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When and how do surgeons initiate noticings of additional concerns?

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ABSTRACT

Objective: Physicians are trained on how to best solicit additional concerns from patients. What has not yet been studied is when and how physicians *initiate* additional concerns. This analysis focuses on when and how general surgeons share their noticings of medical problems unrelated to the upcoming (or recent) procedures that patients are being seen for.

Methods: 281 video-recorded medical encounters with 95 patients from a rural Texas (USA) general surgery private practice were reviewed for surgeon noticings of additional concerns. In addition to analyzing the videos using Conversation Analysis, the author conducted 9 months of ethnographic research to gain understanding of the local setting.

Results: 22 cases of surgeon noticings were found in 17 visits and were typically detected during the physical examination. Surgeons shared noticings adjacent to their discovery and predominantly framed noticings as bad news tellings. This framing helped mitigate 4 dilemmas surgeons encountered: unknown patient awareness of concern, surgeons' rights to assess areas unrelated to upcoming (or recent) procedures, not meeting the desired health optimization outcome & putting additional burden on patients, and other contextual factors specific to the visit that make sharing a noticing difficult. In addition to alerting patients and potentially activating earlier treatment, sharing noticings can also function to help build physician-patient relationships across time and curtail future patient worry.

Implications: Each surgeon noticing is potentially a concern that may have otherwise remained undetected and untreated, and speaks to the importance of physicians taking time to conduct thorough physical examinations.

1. Introduction

Many medical encounters are structured to address a single concern (Beckman et al., 1985; Robinson, 2003); however, patients often have additional concerns they would like to discuss but have difficulty broaching them (Heritage et al., 2007; Robinson et al., 2016; White, 2018). Additional concerns are medical problems (Byrne and Long, 1976) that are *prima facie* unrelated to the main reason for the visit. Consequently, interventions have been developed to help physicians better solicit additional concerns from patients (Heritage and Robinson, 2011; Robinson et al., 2016; Leydon et al., 2018; Stuart et al., 2018). What has not yet been studied is when and how physicians *initiate* additional concerns and what functions they serve.

This analysis focuses on additional concerns raised by general surgeons in response to noticing physical abnormalities on patients' bodies that are unrelated to upcoming (or recent) procedures. While surgeons are potentially on the lookout for abnormalities while examining patients, they are not explicitly seeking to discover melanomas, lumps, etc. Nonetheless, if they do inadvertently detect something, sharing noticings can potentially contribute to early detection and better health

outcomes. However peripheral, physicians optimally take responsibility for patients as a whole and not just for the isolated area the appointment was scheduled for.

Mundane noticings in everyday life can be about good or bad events, and there is a preference for (other) noticing over (self) announcing (Schegloff, 2007) (e.g., a friend noticing a new haircut). In everyday life situations can also arise when it is more socially appropriate to *not* notice, in what Goffman (1959) calls acts of *tactful inattention*. In institutional settings, noticings have different interactional import for participants (Halkowski, 2006; Heritage and Clayman, 2011). In medical encounters it is the physician's duty to notice, and physician noticings are delivered and interpreted as done "for cause," and function in closer alignment to the Merriam-Webster definition as the "condition of being warned." As this analysis will demonstrate, surgeons face interactional dilemmas when conveying noticings, as surgeons must take into account both the context in which these noticings emerge and the burden now placed on patients to respond and cope with being told about unanticipated additional concerns.

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1.1. Data, method, & setting

The data used are part of a longitudinal observational study of office visits from a rural Texas general surgery private practice, with all four surgeons participating in the study. All patients are asked to participate by the receptionist when checking-in, and only those who understand and sign the consent forms are enrolled (minors are eligible with guardian consent). Consenting patients have their visit video recorded, as well as subsequent visits. In order to control for the variety of patients seen, this study analyzes data from patients who underwent cholecystectomies, hernia repairs, or colonoscopies and had both pre- and post-operative visits recorded between June 2013–October 2016. In total, 281 visits that spanned 95 patients qualified, and these visits ranged from 10 min to 1.5 h. The University of California Los Angeles institutional review board approved this study and names are omitted to maintain anonymity.

The videos were analyzed using the method of Conversation Analysis (CA), in which cases of a recurring interactional practice are analyzed for their sequential organization, design, and social action (Sidnell and Stivers, 2012) and were transcribed according to CA conventions (Jefferson, 2004). Choosing to study a small town private practice was a deliberate choice in order to gather data outside the more studied urban medical center setting and to add to our understanding of physician-patient experiences. In order to understand the local context in which these visits occurred, the author spent nine months conducting ethnographic observations of this surgery practice and rural hospital to see how their infrastructure, setting, and relationships with their patients shape medical care (Emerson et al., 2011). For instance, the author learned about the different types of specialty care that were not locally accessible, which changed dramatically as nearby clinics shut down and even the hospital's obstetrics department closed during the study period (see Kaufman et al. (2016) on rural hospital closures). Furthermore, the author observed how being referred to a specialist outside of town can affect patients' willingness and ability to adhere to the surgeon's recommendations. In turn, this awareness of the local context can affect the interpretation of how physicians deliver noticings and how patients receive them. As Maynard (2003) describes, there is an affinity between Conversation Analysis and ethnography as methodologies to work in tandem, and combining these approaches benefited the analysis. Lastly, this time in the field allowed the author to discuss cases with the surgeons to gain their insight into the medical relevance of noticings, their relationships with patients, and how they view their role as rural physicians.

2. Analysis

After reviewing all 281 visits, 22 cases of surgeon noticings were found in 17 visits (6% of total visits; 4 visits had 2 noticings), which indicate that noticings are a relatively uncommon phenomenon. One explanation for this infrequency could be that there is nothing extra or problematic on patients' bodies to be noticed. A second could be that surgeons do not articulate all they notice. There are countless things perceivable on patients' bodies (e.g., wrinkles, tan lines, bad breath), but surgeons do not relay an online narration of everything they observe. Instead, they filter observations and only share information they deem relevant or actionable. Consequentially, patients listen to noticings not as mundane commentary but instead as authoritative observations that can affect future medical care (Drew, 1991; Heritage, 2012a, 2012b).

While surgery visits have different phase structures than acute primary care visits (Robinson, 2003; White, 2018), both share the “one visit, one problem” objective, as patients are being seen for a single reason—which in these visits is to prepare patients for upcoming procedures or to assess them post-operatively. When surgeons examine patients pre-operatively, they are evaluating whether patients are physically fit to undergo surgery. Even though family doctors have

referred most of these patients and ostensibly recently examined them, these surgeons also perform their own examinations, and both surgeons and patients are orientated to this examination as being relative to the upcoming (or recent) procedure. Consequently, if surgeons notice additional concerns that are not relevant to that procedure, these are perceivably unexpected announcements for patients.

2.1. Noticings as dispreferred first actions

Because of the focused context of these visits (cf. Heritage and Clayman, 2011), it could seem inapposite for surgeons to announce additional concerns as straightforward, non-problematic news announcements. Indeed, the vast majority of noticings were found to have a dispreferred turn-design (detailed below), which helps mitigate their unexpected nature. The dispreferred design also orients to the institutional nature of noticings as being done as a warning of a potential concern that warrants further investigation. Thus, noticings are initiating actions that sequentially place patients in a recipient position and holds them accountable to provide a response (Stivers and Rossano, 2010).

Furthermore, even before surgeons articulate a noticing, these data show that during examinations surgeons pay extra attention to the problematic area. In turn, patients are likely able to perceive that surgeons are noticing something. As socialized participants in medical encounters, patients know that physicians examine for cause and can interpret this concentrated, extra attention as a harbinger of bad news. In turn, surgeons can anticipate this and design noticings with a sensitivity to patients bracing themselves for something negative. Thus, even before noticings are articulated, the act of prolonged examination can be interpreted as a dispreferred action.

As Maynard (2003) described, physicians “shroud” bad news deliveries (in contrast to “exposing” good news) and found bad news to be delayed, softened, accounted for, and hedged. In orientation to the preference-system (Pomerantz and Heritage, 2013), speakers of dispreferred turns are signaling that what comes next may be undesirable by including delays, self-repairs, hesitations, minimizations, apologies, and/or accounts. By looking at how surgeons design and share noticings with patients, these features become evident:

1. **Delays** – In the beginning of the noticing's turn and throughout, silences, breaths, or “filler” words work to stall the articulation of the concern.

Ex: 1
01 DOC: .hh Are these (.) uhm splotches on your legs
02 is that just n-natural,

Ex: 2
01 DOC: You have these little u:hm (0.5) what are called
02 pterygiums. They're little like skin growths that
03 headin' they're heading across your eye.

2. **Reformulations** – Surgeons can cut-off the noticing in the middle of its articulation and redesign the syntax. In Example 3, the surgeon begins with an interrogative that starts with “Have you” and abandons this design for a declarative, “You have”. In Example 4, the surgeon starts with a declarative and switches to an interrogative.

Ex: 3
01 DOC: Have you had your ah (2.5) You have ah- (5.0)
02 You have a little bit of a flow murmur.

Ex: 4
01 DOC: Hm you may have a li:ttle- (.) do you think
02 that's come ba:ck,

3. **Minimizations** – Surgeons downplay additional concerns with words like “little” (see Ex 2, 3, 4), “small”, or “just” (not shown here).

Ex: 5
01 DOC: There might be a **small** one on this side too here.

4. **Hedgings** – Surgeons initially present additional concerns as a possibility (as opposed to a certainty) by using epistemic modal verbs like “may” (Ex 4) or “might” (Ex 5) which convey less than complete certainty.
5. **Avoidance** – Surgeons can use locally subsequent referents (Schegloff, 1996) like “one” (Ex 5) or “that” (Ex 4) instead of the actual term, thus avoiding articulating the bad news specifically (Maynard, 2003).

The following three cases of surgeon noticings will further demonstrate how participants orient to them as dispreferred actions. Case 4 serves as a deviant case to show that there are instances in which a preferred-design is used, which demonstrates that like all social actions, even though there may be a normative way of delivering them in particular contexts, social interaction is not confined to a fixed rubric, and participants have agency to simultaneously adapt to and shape how conversations unfold in real time.

2.2. Case 1: parotid gland

This patient in her mid-sixties is being seen for a routine colonoscopy consultation, and it is her first time meeting this surgeon. While taking her medical history, the surgeon inquires about a family history of colon cancer, which she denies. After 8 s of silence, the patient recalls her personal history of a parotid gland tumor (line 1). Although he briefly touches a scar near her ear and asks if it is related to her parotid gland procedure (line 15–16), this activity is still embedded in history taking. As evident in her telling, undergoing this procedure was a traumatic experience, and even though it occurred decades prior to this visit when she still lived in a city, she delivers an emotional account of a partial facial paralysis complication that lasted for six months.

The excerpt below shows this first exchange about her parotid gland. The patient has presented it entirely as part of her past, fitted to the activity of history taking (note the past tense throughout), and provides no indication that it is of current concern. She even prefaces it with “I forgot to put on there”, which suggests the offhandedness of her remark. This excerpt helps build context, and the noticing will be presented next.

Case 1: Parotid gland (history taking)

01 PAT: And I forgot to put on there that I had an
02 ult- a parotid (0.5) ultrasound too:.
03 DOC: Mokay. Did you have an operation on your parotids
04 or did they just [did
05 PAT: [They took they took eight percent
06 of this parotid gland you [can see
07 DOC: [parotid uh huh,
08 (0.2)
09 PAT: Because there was a tumor on it and it was growing.
10 DOC: It was benign
11 (.)
12 PAT: Well they called it a mixed.
13 DOC: Mixed tumor. So those are kind of benign tum[ors.
14 PAT: [Yeah.
15 DOC: And this scar here ((touches her face)) was it for
16 your- was it part of your parotid,
17 PAT: Yes. Because they slit me open
18 DOC: Above your ear, all the way down.
19 PAT: Uh huh.
20 DOC: Mokay.
21 PAT: And of course the bad thing about that was uhm (.)
22 I guess it was in that night, (0.2) uh (0.2) ha my
23 right side paralyzed
24 DOC: Right.
25 PAT: And it took about six months for it to come back.

Moving forward 10 min, they are now engaged in the physical examination. This surgeon has a routinized head-to-toe exam he conducts on all pre-operative patients. He first checks her eyes and throat, and

after inspecting her throat, he walks behind her to assess her lymph nodes and asks her to swallow. He places both hands on the area of her parotid gland and begins palpating. At one point the surgeon lifts his eyebrows, which appears to display a registering of something that necessitates further investigation, even though parotid gland issues do not interfere with her upcoming colonoscopy. As he begins this palpation, the patient opens her jaw and makes her parotid gland more easily assessed. This movement reveals her understanding of the surgeon's concentrated touch and helps to establish and confirm joint attention. She remains quiet during the 12-s investigation, aligning herself to being examined for an additional concern that is unrelated to her upcoming colonoscopy. The surgeon then shares his noticing:

Case 1: Parotid gland continued (physical exam)

((surgeon silently palpates patient's face
for 12 seconds))
01 DOC: Hm you may have a li:ttle- (.) do you think
02 that's come ba:ck,
03 (0.2)
04 PAT: Well I went in and had it checked hh a few
05 years ago..

The surgeon initiates with “hm”, which helps delay the upcoming dispreferred talk. Additionally, he first designs his noticing with the declarative informing, “you may have a little” but cuts himself off before articulating the problem. Presumably he stops short from saying the word “tumor” based on later discussions (not shown here). He reformulates his noticing with an interrogative, “Do you think that's come back?”. Again the surgeon avoids “tumor” and instead uses the referent “that”. Using a locally subsequent reference form (Schegloff, 1996) not only enables him to avoid naming the problem, the referent “that” also assumes the patient understands him based on where he's touching and because of their recent discussion in which she was the first to articulate the word “tumor” (line 9).

This reformulation from a declarative informing into a yes-preferring interrogative marks a downward shift in epistemic rights by the surgeon (Heritage, 2010) and places the patient in the position to first evaluate her own body. Since parotid gland issues fall outside this general surgeon's domain of practice and because she has had previous personal experience with it (and presumably could recognize a recurrence), this reformulation and epistemic downgrade mark the surgeon relinquishing his role as the medical expert and instead prioritizing a display of deference to the patient's rights as the experiencer. In sum, the surgeon treats the patient as “expert” (Tuckett, 1985). Furthermore, this solicitation for the patient's input occurs after an extended examination, and his question treats her as also having the experiential knowledge to evaluate how having a parotid gland tumor feels when palpated, something only she can know.

By designing this interrogative as yes-preferring, the surgeon reveals his stance towards what he believes to be the answer to the question (Bolinger, 1978; Heritage, 2010; Raymond and Heritage, 2013). Although “Do you think that's come ba:ck,” is designed for a “yes” answer, it cross cuts the health optimization preference (Schegloff, 2007) for there to be no additional concerns. Furthermore, this noticing conflicts with the patient's initial description of her tumor as a past concern with no allusion to a present one, even though she has the normative responsibility for monitoring her own body (Halkowski, 2006; Parsons, 1951) and has the experiential knowledge and capacity to detect a recurrence. When weighing how to formulate the noticing as something the patient is already aware of (or not), it appears the surgeon takes the position that she has not been. Thus, his noticing will overall be new news for her, even though by the time he articulates it after 12 s of examination, it probably will no longer be unexpected.

Additionally, there is a looming contextual dilemma the surgeon must navigate. As the patient recounts, her past surgery was traumatic due to a complication. Sharing that there may be a new tumor growth will assumedly not be welcomed news, and he may anticipate her resistance. An affordance of designing this noticing ultimately as an

interrogative is that it allows for the patient to articulate for herself what she thinks, in a process [Maynard \(2003\)](#) calls “realization,” which allows recipients of bad news to better come to terms with it. Because the patient was not seeking help for her parotid gland, only mentioned it as part of her medical history, and it bears no consequence for her upcoming procedure, sharing this unexpected topic is a delicate undertaking.

Lastly, the rural setting also contributes to how she receives this news. Because she underwent this procedure before moving to a small town, there is the added assumption that she must leave town to have her gland assessed. Her “went in” (line 4) refers not only to seeing a physician but also driving to a city, something she shares that she does infrequently due to her older age, which can account for her not recently following-up on her parotid gland. Later, once she realizes that this gland can be biopsied locally, she expresses relief and asks the surgeon for help.

2.3. Case 2: varicose veins

This patient is in his mid-seventies and is being seen for a routine colonoscopy consultation. He has been a patient of this surgeon for over thirty years, and they are also friends outside the clinical setting. This interaction occurs 6 min into the physical examination. The patient is lying on his back while the surgeon silently examines his legs, which are noticeably a dark, red color. The talk immediately preceding this 11 s of silence was non-medical talk; thus, the turn-preface “Listen” (line 1) is a shift-implicative, marking the resumption of the medical task at hand ([Jefferson, 1972](#)), and is the beginning of the surgeon's noticing.

Case 2: Varicose veins

```

((surgeon silently examines patient's legs
for 11 seconds))
01 DOC: Listen you're you're kind of like me. My legs look
02 like your legs do down here. and I-I-I don- I
03 haven't done it yet so I can't (.) tell you that
04 you gotta do it but .hh it-it probably be good hh
05 to hh y- (.) wear like a knee length support hose
06 just to- its- just to (0.2).hh support those veins
07 down in the end of your [uh- by your ankles=
08 PAT: [((slight single nod))
09 DOC: =and stuff because if we live to be o:ld enough,
10 (0.2).hh my legs look like they can break down at
11 an(h)y ha at any moment because I'm on my
12 [feet all the time.
13 PAT: [((slight single nod))
14 (.)
15 PAT: [Uh
16 DOC: [But in Texas weather you know nobody wants to
17 wear support hose during the summer but maybe when
18 the weather gets cooler. I-I do yo- I- I bought a
19 pair of knee high support hose but I haven't worn
20 'em yet.
21 (.)
22 PAT: .tch I always wore over the calf (.) socks .hh uh
23 (.) when I was working because I had long pants.
24 DOC: Uh huh,
25 PAT: I don't put on long pants seven times a year.
26 DOC: Huh. (0.2) So you're- I-I do see you in sh-shorts
27 a lot so that's (0.2) .hh hh (1.0) Yeah when you're
28 (0.2)around the house you need to (.) throw some on.
29 PAT: (eh)
30 DOC: My problem is that they take a long time to get on
31 and I never h- I'm always running late so it's just-
32 just a problem.
((surgeon begins to examine patient's groin))

```

As evidence of noticings being oriented to as a dispreferred action that anticipate patient resistance (cf. [Stivers, 2005](#); [Hudak et al., 2011](#)), the surgeon avoids articulating the actual diagnosis (“poor circulation” or “varicose veins”) throughout this entire discussion. Instead, he indirectly describes the patient's legs by relating them to his own leg troubles, showing empathy to his patient and friend. This relational work implies needing to wear support hose is not the patient's fault, is common in people their age, and minimizes the problem.

Earlier in the visit the patient expressed frustrations with getting older and said, “As far as living till after eighty, I hope I don't live to be that long.” This statement has seemingly colored the rest of the visit, in addition to other complaints about aging. Thus, the surgeon appears to struggle adding yet another concern to the patient's list, especially one that requires a lifestyle change (and potentially a daily and physical reminder of getting old). It takes the surgeon five turn-construction-units ([Sacks et al., 1978](#)), that are delayed with hitches and restarts, hedged, and reformulated, before he delivers the treatment recommendation (lines 4–5). Indeed, both times the surgeon provides a treatment recommendation (lines 4–5, 27–28), he simultaneously backs down from his medical expert status ([Drew, 1991](#); [Heritage, 2012a, 2012b](#)) and instead provides a reluctant suggestion, much like a friend giving unsolicited advice (see [Brown and Levinson, 1987](#); [Goffman, 1967](#)). In fact, by simultaneously positioning himself as friend and physician while providing medical advice, the surgeon seems to experience “role strain” ([Goode, 1960](#)), not quite finding solid footing from which role to offer advice.

In line 3 the surgeon prefaces the recommendation with, “I can't (.) tell you that you gotta do it”. He acknowledges that the Texas heat makes it undesirable to wear hose, broadening the timeline for the patient to adhere to his advice until it gets cooler. However, the patient makes an implied objection on the grounds of visibility, since he always wears shorts regardless of season. The surgeon tailors his final push to convince him to wear hose by addressing the visibility issue, telling him to wear them while at home (lines 27–28). Yet, the surgeon again retreats from the already minimized action of “throwing” hose on by revealing that he cannot follow his own advice because stockings require too much time to put on.

2.4. Case 3: melanoma

This patient is in his early-eighties and is in for a routine colonoscopy consultation and has a long-standing relationship with the surgeon. This excerpt begins near the onset of the physical examination, as the surgeon completes examining the patient's eyes with a flashlight. He then shifts his gaze up and shines the flashlight onto a large mole on the patient's forehead. As made evident in this visit, the patient has a history of skin cancer on this area. The surgeon touches the mole and articulates the noticing, line 1.

Case 3: Melanoma

```

01 DOC: Let me look at this spot up here
02 (1.5) ((surgeon rubs spot on patient's forehead))
03 That little mole looks (.) looks all right.
04 (.)
05 DOC: It's where your melanoma was.
06 (.)
07 DOC: [But you've you've ha[ve you
08 PAT: [Yea:h [I'm going next week
09 (0.2) Thursday to (0.2) ((name of dermatologist))

```

The surgeon initiates his noticing with a directive, “Let me”, a token request for permission ([Heritage and Clayman, 2011](#)) to do something extra—to look at a part of the body the patient has not asked for help about. The referent “this spot” presumes and relies on the patient being able to recognize what the surgeon is referring to by where he places his hands and from his gaze. Because the patient has a history of melanoma, coupled with the fact that this mole is large and on his face (unlike a mole on a hard to see area of one's body), the surgeon treats the patient as already inhabiting common ground with respect to the problematic area and refers to it as “this spot”.

Through line 6 the patient has remained still, silent, and has assumed a middle range gaze ([Heath, 1986](#)). This stoicism while being examined is potentially problematic for the surgeon, because it competes with outwardly displaying recognition or understanding of the motivation for the surgeon to look at his forehead. While there is a clear transition-relevance-space for the patient to talk after the surgeon's

positive assessment (Ford and Thompson, 1996; Sacks et al., 1978), the patient does not take hold of the interactional floor, and after a beat of silence (line 5) the surgeon continues, “It’s where your melanoma was.” The past tense “was” reinforces the positive assessment of “all right”, that this concern is still in the past. In addition, this explicit naming of the problem appears to be the surgeon’s partial backing down from his assumed stance that the patient has, throughout this noticing, understood why he is examining his mole.

A dilemma of taking a stance about a patient’s awareness is that there is room for error. However, the patient’s confirming “Yeah” (line 8) demonstrates he is indeed aware and that this concern falls within his experiential domain. Because the patient waited a beat to respond, his “Yeah” overlaps with the surgeon’s continuation. While the surgeon concedes the floor to the patient, the surgeon’s struggle to formulate a question is still decipherable. His question begins with “but” (line 7), which contrasts with the past tense dimension of the previous lines. It appears reasonable to assume that he is on his way to asking the patient if he is monitoring his mole, and it is evident that the patient also infers this by his response that he already has an upcoming dermatology appointment. Thus, the patient attempts to curtail any inference that he has not been watching his melanoma site. Although the surgeon is seemingly going the extra mile in noticing and remembering the patient’s medical history, this is risky because it potentially threatens the patient’s self-presentation. In other words, a noticing’s unintended consequence is that it can place patients on the defensive, adding to the delicacy work needed when formulating them.

2.5. Case 4: cyst

This final case demonstrates that noticings can be shared straightforwardly, without orientating to them as dispreferred turns-at-talk. For instance, when surgeons are able to provide an easy solution to the problem, noticings can be framed as preferred social actions. In fact, in this next case, the surgeon embeds the noticing inside the treatment recommendation itself.

This is the same patient and visit as in Case 3, and this interaction occurs 2 min later in the physical examination. The surgeon is tapping the patient’s back, listening to lung sounds when he notices a sebaceous cyst on the patient’s shoulder and touches it with his left hand. Meanwhile, the patient is in the middle of telling a story about an unrelated medical procedure from many years prior. The surgeon rests his hand near the cyst and moves laterally to the patient’s body so he can better engage with the story. For 17 s, the surgeon holds this position until story completion. It is through this sustained touch that the surgeon’s noticing begins to surface as a public event, since touch is done (and interpretable) as done for cause during the physical examination. As soon as the patient ends his story, the surgeon resumes his position behind the patient. Once again, touch enables the patient to share joint attention, as the surgeon presses on the cyst with both hands and asks without delay, hedges, or reformulations:

Case 4: Cyst

01 DOC: Do you want to get rid of this anytime?
02 PAT: Yes I do,

The noticing is presuppositionally embedded in the “Do you want” offer format and when used “before the offer is made, the problem it educes is not treated by either participant as something in need of remedy” (Curl, 2006: 1265). In other words, the cyst is first raised and oriented to as existing in the surgeon’s same turn-at-talk that seeks to remedy it.

The phrase “get rid” works to minimize the work necessary to resolve this problem (Clayman and Heritage, 2015). The surgeon frames this offer as requiring little work and thus not a major problem. Moreover, even though he has found and initiated an additional concern that the patient now needs to cope with (and pay for), the straightforwardness of the noticing’s delivery presents it as an easily

resolvable and acceptable issue. In fact, the surgeon later tells the patient that he can take care of this while he is under for the colonoscopy, offering this procedure at no additional cost minus the pathology report.

As discussed before, by referring to the cyst with the word “this”, the surgeon uses a locally subsequent form where normally a locally initial reference form would be (Schegloff, 1996). By doing this, the surgeon assumes (and displays this assumption) that the patient already understands and is aware of what he is talking about via touch. Lastly, the open-ended time reference “anytime” conveys that this is not an urgent problem, leaving it up to the patient to decide if and when he wants treatment, which he does readily accept.

Thus, although noticings in this collection were found to be predominantly framed as dispreferred turns-at-talk, depending on the specific circumstances of the additional concern and that particular patient’s situation, surgeons can select to present their noticings as dispreferred or preferred turns-at-talk.

3. Discussion

3.1. Dilemmas of noticings

Four dilemmas were found that surgeons repeatedly face when framing noticings. These dilemmas are evident in the talk itself, as surgeons select how to initiate unexpected attention to concerns patients are neither there to be seen for nor had expressed concern about. While surgeons most likely do not grapple with all dilemmas for each case, several dilemmas are at stake for most. Because humans normatively operate under the *interaction order* of social affiliation (Goffman, 1967, 1983), the way surgeons formulate noticings can display the interactional work and cushioning they do in order to combat these potential dilemmas. In no particular order, the dilemmas surgeons contend with:

3.1.1. Patient awareness

- Surgeons may not know if patients are already aware of the concern. Because of the social norm against telling others what they already know (Goodwin, 1979; Sacks, 1973: 139), this can lead to the dilemma of how to frame noticings. Should surgeons frame it as an already known problem (Case 4) or as a concern patients may not be cognizant of (Case 1)? Patient awareness also can create difficulties for surgeons on how to first refer to the area of concern. For instance, “your melanoma” (Case 3), done without a diagnosis or explanation of what melanoma means, treats the patient as already aware. This is in contrast to detecting pterygiums in the patient’s eyes (Ex 2), in which the surgeon describes and defines this medical term, treating this as new news for the patient.
- In addition, not being aware of a concern can threaten patients’ role as good patients who monitor their bodies and seek medical help for ailments (Parsons, 1951). Recall in Case 3 how by broaching the topic of the patient’s melanoma, the surgeon potentially threatens the patient’s presentation of being a good patient who follows-up on his own care.

3.1.2. Rights to assess

- Do surgeons have rights to assess concerns that fall outside of their domain of expertise? This dilemma is evident in Case 3 when the patient announces that he already has a dermatology appointment. The patient treats his melanoma as peripheral to his current visit, as does the surgeon when he begins to inquire about the patient seeing another physician.
- How do surgeons orient to their rights to assess a patient’s whole body, including areas that are unrelated to reason for the visit? This is noticeable in Case 3 by the surgeon’s token request, “Let me”,

before examining the patient's forehead. Surgeons were also observed alerting patients to anticipate a full-body examination with statements such as, "I'm going to check you out from head to toe." Thus, by foreshadowing next actions, surgeons set expectations and cope with this dilemma of bodily access. These examinations also align with these rural surgeons' ethos of caring for whole patients and practicing "general" general surgery, in contrast to urban general surgeons who they view as having a more specialized scope of practice.

- c. For chronic medical concerns outside their scope of practice, it is unclear who has primary rights to assess—surgeons, who have limited expertise, or patients, who may have more familiarity but lack professional expertise. For instance, in Case 1 the surgeon defers to the patient in her rights to first assess the recurrence of her parotid gland tumor, a condition that falls outside the general surgeon domain.

3.1.3. Health optimization & additional burden

The less patients have to cope with medically, the better. Thus, it is not an optimal outcome when surgeons notice extra areas of potential concern, especially when patients do not appear aware of its existence or recurrence. Furthermore, because there is a set agenda for these surgery visits to discuss a particular procedure, the physical examination is performed under this context. When surgeons point out a potential concern that is not related to the upcoming colonoscopy (for instance), this noticing can counter patient expectation for why the surgeon is assessing their bodies. In consequence, because surgeons may anticipate that patients can be caught off guard by their announcement and are putting patients in a position to now have to respond to this news (an additional burden in and of itself), noticings can be considered a form of bad news, a difficult informing to share.

3.1.4. Other contextual factors

These are specific to particular patients and may relate to something already discussed that can lend itself to making a new noticing problematic. For instance, the patient in Case 2 had already expressed frustration about aging. Adding anything onto this list of possible concerns would not be welcomed news, and the surgeon orients to this potential patient resistance.

3.2. Minimizations

Surgeons almost always included diminutive descriptors like "little" or "small" in their noticings (20/22 cases). This presents a puzzle: Why do surgeons initiate an additional concern while simultaneously diminishing it? The analysis shows that in addition to minimizing a dispreferred action, diminutives can also tackle the aforementioned dilemmas surgeons face. For instance, "little" allows surgeons to minimize the health optimization dilemma. While it is bad news to be told that an unexpected and extra abnormality has been detected, it is not too bad since it is just a "little" problem. Diminutives can also alleviate the dilemma of patient awareness. If patients have not yet noticed new areas of concern, it does not reflect poorly on their ability (or commitment) to monitor their bodies, since "little" alludes to problems being hard to detect or nascent. Thus, diminutives can absolve patients from feeling irresponsible.

Lastly, surgeons have other resources to minimize a noticing beyond diminutive descriptors, as seen in Case 2 in which the surgeon minimizes the issue of poor circulation by sharing that he too has this condition but has yet to treat it himself, despite being a physician who knows better.

3.3. When noticings are shared

Surgeons detected the most concerns during the physical examination phase (19/22), but physical abnormalities can catch the surgeon's

attention whenever they are interacting with patients (e.g., during history-taking or shaking hands goodbye). The noticing and sharing of the concern occurred congruently, or "online" (see [Heritage and Stivers, 1999](#)), in almost every case (20/22). Both exceptions of delay involved rectal issues, and upon review, the surgeon responded that he tries to complete rectal examinations as quickly as possible since they are uncomfortable for the patient. He also finds it a physically difficult position in which to launch a conversation and therefore prefers to wait until patients are repositioned to raise and discuss additional concerns.

The advantage of online noticings is that joint attention is already achieved as a product of haptic connection (see [Cekaite, 2010](#); [Goodwin, 2006](#)). Touch preceding (or simultaneous with) the articulation of noticings occurred in the vast majority (19/22). Patients are able to discern what surgeons are referencing by where they are being touched. Thus, the work of mutual orientation to a certain place on the body is not verbally necessary, which is unique to this setting in which the noticeable object is situated on a person's body that is responsive to touch. Therefore, the advantage of articulating the noticing online is that it removes the burden of having to work for joint attention. Furthermore, another resource garnered by haptics is that an abnormality can be earmarked on the patient's body as in need of discussion by the surgeon maintaining contact with that spot. Often overlapping talk occurs during physical examinations and by maintaining tactile contact, the surgeon can signal what topic may be next in queue, as seen in Case 4.

While sequentially noticings are in first position from a verbal point of view, they often occur responsively to this haptic exchange, which can contribute to the design of these noticings. Lexical referential terms such as "this" or "that", normatively found in sequentially local positions, can now be used in a locally first-positions ([Schegloff, 1996](#)) because of the affordance of touch, as seen in Cases 1 and 3.

3.4. Functions of surgeon noticings

Surgeons sharing noticings about unsolicited and extra concerns on patients' bodies is an inherently delicate form of social action because of the context in which they are raised and makes them an unexpected announcement that patients now must cope with. Thus, surgeon noticings are typically dispreferred first-actions, and surgeons need to carefully navigate through interactional dilemmas in order to arrive at the most appropriate delivery.

What then is gained by surgeons sharing these noticings? The benefit seemingly must outweigh the interactional costs in order to justify relaying this information. Recall, surgeons potentially threaten patients' presentation of self and rights to evaluate their own bodies, increase patients' stress and financial strain, tread into medical territories outside their general surgery domain, and extend into areas of patients' bodies that they have not come in prepared to discuss. Surgeons may also be heard as self-interested and touting for additional business. If these noticings are potentially so problematic, why bring them to surface? Three distinct functions of surgeon noticings were identified.

3.4.1. To alert patients to areas of concern

In order for surgeons to gauge patient awareness and determine whether the concern has already been addressed, surgeons must initiate a discussion. Because early detection and treatment is considered optimal medical care, by telling patients about abnormalities, no matter how small or relevant to their domain, surgeons prioritize a high standard of care over the dilemmas they must consider when sharing.

3.4.2. To build and maintain relationships across time

There is more to patient care than detecting, diagnosing, and treating. At the core, these medical interactions are two people engaging with one another. Their encounters can span decades, and one mechanism for building relationships and showing care is by the act of remembering. For example, the surgeon's inquiry about the patient's

past melanoma in Case 3 extends beyond just providing physical care. It is the fact that the surgeon remembered *and* cared to inquire about a problem, even though outside his domain of practice, that can help build relationships.

3.4.3. To curtail future worry

There were a couple cases in which surgeons share noticings to then immediately dismiss them as non-problematic (to a greater degree than just minimization). For instance, a surgeon spotted sunspots on a patient's back and told him, "You have a couple of these just sun-what I call kind of like sunspots on your back. That don't look like anything bad at all". When asked why he bothered mentioning the sunspots, the surgeon replied that he has known this patient for years and suspects that if he noticed them at home on his own, he would get very worried and schedule an urgent appointment. The surgeon's intent, as he told me, was to prevent this unnecessary worry and visit.

4. Conclusion

This analysis focuses on additional concerns initiated by general surgeons in response to noticing physical abnormalities on patients' bodies unrelated to the upcoming (or recent) procedures. Surgeons must take into account both the context in which these noticings emerge and the burden then placed on patients to respond and cope with being told about unanticipated concerns. Surgeons were found to predominantly frame noticings as "dispreferred turns-at-talk," similar to other medical bad news tellings, as this design can mitigate dilemmas surrounding patient awareness, rights to assess, health optimization, and other contextual factors. Noticings were found to have functions beyond alerting patients to additional concerns, as they also serve to build and maintain relationships, and curtail future worry.

While 22 cases of noticings may seem small, these are 22 opportunities in which patients potentially received help that they may not have otherwise. If neither patient nor physician mention additional concerns, then concerns persist in silence. Thus, not only is it important for physicians to solicit additional concerns from patients, it is likewise imperative for physicians to raise them themselves. Several patients in this study suffered from treatable concerns for decades because they thought treatment was not possible since no physician had ever mentioned or offered it, and these patients were incredibly grateful that surgeons shared their noticings and accepted treatment for them.

In an age of over-specialization in medicine in which patients' bodies are segmented and require seeing a specialist for each fragment, it can be difficult for patients to get their whole body assessed. Each specialist can assume another will see to the areas they don't, and they can also assume patients have a primary care physician who looks at their entire body. The problem lies in these assumptions and speaks to the importance of physicians taking the time to conduct thorough physical examinations, a dying art in medicine (Feddock, 2007). While modern patients see more physicians and have more medical appointments now than ever, ironically more care does not guarantee better care. Every visit should be viewed as an opportunity to treat patients holistically, even when it extends beyond the "one visit, one problem" default orientation.

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