2

Soliciting patients' presenting concerns

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

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

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

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

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

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

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

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

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

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

Data

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

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

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

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

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

Analysis

Question formats designed to solicit new concerns

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

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

Extract 1: SHOULDER PAIN

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

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

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

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

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

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

Extract 2: EAR PROBLEM

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

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

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

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

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

Quantitative results for new-concern question formats

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

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

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

Question formats designed to solicit follow-up concerns

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

Extract 3: SORE ARM

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

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

How are you feeling?

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

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

you feeling? Researchers have included *How are you feeling?* in the category of *How are you?*-type questions, including *How are you?* and *How are you doing?* (Frankel 1995b; Jefferson 1980b). Despite the fact that these question formats all contain lexical and grammatical similarities (e.g., they all begin with *how are you*), all can occur as solicitations of patients' presenting concerns, and all can relevantly be receipted with a range of identical evaluative responses (e.g., *Great, Fine*, and *Terrible*) (Jefferson 1980b; Sacks 1975), they nonetheless accomplish different actions (Button and Casey 1985; Coupland et al. 1994; Jefferson 1980b; Schegloff 1986). On the surface, *How are you feeling?* may appear to be open-ended and social (vs. medical). In contrast, this chapter argues that *How are you feeling?* is narrow and biomedically focused. The question format *How are you feeling?* holds special interest because, unlike other follow-up-concern formats, such as *How's the dizziness?*, the nature of the object that it solicits an evaluation of is less clear (to analysts, but not to participants). Because of this opacity, the action accomplished by *How are you feeling?* is more likely to be misinterpreted by researchers, whose findings are being used to train physicians. What follows is an analysis of the action accomplished by *How are you feeling?* in mundane and medical contexts, respectively.

"How are you feeling?" in mundane conversation. In their analysis of mundane conversation, Button and Casey (1985) included *How are you feeling?* in a category of turns they called *itemized news inquiries*, which are designed to accomplish topic nomination. According to Button and Casey, itemized news inquiries display: (1) a speaker's orientation to a particular event; (2) a speaker's orientation to the event as *live* or *ongoing*; (3) that a speaker has some access to, and knowledge of, the event; (4) a speaker's orientation to the event as being known about by the recipient; (5) that a speaker's knowledge is only partial relative to that of the recipient and thus that there may be news to tell since last time; and (6) a speaker's "'willingness' to hear recipient's news, thereby shaping some part of the conversation around co-participant" (Button and Casey 1985:48). In sum, itemized news inquiries are "requests to be brought up to date on developments concerning an ongoing recipient-related activity or circumstance, and are oriented to finding out about the latest developments, the latest news about

the activity or circumstance" (1985:8). Button and Casey described *How are you feeling?*-type utterances specifically as "solicitous enquiries into troubles which recipients are known to have" (Button and Casey 1985:8; see also Jefferson 1980b) and noted that *How are you feeling?* contrasts "with enquiries into personal states – such as 'How are you' – which do not presume a trouble" (1985:9).

Extending previous research, this chapter argues that, in both mundane and medical contexts, *How are you feeling?* performs the action of soliciting an evaluation of a particular, recipient-owned, currently experienced condition that is known about by the speaker and typically related to physical health. For example, Extract (4) is drawn from a dinner conversation between friends. At line 1, John, the husband of one couple, asks Ann, the pregnant wife of another couple, "How are you feeling. (.) these da:ys."

Extract 4: FAT

1 JOHN: How are you feeling. (.) these da:ys.
2 ANN: Fa:t.
3 JOHN: ((nods for 1.3 seconds while chewing food))
4 ANN: ( ) I can't- I don't have a waist anymore

Ann initially responds with "Fa:t." (line 2). At line 3, John nods while chewing a piece of food, and Ann continues her response with "( ) I can't- I don't have a waist anymore" (line 4). Ann's response of "Fa:t." and her subsequent complaint about losing her figure constitute both negative self-descriptions and negative evaluations concerning one particular aspect of being pregnant – that of gaining weight. In sum, Ann displays her orientation to John's "How are you feeling. (.) these da:ys." as a solicitation of an evaluation of a particular and ongoing, physical-health related condition (in this case, pregnancy).[9] Although the argument being made is for the question format *How are you feeling?*, Ann is admittedly responding to "How are you feeling. (.) these da:ys." (line 1). Turn-terminal,

[9] Researchers have described *How are you feeling?* as inquiring into "troubles" (Button and Casey 1985; Jefferson 1980b). Although pregnancy is not generally considered to be a trouble per se, it is notable that Ann responds with troubling features of her pregnancy and, in that sense, orients to it as a trouble. Nonetheless, this chapter errs on the side of caution when it describes *How are you feeling?* as inquiring into "conditions."

temporal modifications, such as "these da:ys," do not change the action accomplished by *How are you feeling?*, but rather further specify and/or clarify the conditions being inquired into.

For another example, see Extract (5), drawn from a mundane telephone conversation between two friends, Helen and Joyce.

Extract 5: EVERYTHING'S ALRIGHT

1	HELEN:	How are you feeling Joyce.=
2	JOYCE:	=Oh fi:ne.
3	HELEN:	'Cause- I think Doreen mentioned that
4		you weren't so well? A few [weeks ago:?]
5	JOYCE:	[Ye:ah,]
6	JOYCE:	Couple of weeks ago.
7	HELEN:	Ye:ah. And you're alright no: [w?
8	JOYCE:	[Yeah.

Prior to this conversation, Helen has been informed by a third party, Doreen, that Joyce is ill. However, by the time of this conversation, Joyce has recovered (see line 8, where Joyce agrees with Helen's proposal that Joyce is "alright no:w?"). When Helen asks, "How are you feeling Joyce." (line 1), she solicits an evaluation of an ongoing physical-health condition that no longer exists. Thus, Helen's question embodies an incorrect presumption that Joyce is currently ill, and presents Joyce with an interactional conundrum. That is, it makes relevant an evaluative response, but any such response will tend to be heard as an evaluation of a particular and ongoing health condition, which is no longer relevant for Joyce. Heritage (1998) argued that prefacing responses to questions with the particle *Oh* can be a practice for indicating that such questions are inapposite. Joyce's "Oh fi:ne." (line 2) claims that she is not currently experiencing an ongoing, physical-health condition (i.e., she is "fi:ne") and that Helen's "How are you feeling Joyce." (line 1) is inapposite for making such a presumption. Helen displays her understanding that her question was inapposite by going on to explain that her "How are you feeling Joyce." (line 1) was asked based on the presumption that Joyce was ill – with "'Cause- I think Doreen mentioned that you weren't so well? A few weeks ago:?" (lines 3–4), Helen accounts for, and defends, the asking of her question. Furthermore, Joyce agrees with this presumption with "Ye:ah," (line 5). Thus,

both Helen and Joyce display that Helen's "How are you feeling Joyce." was indeed designed to solicit an evaluation of a particular and ongoing physical-health condition.

"How are you feeling?" in physician–patient visits. In the previous section, it was argued that, in mundane conversation, *How are you feeling?* performs the action of soliciting an evaluation of a particular, recipient-owned, currently experienced condition that is known about by the speaker and typically related to physical health. As such, as a solicitation of patients' concerns, *How are you feeling?* is suited to the solicitation of follow-up concerns.[10] Initially, this is supported by anecdotal evidence from medical textbooks. For instance, regarding how to begin a medical interview in a hospital context, where patients have known-about and continuing illnesses, medical textbooks advise physicians to first "inquire how the patient is *feeling*" (Bates et al. 1995:12; emphasis added). One suggested solicitation is: "Before I ask you about your illness itself [note the presumption of a preexisting illness], I want to check how you're *feeling* right now?" (Cohen-Cole 1991:56; emphasis added).

Evidence also comes from actual physician–patient communication. For example, in Extract (6), the patient is visiting the physician to follow up on a severe sinus infection.

Extract 6: SINUSES

1	DOC:	Hi mister A[nderso:n. [How are y]ou:::.=
2	PAT:	[Hi:: [( )]
3	PAT:	=Oka::y,
4	DOC:	How are you feelin' to[da:y.]
5	PAT:	[.hhhh]h Better,
6	DOC:	And your sinu[se[s?]
7	PAT:	[.h[.h] ((two 'sniffs'))
8		(.)
9	PAT:	(W)ell they're still: they're about
10		the same.

[10] Talk in institutional contexts often involves a reduction in the range of interactional practices that participants deploy in mundane contexts and a specialization and respecification of the mundane practices that remain (Drew and Heritage 1992). In physician–patient visits, this does not appear to be the case for *How are you feeling?*, which is a mundane practice that just happens to accomplish an action perfectly suited to physicians' goals of following up on old concerns.

At line 4, the physician asks, "How are you feelin' toda:y." The addition of "toda:y" invites the patient to evaluate the current state of his condition relative to its previous state (presumably during the prior visit). The patient responds with "Better," (line 5), which is a report of improvement on, and thus a positive evaluation of, the state of a particular and ongoing health condition (i.e., his general, sinus-related condition). This is partially supported by the physician's subsequent question, "And your sinuses?" (line 6). By prefacing her question with the word "And," the physician communicates that it is a next question in a series of agenda-related questions begun with "How are you feelin' toda:y." (Heritage and Sorjonen 1994). Insofar as this question requests an evaluation of a specific aspect (i.e., sinuses vs. headaches or sneezing) of the patient's general, sinus-related condition, the physician displays that her "How are you feelin' toda:y" was designed to solicit an evaluation of a particular, ongoing, physical-health condition.

For another example, see Extract (7). In the previous visit, the patient had been ill due to high blood pressure. During that visit, the physician attempted to control the blood pressure by increasing the patient's prescription of a drug named Chlonadine. The current visit has been arranged to follow up on the patient's blood pressure.

Extract 7: NO ENERGY

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 1  DOC:  Hi Missis Mo:ff[et,
 2   PAT:                 [Good morning.
 3  DOC:  Good mo:rning.
 4  DOC:  How are you do:[ing.]
 5   PAT:                  [Fi:n]e,
 6        (.)
 7  DOC:  How are y[ou  fe[eling.  ]
 8   PAT:             [Much [(better.)]
 9   PAT:  I feel good.
10        (.)
11  DOC:  Okay.=so you're feeling
12        a little [bit better] with thuh
13   PAT:          [Mm hm,]
14  DOC:  three: of thuh [Chlon]adine?
15   PAT:                [Yes.  ]
16        (.)
17  DOC:  O:ka:y.
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Table 2.2 *The relationship between follow-up-concern visits and different question formats*

	New-concern question format	Follow-up-concern question format	"Other" concern question format	Total
Follow-up-concern visits	4 (26.7%)	10 (66.7%)	1 (6.6%)	15 (100%)

In response to the physician's "How are you feeling." (line 7), the patient says "I feel good." (line 9). After the physician accepts the patient's response with "Okay." (line 11), she goes on to formulate an upshot of the patient's response: "so you're feeling a little bit better with thuh three: of thuh Chlonadine?" (lines 11–14; for formulations, see Garfinkel and Sacks 1970; Heritage and Watson 1979). The physician's formulation seeks to confirm that the patient's response was an evaluation of her high blood pressure condition. At line 15, the patient confirms that formulation. In sum, both physician and patient display an understanding that the physician's "How are you feeling." was designed to solicit an evaluation of a particular, ongoing, physical-health condition.

Quantitative results for follow-up-concern question formats

The data contain 15 cases where patients are visiting physicians for follow-up presenting concerns. Table 2.2 displays the relationship between visits in which patients had follow-up concerns (i.e., follow-up-concern visits) and the types of question formats that physicians used to solicit those concerns.

In 10 out of 15 cases (66.7 percent) where patients had follow-up concerns, physicians used follow-up-concern question formats. In 4 cases (26.7 percent) physicians used new-concern formats. (These *deviant* cases are discussed below.) In 1 case (6.6 percent), physicians used some other question format. Table 2.2 shows that, in visits where patients had follow-up presenting concerns, physicians were considerably more likely to use follow-up-concern question formats than they were to use new-concern or other-concern formats. This

supports the previous, qualitatively supported claim that follow-up-concern question formats communicate physicians' understandings that patients have follow-up concerns.

Question formats designed to index chronic-routine visits

There also appear to be questions designed to communicate physicians' understandings that patients are visiting to deal with chronic-routine concerns (e.g., monitoring blood pressure or diabetes). During these visits, physicians are commonly faced with two simultaneous issues. On the one hand, these patients generally visit physicians on regular bases (e.g., monthly). Although patients' routine concerns are often in a state of control, they can become problematic and thus need to be monitored. On the other hand, physicians are simultaneously faced with the possibility that these patients also have new concerns. This section focuses on one question format that simultaneously addresses both issues: *What's new?*[11]

"What's new?" in physician–patient visits. *What's new?*-type question formats allow patients the opportunity to topicalize new medical concerns as first items of business and display physicians' orientations to new medical concerns as being immediately current, newsworthy events relative to routine concerns. As a result, *What's new?*-type question formats simultaneously communicate physicians' understandings that: (1) patients have routine concerns; (2) patients may have new concerns; (3) there is a distinction between new and routine concerns; and (4) both new and routine concerns are potentially relevant. Additionally, *What's new?*-type question formats project a structure for the ensuing visit by projecting at least two potential interactional trajectories. First, if patients have new concerns (and opt to present those concerns), then they will be dealt with first, and upon completion of dealing with those concerns the visit will proceed to dealing with routine concerns. Second, if patients do not have new concerns (or opt not to present new concerns), then the visit will proceed directly to dealing with routine concerns.

[11] Contrary to *How are you?* and *How are you feeling?*, the question format *What's new?* operates differently in medical versus mundane contexts. For a review of *What's new?* in mundane contexts, see Button and Casey (1984, 1985).

The first of these trajectories can be seen in Extract (8). This routine visit is organized around monitoring a variety of medical issues concerning the patient's lungs, heart, blood pressure, vision, and hearing. After the visit is opened, the physician asks, "anything new?" (line 33).

Extract 8: EAR PAIN

33	DOC:	hh Uh:m (0.8) .mtch=anything new?
34		(0.8)
35	PAT:	Nothing: really too new:, but °uh-°
36		I don' know (I/I've) been havin' a funny
37		pai:n, (0.5) an' it swells up right in
38		he::re, ((referring to her head))
		((12 lines deleted))
51	PAT:	.hh An' I never had that before=uh course
52		I've had trouble with this ear for quite a
53		whi:le . . . ((Patient continues))
		((144 lines deleted – history taking and physical exam))
198	DOC:	Uh:m=hh (3.9) We'll j'st keep an eye on
199		things. >It'll<
200		(1.1)
201	DOC:	Check again la:ter.
202		(0.7)
203	DOC:	Uh:m (.) remind me next time.
204		(1.6) ((DOC prepares stethoscope for use))
205	DOC:	Huh uh:hh That's fine. just like
206		that's good.
207	PAT:	.hhhhh hh[hhh
208	DOC:	[(Dee-) deep breath,

The format of the physician's question, "anything new?" (line 33), shapes the patient's response in at least two ways. First, the use of the negative-polarity item *anything* (Horn 1989) establishes a practice-based preference (Schegloff 1988) for a *No*-type response, or a report of no new concerns (regarding preference, see Pomerantz 1984a; Sacks 1987; Schegloff 1988). Second, the action of soliciting new medical concerns relative to routine concerns may embody a structure-based preference (Schegloff 1988) for a *No*-type response; that is, patients who already have a series of ongoing concerns may not want to be seen as having new concerns (see Heritage and Robinson this volume). Nonetheless, the patient has a new concern to present. The patient's initial, long pause (0.8 seconds at line 34)

communicates that she is about to produce a dispreferred response, that being a new concern. When the patient begins with "Nothing: really too new:," (line 35), she simultaneously denies the presence of a completely new concern – thereby partially managing face issues involved with having a new concern (see Brown and Levinson 1987) – yet communicates that she has a relatively new concern.

As projected, the patient ultimately presents a new concern, a pain in the left side of her head (lines 35–38). The patient explicitly orients to the concern as being new when she says, ".hh An' I never had that before" (line 51). The physician and patient spend a long time dealing with the new concern. In fact, after 144 lines of talk, the physician is not able to diagnose the concern (lines 198–203). Note that, upon completion of dealing with the new concern, and in accordance with the interactional trajectory projected by the physician's "anything new?", the physician immediately begins to deal with the patient's routine concerns – at line 204 he prepares his stethoscope for use, and at lines 205–208 he begins checking her lungs.

For an example of the second trajectory, see Extract (9).

Extract 9: BLOOD PRESSURE

3	DOC:	(Eh) So what's new.
4		(0.2)
5	PAT:	Nuh I just came in fer thuh blood pressure
6		reche:ck,
7		(.)
8	DOC:	Mm [hm:,]
9	PAT:	[Which I] guess was hi:gh,

Contrary to the physician's "anything new?" in Extract 8, here the physician's "So what's new." (line 3) is grammatically designed so as to prefer a *Yes*-type response, or a report of new concerns (see Sacks 1987; Schegloff 1988). Despite this, the patient does not have a new concern to present. The patient's initial, brief pause (0.2 seconds at line 4) may communicate that she is about to produce a dispreferred response, that being a report of no new concerns. This is partially supported by the patient's subsequent "Nuh" (line 5), which is hearably on its way to *Nothing* and thus to rejecting the existence of new concerns. If so, then, according to the second interactional trajectory, we should expect the patient to continue to deal

with her routine concerns. Indeed, the patient continues to present a routine concern as her reason for visiting the physician: "I just came in fer thuh blood pressure reche:ck,". The patient's "just" (line 5) minimizes her routine concern, and this may be motivated by the physician's assumption, built into the design of his "So what's new." that the patient has new concerns.

Question formats that do not index patients' institutionally relevant concerns

New-concern, follow-up-concern, and routine-concern question formats are similar in that they index patients' institutionally relevant concerns. Consequently, these formats communicate that physicians are shifting into the activity of dealing with patients' concerns. However, there is at least one question format that does not, in and of itself, index patients' institutionally relevant concerns: *How are you?* In mundane contexts, *How are you?* regularly functions as a request for an evaluation of a recipient's current and general (i.e., unspecified) state of being, such as *I'm fine* (Jefferson 1980b, 1988; Sacks 1975; Schegloff 1986). *How are you?* functions similarly in the opening phase of visits when physicians produce it *prior* to displaying their readiness to deal with patients' concerns (Frankel 1995b; Heath 1981; Robinson 1999). This does not mean that *How are you?* cannot be produced by physicians, and understood by patients, as a solicitation of patients' concerns, nor does it mean that patient's do not exploit *How are you?* as an opportunity to produce, or refer to, their concerns (Robinson 1999). However, this does mean that how *How are you?* gets produced and understood as a solicitation of patients' presenting concerns and is accomplished by interactional practices other than turn design, such as intonation (Schegloff 1986) and the turn's positioning in sequences and activities (Robinson 1999).[12]

Relevant to the present chapter, *How are you?* performs a different action compared to other apparently similar question formats,

[12] Jefferson's (1980b) data show that, in mundane contexts, the question format *How are you doing?* can solicit a conventional response and thus be treated very similarly to *How are you?* However, Jefferson's data also show that *How are you doing?* can solicit an update on, and thus index, a specific event, in which case it would operate similarly to *How are you feeling?* More research needs to be done on the operation of *How are you doing?*

such as *How are you feeling?* For example, return to Extract (6) above. In response to the physician's "How are you:::." (line 1), the patient responds with "Oka::y," (line 3), which treats the physician's solicitation as a request for an evaluation of his current and general (i.e., unspecified) state of being. However, in response to the physician's subsequent turn, "How are you feelin' toda:y." (line 4), the patient responds with "Better," (line 5), which, as argued earlier, is a report of improvement on, and thus a positive evaluation of, the state of a particular and ongoing health condition. Insofar as the physician produces "How are you feelin' toda:y." as a next action after "How are you:::.", and insofar as the patient produces a different form and type of response to each solicitation, both participants display that the two question formats are produced and understood as accomplishing different actions.[13]

[13] It was argued earlier that the question format *How are you feeling?* performs the action of soliciting an evaluation of a particular, physical-health-related condition. The re-examination of Extract (6) raises the possibility that participants' understandings of *How are you feeling?* are at least partially, if not wholly, shaped by the fact that it is sequentially positioned immediately after a sequence initiated by a *How are you?*-type question, as is the case in Extract (7) (see lines 4–5, 7–9). In other words, it might be argued that patients understand physicians' *How are you feeling?*-type questions as indexing medical concerns in part, or entirely, because they follow questions that do not index medical concerns. Although the sequential positioning of *How are you feeling?* certainly contributes to participants' understandings of the action that it accomplishes, it is important to note that *How are you feeling?*-type questions do not always follow *How are you?*-type questions and are not reliant on such a positioning for their sense. For example, see Extract (A), in which a mother has brought her son (i.e., the patient) in to follow up on a cold.

Extract A: COLD

13	–>	DOC:	Ri:ght. how do you feel no:w?
14	–>	SON:	hhehh ((throat clear)) B't be:tter.
15		DOC:	Bit be:tter. looks a bit [better [doesn't he?]
16		MOM:	[Looks [bri:ghter.]
17			doesn't he:. ye:s.=

At line 13, the physician asks, "how do you feel no:w?" The addition of "no:w" invites the patient to evaluate the current state of a condition relative to that during the prior visit. The patient shows that he understands the action performed by the physician's question by responding with "B't be:tter." (line 14), which is a qualified report of improvement on, and thus a positive evaluation of, the state of a particular and ongoing health condition (i.e., his cold). This analysis is supported by the mom's subsequent assessment of her son, "Looks bri:ghter." (line 16), which is a colloquial assessment of improved physical health and which displays the mom's understanding of the son's "B't be:tter." as an evaluation of a physical-health condition.

Question formats that are inappropriately fitted to patients' concerns

So far, it has been demonstrated that physicians use particular question formats to solicit particular types of presenting concerns. If particular question formats are designed to index particular types of concerns and reasons for visiting physicians, then physicians and patients should orient to the appropriateness or inappropriateness of different question formats for the solicitation of different types of concerns. This is what the data support. Return to Table 2.2. In 4 of the 15 cases where patients had follow-up concerns, physicians used new-concern question formats. *In each of these four cases, physicians are held accountable for inappropriately designing their solicitation*. Three of these cases are presented below. For instance, see Extract (10).

Extract 10: DIZZINESS

5	DOC:	So what can I do for you today.
6		(0.2)
7	PAT:	Uh:m- (0.2)
8	DOC:	Oh yes. yes.
9		(0.2)
10	DOC:	.hhh How's the dizziness.=hhh
11	PAT:	Well I went to a therapi:st . . .

In response to the physician's new-concern question format, "So what can I do for you today." (line 5), the patient: (1) briefly pauses (0.2 seconds at line 6) and thus delays her answer; (2) projects, but again delays, her answer with "Uh:m-" (line 7; see Schegloff 1996d); (3) cuts herself off (denoted by the hyphen after "Uh:m-"), which can be a practice for initiating self-repair (Schegloff et al. 1977); and (4) briefly pauses (0.2 seconds at line 7), which yet again delays her answer. All of these things display that the patient is having trouble producing her answer and, reflexively, that she is having trouble dealing with the physician's question (see Lerner 1996; Schegloff 1979). This analysis is partially supported by the fact that, before the patient produces her answer, the physician, who is reading the records, interjects with "Oh yes. yes." (line 8), which embodies a claim to remember the patient's medical history (Heritage 1998). The physician subsequently resolicits the patient's

presenting concern, this time with a *different* question format: "How's the dizziness." (line 10). This question format requests an update on a specific medical concern and displays the physician's revised understanding that the patient is visiting for a follow-up (vs. new) concern. In sum, the patient displays trouble with producing a response to the physician's new-concern question format, the physician holds himself accountable for initially soliciting the patient's concern with an inappropriate question format (i.e., a new-concern format), and the physician reformats his question to solicit a follow-up concern.

For a second example, see Extract (11):

Extract 11: INFECTED FOOT

9	DOC:	An::d what brings you here to see see us
10		in the clinic?
11		(1.0)
12	PAT:	Well my (.) foot (1.0) uhm (1.0)
13	PAT:	I was in here on Sunday night=
14	DOC:	=Mmkay
15	PAT:	It's actually a follow up
16	DOC:	Yeah I read over your report uh: that
17		they dictated from the emergency room
18		on Sunday . . .

In response to the physician's new-concern question format, "An::d what brings you here to see see us in the clinic?" (lines 9–10), the patient: (1) produces an extended pause (1.0 second at line 11); (2) begins her answer with "Well," which projects some lack of fit between her answer and the physicians's question (for review, see Schegloff 1995); and (3) begins her answer with "my (.) foot" (line 12), but then delays its progression with two long (1.0-second) pauses and "uhm". Similar to Extract 10, all of these things display that the patient is having trouble producing his answer and, reflexively, that he is having trouble dealing with the physician's question (see Lerner 1996; Schegloff 1979). This trouble stems from his struggle to respond relevantly to a question format that is *inappropriately* fitted to his follow-up concern. This is supported by the fact that the patient subsequently abandons his description and restarts his answer by informing the physician: "I was in here on Sunday night"

(line 13). Here, the patient begins to extricate himself from the relevance of the physician's question by indicating that this is not the first time that he has been seen for this particular concern and thus that he has a follow-up concern. The physician's "Mmkay" (line 14) is unresponsive to the patient's informing in terms of the problems that it communicates about the physician's question. At line 15, the patient informs the physician "It's actually a follow up"; the "It's" refers to the patient's reason for the visit. Here, the patient upgrades his informing at line 13 and corrects the physician's mistaken assumption, embodied in the design of the physician's question format, that he has a new concern.[14] In sum, rather than answering the physician's question, which makes relevant the presentation of a new concern, the patient corrects its presupposition concerning the nature of his concern and thus holds the physician accountable for its production.

For a third example, see Extract (12):

Extract 12: MILDLY ABNORMAL SMEAR

49	DOC:	.h Tell me what thuh problem is. th[en.]
50	PAT:	[Well]
51	PAT:	there isn't a problem it- I jus' got a
52		letter from: I had a sme:ar?
53		(0.2)
54	PAT:	Before Christmas?
55	PAT:	[An' I got a letter]=
56	DOC:	[Oh::]=
57	PAT:	=[saying that you wanted to] discuss the
58	DOC:	=[ri:::ght]
59	PAT:	results,

In response to the physician's new-concern question format, "Tell me what the problem is." (line 49), the patient begins by denying the existence of a problem: "Well there isn't a problem" (lines 50–51). Thus, rather than answering the question, the patient begins by rejecting its presupposition that a problem exists. At line 51, the patient twice starts, and then abandons, an answer. The patient first cuts herself off after "it-" and then says, "I jus' got a letter from:". It is possible that, with the latter, the patient was on her way to

[14] The correction is partially accomplished though the use of "actually" (line 15).

producing something similar to what she produces at lines 55–59, "An' I got a letter saying that you wanted to discuss the results," (for word repetition and its functions, see Schegloff 1996a). If so, then the patient abandons a response that would have overtly corrected the physician's presupposition that she has a new concern; that is, she abandons a response that would have informed the physician that her current concern is a follow-up. The patient abandons this response in favor of one that informs the physician that she had a pap smear, "I had a sme:ar?" (line 52), and thus in favor of one that less explicitly corrects the physician's presupposition by allowing the physician to arrive at it independently (for the preference for self-correction, see Schegloff et al. 1977). Note that the patient produces "I had a sme:ar?" with rising intonation, pauses (line 53), and then produces a rising-intoned increment, "Before Christmas?" (line 54), all of which pursue a response from the physician. It is only when no response is forthcoming that the patient reproduces a version of her previously abandoned response (lines 55–59). Simultaneously, the physician produces "Oh::=ri:::ght" (lines 56–58). The "Oh::" displays both her receipt of the information and her change from an uninformed to an informed state concerning the information. The "ri:::ght", which is produced after the patient has produced "An' I got a letter" but before the patient has completed her informing, prematurely treats the patient's informing as both complete and sufficient (Schegloff 1995). By producing "Oh::=ri:::ght", the physician displays both newfound and early recognition of the patient's concern. In sum, both the patient and the physician hold the physician accountable for soliciting the patient's follow-up concern with an inappropriate (i.e., new-concern) question format.

To review, in each of the four cases where physicians used new-concern question formats to solicit follow-up concerns (see Table 2.2), there was an orientation by both physicians and patients to the *inappropriateness* of those formats. Thus, in 14 out of 15 cases (93.4 percent), physicians and patients displayed their understandings that follow-up concerns are appropriately solicited with follow-up-concern question formats.

Physicians can also be held accountable for using new-concern question formats to begin chronic-routine visits. For example, see Extract (13).

Extract 13: BLOOD PRESSURE

13 DOC: How can I help.
14 PAT: Oh its just for a (.) checkup. thank you,
15 DOC: For the pressure? ((i.e., blood pressure))
16 PAT: Yes.

In response to the physician's new-concern question format "How can I help." (line 13), the patient begins by producing the particle "Oh" (line 14), which claims that the physician's question is inapposite (Heritage 1998). The patient continues to produce "its just for a (.) checkup. thank you," (line 14); the "its" refers to the reason for the visit. The patient's "just" mitigates the nature of this reason relative to that presupposed by the physician's new-concern question format. Here, the patient addresses and corrects the presupposition, indexed by the physician's "How can I help.", that she has a new concern. Rather, she has the routine concern of monitoring her blood pressure.

Discussion

This chapter demonstrated three things. First, when physicians solicit patients' presenting concerns, subtle differences in how physicians design/format their questions subtly change the action that those questions perform. Second, physicians and patients orient to the existence of at least three different types of reasons for visiting physicians: dealing with new, follow-up, and chronic-routine concerns. Third, physicians format, are understood to format, and are held accountable for formatting, their solicitations so as to be appropriately fitted to patients' reasons for visiting, and thus to patients' types of concerns. Along these lines, this chapter described question formats that index new, follow-up, and chronic-routine concerns, such as *What can I do for you?, How are you feeling?*, and *What's new?*, respectively. This chapter also described the question format *How are you?*, which does not, in and of itself, index patients' institutionally relevant concerns. Finally, this chapter described cases in which physicians inappropriately format their solicitations relative to patients' types of concerns and the resultant interactional consequences.

These findings have implications for research and training. For example, social scientists and medical professionals alike have considered the question format *How are you feeling?* to be open-ended and sensitive to non-biomedical aspects of patients' concerns (Coupland et al. 1994; Seidel et al. 1995).[15] To the contrary, this chapter demonstrated that, in both mundane and medical contexts, *How are you feeling?* performs the action of soliciting an evaluation of a particular medical condition that is related to physical health. Thus, *How are you feeling?* not only performs a different action from other traditionally open-ended question formats, such as *How are you?*, but it is also more narrow and biomedically focused. This is not to say that *How are you feeling?* cannot be an appropriate or sensitive question format. In contrast to new-concern formats, such as *What can I do for you?*, *How are you feeling?* is especially suited to the goal of soliciting follow-up concerns. Furthermore, *How are you feeling?* is affiliative in at least three ways. With it, physicians claim: (1) to have a relatively intimate level of knowledge of patients' lives; (2) a shared, prior relationship with patients; and (3) a level of concern for patients, and express a willingness to listen to patients' concerns (see Button and Casey 1985).

This level of attention to language in context has consequences for medical care. For example, there is evidence that how physicians solicit patients' concerns can have consequences for patients' perceptions of physicians' competence and credibility, and thus for patient outcomes, such as satisfaction. For example, return to Extract (11) above. In this case, the physician is an intern. The physician's question format, "An::d what brings you here to see see us in the clinic?" (lines 9–10) communicates an incorrect understanding that the patient has a new concern. This is one potential strike against the physician's competence and credibility. After the patient overtly corrects the physician, "It's actually a follow up" (line 15), the physician does not acknowledge the correction, as is often the case (see Jefferson 1987; Schegloff et al. 1977). Rather, he simply agrees with the patient, "Yeah" (line 16). This is a second potential strike. Finally, after agreeing with the patient, the physician goes on to inform

[15] Coupland et al. argued that the question format *How are you feeling?* "allows patients to represent (a version of) their affective responses to a wide variety of personal circumstances, whether traditionally within the bio-medical frame or not" (1994:107).

him that he had, in fact, read his records prior to the visit: "I read over your report uh: that they dictated from the emergency room on Sunday" (lines 16–18). Thus, the physician implicitly admits that his initial question format was produced with the knowledge that the patient had a follow-up concern. This is a third potential strike. It is possible that this intern has been trained to solicit patients' presenting concerns with one, and only one, class of question format (i.e., new-concern) and that he has little conception of the interactional dynamics of this process.

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. One area where training can improve is in how physicians solicit patients' presenting concerns.