in=  
152 PT: mm [hm 153 SG: [and then we’ll let you on your way today? okay?  
154 PT: oh:kay= 155 SG: =and i’ll bring you a form for those blood tests, [alright?]  
156 PT: [mm hm=  
157 SG: okay. {{(voc))  
158 PT: [thanks.
By using the shift implicative *well* in line 149, the surgeon shows that he does not respond to the patient’s non-minimal response as accepting the premise of the pre-closing as such. While the surgeon had the opportunity to attend to this comment and further expand away from closing, he re-starts the pre-closing sequence by continuing with closure-relevant behaviours. These include paperwork necessary for surgery (lines 149-50), diagnostic testing (line 155) and indicating that the patient should not leave the room (*then we’ll let you on your way*) (line 153). The use of multiple pre-closing types demonstrates that these actions are simultaneously doing pre-closing and summarising the results of the consultation for the patient.

9.5.2 Non-minimal resistance to possible pre-closing

Throughout this data there are examples of interactional resistance by patients to all the different types of pre-closing. As we have seen, there is also frequently an ‘opening up’ of the closure-relevant environment by surgeons after patient acceptance of pre-closing. In the consultation used to exemplify patient resistance to closure (extract 9.4b-d), there were four attempts at pre-closing before the consultation is closed.

**Ex. 9.4b: SS-SP07-02**

166 SG: ok[ay
167 PT: [uhm °so:°
168 SG: so i’ll give you a _form_ for the _blood tests_ (. ) _uh:m if:_
169 (. )
170 SG: [if:
171 PT: [now d-
172 SG: yeah;
173 PT: do i need to have them done here or::=  
174 SG: =_uh:m ( . ) you can have them _out_ ( . ) where ever you _live_; yeh
175 PT: out out at the _medical centre:_?
176 SG: _medical centre_ do them.

In extract 9.4b, the surgeon attempts a pre-closing in line 168 using arrangement making for diagnostic testing. The patient then asks a question regarding the diagnostic testing (line 173) which leads to further comprehensive history taking and diagnosis talk (not shown).
Ex. 9.4c: SS-SP07-02
310 SG: uh::m so i’ll i’ll give you a form for those blood tests
311 PT: fasting lipids and everything?
312 SG: mm hm,=
313 PT: =uh:m i’ll (.:) get an appointment with paul wellington? our
314 SG: endocrinologist?
315 PT: mm: [hm,
316 SG: [and if you’re alright off the: fos’max jus stay off it
317 PT: until you see him;
318 SG: he may wanna do th- repeat the bone density scan,
319 PT: mm [hm
320 SG: [and consider something else if needed;
321 PT: [right,
322 SG: [uhm (.:) yih know
323 PT: .hhh yeah i had a bone density scan jus before i left
324 SG: [america

The second attempt at pre-closing occurs in line 310 in extract 9.4c, where the surgeon uses arranging diagnostic testing (lines 310-11), referring on (lines 313-4), and reiteration of advice (lines 316-7) as the possible pre-closing. While the patient appears to accept these pre-closings, he then begins talk about previous diagnostic testing and then asks a question regarding his diagnosis. The opportunity for him to do so was made by the surgeon, who, even though faced with a closure-relevant environment after the patient’s acceptance of the pre-closing, did not begin a terminal exchange sequence.

Ex. 9.4d: SS-SP07-02
563 SG: =i’ll write you thee uh:: lab fo:rm?
564 PT: okay uh[:m]
565 SG: [all]right?
566 PT: shall i stay here [or go o-
567 SG: [yeah do you wanna wait here;; i’ll [just]=
568 PT: [(um)]
569 SG: =write the lab form.
570 PT: okay well thanks very much;
571 SG: no problem_
The diagnostic talk continues until line 563, when the surgeon again uses arranging diagnostic testing as the third possible pre-closing in extract 9.4d. In this instance the patient accepts the pre-closing, asking if he should remain in the room while he waits for the form (line 566). The patient’s question is answered, the two participants close the consultation and the surgeon leaves.

9.6 Conclusion

Pre-closings, as they usually include some form of arrangement making, are not only produced in the service of closing the interaction, but also so that the surgeon can summarise the treatment recommendation thus allowing the patient the interactional opportunity to confirm, disconfirm or question the arrangements that have been agreed upon. As West describes (2006, pp. 404-405):

What is possible here is that, even though doctors are the ones who must hurry things along (by initiating pre closings), they nevertheless show that they are attentive to the interests of their patients, and therefore on top of doctoring them. Through the display of other-attentiveness that, in ordinary conversation, allows speakers to shift topics or close down a state of talk (Jefferson, 1984a), these doctors not only shift topics and close down states of talk, but simultaneously, display their doctoring.

The various types of possible pre-closing allow for the patient, the surgeon or any other party present, to raise previously unmentioned mentionables (Schegloff and Sacks, 1973). Of the seven types of possible pre-closing described in surgeon-patient consultations, one is unique as compared to primary care interactions. This is referring back. Surgeons are able to utilise the referring doctor not only as a way of closing the consultation but also as providing the patient with a trajectory of care. The monotopical nature of surgeon-patient consultations also affects the way in which consultations close as it lessens the likelihood of new, unrelated concerns being raised at the end of the visit.
Chapter 10: Conclusions

10.1 Summary of findings

Communication is a central part of health care delivery, from health care providers communicating with patients and families, to communicating with colleagues in theatres to handing over patients through referrals and discharges. Ensuring that it is ‘good’ – that is, clear, accurate and patient-centred – communication is essential for safe patient care and positive patient experience. As Robinson explains (2006, p. 47):

As visit time shrinks, practices of communication, especially those involving first impressions, will have an increasing effect on patients’ satisfaction, which correlates with important variables, such as patients’ willingness to adhere to medical advice, and – perhaps most importantly for physicians – their willingness to sue for malpractice.

However, previously there has been little research in surgeon-patient consultations. Much of that which has been done has used primary care research as a basis, without questioning that the assumptions of that research may be different for surgeon-patient consultations.

The purpose of the current research is to provide a basic understanding of the inner workings of actual surgeon-patient consultations, comparing them to what we know about primary care interactions, as well as developing an understanding of how patients participate within them. Conversation analysis (CA), being the microanalysis of naturally occurring talk, was an ideal choice for studying this. CA focuses on the normative orientations of participants in co-constructing and making sense of conversational actions. Following Heritage and Clayman (2010, p. 42, emphasis in original), “[t]he purpose of describing these sections is to identify task orientations which the participants routinely co-construct in routine ways, and to see how they depart from these orientations as well”. In this research, CA has helped provide a detailed picture of the co-constructed interactional achievement that is the surgeon-patient consultation. In this chapter, I firstly summarise each of the analytic chapters presented above (chapters 4-9). Secondly, I consider the implications of this research and finally, I reflect on how this research addressed the research proposition posed at the start of this thesis.
10.1.1 Overall structural organisation

As stated throughout this thesis, the central proposition of this research is that the overall structural organisation of surgeon-patient consultations differs from primary care consultations. Chapter 4 in describing the overall structure, particularly dealt with this proposition. Participants in these consultations oriented to an overall structure of activities that is different from primary care consultations.

There are a series of interrelated activities that are put into play when a patient is referred to or returns for a follow-up in a surgical clinic. This series can be described as an overall project and is oriented to addressing the patient’s reason for their visit.

The overall project of first and check-up visits was shown to be:

Activity 1: Establishing mutual understanding of the referral and achieving alignment
Activity 2: Establishing the patient’s description (and perspective) of their problem
Activity 3: Gathering further information through verbal and/or physical examination
Activity 4: Reformulating the problem
Activity 5: Proposing next steps
Activity 6: Closing the consultation

The overall project of follow-up visits was shown to be:

Activity 1: Re-establishing the clinical relationship
Activity 2: Establishing the patient’s description (and perspective) of their problem since the previous appointment
Activity 3: Gathering further information through verbal and/or physical examination
Activity 4: Reformulating the problem
Activity 5: Proposing next steps
Activity 6: Closing the consultation

While these overall structures are similar to those described by others (Byrne & Long, 1976; Cohen-Cole, 1991; Helman, 1981; Heron, 1975; Kurtz & Silverman, 1996;
Neighbour, 1987; Pendleton, Schofield, Tate, & Havelock, 1984; Silverman, Kurtz, & Draper, 2005; Stewart et al., 1995; Stott & Davis, 1979), there are key differences particularly in the role of opening activities and in how each of the six activities of the consultation plays out, a finding which is pursued in the analysis of each of the individual activities. Throughout the consultation, there are points of interactional agency for patients: that is, patients are given the opportunity to participate within the consultations and are given interactional licence to do so. By looking not only at the overall structure of these consultations but also the individual activities that make up the consultation, the various points of interactional agency for patients were elucidated. As Gafaranga and Britten state (2007, p. 119), “in order to understand patient participation, one must look, not at the consultation as a whole, but rather at specific significant activities”.

In each of the activities, the participants have different goals and orientations as compared to primary care consultations, which affect not only structure but also the level of patient participation. There are activities that afford more opportunity for patient participation (Activities 1, 2, and 5) and those that provide less (Activities 3 and 4). The following five sections summarise the findings regarding each activity.

10.1.2 Openings: opening elicitors, the referral recognition sequence and problem presentation

The function of a referral is to handover the care of the patient, a process that also foregrounds the role of the general practitioner (GP) as the gatekeeper to secondary health care services. The agenda of first and check-up surgeon patient consultations is set by the referral letter. The letter reduces the epistemic distance between the surgeon and the patient as compared to if the patient had self-referred (and thus the surgeon would be unaware of the presenting problem). Through these opening activities, the patient and the surgeon develop a shared epistemic understanding and a shared orientation to the sequential relevance of particular activities at the beginning of the consultation. In first and check-up visits, this shared epistemic understanding also includes the perspective of the referring doctor that is found in the referral letter. The two activities at the start of first and check-up surgeon-patient consultations are:

1. Establishing mutual understanding of the referral and achieving alignment
2. Establishing the patient’s description (and perspective) of their problem
The two activities at the start of follow-up surgeon-patient consultations are:

1. Re-establishing the clinical relationship
2. Establishing the patient’s description (and perspective) of their problem since the previous appointment

There are five different types of opening elicitor in the surgeon-patient consultations in this data:

1. ‘In your own words’ elicitors, which are problem presentation elicitors that occur after or are embedded within the referral recognition sequence and as such are bound by the context of that activity.
2. Referral-based elicitors, which are elicitors that include an implicit or explicit allusion to the referral letter, referring doctor and/or referred problem and are responded to by patients as eliciting a problem presentation.
3. Open problem presentation elicitors, which are broad, non-specific elicitors that are generally inapposite in referred visits and thus occur infrequently in this data.
4. ‘How are you’ elicitors, which are ambiguous elicitors that could be interpreted as either part of the greeting sequence or as eliciting a problem presentation.
5. Follow-up elicitors, which are elicitors that reference the previous visit by the patient and by doing so re-establish the clinical relationship between the surgical clinic and the patient.

In surgeon-patient consultations, patients are encouraged to confirm or disconfirm the correctness of the letter through an understanding of why they have been referred via an interactionally designated space to do so, the referral recognition sequence. In this sequence, the participants orient to the relevance of the referral letter at the beginning of the consultation as the patient is handed over from the care of referring doctor to that of the surgeon. This sequence provides a structural opportunity for patients to have agency in the opening activities of the visits, which is important in referred visits where the referral letter sets the agenda. Being able to participate in developing the mutual understanding of the presenting problem through this sequence and the problem presentation is important not only for the progressivity of the consultation but also for
safe patient care. These sequences are co-constructed activities that can be simple or complex, and this complexity may be determined by the quality of the referral letter received. Referral recognition sequences are normatively required in first and check-up surgeon-patient consultations, just as are problem presentations.

Problem presentations in surgeon-patient consultations do not vary significantly in structure from primary care consultations, despite the different local context that is created by the opening elicitors and the referral recognition sequence. Problem presentations occurred in all three types of visit and ranged from brief descriptions to longer narratives. They appeared to be less likely to occur in check-up visits. However a key difference between primary care and surgeon-patient consultations was how (and how frequently) patients accounted for the visit. That is, patients in these consultations did not often justify or account for the presentation of their problem and their visit and when they did, they often invoked a third party expert, the referring doctor. Legitimacy was not oriented to by surgical patients as much as has been described for primary care patients (Heritage & Clayman, 2010; Heritage & Robinson, 2006b).

Further research into the openings of surgeon-patient consultations could include comparing actual referral letters with how the referral recognition sequence plays out and thus developing a system of improving referral letters based on interactional evidence. Another interesting comparison would be the similarities and differences between the Activities 1 and 2 in first and check-up visits as compared to follow-up visits. More data than that available in this study would be necessary to achieve this.

10.1.3 Examination: history taking and physical examination

Examination is a key activity in surgeon-patient consultations in the development of the surgeon’s objective understanding of the patient’s presenting problem in order to proceed to the next activity of reformulating the patient’s problem in light of the new evidence collected. Examinations, like problem presentations, did not vary significantly in structure to those found in primary care consultations. Due to the goals of history taking, the local environment is quite restrictive for patients as surgeons ask questions and patients are normatively required to answer them. However, even within this locally, interactionally restrictive context, patients are able to answer beyond the constraints of the question in order to participate differently during the history taking activity. The
activity conducted here is *gathering further information through verbal and/or physical examination*.

Two different types of history taking were identified in surgeon-patient consultations: problem-specific history taking and comprehensive history taking. Problem-specific history taking, as the name suggests, is geared towards gathering information regarding the patient’s presenting problem, while comprehensive history taking is undertaken in order to develop a broader picture of the patient’s general health and lifestyle. Mixed history taking can also occur, with some questions being asked that relate to both the specific problem and to the patient’s general health background. History taking can also occur during physical examination, as can other verbal activities, such as procedural talk, online commentary and social talk.

The differences between the two types of history taking go beyond the mere topical orientations of the questions; there are structural variations as well. Comprehensive history taking questions are often designed for ‘no problem’ responses while problem-specific history taking questions often allow patients the interactional opportunity to give extended responses. Patients can, of course, answer beyond the topic and action agendas of history taking questions with either expanded answers or narrative expansions. The expansions may be to account for not being able to answer a question, to pre-empt negative inferences that could be made from an answer, to account for the visit, to express theories of illness or to talk about lifeworld concerns.

Little can be said in regards to physical examination from the data as no physical examinations were captured on video. What can be noted is that in all consultations with a physical examination, the surgeon used verbal cues to transition from history taking. This differs from primary care consultations where verbal cues into physical examination were not observed (Robinson & Stivers, 2001). Further research into surgeon-patient consultations could include collecting and analysing data around the non-verbal actions of transition from history taking to and from physical examination and the other activities therein.
10.1.4 Diagnosis

The activity of reformulating the problem in surgeon-patient consultations (which is referred to more generally as diagnosis, even though an actual diagnosis might not occur), displays differences to primary care consultations. These differences stem from the additional sources of diagnostic reasoning – specialist knowledge and the referral letter – found in surgical consultations. There were six different diagnosis action types in this data:

1. No problem diagnosis, where the patient is given the all clear in terms of the surgeon’s area of expertise (that is, the surgeon may acknowledge that there is a problem, but it is out of his or her realm of medical practice).
2. Delivery of diagnostic test results, whereby test results are delivered to the patient.
3. Diagnosis with explicit reference to diagnostic testing, in which a diagnosis is made and the surgeon uses the diagnostic test results as evidence.
4. Pre-diagnostic testing hypothesis or provisional diagnosis, which occurs when there is not a firm diagnosis and more testing is needed, however it often indicates the probable diagnosis (or at least an assessment of a probable diagnosis), prior to sending the patient for testing.
5. Re-stating the diagnosis from the referring doctor, which involves the surgeon confirming the diagnosis given in the referral for the patient.
6. Diagnostic statement, which is a bald diagnostic statement with no reference to any evidence.

This data shows that surgeons attend to the importance of providing evidence for their diagnostic reasoning, with only one bald diagnostic statement given. All others involved either the explicit reference to evidence or a close inferential distance between the evidence and the diagnosis.

The type of news delivered and how it is delivered are clearly linked in this data. There are five different types of news, with only one type displaying no homogeneity in the way in which it is delivered. The five news types and their related delivery styles are listed below.
1. **Bad news delivery** displayed no homogeneity in how it was delivered, which may be because in one consultation diagnostic test results may display bad news, while bad news might be discovered in another way in a different consultation. More data is needed to explore bad news delivery in surgeon-patient consultations further.

2. **Previously known bad news** occurred in consultations where patients were already aware of their diagnosis. These were formulated as a restatement of the news from the referring doctor.

3. **Good news** was produced as the delivery of diagnostic test results.

4. **Uncertain news** was delivered as a pre-diagnostic testing hypothesis as the surgeon was only able to provide a provisional diagnosis prior to referring the patient on for (further) diagnostic testing.

5. **No news** was presented as a ‘no problem’ diagnosis, with the ‘not in my realm’ caveat if appropriate.

In contrast to primary care where responses to diagnosis do not necessarily occur (Heath, 1992; Peräkylä, 2006), almost all of the consultations in this data included a minimal or extended response to the diagnosis. Minimal responses included continuers and acknowledgement tokens, with patients passing up the opportunity to talk, demonstrating their orientation to the next relevant activity of treatment recommendation. The extended responses included those that justified the visits, requested a treatment recommendation, asked about the diagnosis, displayed knowledge about the diagnosis, asked for information about the diagnostic procedure and resisted the diagnosis.

Diagnosis is a co-constructed activity in surgeon-patient consultations, with a number of extended responses to diagnosis occurring, many of which do not represent disagreement between participants, as suggested by Heath (1992). Further research into diagnosis might include developing a greater understanding into how patients respond to diagnosis (minimal versus extended responses) and whether there is any connection to news type.
10.1.5 Treatment

In surgeon-patient consultations there are at least three parties involved in the process of shared decision making: the patient, the surgeon and the referring doctor. Added to this might be others present such as support persons, trainee interns, registrars (who often consult with more senior clinicians), nurses, and other allied health staff. Despite this increased interactional complexity as compared to primary care consultations, in surgeon-patient consultations, treatment recommendations, which comprise the activity of proposing next steps, must be accepted prior to the consultation moving towards closure, just as in primary care consultations (Stivers, 2005, 2006). There are a number of different types of treatment recommendations in surgeon-patient consultations and their occurrence was not mutually exclusive. These recommendations are:

1. **Surgery**, which when recommended as the treatment was also recommended as the only treatment and was recommended in a direct and simple manner.

2. **Diagnostic testing**, which only once was resisted by a patient in this data, though was often offered as a treatment recommendation along with others such as referring on.

3. **Lifestyle changes**, which involved recommending that the patient change some aspect of their lifestyle or behaviour and were also often delivered with other treatment recommendations.

4. **No treatment, follow-ups and referrals**, which worked together to ensure that a patient was not sent away without a next step whatsoever (as when there was no treatment for the problem, the patient was offered either a follow-up visit or was referred back to their referring doctor), thus minimising the risk of resistance from the patient.

The normative requirement for acceptance is another key point of interactional agency for patients who have the opportunity to passively or actively resist a treatment recommendation. Overall there was little resistance to treatment recommendations in this data. This is likely to be because no patient was ever given ‘no proposal of next steps’ whatsoever in any consultation. Surgeons pursued acceptance by modifying the treatment recommendation, reiterating their evidence for the proposed treatment, restating their recommendation and by using tag questions. They responded to resistance with concessions, alternative treatments and alterations of...
recommendations. The interactional achievement of the treatment recommendation demonstrates how shared decision making is managed and negotiated within the surgical consultation.

Treatment options and risks were not discussed with great frequency in this data, but this would be an interesting area for future research. The impact of the clinic staffing and how the clinic runs would be an important consideration in understanding the influences on why options and risks might not be discussed. Surgeons, however, did focus on discussing the practical side of surgery, such as arranging dates and discussing recovery time when surgery was the recommended treatment.

10.1.6 Closings

The activity of closing the consultation is a key part of doctor-patient consultations as this represents the point at which both the doctor and the patient can raise additional items prior to the closure of the encounter. In contrast with primary care, in surgeon-patient consultations closure is not often a place where additional health concerns are raised (White, Levinson, & Roter, 1994), but rather where the opportunity for further discussion regarding any aspect of the presenting problem might be discussed. The way in which closure is achieved, that is, through the use of possible pre-closing sequences, is reflective not only of primary care consultations but also of everyday, mundane conversation.

In surgeon-patient consultations this is done through final-concern sequences, arranging surgery, referring back, referring on, arranging diagnostic testing, organising a follow-up and instructions regarding front desk paperwork. More than one pre-closing sequence could occur in these consultations as either of the participants ‘opened up’ the activity of closing. There were two non-minimal types of responses to pre-closing first pair parts. Non-minimal acceptance was where patients accepted the move towards closure in a non-minimal way, often with a comment or assessment regarding the presenting problem, its diagnosis or treatment. Non-minimal resistance to pre-closing also occurred, with patients using the pre-closing environment to further discuss the presenting problem, its diagnosis or treatment. Surgeons were also able to ‘open up’ the activity of closing. Further research in this area could include the collection of
more data to analyse the different types of previously 'unmentioned mentionables' (Schegloff & Sacks, 1973) that are raised in the pre-closing environment.

10.2 Practical implications and applications

Robinson argues that (2001, p. 639) “[a]n examination of the structure of physician–patient communication, including the norms and rules of interaction itself, is one path to understanding and solving problems in health care”. Yet, direct clinical utility of findings from this type of descriptive research can be difficult to identify. Instead, research that describes issues tends to pose a number of questions. These are not value judgements, but are rather reflective questions regarding practice that surgeons, colleges, medical boards, medical schools and indemnity insurers might like to consider. In this section, I firstly pose two reflective questions, secondly I briefly discuss some of the findings that affect patient participation and finally I recommend areas for future research (beyond those noted above in the summary of findings from this research).

10.2.1 Reflective questions

There are two key reflective questions that arise from this research. These questions might be answered by further research using a variety of methodologies such as conversation analysis, interviews, ethnography, and surveys.

1. *What are the functions and goals of the different types of surgeon-patient consultations?* This could include sub-questions such as what, if any, is the role of the surgeon as patient educator, whether there are role variations based on specialty, what are the key differences between first, check-up and follow-up visits, and what are seen as the ideal functions and goals of surgeon-patient consultations. Through understanding the functions and goals of surgeon-patient consultations, training for both referring doctors and surgeons might be improved and patient education modules developed to assist them in understanding what is involved in surgeon-patient consultations.

2. *How optimal is current practice?* The current research specifically did not make value judgements on what is good and bad communication in
surgeon-patient consultations. Involving surgeons in reflective practice may assist in appropriately developing such judgements and lead to improvements in practice based not only on actual consultations but also on a defined set of functions and goals that the above question could help develop.

10.2.2 Patient participation

Patients are not always able to participate in defining the agenda of the consultation (Peräkylä & Ruusuvuori, 2007) such that patient participation in medical consultations needs continuous examination and re-examination. There are a number of considerations regarding patient participation that this research has brought to light, primarily around the openings of surgeon-patient consultations. As the opening of consultations affects the rest of the consultation, these can be seen as essential considerations in improving patient participation in surgeon-patient consultations.

As surgeons routinely perform consultations with patients, it is important for them to acknowledge that there is institutional asymmetry due the relative inexperience of patients. This is not just in terms of (lack of) knowledge of how the health system works, but also how the consultation works, and is related to the reflective questions posed above. Ensuring patients are comfortable in the consultation and that they have the opportunity to present their problem in their own words is important. When considering the possible asymmetry in agendas between surgeons and patients, it is important to remember that “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” (Robinson, 2003, p. 47).

This is related directly to the choice of opening elicitors. As problem presentation is a key point of patient agency in doctor-patient consultations, ensuring that an appropriate elicitor that is designed to prompt patients to tell their story in some detail is important, particularly as the referral letter may not align with the patient’s understanding of their problem or why they have been sent to the surgeon. This is a problem unique to referred consultations as patients may orient to the conversational norm of not telling someone something that they already know, in this case the problem as explained in
the referral letter. ‘In your own words’ elicitors attend to the two different interactional pressures placed on the surgeon. These are ensuring that the patient is able to present his or her problem in his or her own words, while also being mindful that the patient is aware of the decreased epistemic distance between the patient and the surgeon caused by the referral letter. As such, these elicitors appear to promote patient agency within surgeon-patient consultations. This could be an ideal starting point for further research in this area. Unambiguous opening elicitors that attend to the epistemic distance between participants and to the particular visit types are important for the progressivity of the interaction and for ensuring a detailed problem presentation from the patient.

Referrals are generally for single concerns. As multiple concerns are usually not relevant in surgeon-patient consultations, the concern for increasing patient participation in these consultations can be limited to problem presentation and patient involvement in decision making. The referral recognition sequence, as described above and in chapter 5, is a key point of patient agency in first and check-up surgeon-patient consultations. For both referring doctors and surgeons, improving referral letters, ensuring that the correct referral letter is available and ensuring the patient understands why they have been referred would all assist in improving the progressivity of the consultation and continuity of care. A clear referral letter is necessary in order to allow surgeons to understand the referring doctor’s conception of the patient’s presenting problem and to allow them to confirm that with the patient. This leads directly into what further research might be undertaken in light of these findings.

10.2.3 Further research

The scope of this research was to describe the overall structure, and activities therein, of surgeon-patient consultations. On the basis of this descriptive work, it is possible to identify numerous possible research trajectories. As this research has focused more broadly on the consultation as a whole, and the focus has been on providing an action analysis rather than a more detailed analysis of the nuances of conversational structure in order to provide descriptions of each activity of the consultation, future conversation analytic research might usefully focus in more detail on each of the individual activities and the interactional features that occur within these.
This research also worked with varied data containing numerous specialities and visit types. Collecting and analysing more homogenous data might reveal more interesting findings regarding visit types and differences between surgical specialties. Some cursory observations regarding similarities and differences between surgical specialties in this research found that different clinic structures might affect the amount of information given to patients and the lengths of consultation. For example, in the breast cancer clinic, where there was a clinic nurse who would speak to the patient after the consultation and who was able to be contacted after the patient left, the consultations were shorter than in the general surgery clinic.

As this research was conducted in New Zealand, its applicability to different health systems in different countries might be limited. While it might be applicable to other referral-based systems, such as in Australia, further research on different surgeon-patient consultations and their overall structure in different systems (and in different languages and cultures) would be an interesting next step for research into this area. It has also been noted throughout this thesis that some of these findings might also be applicable to non-surgical specialties in New Zealand. As such, comparing the structure of consultations conducted by both surgeons and non-surgical specialists is another possible avenue for research.

This is a burgeoning research field and, as such, there are many opportunities to develop further research to create an evidence-based body of literature upon which training and education for surgeons might be based.

10.3 Concluding remarks

The structures of everyday, mundane conversation pre-date any form of institutional interaction (Drew & Heritage, 1992a; Heritage & Clayman, 2010) and the “interactional practices through which persons conduct themselves elsewhere are not abandoned at the threshold of the medical clinic” (Heritage & Maynard, 2006b, p. 13). In analysing naturally occurring interaction, the questions posed in CA research can only be answered by the detailed analysis of recorded data (Clayman & Gill, 2004). In that data, no detail, no matter how minute, can be dismissed as being “disorderly, accidental or irrelevant” (Heritage, 1984a, p. 241).
Like all institutional interactions, communication in medical care requires constant re-examination due to the continuously changing contextual factors that affect health care delivery. This is particularly important for surgeon-patient consultations as so little research has previously been carried out. The impact of not continuing research in this field is significant, as this “means there is not much of a base on which to build curricula or standards of practice” (Maynard & Frankel, 2006, p. 248).

The primary goal of this research was to understand what actually goes on in the institutional interaction of surgeon-patient consultations. This research provides the first comprehensive description of the overall structure of surgeon-patient consultations as well as of the individual activities within that structure. By using conversation analysis, an in depth description of not only the activities of the consultation but also of patient participation within these activities was possible. This research demonstrates that surgeon-patient consultations are structurally distinct from primary care consultations. This new perspective on, and understanding of, surgeon-patient consultations is an important step in surgeon-specific research and has the potential to enhance specialist training.
References


References

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References


Appendix: Conversation Analysis: Summary of Terminology and Concepts

The following is a summary of some of the key terminology and concepts of conversation analysis.

**Turn-taking rules**

The structure of talk is locally managed by the participants’ orientation to so-called ‘rules’ of turn-taking. These rules were identified by Sacks, Schegloff and Jefferson (1974). As Heritage summarises, “turns are allocated among conversationalists by reference to a set of rules which apply recursively on a local, turn-by-turn basis” (1984a, p. 263). Central to turn-taking is the idea that talk consists of turn construction units (TCUs). These units, like utterances, often appear complete when they are grammatically, semantically, and intonationally complete. However, TCUs are, in practice, determined complete by the participants in the conversation as they orient to what is adequate for the utterance to be understood as possibly complete. That is, they may not fit into an objectively describable set of properties (ten Have, 1999), yet they may be treated as complete by the participants.

Once a person has the floor they are generally entitled to only one TCU (Sacks et al., 1974). At the end of each TCU is a point of possible completion of the speaker’s turn and this is referred to a transition relevance place (TRP). A TRP is the point where one of the most fundamental features of conversation can be found: the occurrence of a possible speaker change. To retain the flow of conversation, participants orient to TRPs and attempt to project when they will occur. That is, they listen for places where a TCU could reach a point of possible completion (Nofsinger, 1991). This is where speaker change becomes legitimate (Gardner, 2004). At this point, the rules of turn-taking come into play (C is the current speaker and N is the next speaker) (Sacks et al., 1974):

**Rule 1- applies initially at the first TRP of any turn**

(a) If C selects N in current turn, the C must stop speaking, and N must speak next, transition occurring at the first TRP after N-selection.
(b) If C does not select N, then any (other) party may self-select, first speaker gaining rights to the next turn.

(c) If C has not selected N, and no other party self-selects under option (b), then C may (but need not) continue (i.e. claim rights to a further turn-constructional unit).

**Rule 2 – applies to all subsequent TRPs**

When rule 1(c) has been applied to C, then at the next TRP Rules 1(a)-(c) apply, and recursively at the next TRP, until speaker change is affected.

These rules form the structural backbone of conversation as they provide a systematic way for speaker change to occur. As Nofsinger states (1991, p. 86): “this locally, interactionally, participant-managed turn system – with its three part turn-allocation practices operating at the TRP – is one of the defining characteristics of conversation.” This system has not only described the turn-taking structure of English language conversation, but has also aided in the description of turn-taking structure in Thai, Japanese, Finnish, and German conversations (Gardner 2001:271). While these rules help explain conversational turn-taking structure, it is important to remember that turn organisation and allocation is not determined ahead of time in everyday conversation (Nofsinger, 1991:80). When it comes to institutional interactions, however, the case may be somewhat different, with the courtroom, for instance, displaying one of the most restricted turn-taking structures.

Despite, or because of, participant orientations to the turn-taking rules, instances of simultaneous talk often occur. Participants may aim for ‘no gap, no overlap’ in conversation (Sacks et al., 1974), however there are several kinds of simultaneous talk, each of them identifiable by the participants involved as they respond to them differently depending on how and when the simultaneous talk occurs and how they interpreted it (Nofsinger, 1991). According to Jefferson (Jefferson, 1984b), there are four categories of simultaneous talk: transitional overlap, recognitional overlap, progressional overlap, and simultaneous starts. A fifth category of simultaneous talk is interruption. While there are sub-types in some of these categories, I briefly describe only the five broad categories.
Transitional overlap is where the incoming speaker projects the end of the current speaker's TCU and aims to start speaking at the TRP, which sometimes means that they begin speaking prior to the actual end. In recognitional overlap the incoming speaker is orienting not only to the TRP but also the action of the utterance-in-progress. In recognition of the import of what is being said, the incoming speaker may begin talking in overlap with the current speaker. To aid the progressivity of the interaction, a speaker may overlap with the current speaker if there are hitches, such as stutters, cut-offs, repetitions, or pauses, in their TCU. This is referred to as progressional overlap.

Simultaneous starts can occur in multi-party conversations where two participants may begin at the same time due to the structure of the turn-taking system. Rule 1b permits speakers to self-select if no speaker is selected according to rule 1a. As such, two (or more) speakers may self-select at the same time, resulting in overlapping talk. Two speakers may also begin talking simultaneously after what is known as a ‘continuing state of incipient talk’ (Schegloff, 2007), where participants are co-present but not actively engaged in conversation. As this system allows participants to project the relevant place to begin speaking, true interruption in the CA sense rarely occurs. In CA, interruption is “simultaneous talk that does not occur at or near a TRP” (Nofsinger, 1991, p. 102). As such, most simultaneous talk is actually overlapped talk.

**Sequence organisation**

A turn projects the next relevant activity, or range thereof, to be performed by the next speaker (Heritage, 1984a). This is referred to as sequential implicativeness, which means that a turn “has sequentially organized implications” (Schegloff & Sacks, 1973, p. 296). For example, “questioners attend to the fact that their questions are framed within normative expectations which have **sequential implications** in obliging selected next speakers to perform a restricted form of action in the next turn, namely, at least, to respond to the question with some form of answer” (Heritage, 1984a, pp. 249, emphasis in original). Answerers are responsive to these sequential implications, as even if they do not answer the question, they provide an account for their not answering (Heritage, 1984a). Regarding those responses that are relevant in that they attend to the sequential implications of the previous turn, Heritage note that “when the relevant ‘next’ occurs, it is characteristically treated as requiring no special explanation: a relevantly produced next action is specifically non-accountable” (1984a, p. 253). Closely
linked to sequential implicativeness are relevance rules (Schegloff, 2007) and the concept of conditional relevance (Schegloff, 1968). Relevance rules binds “actions together into coherent sequences” (Schegloff, 2007, p. 21). Conditional relevance means that once a first is made a second is expectable and if it is not delivered, it is considered to be ‘officially absent' (Schegloff, 1968).

The sequential organisation of talk is analysed in terms of adjacency, that is, that a speaker refers their turn to the one immediately prior to theirs and that their turn influences what is said in the next speaker’s turn. Sequence organisation is commonly analysed in terms of adjacency pairs. As the name suggests, adjacency pairs consist of two turns that are found adjacent to each other. Schegloff and Sacks identify five features of adjacency pairs (1973, pp. 295-296):

1. Two utterance length.
2. Adjacent positioning of component utterances.
3. Different speakers producing each utterance.
4. Relative ordering of parts (i.e., first pair parts precede second pair parts).
5. Discriminative relations (i.e., the pair type of which a first pair part is a member is relevant to the selection among second pair parts).

Adjacency pairs provide a “normative framework for actions which is accountably implemented” (Heritage, 1984a, pp. 247, emphasis in original). These pairs form the basis of sequence organisation in talk, with most turns either receiving or acting as what is known as a second pair part. This pattern can be clearly identified in greetings, where, in English, a first pair part of “How are you?” will often receive the obligatory second pair part of “Good”. The rules guiding this adjacency of first pair and second pair parts have been formalised by Schegloff and Sacks (1973, p. 296):

Given the recognizable production of a first pair part, at its first possible completion its speaker should stop, a next speaker should start, and should produce a second pair part of the same pair type of which the first is recognizably a member.

There are typical types of first pair parts (FPP) and second pair parts (SPP) applicable to all adjacency pairs. Typical FPPs include questions, greetings and requests, and are...
often followed by their typical SPP counterparts, answers, greetings and grants or rejections, respectively. When an adjacency pair forms the basis of a sequence, it is referred to as a base adjacency pair. This base adjacency pair (BAP) consists of a base first pair part (BFPP) and a base second pair part (BSPP) and can be expanded upon. In sequence organisation, there are three types of expansion: pre-expansion, insert expansion, and post-expansion.

Pre-expansions occur prior to the base adjacency pairs for a number of reasons, such as to contextualise the utterance or to save face, yet they all project and anticipate the following sequence (ten Have, 1999). Pre-sequences allow participants to locally work towards a preferred following sequence by pre-empting the second pair part speakers' response to the primary action of the sequence (Heritage, 1984a). For instance, a pre-invitation projects an invitation and occurs in order to ensure that the inviter receives a positive response by ascertaining whether the addressee will be available for whatever the event may be. This acts as a face-saving device for the inviter, because if the addressee indicates that they will not be free, there will be no need to make the actual invitation. Other types of pre-expansions include pre-expansions and prefaces to stories. A go-ahead is a common response type to a pre-expansion FPP and indicates to the original speaker that they may continue with the story, question, or invitation. Other pre-expansion SPPs are blockings, which stop the first speaker from continuing and pre-empting responses, which predict with what the first speaker was going to continue in the BFFP.

Insert expansions occur between a BFPP and a BSPP. They are motivated by need for more information before the BSPP can be delivered. A post-first is the clarification of what was said in the BFPP because of problems with hearing, speaking or understanding. A pre-second is oriented towards the projected response (BSPP) as something may need clarification or explanation before a response can be made (ten Have, 1999). An insert expansion “is the sequence – and its underlying adjacency pair – which supplies the underlying structure by reference to which this coherence can be achieved (by us as analysts, but in the in the first instance by the participants) – with the talk understood as either operating retrospectively on the first pair part or to be considered as having prospective bearing on the second pair part which that first pair part has made conditionally relevant” (Schegloff, 2007, p. 114).
Post-expansion sequences occur after BAPs and vary from a minimal response, to another adjacency pair to an extended post-expansion sequence consisting of multiple turns (ten Have, 1999). Minimal post expansion is one additional turn added after the BAP, such as a sequence closing third (Schegloff, 2007). Non-minimal post expansions consist of an adjacency pair, as the first turn after the BSPP is another first pair part, thereby making a second pair part relevant (Schegloff, 2007). These can be repairs, topicalisations, rejections or disagreement with the BSPP, or reworkings of the BFPP (Schegloff, 2007).

**Repair**

Repairs occur frequently in conversation. Repairs are not concerned with correction ‘errors’ in conversation, but are instead addressed to problems in speaking, hearing or understanding of talk (Schegloff, 2007). That is, they aid the progressivity of conversation when there are difficulties of hearing or understanding. Repair mechanisms allow speakers to demonstrate context. Any turn can become a “trouble source” in need of repair, and it becomes so if the participants initiate a repair sequence. To emphasise this, the trouble source is only identifiable when a repair initiation occurs; it is not a trouble source unless it is treated as one by the participants in the conversation. There are two types of repair initiator: self-initiated repair and other-initiated repair. There are also two types of repair: self-repaired and other-repaired. Together, there are four possible repair combinations:

- self-initiated, self-repair
- self-initiated, other-repair
- other-initiated, self-repair
- other-initiated, other-repair

Repair sequences are described not in terms of where the trouble source occurs, but instead by reference to where the repair initiator occurs in relation to the trouble source. Repair initiators can either be trouble-source specified, that target a particular point in the utterance or trouble-source unspecified, that target the utterance in general. There is a repair initiation opportunity space that limits the relevance of a repair initiator – within one turn to four turns. There is also a preference for self-initiation of repair and
self-repair (and even for self-repair when it is other-initiated) (Schegloff, Jefferson, & Sacks, 1977). There are four types of repair: same turn repair, transition space repair, next turn repair and after next turn repair.

Same turn repair by nature of its location is always self-initiated within a single TCU. The markers that indicate a same turn repair initiator include cut-off, sound stretches and other hitches. In same turn repair, the repair initiator does not locate repairable. Schegloff identifies ten ways of achieving of same turn repair (unpublished course notes), including replacing, aborting and parenthesising. Transition space repair is also self-initiated, however it occurs at the end of the TCU where the trouble source is, in the transition relevance place. Next turn repair is other-initiated, although, as mentioned previously, it is often then self-repaired as there is a preference for self-repair. After next turn repair there can be third position and third turn repairs. These occur after the second turn and respond to a displayed misunderstanding by the second position speaker.

Repair plays an important role in maintaining the intersubjectivity in conversation. Recipients display their understanding of the previous turn in the production of their own turn (Heritage, 1984a). This allows the first speaker to repair what they said in order to ensure mutual understanding and intersubjectivity. By not repairing at this point, the first speaker implicitly asserts that the recipient understood their prior turn and expressed that understanding in their subsequent turn (Heritage, 1984a). Understanding in conversation is not confirmed overtly by participants but is instead implicit in the their continuing turns (Heritage, 1984a).

**Silence**

It is commonly recognised that silence can be very powerful in conversation and can hold much meaning. However, common knowledge appears to underestimate the significance and complexity of even the smallest silences that appear in everyday conversation. In conversation, a significant silence, that is one that has the ability to be recognised as a pause and has the ability to affect the conversation, can range from just two-tenths of second in length (Sacks et al., 1974). The position of where a silence occurs in relation to the TCU affects how it is treated by the participants in the conversation (Nofsinger, 1991). Three types of silence have been identified by their
position: the lapse, the gap, and the pause (Nofsinger, 1991). The lapse occurs during and after a TRP when no participant has taken the floor in the conversation and is often associated with the participants disengaging from active talk (Sacks et al., 1974). The gap is generally a brief silence between TCUs, either between one speaker’s TCUs or during speaker change. The pause is a silence within a participant’s turn and is therefore attributable to that participant.

**Turn design**
In conversation, a TCU can represent more than one action (Schegloff, 2007) and “there is not an absolute one-to-one correspondence between the grammatical form of an utterance, and the action it performs” (Clayman & Heritage, 2002, p. 100). Turn design refers to two distinct phenomena: “(a) the selection of an activity that a turn is designed to perform; and (b) the details of the verbal construction through which the turn’s activity is accomplished” (Drew & Heritage, 1992b, p. 32). Actions are therefore analysable not only by what they are doing (or intended to be doing) but how they are performed. That means turns are analysed in terms of action and composition of the turn that the speaker has chosen from the alternatives available (Heritage, 2004). Key to turn design is recipient design. Recipient design ensures that turns are designed with reference to and sensitivity to the recipient of the turn (Sacks et al., 1974). As conversational participants, “we construct our talk by reference to how it will be heard” (Silverman, 1998, p. 6). Participants also choose terms that are context-sensitive, that is, the talk is oriented to be appropriate to the setting in which they are speaking (Heritage, 2004) as well as the preceding talk that provides the context for the next speaker. Importantly, the action of a turn is dependant of its position and its composition (Schegloff, 2007); that is, a turn’s sequential positioning is just as important as its design in how the action it is performing is understood.

**Utterances**
A central feature of talk is that it is not produced in sentences as it is in written language (Silverman, 1998). Instead of sentences, talk is structured using *utterances*. The idea is that an utterance is not necessarily a complete sentence yet it may still make sense in the context of the conversation in which it occurs. *Utterance* is a term that attempts to encapsulate the units found in conversation, but unfortunately there are no hard and fast defining characteristics of an utterance (Ford & Thompson, 1996; Schegloff,
1996b). Some guidelines to what an utterance could be is all that can really be provided. Key to this concept is that an utterance is generally semantically complete. Therefore, depending on the preceding talk, a mere ‘ok’ may be semantically complete within the conversational context. Utterances are also often grammatically complete and are usually intonationally complete. Of course, an utterance may not be semantically, grammatically, or intonationally complete, however this may cause problems in the conversation and will often be dealt with in the following utterances until the utterance is understood.

**Preference organisation**

Related closely to both turn design and sequential organisation is preference organisation. In conversation there is a preference for ‘agreement’ and a dispreference for ‘disagreement’ (Sacks, 1987). Here agreement refers to a grammatical alignment between two turns and to the type of response (type-conforming or type non-conforming) rather than a psychological orientation of the participants. Preference organisation is concerned with the social/interactional structures of sequences and “a structural relationship of sequence parts” (Schegloff, 2007, p. 61). First pair parts can be designed to prefer certain types of responses and second pair parts can be produced either as preferred or dispreferred. For example, pre-expansions used by (potential) base first pair part speakers to increase the likelihood of receiving a preferred base second pair part (Schegloff, 2007).

There are structural variations to how preferred and dispreferred actions are performed (Sacks, 1987). Heritage states that “actions which are characteristically performed straightforwardly and without delay are termed ‘preferred’ actions, while those which are delayed, qualified and accounted for are termed ‘dispreferred’” (1984a, p. 267). Preferred actions are generally affiliative, which dispreferred actions are disaffiliative (Heritage, 1984a), which provides explanation as to why dispreferred actions and delayed, qualified and accounted for in conversation. Accounts in particular are important in maintaining relationships between participants and social solidarity (Heritage, 1984a). As a delay in response can signal a dispreferred response, it also provides a space for the first speaker to reformulate their first pair part to one that will receive a preferred response (Heritage, 1984a). While people orient to the organisation of preference and dispreference in talk-in-interaction, “every social setting is a world full
of diverse interests and positions and turf and stances, all being managed (among other ways) in talk-in-interaction, and these are not suppressed or dominated by the organization of preference/dispreference” (Schegloff, 2007, p. 72)