## Title

Additional Concern Initiations in General Surgery Visits: A Longitudinal Analysis of Doctor-Patient Communication



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## Publication Date

2017

Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA

Los Angeles

# Additional Concern Initiations in General Surgery Visits: A Longitudinal Analysis of Doctor-Patient Communication

A dissertation submitted in partial satisfaction of the requirements for the degree of Doctor of Philosophy in Sociology

by

Anne Elizabeth Clark White

2017

ABSTRACT OF THE DISSERTATION

Additional Concern Initiations in General Surgery Visits:

A Longitudinal Analysis of Doctor-Patient Communication

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Doctor of Philosophy in Sociology

University of California, Los Angeles, 2017

Professor John Heritage, Chair

This dissertation analyzes video-recordings of general surgery office visits in order to investigate when and how patients initiate additional concerns, and investigates why some patient-initiated additional concerns are more likely to receive the surgeon's help than others. This dissertation also examines how surgeons themselves initiate additional concerns during the office visit, and the interactional dilemmas they face when telling the patient about this new area of concern. In other words, how do patients and doctors try to introduce extras into the interactions, how do they formulate them as legitimate, and how are they recognizable?

Additional concerns are medical problems (e.g., pain, skin lesions, hernias) that are seemingly unrelated to the main reason for the visit. This analysis utilized a mixed-methodology approach combining Conversation Analysis, ethnography, interviews, and statistics. Data are video recordings of pre- and post-operative office visits for hernia repairs, colonoscopies, and

cholecystectomies, with a longitudinal focus of following patients across consecutive visits. This community-based study, set in rural Texas, serves as an example of the importance of incorporating the setting and context into analysis, and shows that rural patients raise additional concerns frequently and early in their visits.

Patient-initiations of additional concerns were analyzed by looking at their turn design and position in order to assess what characteristics contributed to them receiving "help" by their general surgeon. This analysis identified where in the visit's phase-structure these concerns arose and three methods patients used to launch them: fitted to method, fitted to topic, or disjunctive. Each concern was coded and analyzed for a variety of design features (e.g., lexical choice, social action, first or subsequent mentions) and contextual factors (e.g., concern falls inside or outside the surgeon's domain of expertise, patient mentions another doctor in relation to this concern, the degree of the relationship between the surgeon and patient). In total, 62 patients spanning 175 visits were coded with 377 patient-initiated concerns found. 188 of them ultimately received help.

Next, surgeon-initiations of additional concerns were analyzed for their turn-design, position, and function, with a focus on when surgeons perceptually notice a physical abnormality on the patient's body and how they discussed this with their patient. Only 22 surgeon-initiated additional concerns were found in the data collection, and this analysis argues that this is because surgeons orient to raising additional concerns as first-position dispreferred actions. As the analysis reveals, surgeons must cope with several interactional dilemmas when presenting them, including patient awareness, rights to assess, health optimization, and other contextual factors. By investigating how rural patients and surgeons initiate and discuss additional concerns, this dissertation shows how the surgeon's domain of practice consists of permeable boundaries that are negotiated, constituted, and enacted during visits.

This dissertation of Anne Elizabeth White is approved.

Tanya Jean Stivers

Derjung Mimi Tarn

John Heritage, Committee Chair

University of California, Los Angeles

2017

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ACKNOWLEDGEMENTS

I am incredibly grateful for the seven years that I spent at UCLA in the Sociology Department (2010-2017). In my first year, I discovered Conversation Analysis and this has forever changed the way I view the world. John Heritage, Steve Clayman, and Tanya Stivers have been integral to my analytical development, and I could not have asked for better instructors, mentors, and friends. I have been welcomed into a close-knit and international CA community that has also provided incredible support and friendships throughout the years.

I feel very indebted to my dissertation committee, John Heritage, Jack Katz, Tanya Stivers, and Mimi Tarn for all their guidance and patience. Two conversation analysists, one ethnographer, and one medical doctor all sitting at the same table sounds like a set-up for a bar joke, but in fact this diverse team was what enabled me to conduct the type of research I hoped to do. I especially thank John for being such a fantastic chair and mentor.

Not only have I learned how to be a researcher at UCLA, but I also have made friendships that I know will continue beyond Haines. I couldn't have asked for a better cohort to have gone through this process with, and we are forever tied by this experience. I want to thank Becca, Aaron, Cassandra, Ariana, Karra, Nicole, Ashley, Mirian, and Chris for late night dinners, sofas to crash on, writing retreats, camping trips, and karaoke celebrations! I also especially want to thank Chase Raymond, Laura Loeb, Lisa Gallo, Mitch Duneier, Alice Goffman, and Federico Rossano for their help throughout.

I want to thank my family for their encouragement and support. My wonderful parents made sure that "books wouldn't get in the way of my education" and taught me to always think of the experiences of others—the perfect recipe for a sociologist in the making. Nana, who lived through the Great Depression, taught me to be grateful for the opportunities that I have, and her daily writing habits are an inspiration. I have three fantastic and very different siblings, Mary,

John Pat and Scottson, and I wouldn't be who I am today without them, their spouses, and my nephews.

Lastly, this is a study about a small town community and the relationships rural patients and their surgeons share. This project would not have been possible without the patients, surgeons, and office staff generously giving me their time and allowing me to document their experiences. Healthcare should be accessible to everyone, and as one small town hospital after another are being shut down, I hope to show how devoted these surgeons are to providing the highest standards of care, even as practicing rural medicine becomes more and more difficult to navigate. I am inspired by their dedication to their calling, and I hope this dissertation does them justice.

# BIOGRAPHY

Anne Elizabeth White's main research interest is Medical Sociology. Her dissertation focuses on doctor-patient communication in rural settings with a focus on clinical general surgery interactions using a mixed-method approach combining Conversation Analysis, ethnography, interviews, and statistical analysis. She will receive a PhD in Sociology from University of California, Los Angeles and obtained her BA in Sociology from Princeton University. She next will be a QSCERT Post-doctoral Fellow at the University of California, Davis. She recently published "Time Reference in the Service of Social Action" in *Social Psychology Quarterly.*

# Chapter 1: Introduction

Extras are part of people's everyday life. Sometimes the extra is part of a request—a student can email for extra office hours or a customer can ask for extra ketchup. But extras can also be unanticipated, like a free upgrade to a business class airplane seat or the free slice of pie your favorite waiter drops off. The former are extras that a person feels entitled to receive, while the latter are extras that come as surprises, tokens of goodwill. If one imagines these two types of extras on a spectrum, then in the middle resides the extras that blur the line between entitlements and gifts. Somewhere in this middle are the lagniappes—the 13$^{th}$ donut in the baker's dozen, the biscotti that accompanies your espresso. While these extras are not necessarily guaranteed, they can become expected. Somewhere in the middle are the extras that we are not quite sure if we are entitled to ask for, but we also can feel like we deserve them.

This dissertation centers around this middle type of extras. Specifically, this dissertation will focus on the extra attention to an additional medical concern that the patient asks for during an office visit or that the physician initiates. The dilemma for patients can be determining whether or not they are entitled to ask for help about something extra, especially if this extra does not fall under the specialty of that doctor. A related, indeed reciprocal, dilemma for the doctor is bringing to the patient's attention an additional problem that the patient has not even asked to be evaluated. While these extras may not be necessary for the overall purpose of the visit to be achieved, they can potentially bring the participants closer together or, alternatively, create a divide.

To make this phenomenon more concrete, here is an example[1] of a patient seeking extra help from his general surgeon about a swelling on his back from a recent surgery (not performed by this surgeon). In line 4 the patient makes a request for the surgeon to evaluate an area of the body that is not related to the overall purpose of the visit nor falls under this surgeon's domain.

Example 1

```
01  PAT: .hh Anyway, (.) You're a surgeon[t] ((reaches out and touches
02        surgeon on the knee))
03        (1.0)
04  PAT:  I want you to look at something= ((patient standing up))
05  DOC:  =Sure.
06  PAT:  Cause I couldn't get another (.) surgeon (.) to take a look.
07  DOC:  Sure.
08  PAT:  I had back surgery.
09  DOC:  Okay,
10  PAT:  And (0.4) the top, (.)  I can't really look at this.
11        ((patient has stood up and lifted shirt))
12  DOC:  Right  ((looking at patient's back))
13  PAT:  There's a puffiness, (.) This is nice and smooth
14  DOC:  Right.
15  PAT:  This is a little puffy. I think there's some fluid behind it.
16        Should it be of concern,
```

This video-taped interaction will be analyzed in fuller detail in a later chapter, but I provide this example here to illustrate the work this patient does to get the surgeon on board to helping him with something extra, including two accounts for his request (line 1 and line 6). Accounts are one of the ways in which patients can seemingly straddle the line between feeling entitled to ask for this help while also demonstrating awareness of this request as a reach.

By focusing on these extras, I hope to address the larger question about the scope and boundaries of a successful and collaborative medical relationship. What is it that each participant wants out of their interactions and how is this accomplished? As Erving Goffman wrote about initiations and how participants orient to them:

> An understanding will prevail as to when and where it will be permissible to initiate talk, among whom, and by means of what topic of conversation. A set of

[1] For Jeffersonian transcript conventions (2004), see Appendix A.

> significant gestures is employed to initiate a spate of communication and as a means for the persons concerned to accredit each other as legitimate participants (1967, 33-34).

This dissertation analyzes video-recordings of general surgery office visits in order to investigate when and how patients initiate additional concerns (Chapter 2), and investigates why some patient-initiated additional concerns are more likely to receive the surgeon's help than others (Chapter 3). This dissertation will also examine how surgeons themselves initiate additional concerns during the office visit, and the interactional dilemmas they face when telling the patient about this new area of concern (Chapter 4). In other words, how do patients and doctors try to introduce extras into the interactions, how do they formulate them as legitimate, and how are they recognizable?

## 1.1 ACCESS TO HEALTHCARE IN RURAL AMERICA

The setting for this study is a rural Texas general surgery practice. This is an ideal setting to study additional concern initiations because of the close, long-term relationships that patients and their surgeons have, which can cultivate a hospitable environment for patients to feel comfortable and entitled to seek extra attention. This setting differs from the main body of previous research on doctor-patient communication that has almost exclusively concentrated on acute primary care visits in urban medical settings. This dissertation extends the investigation of additional concerns to secondary care settings, as well as illustrating the need for more research to be conducted in rural areas.

Depending on the definition (i.e., administrative, land-use or economic factors) used to demarcate an area as rural, it is estimated that almost 60 million Americans live in a non-urban area. Texas has the largest rural population (Rabinowitz et al. 1999) and only 10.36% (or 2,617 surgeons) of the active members of the American College of Surgeons practice medicine in a

rural area (Caropreso 2011). "While 20 percent of the US population live in rural America, only 9 percent of physicians of practice there" (Rabinowitz et al. 1999, 2). Contrary to the belief that people who live out in the countryside are healthier and more active than their urban counterparts, "people who live in rural areas of the US are sicker, older, poorer, and more often medically uninsured that those living in metropolitan areas" (Rabinowitz et al. 1999, 2). Thus, rural areas have a dearth of doctors to contend with a sicker population, which has been dubbed the "Inverse Care Law."

Because of their lower average salaries and the higher incidence of rural poverty, rural residents (on the whole) are less able to purchase needed health care services. Costs of time, taking off work, needing to find childcare coverage, and transportation are additional barriers that rural populations must surmount if local care is not available (Mutel and Donham 1983). Furthermore, to make matters even more skewed, there is a disparity of Medicare reimbursement for urban and rural patients. On average, rural areas received 22% less compensation (Minge 2002). This is still relevant in 2017 as rural healthcare systems (both hospitals and private doctor clinics) are compensated at a lower rate than their urban counterparts. Over 1/3 of the nation's population utilizes Medicare, and because rural areas proportionally have a larger elderly population than cities, this places an extra burden on small town hospitals and doctors' practices. In other words, rural doctors care for sicker patients for less pay. Patients in cities enjoy extra benefits including, hearing aids, eyeglasses, prescription drugs, etc. that rural patients may not have access to, even though they both pay the same pay roll tax for Medicare.

Tracking where healthcare money gets spent should be of paramount concern to anyone interested in the US national economy. Healthcare expenditures account for approximately 17% of the GDP, more than any other country in the world. If it continues to increase at the same

rate, it will reach 30% by 2040 (Fuchs 2013). Furthermore, the health care sector employs 10-15% of the rural work force (Doeksen 2000). Roughly 60% of funding for rural healthcare comes from Medicare. Recent cuts for Medicare reimbursements, due to the Affordable Health Care Act (AHCA), coupled with the 2014 deadline that all hospitals must implement electronic medical records (that costs on average a minimum of $2 million per hospital) are forcing already struggling rural hospitals to close at a staggering rate (Holmes 2015). In the last few years, more rural hospitals closed than in the last 15 years combined.

When hospitals shut down, there is a direct spillover effect in the community. In his report to the US Congress, Congressman Minge from Minnesota wrote,

> The availability of trusted, accessible health care services is critical to rural quality of life. It influences the willingness of people to move to or remain in rural areas. Residential choices of retirees, the ability to attract new businesses, professionals, and other key or highly skilled employees…are affected by the availability and perceived quality of local health care services (2002, 7).

The domino-effect of a doctor leaving a community can impact the whole town—jobs are lost, pharmacies close without local doctors, retirees may opt for other towns, patients must now drive longer distances for care (which could be too much of a burden for the elderly, causing them to relocate or not seek care), property values drop where access to care is limited, etc. (Minge 2002, 31).

Cordes et al. (1999) warns, "Loss of general surgical care for trauma and common surgical emergencies could result in worst outcomes in more rural areas. In addition, the loss of revenue from general surgery may threaten the financial health and economic implications for the local community." On average, "a surgeon with an inpatient practice in a small rural community contributes $1.54 to $2 million to the economic life of that community. Small rural hospitals cannot survive without surgical service, and often the hospital is the largest employer in

the community" (Sheldon 2009). Not only does a community losing their general surgeon take an economic hit, but residents will suffer as well. Without access to local care, many patients delay treatment due to the inconvenience or inability to find transportation to a bigger city (Stevermer, Supattanasiri and Williamson 2001), and most patients prefer their care to be done in the local community hospital (Sheldon 2009).

As rural hospitals are rapidly shutting their doors across the nation and doctors are leaving small towns, I believe that what is being lost is more than just access to care, but also the loss of this aspect of local community. Small town doctors are practicing "a dying art" of medicine, and much like a biologist fixates on an endangered species before it disappears, I want to capture the relationships between rural patients and their local general surgeons.

**1.2 THE SETTING**

An overall objective of this dissertation is to layer context into our understanding of office visit encounters. These medical visits are not situated inside a vacuum but are embedded inside a general surgery practice that has its own history, which is located adjacent to a county hospital that serves a local community (all of which also have their histories to tell and understand as well). These visits are also situated in time, and this must also be kept in mind because standards of medical care, access to healthcare, and even the existence of specialized care in small towns is embedded in how these interactions unfold.

Often the outside world and small-town life makes its way inside the patient visit, in casual conversations about local events, friends in common, and so on. But because this dissertation is focused on the initiations of additional concerns, this ordinary talk (that can consume more time than the medical talk itself) often falls outside the scope of this analysis. It would be difficult, if not impossible for readers to get a sense of the local setting from the

confined walls of the patient room, and I have ignored the ordinary talk about local matters that does occur inside the visit in the empirical chapters, unless it is relevant to that chapter's analysis.

Thus, my aim here is to describe the histories of the town, hospital, and general surgery practice in order to give readers a sense of what else is going on outside the confines of the medical visit. I want to ground the medical talk in the historical and local context of this community, and hope that readers can carry this with them when reviewing the empirical chapters.

### 1.2.1 HISTORY OF THE TOWN

In the early 1820's, Stephen F. Austin, the first governor of Texas, founded Townsville[2] on the banks of a major river. Two decades later, German and Czech immigrants arrived and homesteaded farms in the area, the rolling hills and oak trees reminiscent of their homelands. Unlike surrounding towns that have fluctuated in size, Townsville has held a steady population between 4,000 and 5,000 residents since the early 1900's. Townsville sits between three large cities, each over 60-100 miles away. While some residents commute to a city for work, for most, driving to the city is a special event in order to catch a movie or go shopping. Townsville is a three-stoplight town (3.5 square miles), and traffic backs up only when a train trudges through. Driving across town takes less than ten minutes, and even though streets are wide, flat, and shaded by pecan and oak trees, people prefer to drive the three blocks in their air-conditioned trucks to go from their house to the grocery store.

Townsville is the county seat, and the 1890's Gothic-style courthouse sits as the town's crown jewel in the center of the town square. Local shops surrounding the courthouse include a

[2] Just like the names of people, places have also been given pseudonyms to adhere to IRB guidelines.

4th generation-run butcher shop, a men's shop, a wine bar (a new addition), an optometrist's office, a dental office, a 3rd generation Chevrolet/GMC dealership, a barber shop, two cafes (both serve chicken fried steak), a 3rd generation bakery that specializes in kolaches (a Czech pastry), a Hallmark card store, four lawyer's offices, Curves, Dow & Jones, a title shop, an accountant, a local art museum, three state banks, an appliance store, numerous women's boutiques, and several antique stores. Many families have been in the area for several generations, and businesses are often family-run and passed down. Residents take pride in their small community as being self-sufficient with strong local businesses. The power plant is one of the main employers of the community, as is the single K-12 public school and the community hospital. Construction, manufacturing, transportation/warehousing, farming and ranching comprise the other major industries for the residents.

Nightlife within the city limits is slim, nothing more than the bowling alley or a small music venue. Teenagers often park their cars and hang out at the car wash at night, or visit each other at their places of employment like the convenience store or Dairy Queen. High school sports reign and are the main source of entertainment. The school colors are displayed proudly in home décor, waiting rooms, manicures, and store displays. The single-screen movie theater burned down twenty years ago and was never rebuilt. Several country-western dance halls, some more than 100 years old, scatter the countryside. Teenagers and adults alike go two-stepping on Wednesday nights in the summer and Saturday nights year-round. Other than seeing each other at sporting events, these dances are one of the main ways that residents of neighboring small towns intermingle.

The hospital and professional building are situated on the edge of town, about two miles from the town square, along a two-lane highway and surrounded by undeveloped land. There is

a sense of isolation when approaching the medical campus, since it is on the far-side of the bypass, even past the fair-grounds. Everyone drives to the hospital, and a large parking lot envelops the buildings, with the heliport off to one side. There is not a stoplight at the entrance to the hospital, just a right-hand turn lane on the approach from town. The left-turn exit when leaving the hospital is notoriously dangerous because of a downward slope when looking right. Eighteen-wheeler trucks can appear out of nowhere and at fast speeds, not yet needing to slow down for the city limits. People joke that this intersection is good for hospital business. Within a half-mile radius of the hospital, there is little more than a gas station, the police station, a few houses on large lots set back from the highway, and a barbeque restaurant that is primarily a lunch and weekend spot. There is one fast food restaurant about a mile from the hospital open 24 hours, where nurses and doctors frequently make late night runs. Otherwise, most restaurants are closer to the town square, including the Dairy Queen and a local Mexican food restaurant where I ate many late night dinners with the surgeons. While busy during the day, when leaving the hospital at night, it is common to find skunks, raccoons, deer, and feral cats emerging from the nearby fields and scampering across the parking lot.

### 1.2.2 HISTORY OF THE PRACTICE

The doctor-patient interactions have been gathered from a private general surgery practice located in the professional building adjacent to the hospital, and it is a five-minute walk from the operating room door to the office door. There are three[3] partners in this practice, Drs.

[3] In December 2016, a 4th surgeon joined this practice and agreed to participate in the study. While her patient visits are now currently being recorded for future studies, this new surgeon will not be further discussed in this dissertation since the dissertation data is culled from the June 2013-June 2015 videos.

Allen, Sosa, and Gupta (other partners have come and gone throughout the years).[4] Dr. Allen grew up in south Texas and completed his medical school and residency training in Texas. His first (and only) post-residency position has been in the Townsville private practice he founded in the late 1970's. He has always lived inside the town's city limits, wanting to be able to get to the hospital as quickly as possible.[5] With his wife, they raised four children who attended the local public school and now is reliving the same school events for his grandchildren (one of his adult children has remained local). Dr. Allen moved to Townsville because he wanted to establish a general surgery practice in a community that did not have access to that type of care. Now 30 years and eight partners later (Drs. Sosa and Gupta included), it is only a slight exaggeration to say that he has either operated on, delivered a baby,[6] or at least consulted on at least one member of every family that lives in Townsville.

Dr. Sosa also attended medical school in Texas, but he did his residency through the Army in West Texas while enlisted before moving to Townsville in in the mid-1990's. He also raised two children in town with his wife, but unlike Dr. Allen, has always lived out in the countryside, a 20-minute drive from the hospital. His son is a star baseball player for the high school team, and Drs. Allen and Sosa try to watch most of his games together. In 2013, Dr. Sosa started working part-time in Townsville due to a family illness, only seeing patients a few days a month and covering his nights of emergency room call for the practice. As of August 2017, this

[4] There is one other general surgeon who currently practices in Townsville. He originally was part of Drs. Allen, Sosa and Gupta's practice, but he left and joined another physician's practice. This surgeon was not part of this study. All other past partners left Townsville immediately when they departed from the larger group.

[5] In fact, when the new hospital was built he was concerned about the increased distance. From the old hospital, which was also situated in town, the distance to his house was exactly one mile. From the new hospital, now on the outskirts of town, the distance is now 2.5 miles. Since traffic does not exist in town, this is really only a difference of a few minutes of driving—but enough to concern Dr. Allen.

[6] While Townsville has been fortunate to have a local OB/GYN for about the last 10 years, not always has there been one, and they have come and gone throughout the years. Whenever there was not a local OB/GYN, the family doctors assumed much of this responsibility. The general surgeons were available to perform cesareans.

is still Dr. Sosa's current arrangement, and his partners understand and support his situation but also hope for his full-time return.

Dr. Gupta joined the practice in early 2000's. He grew up on the East Coast and moved to Texas for college. He completed his medical school and residency in Texas and did a Critical Care Fellowship in the Midwest. He has never actually resided in Townsville, but commutes from a larger city an hour away where his wife works as a physician. He now has two younger children, and in recent years he has limited his work hours in order to be the primary caregiver for his kids.

Practicing medicine in a small town makes being a doctor one's master status (cf. Hughes 1945). Unlike an urban doctor who can shed the white lab coat and slip into anonymity when leaving the hospital or office parking garage, in a small town everyone knows who their local doctors are, regardless of dress, time, or place. I have seen patients lift up their shirts in the frozen food aisle when they cross paths with these surgeons so that they can check the progress of their healing wounds. And other times, the surgeons themselves initiate medical interactions outside the medical setting. For instance, when discussing the topic, in general, about initiating medical concerns to a patient that s/he has not sought help for, one surgeon told me that he is worried about the cashier at the local Mexican restaurant he frequently eats late night dinners (the hospital cafeteria closes at 5pm). The cashier has a pre-cancerous looking mole on her chin, and Dr. Allen told me with frustration, "When I see her [at the cash register] I have offered for her to come see me at the office so I can biopsy it for free, but she hasn't ever made an appointment." Thus, professional boundaries and personal ties are constantly being blurred and intertwined, and medical care is being provided outside the office setting as well.

Rural doctors often have "dual relationships" outside of the medical setting with their patients as neighbors, members of the same community organizations, parents of children who are friends with one another, etc. (Baca 2011). In these communities, where a physician's home phone number is listed in the local directory and everyone in town knows whose house is whose and what car they drive, the lines between work and home, on-call and off-call, doctor and neighbor are frequently blurred. As seen in this fieldnote (September 2014), there is no true escape from the hospital:

> At a home football game, Dr. Allen arrived three minutes before half time because he got held up in an emergency appendectomy. It was a drizzly evening, and fans are huddled together, sitting on towels in an attempt to at least keep their seats dry. He arrives wearing khakis, a collared shirt, and his jacket that has the school's colors, which means that he took the time to go home to change (out of his scrubs) before coming to the game, even though he will return to the hospital right after the game, also entailing a wardrobe change. As he walked towards his seat, he smiled and waved to various people in the crowd. As he carefully climbed the three rows of slippery bleachers, he reached out his hand and shook the man's hand who was sitting in front of us. The woman sitting next to him took her eyes off the game in order to greet Dr. Allen. She joked about how he escaped from the hospital, that she didn't think he was going to make it. I recognize her as a nurse at the hospital who apparently was there when the emergency appendectomy patient got admitted. Even at the football game, there is no escaping the hospital.

These surgeons have a grueling schedule, often called into the emergency room (ER) for consults that lead to middle-of-the-night operations. They then need to be ready to operate again at 7:30 am for their first scheduled procedures. It is not unusual for them to work 18-hour days, and often they take showers and naps in the doctor's lounge if they do not have time to go home. They also cover three weeks of the hospital's surgery ER call.[7] Without 24-hour surgery coverage, the hospital would get demoted (and potentially lose funding) to a lesser-tiered hospital. Thus, when planning on going out of town, the surgeons must coordinate their

[7] The 4th week is covered by the other general surgeon no longer in this group.

schedules so that only two surgeons are away at a time, just in case two are needed for a bigger operation.

In a typical week, the surgeons cumulatively see about 60 patients in the office for visits (including pre- and post-operative visits) and perform about 10 cases a week (some by themselves, some assisted). About half of their cases are colonoscopies and endoscopies, 40% are comprised of hernia repairs, cholecystectomies, and appendectomies, and 10% are breast biopsies and colon resections. The scope of this practice and percentage breakdown no doubt looks very different from an urban general surgeon's (cf. VanBibber, Zuckerman and Finlayson 2006), and this is part of what draws these surgeons to this setting. In Townsville, they consider themselves to be "general" surgeons in the truest sense of its description. The surgeons estimate that 70% of their patients come via referrals, and the other 30% come in on their own, and 50-60% of their patients are on Medicare, 8% are Medicaid, 5% are indigent, and the rest of the patients either self-pay or are privately insured.[8]

The office employs a permanent staff of four women including a receptionist, a billing and collections worker, and two nurse assistants who take patient vital signs before the surgeon sees them, and often assist throughout the duration of the visit as well. Many of these women have worked for this office for over ten years. The receptionist has been there for over twenty, and other retired employees have worked 20+ years as well. They are a close-knit office crew. They take turns bringing cinnamon rolls, pots of soup, and casseroles into the office, more often

[8] The majority of Townsville residents identify as White Non-Hispanic (72.5%), followed by Hispanic (19.6%), and Black (6.5%)[8]. In comparison, Texas is 44.8% White Non-Hispanic, 38.6% Hispanic, 11.4% Black, and 4% Asian. The county's median household income in 2012 was $43,515, slightly lower than the state's ($44,889). About 60% of public school students in the area receive lunch assistance, also slightly less than the state's average. Older residents (65+) are substantially over-represented in the county (21.5% or 5,455 residents) in comparison to Texas overall (10.3%). This information was gathered by the Community Hospital Corporation (CHC) in their May 2013 and 2016 report of the county hospital. They utilized demographic data provided by Truven Health. This information is publically available and found on the hospital's webpage.

than not eating their breakfasts and lunches together, and making sure that the surgeons eat too. Many see each other during the weekends as well, and their families are well-acquainted.

The office operates on hybrid system of both electronic medical records and paper charts. For most of the patient visits in this collection, the nurses have compiled the pertinent paperwork for the patient and placed it outside of the exam door for the surgeon to review before entering, and then he brings the chart into the visit with him. The norm for this practice is for surgeons to take notes during the visits by pen and paper unless otherwise noted in the analysis. Afterwards, the nurses input this information into the computers.

### 1.2.3 HISTORY OF THE HOSPITAL

All of the surgeons in this practice have operating privileges at the Level 3 County hospital, which serves a population of approximately 40,000 residents in the surrounding area. County Hospital is the 3rd generation hospital of Townsville. Built in the mid-2000's on the edge of town, it is positioned close to the border of the two adjacent counties it serves. It is a 65-bed, 100,000 square-foot not-for-profit hospital. There are three operating rooms, two endoscopy rooms, 15 ER beds, and three intensive care unit (ICU) beds (which are not used due to the large expense of hiring ICU nurses). The hospital's slogan is "Advance Hometown Healthcare", and it claims,

> County Hospital isn't just convenient, it's a place for advanced medical care that just happens to be close to home. County Hospital has the expertise and resources for you and your family… We offer inpatient, outpatient, and emergency services with compassionate care, focusing on respect and care for the whole person.[9]

In 2012-2013, the hospital yielded 2,305 admissions, 317 births and 50,164 outpatient visits. It employs approximately 175 personnel, and currently gives privileges to 7 family

[9] Hospital website

medicine physicians, 5 general surgeons, 1 obstetrician-gynecologist, 2 pediatricians (their office is located 15 miles away in a neighboring town), 2 orthopedic surgeons (1 also serves neighboring towns, 1 works full-time in Townsville), 3 cardiologists (all live 40 minutes away), 1 neurosurgeon (spine only) and 1 emergency medicine doctor (the hospital hires temporary ER doctors from larger cities to help with coverage). A urologist visits Townsville (from a nearby city) bi-weekly to see patients in a local clinic but does not perform procedures at County Hospital. In total, 23 physicians serve the area. While some are long-term residents, others stay for only short stints. About half of these physicians have offices in the adjacent professional building. Others have offices in other parts of town.

In 2013 and 2016, the Community Hospital Corporation (CHC) reviewed County Hospital and identified the following needs: 1) additional primary care and specialty care providers—especially oncologists and wound care specialists; 2) more preventive work and education centered around issues of obesity, diabetes, binge drinking, and other chronic conditions; 3) access to mental health services and providers, and 4) better access to care for Hispanic, indigent, and elderly populations.

While County Hospital works to attract and care for local patients and keep them in its care, there are holes in the services it provides. In addition to ICU patients getting transferred, most patients with thoracic, cardiovascular, and neurological conditions get transferred to large cities. While this list may seem long, these conditions occur relatively infrequently, and most transfers are for patients with heart attacks. "They have made it really easy for us to transfer patients [to their affiliate hospital]. All we have to do is pick up the phone, and it's a quick call", says Dr. Allen. "It is about 30 minutes away by helicopter, and 1 to 1.5 hours by ambulance." Non-emergency transfers from the general surgeons in Townsville include impacted kidney

stones (those that are stuck in the ureter) and common bile duct stones. Patients also travel up to 40 minutes for chemotherapy and radiation therapy, services that are not provided in Townsville.

Surgeons also transfer patients with more complex medical conditions or unexpected findings to bigger cities. For instance, if a gallstone is found lodged in the common bile duct during surgery, the protocol is to transfer the patient (via ambulance) to a gastroenterologist specialist in a nearby city the following day. If that specialist cannot remove the gallstone, the patient will then be transferred to another large city to a subspecialist. In one such pre-operative visit, the surgeon describes the subspecialist as someone "who does nothing but take care of all the stones that no one else can get out. And if he can't do it, which is very unlikely, then you'd come back to Townsville, and we'd have to do a big operation and take out the stone the old-fashioned way (gesturers a big cut). But the odds that you have a stone there to begin with are pretty small."[10] Even though it is very unlikely, a County Hospital patient with a complicated gallstone faces potential transfers from Townsville to two large cities (about 3 hours apart) and then back to Townsville. That is three ambulance rides. Not to mention the trouble for the patient's family to take off work, drive to these unfamiliar hospitals, find overnight accommodations, etc.

The upshot is that rural patients have to not only decide whether they want to undergo surgery, in addition they must figure out whether or not it makes the most sense for them to get operated on in Townsville and hope that the procedure goes smoothly, or hedge their bets and go to a bigger city hospital that can also take care of more complex conditions. How surgeons present these logistics of care, and how patients decide where to get their care seems a unique problem to rural areas.

[10] Taken from patient visit 6-14-13 Video 05, 4:15

I found that there is this folk sense by some residents that bigger cities mean better care, and this sentiment is something that local doctors have to fight against. As a rural doctor in Maine interviewed by McPhee in his book, *Heirs of General Practice*, wrote,

> The quality of care can be every bit as good in a place like this [a small town] as in a big-city hospital. The risk of a small hospital is that a poor physician can have more effect. A good one, on the other hand, can do more, and therefore be more effective. In a small hospital, the coming or going of a couple of people can dramatically impact the quality of care. If you have good people, you can do wonders (1986, 84-85).

While it is obvious that surgeons cannot practice their trade without an open hospital and its operating room, what may be less transparent is that without surgical care, a rural hospital's classification decreases from a facility that can admit and treat emergency patients (Level 3) to a facility that can only stabilize and transfer these patients (Level 4). A rural hospital keeping its doors open is precarious, as often reported in the media.[11] In the past five years, one neighboring hospital, thirty minutes away, has opened and closed its doors twice. Another rural hospital twenty minutes away has been bought by an urban hospital and functions as an urgent care center and is a now just a staging ground for transferring patients to the city. Neither of these hospitals housed full-time surgeons in recent years. Even with the surgeons practicing full-time in Townsville, County Hospital's staying open and as a full-service facility is a tenuous situation. Surgeons and hospitals have a symbiotic relationship, which is true for urban areas as well. In a rural area, however, the weight of maintaining a certain level of care literally can fall on only a few shoulders.

[11] On 8-3-17, a top news story on CNN was the rapid rate of rural hospitals closing and the impact this is having on patients who live in hospital deserts: http://www.cnn.com/2017/08/03/health/hospital-deserts/index.html

## 1.3 TURF BATTLES

"Turf battles", a term from medical anthropology, involve the conflict between different specialties of doctors fighting over the rights to perform particular procedures. Scottish physician, Dr. John Gregory, first provided a written account of this phenomenon in the mid-18th century and describes turf battles as the "oldest and most persistent ethical problems in the history of medicine" (Jones, McCullough and Richman 2005, 1). Of course, battles over the rights to procedures are only as old as the procedure itself. As medical technology advances and new procedures are invented and discovered, the staking of claims expands.

Several authors have written about the historical process of medical divisions, including Starr, who asked, "While medicine itself became highly specialized, the division of labor among physicians was negotiated by doctors themselves…Who would control and make money from the new kinds of work that [technology] created?" (1982, 220-221)). Starr also speaks to the battle between specialists and general practitioners: "When specialists claimed that various techniques and procedures required their skills, general practitioners often found themselves damned in the same breath as non-physicians" (223). This is especially relevant in a rural medical community, where physicians often struggle financially to keep their practice open, and the close-knit patient community is able to keep track of where patients receive treatment and for what types of ailments.

The general surgeons studied in this dissertation often discussed with me and their staff the difficulties of their expenses, with operational costs increasing and Medicare and Medicaid reimbursing on the decline. They heavily rely on local doctors to send them referrals and not to encroach upon their medical domain. This became a contentious issue in the mid-2000s when a new family doctor arrived and sought hospital privileges to perform colonoscopies. Up until that

time, the general surgeons had been the only group to provide this service for the community. The surgeons protested the family doctor's request for colonoscopy privileges to the hospital board, claiming that it was a better medical standard for patients to have colonoscopies performed by general surgeons, in the event of a complication. The hospital board, however, disagreed and sided with the family doctor who had been trained to do colonoscopies during his residency.

As one surgeon explained to me ten years after this decision, there was more at stake than just standards of medical care. There is an economic component as well, with colonoscopies bringing in a large portion of his practice's revenue. In Dr. Allen's words, "We could treat [patients] ourselves for all the things that family doctors do, but we don't. We refer the patients back, and we need them to refer to us too. If they want to have a surgeon in town to see their patients, then they need to leave us with enough business to keep our doors open. It's like a pie, and there's only so much pie to go around, and we have to share it. But I do still believe that a surgeon's eyes are better at doing scopes [colonoscopies] than a family doctor's and less risky."

Turf boundaries can be formally established by a hospital board, as seen in the case above, or can be informally managed amongst the doctors themselves. Through the history of their professional relationships with one another, tacitly accepted boundaries can evolve and perhaps are only brought to the surface or problematized when a newcomer comes to town. But this is an extreme example, and I believe that these boundaries are actually waged in much smaller and nuanced ways—in everyday office visit interactions. While Starr (1982), Rodwin (1993), and Freidson (1988) wrote about the historical transformation of medicine from a bird's-eye view, in this dissertation I will show, on the ground-level, how surgeons negotiate the boundaries of their practice in their everyday interactions with patients. I approach this topic of

turf battles by delineating between additional concerns that fall inside the general surgeon domain for this particular practice (which has a wider scope than urban general surgery domains) and additional concerns that fall outside the general surgeon domain (Chapters 2 and 3 will discuss these boundaries in more depth).

It is during these conversations that the maintenance of domain boundaries is daily reinforced or breached. Specifically, by looking at how patients and surgeons initiate additional concerns that fall outside the general surgeon domain, we can see how participants orient to these expansions. Although patients may not realize that the additional help they are asking for falls outside a surgeon's domain, I nonetheless ask whether and how this affects the medical help they receive (Chapter 3). Furthermore, when surgeons notice problems that fall outside their medical scope, how do they deal with them? Can we see patients orienting to these noticings as appropriate for this type of physician or inapposite (Chapter 4)?

## 1.4 ISSUES SURROUNDING ADDITIONAL CONCERNS

I define additional concerns as medical problems (e.g., pain, difficulty sleeping, rashes) or worries (e.g., advice on quitting smoking, complaint about medication, request for paperwork to submit to insurance (Byrne and Long 1976; Robinson 2003)) that are prima facie unrelated to the main reason for the visit and are presented as new topics. Studies of patient visits in primary care settings show that 40-50% of patients would like to discuss more than one medical problem with their doctor (Heritage et al. 2007; Kaplan et al. 1995; Stewart et al. 1986). However, it can be difficult for them to present multiple concerns because the default structure of a visit is to address a single concern (Beckman, Frankel and Darnley 1985; Heritage et al. 2007; Robinson 2001; Robinson and Heritage 2015; Robinson, Tate and Heritage 2016). Much research and many resources have been devoted to improving doctor-patient communication (again, focused

in primary care settings) in order to solicit more patient concerns (Heritage and Robinson 2011; Robinson 2006b; Robinson and Heritage 2015; Robinson, Tate and Heritage 2016) with the goal of lessening patient anxiety about unaddressed concerns (Heritage et al. 2007), improving treatment (Larsson, Saljo and Aronson 1987), and reducing additional medical visits, which in turn reduces medical costs, and enhances doctor-patient relationships (Fisher 1991). Medical textbooks offer recommendations to effectively inquire about additional patient concerns (Cohen-Cole 1991; Heritage and Robinson 2011; Roter and Hall 1992; Seidel et al. 1995; Swartz 1998); however, doctors infrequently make these inquiries in their everyday practice (Beckman, Frankel and Darnley 1985; Beckman and Frankel 1984; Heritage et al. 2007; Kravitz et al. 1996; Marvel et al. 1999). Moreover, depending on where in the visit they inquire about additional concerns and how they design questions, doctors have more or less success in soliciting these problems (Bates, Bickley and Hoekelman 1995; Boyd and Heritage 2006; Cohen-Cole 1991; Coupland, Robinson and Coupland 1994; Frankel 1995; Robinson and Heritage 2015; Swartz 1998).

Previous researchers have found that the most likely phase of the primary visit for patients to present their chief complaint is right after the opening of a patient visit (Byrne and Long 1976; Heath 1981; Robinson 1998; 2003). Because only having one chief complaint is sufficient to merit patients scheduling a medical appointment, previous research claims a patient with several concerns may be "blocked from sharing all but a small portion of the information he or she is prepared to report" (Beckman and Frankel 1984, 695) since the default primary patient visit is organized around dealing with only one chief complaint. After this problem is resolved, the structure typically moves the visit typically towards closing (Robinson 2001; West 2006; White, Levinson and Roter 1994; White et al. 1997).

Because primary care doctors rarely solicit additional concerns, if the patient wishes to address more than one concern, then the patient must perform additional interactional work to reveal these additional topics. Not only does launching additional concerns require patients to work to break the flow of a single problem-designed visit, patients must work to overcome their back-seat position since doctors take control of the conversation for the duration of the patient visit after the patient's opening statement, which then "shifts the focus of information gathering from a patient-centered format" to a medically-centered one (Beckman and Frankel 1984, 694; Frankel 1990; Heritage and Robinson 2006a).

Two research studies, one of primary care doctors and the other of internists, both found that doctors initiate over 90% of questions during the visit (Frankel 1984; West 1983). Doctors hold the interactional floor by "asking increasingly specific, closed-ended questions that effectively halt the spontaneous flow of information from the patient" (Beckman and Frankel 1984, 694), and this has been observed in both primary care settings (Frankel 1990; Greenfield, Kaplan and Ware 1985; McGee and Cegala 1998; Mishler 1984; Roter 1977; Todd and Fisher 1993; West 1984) and in specialized care (Peräkylä 1995). From a conversation analytic perspective, this can be assessed by observing that primary care doctors from the history-taking stage onward produce the vast majority of first pair parts which constrain a patient's next turn-at-talk since the question-answer adjacency pair narrows the scope of what the patient is held accountable for saying in second position (Robinson 2003; Schegloff and Sacks 1973).

If doctors do solicit additional concerns, this typically occurs after the primary concern has been resolved (White, Levinson and Roter 1994; White et al. 1997). "If patients' additional concerns are addressed, it tends to occur at the end of the encounters" (Robinson 2001; Robinson, Tate and Heritage 2016), which places them in the closing phase of the patient visit.

It is worth underscoring the observation that the vast majority of closings were found to be initiated by the doctor (West 2006; White et al. 1997), which shows that while doctors may be ready to close a visit, almost 25% of the time patients still have unresolved issues (White et al. 1997).

White et al. (1997) found that 21% of primary care patients raise new concerns during the closing phase. These are known as "door knob" presentations since often the doctor literally has one hand on the doorknob, and the patient says something like, 'Oh, but one last thing…' (Rodondi et al. 2009), which takes interactional work to re-open a sequence (Schegloff and Sacks 1973). Barsky (1981) calls late announcements of medical problems patients' "hidden agendas" and hypothesizes that there are certain topics that the patients do not feel comfortable sharing at the beginning of the visit, and rather wait until later to discuss them. Barsky found these types of concern to be mainly psychosocial concerns.

Because both time and interactional work have been done to close a patient visit and a newly generated problem presentation may render the just delivered diagnosis and treatment null and void, this is not an ideal environment for patients to launch new concerns nor for doctors to fully address them, especially since doctors are already consistently pressed for time (Robinson 2001).

## 1.5 LAUNCHING NEW TOPICS IN CONVERSATION IN GENERAL

Launching new topics is not a problem that is unique to the medical encounter. In ordinary talk, there are mechanisms for mobilizing new topics, a practice that is not done at random (Button and Casey 1984; 1985; 1988; Schegloff and Sacks 1973). I will demonstrate how patients exploit the preference for contiguity in talk (Sacks 1987), a practice found in ordinary talk, in their institutional interactions with surgeons in order to initiate additional

concerns. Schegloff and Sacks (1973) describe one practice of introducing new topics as "fitting", which requires the speaker (e.g., the patient) to hold off on broaching a new topic (e.g., an additional concern presentation) until it can "occur naturally" in the conversation. One way that "fitting" can be done is to extract something said by one's interlocutor, and then use that previous talk as a bridge into a new topic.

In Jefferson's (1978) analysis of the sequential design of stories in ordinary talk, she describes how new stories can be "triggered" by prior talk, but this does not necessarily guarantee it will be "topically coherent" (Sacks 1968, April 17) with what came before. Common practices that speakers use to show that their new stories are "locally occasioned" are to extract a word from prior talk and repeat it in the stories preface (Jefferson 1978) or to use turn-initial particles such as "Oh" to display the new story was triggered by what came before (Heritage 1984; Jefferson 1978).

This practice of fitting a new story to a prior turn-of-talk is also known as step-wise topic transition, described below:

> A general feature for topical organization in conversation is movement from topic to topic, not by a topic-close followed by a topic beginning, but by a stepwise move, which involves linking up whatever is being introduced to what has just been talked about, such that, as far as anybody knows, a new topic has not been started, though we're far from wherever we began. (Sacks, lecture 5, Spring 1972, 15-16)

Jefferson (1984) also describes this step-wise technique in her analysis of how recipients of troubles talk maneuver out of an interactionally sticky topic and into less face-threatening talk.

While patients may legitimately find an aspect of a doctor's previous talk to grasp onto to generate leverage from which to broach a new topic, all patients really need is an appearance of a tie from which to maneuver. An example of one of these exploited appearances is found in Stivers and Heritage's (2001) article "Breaking the Sequential Mold" in which a doctor inquires

"where" the patient's mother's cancer was, and the patient manages to appear responsive to the question but really exploits the meaning of "where" in her answer in order to transition into a narrative about how her mother was in "Arizona"—not the "where" the doctor had in mind.

These step-wise transitions are in direct contrast with door-knob concerns described above in White (1994) and Rodondi's (2009) research in which "By the ways" are an example of a misplacement marker which recognizes "that an utterance that is thereby prefaced may not fit, and that the recipient should not attempt to use this placement in understanding their occurrence" (Schegloff and Sacks 1973, 320). This is a departure from the norm, which is that interactants work to hear next-turns-at talk as produced by reference to prior talk, and hold each other accountable if next utterances are not related to the prior turn (Sacks 1972b, Lecture 4 and Sacks, 1971 April 9).

In addition to misplacement markers, there are a variety of resources speakers have to initiate new topics in first position to demonstrate topic-shifts including other shift implicative prefaces (e.g. Ex 8 "Well" (Heritage 2015), Ex 10 "Okay" (Beach 1995)), pre-sequences (Schegloff 2007) and pitch resets (Couper-Kuhlen 2001). Jefferson (1984) labeled new topics that were a departure from the prior interaction as "disjunctive", a term I will borrow for this analysis.

## 1.6 METHODOLOGIES AND DATA

This dissertation seeks perspectives from multiple-levels of analysis. In order to understand the doctor-patient relationship, not only does this analysis describe single turns-of-talk, but it also provides background information about the patient and the purpose of that visit, where this visit falls in terms of the patient's overall medical trajectory, and their past

relationship with this surgery practice. Because the type of medical care provided in this practice does not occur as a series of unconnected incidents, neither should the analysis.

While employing several methodologies, this dissertation is rooted in a grounded-theory approach (Glaser and Strauss 1967). The ideas for these chapters and the analysis were first and foremost rooted in the data, built from the ground up. The fieldsite was selected because it met criteria for understudied populations in applied medical Conversation Analysis, that of doctor-patient interactions in a rural setting and in a secondary care context. Those two criteria were my warrants to begin data collection even though concrete topics for investigation had not yet been determined. I decided to study a rural Texas general surgery practice to which I had good access, and after ensuring that I could enlist the office staff to help conduct the daily collection of patient videos without me being present. This trust was crucial in order to successfully collect longitudinal data.

From the outset of the dissertation, I knew that I wanted to combine the methodologies of Conversation Analysis (CA) and ethnography. Trained in both, I believe these two methods are stronger when combined for this type of interactional project. One critique of CA is that it takes interactions out of context, that these recorded interactions are cross-sectional snippets of participants' lives, and that researchers cannot understand the talk if they do not know relevant background information. Analysis is constrained to that moment in time, and often conjectures of contextual information are posited but never verified. Ethnography has its own critiques as well, including the accuracy of fieldnotes in capturing and portraying conversations. Ethnographers can paraphrase talk or condense several conversations into a single discussion, and this leads to debates about the reliability of data. Ethnographers can use cameras or audio-

recorders to capture data, but much like the current debate over when police officers switch on their body cameras, when ethnographers choose to record can lack systematicity.

The strength of ethnography is the knowledge gained from spending countless hours with participants. Participants become more than just "speakers" and "recipients", as ethnography gathers information about their personal biographies and the community they live in. The strength of Conversation Analysis is that it provides a structured approach to collecting data, with clear boundaries of when recording begins and ends. These recordings can be reviewed countless times, and thus provide the ability to revisit the field site with different questions in mind. Transcripts provide access to a micro-level of interaction that is simply inaccessible in real time. The ethnographer of communication who does not record and transcribe can examine levels of interaction but cannot drill down to such features as lexical choice, prosody, hesitations and morpho-syntax.

CA tends to have a more microscopic focus, looking at the turn-level to determine what syntax, lexical items, and prosody were used to construct an utterance and, through the utterance, a social action. CA can expand out, but it is limited to the confines of recorded talk-in-interaction. It can place a single utterance in relation to the overall sequence organization, and position that utterance in relation to the overall phase-structure of that interaction. However, utterances can form part of more overarching interactional projects that can influence how they are designed, and this may not be evident without knowing what occurs outside this isolated incident.

One way to combat this critique is by recording the same patients across time, the approach this dissertation has followed. This longitudinal perspective helps delineate project-level objectives that can be influencing turn-level interaction. Furthermore, by being able to

supplement the recordings with ethnographic knowledge of the patient's history, knowledge of the standards of medical care for those specific surgeons and for this particular time in history, etc. helped me to explicate project-level motivations even further.

Thus, in this mixed-method approach, not only can conversation-analytic findings contribute to the understanding of ethnographic data, but ethnographic findings about a context can also provide insight into the moment-by-moment talk occurring in a given setting (e.g., Maynard 2003). In other words, I find that the analytic holes of Conversation Analysis get patched with the strengths of ethnography and vice-versa.

### 1.6.1 DATA COLLECTION

The video data collected for this dissertation are part of a mixed-method, longitudinal study of doctor-patient relationships that occur in a general surgery private practice in rural Texas. Data collection for the multi-year study began in June 2013 and is still ongoing. I initially spent a week in the office installing the video camera and training the office staff on how to upload, save, and catalog the recordings. During this time, I also guided the receptionist on how to approach patients to participate in the study when they checked-in for appointments and how to answer their questions about participation. This was all in accordance with IRB protocol.[12] After leaving Texas, I continued to monitor data collection remotely and was available to answer questions. For the last four years, I visited the office every several months to organize the new video data, check the equipment, and spend time with surgeons and office staff.

All surgeons have agreed to participate in the study, and approved their office staff to help facilitate data collection. All patients who visit this practice are asked by the receptionist when they check-in to participate in the study, and only those who understood and signed the

[12] This is a UCLA issued IRB, #13-000791-CR-00004.

written IRB consent forms are placed in the Exam room #5, where the video camera is permanently placed.[13] Once a patient signed up for the study, all subsequent visits are recorded, as one of the over-arching goals of this study is to understand how patient/doctor relationships and their medical care are maintained and evolve over time. Patients are free to stop participating at any point, but to-date, no patient has asked to stop. As of August 1, 2017, 1285 patient visits have been video recorded, and 536 patients have participated in the study.

The ethnographic portion of the study began a year and a half after data collection begun. From January 2015-June 2015, I lived in this small town and spent most work days in the office. My desk was in the hub of the back office, positioned between the two nurse assistants' desks. From this vantage point, I could see the patients as they were led to their patient room. They would first stop in front of my desk to get weighed. The surgeons would gather here also before entering patient rooms to get briefed by the nurses about who each patient was and why they were being seen. When patients left the patient room, I would see them exit and could hear them scheduling their follow-up appointments or making arrangements for future surgeries. Also, because I was positioned between the nurses, I could hear their conversations about patients, their phone calls back and forth with the hospital staff in order to schedule procedures, order labs, admit patients, etc., and other ins and outs of patient care. On occasion, surgeons would introduce me to different patients who were already participating in the study. I would thank them and explain to them about the importance of applied medical research.

Most of my time in the office was spent in the early part of my reviewing the data, organizing it, finding themes, and transcribing examples. It was incredibly beneficial to be in the

[13] The video camera is turned on for participating patients a few minutes before they enter the room in order to capture the entire visit. Once the visit is complete and everyone leaves, the nurse returns to the room and turns off the camera while they prepare the room for the next visit. Patients who are not participating in the study are also seen in this examination room, but the camera always remains off during their visits.

office during this process, because I could stop and ask the nurses and surgeons about the background of certain patients and medical protocols. I would make note of this information in the document with the transcript. If something particularly eventful occurred in the office, I would write a fieldnote daily in the traditional style of thick description (Geertz 1973).

After office hours, I often continued my coding work in the hospital, sitting next to the surgeons as they spent hours of dictating patient notes and completing their paperwork. This access allowed me to observe the surgeons in both settings, both in their private office and next door in the hospital, as they constantly are walking back and forth. I also was invited to attend several meetings with the hospital administrator and the surgeons in regard to the practice hiring a new surgeon. This was of particular background interest to me, how small towns recruit and retain specialists.

In addition to the time spent at work, I also spent time with the surgeons in the community as well. They often ate dinner together at the local Mexican food restaurant or got fast food hamburgers. I also joined in on attending their children's (or grandchildren's) sporting events and spent time with their families. This was a good way for me to see how permeable their medical and social selves were. The surgeons often encountered patients, hospital staff, and their relatives while out in town. Medical and social talk often intertwined, much like I found in the video data as well.

### 1.6.2 FINDING THEMES

In terms of deciding what themes to focus on for the dissertation, I first spent several weeks watching patient videos. I randomly selected patients and watched all of their recorded visits in chronological order to gain a sense of their overall medical trajectories and relationships

with their surgeon. I took notes and tagged videos in ELAN.[14] At this initial stage I made numerous tags and constantly added new ones. For instance, these included "surgeon second stories" (when surgeons complain themselves about suffering from a similar ailment), "other snag" (when a family member of the patient would solicit the surgeon's medical advice for their own problems), "pain medication", "twofers" (when patients would try to get two operations performed at once), etc. Upon first diving into the data, I did not know what I was going to find, so I kept track of luminous data (Katz 2001).

After reviewing all recorded visits for 40 patients, my interest in the theme of additional concern initiations emerged and solidified. Unlike the previous research that I outlined above, I saw patients initiating additional concerns frequently and throughout the visit. Furthermore, I found it interesting to track the additional concerns across visits, taking advantage of the longitudinal nature of this data. Sometimes an additional concern appeared in one visit and then was never mentioned it again, but other times a concern could escalate and even turn into a focal issue. The topic of doctors initiating additional concerns had yet to be addressed in the literature.

Additionally, this topic was interesting in terms of the uniqueness of this fieldsite. Because this is a rural general surgery practice, the domain of their practice has a wide breadth, often overlapping into family medicine, gynecology, etc. How would general surgeons address concerns that fell outside their domain? This topic also raised issues of the doctor-patient relationship. For instance, are patients seeking extra help from surgeons because of their close connections with their surgeons outside in the community? I found that this topic of how additional concerns are initiated could serve as an interface across these several analytical issues.

[14] ELAN is a free software developed by the Max Planck Institute for Psycholinguistics that helps annotate video and audio data.

### 1.6.3 NARROWING THE DATA

Because of the large number of patients in the study and the multitude of reasons for their visits, from a thorn being stuck in a foot to breast cancer with reconstructive surgery, I narrowed my dissertation collection to visits recorded between June 2013-June 2015, and to patients who were seen for at least one of the following three procedures: cholecystectomy, hernia repair, or colonoscopy (which are often paired with an upper gastrointestinal endoscopy). Because this is a general surgery practice, I wanted to capture patients that were being seen for care directly relevant to the services these rural surgeons provide. I also wanted to capture more serious conditions that required more than one appointment, in order to benefit from the longitudinal aspect of this study.

The rationale for grouping these types of patients together for this study is fourfold. First, most of these procedures are non-emergency and can be scheduled electively, which allows the opportunity for the whole spectrum of the treatment process to be captured, including pre-operative visits. This is not always possible for surgical matters such as appendectomies that have a sudden onset and are admitted through the ER, which curtails a pre-operative visit. In contrast, hernias and gallbladder disease commonly have on-going symptoms that are bothersome but manageable enough to have time for the patient to be seen in the office pre-operatively. As for colonoscopies, the impetus for this procedure is usually the patient's age (generally 50+ years old) making screening relevant and/or presenting medical issues such as blood in the stool or a family history of colon cancer. Colonoscopies, like hernia repairs and cholecystectomies, are almost always scheduled. Second, these are serious procedures that must be performed under anesthetic and in the hospital, and third, only a singular procedure is the norm for taking care of the issue. This is in contrast to other illnesses that require multiple

procedures. For instance, breast cancer patients may first undergo a biopsy, then a mastectomy, etc. Lastly, in order to make this collection, patients needed to have both their visits immediately preceding the procedure and immediately following it recorded[15] for the sake of continuity and to allow analytical comparisons to be found between pre- and post-operative visits.

### 1.6.4 COLLECTION BUILDING

Once I had compiled all the patient visits that met the requirements for the collection, in accordance with conversation analytic methodology (Goodwin and Heritage 1990; Heritage 2010a), I reviewed the videos for potential instances of patient- and surgeon-initiated additional concerns. The *initiation* of an additional concern was salient to how I counted them. For instance, if a patient initiated a concern at the beginning of the visit and then brought up the same concern again later in the visit (with other topics discussed between), this was counted as two separate initiations (even though topically they addressed the same concern). Coding began as soon as the surgeon entered the room, and the visits were watched in their entirety until the visit ended. These visits range from a quick 10-minute visit (e.g., a post-operative visit to check that incisions were healing properly) to 1.5 hours visit (e.g., a pre-operative visit explaining why a cholecystectomy is needed, how the procedure is performed, the risks, etc.). As additional concerns were collected, they were tagged in ELAN to later be transcribed and coded further for specific properties.

[15] Not all patients sign up to participate in the study on their first visit to the office. Instead, many patients already were seeing these surgeons for many years, so their first "recorded" visit can fall anywhere in their spectrum of care. Also, because of the limitations of only one camera, when more than one participating patient is scheduled at the same time with different surgeons, their visits occur simultaneously, and only one patient's visit can be recorded. That means that "missed" visits occur in this data set, but I have accounted for this by only selecting patients for whom, at minimum, I have captured both the visits immediately before and after the surgical procedure.

As Schegloff (1997) recounts in his description of how to build a collection and decipher where to draw boundaries, "such observations…are made on a *non*-first exposure" (501). This process of determining what exactly is a patient-initiated additional concern and a surgeon noticing required several passes through the data, as boundaries were redefined and consequently new cases assembled and others discarded until a cohesive and consistently code-able phenomenon emerged (Schegloff 1997; Sidnell 2013). I made sure to collect broadly any instance I thought could qualify, and I reviewed each instance multiple times to see if it should remain in the collection or be discarded. In the analytical chapters, I will in more detail discuss how these phenomena were defined and what criteria they met to qualify for the collections.

### 1.6.5 CODING

After collecting about 75 instances of patient-initiated concerns, I reached a saturation point (Glaser and Strauss 1967) of how I could qualitatively analyze the data. When reviewing these cases and trying to make sense of them, I found subthemes and began to track recurring features that occurred frequently in the data. At the individual case level, I wanted to see the range of ways patients selected to formulate their initiations. I also wanted to see how frequent these features (and their combinations) were. By having a set coding schema, I could then see if individual case analysis could be generalizable to the whole data collection. Furthermore, could the patient's design of the initiation then affect the surgeon's response? Once this coding schema was finalized, I re-watched the entire collection to make sure each instance received the same coding assignments (see Sidnell (2013) for an overview of the iterative process of collection building in CA). A more precise explanation of how these features have been coded for will be discussed in Chapters 2 and 3. Here is the list of what I coded for to capture how and when patients initiated concerns: method used, phase of visit, phase of treatment, physically

evaluable, first or subsequent mention, type of concern, surgeon's domain, social action, mentions another physician, mentions another treatment plan, qualifies, and level of doctor-patient relationship. I also coded the outcome of these initiations as either helped or not helped, the operationalization of which I discuss in Chapter 3.

### 1.6.6 QUANTITATIVE AND QUALITATIVE APPROACH

Because these patient-initiated additional concerns frequently appeared in my data, I realized that it was possible to build a large enough collection to analyze with statistics and have significant results. I was curious if what I observed through qualitative analysis at the individual case-level would hold up at the aggregate level (see Stivers (2015) on the role of coding and CA). I knew that in order to have statistically significant findings, I would need to gather several hundred cases. For six months, I worked with three undergraduate research assistants to build the collection to an appropriate size to run statistics. Together, we found and coded 300 more cases of patient-initiated additional concerns, a point at which I would have the power to observe statistically significant associations if they occurred. I also had one research assistant recode 15% of these 377 patient-initiated additional concerns to assess inter-observer reliability tests (discussed in Chapter 3). To control for the fact that patients could contribute more than one data point, I used Generalized Linear Mixed Models (Baayen 2008) (discussed in more detail in Chapter 3).

Furthermore, once coding and the analysis were completed and I was in the writing phase, I returned to Texas to conduct informal interviews with patients (see Chapter 3). After spending so much time reviewing the videos and analyzing how and when patients initiated additional concerns, I decided that it would be prudent to ask patients themselves about how they view raising additional concerns, to see if they have any particular strategies on how they do so,

and what type of response they were looking for from their surgeons. My aim was not to match specific patients with their particular visit in order to see if what the patient told me held up to their actions. Instead, my hope was to get a general sense of how patients view bringing up additional concerns to their surgeon. I began the conversation by asking them, "Do you ever have additional concerns that aren't the reason for the visit that you'd like to discuss with your surgeon, and if so, how do these get brought up?" Patients were selected to be interviewed if they were already sign-up for the study, had appointments the week I was in Texas, and agreed to talk to me (follow-up surveys were approved by my IRB). I approached them before their appointments if I knew there was going to be a long wait to see the surgeon or once their appointment was finished. I met with them in a private room in the back office. In total, I conducted 16 informal interviews, lasting about half an hour each. These interviews were not recorded. Rather, I took notes during our conversation and immediately after typed a detailed report.

The analytical process used for the surgeon-initiated noticings chapter 4 began in the same way as for the patient-initiated additional concerns. While I initially was collecting data on how patients raised additional concerns, I noticed that surgeons also initiated new concerns. Previous research has always focused on the patient's need to get additional concerns onto the interactional floor and the need for doctors to help them do so but, as of yet, no one had looked at the interactional difficulties for doctors themselves to initiate new concerns. This phenomenon of surgeon initiations differed from those of patients because surgeon noticings occur very rarely (only 22 instances were found). I knew that collecting enough instances to run multivariate analysis would be an unrealistic fit for this aspect of the study. Instead, after carefully setting the boundaries of what constituted a surgeon-initiated noticing, I analyzed each instance in-depth.

Again, similarities and differences began to emerge, and there were a few features that I tracked across the visits such as 1) did touch precede the surgeon noticing, 2) how did the surgeon first refer to the physical abnormality he noticed, 3) did he minimize the noticings with words such as "little", etc.

Because it was the surgeons' perspective I was focused on for this chapter, I decided to informally interview them as well about what types of physical abnormalities warrant sharing with the patient, and how and when they do so. These interviews also occurred well after collection building was completed, and I was in the analysis and writing phase. In person, I reviewed some of the videos with the surgeons, asking them to explain to me what exactly they noticed on the patient's body, what the medical protocol is for dealing with it, and why did they raise it then versus waiting until later in the interaction? As is evident in the empirical chapters, I often wavered between an outsider's objective point of view while also trying to take into account each participant's viewpoint as well (i.e. both emic and etic perspectives (Kottak 2006)).

### 1.6.7 SUMMARY

Three empirical chapters comprise this dissertation:

**Chapter 2: Patient-initiated additional concerns**

**Chapter 3: Which patient-initiated additional concerns receive help?**

**Chapter 4: Surgeon-initiated noticings of additional concerns**

Chapter 2 is qualitatively driven, using the methodologies of Conversation Analysis and ethnography to describe how and when patients initiated the 377 instances of patient-initiated additional concerns. Chapter 3 builds on Chapter 2, further describing and illustrating the coding system and adds statistical analysis and interviews. Chapter 4 shifts attention to the surgeons'

behavior and is comprised of a collection of 22 instances. Chapter 4 uses Conversation Analysis, ethnography, and interviews for its analysis.

Ultimately, the interactions were my guide during the entire process. First, I found themes that emerged out of them, and then I utilized methodologies that I felt best would help explain what was occurring inside of them. The variables chosen for the quantitative analysis was derived first from qualitative analysis after spending several months watching the videos and spending time in the field. The combination of several different methodologies in this dissertation has been targeted at capturing the story in all its nuances. In particular, the goal has been to explain what patients and surgeons are doing when they bring up additional concerns and how these actions are recognizable.

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# Chapter 2: Patient-initiated Additional Concerns

Previous studies of doctor-patient interaction have described patients as having restricted rights, holding the interactional floor only during the initial problem presentation phase and then deferring to physicians to lead them through the remainder of the visit (Beckman, Frankel and Darnley 1985; Frankel 1990; Heritage and Robinson 2006b; Robinson 2003). In contrast, this chapter will shed new light on increased patient involvement and initiative by focusing on how and when patients initiate additional concerns. Patients often have agendas that extend beyond the focal concern (Heritage et al. 2007; Kaplan et al. 1995; Stewart et al. 1986). Instead of waiting to be asked about additional concerns, which is not always guaranteed (Robinson, Tate and Heritage 2016), I found that patients actively monitor the progress of their visits, finding and creating opportunities to initiate new topics. As these data reveal, patients are not passive participants drifting in the wake of a static sequence of events. On the contrary, patients are active co-participants and together with their general surgeon, help to create collaborative visits that can address multiple concerns.

While I support contemporary research that seeks interventions to enhance patient involvement and shared decision-making, I argue that patients are already using local methods to initiate additional concerns. It is imperative to fully recognize and understand the practices patients have independently developed in order to better contribute to patient interventions. Thus, the aim of this chapter is to systematically analyze how and when patients initiate additional concerns in order to study their effectiveness (see next chapter), make physicians more aware of

embedded patient initiations that may get overlooked, and inform future research on patient empowerment.

## 2.1 DEFINING PATIENT-INITIATED ADDITIONAL CONCERNS

In order to make a collection of patient-initiated additional concerns, I needed to establish a clear definition of this term. Here is an outline of the considerations that went into this definition, each to be described in-depth:

1) What is an additional concern?
2) Whose perspective should I adopt in making this decision?
3) How is the additional concern medically related to the focal concern?
4) Is the concern patient-initiated vs. doctor-solicited?
5) What social actions qualify?

**1)** Patient-initiated additional concerns are defined in this analysis as medical problems (e.g., pain, difficulty sleeping, rashes) or concerns (e.g., advice on quitting smoking, complaint about medication, request for paperwork to submit to insurance (Byrne and Long 1976; Robinson 2003) that are unrelated to the main reason for the office visit, raised by patients on their own initiative, and are ongoing concerns (as opposed to their medical history).[16]

**2)** In order to determine that participants were indeed oriented around a focal concern from which an additional concern can depart, I first considered each participant's perspective. From my observational field research in the office, I confirmed that patients referred to focal concerns when scheduling appointments with explicit orientations such as, "I need to schedule an appointment to discuss having my gallbladder taken out." From the surgeon's perspective, I observed nurses briefing them in the hallway about the reason for the visit before they entered

[16] See Appendix B for a table of the 377 patient-initiated additional concerns by topic.

the patient room,[17] so it was clear that professionals shared this orientation too. Thus, focal concerns were a known entity for all interactants, which allows for the possibility of additional concerns to exist as well.

**3)** Next, each additional concern collected needed to be determined as unrelated to the focal concern. After reviewing the collection, I observed a few instances in which patients confounded concerns (e.g., thinking that the focal and additional concern were closely related when they medically were not). This necessitated a systematic coding process for incongruities between participants' perspectives. Even though it occurred rarely, I could not assume patients and surgeons shared common ground (Clark 1996) about concerns' relatedness, and I needed to decide whether to consistently code from the patient's point-of-view or from the surgeon's. I also considered that there could be more at stake than a knowledge breach—perhaps patients feigned a medical connection agentively to warrant raising it. Because I cannot judge intent from my analytic perspective, I ultimately decided the most objective measurement was to base my relatedness coding from the surgeon's perspective. Indeed, I realized that in the vast majority of the collection patients produced additional concerns without explicitly stating (one way or another) its relatedness to the focal concern, and that I already was classifying these concerns based off of the expert opinion of medical relevance and not patient production. Thus, the most consistent coding practice was to use the medical expert perspective for determining that an additional concern was indeed separate from the focal concern.

[17] While surgeons in this study did not appear to keep track of their daily roster of patients because this line-up frequently changes (due to cancellations, emergency surgeries that require the day to be rescheduled, etc.), surgeons and nurses do discuss more generally what the week ahead looks like. They work together to flag more medically difficult or unusual patients a few days ahead of their scheduled appointment so that the surgeons have time to conduct research on this condition and be prepared for the visit.

**4)** The next qualification to assess was that the concern was patient-initiated and not doctor-solicited. The cleanest examples were when patients launched new concerns in a sequentially first position, meaning that the concern was not related to prior talk or activity. These often emerged out of silences or other interactional junctures (Frankel 1990). Previous researchers have nicknamed these first position initiations "door-knob presentations" because they found patients often raise extra concerns at the end of the visit when the doctor already has one hand on the doorknob to leave (Barsky 1981; Robinson 2001; Rodondi et al. 2009; West 2006; White et al. 1997). These misplaced initiations often begin with "By the way", helping to mark that what comes next is unrelated to prior talk and inapposite to the final phase's agenda of closing down the interaction (not opening up a new topic).

As this analysis will show, patients can initiate additional concerns in other phases of the visit and in non-first positions as well (i.e., responsive or 2nd position). However, not all responsive positions qualified for this collection. A boundary must be drawn between concerns that were *patient-initiated* versus *doctor-solicited*. Doctor-solicited concerns are defined as any concern that follows a physician's direct and open-ended solicitation for additional concerns (Heritage et al. 2007). For instance, if in response to a surgeon's inquiry, 'Is there something else that is bothering you today?' a patient mentioned difficulty swallowing, then this did not make the collection. Additionally, concerns solicited from a specific history-taking inquiry did not qualify. For example, if a surgeon asked, 'How's your stomach feeling?' and the patient answered that she's experiencing abdominal pain, this complaint was also not considered patient-initiated since the response directly conformed to the topic agenda of the inquiry (cf. Heritage and Clayman 2010). However, if following a history-taking inquiry the patient transformed her response to, 'My stomach feels fine, but I've been having problems urinating', the patient did not

conform to the topic-agenda of the question. That pivot from discussing one's stomach to one's urinary condition would be coded as a new topic initiated by the patient and therefore would qualify for this collection.

**5)** Finally, the last boundary established was what types of social actions qualified as doing initiating. There are various verbal and non-verbal actions a patient can perform to alert a surgeon to an additional problem. This collection only includes articulated turns-at-talk. Even though actions such as limping or scratching and non-lexicalized turns-at-talk like moaning or grimacing can be initiating actions (McArthur, forthcoming), I leave these for future research, acknowledging that they may have action implications that overlap with lexicalized turns-at-talk. But do all lexicalized turns-at-talk do initiating work? In order to qualify as an initiation, does it directly need to be soliciting help from the surgeon? If so, then this definition would limit patient social actions to turns-at-talk that launch an adjacency pair sequence like a request-grant or question-answer sequence that makes a response conditionally relevant (Schegloff and Sacks 1973). These instances are very recognizable initiating-type actions, but what about more subtle practices such as informings, noticings, and musings that do not pragmatically hold the surgeon accountable to respond? Are these initiating enough?

I reviewed one such boundary case in order to determine where to draw this initiating line. In this case (to be more fully explored in Ex. 6), an elderly patient is being seen for a post-operative hernia visit and is experiencing physical difficulty getting onto the examination table. As he slowly walks towards the table the patient says, "I just got an injection in my knee". I pondered whether this turn-at-talk was initiating a new concern or not. First, the social action was both an account for slow movement and an informing, and neither holds the surgeon

accountable for a response to the same degree as an explicit request would. Secondly, this concern seems to already have been medically dealt with, since the patient mentions receiving an injection. At first pass, all signs seem to point towards this turn-at-talk as *not* being an initiating turn. However, because of the institutional setting of this informing/account and the epistemic imbalance between patients and doctors (Heritage and Clayman 2010), I believe that any articulated expression of an on-going medical difficulty (as evident by the patient's limping and slow movement), regardless of social action or how many other doctors the patient mentions consulting, still brings to the surface-level of interaction a medical concern.

Moreover, regardless of its presentation or how pressing of a concern it may be, all additional concerns open up the interactional space for a surgeon to topicalize it. Judging initiating concerns only by the surgeons' responses would lead to losing many cases—even of true first-pair-parts (like questions) that surgeons sequentially delete (cf. Schegloff 2006 footnote 6). Thus, any new concern, regardless of social action type, qualifies as an initiating turn.

## 2.2 DEFINING VISIT-PHASES OF GENERAL SURGERY VISITS

Unlike acute primary care visits in which a systematic 6-part phase structure has been established (i.e., openings, patient problem presentation and history taking, physical examination, diagnosis, treatment recommendation, and closings (Byrne and Long 1976)), secondary care visits (as well as follow-ups in primary care) have varied structures and no ideal-type phase-structure pattern has yet been determined (cf. Robinson 2003). As a result, the phase-structure of an acute primary care visit that is structured around finding a diagnosis and providing a treatment plan is not always relevant in other types of visits.

Because this study includes both pre- and post-operative visits for hernia repairs, cholecystectomies, and colonoscopy patients, the visit's agenda varies. Because there is no

known or established phase structure in secondary care and because of the variety of type of visits, I needed to establish an applicable visit-phase sequence for my secondary care data. I found the common denominator across all visits was a physical examination—be it for diagnostic purposes, pre-surgical inspections, or post-operative healing assessments. Thus, I decided that the physical examination should serve as the relative anchor, resulting in a 3 phase-structure for general surgery visits: the pre-physical examination, physical examination, and post-physical examination.

By understanding and being able to code *when* patients initiate additional concerns in these visits, this enabled me to later investigate whether a relationship exists between the *how* and the *when* patients launch additional concerns. Now that I have defined the phenomena and collection building process of patient-initiated additional concerns, I am confident that a replicable and understandable collection exists with clear boundaries that can be analyzed.

## 2.3 CODING SCHEMA

A total of 377 patient-initiated additional concerns were identified during the 175 visits that qualified for this study, and were coded for inductively driven characteristics. As discussed in Chapter 1, patients were selected because their visits were captured between June 2013-June 2015, were seen for either cholecystectomy, hernia repair, or colonoscopy procedures, and both visits immediately before and after the procedure were captured. Two or more additional concerns were raised in 80 visits, one concern in 37, and none in 58. Only 3 of the 62 patients whose visits were analyzed for this study did not raise a single additional concern in any of their

visits. Table 1 shows the distribution of patients who were seen for each procedure and by which surgeon,[18] and Table 2 breaks down the additional concerns by procedure and surgeon.

**Table 1: Distribution of patients by type of procedure and surgeon**

| | **Total** | Dr. Allen | Dr. Sosa | Dr. Gupta |
|---|---|---|---|---|
| Cholecystectomy | **7** | 4 | 2 | 1 |
| Hernia Repair | **5** | 4 | 1 | 0 |
| Colonoscopy | **50** | 33 | 7 | 10 |
| **Total** | **62** | 41 | 10 | 11 |

**Table 2: Distribution of additional concerns by procedure and surgeon**

| | **Total** | Dr. Allen | Dr. Sosa | Dr. Gupta |
|---|---|---|---|---|
| Cholecystectomy | **45** | 37 | 5 | 3 |
| Hernia Repair | **25** | 21 | 1 | 3 |
| Colonoscopy | **307** | 259 | 20 | 28 |
| **Total** | **377** | 317 | 26 | 34 |

After watching scores of patient visits, transcribing, and analyzing patient-initiated concerns on a case-by-case basis, I developed and refined a list of characteristics that are applicable at the aggregate level as well. In other words, these characteristics are general features that no matter how unique or unusual a singular case may seem, they can be evaluated for any visit in this collection. Because this chapter focuses on the how and when an additional

[18] There is a larger volume of Dr. Allen patients participating in this study overall, which is reflective of Dr. Allen being the only full-time surgeon in this practice during these years of data collection. As discussed in Chapter 1, both Drs. Sosa and Gupta have been working part-time due to familial obligations. In Chapter 3, when using statistical analysis, models will take into account which surgeon the patient saw and for which procedure.

concern is raised, only the pertinent characteristics will be described here. Additional characteristics will be discussed in the next chapter when they become analytically relevant.

The patient-initiated additional concerns were coded for the following features:

- **How the concern is raised**:

  **Fitted-to-topic method*:*** patient uses practices such as step-wise transition or backlinking techniques to introduce additional concern as related to previous talk. For example, surgeon asks about X and patient transforms reply to deal with Y.

  **Fitted-to-activity method*:*** patient takes advantage of the surgeon being physically near the concerned area to direct attention to it. Or another "physical" activity occurs and triggers a concern. For instance, a patient is walking slowly and this prompts him to provide an account about his bad knee.

  **Disjunctive method:** patient launches additional concern in first position. Additional concern is unrelated to either immediately prior talk or activity, nor does patient attempt to backlink a concern to previous talk or activity.

- **What *phase of the visit* did the patient initiate the concern?**

  **Phase #1: Pre-physical**: includes greetings and other preliminary non-medical talk, problem presentations, history taking, logistics of up-coming procedures and risks, discussion of how patient is doing post-operatively, lab results, etc.

  **Phase #2: Physical examination(s):** begins from the point in which the surgeon first examines a patient (could be a formal examination in which the patient is placed on the examination table or an impromptu examination in which the surgeon more quickly looks at one particular area even though the patient is not undergoing a head-to-toe examination) until the last time the surgeon physically looks at the patient. Depending on the type of visit (pre-operative vs. post-operative) the surgeon may perform one head-to-toe examination and/or numerous more localized examinations.

  **Phase #3: Post-physical:** Any talk that occurs after the last physical examination. This could include diagnosis, treatment recommendations, pre-operative discussion, laboratory results, closings, etc.

- **What *phase of the procedure* did the patient initiate the concern?**

  **Pre-operative:** Visits prior to the procedure. Patients may or may not have been referred to the general surgery practice with a diagnosis. These visits can include discovering if a procedure is needed, explanations of why it is warranted, how it is performed, potential complications, what is expected behavior pre-operatively, what to expect post-operatively, arrangement making, etc.

  **Post-operative:** Visits after the procedure. These visits can include surgeons delivering results or findings from the procedure, examining incision sites, dealing with complications, removing sutures, etc.

## 2.4 *HOW* PATIENTS INITIATE

I found three observable methods for how patients launch additional concerns at the sequence level of interaction: Fitted-to-topic, Fitted-to-activity, and Disjunctive. These methods will be illustrated with a discussion of three instances of each.

### 2.4.1 *FITTED-TO-TOPIC* METHOD

Patients can "fit" their concern to a topic already in progress, which makes their additional concern presentation independent of phase structure but dependent on topic-agenda. While the concern is explicitly first introduced by the patient, the position of this initiation is responsive to the overall topic. In this collection patients initiated concerns most prevalently with this method, two-thirds of the time.

In our first example, Ms. Douglas[19] is a white patient in her mid-sixties and recently was admitted to the local ER for severe anemia. Her family doctor referred her to this general surgery practice for a colonoscopy consult. This is her first recorded visit and first time meeting Dr. Allen. After some casual getting-to-know-each-other talk about who the patient is related to in the community (has a common local surname) and where she is from, Dr. Allen begins asking

[19] All participants' names have been changed to maintain anonymity of persons and place according to IRB stipulations.

her questions and taking her medical history. When Dr. Allen asks her about her appetite and weight (lines 1-2), the patient first responds to the topic of that question and then transitions into an additional concern about having high blood pressure and potentially getting off medication for it (lines 7-9). The initial turns of the additional concerns have been bolded in all examples.

Example 1: High blood pressure

```
01  DOC:  Your appetite has been good and your weight's [been holding=
02  PAT:                                                [((single nod))
03  DOC:  =[you're not [gaining or losing, [staying about the same
04  PAT:   [.hhh       [Well-              [Well I've been working on
05        losing
06  DOC:  Uh huh,
07  PAT:  Because that's been one of those things cause I was hoping to
08        lose enough maybe to get off, (.) the blood pressure
09        medicine. I had been (.) a high of three thirty but I've (.) been
10        down and (.) I've (.) been (.) losing [uh
11  DOC:                                        [Good for you
12  PAT:  So that's what I've been working on…
```

I found that this is a common practice patients use to fit an additional concern into a conversation—when the surgeon asks about X, the patient transforms the response to talk about Y. Dr. Allen first asks the patient a declarative-format inquiry (Heritage 2010b), "Your appetite has been good", which is also a B-event statement[20] (Labov and Fanshel 1977:100-101) that makes relevant a confirmation by the patient. This is a standard question in the sequence of obtaining medical history, and because Ms. Douglas is visibly above average in weight, the surgeon has not only designed the question to favor his presumption that she has a good appetite but also moves forward to the next question in the series about the status of her weight. Ms. Douglas nods to confirm her good appetite once in line 2 (it comes too soon to be confirming the

[20] Events can be categorized in accordance with the participants' rights and obligations to knowledge of, or experience with, the event (Heritage 2012; Heritage and Raymond 2005; Labov and Fanshel 1977:100-101). A-events pertain to the speaker's domain, B-events to the recipient's domain, and AB-events are shared by both participants.

next question about weight holding). Because this is Ms. Douglas's first time in this office there is no previous weight measurement to formulate a base-line comparison.

What is initially Dr. Allen's second, declarative-format, yes-preferring inquiry, "Your weight's been holding" gets expanded into a series of candidate answers, "You're not gaining or losing, staying about the same" which is a more appropriate design for this first time visit. Ms. Douglas' turn-initial "Well" (cut-off and redone again) in line 4 signals that her response is not going to be type-conforming (Raymond 2003), is likely to be expanded (Heritage 2015), and is deviating from the current topic (Heritage 2015; Sacks 1987; Schegloff and Lerner 2009). Indeed, she transitions from the topic of losing weight to her hope of getting off blood pressure medication (lines 7-9). It is evident from the patient's response that she sees a direct correlation between losing weight and her blood pressure dropping.

Because blood pressure is a standard topic during history taking, Ms. Douglas, a seasoned patient in other medical practices, is likely aware that this topic might eventually be addressed (cf. Stivers and Heritage 2001 on expanded answers doing preemptive work). Due to the normative obligation for patients to monitor and seek help for their medical issues (Parsons 1951), Ms. Douglas does more than getting an additional concern on the table early on. She actively sculpts her presentation of self to this new surgeon before her (cf. Goffman 1959; Heritage and Robinson 2006b), showcasing herself as a responsible patient even if not in perfect health.

Patients can initiate additional concerns related to the topic in other sequential positions as well, not just as responses to inquiries. In the next Example (2), we will see an additional concern being launched in first position. Ms. Franklin is an African American patient in her mid-60s and is hard of hearing. She is overdue for her next colonoscopy and has a family history

of colon cancer. Ms. Franklin has known Dr. Sosa for at least 12 years, and together they have been through several procedures. This interaction occurs near the beginning of the visit. After briefly discussing that she is due for another colonoscopy, Dr. Sosa is looking for the date of her previous one by flipping through her paper medical chart. At this point, Ms. Franklin initiates the topic of another past procedure that Dr. Sosa also performed, an umbilical hernia repair (line 5). She connects this additional concern onto the topic of other things for him to look for while searching.

Example 2: Hernia

```
01  DOC:  That's why we might have forgot those years. ((trying to
02        figure out when last scope was))
03        (1.0)
04  DOC:  So back in two thousand six. Let's just see.
05  PAT:  Okay. .h Do you remember now when I had that hernia too:, (.)
06        cause you did that surgery on my hernia,
07  DOC:  Yes ma'am. (.) That was back in two thousand six. Yes ma'am. And
08        the hernia was- that was in- that twelve years ago. that was
09        two thousand o:ne,
10  PAT:  O:kay
11        (2.0)
12  PAT:  [Because it came back.
13  DOC:  [(W)
14  DOC:  It d:id,
15  PAT:  haha Y:eah
```

Ms. Franklin initiates an adjacency pair sequence in line 5 with a preliminary questions ("pre")[21] (Schegloff 1980), "Do you remember now when I had that hernia too:," which not only draws the surgeon's attention to this topic but links her hernia repair to the topic of previous procedures that Dr. Sosa performed. By framing her question with "Do you remember" the patient poetically ties this turn-at-talk with Dr. Sosa's previous musing, "That's why we may have forgot those years" (line 1) (Jefferson 1996). What at first may appear on the surface-level to be

[21] A pre-expansion is a sequence organization term that refers to "the first place that a two-part unit [like a request-granting sequence] can be expanded [and] is before its first part" (Schegloff 1980: 28). Thus, pre's are preliminary to something else and does two things: "it projects the contingent possibility that a base FPP [first pair part like a request] will be produced; and it makes relevant next the production of a second pair part, namely a response to the pre-[request]" (29).

just a request for information and is initially treated as such by Dr. Sosa with his type-conforming answer, “Twelve years ago, that was two thousand o:ne,” (lines 8-9), later becomes evident as a preface to the launching of an additional concern, “Because it came back.” (line 12).

The patient “fits” this additional concern right on top of the reason for her visit. Ms. Franklin has the interactional burden of not only bringing up an additional concern, but she also must contend with the delicacies of raising a concern about an issue that might be interpreted by Dr. Sosa as a dissatisfaction with his skills as a surgeon. While using “pre-s” is a common practice for speakers doing delicacy work (Schegloff 1980), the unmitigated medical assertion, “Because it came back.”, however, does not appear to perform much face-saving work for the surgeon. Dr. Sosa’s elongated request for confirmation, “It d:id,” with a sing-songsy tone of surprise (but not of disbelief) does not epistemically push back on the patient’s claim but instead treats it as valid. Because hernia recurrence rates can be as high as 28% (Martis et al. 2011) depending on the exact procedure technique and patient physique (Kulaçoğlu 2015), Dr. Sosa probably is not surprised that Ms. Franklin, a heavy set woman, has a hernia recurrence. Ms. Franklin’ laughter in line 15 before her confirming “Y:eah” may work as backing off of her strong stance in her previous turn (Haakana 1999) since Dr. Sosa did not react to it as a problematic assertion.

Moving on to our next example (3), patients do not always fit their concern to the topic immediately preceding it but instead can “backlink” the additional concern to other previous talk (Local and Walker 2004 on “back-connecting”; Sacks 1966 on "tying rules" in Spring 1966:14; Schegloff 1996c:69).[22] In this collection, an additional concern may first appear to be a

[22] De Stefani, Elwys, and Anne-Sylvie Horlacher. 2008. "Topical and sequential backlinking in a French radio phone-in program." *Pragmatics. Quarterly Publication of the International Pragmatics Association (IPrA)* 18(3):381-406. have furthered Schegloff’s work by showing that speakers can backlink to talk, even if it is not their own (385), and this work does not have to occur only in turn-beginnings (404).

disjunctive concern if not topically related to the immediately preceding turn-at-talk[23]—that is until backlinking work is performed, showing that it is, indeed, topically-fitted. In this example (3) Ms. Holt is a 57-year-old, white patient in to see Dr. Allen, her surgeon for several years, for her colonoscopy report. A few months prior to this visit, Ms. Holt came in to see Dr. Allen because she was concerned about seeing blood in her stool. Dr. Allen recommended a colonoscopy procedure with hopes of detecting the source of her bleeding, which she has now undergone about six weeks prior to this scope report visit.

This interaction occurs near the beginning of the visit. Dr. Allen enters the room and first apologizes for having her wait, and they exchange greetings. He accounts for his apology by sharing that he is trying to get out of town before the "craziness" takes control (line 8). After some talk about his upcoming trip and how he will be traveling with another local doctor, Dr. Allen transitions into the reason for the visit, by asking, "So you got through your scopes okay?" (line 23). Robinson and Heritage (2006) have shown that opening questions are reliable indices of the types of consultation the participants believe they are involved in. In this case Dr. Allen's opening indexes that from his point of view: 1) this is a follow-up visit 2) helps orient the patient that he thinks that this is the main reason for the visit 3) solicits an update or assessment of that particular concern 4) and in doing so, embodies the surgeon's claim to have prior experience with the concern in the question (in this case, as the performer of the procedure). Dr. Allen's question is a polar question that favors a "yes" answer, which also displays his optimism that the patient has fared well (Boyd and Heritage 2006). As Heritage (2011) asserts, "Physicians, when formulating polar questions, are without a hiding place: they will unavoidably communicate their

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[23] In fact, 15 instances of the disjunctive method were subsequent mentions of additional concerns that were first introduced as "fitted" (to either talk or activity) earlier in the visit. However, in the subsequent mentioning, there was no backlinking work done, thus the patients produced the concern as not rooted in either past or immediately-previous talk or activity. Therefore, the subsequent concerns were produced as disjunctives.

expectations and beliefs about likely desirable patient responses" (340). Dr. Allen's question now places Ms. Holt as the second speaker, and she is held accountable to answer this question in her next-turn-at-talk (lines 24-28).

Example 3: Hip concern

((Dr. Allen knocks then enters))

01 DOC: Hey there.
02 PAT: H:ey Dr. Allen.
03 DOC: Sorry for keeping you hostage<[How are you doing today.
04 PAT: [haha
05 PAT: Okay. Fine. And how are you,
06 DOC: Good. Doing good. I'm trying to g- (.) supposed to go out
07 of town tomorr:ow and uh (1.0) ((sitting down)) and so it's
08 the (0.2) craz[iness that appears [between now and tomorrow=
09 PAT: [(catch up) [haha
10 DOC: =and I'm trying to (0.4) deal with. Just a little bit. (0.5)
11 trying to (0.2) Trying to get out of to:wn. So
12 PAT: And is this where you're going to the- when you're going out
13 of the country?
14 DOC: Uh huh. [It's tomorrow night
15 PAT: [That's gonna be exciting.
16 DOC: Uh huh. And Dr. K's is going to be there so it's gonna be
17 fun to [uh
18 PAT: [C:ool.
19 DOC: I'll see him all the way- I'll see him more there than I've seen
20 him here lately.
21 (0.5)
22 DOC: .hh So that will be good.
23 DOC: So you got through your scopes okay?
24 PAT: I di:d, **I'm having a (.) heck with my left hip.**
25 **(hurts really) I'm getting ready to go out of town on**
26 **Wednesday and uh (.) I'm hoping maybe to get a cortisone**
27 **shot in it or something tomorrow and I don' kn-I'm sure you**
28 **don't h(h)andle anything like that haha so= ((laugh tokens))**
29 DOC: =R:ight.
30 PAT: .hh I'll call Dr. M's office and see if I can get one in
31 Smithtown tomorrow [(or see if).
32 DOC: [Your blood count today looks pretty g:ood.
33 PAT: That's what I was going to ask you. U:hm. It looks okay?

Ms. Holt first produces a repetitive and agentive answer, "I di:d," (line 24) (Hayano 2011; Heritage and Raymond 2012; Schegloff 1996a) and then uses this responsive position as a vehicle to launch an additional concern presentation (lines 25-28). Ms. Holt builds her second

turn-construction unit (TCU),[24] "I'm having a (.) heck with my left hip." with no delay or prefaces, almost as if it too is in response to Dr. Allen's question. In a way, she takes advantage of being the recipient of an inquiry question (even though it was a follow-up question) by answering as if Dr. Allen were asking about a new concern (cf. Robinson 2006b), which is one way that she "fits" her additional concern to the ongoing talk.

The second practice Ms. Holt employs is "backlinking" (Schegloff 1996c:69) her concern to the previous topic of going out of town. She missed an opportunity to initiate her additional concern to this topic while it was still ongoing, and then she missed another opportunity to use step-wise transition to lead into her additional concern because Dr. Allen asked her a follow-up question that shifted topics in line 23. Thus, Ms. Holt faces the dilemma of whether to go back to a previous topic that is now once-removed. After producing her additional concern as if it were part of the response to Dr. Allen's inquiry about her scopes, she backlinks her additional concern to topic of going out of town, recycling "to go out of town" in her turn-design (line 25) which echoes the construction of Dr. Allen's turn-at-talks (line 6-7, line 11) (cf. Goodwin 1990).

Ms. Holt goes one step further and formulates a request with cross-cutting preferences (Schegloff 2007) in lines 26-28, "I'm hoping maybe to get a cortisone shot in it or something tomorrow and I don' kn-I'm sure you don't h(h)andle anything like that haha". Ms. Holt self-repairs her question by cutting-off "I don' kn-" (presumably "know" was beginning to be articulated), which would have positioned the patient as in an unknowing position (K-) in regard to the feasibility of her request and then reformulates it to, "I'm sure you don't h(handle)", which repositions herself as in a knowing position (K+) to the type care a general surgeon provides

[24] A *TCU*, or *turn-constructional unit*, is a self-contained unit of speech during a turn-at-talk that is syntactically, pragmatically and intonationally complete. Depending on context, this could be a word, a clause, or a sentence (Sacks, Schegloff, and Jefferson, 1974)

(Heritage 2012a). The grammatical design of the reformulated polar question favors a "No" response; however, insofar as this is an indirect request the action bias is for a "Yes" response so that she can receive her shot today without the trouble and expense of making an appointment with her family physician. While "I don' kn-I'm sure you don't h(h)ndle anything like that haha" is grammatically declarative in design, because it is a B-event statement that follows a complaint, this makes the social action of her turn an indirect request and sets up this situation as something needed to be solved.

Ms. Holt laughs while producing "handle" (line 28) and ends her turn with laugh tokens, indicating an orientation to having done a medical misdeed (2001; Haakana 1999) of requesting something from a surgeon that typically falls under another physician's domain. In addition, Ms. Holt's laughter is doing "troubles resistance" to her overreach (Jefferson 1984), and Dr. Allen does not provide reciprocal laughter. Furthermore, his single-word response, "R:ight" (line 29) is latched to the patient's previous turn, which displays Dr. Allen as not "doing" giving a dispreferred response by delaying, hedging, apologizing or accounting for why he is not granting her request (Sacks 1987). This seemingly reflects his understanding that the patient knows her turn was an overreaching request that warrants no further explanation from him. After the surgeon's quick confirmation of "R:ight." that he is not one to give a cortisone shot, he sequentially deletes the patients next turn about her future arrangement makings with her family doctor about this topic (lines 30-31), and he proceeds to talk about her blood count results (lines 32-33).

### 2.4.2 *FITTED-TO-ACTIVITY* METHOD

This analysis has identified a second local resource patients utilize—patients can initiate additional concerns by capitalizing on the on-going physical activity during the office visit. The ongoing physical activity can include how the surgeon and patient's bodies are positioned vis-à-vis one another, where the surgeon's gaze is focused, and other physical activities that occur during a visit such as the patient moving on and off the examination table and the act of the examination itself. Patients can legitimize their drawing focus to an additional area since the contingency placed on the surgeon to look at the concerned area is at its smallest at-that-moment (cf. Curl and Drew 2008). Furthermore, the activity of looking at a problem area does not break from the activity-at-hand (cf. Goodwin 1986 on body positioning being exploited for ecological contiguity).

A limitation of this fitted-to-activity method is that the additional concern needs to connect to a physical activity or part of the body in order to be made relevant. Concerns that can be physically evaluated (e.g., sore throat, a cyst, or a swollen ankle) lend themselves well to this method, but patients with other concerns that are not associated with one part of the body or are more internal in nature (e.g., mental health disorders, high blood pressure, or diabetes) did not initiate with this method, which may account for it being the least prevalent method.

In the next example (4) Mr. Hall is a 58-year-old, white patient who is scheduled to discuss the results of his recent colonoscopy procedure. Mr. Hall and Dr. Allen have a long-standing medical relationship, and Dr. Allen has cared for several of the patient's family members as well. This excerpt occurs near the end of the physical examination phase, and the surgeon has just completed palpating the patient's abdomen. Dr. Allen instructs the patient to sit up (line 1), and while Mr. Hall is in this process—his legs are still stretched out and very near to

where the surgeon is standing at the end of the examination table—he launches an additional concern presentation about his shins being red.

He draws in Dr. Allen's attention by pushing down his socks and lifting up his pant legs so that his shins are more visible. Mr. Hall first launches a pre-pre sequence in line 2, "I wanted to ask you." which indicates that what the patient is about to ask is a "delicate matter" (Schegloff 1980). Here the delicate matter perhaps is that the patient is the type of person who is concerned over red shins (cf. Heritage and Robinson 2006b). In addition, while the surgeon has signaled that the examination is over by telling Mr. Hall to sit up, the patient resists this closure of this physical examination phase in order to have Dr. Allen take notice of his shins.

Example 4: Red shins

```
01  DOC:  Mkay. Let me get you to sit back up.
02  PAT:  I wanted to ask you.
03  DOC:  Uh huh,
04        (.)
05  PAT:  If you've looked at (.) how my shins get red sometimes,
06  DOC:  Uh huh,
07  PAT:  See like today it's red again (0.4) and two days from now you
08        may not hardly see any=
09  DOC:  =red at all.
10  PAT:  Is there any certain thing that's causin' that,
11        (1.0)
12  DOC:  .hh You know I don't know. I think- I think some of it is uhm
13        (.) maybe or you up on it more sometimes more than others or
14        is there any rhyme or reason…
```

Even though Mr. Hall's shins are unrelated to the overall agenda of the visit, he raises this issue with Dr. Allen. Since the phase structure is appropriate (the patient has managed to keep open the physical examination phase) and since Dr. Allen is already physically positioned near his legs, Mr. Hall takes advantage of this point in the interaction to "fit" his additional concern to the ongoing activity. Perhaps the examination reminded him of this concern or maybe he has been considering when the best time was to raise it. Regardless, it appears that Mr. Hall has evaluated this point in the visit as an opportune time to do so and rather than waiting for the surgeon to ask

him if he has another concern (an uncertain future event), the patient takes the initiative by not letting this opportunity pass by.

Mr. Hall's first question, "I wanted to ask you." (line 2) is sequentially a pre-pre. This structural design affords the patient the interactional space to address his additional concern in a way that if he just directly asked in line 2, for instance, "Is there any certain thing that's causing my shins to be red?" would not (Schegloff 1980). Instead, by asking a pre-pre, which Dr. Allen's responds to as such with the go-ahead "Uh huh," in line 3, the patient secures the buy-in from the surgeon and allows him time to display his shins. Lines 7-8 are the patient's pre-sequence with the main question occurring in line 10, "Is there any certain thing that's causin' that," and by the occurrence of this turn-at-talk, the surgeon is now fully oriented to the activity of examining the shins. By inquiring into the cause of red shins, Mr. Hall presupposes that Dr. Allen may be able to provide an answer. In return, the surgeon treats the patient's initiation as an unproblematic problem presentation and further topicalizes it.

In the next example (5), Ms. Phillips, a 76-year-old, white patient, is in for a follow-up appointment for her anemia. She has recently undergone a colonoscopy and an upper gastrointestinal endoscopy. Moments before the physical examination begins, Dr. Allen turns to her husband sitting in the corner and asks both of them if they are surviving the cold weather, this visit occurring mid-February. Ms. Phillips mentions that this cold weather is causing them some difficulties with their reclaimed furniture business, since they have an outdoor booth they need to prepare for the upcoming spring antique festival. This talk continues while she lies down on the examination table and Dr. Allen palpates her abdominal area. Dr. Allen instructs her to take a deep breath (line 1), and Ms. Phillips raises an additional concern about sometimes experiencing pain in that same area he is currently pressing on.

Example: 5 Stomach pain

```
01  DOC:  Take a deep breath. ((Dr. Allen palpates patient's stomach while
02        she breathes))
03  PAT:  ((inhales))
04  DOC:  Out
05  PAT:  ((exhales))
06  PAT:  The only place that I have pain is right-right right in there
07        ((points to her right abdomen area where Dr. Allen had just been
08        pressing))
09  DOC:  Right here ((touches that area))
10  PAT:  It-it you know at times.
11        (.)
12  PAT:  It would be right there.
```

There is no indication from the production of the Ms. Phillips' informing that she is currently experiencing pain in that area or as a result from her stomach being palpated or from her breathing, but instead the memory of pain is evoked from the surgeon examining this part of her body. It appears to be a fleeting pain "at times" (line 10) that "would be right there" (line 12), and is still an ongoing issue based off of the present tense "have" in line 6.

Pain is phenomenologically an interesting type of concern since it is not objectively discernable to physicians, who may be able to observe a patient *suffering* from pain or infer that something *looks* or *could be* painful, but pain itself is never visible. Thus, in order for patients to convey that an otherwise normal looking area that is not currently causing them distress can, at times, cause them pain, they must articulate this information (cf. Heath 1989; McArthur forthcoming). By "fitting" this concern to the ongoing activity, Ms. Phillips has seemingly found an appropriate place to do so.

In our last example (6) of this method, Mr. Miller[25] is a 77-year-old, white patient scheduled for a post-operative hernia repair visit. He has known Dr. Allen for many years, spanning several hospital stays and procedures together. Mr. Miller is in a set of Dr. Allen's patients that, unbeknownst to them, are purposefully scheduled at the end of the day to allow for longer visits that are both medical and social engagements. The office staff is accustomed to this and all but one assistant clocks out after 5pm, leaving Dr. Allen and his patients/friends to talk and take their time. Dr. Allen tells me that Mr. Miller is "one of my favorites."

After several minutes of talk about their families they finally settled down to the task at hand, evaluating Mr. Miller's recovery from a hernia repair. This excerpt occurs when Dr. Allen asks Mr. Miller to get onto the examination table. The patient slowly stands up from the chair and places his hands on the edge of the examination table to guide himself towards the foot of the table, where he next will step. Dr. Allen stands as well, grasping the patient's elbow for support. The patient accounts for his slowness in movement with an informing (line 1).

Example 6: Knee

((patient slowly walking to table))
01 PAT: **I-I just got a- (0.2) ((rubs right knee)) got an injection in**
02 **my knee,**
03 (0.5) ((Dr. Allen places hands on patient's back for support))
04 DOC: °Okay.
((Dr. Allen proceeds to help patient onto table))

[25] Mr. Miller and his wife, who accompanies him to every visit and is also a patient of Dr. Allen's, were the middle and high school band directors for a local school for over fifty years. One late afternoon, as I was passing through the patient waiting room towards the back office I overheard Mr. and Mrs. Miller greeting another patient, a middle-aged African American man, who was leaving from his visit. Mr. Miller stood up to shake this man's hand and joked, "How many fights did you stop today?" He chuckled and said, "At least five." Mr. Miller said he had an idea of this already because his grandson came home from school earlier saying he had to dodge fights left and right. They exchanged some more stories and commented on how it was good to see each other, and it was evident that they were former colleagues. In a lot of ways the waiting room in a small town doctor's office is a public place much like a grocery store where it is very likely to run into an old friend, co-worker, or acquaintance. Neither of them asked or inquired about why the other one was at the surgeon's office, allowing for some degree of privacy to still be maintained.

Mr. Miller's account is fitted to the ongoing physical activity of the moment, his getting onto the table. This account, while not explicitly asking for Dr. Allen to evaluate the area (as in the "red shins" Ex 4), still goes on the record as an informing that the patient is having ongoing difficulties with his knee, enough so to warrant seeing another doctor about it and to receive an injection. Even though it is not a direct request for help, I argue that the patient has indeed launched an additional problem presentation, and his knee is now available to be addressed as a potential topic for discussion.

Not all patient-initiated additional concerns are explicit solicitations for help but instead can be embedded in the on-going talk or activity, as seen in Mr. Miller's case. As mentioned previously when defining "patient-initiated additional concerns", if doctors or medical sociologists, who code and make collections of interactions, only register the more overt variety of additional concerns and disregard turns-at-talk like, "I-I just got a- (0.2) got an injection in my knee," solely as an informing, a nuanced understanding of how patients monitor the progress of their visits and create interactional spaces to raise concerns in more subtle ways goes unnoticed. Again, the goal for this chapter is to fully expose and give patients credit for the range of methods and practices they use to initiate their additional concerns.

### 2.4.3 *DISJUNCTIVE* METHOD

In contrast to the two "fitted" methods, which were responsive to the ongoing topic or activity, patients can make no attempt to link the additional concern to anything that came before. Instead patients can in first-position initiate a "disjunctive" additional concern: "disjunctive" because it is not connected at the sequential level to previous turns-at-talk (cf. Jefferson 1984 on "topical disjunctures") or current physical activities. Recall, it is not until

patients deliver the base-sequence turn-at-talk that we can evaluate if the method used was indeed disjunctive or was actually fitted-to-the-talk by backlinking to prior talk.

Raising any additional concern is an imposing action, in that it not only contradicts the default "one visit, one problem" orientation (Beckman, Frankel and Darnley 1985; Heritage et al. 2007; Robinson 2001; Robinson and Heritage 2015; Robinson, Tate and Heritage 2016) but it also requires surgeons to stop the activity-at-hand and turn to an issue that might not otherwise have been discussed. I argue that the disjunctive method is a high stakes and agentive move by the patient since it is more than just a transition from an ongoing activity or topic. Instead disjunctive additional concerns are complete departures from the ongoing interaction.

In our first example (7) of this disjunctive method, Ms. Stewart is a 69-year-old, white patient who is seeing the surgeon for both a colonoscopy consultation and an examination of her mastectomy incision. She has been a patient of this practice for over five years, and both Dr. Allen and Dr. Gupta have been involved in her breast cancer diagnosis and treatment, which entailed several surgical procedures. During the two-year span that this study focuses on, June 2013-2015, Ms. Stewart had ten office visits that spanned post-operative visits for her mastectomy and pre/post-operative visits for her colonoscopy and upper GI endoscopy procedures.

In this visit, Ms. Stewart complained about pain from her mastectomy incision scar, and Dr. Allen has her lie down on the examination table so that he can examine her. For the last several turns-at-talk, Dr. Allen has been coaching her on how to massage her chest to help alleviate some of this pain. He is mid-TCU when Ms. Stewart overlaps his talk and raises a completely different topic, a complaint about an antibiotic that Dr. Allen prescribed to her

recently (unrelated to her incision site). She references the medication as "that antibiotic" (line 1), which indexes that she believes this is enough of a referent to be recognizable to him.

Example 7: Antibiotic

```
01  DOC:  Just massaging it like right now looks better than it did.
02        .hh Just try to get the- (.) that swelling [out of that flap
03  PAT:                                             [Oh and that
04        antibiotic so: sick on both of those. (.) it was h:orrible.
05  DOC:  [Well let's not
06  PAT:  [You gave me one that you can't eat two or three hours before
07        you take it, and two or three hours after
```

What is normatively due at the end of an advice-giving sequence is for the patient to display some form of understanding and/or acceptance of it (Heritage and Sefi 1992; Pomerantz 1984). Instead, the patient moves away from the help that the surgeon is currently delivering and initiates an off-topic complaint. There are various turn designs that speakers can utilize to deliver disjunctive talk to show that what they are about to say is topically disconnected from the previous talk. Here the patient uses the turn-initial particle "Oh" (line 3) to signal that what will follow is an inapposite and abrupt change of topic (Heritage 1984; Jefferson 1978). Combined with the overlapped initiation and the drawn-out, extreme case formulation "h:orrible" (Pomerantz 1986), the patient attempts to take control of the interactional floor and shift attention away from her mastectomy site to another medical problem she is having.

Another sequential practice patients can utilize to launch a new concern in first position is to include pre-sequences that are pre-questions or pre-announcements. While pre-sequences can be used in fitted-to-topic initiations as well, as discussed before in Examples 3 & 4, the affordance of this sequential design is to create a buffer space for the patient to secure the surgeon's attention and garner his acceptance for the patient to now hold the interactional floor. Examples 8-10 below are examples of disjunctive patient-initiated additional concerns that are initiated with pre-sequences (bolded).

```
Example 8: Blood count
01  PAT:  Well I was gonna tell you. I don't know if Dr uh Dr
02        Ken's father sent you my blood count? that I knew of…

Example 9: Dizziness
01  PAT:  Now let me ask you one question real quick.  This
02        dizziness (.) I used to not have it…

Example 10: Umbilical hernia
01  PAT:  Okay. One other thing.
02  DOC:  Sure.
03  PAT:  You may cover it.  When I was…((goes on to discuss umbilical
04        hernia))
```

When patients perform this interactional work to show that the additional concern is unrelated to previous talk nor about the main purpose of the visit, they often do so with shift implicatives (e.g. Ex 8 "Well" (Heritage 2015), Ex 10 "Okay" (Beach 1995)), pre-sequences, or pre-pre sequences (Schegloff 1980). Patients may also perform interactional work in an attempt to minimize the disjuncture like (Ex 9: "one question real quick"), or to justify it (Ex: 10 "You may cover it." Or Ex:11 ".hh Anyway. You're a surgeon[t]" as discussed in the next example).

In the next example (11), Mr. Carter, a white patient in his early 70s, is in to see Dr. Allen to receive the results from his colonoscopy and upper GI endoscopy procedures. Mr. Carter has an on-going difficulty of food getting caught in his esophagus. When he is told that his endoscopy report showed evidence of a small hiatal hernia but otherwise was a good report, it becomes evident that this is not good news for him. The patient appears frustrated that no one is able to give him the diagnosis that he thinks he has for his swallowing difficulty—holes in his esophagus that trap food. Mr. Carter complains that he and Dr. Sosa disagreed about this in the past and that he "did not like his bedside manner" and thus requested a new surgeon. Dr. Allen and Mr. Carter continue to discuss different medication options to treat his esophageal symptoms and the causes behind his symptoms (line 1).

Mr. Carter shifts abruptly to a new topic in line 4 with a turn-initial particle "Anyway" and an account for why this additional concern is relevant (even though unrelated), because Dr. Allen is a "surgeon" and he "couldn't get another (.) surgeon (.) to take a look" line 4. He also includes a pre-request in his formulation, "I want you to look at something" (line 7). This initial work is done as a bridge into the additional concern, which is a potential complication from a back surgery performed by another type of surgeon (not in this practice).

Example 11: Fluid build-up

```
01  DOC:  That's why I think it's just spasm is what you're having
02  PAT:  Once I'm past that I don't have any problems
03  DOC:  Right.
04  PAT: .hh Anyway, (.) You're a surgeon[t] ((reaches out and touches dr
05        on the knee))
06        (1.0)
07  PAT:  I want you to look at something= ((pt standing up))
08  DOC:  =Sure.
09  PAT:  Cause I couldn't get another (.) surgeon (.) to take a look.
10  DOC:  Sure.
11  PAT:  I had back surgery.
12  DOC:  Okay,
13  PAT:  And (0.4) the top, (.)  I can't really look at this.
14        ((has stood up and lifted shirt))
15  DOC:  Right  ((looking at back))
16  PAT:  There's a puffiness, (.) This is nice and smooth
17  DOC:  Right.
18  PAT:  This is a little puffy. I think there's some fluid behind it.
19        Should it be of concern,
```

Mr. Carter appears to be an assertive patient throughout the course of his visit. His mention of disliking Dr. Sosa, Dr. Allen's partner of eighteen years, and request to switch surgeons most likely puts Dr. Allen on guard that this is not a typical patient and should be handled delicately. Furthermore, by explicitly categorizing Dr. Allen with "You're a surgeon[t]" (line 9), which on the surface-level looks like an informing but in practice provides no new news, falls outside the patient's epistemic domain to proclaim. Mr. Carter is performing "altercasting" work, which is described as casting someone into a role in an attempt to manipulate the situation (Charon 1979). This turn-at-talk, coupled with placing his hand on Dr. Allen's knee, are assertive moves Mr.

Carter deploys to take charge of how this sequence will unfold. Moreover, Mr. Carter stands up in line 7 while articulating the pre-request "I want you to look at something" while making his area of concern visible to Dr. Allen. This physical manipulation of his body increases the pressure for this concern to be taken up.

I argue that launching an additional concern using the disjunctive method is interactionally a high stakes project. For patients making moves in first-positions that alters the course of an activity and that switches the topics of conversation are significantly more assertive than "fitting" it onto an ongoing topic or activity. In contrast to both fitted methods, the disjunctive introduction of an additional concern asserts that this concern is of enough importance to supervene over the focal concern for the visit. By breaking the interactional flow, it places the additional concern on the forefront of the patient's mind.

## 2.5 DISTRIBUTION BY METHOD

Overall the fitted-to-topic method is undoubtedly the most prevalent method (66.3%) patients use when initiating additional concerns. This underscores the importance of talk in doctor-patient visits. It is not just the information that gets passed back and forth during these conversations, but it is the act of talking itself that facilitates more opportunity spaces that patients can find purchase to launch their additional concerns. Table 3 suggests that patients

**Table 3: Distribution of additional concerns by method**

| | **Instances, n (%)** |
|---|---|
| Fitted-to-topic | 250 (66.3) |
| Fitted-to-activity | 51 (13.5) |
| Disjunctive | 76 (20.2) |
| **Total** | **377** |

treat the fitted methods (both talk and activity) as the socially preferred way to raise an additional concern, comprising 80% of all patient-initiated additional concerns. Thus, I argue that the fitted

methods are the preferred methods because patients, while wanting to get their agenda on the table, also want to disrupt the flow of the visit the least. Patients initiate additional concerns while simultaneously displaying deference to medical authority.

The relative dearth of the disjunctive method (in comparison to the fitted methods) suggests that patients orient to this method as a dispreferred first action, since it is a high stakes endeavor that fully deviates from the ongoing path of the visit. While the fitted-to-activity method also has a low frequency, I attribute that it is a method that is not always an available practice because not all concerns can be physically fitted to an activity. This will be discussed more in the next section pertaining to phase-levels.

## 2.6 PHASE-LEVEL IMPLICATIONS

In the analysis thus far, I have demonstrated how patients initiate concerns by identifying three distinct methods. When illustrating these methods with examples, I also discussed the different sequential position in which these patient-initiations can occur. I showed that the fitted methods can occur in both first and responsive positions, while the disjunctive method is unique in only occurring in first position. In this next section, I want to situate these additional concerns at a broader level, zooming out from our previous turn-level focus in order to shift focus to visit-phase level implications. See below for the distribution of concerns by visit-phase.

**Table 4: Distribution of additional concerns by visit-phase**

| | **Instances, n (%)** |
|---|---|
| Pre-physical | 227 (60.2) |
| Physical examination | 96 (25.5) |
| Post-physical | 52 (13.8) |
| **Total** | **377** |

While previous research found that acute primary care patients tended to raise additional concerns after the focal concern was resolved and during the closing phase of the visit (Barsky 1981; Robinson 2001; Rodondi et al. 2009; West 2006; White et al. 1997) this occurrence rate appears different in my collection. In fact, the pre-physical phase of general surgery visits was the *most* likely phase that patients initiated additional concerns, while the post-physical phase was the *least* likely phase for additional concerns to be initiated. It is important for both researchers and doctors to be cognizant of this difference. Additional concerns can, and indeed are, raised *throughout* visits, not just nearing the end. Because additional concerns can be raised using a variety of methods and social actions, researchers and doctors should monitor for them from the very onset of patient visits.

Furthermore, this early distribution of patient-initiated additional concerns supports Robinson and Heritage's (2015) intervention work in primary care that states that the ideal time for doctors to solicit additional concerns is earlier on in the visit. This present study makes evident that additional concerns already appear to be on the forefront of patients' minds since patients initiate an overwhelming majority of them during the pre-physical stage. Thus, asking about them earlier would be beneficial.

Next, let's investigate whether a relationship exists between how a concern was raised and when it was initiated. Table 3 shows the distribution of method by visit-phase.

**Table 5: Distribution of method used to initiate additional concern by visit-phase**

| | **Total** | Pre-physical, n (%) | Physical, n (%) | Post-physical, n (%) |
|---|---|---|---|---|
| Fitted-to-topic | **250** | 186 (74.4) | 27 (10.8) | 37 (14.8) |
| Fitted-to-activity | **51** | 0 (0.0) | 49 (96.1) | 2 (3.9) |
| Disjunctive | **76** | 41 (53.9) | 20 (26.3) | 15 (19.7) |

This table also shows that the fitted-to-topic method was used almost 74.4% of the time during the initial, pre-physical phase. This large rate of fitted-to topic initiations found so early in the visits appears to show that patients closely monitor the interaction and quickly find opportunities to step-wise transition into their additional concerns. Or, while it may be that patients are reminded of their concern by the interaction itself, there remains the question of why patients look for moments to 'fit' these issues to the context, rather than waiting for a later 'disjunctive' opportunity. The disjunctive method (while more evenly dispersed across the phases), also was used the majority of the time in the early phase of the visits. Thus, patients are demonstrating a strong level of initiative, not waiting until the end of the visit to raise "door knob presentation" concerns, nor are patients taking the backseat in the interaction, waiting to be asked for direct solicitations about additional concerns.

It is not too surprising that almost all fitted-to-activity concerns (96%) were raised almost exclusively during the physical examination. However, the most important finding here is that the physical examination phase has value beyond the surgeon performing diagnostic or assessment work. Rather the time spent touching and maneuvering the patient's body opens up an opportunity space for patients to raise concerns that they might not have felt comfortable with by fitting-it-to-talk or by using the disjunctive methods.

### 2.6.1 PRE-OPERATIVE VERSUS POST-OPERATIVE DISTRUBITION

Context is vital to understanding the environment from which a turn-at-talk is produced, and just as it is important to situate additional concerns at the phase-level of a treatment, it is also useful to understand where this concern is raised in the trajectory of the patient's care for their hernia repair, cholecystectomy, or colonoscopy procedures. One of the unique attributes of this study is the longitudinal dimension of its design, which enables me to follow patients through the

spectrum of their treatment, from their pre-operative consultations to their post-operative follow-ups. This longitudinal lens allows me to assess the trajectory of additional concerns spanning more than one visit. Table 6 below shows the distribution of additional concerns raised by type of visit.

**Table 6: Distribution of additional concerns at the treatment-phase**

| | Instances, n (%) |
|---|---|
| Pre-operative | 226 (59.9%) |
| Post-operative | 151 (40.1%) |
| **Total** | **377** |

From this distribution, we can see that there is a tendency for patients to raise concerns more often during pre-operative visits, with 59.9% of total patient-initiated concerns being raised then. Just as patients were more likely to raise concerns at the earlier phase of their visit, it appears this trend continues at the larger level as well.

Below is the distribution of method across the pre- and post-operative visits.

**Table 7: Distribution of methods to initiate concerns at the treatment-phase**

| * | **Total** | Pre-operative, n (%) | Post-operative, n (%) |
|---|---|---|---|
| Fitted-to-topic | **250** | 143 (57%) | 107 (43%) |
| Fitted-to-activity | **51** | 40 (78%) | 11 (22%) |
| Disjunctive | **76** | 43 (57%) | 33 (43%) |
| **Total** | **377** | **226** | **151** |

***Chi2=8.4, p=.01**

This table shows that the fitted-to-topic and disjunctive method share an equal distribution across all visits and are slightly more likely to occur during pre-operative visits. It is noteworthy that the fitted-to-activity method is much more likely to occur during pre-operative visits (4:1), which

we know from the previous section almost exclusively occurs during the physical examination phase. Further exploration of how physical examinations vary during the pre-operative vs. post-operative visits may reveal why patients are more likely to initiate additional concerns in one over another. It may be an issue of primacy—that patients grab ahold of the first opportunity available to bring up a concern, leaving little to discuss during subsequent examinations. Or maybe there is something inherently different in how pre-operative physical examinations are conducted that create more opportunity spaces for patients? My hypothesis is that pre-operative physical examinations are more thorough, and I leave this investigation for a future project.

## 2.7 DISCUSSION & CONCLUSION

By examining how patients design their turns-at-talk, we can see how patients launch and present their additional concern in *that* moment of interaction with their surgeon. This study demonstrates that patients do not have to wait for "door knob" type opportunities, nor do they have to wait to be directly asked by their doctor if they have "Something else?" in order to initiate additional concerns. Instead, patients have three distinct methods from which they launch additional concerns: fitted-to-topic, fitted-to-activity, and disjunctive. These can be articulated through a variety of social actions including informings, complaints, musings, inquiries, requests, and so on.

Patients initiated nearly a quarter of additional concerns during the physical examination phase. Often these pre-operative examinations include a head-to-toe check, including rectal, vaginal, and breast examinations. Dr. Allen, the oldest surgeon in the practice, is known throughout the community for being very thorough during his examinations, even removing patients' socks to check between toes for malignant moles that otherwise get overlooked. He believes that all doctors should not fixate just on the focal concern during the examination and

views any visit as a good opportunity to look at the patient's body as a whole, since they might not get this care elsewhere. This is a sentiment he shares with everyone (his partners, patients, nurses, rotating medical students, nurses-in-training, and with me).

It may be that urban general surgeons' examinations are conducted differently from this rural practice, which can lead to different findings in the rate of fitted-to-activity concerns found in them. Research has shown that doctors are spending less and less time examining and touching their patients and instead rely more on technology, radiological results and laboratory reports to base their patient assessments (Kravitz et al. 1996). In his TED talk (2011), Dr. Abraham Verghese refers to the physical examination as a dying art form, and patients report doctors who fail to examine, as failing to care about them (Kravitz et al. 1996). This study illuminates why patients may feel that something is missing from their visits when doctors do not examine them—they lose not only the diagnostic value of this practice, but patients also lose access to one of their methods (the fitted-to-activity) to initiate additional concerns.

Because patient-initiated additional concern presentations are done in way that subordinates them to the main reason for the visit, they may require a different strategy in the patient's presentation of self. Heritage and Robinson (2006b) discuss how the patient's dilemma in seeing a doctor is that they must work to display themselves simultaneously as 1) someone who does not rush to the doctor at the first sign of trouble (i.e., the patient is trouble's resistant), yet 2) also as someone who does have a significant enough concern to warrant medical attention. In addition, the patient's dilemma is to "balance between being sufficiently attentive to one's symptoms while not excessively concerned about them" (Halkowski 2006, 103). I conjecture that once a patient has proven to have one legitimate reason to be in the surgeon's presence, the patient may feel justified to bring up an additional concern, that standing on its own may not

have warranted scheduling an appointment, but now that the patient is already there and has the surgeon's attention, feels confident in raising it. They can do this either by waiting or creating opportunity spaces to launch their concerns from.

Waiting to raise an additional concern presentation until it seems fitted to the interaction or ongoing activity can help patients come across as not too demanding or hyper-vigilant. In consequence, patients do not need to undergo the same presentation of self type interactional work necessary when presenting the focal problem. Instead, patients may need to perform a different type of work of how to "fit" additional concerns into the flow of interaction as non-obtrusively as possible. The fitted methods are very similar to how speakers in ordinary conversation launch new topics, using step-wise transitions and/or backlinking practices. Patients create 'natural' moments to raise their additional concerns, so as to make them seem connected to the on-going talk or activity. In addition, patients can take advantage of the surgeon being near a physical problem, usually during the physical examination phase, as the appropriate time to launch a new concern. And finally, patients can launch additional concerns in first position by using the disjunctive method, a higher stakes undertaking that is unrelated to either previous talk or activity.

As Sacks (1987) explained, there is a preference for contiguity in talk, and we can see that norm being applied in this medical setting when patients work to connect their additional concerns onto an on-going topic using "step-wise transition" or "backlinking" techniques. I argue that using fitted methods (both to topic and activity) is seemingly less interactionally obtrusive than launching a new topic completely (the disjunctive method). Patients appear to orient to the fitted methods as the interactionally preferred methods to initiate new concerns.

While “fitting” may be the most common way to get additional concerns on the table, we will wait to see whether or not this is the most effective way to get them “helped” in a later chapter.

By examining patient-initiated additional concern presentations, we gain insight into how general surgery patients are not as passive in their patient role as previous research suggests. Thus, in certain setting patients are already utilizing agentive methods to get their additional concerns on the table, revealing them as more capable in steering interactions with physicians than previous research has given them credit.

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# Chapter 3: Which patient-initiated additional concerns receive help?

In the previous chapter I identified and described three different methods patients used to initiate additional concerns and how this corresponded with the timing of their initiations (both at visit- and treatment-phase levels). This chapter will elucidate whether the ways patients initiate additional concerns impact how surgeons respond to them. The first research question I address is whether the method, phase and design of a patient-initiated additional concern affect the patient's likelihood of receiving help. Second, does the design of additional concerns index how accountable patients hold surgeons to provide help for particular types of concerns? Expanding on this, can we see patients orienting to a folk understanding of different types of concerns being more or less likely (or entitled) to receive help and perhaps, as a consequence, are patients manipulating how they present the concern to increase its chances?

As discussed in the previous chapter, pre- and post-operative general surgery visits do not follow the normative 6-phase structure documented for acute primary care visits (Robinson 2003). Furthermore, while primary care patients typically raise "door knob" concerns near the closing of the visit (Robinson 2001; Rodondi et al. 2009; West 2006; White et al. 1997), this study has found patients initiating additional concerns throughout the office visit—actually with a preponderance of patients initiating additional concerns in the pre-physical phase. Patients, as evident in the data, are deviating from the default pattern of one-visit-equals-one-problem (Beckman, Frankel and Darnley 1985; Heritage et al. 2007; Robinson 2001; Robinson and Heritage 2015; Robinson, Tate and Heritage 2016) and are seeking "extra" help from their visit.

This chapter will elucidate whether how patients initiate additional concerns can impact their prospect of receiving help, and if they are strategically designing their concerns to be helped.

This issue of presentation-style leading to different outcomes has been previously studied mainly with a focus on physician's behavior (Boyd and Heritage 2006; Heritage et al. 2007). For instance, Heritage and Robinson (2006a) analyzed physicians' opening questions and found that different structures and designs affect patients' forthcoming problem presentations. Moreover, Robinson (2006b) found that even subtle differences in the design of the doctor's solicitations for additional concerns can alter the action of the question and thus the patient's response. Expanding beyond office visit interactions, Boyd's (1998) analysis of phone interactions between surgeons and insurance medical reviewers found that how reviewers initiated the conversation about a patient's reported need for surgery led to different approval rates for procedures.

In office visits there is no middleman serving as a gatekeeper as seen in bureaucratic institutions such as insurance companies. Instead surgeons themselves directly filter and assess patients' additional concerns as they unfold in real time. Surgeons too have limited resources to cope with all of patients' concerns, so patients must work to make *this* problem appear relevant for *this* surgeon at *this* time. Alas, not all additional concerns get helped and deciphering what interactional factors can contribute to increasing or diminishing the likelihood of getting help is the aim for this chapter.

### 3.1 DEFINING "HELPED" VERSUS "NOT HELPED"

For the purpose of this study, a patient-initiated additional concern is considered "helped" when the surgeon provides the patient with a plan on what the next course of action should be to cope with this additional concern. Being helped can entail that the surgeon orders diagnostic

tests, provides a treatment recommendation, refers the patient to another type of physician, confirms the course of treatment that the patient is already underway with, or even dismisses the concern as not problematic.[26] A key feature is that the concern goes beyond the surgeon "taking it up", which can include the surgeon asking a follow-up question or examining the area of concern. "Taking up" a concern is not equivalent to providing patients with a definite course of action. Because help can occur not directly following the patient's initiation, the entire office visit was watched to ensure that delayed help was captured. This classification is rooted in both emic and etic perspectives (Kottak 2006). I watched the recordings of these office visits as an outside observer and then determined whether the surgeons' responses met the criteria to be coded as helped.

"Not helped" can range from the surgeon not orienting or responding at all to the patient's additional concern presentation, to providing a minimal response token (e.g. "Okay", "Oh") or an assessment (e.g., "That must be painful"), to "taking up" the concern but without the additional step of articulating a definite course of action. Ultimately, patient-initiated additional concerns were coded as having a binary outcome category or either "helped" or "not helped". As the outside observer, I monitored how surgeons responded to additional concerns and whether patients left the office visit with sufficient resources to have been "helped", or if they departed lacking adequate information to understand what the next steps should be.

[26] In my data I have not seen a single instance of a surgeon explicitly telling the patient that there was not enough time to discuss this concern and that the patient should schedule another appointment to do so. From conversations I have had with urban doctors when discussing this dissertation, I have often been told that they cannot help all the additional concerns that patients have because of their strict time schedule that they need to maintain, with each visit constrained to a 10-15 minute timeframe. They said they often suggest to the patient to schedule another appointment to focus on this problem, which affirms the norm of 1-visit-equals-1-problem. This strict time constraint of segmenting office visits into 10-15 minute units and maintaining a strict schedule is not how the office I observed operates. In my field site, surgeons are almost always late to their office visits after a morning of operating and view part of the deal in keeping patients waiting is that they will not rush their visits together once the patient is seen.

## 3.2 QUALITATIVE HYPOTHESES OF CHARACTERISTICS

The analysis will unpack the different characteristics that patients can include in their presentation of patient-initiated additional concerns and will combine both a Conversation Analysis and ethnographic perspective—as done in the previous chapter—to analyze individual cases. I also conducted 15 interviews with patients after data collection and coding were completed. During a two-day visit to the field site, I asked any patient in the study if I could interview them. All 15 patients I asked agreed to participate. I wanted to see how patients responded to the question, "If you have an additional concern you'd like to discuss with your doctor, do you have a way in which you like to bring it up?" The insight gained from these interviews will be addressed in the discussion section.

Because this chapter also extends to predicting outcomes, generalized linear mixed model analysis is included to answer the research questions and gain an aggregate-level perspective. The first model will address which additional concerns were more likely to receive help, and the second model will examine whether there is evidence of patients manipulating the turn's design in order to increase their likelihood of receiving help. The models used for this chapter will include the characteristics discussed in the previous chapter and also incorporates additional characteristics that are now relevant to answer this chapter's research question. Thus, in addition to evaluating the "how" and "when" of each concern presentation (summarized again here), I will describe each of the new characteristics and make initial predictions of how they individually may impact the outcome.

**Method:** There are three methods patients use to initiate additional concerns. Using the *fitted-to-topic* method (n=250), patients can transition into their additional concern by

building on, stepwise transitioning from, or backlinking to the previous topic of conversation. Or, patients can transition into their additional concern by building off of the ongoing physical activity and/or positioning of their body vis-à-vis the surgeon's, called the *fitted-to-activity* method (n=51). Alternatively, patients can initiate their concern as unrelated to either previous talk or activity using the *disjunctive* method (n=76).

*Hypothesis:* As revealed in the previous chapter, the fitted-to-topic method is by far the most prevalent method patients use and delivers the smallest imposition to the surgeon. While interactionally this is the least interruptive way to raise a concern, I hypothesize that this is not the most effective method. Because it "fits" with the ongoing topic, the additional concern may run the risk of getting pushed under the current of the ongoing discussion. I also conjecture that concerns brought up in this way risk being perceived as secondary, only brought up because they were touched upon in some way, but otherwise not critical enough to warrant the patient initiating on its own. This could add to its susceptibility of not getting helped.

In contrast, when patients present additional concerns as a disjunctive it has the interactional benefit of breaking from the current talk or activity and projects the additional concern as a discrete and distinctive matter to be addressed. By breaking the interactional flow, perhaps patients are making more of the additional concern by increasing its prominence and salience in the interaction. This in turn may be interpreted as a proxy for how concerned the patient is about the problem. Thus, I hypothesize that presenting concerns with the disjunctive method increases the concern's likelihood in receiving help.

**Visit-phase:** Visits were divided into three phases: *pre-physical* (n=227), *physical* (n=96), and *post-physical* (n=54).

*Hypothesis***:** I hypothesize that concerns initiated in the pre-physical or physical phase are the most likely to be helped because they sequentially do not require the participants to backtrack within the structure of the visit in order to revisit the physical phase to assess the problem. Once the patient has moved out of the position to be examined, needing to reinstate that phase potentially increases the contingency of receiving help, and I predict decreases its likelihood of being helped.

**Treatment-phase:** Are *pre-operative visits* (n=226) or *post-operative visits* (n=151) more likely to be helped? Recall, this collection is comprised of patients being seen for hernia repairs, cholecystectomies, and colonoscopies. In order to qualify for this collection both the pre-operative and post-operative visits needed to be captured, and if the patient had other recorded adjacent visits, they were coded as well.

Because colonoscopy procedures are often performed as a diagnostic tool for other, more invasive surgeries, at times pre- and post- colonoscopy visits were part of a larger cholecystectomy or hernia repair context. For the few cases that populate this collection, I coded the visits in relation to the most invasive procedure (i.e., the cholecystectomy or hernia repair).

*Hypothesis:* I hypothesize that concerns raised during pre-operative visits are more likely to receive help because surgeons are attentively listening to patients to identify possible reasons for *not* operating if patients have other, more urgent concerns that need to

be addressed first.

**Physically evaluable:** Can the surgeon *directly evaluate* the concern during this visit (Yes=157) (No=220)? Are patient-initiated additional concerns that surgeons can immediately examine (e.g., sore throats, cysts, moles, hernias) more likely to receive help than concerns that are not immediately perceivable (e.g., sciatic nerves, hearing loss) or non-tangible (e.g., insomnia, desire to quit smoking)?

*Hypothesis*: I hypothesize that patient-initiated additional concerns that are physically evaluable are more likely to receive help than additional concerns that require further diagnostic testing or are non-tangible. Because physically evaluable concerns are directly accessible on the patient's body, patients can gesture towards or maneuver their body to make the concerned area visible to the surgeon. This haptic presentation coupled with their verbal initiation provides patients with more resources to capture and direct the surgeon's attention. Furthermore, this increases the pressure for the concerned area to be examined. Once patients have produced a problem presentation that is successful in receiving an examination, patients have gotten doctors on the path towards help (cf. Robinson 2003 on phase structure of office visits).

**Mention:** Was this the first mention (n=289) or subsequent mention (n=88) of the additional concern? For instance, if a patient initiates the same concern in the pre-physical stage of Visit #2, during the post-physical stage of Visit #2, and again in Visit #4, these are coded as 3 separate initiations. Only the "first" mention in the pre-physical stage of Visit #2 gets coded as such, and the following two instances are coded as

"subsequent". I am interested in knowing whether there are differing levels of interactional pressure for surgeons to help first versus subsequently mentioned concerns.

*Hypothesis:* I hypothesize that if a patient is persistent and initiates the same additional concern more than once, this increases the pressure for the surgeon to help since it shows the patient cares enough to resurrect it. Thus, subsequent mentions will receive help at a higher rate than first mentions.

**Concern type:** Is the concern *acute* (n=67) or *chronic* (n=310) in nature? When reviewing this collection and trying to assess potential motivations for patients to raise an additional concern, I wondered whether there was an interactional difference between concerns that a patient could raise in any visit (meaning in this visit, the previous or next one) versus a concern that is relevant potentially only in the here-and-now. The former type are generally ongoing and slow changing concerns (e.g., high blood pressure, a hernia that has been protruding for years, or a historically bad knee) and are coded as *chronic* and could be discussed in any visit because they are always present as a background issue. In contrast, there are concerns that could not have been raised previously or were not of concern in the last visit (e.g., a sinus infection, a recent spider bite, or red shins that sporadically flare up). These are coded as *acute* because of their temporal nature–can be a recent, fleeting, or sporadic—which also might not be evaluable in a future visit.

*Hypothesis*: I hypothesize that acute additional concerns increase the interactional pressure for *this* doctor to attend to *this* problem right *now.* Chronic concerns may have the intrinsic burden of "why this now?" If it is an ongoing concern then why hasn't the

patient mentioned it before? Or can this wait until another visit or perhaps for a more appropriate doctor? Thus, I predict that acute concerns receive help at a more frequent rate than chronic concerns.

**Surgeon domain:** Does the additional concern fall *inside* or *outside* of this *general surgeon's practice domain* (Inside domain=114) (Outside domain=263)? In order to determine this categorization, I asked the surgeons in this study to draw the boundaries of their practice's domain. They believed that their domain is broader than it would be if they practiced in an urban setting, and this is something they frequently describe as a benefit of small-town medicine, that they get to be true "general" surgeons. Some examples of outside domain concerns that were found in the collection include chronic pain, flu shots, erectile dysfunction, kidney problems, knee problems, ringworm, arthritis, bladder complaints, and hearing difficulties. Examples of inside domain concerns include blood in the stool, hemorrhoids, irritable bowel syndrome, abdominal pain, chronic gas issues, cysts or masses, chronic constipation, breast cancer, colon cancer, gallstones, hernias, ulcers, and carpal tunnel syndrome.

*Hypothesis:* I hypothesize that concerns inside the surgeon's domain will exert more pressure on the surgeon to provide help, while concerns that are outside their domain will receive help less often since there are differing levels of accountability at stake for each one. For inside domain concerns, patients have more leverage for presenting this concern as relevant for this setting, and surgeons will feel more motivated to treat concerns that fall under their responsibility and are part of their livelihood to do so. For outside domain concerns, even if surgeons want to provide help, they may not

have the knowledge or resources on what the next steps should be. Furthermore, I find it feasible that surgeons may sidestep outside domain issues as not to intrude on other local doctor's territories. While referring may be a resource, there may be interactional reasons why surgeons choose not to in certain contexts.

**Social action:** Is the concern designed as an *informing* (n=270) or as an *inquiry* (n=107)? Instead of coding for the sentence-type of a turn (declarative, interrogative, directive), I took the CA approach of looking at the action of the turn. Informings include announcements, complaints, noticings and stories. Inquiries include requests for information or requests for action. Whenever there is an inquiry present somewhere in the presentation of an additional concern, which can span several turns-of-talk, the presentation as a whole was coded as an "inquiry", even if an informing occurs before or after the turn containing the inquiry. I take the stance that inquiry formulations trump informings for coding purposes since an inquiry holds the recipient more accountable to respond than informing actions (Schegloff 2007; Stivers and Rossano 2010).

*Hypothesis:* I hypothesize that inquiries are more likely to receive help than informings because inquiries launch an adjacency pair sequence that hold surgeons more accountable to provide a response than informings do. Furthermore, inquiries place the patient in an epistemically-minus position vis-à-vis the surgeon (Heritage and Clayman 2010; Heritage and Raymond 2012), because the patient displays that that they are seeking knowledge for which s/he believes the surgeon can provide. Thus, surgeons are driven to address their concern in order to right this epistemic imbalance (Heritage 2012a).

**Content details:** In the presentation of the additional concern, did the patient include:

- Seeing **another physician** about this concern (Yes=166), (No=211)? Patients can do this either explicitly by naming the other physician or implicitly by mentioning that they have undergone a diagnostic procedure or are taking medicine that requires the authorization of a physician.

- Already having a **treatment plan** for this concern (Yes=117), (No=260)? While there is some overlap between seeing another physician and this characteristic, there are treatments plans that patients mention that do not necessarily require physician authorization like taking Tylenol, using a heating pad, or resting. I wanted to make sure I captured these as two separate phenomena.

- A ***qualifier*** in its description (*Intensifying qualifier*=45), (*Diminishing qualifier*=38), (No qualifier=294)? Patients can use a qualifier in an attempt to intensify the problem (e.g., 'It hurts *a lot*') or in order to diminish the problem (e.g., '*Every now and then* I can feel it'). Qualifiers are a resource for patients to take a stance about how minor or severe they think their issue is.

*Hypotheses:* I hypothesize that if a patient mentions having already seen another physician for this concern and/or already has a treatment plan, then the surgeon will hold themselves less accountable to provide help. I hypothesize that if patients ramp up their concerns with intensifying qualifiers, then surgeons will

feel more compelled to help them, and vice-versa for concerns including diminishing qualifiers.

**Degree of relationship:** How well do the patient and surgeon know each other? I devised a sliding scale to best capture the intricate relationships these patients and surgeons have in this rural setting. I wanted to know if there is a different level of expectation and/or accountability patients hold their surgeon to if they have known each other for many years, the surgeon has treated various members of their family, or if they have a friendship or connection outside of the clinical setting. While this is a small town and many residents have been there since birth, newcomers and first time patients are frequently seen in the office as well. Adhering to my CA background, I judged the degree of the relationship grounded in the talk itself.

- 1=Patient and surgeon meet each other for the first time, which is evident in the greeting sequence of these visits (n=94).
- 2=Patient and surgeon already have an existing medical relationship. (n=77).
- 3=Patient and surgeon have a longer, more intricate relationship. For instance, they may have been through multiple medical issues together and/or the surgeon may have taken care of other members of the patient's family (n=143). Again, this is evident in the talk itself (past procedures or inquiries about other family members are discussed during the visits).
- 4=Patient and surgeon have a social relationship outside of this medical setting, and this gets mentioned during the visit. For instance, they discuss going to ballgames together, invite each other over for meals, reference other shared

events, etc. (n=63).

*Hypothesis:* The stronger the relationship, the more likely the patient is to receive help, because patients hold surgeons to (or surgeons hold themselves to) a higher level of accountability to address all their needs.

**Control predictors:** All cases were also coded for fixed effects of *gender* (male/female), *age* and *race* (African American, Latino, White).

**Random effects:** All cases were also coded for random effects to control for patients producing more than one additional concern and the surgeon seen.

**Outcome:** Does the patient-initiated concern receive help? The entire duration of the office visit was reviewed because help can occur in sequences not directly adjacent to the patient's initiation. I found nearly a 50/50 split between concerns that received help (n=188) and those that did not (n=189).

Four cases discussed in the previous chapter will serve as examples to illustrate this coding schema. I first qualitatively analyzed the interactions to explore why a patient-initiated additional concern might or might not receive help. The following section will discuss the generalized mixed linear models I ran to assess aggregate level findings of these phenomena.

In our first example let's revisit Mr. Hall, the 58-year old white patient who initiates a concern about his shins being red and inflamed during the physical phase of his visit (Ex 4, Chapter 2). Mr. Hall fits his additional concern to the ongoing activity of being examined and to

Dr. Allen's physical proximity to his outstretched legs. This interaction occurs as Dr. Allen helps the still-reclining Mr. Hall sit up.

Example 1: Red shins

```
01  DOC:  Mkay. Let me get you to sit back up.
02  PAT:  I wanted to ask you.
03  DOC:  Uh huh,
04        (.)
05  PAT:  If you've looked at (.) how my shins get red sometimes,
06  DOC:  Uh huh,
07  PAT:  See like today it's red again (0.4) and two days from now you
08        may not hardly see any=
09  DOC:  =red at all.
10  PAT:  Is there any certain thing that's causin' that,
11        (1.0)
12  DOC:  .hh You know I don't know. I think- I think some of it is uhm
13        (.) maybe or you up on it more sometimes more than others or
14        is there any rhyme or reason…
```

Proceeding in the same order as the characteristics described, I will identify how I coded each one. In addition, I will provide some single-case analysis on how I think these characteristics individually may be impacting the likelihood of this particular additional concern getting helped in this specific instance.

- Mr. Hall *fits this concern to the activity* during the *physical phase*. By fitting the concern to the ongoing activity of being examined during the physical phase, the patient has seemingly chosen the most interactionally appropriate moment to launch his additional concern. The patient's body is already in position to be evaluated and the act of examining is already the ongoing activity. The contingencies for the surgeon to address this issue are seemingly very low, and I conjecture increases the likelihood of Dr. Allen's willingness to help.

- This visit is a *pre-operative* visit for a cholecystectomy. I predict that the surgeon will want to help with this concern at the earliest possible stage.

- Mr. Hall's red shins *can be physically evaluated*. Indeed, this possibility is directly oriented to in the launching of this problem presentation as Mr. Hall works to make his shins visible. In Line 1, Dr. Allen has taken Mr. Hall's right hand to help him sit up from a reclined position. As soon as he releases his hand, Mr. Hall gazes down at his legs and uses his now free hand to lift up the leg of his jeans to expose his right shin (begins in line 2). When patients deliberately maneuver or display their body in order to be evaluated, it is as if the patient is doubling-down on their presentation of this concern. The additional concern is now both verbally and gesturally initiated.

- This is the *first time* the patient raises this additional concern in this visit. This is the first office visit (of 7) recorded for Mr. Hall.

- Mr. Hall's red shins are an *acute* concern since his shins are in the midst of a flare-up. As Mr. Hall explains, the redness in his shins is sporadic. His red shins might not have been causing problems in the previous visit and potentially could temporarily resolve themselves by the time of the next appointment. Thus, it appears the patient does not want to miss this current opportunity to seek help for this fleeting problem, and places pressure on *this* doctor to help with *this* problem during *this* visit.

- The topic of red, inflamed shins is typically not a concern that on its own warrants a surgical appointment and is a concern that could be addressed in an appointment with his primary care provider. Thus, it is considered *outside the general surgeon's domain,* reducing the likelihood that the surgeon will help with this problem.

- The *social action* of this presentation is coded as an *inquiry*. Mr. Hall launches a pre-pre (Schegloff 2008) in line 2, "I wanted to ask you." which sets up the forthcoming inquiry. The pre-pre receives a go-ahead from Dr. Allen in line 3, "Uh huh,". After describing the intermittent nature of his symptoms, Mr. Hall then produces an interrogatively-phrased inquiry in line 10, "Is there any certain thing that's causin' that," which places him in an epistemically down-graded position vis-à-vis the surgeon (Heritage and Clayman 2010) and launches an adjacency pair sequence that holds Dr. Allen accountable to provide a response (Schegloff 2007; Stivers and Rossano 2010).

  The one second of silence in line 11 belongs to Dr. Allen due to the norms of turn-taking and sequence organization in conversation (Sacks, Schegloff and Jefferson 1974). While Dr. Allen is held accountable to respond, this does not equate him to being held accountable to necessarily "help" Mr. Hall with his red shins. However, by creating a clear interactional space in which Dr. Allen *could* provide help, this makes it more likely for him to do so due to the sequential organization of talk.

- Mr. Hall does not mention having seen or going to see *another physician* in regards to his red shins nor does he state an *ongoing course of treatment* for them. But because he

produces his concern as something not yet treated, the surgeon could feel more pressure to help.

- Mr. Hall does not *qualify* his concern by upgrading or downgrading his concern. While he states that in "two days from now you might not hardly see any" lines 7-8, I do not code that as a downgrade of his concern but rather as part of a description of how it flares up and then fully recedes.

- Finally, this patient has a *long-term relationship* with Dr. Allen that spans several procedures. In addition, Dr. Allen has provided care for Mr. Hall's family members, including his wife who is also present in this visit. Mr. Hall and Dr. Allen's relationship is coded as a "Level 3" as they never reference in any of their 7 recorded visits seeing each other outside of the office for social engagements. But because of their long-standing relationship, Dr. Allen may feel more accountable to help this patient.

In sum, the patient has picked the optimal mix of method and phase-level for his particular type of additional concern. As a patient, Mr. Holt faces the dilemma of figuring out when is the best opportunity to raise his additional concern. By fitting his concern to the activity of being physically evaluated for a physically evaluable concern during the physical phase, he seems to be able to shift attention without derailing the ongoing office visit.

Below is a summary of all the focal characteristics for Mr. Hall's presentation of his patient-initiated additional concern. An asterisk has been placed by the characteristics that I think in *this* particular interaction work to increase the likelihood of Mr. Hall's red shins concern getting

helped by Dr. Allen. I found that characteristics at times can operate differently in local contexts than how I predicted at a more general level.

Method to initiate concern: **Fitted-to-activity***
Phase-level: **Physical***
Treatment-phase: **Pre-op***
Physically evaluable: **Yes***
Mention: **First**
Concern type: **Acute***
Surgeon domain: **Outside**
Social action: **Inquiry***
Mentions another physician: **No***
Mentions another treatment plan: **No***
Qualifies: **No**
Level of doctor/patient relationship: **3***

Up until this point I have focused on the patient's initiation and design of the additional concern, and I will now expand our focus to the surgeon's response. Resuming the interaction where it left off, I have bolded the beginning of the surgeon's response.

Example 1a: Red shins continued

10 PAT: Is there any certain thing that's causin' that,
11 (1.0)
12 DOC: **.hh You know I don't know.** I think- I think some of it is uhm
13 hh (.) maybe are you up on it more sometimes more than others
14 or is there any rhyme or reason
15 PAT: Well there's some days I'm climbing more in and out of the
16 truck [than other days:,
17 DOC: [Uh huh,
18 DOC: Uh huh,
19 WIF: Now last night they were like BLo:od red.
20 DOC: Blood red.
21 PAT: For a change. and a couple weeks before you couldn't hardly
21 even tell it. (.) It's (.) kinda weird.
22 DOC: Uh huh. I'm not sure either. .hh I don't think it's anything
23 terrible but it's just (.) uh (0.2)
24 PAT: It just kinda puzzles me [that one day it's that way and=
25 DOC: [uh huh,
26 PAT: =it's not two days later you can't even see it
27 DOC: Both legs about the same or
28 PAT: Yeah. Pretty much. That one may be a little bit redder than
29 this one. [Today they're pretty much the same
30 DOC: [Yeah.
31 DOC: Yeah. I th-i bet it just has to do with pretty much how much
32 you're up on them. [and it may not (.) it's so hard the=
33 PAT: [moving
34 DOC: =Texas heat but you know you:
35 PAT: I notice it more the warmer it [gets than I do in the winter

```
36          time.
37  DOC:    Uh huh,
38  DOC:    You don't get it any place else [just on your legs
39  PAT:    Mm hmm
40  WIF:    [Just on the legs.
41  PAT:    [Just on my shins.
42  DOC:    Yeah. I'm not sure exactly. You might try- I have some at
43          home I bought it but I just don't have time to get into 'em
44          because I'm usually running late but to try to get uh knee
45          high support hose
46  WIF:    Mm hmm,
47  DOC:    If you have time to get into those I'd be curious to see
48  PAT:    If that helps
49  DOC:    [If that makes it go away.
50  PAT:    [Okay.
51  DOC:    Because I bet that would help. (.) You know
```

After Mr. Hall inquires about the impetus of his inflammation (line 10), Dr. Allen responds to the question but provides a non-answer response, "You know I don't know" (line 12) (Clayman 2002; Stivers and Robinson 2006). Dr. Allen is on his way to providing his best guess as to the cause but then reformulates his conjecture to a follow-up question, "Are you up on it more sometimes more than others or is there any rhyme or reason" (lines 13-14). After Mr. Hall describes his symptoms further and categorizes his problem as "kinda weird" (line 21), Dr. Allen dismisses his red shins as not "anything terrible" (lines 22-23), assuming the medical authority role as the one to evaluate this issue. More discussion and follow-up questions continue, and ultimately the surgeon delivers a treatment recommendation in lines 42-51 for Mr. Hall to try wearing support hose. The patient now has a solid plan on how to deal and treat his red shins, resulting in this case being placed in the "helped" category. In fact, the patient does not raise this concern again in any of his next six office visits.

Next, let's revisit a case that shares some similarities with this "red shins" example. Recall Mr. Miller is in to see Dr. Allen for a post-operative visit for his hernia repair (Ex 6, Chapter 2). Mr. Miller was not scheduled to see Dr. Allen for another month but is experiencing a lot of pain near his incision site, so he preemptively made an appointment to make sure he is

healing properly. Like the "red shins" example, Mr. Miller raises his "bad knee" additional concern as "fitted-to-activity" during the physical phase of his visit. However, instead of designing his turn as an inquiry, Mr. Miller accounts for moving slowly towards the table with an informing, "I-I just got a- (0.2) got an injection in my knee," (line 01).

```
Example 2: Knee

((patient slowly walking to table))
01  PAT:  I-I just got a- (0.2) ((rubs right knee)) got an injection in
02        my knee,
03        (0.5) ((Dr. Allen places hands on patient's back for support))
```

Following the order of the list of focal characteristics:

- Mr. Miller *fits this concern to the activity* of walking. He feels the need to account for his obvious difficulty and slowness in moving towards the table. This occurs during the beginning of the *physical phase*.

  Unlike the previous example in which I think Mr. Hall's presentation method works to increase the likelihood of getting helped because he fits his concern to the activity of getting examined, here Mr. Miller fits his concern to the activity of walking. Since the purpose of the walking is to get Mr. Miller onto the table, this particular type of fitted-to-the activity might be susceptible to getting overridden by the immediate project at hand—having his incision site inspected for infection.

- This is a *post-operative* visit for a hernia repair. I don't think the patient raising this after his hernia repair will increase the likelihood of receiving help.

- Mr. Miller's knee can be *physically evaluated*. Mr. Miller raises this concern at the presumably most optimal time during this visit. By telling Dr. Allen at the beginning of the physical phase, Mr. Miller opens up the largest opportunity window for it to be

explored. Once the patient is on the table Dr. Allen could assess the knee, ask Mr. Miller to bend it, etc.

- This is the *first time* the patient raises this additional concern in this visit. This is the 4th office visit recorded for Mr. Miller, and he did not mention difficulties with his knees in any prior visit nor before the physical-phase in this visit.

- Mr. Miller's bad knee is a *chronic* concern, inferred from his older age, 77. In addition, the lack of account for why his knee is bothering him also lends to the assumption that his knee is suffering from general wear and tear, not an acute injury. I would think that an acute injury would warrant a story-telling. Because it is a chronic concern, I argue that it is less likely to receive help.

- The topic of a bad knee is not a concern that on its own warrants an appointment with a general surgeon and is a concern that is more appropriately suited to his primary care provider or perhaps an orthopedic surgeon or rheumatologist. Thus, it is considered *outside the general surgeon's domain,* and I conjecture less likely to receive help.

- The *social action* of this presentation is an *informing.* Mr. Miller's turn is both a news informing, as it is novel news for Dr. Allen that he received an injection in his knee, and is an account for his slow movement. Even though this informing does place the topic of his bad knee on the interactional table as a possible topic to be addressed, it also runs the risk of being treated just as news and not as an implicit request for help. Furthermore,

because Mr. Miller fits his concern to the activity of walking, if the surgeon asks himself "Why that now?" about why Mr. Miller initiated this concern, thinking that this turn-at-talk is an account and treating it as nothing more seems interactionally sufficient.

- Mr. Miller's implicitly mentions seeing *another physician* in regard to his bad knee and shares that he has received a *course of treatment* in the form of an injection. Because an injection is a singular event (versus taking medicine on an ongoing basis), I think the surgeon doing confirmation work for a past treatment recommendation outside of his surgical domain may be a stretch. Thus, the fact that the patient has already been helped by another physician (even though he is still suffering), I think decreases the chances of Dr. Allen helping out with this type of additional concern.

- Mr. Miller *does not qualify* his concern by upgrading or downgrading his concern.

- Finally, this patient has a *long-term relationship* with Dr. Allen for almost ten years spanning two colonoscopies, a hernia repair, and several in-office procedures for skin growths and boils. His wife, also present in the room, is a patient of Dr. Allen's as well. Mr. Miller and Dr. Allen's relationship is coded as a "Level 3" as they never reference in any of their 7 recorded visits together seeing each other outside of the office for social engagements. Again, I think this long-standing relationship potentially can lead the surgeon to feel more compelled to help.

Below is a summary of all focal characteristics for Mr. Miller's presentation of his patient-initiated additional concern with asterisks placed next to the characteristics I hypothesize work to increase the likelihood of getting helped for this particular case:

Method to initiate concern: **Fitted-to-activity**
Phase-level: **Physical***
Treatment-phase: **Post-op**
Physically evaluable: **Yes***
Mention: **First**
Concern type: **Chronic**
Surgeon domain: **Outside**
Social action: **Informing**
Mentions another physician: **Yes**
Mentions another treatment plan: **Yes**
Qualifies: **No**
Degree of relationship: **3***

Now turning to the surgeon's response:

Example 2a: Knee continued

```
01  PAT:  I-I just got a- (0.2) ((rubs right knee)) got an injection in
02        my knee,
03        (0.5) ((Dr. Allen places hands on patient's back for support))
04  DOC:  °Okay ((Dr. Allen proceeds to help patient onto table))
05        (5.0)  ((patient is struggling to get on table))
06  PAT:  Maybe that's not the best way ((how he's placing his feet))
07  DOC:  Yeah maybe turn- yeah there you go. (1.0) ((Dr. Allen walks over
          to other side of patient)) I'll help you here.
```

Analogous to how a recipient of a question can align to the action of the sequence by providing a response but not to the topic of the question (cf. Heritage and Clayman 2010), Mr. Miller fits his additional concern about his knee to the activity of making his way onto the table; however, it is not relevant to the purpose of this physical phase which is to evaluate his hernia incision. The reason for his having difficulty getting onto the table appears secondary to the act of getting him onto the table in order to fulfill the purpose of this visit.

As evident from the transcript, even though the patient opens up the possibility of his bad knee as a potential topic for discussion, Dr. Allen treats it as an account for his slow movement

and is seemingly preoccupied with the task of assisting Mr. Hall onto the table. During the (0.5) delay in line 3, Dr. Allen is repositioning his hands to find the best spot to provide support. Dr. Allen's quiet and delayed news receipt token "Okay." in line 4 acknowledges this information (Beach 1995) but does not expand upon this topic. This "Okay" also performs shift-implicative work to the activity of getting Mr. Miller standing at the foot of the table to actually taking his first step onto the table. In line 6, Mr. Miller is trying to figure out which foot is best to lead with up the step. The patient's bad knee does not get discussed again during the visit. Thus, while Dr. Allen acknowledges that he heard Mr. Miller' concern, no help is given.

In our next example (Ex 11, Chapter 2) Mr. Carter and Dr. Allen have been discussing the results from his colonoscopy and upper GI endoscopy procedures, and after a lengthy discussion about what may be causing food to get stuck in his esophagus, Mr. Carter at line 4 abruptly launches a new, disjunctive topic about swelling in his back due to a prior back surgery (not performed by Dr. Allen or any of his partners).

```
Example 3:  Fluid build-up

01  DOC:  That's why I think it's just spasm is what you're having
02  PAT:  Once I'm past that I don't have any problems
03  DOC:  Right.
04  PAT:  .hh Anyway, (.) You're a surgeon[t] ((reaches out and touches
05        Dr. Allen on the knee))
06        (1.0)
07  PAT:  I want you to look at something= ((patient standing up))
08  DOC:  =Sure.
09  PAT:  Cause I couldn't get another (.) surgeon (.) to take a look.
10  DOC:  Sure.
11  PAT:  I had back surgery.
12  DOC:  Okay,
13  PAT:  And (0.4) the top, (.)  I can't really look at this.
14        ((has stood up and lifted shirt))
15  DOC:  Right  ((Dr. Allen looking at patient's back))
16  PAT:  There's a puffiness, (.) This is nice and smooth
17  DOC:  Right.
18  PAT:  This is a little puffy. I think there's some fluid behind it.
19        Should it be of concern,
```

Following the order of the list of characteristics:

- Mr. Carter presents his additional concern using the *disjunctive* method as it is unrelated to the prior talk or activity. It is a complete shift of topic as indexed by ".hh Anyway," in line 4 (Jefferson 1981). This occurs during the *pre-physical phase*.

  Not only does Mr. Carter shift the topic from his esophageal problem to this back concern, he also shifts the activity from being a discussion to requesting an examination by his repositioning of his body. Even though they are not in the physical phase, Mr. Carter proposes engaging in that activity. This is a high stake move the patient has launched, and he doubles down both verbally and physically. In first position the patient attempts to take charge of the visit. This move entails a large imposition towards Dr. Allen and ramps up the interactional pressure for him to look, at minimum, at his back. This moves the patient one step closer to receiving help, and thus I argue increases the likelihood of receiving help.

- While Mr. Carter is receiving the results of his colonoscopy procedure, the broader context is that this visit serves as a *pre-operative* visit for a hernia repair.

- Mr. Carter's fluid build-up on his back can be *physically evaluated*. While at the moment the patient initiates his concern, his back is not visible to Dr. Allen. However, through the course of his presentation Mr. Carter stands up, lifts his shirt, and positions his body to make his back available to be examined. Much like Mr. Hall's move in making his red shins visible, I think using haptic pressure is a strong interactional resource for patients to get their concern examined and ultimately helped. Moreover, Mr. Carter details how this

area of concern on the top of his back is in a difficult position that he cannot see himself (line 13), warranting the need for another's evaluation.

- This is the *first time* the patient raises this additional concern during this visit, and this is Mr. Carter's first recorded visit (of 4) for the study.

- Mr. Carter's fluid build-up is an *acute* concern. This is not evident in the excerpt above, but shortly after the patient reveals that he had his back surgery about a week prior. Mr. Carter's last appointment with Dr. Allen was before this surgery, so this concern did not exist before to have been mentioned previously.

- The topic of a fluid build-up on his back from a previous surgery performed by another specialist is outside the *general surgeon's domain.* In fact, Mr. Carter actively works to display that he knows that this is not pertinent to Dr. Allen and accounts for his raising it by launching a pre (line 7), which points forward to a delicate topic and explicitly states (line 9) that he could not find another physician to look at this area of concern (Schegloff 1980). Interestingly, Mr. Carter fully orients to his knowing that what he is about to do next is not appropriate for *this* visit and *this* type of doctor, nevertheless he proceeds to raise his concern.

- The *social action* of this presentation is an *inquiry* because at the end of his presentation Mr. Carter asks, "Should it be of concern," (line 19). This now launches a conditionally relevant second pair part that I argue increases the likelihood of receiving help.

- Mr. Carter explicitly states that he has been unsuccessful in getting another physician to look at his fluid build-up, thus this concern is a "no" for seeing *another physician.* By being explicit about his lack of success in receiving medical attention from others, I argue increases the interactional pressure for Dr. Allen to help him. He does not mention any ongoing *course of treatment* that he is using to help decrease the puffiness in his back, which I think also sets the patient up to be helped more.

- Mr. Carter *qualifies* his concern by *diminishing* his concern with a "little puffy" line 18. In one regard, downplaying his concern with this description could work to lessen the severity of his concern and undercut his seemingly urgent desire for help. On the other hand, by not describing his swollen back with superlatives, Mr. Carter does not set himself up for a dis/agreement about its severity. Instead, he leaves his back for the surgeon to assess. I think the downgrading of his concern near the end of his presentation (coupled with his hedged "I think" in line 18) works to temper his insistence and already high imposing actions. While Mr. Carter has, in a sense, hijacked the visit, he leaves some room for Dr. Allen to still be the medical expert. For this particular case, I think the diminishing qualifier provides both important interpersonal work and does not set the patient up to be refuted (for over-exaggerating the severity) and thus, contrary to normative expectation, increases the patient's chances of being helped.

- Finally, this patient has a *level 2 relationship* with Dr. Allen. As mentioned in Chapter 2, Mr. Carter was originally a patient of another general surgeon in the practice but because

of a personality conflict Dr. Allen has taken over the care of this patient, and they are near the beginning of their relationship with each other.

To summarize, here are the characteristics for Mr. Carter's presentation of his patient-initiated additional concern with asterisks next to the ones I believe contribute to the patient's likelihood of receiving help:

Method to initiate concern: **Disjunctive***
Phase-level: **Pre-Physical**
Treatment-phase: **Pre-op**
Physically evaluable: **Yes***
Mention: **First**
Concern type: **Acute***
Surgeon domain: **Outside**
Social action: **Inquiry***
Mentions another physician: **No***
Mentions another treatment plan: **No***
Qualifies: **Diminishes***
Degree of relationship: **2**

Picking up from where the transcript left off, let's now turn to the surgeon's response:

Example 3a: Fluid build-up continued

18 PAT: This is a little puffy. I think there's some fluid behind it.
19 Should it be of concern,
20 (1.0) ((Dr. Allen is looking at back))
21 DOC: **I:- there is fluid back there** and I would sa:y (.) it's
22 nothing to be worried about right now. I-I know in my o:wn
23 (.) experience from doing operations back here that the fluid
24 hangs around f- How long ago did you have this do:ne,
25 PAT: This was d:one ah:, (1.0) nearly a week ago today.
26 DOC: A week ago. Yeah I wouldn't worry about it at this point. It
27 looks pretty good for just being a week out. But you're
28 right. You have about a (0.2) couple tablespoons worth of
29 fluid in that. (.) wound. But I think you're- think you're
30 alright.
31 PAT: Okay. <Thank you=it'll be alright>
32 DOC: It doesn't look infected…

((patient complains about his back surgeon not wanting to look at it sooner than his scheduled follow-up))

33 PAT: …but by the same token I don't want to ignore it [if it's:
34 DOC: [Absolutely.
35 DOC: It looks fine. I do know in my own experience of excising

```
36        like lymphomas and things in that area that that fluid will
37        hang around for several months [before
38  PAT:                                 [And that's the only place
39        where it's still really s:ore
40  DOC:  [Mkay.
41  PAT:  [And I was hoping that they'd take a little bit of incision
42        and let the fluid out and then flatten out and I'd heal
43        quicker.
44  DOC:  Yeah I think though that the danger is getting it infected if
45        you open it up so- the-the best thing is unless-unless you're
46        getting pushed to do something I'd just leave- leave it
47        alone.
48  PAT:  Okay.
49  DOC:  [And see how it does
50  PAT:  [I appreciate that.
11  DOC:  You're most welcome.  ((they shake hands))
```

As soon as Mr. Carter rotates his body and lifts up his shirt to display his back to Dr. Allen, the surgeon complies with the patient's request and focuses his attention on the area of concern. Dr. Allen confirms the patient's assessment that the puffiness does exist and is caused by retained fluid (line 21). Dr. Allen works to appease Mr. Carter's fear by evaluating the patient's back as normal in appearance for being post-operative. Dr. Allen draws from his own experience operating on that area of the body to ground his claim.

The duration of time from the operation becomes relevant to Dr. Allen's assessment as he is about to provide a normal duration of time for fluid to be expected, but then he realizes that he does not know the date of the patient's surgery (line 24). If Dr. Allen completed his turn-at-talk and provided a time reference after "the fluid hangs around for…", he runs the risk of providing a timeframe that is incongruent with the patient's experience. For instance, if Dr. Allen tells Mr. Carter that it is normal for fluid to hang around for two months but the patient had had his surgery five months ago, this could potentially induce the patient to worry more rather than mollifying him. Thus, by cutting himself off on the word "for" before articulating a time reference, Dr. Allen avoids the potential consequences of a temporal mismatch (see Schegloff, Jefferson and Sacks 1977 on self-repair work). After this cut-off, Dr. Allen reformulates his turn

to a question about when the patient had this back surgery. This maneuver now positions the patient as the interactant to provide a time reference, which gives the surgeon a definitive marker to then assess as normal (as seen in lines 26-28).

While Dr. Allen aligns to Mr. Carter's request by examining and evaluating the area of concern as non-problematic, Dr. Allen does further interpersonal work by acknowledging that Mr. Carter was accurate in noticing that fluid has built-up. Because the patient's presentation of self is at stake when presenting a concern (Goffman 1959; 1967), and perhaps even more so when presenting an additional concern that has diverted from the normal course of the visit and its focus, Dr. Allen's repeated confirmation of the fluid existing—line 21 "there is fluid there" and later in lines 28-29 "But you're right. You have about a (0.2) couple tablespoons worth of fluid in that. (.) wound."—helps to affirm the patient's noticing of this swelling as accurate. In other words, the surgeon confirms puffiness and registers the patient's observation as valid while wanting to alleviate his concern about a non-problematic concern.

Mr. Carter maintains his stance as a proactive patient when he explains that he does not want to ignore a problem (line 23) and then suggests that he would like to have this extra liquid drained in order to speed up the healing process (lines 41-43). At this point Mr. Carter moves from presenting a problem to proposing his own treatment recommendation, a move into the medical expert domain of knowledge that also ignores Dr. Allen's previous assessment that there is nothing to be concerned about. Mr. Carter frames the treatment recommendation as something that he would like his back surgeon to do with "I was hoping that they'd take…" (line 41), not as a direct proposal for Dr. Allen to perform, although this could be taken up as an indirect request for Dr. Allen since incising infections is something that general surgeons perform.

This once-removed advice on what Mr. Carter thinks another physician should do sets Dr. Allen up in an interesting position. Since it is his own treatment recommendation that Mr. Carter is indirectly seeking an assessment of, it is not a straight-forward second-opinion solicitation. Again, Dr. Allen. performs delicacy work by fronting his response (lines 44-47) with a "Yeah" agreement token (Heritage and Raymond 2005) before countering the patient's hope of how his back should be treated. Dr. Allen restates his position about leaving the area alone unless the patient gets pushed to do something else. Indirectly, the surgeon is telling the patient that he should defer to medical authority on this, while simultaneously trying not to infringe upon the back surgeon's rights to treat his patient as he best sees fit.

This presentation of an additional concern concludes with a token of appreciation "I appreciate that" (line 50), which I have not observed happening mid-visit in any other visit in this data set. While Mr. Carter delivers this turn he makes an outward motion with his hand that may have just been an exaggerated gesticulation, but because it is produced simultaneously with his appreciation gesture, the surgeon interprets it as a first move towards a handshake. Dr. Allen goes in and shakes the patients hand while telling Mr. Carter, "You're most welcome." (line 51). This additional concern sequence has become a completely bracketed off spate of interaction from the rest of the visit, beginning with the patient's ".hh Anyway" in line 1 and ending with this appreciation-sequence plus handshake. The whole interaction sequence was built and perceived as the patient requesting the surgeon to do him a favor by looking at his puffy back.

I argue that the patient compensates for the out-of-domain nature of his concern, which is not appropriate for a general surgeon to take care of, by ramping up the interactional pressure (by initiating the concern as a disjunctive, using a pre-sequence, lifting up his shirt and positioning his back to be seen, detailing how no other doctor will agree to look at it and that he cannot see

the top of his back himself, framing the response with an inquiry) for Dr. Allen to attend to this problem. As it becomes evident, Mr. Carter's assertiveness pays off with Dr. Allen evaluating his back and delivering help (even though it might not be the help the patient wanted).

While this 'no-problem' assessment should be good news for Mr. Carter, it also aligns Dr. Allen's stance with the back surgeon's position that no urgent appointment was necessary to evaluate his back and that Mr. Carter is okay to maintain his regular follow-up schedule. To a degree, the medical authority is united against a patient who wishes to claim his footing as a medical expert himself (on a side note, earlier in the visit the patient shares that both of his parents were physicians). While the patient achieves a victory in getting help for his additional concern, it is at the cost of his sense of self as someone who can accurately medically evaluate the needs of his body. As evident by the delicacy work described in the interaction, Dr. Allen tries his best to attend to both the physical and emotional needs of his patient.

In the final example, I will examine a case in which the additional concern does fall into the domain of the general surgeon, which is in contrast to our previous three examples. Recollect Ms. Franklin is an African American patient in her mid-60s who's scheduled to see Dr. Sosa for a colonoscopy consult (Example 2, Chapter 2). Near the beginning of her visit Ms. Franklin raises an additional concern about her umbilical hernia reappearing. She fits this concern to the topic of previous procedures (including past colonoscopies) Dr. Sosa has performed on her. When Ms. Franklin mentions the hernia repair (line 5), Dr. Sosa continues to scan her chart to see when this was done and announces that the repair was "twelve years ago. that was two thousand o:ne," (lines 8-9).

Example 4: Hernia[27]

```
01  DOC:  That's why we might have forgot those years. ((Dr. Sosa trying to
02        figure out when last scope was))
03        (1.0)
04  DOC:  So back in two thousand six. Let's just see.
05  PAT:  Okay. .h Do you remember now when I had that hernia too:, (.)
06        cause you did that surgery on my hernia,
07  DOC:  Yes ma'am. (.) That was back in two thousand six. Yes ma'am. And
08        the hernia was- that was in- that twelve years ago. that was
09        two thousand o:ne,
10  PAT:  O:kay
11        (2.0)
12  PAT:  [Because it came back.
13  DOC:  [(W)
14  DOC:  It d:id
15  PAT:  haha Y:eah
16  (0.2)
17  PAT:  But I don't have no problem with it. It don't bother me.
```

- Ms. Franklin *fits this concern to the topic* of previous procedures Dr. Sosa has done on her during the *pre-physical phase*. As evident in the transcript, the way Ms. Franklin fits the topic of another procedure to the discussion of her last colonoscopy first gets interpreted by Dr. Sosa as a request for information. This could be a potential weakness of this fitted-to-topic method, that it is too embedded in the ongoing talk that it risks not getting picked up as a new topic. By initiating this concern during the pre-physical stage, Ms. Franklin has made an implicit request for her hernia to be looked at during the forthcoming physical phase. I think this early initiation also shows that this is a pressing concern for her and increases her chances of receiving help.

- This is a *pre-operative* visit for a colonoscopy/endoscopy (and ultimately a hernia repair). Sometimes surgeons will do some exploratory work on a possible hernia (depending on

[27] Hernia complaints that are first seen in office visits are often elective surgeries (in contrast to hernia issues that come in via the ER and need to be operated on immediately). For more minor hernias, surgeons often tell patients that it is to their own discretion whether or not they would like to have a hernia repaired based off of how bothersome it is. However, if a hernia is larger or the surgeon is worried about it growing to a substantial size, they may push for a hernia repair out of the medical concern of bowel getting trapped in the hernia, potentially cutting off blood supply and necessitating an emergency surgery.

its position) while the patient is undergoing the colonoscopy procedure, so I think it is to Ms. Franklin's advantage to have initiated this concern in her pre-operative visit.

- Ms. Franklin' hernia can be *physically evaluated* but not in her current seated position. Ms. Franklin is sitting in the chair next to the table, and Dr. Sosa is seated on a stool about 5-6 feet away looking at his laptop. During most of this interaction he can only see Ms. Franklin peripherally because his body is facing her at a 45 degree angle. Even when she briefly touches her abdomen in her next turn-at-talk (seen below in the surgeon's response section), Dr. Sosa did not turn his head and likely did not catch where exactly she gestured. Unlike Mr. Carter in the previous example, Ms. Franklin does not stand up and lift her shirt in order to initiate being physically examined in that moment. Ms. Franklin still attends to this being the pre-physical phase of the visit, and while she's initiating an additional concern, she tries not to disrupt the normal trajectory of the visit. I still think that since her hernia can be evaluated during her examination, this increases her chances of being helped.

- This is the *first time* the patient has raised this additional concern in this visit. This is the 1st office visit recorded for Ms. Franklin (of 3 visits) and it has been about 6 years since she last saw Dr. Sosa.

- My best conjecture is that Ms. Franklin's hernia is an ongoing, *chronic* concern. Similar to my evaluation of Mr. Miller's bad knee in Example 2, Ms. Franklin gives no indication in the excerpt above or in any proceeding talk that the hernia's reoccurrence was the

result of an acute injury, which I think would warrant a story-telling about that incident. Thus, because umbilical hernias are most common in overweight women who have had multiple pregnancies (all relevant for Ms. Franklin), the lack of a story about an acute incident (nor Dr. Sosa's inquiry into one), I think indicates a chronic concern.

- The topic of a hernia is firmly rooted inside the *general surgeon's domain.* It is one of the more common elective surgeries that this group of general surgeons perform. I believe this clearly holds Dr. Sosa accountable to provide help for a concern in his domain, especially since he was the surgeon who performed her first hernia repair.

- The *social action* of this presentation is an *inquiry* because Ms. Franklin first questions Dr. Sosa with an interrogative "Do you remember…" in line 05. Dr. Sosa first responds to this inquiry as seeking information. He conforms to her "when" question with a confirmation token plus date (Fox and Thompson 2010; Stivers 2010). Ms. Franklin then provides an informing as the upshot with, "Because it came back" (line 12).

- Ms. Franklin does not mention seeing *another physician* in regard to her hernia, and in fact directly implicates Dr. Sosa as the precise doctor to address her concern to since he performed her previous hernia repair. She does not mention any current *course of treatment* she is using to help alleviate her symptoms.

- Ms. Franklin *qualifies* her concern with a downgrade in line 17, "But I don't have no problem with it. It don't bother me.". Why does she raise a concern and then say that it

doesn't bother her? It seems cross-cutting to her agenda. However, Ms. Franklin is coping with the dilemma of both trying to display being a good patient (someone who actively monitors and reports on her body) while at the same time not wanting to be construed as someone angling for unnecessary procedures. Or perhaps she may feel that Dr. Sosa could interpret her additional concern as a complaint sequence about her previous hernia repair, and she is backing away from that. Alternatively, Ms. Franklin may be anticipating the question most typically asked by surgeons following the discovery of a hernia is about how bothersome it is. Often small hernias are repaired at the patient's discretion. While saying that her hernia is not bothersome may decrease the chances of being given a surgical treatment recommendation, I do not think it does enough diminishing work to avoid Dr. Sosa from wanting to assess it for himself.

- Finally, this patient has a *long-term relationship* with Dr. Sosa, lasting at least 12 years. However, they see each other very infrequently. It has been about 6 years since their last interaction. I coded their relationship as a "Level 2".

Below is a summary of all characteristics for Ms. Franklin' presentation of her patient-initiated additional concern with asterisks places next to the characteristics I hypothesize work to increase the likelihood of getting helped for this case:

Method to initiate concern: **Fitted-to-topic**
Phase-level: **Pre-physical***
Treatment-phase: **Pre-op***
Physically evaluable: **Yes***
Mention: **First**
Concern type: **Chronic**
Surgeon domain: **Inside***
Social action: **Inquiry***

Mentions another physician: **No**
Mentions another treatment plan: **No**
Qualifies: **Yes – diminishes**
Degree of relationship: **2**

Unlike the previous 3 examples in which the additional concern was addressed in the immediately following turns, the topic of Ms. Franklin' hernia gets discussed in all three phases of the visit. If we were to look just at the adjacent talk, it would appear that Dr. Sosa did not help Ms. Franklin. He does ask a follow-up question but then moves on to the next history-taking question. Picking up from where the interaction left off in the pre-physical phase:

Example 4a: Hernia continued

```
16  (0.2)
17  PAT:  But I don't have no problem with it. It don't bother me.
18  DOC:  How big is it?=we just fixed it with sutures. We didn't put mesh in
19        there huh, ((Dr. Sosa is reading over her chart))
20        (3.0)
21  DOC:  This might have been where it's at. We'll have to look and see.
22        (2.0)
23  DOC:  .hh Alri:ght.
24        (2.0)
25  DOC:  Have you been having any trouble with the bowels…
```

Because Ms. Franklin raised a physically evaluable concern while seated and in the midst of getting asked a series of history taking questions related to her necessity of a colonoscopy and does not work to make this part of her body readily visible to the doctor (as Mr. Carter did in Example 3 by standing up and lifting his shirt to display his back), in order to fully evaluate Ms. Franklin's concern Dr. Sosa would need to both stop his current line of questioning and completely reposition Ms. Franklin' body since an umbilical hernia needs to be examined when the patient is lying or standing.

Dr. Sosa does not choose this option but instead he acknowledges her concern with a confirmation check "It d:id" (line 14) and then a follow up question about its size (line 18). When he asks the "how big" question he does not leave an opportunity space for Ms. Franklin to

reply because he rushes into another TCU (Ford and Thompson 1996) because he has just found his notes on her previous hernia repair. He reads this aloud, "we just fixed it with sutures" and then muses aloud, "We didn't put mesh in there huh,". Ms. Franklin does not respond to this declarative statement + tag. She is not in the epistemic position to know what this mesh is or if it was used during her previous operation (Heritage 2012a). Dr. Sosa then states that this concern will be dealt with in the future (note tense) "We'll have to look and see." (line 21), does a shift implicative "Alri:ght." (line 23) and continues with his history taking questions.

It is not until several minutes later during the physical phase that the topic of the hernia resumes. As Dr. Sosa performs a head-to-toe examination and palpates her abdomen, Ms. Franklin lets out a groan. Dr. Sosa connects the patient's response cry (Goffman 1978) to her additional concern of a new hernia. In line 26, Dr. Sosa retopicalizes Ms. Franklin's hernia with a declaratively formatted request for confirmation with "Say that hernia's back a little bit?". He continues to press on Ms. Franklin' abdomen and in lines 45-53 delivers a treatment recommendation for another hernia repair that this time will include using mesh in the repair.

Example 4b: Hernia continued in physical phase

((Patient makes pain noise when Dr. Sosa palpates near her umbilicus.))
26 DOC: .hh Say that hernia's back a little bit?=
27 PAT: =Yeah. Like that. Ah: [Ah: ((pain noise))
28 DOC: [Okay.
29 (0.2)
30 DOC: I'm sorry that's hurtin' you huh?
31 PAT: It's kinda tender right there. hh If you're pressing [on it.
32 DOC: [Is that
33 knot always there? [Does it go away if yo-
34 PAT: [Yeah.
35 (3.0) ((doctor continues to palpate))
36 DOC: (°I might want to ((mumbles))) ((Dr. Sosa seems to be talking to
37 himself))
39 PAT: Eh: ((pain noise))
40 DOC: This hurts you huh?
41 PAT: Ah:
42 (0.2)
43 DOC: Mka:y.
44 (0.2)
45 DOC: .hhh I may put a piece of mesh in the:re. hh (0.5) .hh I may do an
46 operation where you can make a little incision here here and here

```
47        we can go put a piece of mesh in there or a scre:en, (.) but we
48        need to think about that for yo- especially if it's getting a
49        little bit bigger where it's hurtin'. .hh If it gets too big then
50        we can't do it that way.
51  PAT:  [Oh oka:y
52  DOC:  [But with that screen in there we can get it in there sometimes and
53        take care of that before it's more of a problem.
54        (3.0) ((Dr. Sosa moves on to palpate her underarms)
55  DOC:  .hh Just feeling in here for swollen glands…
```

Ms. Franklin accepts the treatment recommendation in line 51 "Oh oka:y." and Dr. Sosa moves on to examine other areas of her body. At this point, I coded this patient-initiated additional concern as being "helped" since the patient has a game plan of how she is supposed to deal with her hernia.

The hernia topic emerges once more during the post-physical stage when Dr. Sosa moves into closings by telling Ms. Franklin that it was good to see her (line 55). Before this, Dr. Sosa spent several minutes explaining the colonoscopy/upper GI endoscopy procedure, how to prepare for it, how it is performed and potential complications. He reopens the topic of the hernia in line 64.

Example 4b: Hernia continued in post-physical phase

```
55  DOC:  Well it's good to see you again.  Sorry [it's under these=
56  PAT:                                          [^You to:o.  It's been
57        a while.
58  DOC:  =circumstances.
59  PAT:  [It's been six years
60  DOC:  [I guess that's good.
61        (.)
62  DOC:  I guess that's good huh,
63        (.)
64  DOC:  .hh We may have to talk about that hernia. We got a different
65         w- we'll try some mesh in there this time.
66  PAT:  [Alright.
67  DOC:  [Make sure everything's alright. We'll get that done maybe we can
68        take care of that for you [too.
69  PAT:                           [Okay.
70  DOC:  Before it gets too big. Before it causes more problems.
71  PAT:  Is it?
72  DOC:  It's getting a little bit<hopefully we can get that fixed for ya.
73  PAT:  Oka[y.
74  DOC:     [And [nurse] should call you… ((talks about scheduling))
```

In contrast to the other procedures that will be performed in the immediate future, Dr. Sosa now seems to expand the timeframe for when the hernia should be repaired. During the physical, he alluded to sooner as better than later, but now he appears more cautious with "We may have to talk about that hernia." (line 64) and then circles back to "Before it gets too big. Before it causes more problems." (line 70). That is not a definitive time reference that Ms. Franklin can interpret for meaning since Dr. Sosa never articulates the rate at which he believes her hernia is growing (Raymond and White 2017).

The visit ends with Dr. Sosa explaining how his nurse will call Ms. Franklin to find a date that works for her procedures. He does not explicitly reference that the nurse will also schedule her hernia repair. This visit took place in early September, and in late September Dr. Gupta performed the colonoscopy and upper GI endoscopy since Dr. Sosa was out of town. About a month later, Ms. Franklin had an office visit with Dr. Gupta to review the results from her procedures. It is evident from this interaction that a hernia repair had not yet been scheduled or discussed further. During her follow-up visit with Dr. Gupta, Ms. Franklin again initiates her concern about her hernia. While this is the first time that Dr. Gupta is hearing this concern, Ms. Franklin refers to her hernia as "that hernia" and relays that Dr. Sosa has already told her that it should be operated on. Dr. Gupta consults her chart to review Dr. Sosa's documentation, examines her, and concurs that a hernia repair is needed. Ultimately, Dr. Gupta repairs her hernia in December.

I cannot definitively claim that if Ms. Franklin had never mentioned her hernia concern then her surgeons would have never detected this problem on their own. It is also indeterminable whether if Ms. Franklin had not pursued her concern with Dr. Gupta, whether Dr. Sosa would have followed up to schedule her hernia repair. But what is evident in the data is that Ms.

Franklin performed a lot of interactional work to get her hernia on the table for discussion, which ultimately did result in an operation.

Ms. Franklin provides a good example of the limits of just looking at a single visit to capture the full trajectory of a medical concern. Even though according to my coding schema Ms. Franklin was "helped" in her initial pre-operative visit with Dr. Sosa, it really was not until her follow-up visit with Dr. Gupta that this "help" gets transformed into action. As I move on to discuss the statistical models and their results, I want to stress that looking at these doctor-patient interactions both as single case analyses across time and at the aggregate level is the most reliable way to gain an understanding of what takes place during these visits. Moreover, while I made generalized predictions for each characteristic at the beginning of this chapter, it is evident that I do not uniformly hold all of these characteristics to operate identically once they are embedded in specific contexts (for instance, in Example 1 I thought that the patient fitting his red shin concern to the activity worked to his advantage in getting helped while in Example 2, I thought that fitting his bad news concern to the activity worked to that patient's disadvantage). That is why I will now turn to our aggregate level findings to see if there are larger trends and patterns to be found, while still considering that each case is unique and that micro- and macro-perspectives have both their own analytical strengths and weaknesses.

### 3.3 INTER-OBSERVER RELIABILITY

AW coded all instances of patient-initiated additional concerns. To assess the accuracy of the coding, a second observer[28] coded a random sample of 15% of all the patient-initiated additional concerns. The agreement between the original coder and the second observer was good (0.61-0.80) or very good (0.81-1.00) for all the following variables: concern type (Cohen's

[28] This second observer was a UCLA Sociology honors undergraduate student who had completed the research methods and Conversation Analysis courses. She received independent study credit for her work.

k= 0.79), method (k=0.85), social action (k= 0.86), other doctor (k= 0.83), treatment plan (k= 0.74), qualifier (k=0.77), and helped (k= 0.83) (see Altman, 1991).

### 3.4 STATISTICAL ANALYSIS

To analyze the data I conducted Generalized Linear Mixed Models (GLMM) (Baayen 2008). The first model assessed which factors affect the likelihood that a patient's initiated additional concern will be helped or not. The second model investigated which factors affect the likelihood that the patient's additional concern will be delivered as an inquiry or an informing. Social action (inquiry vs. informing) was chosen as the best proxy for measuring patients' sense of entitlement for initiating a concern and how accountable they hold surgeons to provide help (high entitlement=inquiries, low entitlement=informings). Because of the norms of sequence organization in talk (Schegloff 2007; Stivers and Rossano 2010), inquiries hold surgeons more accountable to provide a response than informings do. Thus, when patients design concerns using the inquiry format they intensify the interactional pressure for surgeon uptake. If patients use the inquiry design for concerns that are inside the general surgeon's domain at a higher rate than they do for concerns outside the general surgeon's domain, I believe this shows patients are matching their high sense of entitlement to their high expectations of receiving help. Conversely, if patients tend to design their concerns as informings for outside domain issues, this displays patients' low sense of entitlement and low expectations for receiving help. However, if patients use inquiries more frequently for outside domain issues, this can be interpreted as patients attempting to capitalize on the norms of sequence organization to bias surgeons into providing help for concerns that patients regard as an interactional stretch to be raising. Additionally, seeing any correspondence between Social action and Surgeon domain shows that

patients orient to a folk sense of what type of care general surgeons provide.[29]

Independent variables[30] for the two GLMM models are shown in Table 1 and 2 below. Initially, I assessed the relationship of all independent variables of interest on the outcome variables using a full model and compared it with a null model comprising only the random effect (who the specific patient (n=62) and surgeon (n=3) were) using a likelihood ratio test (Dobson and Barnett 2008). Once this revealed significance, I inspected the significance of the individual interactions and main effects.

I ran the models in R (version 3.3.2) (R Development Core Team 2012) using the function glmer of the package lme4 (Bates et al. 2014). I used a binomial error structure and logit link function and estimated coefficients using Maximum Likelihood. Likelihood ratio tests were conducted using the R-function Anova. P-values of main effects were those provided by the output of the function glmer. I additionally calculated the odds ratio for each predictor by exponentiating the estimates provided by the glmer function.

I z-transformed the independent variables "degree of relationship with surgeon" and "patient's age" and used the corresponding z-scores in all models. For Model A I included interactions of the independent variable Surgeon domain[31] with all fixed effects apart from

[29] Outside the entrance to the office there is a list of the top 10 types of procedures that this general surgeons' practice provides. This sign (placed in 2013) is an attempt to educate patients in this professional building about the breadth of services offered, as not to lose patients to bigger city hospitals. There is one family doctor in particular, whose office is directly across from the surgeons', that is perceived as unnecessarily referring patients non-locally by claiming that no one in this small town can provide this type of care, while in fact this care is provided locally.

[30] During this quantitative analysis, I use the term "independent variables" synonymously with the term "characteristics" found in the qualitative analysis. Because this study uses a mixed-method approach, descriptors vary depending on the normal nomenclature of each method.

[31] Interactions between each predictor and Surgeon domain were included in the model because of my interest in how patients and surgeons negotiate boundaries in this rural setting where the general surgeon's domain is broad and seems often to extend into other specialties. This issue of "turf battles" has received a lot of attention in the medical anthropology literature but has yet to be studied at the interaction level. A statistical comparison of a model not including any interaction with Surgeon domain to the final reduced model A including some interactions of the independent variable with Surgeon domain shows a significant difference ($p<0.01$) and that the one including the

Social action.[32] When interactions were not significant, I removed them from the model and inspected the results of the remaining interactions and main effects. For Model B the same independent variables were used as in Model A with the exception of "Social action", as that was the dependent variable for Model B. No interactions were included for Model B.[33]

**Table 1: Distribution of additional concerns by predictor**
(data are given as percentages unless indicated)

| | All additional concerns (n=377) |
|---|---|
| Method | |
| **Fitted to topic** | 66.31 |
| **Fitted to activity** | 13.53 |
| **Disjunctive** | 20.16 |
| Visit-phase | |
| **Pre-physical** | 60.21 |
| **Physical examination** | 25.46 |
| **Post-physical** | 14.32 |
| Treatment-phase | |
| **Pre-operative** | 59.95 |
| **Post-operative** | 40.05 |
| Physically evaluable | |
| **Yes** | 41.64 |
| **No** | 58.36 |
| Mention | |
| **First** | 76.66 |
| **Subsequent** | 23.34 |
| Concern type | |
| **Acute** | 17.77 |
| **Chronic** | 82.23 |

interactions is a better model (AIC 341 for the model including the interactions vs. AIC 351 for the one not including the interactions).

[32] The initial inclusion of the interaction between Surgeon domain and social action led to a significant problem of convergence for the model and a large Eigenvalue ratio. Once this interaction was removed the model could converge, and therefore I opted to exclude this interaction.

[33] The outcome in Model A is the surgeon's response while the outcome in Model B is all focused on the patient's behavior. While I was curious to see if Surgeon domain affected the social action used to initiate an additional concern, I did not think the surgeon domain shaped the outcome in Model B to the same degree as it did in Model A. That is why I chose not to run an interaction with it in Model B.

| | |
|---|---|
| Surgeon domain | |
| **Inside** | 30.24 |
| **Outside** | 69.76 |
| Social action | |
| **Informing** | 71.62 |
| **Inquiry** | 28.38 |
| Mentions another physician | |
| **Yes** | 43.77 |
| **No** | 56.23 |
| Mentions another treatment plan | |
| **Yes** | 31.03 |
| **No** | 68.97 |
| Qualifies | |
| **Intensifies** | 11.94 |
| **Diminishes** | 10.34 |
| **None** | 77.72 |
| Degree of relationship | |
| **1** | 14.59 |
| **2** | 30.77 |
| **3** | 37.93 |
| **4** | 16.71 |
| Patient age, mean (SD) | 63.33 (10.40) |
| Race | |
| **Black** | 3.18 |
| **Latino** | 3.98 |
| **White** | 92.84 |
| Gender | |
| **Female** | 45.89 |
| **Male** | 54.11 |
| Surgeon | |
| **Dr. Allen** | 84.08 |
| **Dr. Gupta** | 9.02 |
| **Dr. Sosa** | 6.90 |

**Table 2: Percentage of additional concerns helped or produced as inquiries by predictor**[34]
(data are given as percentages unless indicated)

| | Helped additional concerns (n=188) | Additional concerns with inquiry social action (n=107) |
|---|---|---|
| Method | | |
| **Fitted to topic** | 43.20 | 21.20 |
| **Fitted to activity** | 52.94 | 23.5 |
| **Disjunctive** | 69.74 | 55.26 |
| Visit-phase | | |
| **Pre-physical** | 49.34 | 26.87 |
| **Physical examination** | 43.75 | 23.96 |
| **Post-physical** | 62.96 | 42.59 |
| Treatment-phase | | |
| **Pre-operative** | 46.90 | 24.34 |
| **Post-operative** | 54.30 | 34.45 |
| Physically evaluable | | |
| **Yes** | 50.96 | 24.84 |
| **No** | 49.09 | 30.91 |
| Mention | | |
| **First** | 49.48 | 29.41 |
| **Subsequent** | 51.14 | 25.00 |
| Concern type | | |
| **Acute** | 65.67 | 40.30 |
| **Chronic** | 46.45 | 25.81 |
| Surgeon domain | | |
| **Inside** | 78.95 | 37.72 |
| **Outside** | 37.26 | 24.33 |
| Social action | | |
| **Informing** | 32.96 | N/A |
| **Inquiry** | 92.52 | N/A |
| Mentions another physician | | |
| **Yes** | 40.61 | 14.55 |
| **No** | 57.08 | 39.15 |

[34] Note, Table 2 does not include interactions that are used in Model A and as specified in footnote 7, they make a difference for the model.

| | | |
|---|---|---|
| Mentions another treatment plan | | |
| **Yes** | 33.33 | 13.68 |
| **No** | 57.31 | 35.00 |
| Qualifies | | |
| **Intensifies** | 44.44 | 17.78 |
| **Diminishes** | 48.72 | 20.51 |
| **None** | 50.85 | 31.06 |
| Degree of relationship | | |
| **1** | 25.45 | 5.45 |
| **2** | 54.31 | 30.17 |
| **3** | 51.05 | 28.67 |
| **4** | 60.32 | 44.44 |
| Patient age, mean (SD) | 64.01 (10.56) | 65.00 (9.12) |
| Race | | |
| **Black** | 66.67 | 33.33 |
| **Latino** | 53.33 | 33.33 |
| **White** | 49.14 | 28.00 |
| Gender | | |
| **Female** | 50.29 | 30.61 |
| **Male** | 49.51 | 26.47 |
| Surgeon | | |
| **Dr. Allen** | 50.16 | 28.39 |
| **Dr. Gupta** | 41.17 | 29.41 |
| **Dr. Sosa** | 57.69 | 26.92 |

**Results for Model A**

Model A investigated why some patient-initiated additional concerns were more likely to receive help. The dependent variable was whether the patient received help for their patient-initiated additional concern (yes/no). Initially I compared the full model comprising the factors of interest, their interactions with surgeon of domain and the random effects with the null model comprising of gender, age, race, and the random effects using the likelihood ratio test (Dobson and Barnett 2008). The comparison between the full model and the null model was significant (GLMM: $p < 0.001$, N = 377, $\chi^7_{39} = 218.31$). I dropped all non-significant two-way interactions

with Surgeon domain (all p>0.11) and compared the reduced model to the original full model. The reduced model was not significantly different from the original full model (p=0.75, N = 377, $\chi^{27}_{39}$ =8.43). I then ran the reduced model including all original predictors plus the interactions of Surgeon domain with Method, Treatment Plan and Qualifier. I found two significant two-way interactions between Surgeon Domain*Method (GLMM: $p < 0.05$, N = 377, $\chi^{25}_{27}$ = 6.86) and Surgeon Domain*Qualifier (GLMM: $p < 0.05$, N = 377, $\chi^{25}_{27}$ = 8.52).

**Social action:** The linguistic formatting of the initiation was highly significant. The odds of a patient receiving help for an inquiry were 56 times larger (Z=7.07, p<0.001) than the odds of receiving help for an informing.

**Mention:** Whether the concern was a first or subsequent mention had a significant effect. The odds of the patient receiving help for a concern for a subsequent mention were 3 times larger (Z=2.55, p=0.01) than the odds of receiving help for a first mention.

**Concern type:** Whether the concern pertained to an acute or chronic matter had a significant effect. The odds of a patient receiving help for an acute concern were 5 times larger (Z=3.06, p<0.01) than the odds of receiving help for a chronic concern.

**Other doctor:** Whether the patient mentioned having seen (or going to see) another physician about the additional concern had a significant effect. The odds of a patient receiving help when having mentioned another physician were 3 times larger (Z=2.61, p<0.01) than the odds of receiving help for a concern that did not mention another physician. Recall that the surgeon confirming that going to see another physician was a good plan counted as "helped".

**Visit-phase:** In what phase of the visit a patient initiated an additional concern had a significant effect ($p < 0.05$, $\chi^{25}_{27}$ = 6.14). The odds of a patient receiving help for a concern raised in the pre-physical phase were 4 times larger (Z=2.37, p<0.05) than the odds of receiving

help for a concern raised in the physical phase, while the odds of a patient receiving help was not significantly different for concerns raised in the post-physical vs. physical phase ($Z=1.36$, $p=0.28$).

**Method and Surgeon domain:** The importance of the method of initiating an additional concern was heavily conditioned on whether the concern was inside or outside the surgeon domain. Examining the two-way interaction between Surgeon Domain and Method revealed that, in general, when the concern was inside the surgeon domain the odds of the patient receiving help were 64 times larger when the concern was presented as fitted-to-the-activity ($Z=2.65$, $p<0.01$) and 11 times larger when the concern was presented as fitted-to-the-topic ($Z=2.02$, $p<0.05$) than the odds of the patient receiving help for concerns presented as disjunctive. On the other hand, if the concern was outside the surgeon domain, the odds of the patient receiving help for a concern presented as fitted-to-topic were 6 times smaller ($Z=-3.37$, $p<0.001$) than the odds of the patient receiving help for concerns presented as disjunctive while there was no difference between concerns presented as fitted-to-activity vs. disjunctive (see Table A).

**Qualifier and Surgeon domain:** The impact of including a qualifier (or not) in the concern's formulation was heavily conditioned on whether the concern was inside or outside the surgeon domain. In particular, for concerns inside the surgeon domain the odds of the patient receiving help for a concern with a diminishing qualifier were 41 times larger ($Z=2.48$, $p<0.05$) and 19 times larger for a concern with no qualifier ($Z=2.63$, $p<0.01$) than the odds of a patient receiving help for concerns with an intensifying qualifier. On the other hand, if the concern presented by the patient was outside the surgeon domain, there was no difference between a concern with an intensifying vs. no qualifiers ($Z=-1.26$, $p=0.21$), while it showed a strong trend

towards significance to be less likely to receive help if concern had a diminishing rather than an intensifying qualifier (Z=-1.77, p=0.077) (see Table A).

**Treatment plan and Surgeon Domain:** The interaction between Surgeon domain and mention of a treatment plan showed a strong trend towards significance (Z=-1.75, p=0.08). The mention of already having a treatment plan made the patient's odds of receiving help less likely in general, but if the concern was inside the surgeon domain then it made the odds of the patient's concern more likely to get helped than when it was outside the surgeon domain. All other predictors were not significant (see Table A below for a summary of all results).

| **Table A:** Model A results, helped=1, not helped=0 (*significant results bolded)* | | | | | |
|---|---|---|---|---|---|
| **Test category** | **Odds ratio** | **Estimate** | **Std. error** | **Z value** | **P value** |
| Intercept | 0.371 | -0.990 | 1.592 | -0.622 | 0.534 |
| **Inquiry social action** | **56.115** | **4.027** | **0.570** | **7.068** | **<0.001****** |
| **Subsequent mention** | **2.971** | **1.089** | **0.427** | **2.549** | **0.011**** |
| **Acute concern type** | **4.922** | **1.594** | **0.520** | **3.062** | **0.002***** |
| **Inside surgeon domain & Fitted to activity** | **64.014** | **4.159** | **1.570** | **2.648** | **0.008***** |
| **Inside surgeon domain & Fitted to topic** | **11.341** | **2.428** | **1.202** | **2.021** | **0.043**** |
| Outside surgeon domain & Fitted to activity | 0.475 | -0.744 | 0.818 | 0.910 | 0.363 |
| **Outside surgeon domain & Fitted to topic** | **0.159** | **-1.836** | **0.545** | **-3.371** | **<0.001****** |
| Inside surgeon domain & Disjunctive | 0.211 | -1.555 | 1.440 | -1.080 | 0.280 |
| **Inside surgeon domain & No Qualifier** | **19.213** | **2.956** | **1.126** | **2.625** | **0.009***** |
| **Inside surgeon domain & Diminishing qualifier** | **41.364** | **3.722** | **1.503** | **2.477** | **0.013**** |
| Inside surgeon domain & Another treatment plan is mentioned | 0.226 | -1.486 | 0.849 | -1.751 | 0.080* |
| Post-physical visit-phase | 2.554 | 0.937 | 0.690 | 1.358 | 0.174 |
| **Pre-physical visit-phase** | **4.109** | **1.413** | **0.597** | **2.366** | **0.018**** |
| **Other physician mentioned** | **3.365** | **1.213** | **0.466** | **2.605** | **0.009***** |
| Pre-operative treatment-phase | 0.864 | -0.146 | 0.415 | -0.352 | 0.725 |
| Concern is physically evaluable | 1.099 | 0.095 | 0.390 | 0.243 | 0.808 |
| Degree of relationship of patient & surgeon | 1.356 | 0.305 | 0.254 | 1.201 | 0.230 |
| Male | 0.496 | 0.278 | 0.496 | 0.561 | 0.575 |
| Age | 1.116 | 0.110 | 0.230 | 0.477 | 0.633 |
| Latino | 0.442 | -0.816 | 1.635 | -0.499 | 0.617 |

| | | | | | |
|---|---|---|---|---|---|
| White | 0.552 | -0.593 | 1.281 | -0.463 | 0.643 |
| p<.10 * p<.05 ** p<.01 *** p<.001**** | | | | | |

**Results Model B**

In this model the dependent variable was whether the patient designed the additional concern as an informing or as an inquiry. Initially I compared the full model comprising the factors of interest and the random effects with the null model comprising of gender, age, race, and the random effects using the likelihood ratio test (Dobson and Barnett 2008). The comparison between the full model and the null model was significant (GLMM: $p < 0.001$, N = 377, $\chi^7_{21} = 72.183$).

**Surgeon domain:** Whether an additional concern was inside or outside the general surgeon's domain had a significant effect on how patients designed their concern. The odds for a patient to design a concern as an inquiry for an inside domain concern were 2 times larger (Z=2.05, p<0.05) than the odds for a patient to design a concern as an inquiry for an outside domain concern.

**Degree of relationship:** I found a significant effect of the patient/surgeon relationship in that the more the co-participants know each other, the more likely the patient is to design the concern as an inquiry (Z=2.42, p<0.05).

**Method:** The type of method used to initiate an additional concern had a significant effect on social action selected ($p < 0.001$, $\chi^{19}_{21} = 15.039$). The odds for a patient to design a concern as an inquiry when presented with the fitted-to-topic method were 4 times smaller (Z=-3.75, p<0.001) than the odds for a patient to design a concern as in inquiry when presented as disjunctive, while a concern presented as fitted-to-activity showed a strong trend towards significance (Z=-1.91, p=0.056) in that the odds for a patient to design a concern as an inquiry

presented with the fitted-to-activity method were 3 times smaller than the odds for a patient to design a concern as an inquiry when presented as disjunctive. In other words, concerns initiated with the disjunctive method were more likely to use the inquiry design than the fitted methods.

**Other doctor:** Whether a patient included mentioning seeing (or going to see) another physician about the additional concern had a significant effect on the social action the patient selected. The odds for a patient to design a concern as an inquiry for a concern that included a mention of another physician were 2 times smaller (($Z=-2.12$, $p<0.05$) than the odds for a patient to design a concern as an inquiry for a concern that did not mention another physician.

**Treatment plan:** Whether a patient included already having a treatment plan for the additional concern had a significant effect on the social action the patient selected. The odds for a patient to design a concern as an inquiry for a concern that mentions already having a treatment plan were 3 times smaller ($Z=-2.02$, $p<0.05$) than the odds for a patient to design a concern as an inquiry for a concern raised without a mention of already having a treatment plan.

All other predictors were not significant (see Table B below for a summary of all results).

**Table B:** Model B results, inquiry=1, informing=0 (*significant results bolded)*

| Test category | Odds ratio | Estimate | Std. error | Z value | P value |
|---|---|---|---|---|---|
| Intercept | 0.490 | 0.912 | 1.177 | 0.775 | 0.438 |
| **Inside surgeon domain** | **1.914** | **0.649** | **0.316** | **2.053** | **0.040**** |
| **Degree of relationship of patient & surgeon** | **1.629** | **0.488** | **0.202** | **2.420** | **0.016**** |
| **Other physician mentioned** | **0.457** | **-0.783** | **0.370** | **-2.118** | **0.034**** |
| **Another treatment plan is mentioned** | **0.399** | **-0.918** | **0.418** | **-2.197** | **0.028**** |
| Fitted to activity (Disjunctive as reference) | 0.316 | -1.152 | 0.603 | -1.909 | 0.056* |
| **Fitted to topic** (Disjunctive as reference) | **0.267** | **-1.320** | **0.351** | **-3.754** | **<0.001**** |
| Post-physical visit-phase (Physical-examination as reference) | 1.626 | 0.486 | 0.549 | 0.885 | 0.376 |
| Pre-physical visit-phase (Physical-examination as reference) | 1.310 | 0.270 | 0.476 | 0.568 | 0.570 |
| Concern is physically evaluable | 0.687 | -0.376 | 0.346 | -1.086 | 0.278 |
| Pre-operative treatment-phase (Physical-examination as reference) | 0.641 | -0.445 | 0.327 | -1.364 | 0.173 |
| No Qualifier (qualifier intensifying as reference) | 2.074 | 0.729 | 0.484 | 1.506 | 0.132 |
| Diminishing qualifier (qualifier intensifying as reference) | 1.347 | 0.298 | 0.656 | 0.454 | 0.650 |
| Subsequent mention | 1.036 | 0.036 | 0.361 | 0.099 | 0.921 |
| Acute concern type | 1.497 | 0.403 | 0.386 | 1.046 | 0.296 |
| Age | 1.315 | 0.273 | 0.188 | 1.459 | 0.145 |
| Latino (Black as reference) | 0.408 | -0.896 | 1.271 | -0.705 | 0.481 |
| White (Black as reference) | 0.352 | -1.044 | 0.902 | -1.158 | 0.247 |

p<.10 * p<.05 ** p<.01 *** p<.001****

### 3.4.1 DISCUSSION OF STATISTICS

Not all characteristics identified in the qualitative investigations at the beginning of this chapter showed my predicted effect on the likelihood of an additional concern of being helped after conducting statistical analysis on the entire dataset. Before discussing the unexpected findings, I will review the quantitative findings that matched my qualitative predictions. To begin, the variable that had the largest interactional effect on an additional concern receiving help was its Social action. I hypothesized, and the statistics confirmed, that framing the concern as an inquiry made it 56 times more likely to be helped than informings. Indeed, this finding supports the sequential organization of talk that holds recipients of questions accountable to provide a response (Schegloff 2007; Stivers and Rossano 2010).

Quantitative analysis also aligned with my qualitative predictions that subsequent mentions, acute concerns, and concerns raised during the pre-physical phase of a visit were more likely to get helped. However, my predictions that mentioning another physician would lead to less help was incorrect. Surgeons performed more confirmation work (which does qualify as "help") than I expected.

By including the interactional effect of Surgeon domain, this revealed findings that were practically impossible to infer otherwise. Specifically, including qualifiers had outcomes that ran counter to my expectation. Patients that used an intensifying qualifier for inside the surgeon domain issues surprisingly received less help than concerns that had either a diminishing qualifier or none at all. In other words, ramping-up a concern did not work when the concern was inside the surgeon's domain. This finding reveals that patients should not over exaggerate their additional concern because it is for the surgeon to assess it as minor or severe (since it falls

inside the surgeon's realm of expertise). Conversely, patients showing troubles resistance[35] by including a diminishing qualifier in their concern presentation appeared to be the most interactionally effective, perhaps because it leaves the surgeon room to be the person to evaluate the concern. Thus, remaining neutral or troubles resistant when presenting additional concerns for inside domain concerns makes it more likely for the patient to receive help.

If the concern was outside the surgeon's domain, intensifying qualifiers again did not increase the likelihood of receiving help while diminishing qualifiers did show a trend of concerns not being helped. That is, displaying troubles resistance for an additional concern for something the surgeon does not typically attend to appears to tip the scale into not receiving help. Thus, the stance patients take when presenting their concerns has interactional import.

Because Social action was the variable that had the highest odds ratio impact on an additional concern receiving help, this reinforced my decision to select Social action as the dependent variable for Model B. Recall Social action was selected as the proxy for analyzing patient entitlement, surgeon accountability, and the potential for patients attempt to manipulate their chances of receiving help. This model sought a systematic explanation for why patients chose one social action type over another. Moreover, I was interested in empirical evidence showing that patients with additional concerns outside of the surgeon's domain were exploiting the inquiry design in order to exert more pressure on surgeons to help them with matters that they felt less of a right to receive help for.

[35] A patient being troubles resistance is part of their presentation of self as a person who does not rush to a doctor at the first sign of trouble and may have tried to first self-remedy. In other words, they work to display that they are not a hypochondriac. By downplaying a concern (vs. ramping it up), this is also a way to display troubles resistance (Heritage, John, and Jeffrey D. Robinson. 2006b. "Accounting for the visit: giving reasons for seeking medical care." Pp. 48-85 in *Communication in Medical Care: Interactions between Primary Care Physicians and Patients*, edited by John Heritage and Douglas Maynard. Cambridge: Cambridge University Press.).

I found several factors related to how patients presented their additional concerns. However, my hypothesis that patients would select the inquiry design for outside domain concerns in an attempt to manipulate the surgeon into helping them more was not confirmed. Instead, patients matched their levels of entitlement with the degree of accountability they held the surgeon providing a response to—high entitlement paired with a high level of accountability for response, and low entitlement paired with a low level of accountability for response. Informings were more commonly found in contexts where patients displayed lower expectations for receiving help (like in contexts where they mention seeing another physician or already having a treatment plan). While in contrast, patients asked questions when they expected help (like when the additional concern falls inside the surgeon's domain).

Further evidence for entitlement matching accountability was found in the measurement for how close of a relationship the patient had with the surgeon. The closer the relationship between patients and surgeons, the more likely it was for the concern to be designed as an inquiry. This supports the claim that patients who felt the right to be assertive (in this case because they knew the surgeon better) also felt more entitled to use the inquiry social action. Although Model A showed no significant effect of surgeons helping long-term patients at a different rate than first time patients, Model B revealed that patients' behavior is affected by how well they know their surgeon. These findings pertaining to patient/doctor relationships perhaps can have import for the research on continuity of care.

### 3.5 LIMITATIONS OF A SINGLE-METHOD APPROACH

In my quantitative analysis I was able to take into account how predictors interact to affect outcomes. In my qualitative analysis I was able to incorporate surrounding talk and other contextual information into my analysis. While I gained a more complex understanding of each

individual case when using qualitative methods, one limitation of this approach was that I only could evaluate the characteristics independently from one another. For 377 instances, it was too unwieldy and unsystematic to try to keep track of different characteristic combinations and evaluate how they might come to bear on the interaction. It was not until I ran Model A (which predicted patients receiving help) that I could perceive how these characteristics/predictors reacted as a unit, and this model revealed significant effects that differed from my initial qualitative predictions.

As seen in Model A, by running an interaction with Surgeon domain it became evident that the method patients chose to initiate their concerns had different odds of receiving help depending on the concern being inside or outside the surgeon's domain. My qualitative prediction that the disjunctive method would consistently yield the highest rate of help (because it works to set the additional concern apart from ongoing talk and activity) was not supported by the quantitative results that found an interaction between Method and Surgeon domain. Instead, Model A revealed that for inside domain concerns the disjunctive method fared significantly worse than the fitted methods.

I could not grasp interactionally why this could be and decided to examine the individual cases in which patients initiated an inside domain concern with the disjunctive method that resulted in "no help". I discovered that all of these cases (n=4) were produced as informings for chronic concerns that already had treatment plans. Because disjunctives can deviate from the progressivity of the visit, perhaps these Concern types did not seem severe enough, from the surgeon's experience and expertise, to derail the visit. Further supporting this line of thought, Model A shows that chronic concerns and informings were less likely to receive help. Thus, there may be more influencing factors for why an inside domain concern does not receive help

than just the use of a disjunctive. By combining the perspective of qualitative and quantitative lenses, a meaningful explanation can be obtained.

### 3.6 PATIENT STRATEGIES & CONCLUSION

From my interviews with 15 patients in which I asked them if they had any strategies on how to bring up an additional concern, not one patient stated that they deliberately frame the concern as an inquiry when they feel more entitled to receive help nor do they try to pressure the surgeon into helping them by asking their concern as a question. Additionally, no patients said they had disparate presentation strategies for inside domain versus outside domain concerns, nor did they seem to be objects of conscious awareness for the patients. I believe that is how social scientists break down interactional behavior, not participants. Although patients may use and benefit from the norms of sequence organization, that does not mean that they are consciously aware of their linguistic actions. Instead, patients attributed raising concerns to their emotions. If they felt comfortable with their surgeon, they claimed this connection made it more likely for them to seek additional help. One patient explained to me that if his doctor asks him a lot of questions about how this part of his body feels, and how that part of his body feels, then he feels more comfortable bringing up other parts of his body as well. His overall assessment of patient care is that "it's really important for the doctor to ask questions to get patients talking." Patient strategies for initiating additional concerns ran the gamut: "Just blurting it out when it comes to me", calling ahead to alert the surgeon about something extra to discuss, waiting until the end of the visit to raise it, writing it down on a sheet of paper to remember (even though I found this only occurring once in my collection), waiting to be asked for additional concerns, following his grandfather's advice that "God gave me a mouth so use it. I have no problems with

communicating with my doctor" (note this patient was in his 80s), and never raising any extra concerns for fear that this will trigger being operated on.

Several patients mentioned during our interviews that they would not bring up an additional concern unless it was really bothering them, and one woman told me, "You might think I'm weird, but the way I do it is if it comes up, it comes up and if not, then it doesn't. And then I just wait and see if it's still a problem later." While my study shows that patients are initiating unsolicited additional concerns at a higher rate and in different phases of the visit than previous research has found, this study cannot answer how often patients avoid mentioning additional concerns.

Finally, while I have claimed that all patient-initiated additional concerns place the concern on the interactional table to be potentially helped by the surgeon (part of my rationale for including informings in this collection), this chapter has operated under the default assumption that patients initiate additional concerns with the desire to receive help for them. One may ask, what other explanation is there for a patient to tell a doctor a concern if it is not for the sake of receiving help? I conjecture that there are instances in which the patient's objective is the transfer of knowledge for knowledge's sake, or righting the epistemic imbalance between them (Heritage 2012a). Perhaps patients are just seeking surgeon awareness over the issue and are satisfied if the surgeon simply receives it as news. That does not negate the possibility of the surgeon finding the additional concern problematic or relevant to address, but patients are not necessarily expecting this doctor to help with this problem right now. A future study that includes exit interviews could help shed light on patient expectations.

Lastly, I wish to highlight Byrne and Long's (1976) research that shows that when patients are given sufficient time and space to express their concerns, the benefit is not solely for

the doctor as an information gathering resource, but in fact patients report feeling better just from having had the chance to articulate their concerns. This cathartic experience of sharing and being heard is in-and-of-itself a beneficial treatment for the patient, and Byrne and Long argue that in consequence, doctors should not interrupt patient's problem presentations. I believe this holds true for additional concern problem presentations as well. When considering that about half of the patient-initiated concerns did not receive "help" according to my coding schema, if we were to incorporate Byrne and Long's finding, I believe that by letting patients articulate their additional concerns, more benefit is being provided than my coding necessarily captures.

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# Chapter 4: Surgeon-initiated noticings of additional concerns

When Mercy Hospital outside St. Louis, Missouri opened its doors in September 2016, it made national headlines because it is a $54 million hospital without any beds (Pepitone 2016). In contrast to a traditional hospital, Mercy Hospital is a hub of telemedicine programs, aiming to keep patients at home while still being cared for by their doctors via two-way cameras, tablets, and various sensors. While telemedicine has previously been utilized for rural patients or to help facilitate interactions in a patient's native language, Mercy Hospital is novel in introducing telemedicine to a broad audience. Many issues of telemedicine are still unknown. Is the care they receive comparable to that of face-to-face interactions? Advertisements claim doctors are capable of physically examining a patient remotely. Is this really possible? These are very important questions to understand, but they are rooted in researchers first having a firm understanding of doctor/patient interaction in traditional patient visits to serve as the basis for comparison.

Past research in face-to-face primary care office visits has shown that there is a default assumption that one visit equals one problem and the visit is structured around dealing with one problem (Beckman, Frankel and Darnley 1985; Heritage et al. 2007; Robinson 2001; Robinson and Heritage 2015; Robinson, Tate and Heritage 2016). However, research has also shown that patients often have more than one concern that in theory they would like to discuss with their doctors but can have difficulty getting it on the table to discuss (Heritage et al. 2007; Kaplan et al. 1995; Stewart et al. 1986). Because of this, much research has been devoted to getting doctors to solicit these additional concerns from their patients (Heritage and Robinson 2011; Robinson 2006b; Robinson and Heritage 2015; Robinson, Tate and Heritage 2016).

What has not yet been looked at is when *physicians* initiate additional concerns and how such concerns get onto the interactional agenda. Thus, this analysis focuses on how surgeons introduce additional concerns that are based upon perceptual noticings of physical abnormalities on the patient's body. Surgeons perceive these abnormalities through the medium of sight, touch, hearing, or smell. This analysis does not include other types of new concerns that surgeons can also encounter and initiate based on information gathered from pathology reports, radiology findings, or problems detected in patient's talk. Indeed, surgeons can notice or infer potential problems based on a variety of sources,[36] but I have narrowed this chapter's focus to this one subset of "perceptual" noticings.

The word "notice" conveys that the discovery was "unmotivated" and not something that was deliberately being looked for (Halkowski 2006; Heritage 2005). In the institutional setting of 911 emergency phone calls, callers who frame their call with the verb "notice" express their discovery as inadvertent or unexpected (Heritage and Clayman 2010). In the office visit setting, while surgeons are always (or should be) potentially on the lookout for abnormalities on a patient's body, they are not explicitly seeking to discover melanomas, varicose veins, lumps, etc. during their pre- and post-op consultations. For example, while lifting a patient's shirt in order to listen to the lungs, a surgeon happens to notice that the patient has a sebaceous cyst on his back. In other words, the surgeon has found something that he was not explicitly looking for. While noticings in ordinary conversation can be either about good or bad events, like a friend noticing a new haircut or commenting on a new dent on the friend's car, the purpose of these

[36] The same definition of additional concerns presented in Chapter 2 applies for this analysis as well (as in, it is unrelated to the focal concern and was not solicited by the patient). However, I have chosen to focus on a specific subset of surgeon initiations—those that were raised due to a noticing. Noticing additional concerns (for the first time and on their own body) is not something that I observed patients doing in these visits, so there is not a direct comparison with patient behavior. I chose not to write a chapter about additional concerns surgeons initiated based upon previous talk or activity (like I did for patients), because I only found a few cases of them. Instead, I found that surgeon initiations from noticings were the most frequent (even though relatively still infrequent) way surgeons initiated new concerns and made for a more in-depth analysis.

mundane noticings is to help build social solidarity (Schegloff 2007). In other words, I care enough about you to perceive changes in your life and demonstrate this to you by sharing them. In institutional settings, however, noticings have different interactional import and participants orient to them differently. In medical settings, physician noticings are delivered and interpreted as done 'for cause', and are interpretable as a form of a bad news delivery (see Maynard 2003). In this context, noticings function in closer alignment to the Merriam-Webster definition as "a warning or intimation of something" or the "condition of being warned".

I hypothesize that the presence of whole, physical patients in front of doctors that they can see, smell, feel, and listen to, will create more opportunities for them to make novel noticings about problems unrelated to the focal concern than they could while having mediated interactions with patients via Skype that has a more limited set of affordances for the examination of patients' bodies. Indeed, during face-to-face visits, doctors unavoidably view the patient's body from all angles while they maneuver around each other in a small exam room. Moreover, by deliberately examining the patient's body during the physical examination, doctors have the ability to catch additional concerns that patients themselves may be unaware of (or for whatever reason choose not to mention to the doctors). Thus, an affordance of co-presence, of doctors and patients sharing an actual room together, is that perceptual noticings can emerge from this setting.

This chapter seeks to answer several questions about surgeon-initiated noticings. How do surgeons design and deliver them? When do they deliver them? And what are the functions of these noticings?

## 4.1 BACKGROUND

One could imagine that patients might welcome being told about new noticings, and perceive their surgeon as meticulous, going above and beyond the expectations and accountability of the provided care. However, if this were the case, these noticings would be designed with preferred turn shapes, i.e., that were straightforward, unmitigated, and delivered without delay (Pomerantz 1984). On the other hand, it is also imaginable that anytime surgeons notice extra abnormalities on a patient's body (that are neither related to the focal concern nor patient solicited) and share this information, the new information may not be well-received. Thus, both participants can orient to noticings as bad news deliveries, resulting in surgeons designing them as dispreferred turns-at-talk. As I will show in this analysis, the latter is the norm.

Why are surgeon-initiated perceptual noticings a rare phenomenon, found in less than 8% of visits in this collection? One possible explanation could be that physically there is nothing extra or problematic on the patient's body to be noticed. A second explanation could be that surgeons do not articulate all that they notice. There are countless things that surgeons see on patients' bodies (e.g., wrinkles, tan lines, acne, cellulite), but they do not relay an online narration (see Heritage et al. 2009 on online commentary) of everything they perceive. Instead, I believe that surgeons filter their observations and only share information they deem relevant or actionable. As one surgeon explained, "Generally, if I see something that I think needs to be done [on the patient's body], I comment about it. I want to catch problems early so that they don't end up with something terrible." As this quote helps to demonstrate, surgeons share noticings with patients when there is something actionable to be done. In other words, they are delivered for cause and not just for observation's sake. Consequentially, patients are listening to

their surgeon's utterances not as mundane commentary that anyone could say, but instead as epistemically (Drew 1991; Heritage 2012a; 2012b; Heritage and Raymond 2005; 2012) and deontically (Stevanovic 2013; Stevanovic and Perakyla 2012) authoritative observations that can affect their future medical care.

In reviewing the 22 instances of articulated perceptual noticings, I found that the vast majority of this collection have characteristics that are found in the designs of dispreferred turns-at-talk (e.g., bad news deliveries). As Maynard (2003) wrote in his book *Bad News, Good News: Conversational Order in Everyday Talk and Clinical Settings*, physicians "shroud" bad news deliveries (in contrast to "exposing" good news). Maynard found bad news diagnoses to often be delayed, softened, accounted for, hedged, and so forth (see Maynard's Ch. 6). In orientation to the preference-system (Pomerantz and Heritage 2013), speakers of dispreferred responses design them in a way to signal that what is to come next is undesired or undesirable, and designed to soften the interactional blow of bad news (Maynard 2003). Some practices that help perform this delicacy work include delays, self-repairs, hesitations, minimizations, apologies, accounts and other features that signal that what comes next is not preferred (Heritage 2016; Lerner 1996; Robinson 2006a; Sacks 1987; Schegloff 1980; 2007; Schegloff and Lerner 2009).

Dispreferred turns-at-talk have been most often studied when in the responsive position. For instance, in ordinary talk the preferred response to an invitation is an acceptance while the dispreferred response is a rejection (Davidson 1984; Pomerantz 1984). Keep in mind, this preference system does not relate to a participant's internal desires (e.g., Even if I have zero personal desire to attend my neighbor's party, I still need to orient to a "No" answer as a socially dispreferred response by designing my turn appropriately (with delays, accounts, etc.)). In regard to this chapter's data, even if a surgeon is inwardly proud of himself for spotting a

melanoma in a hard to see part of the patient's body, it still is socially preferred for him to deliver this as socially dispreferred news to the patient.

First position dispreferred actions have received relatively little attention (Robinson and Bolden 2010). Heritage and Sefi's (1992) analysis on how home health-nurses initiated giving advice to new mothers showed that these were delicate, first position actions. Even though nurses were there to provide expert help to novice parents, this unsolicited advice was often met with resistance by the mothers because they felt their skills were being judged. Heritage and Sefi described how nurses manage their presentations of advice giving by using a "step-by-step" procedure into advice giving (pg. 379). By using this procedure (and variations of it), nurses worked to first align mothers as advice-recipients before delivering the advice proper. This work shares many similarities with the unsolicited, first positioned noticings that these surgeons share with their patients. Both experts are trying to provide help, and must figure out a strategy for balancing the interactional dilemmas of pointing out new concerns with the necessity of bringing them to light.

**4.2 DATA**

Cases for this collection of surgeon-initiated concerns were culled from the same set of patients as the previous chapters. However, because this is an infrequent occurrence (to be discussed later), I expanded the number of visits to observe. Ultimately 95 patients' pre-op and post-op visits were reviewed that encompassed 281 total visits, and 22 cases of perceptual noticings were found. Cases were first transcribed and then analyzed with the methods of Conversation analysis and ethnography. During the analysis stage (and once collecting for this phenomenon was complete), I reviewed some of these cases with the participating surgeon in

order to gain his insight onto the medical relevance of the additional concern, the patient's medical history and their relationship past.

### 4.3 DISPREFERRED ACTIONS

Surgeons can use any of their senses (sight, touch, hearing, or smell) to notice a physical abnormality on the patient's body. This often means surgeons lingering on one area of a body, giving it more attention than other already examined areas. In turn, patients are likely able to notice that surgeons are noticing something. As socialized participants in medical encounters, patients know that physicians examine for cause and can interpret surgeon's extra attention on a part of the body as a harbinger of bad news. Consequentially, surgeons can also anticipate this and design their noticings with sensitivity to patients bracing themselves for forthcoming bad news (see Mead 1934 on taking the role of another). Thus, even before the noticing is articulated, the *act* of noticing is also interpretable as a dispreferred action.

By looking at how surgeons design and share their noticings with patients, it becomes evident that these turns-at-talk are built as dispreferred. The following features of dispreferred turns-at-talk were apparent in these data 1) delays, 2) reformulations, 3) minimizations, 4) hedgings, 5) avoidance.

**1. Delays** – both in turn-beginnings and before the articulation of the actual bad news words. Delays can be done with silences or with "filler" words that delay the articulation of the actual problem.

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

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

Ex: 3
DOC:  Your psoriasis seems to be a little bit (2.9) more noticeable (.) than
      it has been is that
```

Ex: 4
DOC: You have a couple of these just sun- **what I call kind of like** sunspots on on your back.

**2. Reformulations** – surgeons can cut off the noticing mid-TCU and redesign the syntax.

Ex: 5
DOC: Have you had your ah (2.5) You have ah- (5.0) You have a little bit of a flow murmur.

Ex: 6
DOC: Hm you may have a li:ttle- (.) do you think that's come ba:ck,

Ex:7
DOC: .hh Are these (.) uhm splotches on your legs is that just n-natural

**3. Minimizations** – Surgeons shape the additional concern as not a large concern. They can do this with words like "little", "small" or "just".

Ex: 8
DOC: There might be a **small** one on this side too here.

Ex: 9
DOC: Hm you may have a **li:ttle**- (.) do you think that's come ba:ck,

Ex: 10
DOC: You have these **little** u:hm (0.5) what are called pterygiums. They're **little** like skin growths that headin' they're heading across your eye

**4. Hedgings** – surgeons initially present an additional concern as a possibility (as opposed to a certainty). These words like "might" or "may" display epistemic modal verbs conveying less than complete certainty.

Ex: 11
DOC: There **might** be a small one on this side too here.

Ex: 12
DOC: Hm you **may** have a li:ttle- (.) do you think that's come ba:ck,

Ex: 13
DOC: You **migh**t have a little one in your belly.

**5. Avoidance** - Surgeons may use locally subsequent referents (Schegloff 1996b) instead of the actual term, thus avoiding actually articulating the bad news specifically (Maynard 2003).

```
Ex: 14
DOC:  There might be a small one on this side too here.

Ex: 15
DOC:  Listen you're you're kind of like me. My legs look like your legs do
      down here. ((surgeon avoids ever articulating diagnosis – this is the
      closest he gets))

Ex: 16
DOC:  Hm you may have a li:ttle- (.) do you think that's come ba:ck,
```

## 4.4 FRAMING OF NOTICINGS

Surgeons can frame their noticing as a request for information (see Ex 1, 6, 7, 9, 12), an informing (see Ex 2, 4, 5, 8, 10, 11, 13, 14,15), a request for action (see Case 3 below), or as an evaluation (see Ex 3). In the way surgeons decide to initiate their noticings, they can use different frames to tilt their observations towards varying levels of seriousness. In addition, different frames solicit patients' responses in different ways (e.g., to confirm or to help evaluate). Focusing on the surgeons' initial delivery of the noticings, we can see how these different social actions come to bear on the interaction.

Surgeons can have difficulty in framing a noticing, which is evident in their switching one frame for another mid-TCU (cf. Schegloff 2013). For instance, in Ex 16, "Hm you may have a li:ttle- (.) do you think that's come ba:ck," the surgeon begins with an informing, but then cuts himself off mid-TCU and self-repairs to a question frame. This example will be analyzed in more detail in Case 1, but just from this initial line it is evident that the surgeon orients to these action frames as different, and found it worth halting his turn's progressivity in order to solicit the patient's own evaluation (see Drew, Walker and Ogden 2013 on analytical import of self-repairs). Because of the delicate and dispreferred nature of raising these additional concerns, the first move into this new territory will potentially instigate red flags, or worry, in the patient's

mind. Depending on the exact problem and what the surgeon may feel the next steps should be, surgeons need to get the patient more or less on board with what follows (e.g., allowing the area to be further examined, agreeing to future diagnostic tests, or at the least extending the discussion of the condition).

I believe that general surgeons face certain interactional dilemmas when deciding how to frame and when to share perceptual noticings with their patients, which is made evident when examining the delicacy work found within these turns-at-talk. In this paper, I will analyze 3 cases of perceptual noticings oriented to as dispreferred actions, and the 4th case will serve as a deviant case.

## 4.5 ANALYSIS

### Case 1: Parotid gland

The patient is in her mid-60s and is seeing a surgeon for a colonoscopy consultation. This is her first visit and encounter with this surgeon. After some casual getting to know each other talk, the surgeon begins asking her medical history-taking questions. The surgeon is seated on a low stool with paperwork in his hands, including the "new patient" medical history paperwork she filled out in the waiting room. The patient is still dressed in her street clothes, sitting on the edge of the exam table and positioned a bit higher than the surgeon. He is running through the standard set of questions and asks her about a family history of colon cancer (line 1). After 8 seconds of silence, the patient recalls that she forgot to put on her paperwork that she has a history of a parotid gland tumor[37] (begins line 11). This mention incites the surgeon to ask her some follow-up questions about her history with this procedure (line 14).

[37] Parotid glands are a major salivary gland and are located on the side of the face near the ear.

During the discussion that follows, the surgeon remains seated with the paperwork in his hands. Although he does reach up, briefly touches her scar and inquires if this is related to her parotid gland procedure (line 26), this is not yet part of the physical exam phase but instead part of the history taking process. As evident in line 33, having this parotid gland tumor removed was a traumatic experience for this patient. Even though this surgery occurred decades prior, she still delivers an emotional account of a complication from her surgery that resulted in partial facial paralysis for six months. After an extended recounting of this, the surgeon tells a second-story about a facial nerve he saw damaged during residency. They then transition back into history taking.

The transcript below shows this first exchange about the patient's parotid gland. The way the patient has presented this is entirely as part of her past, fitted to the activity of history-gathering that they are engaged in (note the past tense throughout this telling). She provides no hint that this could be a potential area of concern for her. When the surgeon touches her scar, it also appears oriented to the task of understanding her medical past.

Case 1: History taking

```
01  DOC:  And no family history of any: (.) uhm col[on cancer or any= t
02  PAT:                                           [((shakes head no))
03  DOC:  =[type of GI problems at all.
04  PAT:   [((continues to shake head no))
05  DOC:  Mkay ((looks down and is sorting through her paperwork))
06  PAT:  Now my mother I think did have that uhm (.)I think she had
07        (.) whatever that is that hiatal hernia, or whatever
08  DOC:  Okay.=
09  PAT:   =I think that's what my mother (0.2) did have that.
10        (8.0)
11  PAT:  And I forgot to put on there ((points towards papers in
12        surgeon's hands)) that I had an ult- a parotid (0.5)
13        ultrasound too:.
14  DOC:  Mkay. Did you have an operation on your parotids or did they
15        just [did
16  PAT:       [They took they took eight percent of this parotid gland
17        ((touching the area)) you [can see
18  DOC:                            [parotid uh huh,
19        (0.2)
20  PAT:  Because there was a tumor on it and it was growing.
21  DOC:  It was benign
```

```
22        (.)
23  PAT:  Well they called it a mixed.
24  DOC:  Mixed tumor. So those are kind of benign tum[ors.
25  PAT:                                                [Yeah.
26  DOC:  And this scar here ((touches at her head)) was it for your-
27        was it part of your parotid,
28  PAT:  Yes. Because they slit me open ((takes off glasses to better
29        show scar))
30  DOC:  Above your ear, all the way down.
31  PAT:  Uh huh.
32  DOC:  Mkay.
33  PAT:  And of course the bad thing about that was uhm (.) I guess it
34        was in that night, (0.2) uh (0.2) ha my right side paralyzed
35  DOC:  Right.
36  PAT:  And it took about six months for it to come back
37  DOC:  For it to come back
38  PAT:  Mm hm.
```

Let's move forward about 10 minutes into the visit, and the patient is now dressed in a gown, the nurse is now present in the room,[38] and the surgeon is now standing near the foot of the exam table with a stethoscope around his neck. All participants are now engaged in the physical exam phase. It is the standard for this general surgery practice to examine all patients before performing a colonoscopy on them. Consistent with this, this surgeon has a customary head-to-toe exam that he performs on all of his patients. He first looks in the patients' eyes and then throat. This is where this transcript resumes, right at the point when he's finished looking at her throat. The surgeon then walks around her, positioning himself behind her so that he can assess her lymph nodes and asks her to swallow, also part of his routine exam. With his hands on her neck and near her face, he now is standing a few inches above her with a clear view of her parotid gland. He places both of his hands now on that area near her right ear and presses his fingers on the side of her face. Right as he begins this touching, the patient opens her jaw. This

[38] This practice always has a nurse (who are all female) present in the room during the physical exam phase of female patients. Surgeons will delay the beginning of the examination in order to wait for the nurse to join. On the other hand, nurses may or may not be present for male patient physical exams, depending on availability or how much assistance is needed. Because all surgeons have been male, this presumably is an orientation to potential liability lawsuits. However, in December 2016 a female surgeon joined this practice, and it will be interesting to see if this gendered-practice continues.

movement is her attempt to make her parotid gland move, making it more easily examinable.[39] This movement shows that the patient understands the purpose of the surgeon's concentrated touch on that area of her face and helps to establish and confirm joint attention. She remains quiet during the 12 seconds that this investigation continues, aligning herself to being examined for a concern that is not related to the focal reason of the visit.

At one point the surgeon lifts his eyebrows, which I am calling an "internal change of state marker" that appears to be an outward display of a registering of something that necessitates further investigation (see Heritage 1984 on the change of state token "Oh"). It could be that he's paying more attention to this area than usual because of the patient's history. Yet this is not the purpose of the visit and the patient has raised this as part of her past medical history and not as an on-going concern. Thus, anything that the surgeon does here is seemingly unexpected and extra. He then shares his perceptual noticing:

```
Case 1 cont: Physical exam

((11 seconds of silence while surgeon examines patient's face))
01  DOC:  Hm you may have a li:ttle- (.) do you think that's come ba:ck,
```

The surgeon initiates his noticing with "hm", which I'm calling a turn initial ruminative expression. Akin to other types of dispreferred responses, the inclusion of a turn-initial particle helps to delay the upcoming talk. His first attempt at sharing this perceptual noticing is with a declarative informing, "you may have a little". He then cuts himself off before providing a noun—before actually articulating what the problem is. I believe that he cuts himself off from saying the word "tumor" based on discussions they have later in which he uses this term (not shown here). The surgeon then reformulates his noticing with an interrogative, "Do you think that's come back, ". For the second time he avoids the word "tumor" (or whatever noun he

[39] This is the same movement that she will use a bit later when trying to feel for it herself.

would use to describe the problem) and instead uses the referent “that”. Not only does using a locally subsequent reference form (Schegloff 1996b) enable him to avoid naming the problem, the word “that” also assumes that the patient will be capable of understanding what he is talking about based on where his hands have been touching and because of their recent discussion in which she was the first to articulate the word "tumor."

This reformulation from a declarative informing into a yes-preferring interrogative marks a downward shift in epistemic rights by the surgeon (Heritage 2010b) and places the patient in the position as the first one to evaluate her own body. Since parotid gland issues fall outside the general surgeon’s domain of practice and because the patient has had personal experience with having had a facial tumor before and presumably could recognize a reoccurrence, this reformulation and epistemic downgrade marks the surgeon relinquishing his role as the medical expert and instead prioritizing a display of deference to the patient's epistemic rights as the experiencer of a previous episode with the capacity to recognize a potential recurrence. In short, he treats the patient as 'expert' (Tuckett et al. 1985). Furthermore, this solicitation for the patient’s input occurs after her parotid gland was palpated for 11 seconds (and she has helped in this process by opening and closing her jaw). The surgeon’s question treats the patient as also having the experiential knowledge to evaluate how having a parotid gland tumor feels when examined, something only she can know.

By designing this interrogative as yes-preferring, the surgeon still reveals to the patient his stance towards what he believes to be the answer to the question (Bolinger 1978; Heritage 2010b; Raymond and Heritage 2013). Although “Do you think that’s come ba:ck,” is designed for a “yes” answer, it cross cuts the social preference (Schegloff 2007) for there to be no additional concerns. Due to a basic preference for optimal health outcomes during visits, it is

desirable for the patient not to have a reoccurring tumor. Furthermore, this perceptual noticing conflicts with the patient's initial description of her parotid gland as a concern situated in her past with no allusion to it being a present concern. When weighing how to formulate the noticing as something the patient is already cognizant of (or not), it appears that the surgeon takes the position that the patient is unaware of a recurrence, though she is capable of recognizing it once it is pointed out. Thus, his noticing this will overall be new news for her—even though by the time he actually does articulate it after 11 seconds of examination, it probably will no longer be unexpected.

Because the patient was not seeking help for her parotid gland and simply mentioned it as part of her medical history, deciding to present this concern as new news is a delicate action for the surgeon. The patient has the normative responsibility for monitoring her own body (Halkowski 2006; Parsons 1951), and because she has had a tumor before, in theory she has the experiential knowledge and capacity to detect a recurrence. He is thus telling her something she may already know, or should have known.

Lastly, there is a looming contextual dilemma that the surgeon must navigate. As the patient has made evident, her past surgery was a very traumatic experience for her due to complications and facial paralysis. Sharing with her that her parotid gland may again have a tumor growth, especially in this context, will not be welcome news. Similar to Maynard's findings in bad news deliveries, one function of the surgeon's designing this noticing ultimately as an interrogative is that it allows for the patient to articulate for herself what she thinks in a process that Maynard (2003) terms 'realization'. As Maynard found, this has the potential for recipients of bad news to better come to terms with this dispreferred finding.

### 4.5.1 WHEN NOTICINGS ARE SHARED

Before moving on to the next case, I want to draw attention to the "online noticing" of when this perceptual noticing was shared (see Heritage and Stivers 1999 on "online commentary"). The articulation of the medical abnormality happened adjacent to the noticing of it. In fact, 20 of the 22 noticings in the collection were shared "online". In both of the instances in which surgeons expressed a concern in a remote position, both medical concerns involved rectal issues (hemorrhoids and a rectal wart). I reviewed these videos with the participating surgeon and asked him why he did not deliver the noticing as soon as he perceived them. He responded that he knows that the rectal exam is an uncomfortable and painful position for a patient to be in, and that he tries to get that portion of the visit over with as quickly as possible. In addition, it is a physically difficult position to have a conversation with someone— because the two participants' faces obstructed from view of one another. Therefore, he prefers to wait until later in the visit, when they are re-positioned at a better angle, to raise an additional concern, especially since it may require a lengthy discussion about treatment plans, etc.

The advantage of "online noticings" is that joint attention is already achieved as a product of haptic connection (see Cekaite 2010 on how touch is used to transition into activities; Goodwin 2006). Touch preceding (or occurring at the same moment of) the surgeon's articulation of the noticing occurred in the vast majority of "online noticings" (17/20). Patients were able to discern what the surgeon was referencing by where his hands were touching. Thus, the work of mutual orientation to a certain place on the body was not verbally necessary, which I find unique to this setting in which the noticeable object is situated on a person's body that is

responsive to touch.[40] Therefore, the advantage of articulating the noticing online is that it removes the burden of having to work for joint attention. In addition to this, another resource garnered by haptics is that the surgeon can earmark a site on the patient's body as in need of discussion. Often overlapping talk occurs during physical examinations and by maintaining tactile contact with that spot, the surgeon can signal what topic may be next in queue (to be discussed in the 4th case).

While from a sequential organizational position of talk these perceptual noticings are in first position, they can occur in the responsive position to this haptic exchange, and I argue this can contribute to the design of these noticings. Lexical referential terms such as "this" or "that", normatively found in sequentially local positions, can be used in a locally first-positions (Schegloff 1996) because of the affordance of touch—and the advantages of using locally sequential referents will be discussed in the 3rd case.

**Case 2: Varicose veins**

This patient is in his mid-70s and is seeing a surgeon for a colonoscopy consultation. The surgeon and patient have known each other for over thirty years, have been through numerous procedures together, and are also friends outside this clinical setting (as evident in this visit by their discussion of going out for a steak dinner together soon). This interaction occurs about 20 minutes into the visit and more specifically about 6 minutes into the physical examination. The patient is lying on his back, and the surgeon has already examined the top portion of the patient's body and has moved down to the patient's feet to check for circulation.

[40] In my research on nature guiding, I noticed how when guides wished to share a noticing with their guests a lot of preliminary work needed to be done just to get guests to first figure out where to look in order to then see the noticeable object. For instance, pointing out a bald eagle sitting in a tree required work like, "Do you see the limb that's sticking way out? Now look about 3 feet higher and to the right". Thus, establishing joint attention in guiding interactions had to be verbally (and usually gesturally) accomplished. In these medical interactions, the act of touching was enough to accomplish joint attention.

While he is still standing at the foot of the exam table, the surgeon lifts up the exam gown in order to see and feel the patient's legs. For 9 seconds the surgeon silently assesses them. He places one hand on top of each shin and runs them up and down, pressing into the patient's calves with his thumbs. The patient's legs are noticeably a dark, red color. The patient remains silent, gaze fixed at the ceiling. The surgeon begins to share his noticing while still touching the patient's legs but soon walks around the exam table, closer to the patient's face.

It is relevant to note that the talk immediately preceding the 11 seconds of silence was non-medical talk. Thus, the turn-preface "Listen" in line 1 is a shift-implicative and marks the resumption of the task at hand (Jefferson 1972; Sidnell 2007), the physical examination.

Case 2:

((11 seconds of silence while surgeon examines legs))
01 DOC: Listen you're you're kind of like me. My legs look
02 like your legs do down here. ((surgeon removes hands
03 and walks up towards head of exam table to now talk
04 face-to-face with patient)) and I-I-I don- I haven't done
05 it yet so ((patient turns head and makes eye contact
06 with surgeon)) I can't (.) tell you that you gotta do it
07 but .hh it-it probably be good hh to hh y- (.) wear like a
08 knee length support hose just to- its- just to (0.2) .hh support
09 those veins down in the end of your [uh- by your ankles=
10 PAT: [((slight single nod))
11 DOC: =and stuff because if we live to be o:ld enough, (0.2)
12 .hh my legs look like they can break down at an(h)y ha
13 at any moment because I'm on my [feet all the time.
14 PAT: [((slight single nod))
15 (.)
16 PAT: [Uh
17 DOC: [But in Texas weather you know nobody wants to wear
18 support hose during the summer but maybe when the weather
19 gets cooler. I-I do yo- I- I bought a pair of knee high
20 support hose but I haven't worn '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.
27 (0.2)
28 DOC: So you're- ((surgeon turns and walks away to get plastic
29 gloves and puts them on)) I-I do see you in sh-shorts a lot
30 so that's (0.2) .hh hh
31 (1.0)
32 DOC: Yeah when you're (0.2) around the house you need to (.) throw
33 some on.

```
34  PAT:  (eh)
45  DOC:  My problem is that they take a long time to get on and I
46        never h- I'm always running late so it's just- just a problem.
          ((surgeon goes on to examine groin))
```

As evidence of this sharing being a dispreferred action, the surgeon avoids articulating the actual diagnosis that necessitates the wearing of support hose throughout these 46 lines of transcript—the words "poor circulation" or "varicose veins" are never explicitly stated. Instead, the surgeon indirectly describes the patient's legs by relating them to his own personal health problems with "you're you're kind of like me. My legs look like your legs do down here." (lines1-2). By sharing that he too has trouble with his legs, the surgeon shows empathy to this patient with whom he's had a long-term relationship, considers a personal friend, and shares similarities with him in terms of age. This relational work implies that it is not the patient's fault that he has this condition, that it is common in people their age, and minimizes the problem (for better or worse).

The difficulty which the surgeon has in recommending to the patient to wear support hose is evident throughout this telling. It takes the surgeon 5 turn-construction-units before he delivers the treatment recommendation (line 7). These turns are delayed with hitches and restarts, hedged, and reformulated. Indeed, both times the surgeon provides a treatment recommendation (lines 7-8 and lines 32-33), he simultaneously backs down from his medical expert status (Drew 1991; Heritage 2012a, 2012b; Heritage and Raymond 2005; 2012) and instead provides a reluctant suggestion, much like a friend giving unsolicited advice might do (see Brown and Levinson 1987; Goffman 1967). In fact, by positioning himself both as a friend while also providing medical advice, the surgeon seems to experience "role strain" (Goode 1960), not quite finding solid footing from which role to offer advice.

In lines 6-7 the surgeon prefaces the recommendation with, "I can't (.) tell you that you gotta do it but .hh it-it probably be good". He acknowledges that the Texas heat makes it

undesirable to wear them (lines 17-19), broadening the timeline for the patient to adhere to his advice until it gets cooler. However, the patient responds, "I don't put on long pants seven times a year." (line 25), an implied objection on the grounds of visibility, since he always wears shorts regardless of season. The surgeon later tailors his final push to convince him to wear the hose by addressing the visibility issue, telling him to wear them when he's not in public, "Yeah when you're (0.2) around the house you need to (.) throw some on." (lines 32-33). However, the surgeon again backs down from the minimized action of "throwing" support hose on by revealing that he cannot follow his own advice because stockings require too much time to put on.

Furthermore, it is contextually relevant that earlier in the visit the patient expressed frustrations with the process of getting older, and said, "As far as living till after eighty, I hope I don't live to be that long". The patient said this in response to the surgeon telling him that after he turns 80, the patient can back-off from the 3-5 year colonoscopy routine and then decide if he still wants to be scoped regularly. I believe this statement has colored the rest of the visit, in addition to other complaints the patient mentioned earlier about having difficulty sleeping, cleaning himself after going to the bathroom, and so on. Thus, the surgeon appears to have trouble adding yet another concern to the patient's list, especially one that would require a lifestyle change of wearing support hose (which could also be viewed as a daily and physical reminder of getting old). Again, the surgeon attempts to present this problem as one that they have in common, that they are in the same boat, and therefore the patient is not alone in this aging process.

While the patient never directly rejects the treatment recommendation, he does provide two small continuer nods throughout the surgeon's sharing and never officially gets on board

with the surgeon's noticing of an additional problem (Heritage and Sefi 1992). There were ample moments in which the patient could have accepted the surgeon's recommendation or shown awareness to his poor circulation, but instead the patient let numerous transition-relevance-spaces pass (Sacks, Schegloff and Jefferson 1974). The surgeon does not pursue an acceptance to his support hose recommendation after this interaction, they move on to the next part of the physical exam, and this dispreferred topic is not resumed.

**Case 3: Melanoma**

In our third case, the patient is 83 years old and is in to see the surgeon for his routine colonoscopy consultation. This patient has a long-standing relationship with the surgeon, going back over a decade. This transcript picks up right at the beginning of the physical exam phase. The patient is dressed in a gown and sitting on the edge of the exam table. The surgeon, again following the same head-to-toe routine, has just completed examining the patient's eyes with a flashlight. While he is still oriented to that upper part of the patient's head, the surgeon tilts his head up, moves his left hand to the top of the patient's forehead, and with his right hand shines the flashlight onto a large mole. As made evident in this interaction, the patient has had a history of skin cancer on this part of his head. The surgeon's left hand touches the mole at the same time he articulates line 1.

Case 3

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

The surgeon initiates his noticing with a directive, "Let me", a token request for permission (Heritage and Clayman 2010). As a request, the surgeon is asking permission to do something extra—to look at a part of the body that the patient has not asked for help about. This formulation orients to the out-of-order nature of this activity shift to examine part of the patient's body not relevant to the reason for the visit. "Let me" is also a perfunctory request because it does not actually require the patient to do anything other than to continue sitting just as he has been. Furthermore, the surgeon articulates "Let me" while already touching the patient, hence not seeking an actual response.

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, which the patient can observe from his perspective. Because the patient has had a history of melanoma on this site, coupled with the fact that this mole is large and on his face (unlike a mole on one's back where one hypothetically could be unaware of it), the surgeon topicalizes his noticing with the presupposition that the patient will understand why he's examining "this spot". In other words, the surgeon treats the patient as already inhabiting common ground with respect to the problematic area.

Through line 3 the patient has remained still and silent, a seemingly normal reaction when having one's face examined. Moreover, the patient has assumed a middle range gaze (Heath 1986). This stoicism, while aligning to being examined, is potentially problematic for the surgeon because it competes with outwardly displaying recognition or understanding why the surgeon is looking at his forehead. A beat of silence follows the surgeon's positive assessment that his mole looks all right. While in need of further investigation, I find it reasonable to assume that if doctors make requests to look at extra areas on patients' bodies that they have not

sought help for, patients can hold doctors accountable to provide an upshot for this examination. In this case, we can see the surgeon holding up to end of his deal of providing an assessment for his requested examination.

Following this assessment, there is a clear transition-relevance-space since this utterance is completed syntactically, pragmatically, and intonationally (Ford and Thompson 1996; Sacks, Schegloff and Jefferson 1974). However, the patient does not take ahold of the interactional floor, and the surgeon self-selects to speak next and provides a B-event statement (Labov and Fanshel 1977) which reminds the patient that this is where his melanoma was (line 4). The past tense of "where your melanoma was" matches the positive assessment "all right" of this concern still being in the past. In addition, this B-event statement appears to be the surgeon's partial backing down from his assumed stance that the patient has, throughout these turns-at-talk, understood why he's been examining his mole. A dilemma of having to take a stance about a patient's awareness on a perceptual noticing is that there is room for error.

However, the patient responds to this B-event statement with a confirming "Yeah" in line 4, which demonstrates that he is aware of this melanoma spot and this concern does lie within his experiential domain. Because the patient waited another beat to respond, his "yeah" is in overlap with the surgeon again self-selecting to speak next. While the surgeon ultimately drops out of his turn-at-talk and concedes the floor to the patient, the surgeon's struggle to formulate a question is still decipherable. His question begins with "but", which contrasts with the past tense dimension of the previous line. It appears reasonable to assume, from what is articulated, that he is on his way to asking the patient if he still monitors his mole, and it is evident that the patient also infers this too from how he responds. In fact, the patient interdicts the surgeon mid-TCU that he is on top of this situation and that he has an appointment in the very near future with

a dermatologist. By cutting the surgeon's question off early, the patient attempts to curtail any inference that he has not been performing his Parsonian duty of keeping up on his melanoma concerns.

Furthermore, by mentioning a dermatologist by name, the patient displays to the general surgeon that he considers melanoma concerns to fall outside of the general surgeon's domain. Thus, the patient has not mentioned or requested the surgeon to look at his forehead not out of negligence, but because he did not find it relevant for this type of physician during this type of visit (a colonoscopy consultation) to address. Although the surgeon is seemingly going the extra mile in noticing and remembering a past concern about the patient's history with melanoma, this interaction is risky because it potentially threatens the patient's presentation of being a good patient who actively monitors his own body and makes responsible decisions about who to refer specific issues to. If there is a preference for patients to initiate concerns before physicians notice them (to be discussed more later), then patients find themselves needing to account for *not* mentioning an area that receives the physician's attention. In other words, an unintended consequence of a noticing is that it can place the patient on the defensive, adding to the delicacy work needed when formulating these noticings.

### 4.5.2 WHY MINIMIZE?

Before moving on to the final case, I want to draw attention to the word "little" that has appeared in both Cases 1 and 3. Indeed, the diminutive descriptors "little" or "small" were found in 20/22 of noticings in this collection. This presents a puzzle: Why do surgeons do the work of initiating an additional concern while simultaneously diminishing it? In addition to minimizing a dispreferred action, I find that the inclusion of words like "little" can tackle more than one of the dilemmas surgeons face when sharing perceptual noticings. "Little" allows surgeons to

minimize the health optimization dilemma of initiating an additional concern. 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. This word also solves the dilemma of patient awareness (or the Parsonian problem). If the patient has yet to notice for herself this area of concern, it does not reflect poorly on the patient's ability or commitment to monitor her health status, because it is "little", which alludes to problem being hard to detect or nascent in its development. Thus, "little" can absolve patients from feeling like an irresponsible patient. Lastly, surgeons also have other resources to minimize a noticing beyond these lexical words, as seen in Case 2 in which the surgeon minimizes the issue of having varicose veins by sharing that he too has this condition but has yet to treat it himself, despite being a physician who knows better.

**Case 4: Cyst**

In our final case, I will show that there are instances in which a noticing can be shared straightforwardly, without the orientation to it as a dispreferred turn-at-talk. I argue that this is because the surgeon provides an easy solution to the problem. In fact, he embeds the noticing of an additional concern inside the treatment recommendation itself.

This is the same patient and visit as in Case 3, and this interaction occurs about two minutes later in the physical exam. The surgeon is standing behind the patient, tapping his back in order to listen to lung sounds. He notices a sebaceous cyst on the patient's upper right shoulder blade and touches it with his left hand. Meanwhile, the patient is in the middle of an extended telling about an unrelated medical procedure that he had done many years prior. The surgeon leaves his left hand resting on the patient's right shoulder near the cyst site, and moves his body laterally to the patient's so he can better engage with the patient's story. For 17 seconds, the surgeon holds this position until the patient has finished his story. 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 exam phase. Upon the completion of the patient's story, the surgeon takes a step back to once again be positioned behind the patient and brings his right hand up to meet his left. Once again, the surgeon assumes that touch enables the patient to share joint attention with the area of concern (and assumedly cysts are painful when touched). With both hands he presses on the cyst and asks without delay, hedges or reformulations:

Case 4:

DOC: Do you want to get rid of this anytime?

Here the surgeon's perceptual noticing is presuppositionally embedded in the offer that contains the "Do you want" format. As Curl has written about offers, this syntactic format "Do you want" is used when "before the offer is made, the problem it educes is not treated by either participant as something in need of remedy" (2006, 1265). Curl's analysis fits this interaction because at no point before this utterance was a cyst ever mentioned by the patient. The problem 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 amount of work necessary to resolve this problem. Heritage and Clayman (2014) have written about little words like "nip", "hop", and "pop" as referencing actions as simple, low cost and abbreviated. In this instance, the surgeon frames this offer as requiring little work and thus not a major problem, perhaps making it more likely for the patient to accept the treatment recommendation if it is only a minor thing to undergo. Moreover, even though the surgeon has found and initiated a new problem that the patient now needs to cope with (and pay for), the straightforwardness with which he delivers this

line presents this as a minor, and easily resolvable issue. In fact, later in the visit the surgeon tells the patient that he can take care of this while the patient is under for the colonoscopy, essentially offering this procedure at no additional cost minus the pathology report.

And as discussed before, 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 1996b). By doing this, the surgeon assumes (and displays to the patient that he assumes) that the patient is already on the same page with him about what he's talking about via touch. Thus, by using a locally subsequent form the surgeon treats the patient as already aware of this problem. 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 this taken care of.

Thus, depending on the specific circumstances of an additional concern, how involved the treatment recommendation is, whether or not the surgeon believes the patient is already aware of it, and so forth, surgeons can decide whether to present their noticings as dispreferred or preferred turns-at-talk. Core to the field of applied Conversation Analysis in medical interactions, this finding conforms to the idea that doctor/patient interactions are co-constructions with participants taking cues from one another on how to *produce* and *understand* actions through the course of the medical visit (Heritage and Clayman 2010).

## 4.6 LIST OF DILEMMAS SURGEONS FACE WHEN SHARING A PERCEPTUAL NOTICING

By examining the entire collection, several dilemmas emerged from the data that I observed repeatedly shaping these interactions. I will outline four of the dilemmas that I deduced surgeons face when deciding how to best formulate and frame their noticing to the patient. I argue that surgeons are oriented to these dilemmas when raising these additional concerns, and

consequentially these dilemmas influence how noticings are shared with patients. These dilemmas are evident in the talk itself, as surgeons carefully select how to initiate unexpected attention to an area of the body the patient is neither there to be seen for nor has expressed concern about. While surgeons most likely do not grapple with this entire list of dilemmas for each and every case, I venture that several dilemmas are at stake for most. In no particular order, I found the following dilemmas surgeons face when figuring out how to share perceptual noticings with patients:

**1. Patient awareness**

a. The surgeon may or may not know if the patient is already aware of this problem. Because of the social prohibition against telling others what they already know (Goodwin 1979; Sacks 1973, 139; Terasaki 2004), this can lead to the interactional dilemma of deciding how to frame the noticing of and/or reference to the area of concern. Should the surgeon frame it as an already known problem to the patient (as in Case 4 with the cyst) or as a concern the patient may not be aware of (as in Case 1 with the parotid gland tumor)?

Patient awareness also can create difficulties for the surgeon on how to first refer[41] to the area of concern. For instance, "your psoriasis" (Ex 3), done without a diagnosis or explanation of what having psoriasis means, treats the patient as already aware of this condition. This in contrast to the surgeons detecting pterygiums in the patient's eyes (Ex 4), in which the surgeon describes and defines this medical term, treating this as new news for the patient.

b. In addition, not being aware of physically perceivable concern can threaten a patient's role as a good patient who actively participates in the maintenance of his/her health. This involves

[41] As Sacks described in ordinary talk (but it also applies to this doctor/patient interaction), it is the speaker's responsibility to design references as recipient designed. He writes, "If possible, select a description that you know the other knows" (pg. 148) and one should also do so with the most brevity as possible (1992: II).

monitoring their bodies and seeking medical help for ailments (see Parsons 1951 on patients assuming the "sick role"). We saw this dilemma at play in Case 3, in which the patient asserts his being a good patient by alerting the surgeon that he already has schedule an appointment with his dermatologist to discuss his history of melanoma on his forehead. The patient demonstrates that, unrelated to the surgeon's noticing, the patient already was on top of this situation.

In sum, if the area of concern is not new news (as in Case 3), then that can be a problem, but if it is new news (as in Case 1), then that is also a problem.

**2. Rights to assess**

a. Do surgeons have rights to assess concerns that fall outside of their domain of expertise? This dilemma is also evident in the Case 3 in which the patient pushes back to the surgeon's question that presumably was going to ask the patient if he's been having that spot looked at. The patient interjects with an announcement of his dermatology appointment, which directly addresses this domain issue. The patient treats his melanoma as outside of the general surgeon's domain, as does the surgeon when he begins to inquire about the patient seeing another doctor about it.

b. Do physicians have rights to assess a patient's whole body, including areas that are not-related to the focal concern of the visit? Do surgeons and patients operate under a tacit assumption that patients hand over their entire bodies to be evaluated when they step into an exam room? This orientation to examining patient's whole bodies (and not just the focal area of concern) is often oriented to with general statements prior to beginning the physical exam. I often hear surgeons tell patients that they're going to check them over from "head to toe", which alerts patients to anticipate all of their body to be looked at, not just their hernia, gallbladder, etc.

To illustrate this point further, in Case 1 the surgeon is interacting with a first-time patient. When transitioning out of the history-taking phase and into the physical exam phase, he first announces what he's going to do, "Listen, we're going to check you over here" and then asks for consent, "With your permission it looks like you're due for a pap smear" and accounts for his belief in providing this care if the patient is overdue for one. With this 'online explanation' (Heritage and Stivers 1999) providing a description of what is going to happen next, with or without a request for permission, surgeons cope with this dilemma of bodily access.

c. For outside domain, chronic medical concerns that surgeons already know that the patient is aware of, which participant has the rights to assess? The surgeon, who has limited expertise? Or the patient, who may be more familiar with this particular concern but lacks professional expertise (see Billig et al. 1988 on doctor's authority vs. patient knowledgeability)? In Case 1, we can see the surgeon deferring to the patient in her rights to first assess the reoccurrence of her parotid gland tumor, a medical condition that does not fall inside the general surgeon domain.

**3. Health optimization**

The less a patient has to cope with medically, the better. Thus, it is not an optimal outcome when surgeons notice extra areas of potential concern, especially when the patient does not seem to be aware of its existence or reoccurrence (Case 1). Additional concerns can be considered a form of bad news, a difficult informing to share (Maynard 2003).

**4. Other contextual factors**

These are more specific to particular patients. These factors may relate to something that has already been said previously in the visit that can lend itself to making a new noticing problematic. For instance (Case 2), one patient in his mid-70s expressed frustration in getting old, seemingly depressed about the continuous physical struggles he's had to overcome. For this patient, adding anything on to this list of possible concerns would not be welcomed news.

Because humans normatively operate under the *interaction order* of social affiliation (Goffman 1967; 1983), the way surgeons formulate their noticings can display the interactional work and cushioning they do in order to combat these potential dilemmas.

## 4.7 FUNCTIONS OF SURGEON-INITIATED NOTICINGS

Surgeons sharing noticings in first-position about unsolicited and extra concerns on patients' bodies is an inherently delicate form of social action. Indeed, I claim that these surgeon-initiated noticings are typically dispreferred first-actions, and surgeons need to carefully navigate through numerous interactional dilemmas in order to arrive at the most appropriate turn-design. What then is gained by surgeons sharing these noticings? The benefit seemingly must outweigh the interactional costs in the surgeons' minds in order to justify relaying this information. Recall, surgeons potentially threaten patient's presentation of self and rights to evaluate their own bodies, increase patients' stress and financial strain, tread into medical territories outside of their general surgery domain, extend into areas of the patient's body that s/he has not come in prepared to discuss, and add to the rampant problem of over-medicalization in our society. They may also be heard as self-interested and touting for additional business. If

these surgeon-initiated noticings are potentially so problematic, why do surgeons bring them to surface.

I have found three distinct functions that these noticings may serve.

**1. To alert the patient to an area of concern** that the patient may (or may not) be aware of already. There is only one way for the surgeon to gauge whether or not the patient is aware of the problem and/or if this area of concern is already being dealt with—and that is to initiate a discussion about it. Because early detection and treatment is considered optimal medical care, by telling patients about abnormalities, no matter how small or relevant to their domain, these general surgeons prioritize a high standard of care over the dilemmas they must consider when sharing. That is not to undermine the delicacy work that surgeons perform when designing their noticings, but they rather choose to face patient resistance then not to share it.

**2. To build and maintain relationships with patient 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 patients that physicians care about them is by the act of remembering. Remembering to inquire about a melanoma spot on top of the patient's head extends beyond just providing physical care. It is the fact that the surgeon cared to inquire about a problem that he recalls the patient had worried about in the past, even though it is not inside his domain of practice, helps to build a trusting relationship with his patient across time. This benefit surpasses the immediacy of whatever this singular doctor-initiated noticing addressed.

**3. To curtail future patient worry.** There are a couple cases in this collection in which the surgeon informs the patient about an abnormality but then immediately dismisses it as non-problematic (to a greater degree than just minimizing it). For instance, a surgeon spotted some sunspots on the patient's back when listening to his lungs and shares, "You have a couple of these just sun- what I call kind of like sunspots on on your back. That that don't look like anything bad at all but it's just that you got-Most patients have a th-thousand of them on their back and you just have two." I asked this surgeon why he bothered pointing out something to then immediately tell the patient there is nothing to worry about, and he told me that he has known this patient for many years and knows that if this patient spotted these spots at home on his own, he would get very worried and immediately want to be scheduled for an appointment ASAP. The surgeon's intent, as he told me, was to prevent this patient from unnecessary worry and an "emergency" visit.

## 4.8 DISCUSSION & CONCLUSION

Unlike the norms of ordinary conversation concerning the registration of positives in interactants' physical and social milieu where there is a preference for noticings over announcements (Schegloff 2007). I conjecture that in this institutional setting the preference is actually for patient announcements over physician noticings. As discussed in the previous chapters, patients frequently and actively seek opportunities to initiate new concerns. I found that patients raised additional concerns when surgeons were near an area of concern. Besides making sure that this concern gets on the interactional table, an affordance of being the first to raise an additional concern, especially for concerns that are outwardly and physically noticeable, patients avoid the perception of not having noticed an abnormality for themselves. By being the first to mention it, patients also prevent surgeons from having to do this work. Recall that

patients initiated concerns that were fitted-to-the activity, which means physicians were in position to notice this area of concern, 51 times (and from a slightly smaller collection of visits). I argue that this helps show a preference for patients to initiate over surgeons.

While these perceptual noticings were not deliberate search missions on the quest for additional concerns, by conducting thorough head-to-toe physical examinations of patients and by being co-present in a small exam room that necessitates maneuvering bodies in close proximity with one another, these surgeons actively work to create opportunities for these noticings to occur. In an age of over-specialization in medicine in which patients' bodies are segmented and require going to see a separate type of physician for each myriad fragment, it can be difficult for patients to get their whole bodies assessed in one visit. Each specialist can assume that another specialist will see to the other parts of the body that they are not responsible for. Each specialist also can assume that patients regularly see a family doctor to look at their entire body. The problem lies in all of these assumptions, with patients not having a family doctor, or medical concerns can slip through the cracks if they fall near the edges of domains of practice. Yes, patients are probably seeing more doctors and having more medical appointments now than ever, but more care does not guarantee better care. Ask any cook about the phenomenon of too many cooks in the kitchen.

While 22 instances of perceptual noticings may be a small number, these are 22 instances in which patients potentially received help that they may never have gotten. While patient responses to these doctor-initiated noticings will be saved for another analysis, I do want to share that there are mixed reactions. Surgeons do get patient push-back, that they already know about the area and are not worried about it, that their specialist who deals with that area of their body never mentioned it so why should a general surgeon, etc. But there were some cases in which

patients were incredibly grateful that the surgeon had raised the issue. In some cases it was a problem that had literally been bothering them for decades, and they had just assumed that were was nothing to be done to fix it since no doctor had ever offered to help with it. I strongly advocate for physicians to err on the side of over-mentioning rather than under-mentioning. They have the interactional tools to articulate these dispreferred noticings delicately, they just have to use them.

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# Chapter 5: Conclusions

This dissertation examines the initiations of additional concerns during pre-operative and post-operative general surgery office visits. Analysis of *how* and *when* these concerns are launched was conducted from both sides of the interaction, from the patient's and surgeon's positions. While there are different interactional difficulties or dilemmas to overcome (e.g., the "one visit equals one problem" dilemma for the patient or the health optimization dilemma for the surgeon), participants have a variety of practices in which to launch and present their concerns.

While additional concerns are unrelated to the focal reason for the visit, they can be vital to the patient's health and are important for researchers and physicians to recognize. Furthermore, even though these initiations are extras, in a sense, they may be consequential for the long-term relationship patients and surgeons have. Especially in a rural setting, where access to other surgeons is limited, the maintenance of their relationship may mean the difference between patients returning for follow-up appointments and/or other routine care.

By addressing a patient's additional concerns, inquiring about past medical concerns, and drawing the patient's attention to new noticings of potential concerns, the surgeon's actions can reverberate across time and space. Patients can assess the type of care they receive in that moment in time, which can later affect how they conduct themselves in future visits. If a surgeon appears receptive to spending extra time with patients and helping them with additional concerns, then assumedly patients will feel more open to raise other concerns in future visits as well. A benefit of having a limited number of local physicians is that continuity of care and seeing the same doctor for years (if not decades) is almost guaranteed for patients. As one

patient I interviewed explained to me about the benefit of knowing his surgeon for many years, "Having a personal relationship with your doctor is very important. I know Dr. Allen really well and feel comfortable talking to him about anything. I'm not like that with new doctors." This patient continued to tell me about how he recently was in the hospital because of a strep infection, and, "When I was in there, Dr. Allen would stop by two to three times a day just to talk, shoot the breeze, and watch the Olympics." He told me that he felt very comfortable raising additional concerns during his office visits. Another patient echoed this sentiment about continuity of care and the importance of having a long-standing relationship. She told me that her surgeon "knows me and knows all my daughters by now, so I feel comfortable blurting out whatever is on my mind."

Additionally, patients can share with their other local physicians the type of care they received from their general surgeon, similar to the interactions often seen in this data collection in which patients relay to their surgeon other medical interactions and types of care they receive from other doctors. When patients share information with their families and friends in the community about what type of care they received by which doctor, this becomes working knowledge that contributes to patients' sense of expectations of the type of care they will receive. When I asked one patient about how she knows what type of care different doctors provide in town, she said, "I know from talking to people in town and by talking to people in the waiting room and by talking to my friends. I saw my friend who has breast cancer in the waiting room here right now, and I wasn't surprised to see her here." By seeing her friend in this particular setting and by knowing her condition, this helps to inform and reinforce her understanding of what types of care these types of physicians provide. Furthermore, because local doctors work within close proximity of one another, many sharing the only professional building in town, and

all working at the one community hospital, domains of expertise and the type of care provided by each physician is transmittable knowledge and consequential to the doctors' professional relationships.

As seen in this dissertation, patients do orient to additional concerns as being inside or outside the general surgeon's domain by way they frame their concern, and we often see surgeons providing help to concerns both inside and outside their area of expertise. Surgeons also can notice areas of concern outside their expertise and share them with patients. "Turf battles" in the medical field can be a real source of contention amongst physicians, especially in this rural area where finances are strained and during this time in which Medicare is reimbursing less and less. Seeing at the ground-level how these boundaries of domain of expertise get stretched, both by the patients and general surgeons, helps explicate how turf battles transpire.

Studying interactions in this particular setting, a rural specialty practice, has resulted in a collection of additional concern initiations that has revealed behavior unique to any previous findings so far. This was the ideal setting to study this phenomenon because of the close, long-term relationships that patients and their surgeons have. These relationships engender a hospitable environment for patients to feel comfortable and entitled to seek extra attention. This demonstration that patients are capable of, and indeed already are, taking an active role in their medical care can provide insights into other contexts as well. While this dissertation is unique in studying a general surgery practice, because these surgeons extend their care well into the primary care domain, there are applicable findings for both primary care and specialty care studies in similar settings.

## 5.1 THE FINDINGS

### 5.1.1 CHAPTER 2: PATIENT-INITIATED ADDITIONAL CONCERNS

This chapter begins by defining the phenomena of a patient-initiated additional concern (and all the coding parameters thereof). In sum, patient-initiated additional concerns are defined as on-going medical concerns that are unrelated to the main reason for the visit and that patients raise on their own initiative. The 377 instances of these initiations revealed that patients used three different methods to initiate additional concerns during their office visit with their general surgeons: the *fitted-to-topic*, *fitted-to-activity*, and *disjunctive* methods. The fitted-to-topic method was found to be the most frequent method patients utilized, comprising two-thirds of the collection, followed by the disjunctive method (20%) and the fitted-to-activity method (15%).

This chapter next examined when patients raise these concerns, both at the visit and treatment level. These general surgery visits were categorized into three phases: *pre-physical*, *physical exam*, and *post-physical*. In contrast to previous research on additional concerns (which focused on acute primary care settings) that found that patients typically raise additional concerns during the closings of visits, this collection discovered a different finding. In fact, the pre-physical phase of surgery visits was the *most* likely phase that patients initiated additional concerns (60% of the cases), while the post-physical phase was the *least* likely phase for additional concerns to be initiated (only 14% of the cases).

When looking at the relationship between the how and when of patient initiations, it was found that 75% of the time patients used the fitted-to-talk method when raising concerns during the pre-physical phase. I argue that this shows patients are closely monitoring the interaction and are quickly finding opportunities to transition into additional concerns. Likewise, the disjunctive method (while more evenly dispersed across the phases), also was used the majority of the time

in the early phase of the visits. Thus, patients are demonstrating a strong level of initiative, not waiting until the end of the visit to raise "door knob" concerns, nor are patients taking the backseat in the interaction, waiting to be asked for direct solicitations about additional concerns. It is not too surprising that almost all fitted-to-activity concerns (96%) were raised during the physical exam.

Lastly, this chapter looked at these additional concern initiations at the treatment-level. Taking a longitudinal perspective by examining whether initiations occurred *pre-operatively* or *post-operatively*, it was found that patients more often raised additional concerns before their procedures (60% of the time). This analysis found the fitted-to-topic and disjunctive method shared an equal distribution across all visits and were only slightly more likely to occur during pre-operative visits, while the fitted-to-activity method was much more likely to occur during pre-operative visits (4:1).

### 5.1.2 CHAPTER 3: WHICH PATIENT INITIATED CONCERNS RECEIVED HELP?

This chapter investigated whether the ways patients initiate additional concerns impact how surgeons respond to them. In other words, does the method, phase and design of a patient-initiated additional concern affect the patient's likelihood of receiving help? And does the design of additional concerns index how accountable patients hold surgeons to provide help for particular types of concerns?

This chapter begins by defining what a patient receiving "help" entails and then discusses the characteristics that patient-initiated additional concerns were coded for including: the type of method used to initiate the concern (fitted to topic, fitted to activity, disjunctive), the phase of the visit (pre-physical, physical examination, post-physical) and treatment phase (pre-operative or post-operative) the initiation occurred, whether the concern was physically evaluable, if it was

the first or subsequent mention, if the concern was acute or chronic, whether the concern was inside or outside the surgeon's domain, the social action of the concern's design (informing or inquiry), whether the patient mentioned another doctor and/or another treatment plan, whether the patient included a qualifier when describing the concern (which could intensify or diminish), and the degree of relationship that the patient and surgeon shared (on a scale from 1-4). Qualitative predictions were presented first about how these characteristics would individually increase or decrease the patient's likelihood of receiving help.

The chapter then moved on to analyze four examples of patient-initiated additional concerns using Conversation analysis and ethnography. The purpose was to both illustrate the coding scheme and to see how these characteristics operated at the individual level. The surgeon's responses were then provided to reveal whether the patient received help or not. Following this qualitative analysis, aggregate level findings were discussed to see if there were larger trends and patterns to be found. In order to do so, two GLMM models were run to assess which factors better predicted, respectively A) whether a patient's initiated additional concern received help and B) the patient's social action type in raising the concern.

Results of Model A revealed that patients were 56 times more likely to receive help for initiations designed as an inquiry than those designed as an informing, 3 times more likely to receive help for subsequent mentions vs. first mentions, 5 times more likely to receive help for acute concerns vs. chronic concerns, and 4 times more likely to receive help when the concern was raised during the pre-physical phase (the other phases had no significant findings). Examining the two-way interaction between surgeon domain and method revealed that when the concern was inside the surgeon domain the odds of the patient receiving help were 64 times larger when the concern was presented as fitted-to-the-activity and 11 times larger when the

concern was presented as fitted-to-the-topic than the odds of the patient receiving help for concerns presented as disjunctive. On the other hand, if the concern was outside the surgeon domain, the odds of the patient receiving help for a concern presented as fitted-to-topic were 6 times smaller than the odds of the patient receiving help for concerns presented as disjunctive while there was no difference between concerns presented as fitted-to-activity vs. disjunctive.

Lastly, the impact of including a qualifier (or not) in the concern's formulation was heavily conditioned on whether the concern was inside or outside the surgeon domain. If the patient tried to intensify a concern that was inside the surgeon's domain, then this actually did not work to the patient's advantage of getting helped. Surprisingly, patients drastically increased their likelihood of receiving help (for inside concerns) when they diminished their concern or did not use a qualifier in comparison. For outside domain concerns, qualifiers impacted the outcome of receiving help to a lesser degree.

Model B investigated the patient's Social action type (either inquiry or informing) in raising the additional concern. Social action was chosen as the best proxy for measuring patients' senses of entitlement for initiating a concern and how accountable they hold surgeons for providing help. Results revealed that patients were twice as likely to design a concern as an inquiry for an inside domain concern than an outside domain concern, and concerns initiated with the disjunctive method were more likely to use the inquiry design than the fitted methods. This model showed that patients matched their levels of entitlement with the degree of accountability they held the surgeon providing a response to—high entitlement paired with a high level of accountability for response, and low entitlement paired with a low level of accountability for response. Informings were more commonly found in contexts where patients displayed lower expectations for receiving help (for example, in contexts where they mention

seeing another doctor or already having a treatment plan). While in contrast, patients asked questions when they expected help (like when the additional concern falls inside the surgeon's domain).

### 5.1.3 CHAPTER 4: SURGEON-INITIATED NOTICINGS OF ADDITIONAL CONCERNS

This chapter shifts attention from patient initiations to surgeon initiations of additional concerns. This analysis focuses on perceptual noticings of physical abnormalities on the patient's body as the impetus for the surgeon raising an additional concern. Surgeons can use any of their senses (sight, touch, hearing, or smell) to notice a physical abnormality on the patient's body. These can occur during any phase of the visit, but occurred most often during the physical examination phase when the patient's bodies were most exposed. This chapter seeks to answer several questions about surgeon-initiated noticings. How do surgeons design and deliver them? When do they deliver them? And what are the functions of these noticings?

Surgeon-initiated noticings were found in only 8% of the office visits. In reviewing the 22 cases of articulated perceptual noticings that comprised this collection, I found that a large majority of this collection exhibited at least some of the characteristics of dispreferred turns-at-talk. Surgeons often delayed, reformulated, minimized, and hedged when sharing the additional concern with the patient, and often avoided articulating the actual problem by using subsequent reference forms. In other words, surgeons' perceptual noticings were delivered not as good news but instead with a cautious, dispreferred manner akin to Maynard's (2003) bad news findings. Dispreferred turns-at-talk have been most often studied when in the responsive position, and this chapter hopes to contribute to the small but growing literature on first-position dispreferred turns (Heritage and Sefi 1992; Robinson and Bolden 2010).

Surgeons share noticings with patients when there is something actionable to be done. In other words, they are delivered for cause and not just for observation's sake. Surgeons framed their noticings as requests for information, requests for action, or as evaluations and used different frames to tilt their observations towards varying levels of seriousness. Surgeons almost always shared their noticing "online", meaning the articulation of the medical abnormality happened adjacent to the noticing of it (cf. Heritage and Stivers 1999). The advantage of online noticings is that joint attention is already achieved as a product of haptic connection.

This analysis found that the general surgeons faced four interactional dilemmas when deciding how to frame and when to share perceptual noticings with their patients, which is made evident when examining the delicacy work found within these turns-at-talk. These dilemmas included patient awareness, rights to assess, health optimization, and other contextual factors. An argument was made for patient initiated concerns as preferred over surgeon-initiated, as it helps solve the patient awareness dilemma and allows the patient to present themselves as fulfilling their role as a good patient. Lastly, three functions of these noticings were found. Surgeons can alert the patient of an area of concern, build and maintain relationships with the patient across time, and curtail future patient worry.

## 5.2 METHODOLOGICAL CONTRIBUTIONS

This dissertation hopes to contribute to the growing emphasis on mixed-methods approaches in Sociology and to demonstrate how, when combined, Conversation Analysis and ethnography can strengthen each other. The high level of objectivity of Conversation Analysis complements the ethnographic knowledge I gained by spending time in the field and following patients' medical care across multiple visits. These methodologies, both rooted in the inductive approaches of grounded-theory, first and foremost are grounded in the interactions. By looking

at what the participants are doing, I was able to find reoccurring themes, build a collection, and center my analysis around the data. Additionally, these methodologies deal with the construction of social meaning that are important to the participants themselves since they are the ones performing this interactional work. Seeing how initiating additional concerns is both a delicate undertaking for patients and for surgeons is remarkable since they come into the interaction with different levels of expertise, roles, and entitlements. I found that by understanding both the context (provided by ethnography) and the details of the talk (provided by CA), generated the best landscape from which to generate analysis from.

Next, by developing a deep understanding of the data after conducting qualitative analysis, statistical analysis was introduced. Again, a grounded-theory approach was used when creating the coding schema for the statistical models and assessing which interactions to run. By having both case-level analysis and aggregate level analysis, this dissertation hopes to serve as an example of the possibilities that these multiple viewpoints can provide.

Finally, this dissertation hopes to demonstrate the importance of a longitudinal data collection. To my knowledge, no other Conversation Analysis applied medical analysis has followed patients through the trajectories of their illnesses. This examination of consecutive visits in order to see how an additional concern can flare up and become more pressing across time, or conversely disappear and not be discussed again, was important for me to see the bigger picture of this phenomenon. Patients and surgeons do not have one-off encounters, so analyzing them as such can be a disservice to them and to our findings of them. This project demonstrates that it is possible to collect this type of data, patients are willing to participate to studies for an indefinite duration, and office staff can be instrumental in effectively, inexpensively, and reliably collecting data.

## 5.3 IMPLICATIONS FOR PATIENTS & DOCTORS

My aim for conducting applied research is to illuminate aspects of these interactions that help participants understand each other better. Doctor-patient communication has a notorious reputation for its shortcomings, and not only can this lead to tense interactions, distrust and confusion, but it can also have real life and death consequences when communication failure leads to misunderstandings. Indeed, recent research reports that in years spanning 2009-2013, 1,744 deaths and $1.7 billion in hospital costs is a direct result of communication error. And these were only deaths that resulted in malpractice suit, which researchers believes only scratches the surface of all the additional fatalities that go unreported (CRICO 2017).

As this dissertation has shown, the way patients initiate a concern can affect how surgeons respond, and some of these practices have non-intuitive consequences. While guidelines from the National Institutes of Health already recommend that patients write down a list of concerns to discuss before the office visit to help ensure patients can remember all that they want to discuss (an act that only one patient did in my entire collection), this does not capture how patients raise additional concerns that were triggered from the interaction itself. Just as walking the aisles of a grocery store evokes all sorts of needs that one forgot about when at home making a list, being in front of a doctor, talking about certain topics, or having one's body positioned in a certain way, can stimulate concerns that patients themselves might not have realized they wanted to discuss. Similarly, when directly asked by the doctor if they have any other (or some other) concerns they would like to discuss, this may not conjure all concerns either. That is not to discount that patients may also have additional concerns that are pressing and on the forefront of their minds (the ones that would make the written list), but the

methodology and analysis of this dissertation was able to capture and understand the more nuanced ways that interaction occurs and additional concerns are initiated.

That is why the talk itself is so important in these visits: it provides jumping off points that can spur patient needs. My suggestion for physicians is to pay closer attention to the more subtle ways patients are introducing concerns into the conversation. Not all patients explicitly ask for help, but instead they may be seeking help in indirect ways. Patients informing one doctor about the care they receive by another doctor could be an indirect request for confirmation, and these initiations can occur at any moment in the course of the visit, not just at the end.

Additionally, the physical examination was found to be a vital phase for both patients and surgeons to initiate additional concerns. Patients initiated nearly a quarter of additional concerns during the physical exam, and it is not too surprising that almost all fitted-to-activity concerns (96%) were raised during the physical exam. I believe that one of the most important findings of this dissertation is that the physical examination phase has value beyond the surgeon performing diagnostic or assessment work. Rather the time spent touching and maneuvering the patient's body opens up opportunities for patients to raise concerns that they might not have felt comfortable initiating by fitting them to talk or by using disjunctive methods. While the physical examination is a diminishing act that seems to be getting replaced with other diagnostic tools like ultrasound results, lab results, etc., it may be important for this phase to be maintained because of its rich breeding ground for additional concern initiations.

## 5.4 FUTURE STUDIES

I hope that this study can serve as a comparative site for future rural medicine studies and invigorates other scholars to become interested in how different (and similar) small-town

medicine is practiced. By expanding this type of research to other communities, I could then determine whether this dissertation's findings are generalizable to other rural physicians and patients, or if the private practice I studied is unique. While the strength of this study is the longitudinal aspect and the in-depth understanding of this particular set of surgeons and their patients, a wider scope would help to expand this limited data base.

There is a sense of urgency for this type of work to be conducted, as rural hospitals are rapidly shutting down across the country. In fact, as I write this conclusion, the County Hospital in Townsville is debating whether the costs of the birthing center warrant keeping this wing of the hospital open. Once women can no longer have babies at their local hospital and must drive over an hour to receive prenatal care from the doctor who will perform their delivery, it appears to be a slippery slope for the future of this hospital. And if the gynecologist leaves town, this will only further stretch the domain of care general surgeons provide, once again performing emergency caesareans like they did in the years lacking a local obstetrician/gynecologist. Telemedicine may very well be the way of the future, especially in these areas that are losing their access to local care. By being able to study this small-town style of medicine being practiced, this can serve as an important comparison for telemedicine interactions.

My plan is to continue studying this group of surgeons for as many years as they will allow me. By doing so, I can track how changes at the local and national level can be seen in the day-to-day lives of these doctors and patients. By being able to follow the same set of participants across time, while my sample may be limited, there is a nice, established control. I am excited that as this study has surpassed the four-year anniversary of data collection, many patients who came in for their routine colonoscopies in 2013 are beginning to return for their follow-up visits. This is especially exciting as the standard of care for colonoscopies has

undergone a transformation in the past year, with a newly improved, non-invasive method of DNA stool sampling becoming a recommended practice (Robertson et al. 2017; van Lanschot et al. 2017). What will this mean for this general surgery practice, that relies on colonoscopies as a large portion of their earnings? How will this new standard of care be discussed with patients who have been socialized into thinking that colonoscopies are necessary? It will be very exciting to be able to capture and analyze such a potentially dramatic standard of care. In sum, there are so many unexpected and unknown healthcare changes in our future, and I believe having one practice to study through these transformations has indefinite potential for our on-the-ground understanding of how doctors and patients relate to one another.

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# Appendix A: Transcription Conventions

Symbols used in the transcription of speech follow the conventions laid out in Jefferson (2004).

The most frequently used symbols appear below:

| | |
|---|---|
| ? , . | Punctuation is designed to capture intonation, not grammar: Question mark for fully rising terminal intonation; comma for slightly rising 'continuing' terminal intonation; period for fully falling terminal intonation. |
| [ | Left-side brackets indicate where overlapping talk (or other behavior) begins. |
| ] | Right-side brackets indicate where overlapping talk (or other behavior) ends (if detectable). |
| (0.5) | Periods of silence, in seconds. The example here indicates a half-second silence. |
| (.) | 'Micropause' (i.e. a silence less than two-tenths of a second). |
| : | Lengthening of the segment just preceding, proportional to the number of colons. |
| wor- | A dash indicates an abrupt cut off, usually a glottal stop. |
| <u>word</u> | Underlining indicates stress or emphasis. |
| WORD | Exceptionally loud speech relative to the surrounding talk. |
| °word° | Speech lower in volume relative to the surrounding talk. |
| ↑word | Marked pitch rise. |
| ↓word | Marked pitch fall. |
| = | 'Latching' between lines or turn-constructional units (i.e. no silence between them). |
| <word | 'Left push' (i.e. the immediately following talk is 'jump-started'). |
| >word< | Speech delivered faster than the surrounding talk. |
| <word> | Speech delivered slower than the surrounding talk. |
| hhh .hhh | Hearable aspiration, proportional to the number of h's. If preceded by a period, the aspiration is an in-breath. Aspiration internal to a word (e.g. laughter, sighing) is enclosed in parentheses. |

| | |
|---|---|
| ( ) | Talk too obscure to transcribe. Words or letters inside such parentheses indicate a best estimate of what is being said. |
| ((looks)) | Transcriptionist's comments (e.g. for non-vocal behavior). |

# Appendix B: List of patient-initiated additional concerns

1. foot drop
2. foot drop
3. muscular & skeletal problems
4. muscular & skeletal problems
5. Charlie horses
6. back/kidney pain
7. rectum issues
8. high iron
9. flu shot
10. testosterone shots
11. sciatic nerve
12. red shins
13. sugar levels
14. shoulder pain
15. gas
16. gas
17. hiatal hernia
18. milk allergy
19. milk allergy
20. sugar levels
21. sciatic nerve
22. erectile dysfunction
23. sugar levels
24. sciatic nerve
25. sugar levels
26. swollen feet
27. sugar levels
28. hernia
29. hernia
30. blood pressure
31. back pain
32. knee problem
33. difficulty breathing/lung problems
34. difficulty breathing/lung problems
35. swollen hand
36. varicose veins
37. leaky heart valves
38. family history of aneurysm
39. hand pain
40. hiatal hernia
41. leaky heart valves
42. bladder suspension
43. feet issues
44. stomach irritation
45. kidney level
46. fatty tumor
47. itching arm
48. itching back
49. heat exhaustion
50. food caught in esophagus
51. stomach issues
52. fluid build up in back
53. hernia
54. back surgery pain
55. knee surgery pain
56. pain medication concern
57. breast discharge
58. hemorrhoid
59. coughing
60. cold
61. coughing
62. sore throat
63. skin tag
64. thyroid issue
65.heartburn
66. stool leaking
67. hernia
68. prostate
69. vision problems
70. spider bite
71. knee
72. increased sex drive
73. disorientation
74. disturbed sleep pattern
75. testosterone shots
77. diverticulitis
78. prostate
79. burning in esophagus/reflux
80. high blood pressure
81. hemorrhoid
82. constipation
83. joints
84. arthritis
85. bleeding from blood thinner
86. knee replacement surgery

87. eyes
88. hernia
89. knee surgery
90. knee surgery
91. cracked knee
92. insect sting
93. reaction to anesthesia
94. hernia
95. medicine allergy
96. knee surgery
97. cold
98. ringworm
99. cold
100. bladder issues
101. neck pain
102. heart murmur
103. irritable bowel flair/colitis
104. irritable bowel flair/colitis
105. chest pain
106. rectal bumps
107. back pain
108. weakness
109. back pain
110. weakness
111. foot bunion
112. stomach pain
113. high blood pressure
114. back pain
115. erectile dysfunction
116. sore spot/hernia
117. bump on scrotum
118. hernia
119. spot on chest
120. diverticulosis
121. rib cage pain
122. hemorrhoid
123. diabetes
124. fibroid
125. diabetes
126. cholesterol
127. celiac disease
128. back/neck pain
129. breast cyst
130. chest pain
131. arthritis
132. celiac disease
133. celiac disease
134. arthritis
135. nausea
136. hip/back pain
137. ulcer
138. back pain/degeneration
139. hip pain
140. face stinging
141. hardening arteries
142. stomach issues/nausea/ulcer
143. back pain
144. arm pain
145. toe pain
146. muscles aching
147. hip pain
148. stomach pain
149. sugar levels
150. back pain
151. gallbladder
152. gas
153. cravings
154. stomach pain
155. low energy
156. high cholesterol
157. high cholesterol
158. low Vitamin D
159. flu shot
160. allergies
161. thyroid
162. high blood pressure
163. low Vitamin D
164. calcium
165. protein level
166. high blood pressure
167. high cholesterol
168. low Vitamin D
169. back pain
170. breast cancer gene
171. coughing
172. hernia
173. prostate
174. bleeding issues
175. hernia
176. hernia
177. feet/leg swelling
178. reflux

179. blood pressure
180. feeling sick
181. coffee induced sickness
182. frequent bowel movements
183. can't concentrate
184. allergies
185. allergies
186. clearing of throat, allergies
187. allergies
188. liver level
189. hip bone pain
190. feeling full
191. weight
192. stones in common duct
193. glaucoma
194. parotid gland
195. sleep apnea
196. pressure tests
197. vein issues
198. diarrhea
199. stool issues
200. gas
201. bloating
202. pancreas
203. leg pain
204. cholesterol
205. thyroid
206. PSVT
207. arthritis/lower back
208. psoriasis
209. bruising
210. hemorrhoid
211. sinus infection
212. lower back problem
213. constipation
214. hemorrhoid
215. shoulder pain
216. shoulder reconstruction
217. collarbone
218. scapula
219. left arm/collarbone pain
220. hemorrhoid
221. left shoulder
222. left scapula flipped
223. sleepwalking
224. constipation
225. diarrhea/hemorrhoid
226. seizure
227. brain tumor
228. history of cancer
229. brain tumor
230. cubital tunnel syndrome
231. kidneys/bleeing in urine
232. constipation
233. hearing
234. ear wax build up
235. irritable bowel syndrome
236. back pain
237. walking pneumonia
238. bronchitis
239. bronchitis
240. back pain
241. bronchitis
242. fibromyalgia
243. yeast infection
244. mental status
245. feeling doped
246. shoulder pain
247. numb arm
248. elbow
249. difficulty swallowing
250. high blood pressure
251. carpal tunell
252. parotid gland
253. frequent urination
254. spot/bump behind ear
255. spot on cheek
256. spots on leg
257. hump on back
258. heart relaxing
259. heart relaxing/anxiety
260. hemorrohoids
261. hump on back
262. urine stream
263. constipation
264. sternum pain
265. head injury
266. coughing/allergies
267. hiatal hernia
268. hip
269. osteoarthritis
270. hip

271. back pain
272. hiatal hernia
273. protonix/medication
274. right shoulder
275. hernia
276. gas
277. knee inflammation
278. sugar level/diabetes
279. sleep apnea
280. knee infection
281. rupture/diastasis
282. coughing
283. difficulty swallowing
284. sinus drainage
285. difficulty swallowing
286. sinus drainage
287. bowel movements
288. tingly tongue
289. tingly feet
290. bowel movement attacks
291. umbilical hernia
292. hearing
293. pain in torso
294. feet
295. spot on liver
296. hearing
297. chemo making him sick
298. chest nodules growing
299. hearing
300. weight loss
301. teeth
302. hearing loss
303. teeth
304. hearing loss
305. cold and tingly feet
306. dry mouth
307. depression
308. anxiety
309. stomach problems
310. neck pain
311. ulcer
312. sugar levels
313. zantac medication
314. PSA level
315. creatin level
316. colonoscopy
317. prostate
318. testosterone
319. testicle
320. spots on arm
321. testicle
322. prostate
323. sugar levels
324. spot on back
325. spot on cheek
326. spot on head
327. back surgery
328. shortness of breath
329. heart issues
330. sore throat/sinuses
331. pain medication for back injury
332. blood in urine
333. pancreatitis
334. pancreatitis
335. stress
336. pain medication
337. anemia
338. pain medication
339. feet
340. hands
341. prolapse
342. hemorrhoids
343. hands
344. PTSD
345. thyroid
346. PTSD
347. pain medication
348. hands
349. PTST
350. bone spurs in hands
351. disability form
352. PTSD
353. bladder infection
354. leg
355. losing weight
356. pain medication
357. fatty liver
358. fatty liver
359. kidneys
360. swollen lymph nodes
361. ulcer
362. prostate

363. prostate
364. prostate/bleeding issues
365. back problems
366. right foot
367. right foot
368. back problems
369. cold intolerance
370. foot
371. thyroid medication
372. inflamed joints
373. rib
374. neck pain
375. liver pain
376. liver pain
377. prostate