Accomplishing a request without making one: A single case analysis of a primary care visit

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Abstract

Physicians and other care-givers need to recognize the various and often subtle ways that patients make initiatives, such as requesting medical interventions, in medical encounters. Prior research on patients' requests and physicians' responses has limited real-world relevance because it treats 'requesting' and 'responding' as straightforward, discretely codable categories. In this study, we use conversation analysis to investigate how a primary care patient delicately hints that an HIV test is warranted and how her physician recognizes (and responds to) her implicit request for this diagnostic test. Our findings provide an empirically grounded and detailed account of some of the subtle interactional dynamics involved in making and responding to medical requests. By documenting the diversity of patients' and physicians' practices, we will gain a more comprehensive understanding of patients' initiatives, physicians' responsiveness, and patient-centered behavior.

Keywords: *conversation analysis; physician–patient interaction; patients' requests; patients' questions; HIV testing.*

Introduction

At a time of increased interest in patient-centered medicine, more attention is being directed to patients' participation in and satisfaction with their health care. To these ends, investigators have approached the difficult problem of understanding the relationship between patient needs and physician responsiveness by administering pre- and/or post-visit surveys of both parties' expectations and perceptions of clinic visits (Britten and Okoumunne 1997; Butler et al. 1998; Cockborn and Pit 1997; Eisenthal and Lazare 1976; Eisenthal et al. 1990; Froehlich and Welch 1996; Good et al. 1983; Joos et al. 1993; Kravitz et al. 1994;

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Macfarlane et al. 1997; Mangione-Smith et al. 1999; Peyrot et al. 1998). However, it has not been possible, as yet, to determine *whether* and *how* patients actually express their expectations during clinic visits, nor is it possible to know the specific, detailed ways that physicians respond if expectations are made manifest. Additionally, in the studies that investigate the relationship between physician responsiveness and patient satisfaction (Brody et al. 1989; Joos et al. 1993; Kravitz et al. 1994; Like and Zyzanski 1987), the relevant phenomena are conceptualized as essentially binary categories: request or absence of request, the granting or refusal of a request. Such an approach cannot take account of the subtlety and complexity of social interaction; whether or not an activity or series of activities amount to a request is a matter that the participants work out in interaction.

Our analysis of 'a request' is thus bounded by participant actions and displayed orientations. It attempts to fill in the interactional detail that has been missing in prior research. We show how a patient's implicit request emerges over time and how it is responded to as such by a physician. Such attention to requesting as an emergent activity gives a more nuanced understanding of request/response sequences, and a firmer foundation upon which to conceptualize their relationship to matters such as patient satisfaction. Equally important, it shows how patients orient to initiative taking (e.g., requesting medical action) as a delicate activity, a finding that fits with emerging understandings of lay diagnosis.

That patients may formulate their initiatives as delicate activities is related to prior research detailing how, in primary care visits, patients use a variety of methods to show themselves to be appropriately oriented to 'lay' versus 'professional' knowledge and activities; for example, patients may downplay their knowledge about candidate causes for illness or show that they are appropriately attentive to bodily symptoms rather than over or under vigilant (Drew 1991; Gill 1995, 1997, 1998; Halkowski, to appear; Heath 1992; ten Have 1991). Thus, patients manage to put a symptom on the table in such a way that they are seen as observing their bodies in 'appropriate' detail (Halkowski, to appear), and they can put explanations on the table by reporting circumstances in particular sequential contexts and allowing doctors to formulate the upshot (Gill 1995, 1997; Gill and Maynard, to appear). In this way, potentially delicate actions (e.g., 'explaining to the expert') are accomplished through more routine actions, such as reporting (see also Stivers, to appear).

Furthermore, requests for medical action (such as diagnostic testing) are relevant only in the context of some suspected health problem or risk factor: a candidate health issue must be available to which the intervention

is addressed. Thus, for a patient to request an intervention may entail making a candidate diagnosis or proposing a level of risk. In short, calling for an action on the doctor's part (by making a request) is a delicate matter in part because it may also involve these other activities that are typically 'doctor's work', territory in which patients tread lightly.

While the delicacy of requesting in medical encounters may be salient,[1] such an orientation is not surprising where even in everyday interaction it seems that requests fall under the rubric of actions best entered into from an angle: if one does not actually ask, one can avoid being refused outright (although tacit refusals are still possible). Sacks addresses this phenomenon of 'getting something done without ''doing'' it' in terms of achieving interactional outcomes, where the surface form of the utterance does not convey its literal meaning, yet accomplishes something: 'requesting help' by asking for information (e.g., Sacks 1995, vol. 1: 72–80), or 'stating your own name' as a way of getting someone else's (Sacks 1995, vol. 1: 3–11), or using a repair initiator (e.g., *What?*) to preliminarily avoid some disclosure (Sacks 1995, vol. 2: 413).[2]

Thus, we see oblique requests as addressing two simultaneous matters: On the one hand, in medical encounters, to request presupposes some determination of a candidate health problem or some level of risk for a problem; on the other hand, to request is to open the door to the awkward if not face-threatening prospect of being refused. Patients and doctors draw on resources of everyday talk to maneuver through these dilemmas. Here, we use conversation analysis to document the methodical coproduction and organization of a request/response sequence which, on the face of it, is not such a sequence. We examine this in a case study of a primary care clinic visit.

In the visit analyzed here, a middle-aged woman neither requests an HIV test nor asks the doctor for reassurance, yet the plan of action eventually articulated by the physician is to check some blood counts and thus 'reassure' the patient and himself that AIDS need not be a cause of concern. How is this physician's plan of action to be accounted for? What sequence of activities leads to this physician's 'response' to a 'request' that was never made?

To begin with, the patient in this visit raises her concern about AIDS in an oblique way; she reports a fact that had always worried her children: She had blood transfusions in the early 1980s. She thus casts the concern as her children's, not her own, while still getting that particular fact on the table. She subsequently designs an utterance which is framed as a question from her children ('Did you ever get tested for AIDS?') and takes the opportunity space to answer it ('No, I never got tested for AIDS'). These circumstances (she had blood transfusions in

the early 1980s and she has never been tested for AIDS) may indeed warrant medical action, but she presents them in such a way that no request is actually made. Rather, she designs her contributions such that it is her 'kids'' worries that are reported and need to be addressed; in this way her contributions are sequentially designed to get facts on the table without appearing overly concerned.

The doctor and patient 'chuckle together' over this issue of AIDS and he treats her contribution as a bid for reassurance, providing a statistical formulation about the unlikelihood of her being infected. The patient agrees with his assessment, still maintaining a stance of taking the concern lightly. However, later in the visit, once a set of symptoms is raised and the patient displays persistent 'ignorance' about the cause of her symptoms, the physician upgrades the doctorability of her concerns and parenthetically remarks that by looking at some blood fractions he will 'reassure' himself and her that she does not have AIDS.

Thus, the physician is responsive to the patient's concern about AIDS, though his response is more subtle than simply 'granting' or 'refusing' a request for an HIV test (or even a blood test). As our analysis details, the subtlety is accomplished over the course of a long sequence of utterances, and is made possible because patients and doctors, like all conversationalists, use sequencing as a sense-making resource. The relevance for the diagnostic test is built over time, rather than occurring as a single event such as 'a request'. By documenting the complexity and diversity of actual practices, we aim to develop a clearer sense of what it means to be 'patient-centered' and 'responsive' to patients' initiatives.

Data and methods

This article focuses on a videotaped clinic visit, one out of a corpus of videotaped clinic visits collected in the late 1980s in a general internal medicine outpatient clinic. The clinic is located in a teaching hospital in the Midwestern United States.[3] The videotape of the clinic visit was transcribed according to Jefferson's (1974) conventions. Using conversation analysis, we describe the conversational resources the patient uses to raise the possibility that she has a serious health condition, and the resources the physician employs to propose how it should be dealt with (initially and after subsequent talk that apparently leads him to the conclusion that the concern was not adequately addressed). Our concern is not whether these are typical methods or practices in doctor–patient interaction, but rather, it is to show the endogenous organization of this particular case (Schegloff 1987) and to explore in detail the practice of delicacy in requesting and responding.

Background

The patient, a 59-year-old white female, is having her first appointment with her new physician, a younger white male physician. The interview opens with a set of activities characteristic of primary care visit openings (Robinson 1998). The physician reviews the patient's records, greets the patient, embodies readiness to deal with the patient's concerns, and then initiates those concerns by asking her, 'how are things going for you' (line 1):

(1) [Migraine Trouble 1]
1 Dr: Well: uhm: (.) tch how are things going for you.
2 (0.6)
3 Pt: Ah:: good. I think– eah (.) pretty good.

The patient's reply (line 3) projects the introduction of some health problems or concerns. She then produces her reason for the visit. She has come for a routine physical and mammogram, and she is experiencing three health problems: migraine headaches, 'problems' with her bowels, and tiredness. The physician begins a series of queries about her first complaint, the migraines, beginning with a question about what medication she takes for them.

(2) [Migraine trouble 3]
1 Dr: Well now– Let's see– so mig– an' for thuh migraines
2 what do you take for them.
3 Pt: .hhh Ah::=hhhhh Really not– I'm– my husband has
4 hu huh huh (not) been using his an' it really works
5 pretty good. .hh He has some=uh: uh: eight hunded–
6 uh what is it grams er mill[igrams of ibuprofen.
7 Dr: [Ib– Ibuprofen

As Beckman and Frankel (1984) have observed, when a doctor immediately initiates a specific, close-ended question about a concern a patient initially expresses, the appropriate response for the patient is to answer the question (which this patient does; she replies that she borrows her husband's prescription for ibuprophen, lines 3 to 6). However, if the patient has additional concerns or information to share, she then faces the 'practical problem' of finding another appropriate environment in which to raise them during the clinic visit (Beckman and Frankel 1984: 694). This patient faces this problem, but she also faces another. Even if her physician were to have elicited additional concerns at the beginning of the visit, before questioning her about the

ones she initially raised, she faces the dilemma of *where* and *how* to raise the possibility of a serious problem (AIDS) while maintaining the appearance of being a 'reasonable' patient: i.e., one who is not 'out looking' for a problem, nor too willing to suspect that one has a dramatic condition (Halkowski, to appear).[4]

In the present visit, the patient handles the dilemma of where to raise such a serious health concern by capitalizing upon the physician's use of the patient's written health history form during the history taking.[5] The physician's reference to a surgery that the patient had noted on the form, and their subsequent discussion about it, provides an auspicious environment for the patient to raise two additional concerns related to the surgery—ones that she neither noted on the health history form nor presented in the opening moments of the visit.

Our analysis will focus on the second of the two concerns that emerge from the physician's reference to the health history form. We provide only a brief sketch of the first, as follows. After querying the patient about her migraines and then about an ear problem she has been experiencing, the physician refers to the health history form and notes that the patient had a hysterectomy and bladder repair several years before, in 1983.[6] When the physician asks her how her bladder function has been since the surgery, the patient replies that it has been 'very good' and then she takes the opportunity to report a concern she neither raised at the beginning of the visit nor on the health history form: sexual intercourse has been painful since the surgery.

When the physician asks her whether she ever mentioned this problem to the surgeon who performed the operation, she reports that he moved to another state and then she switched insurance plans, so she never went back to see him (see line 1 in Excerpt 3). Then, she provides a negative assessment of the 'continuum' of care provided by 'these health plans' (lines 2 to 3, and 5), and contrasts this current system of care with having the 'old family doctor' (lines 10 to 11).

(3) [Migraine Trouble 13]

1 Pt: So I haven't been ↑back there a:tall, I just
2 ya know, .hh that's thuh problem with some
3 uh these health pla:ns I [feel] (you) don't get
4 Dr: [>Hm hm<]
5 Pt: (0.5) the continuum (y'd) like to see.
6 Dr: Hm hm? tch=okay. We:ll that– that is uh problem
7 I think [ah:] with uh:: .hh >ya know<=
8 Pt: [M hm]
9 Dr: => with so [many changes< in–]
10 Pt: [Not like ha:ving] thee old

11 family doctor.
12 Dr: That's: [that's ah::
13 Pt: [Heh heh heh .hhh]
14 Dr: one ah the changes: (.) we've a:ll had to adjust to
15 I think.
16 Dr: .hh Alright uh– hu– let's see– So:=uh >l:emme just
17 look– < (0.5)

Her assessment bids for the physician to express his own position in regard to the need for closer follow-up and resolution of problems (Pomerantz 1984b).[7] Moreover, it is built for the physician's agreeing assessment, which if given would provide not only evidence of how this physician is likely to treat her, but would also constitute a kind of agreement to provide the type of care that 'thee old family doctor' would provide. The physician provides an agreeing assessment (lines 6 to 7), and then portrays the matter as one that affects everyone (as perhaps a doctor's as well as a patient's problem) and as not 'news' to him (lines 12, 14 to 15). In procuring some alignment from the physician, the patient establishes a favorable environment in which to raise—and receive an attentive response to—a second concern that never received attention after the hysterectomy. When the physician makes a move to close the hysterectomy topic (lines 16 to 17), the patient works to *sustain* this auspicious environment and raise the concern. Our analysis will focus on these activities, and the physician's response.

Analysis: Part 1—Broaching a serious candidate health problem and intervention

In excerpt (4a), the patient raises the possibility that she could have AIDS, as a result of a blood transfusion during the hysterectomy, and she implies that an HIV test could be warranted. The methods she uses to raise this issue are (1) downplaying urgency through delayed placement; (2) testing the waters by reporting a circumstance; (3) avoiding ownership of the concern; and (4) using a question to warrant an answer. These methods both display and address the patient's dilemma: in raising the possibility of AIDS she may be heard to be over-estimating her risk of having contracted an HIV infection from the transfusion and thus, may appear to be 'out looking' for a dramatic illness (Halkowski, to appear). Her approach also deftly handles the possibility that she could be heard to be requesting an unnecessary medical intervention, and that the physician would refuse such a request. Overall, the activities of presenting a candidate health problem and inferring that a diagnostic test could be warranted are accomplished with great delicacy.

A. *Putting the concern on the table*

In lines 16 and 17, (Excerpt 4a), the physician initiates closure of the hysterectomy topic and proposes to resume the activity of taking the patient's history, with '.hh Alright uh– hu– let's see– So:- uh >l:emme just look–<(0.5)' (see Beach 1995). He is simultaneously gazing at the patient's health history form, and right before '>l:emme' (line 16) he flips the form over and looks at the other side. At this projected activity juncture, the patient begins a turn that bids to sustain the hysterectomy topic (line 18). Nonverbally, she also bids to hold the prior topic by maintaining the same facial expression (a smile) from her chuckle at arrow (a) through the doctor's pre-closing moves. Although the doctor is gazing at the health history form until arrow (b), and the patient's facial expression may not be visible to him, her 'smile voice' is audible in line 18 and he may be able to view her expression with his peripheral vision. At line 18, her face still maintaining the same—almost frozen—expression, the patient initiates a story preface ('One uh:: thuh things that's always worried my kids–'), bidding for a slot to produce—and inviting the doctor to listen for—the worrisome matter.

(4a) [Migraine Trouble 13]

12 Dr: That's: [that'.s ah::
↓(a)
13 Pt: Heh heh heh .hhh]
14 Dr: one ah the changes: (.) we've a:ll had to adjust to
15 I think.
16 Dr: .hh Alright uh– hu– let's see– So:=uh >l:emme just
17 look– < (0.5)
18 Pt: One uh [thuh things that's always worried] my kids–
19 Dr: [look through some things here]
↓(b)
20 Pt: .hh uh:: about that I (ws–) also had blood
↓(c)
21 transfusions °when I had (.) thee hysterec[tomy.°
22 Dr: [Mm hm?]
23 Dr: Mm hm
↓(d) ↓(e) ↓(f) ↓(g)
24 Pt: °>An they said<° did you ever get tested for AIDS
(h)↓
25 Didju ever get tested fe(h)r A(h)I(h)DS
26 y(h)a [kn(h)ow?] .hh
27 Dr: [.hh]

28 Dr: We[ll?
29 Pt: [No:?] I never got teste(h)d for AI::DS[y(h)a] kno:w,
30 Dr: [ptch]

The doctor continues his activity of viewing the form until arrow (b), at line 20. Thus, although the patient has the floor at line 20, where she indicates that the worrisome matter is related to the hysterectomy ('.hh uh:: about that'), the doctor's and patient's activities are in competition until arrow (b), when the doctor moves his gaze from the health history form and onto the patient, as she begins to produce (what she initially projects to be) the worrisome matter.

1. *Downplaying the urgency of the concern through delayed placement*
This concern emerges in the middle of the clinic visit. Moreover, the patient pushes its introduction to the very back of this topic (after first expressing her concern about the pain on intercourse and her dissatisfaction with the continuity of care), to an environment where the doctor is initiating topic closure. Although as noted earlier, the physician's initiation of symptom-related queries may well have limited the patient's opportunities for raising this additional concern early on (Beckman and Frankel 1984), the patient did have an opportunity to raise it when the physician first referred to the health history form and inquired about the hysterectomy. By delaying placement of the concern, she downplays its urgency. This may decrease the risk of appearing excessively concerned. (See Robinson [1999: 424] on topicalizing a concern early in a clinic visit, as a way to cast it as urgent or important.)

2. *Testing the waters by reporting a circumstance*
Having invited the physician to listen for the worrisome matter, the patient proceeds cautiously by reporting a circumstance (Drew 1984). In lines 20 and 21, she reports that she had blood transfusions when she had the hysterectomy. By merely informing the doctor of this circumstance, she hands him the opportunity to formulate its upshot at the transition-relevant point at the end of line 21. That is, she gives him the chance to produce (or show recognition of) any medical implications of the transfusion, such as how or whether it might be affecting her health, and/or whether medical intervention (such as diagnostic testing) might now be in order. She thus 'tests the waters' for his reaction, without having to actually perform the activity of formulating the upshot herself—interpreting the diagnostic and intervention-related implications of the transfusion. As Drew (1984: 147) has observed,

> Reportings can enable speakers to test recipients' likely reactions, by finding what they do in response to a position implied through the reporting. But because they thereby avoid taking an official position, speakers leave themselves the option of subsequently revising their position in the light of the other's initial reaction, through any such revision may itself be done implicitly through further reporting … Thus participants may negotiate positions, make concessions, stand firm or hold out on some matter, but without any of these activities having been done officially.

Accordingly, the patient takes on the role of a reporter of events and circumstances, and marks the activity of producing the upshot as a delicate or sensitive activity for her to engage in (Drew 1984; Gill 1995, 1997; Pomerantz 1980, 1984a).[8] The physician meets the reporting with apparent concern, via a facial expression that is markedly serious when he meets her gaze at arrow (b) in Excerpt 4a. The patient's expression then becomes serious, and she raises her eyebrows high and lowers her head at arrow (c), punctuating the micro-pause. The doctor declines to produce an upshot, responding with continuers ('Mm hm? Mm hm') and allowing the patient to formulate what, exactly, is worrisome about the transfusions.

3. *Avoiding ownership of the concern*

Although the patient cautiously tests the waters for the doctor's reaction, she does not take a neutral stance in regard to the concern. In the story preface in line 18, she avoids ownership of the concern by attributing the worry to a third party, her children (Clayman 1988; Drew 1991; Gill 1998; Heritage, to appear a; Pomerantz 1984a). Thus, she bids for it to be interpreted as *their* concern rather than hers. In addition, and as already noted, at line 18 she is still holding the smile that began at arrow (a) in line 13. She thereby distances herself from her childrens' worries, rather than displaying a neutral position.

In lines 24 to 26, following the doctor's continuers, the patient provides the basis for the children's concern about the transfusions. At this point, she also employs reported speech, another resource commonly employed in risky or delicate moments to disown actions (Beach 1996, to appear). At line 24 she shifts footing (Goffman 1981) and takes on the voice of her children asking her, 'did you ever get tested for AIDS'. She marks this shift to reported speech with '°>An they said<°', and with a change in her facial expression through which she mimmicks the urgency of the children's inquiry and displays a reaction toward it: at arrow (d) in Excerpt (4a), she begins to furrow her brow in apparent imitation of the children, and at (e) she pushes her brow forward and crinkles her eyes, bringing up the corners of her mouth. The effect is one of her displaying an inability to suppress her own "amused" reaction

toward the children's worries. By repeating their query at line 25, she portrays her children as insistent, perhaps excessively so. She thus makes herself out, in contrast to the children, as personally unconcerned and only reporting a worry they had expressed to her, while still putting the matter on the table in this clinic visit.

At arrow (f), the doctor smiles. The smile is one of recognition; that is, like a visual 'change of state token' (Heritage 1984) it displays recognition of where the patient is headed and provides initial evidence that he will treat this concern about AIDS lightly or as unwarranted. Providing further evidence that she was 'testing the waters', the patient aligns with his reaction. After the doctor smiles at arrow (f), the patient's smile comes out and fully emerges by arrow (h), and she inserts laughter tokens in 'fe(h)r A(h)I(h)DS y(h)a kn(h)ow?'. Through the smile and laughter, she further distances herself from her children's worried stance, and aligns with the doctor's light take. She also marks that this is a delicate and interactionally problematic matter, and thus shows herself to be aware that the matter she has raised is 'discrepant with … expectations of what a ''good'' and ''reasonable'' patient is like' (Haakana, this issue). Consistent with Haakana's observations, the doctor does not treat her laughter as an invitation for him to laugh along.

Also important is the fact that at arrow (g) the doctor's gaze moves from the patient back to the health history form. Thus, another possible interactional function of the patient's laughter at lines 25 and 26 is that it is a resource to *hearably* convey her alignment with him while he is looking at the form. The 'y(h)a kn(h)ow?' with upward intonation also solicits his continued involvement at a time when he appears to be returning his focus to the form.

4. *Using a question to establish the 'conditional relevance' of an answer*

Note that the patient reports not just what her children said, but a question they put to her: 'Did you ever get tested for AIDS?' She thus (1) provides herself with an interactional warrant to answer the question and indicate whether she was ever tested, or (2) she provides for the doctor to indicate his desire to hear the answer (an inquiry she appears to invite with the elongated opportunity space in 'A(h)I(h)DS' in line 25, as well as with 'y(h)a kn(h)ow?'). Either contingency would provide justification for her to offer the answer, and thus to offer—in a very delicate manner—information that otherwise might be difficult to put on the table.

The patient self-selects to answer the question, in overlap with the doctor's 'Well?' (line 28) which appears to invite her answer. She reports, smiling, 'No:? I never got teste(h)d for AI::DS y(h)a kno:w', (line 29). By packaging this reported fact as 'an answer to a question', it can

come off not only as unmotivated (she is being asked, thus she is following the requirements of the adjacency-pair format and not offering the information solely of her own volition),[9] but also as less constraining to the doctor in terms of the activity it calls for, in return. It establishes one of the necessary contingencies for an HIV test to be ordered (she has never had one), and it is provided in the context of her having established risk or at least her children's fear of risk (the transfusions). The report thus implies that a test may be warranted but it is not an overt request for a test.[10] It does not constrain the doctor to perform the activity a request makes relevant: to grant or decline the request. Therefore, it does not expose the patient to the possibility that 'a request' will be hearably declined or ignored (see Schegloff and Sacks 1973, and also Gill 1998). She does not ask. The reporting vehicle is flexible, in that it can put sensitive, possibly doctor-relevant information on the table while being packaged as an 'answer', and leave open rather than specify what activity is required from the doctor in return.

B. *The physician's response*

As already noted, the doctor smiles and returns his gaze to the health history form in line 24 (arrows a and b, Excerpt 4b). At arrow (c) at line 29 he is smiling and slowly shakes his head, still gazing at the form. He thus provides evidence that he takes lightly the circumstance she is reporting and is turning his attention back to the activity of gathering her health history. Having tested the waters and having found them cool, and having aligned with his light take with her smiles and laughter at lines 25, 26, and 29, the patient draws back further. She reiterates the initial circumstance she reported, but this time smiling and adding laughter tokens: '.HHH but = uh did have blood transfusions when they did thuh hysterectomy .hhh hh heh huh .h' This represents a revision of the initial, more serious stance she had displayed while reporting this circumstance in lines 20 and 21 in Excerpt (4a), but it is also different in that it confirms the circumstance (via the stress on 'did', line 31). After having broached the delicate territory of the diagnostic and intervention-related aspects of the transfusion, she retreats to confirming what she knows first hand and for certain—she did have blood transfusions—but this time treating it more lightly and in line with the doctor's evident position.

The doctor treats these circumstances as requiring reassurance of sorts, but no more. At line 34, still gazing at this health history form, the doctor addresses the probability of her having the candidate health condition, AIDS. He downplays both the number of people who have been

infected by transfusions and characterizes the patient as, apparently, among the healthy. He looks at the patient at arrow (d) and at (e) raises his right hand in the air, shaking it slightly, and then raises it higher in a visual indication of the large percentage of people who 'have done alright'. He thus resists the implication that her circumstance warrants either concern or medical intervention; essentially, by citing an (apparent) state of affairs he obviates the need for concern or testing without declining *per se* to order a test. His gaze returns to the form at arrow (f), line 35, and it remains there for the rest of the excerpt.

The patient's long spate of overlapping laughter is notable here (lines 36 and 38), as it again marks having performed a delicate activity—raising a health concern that, it is now clear, the doctor does not consider to be justified nor in need of any further attention. She also nods, starting at line 36, and at line 38 provides a soft agreement token, 'Uh:: huh?', and then overlapping as the doctor projectably starts a new topic, with an additional agreement, 'I think so'.

(4b) [Migraine Trouble 13]

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                                                    ↓(a)          ↓(b)
24  Pt:   >An they said< did you ever get tested for AIDS
25        Didju ever get tested fe(h)r A(h)I(h)DS
26        y(h)a [kn(h)ow? .hh]
27  Dr:         [.hh         ]
28  Dr:   We [ll?            ]
                                          ↓(c)
29  Pt:       [No:?           ] I never got teste(h)d for AI::DS [y(h)a] kno:w,
30  Dr:                                                          [ptch]
31  Pt:   .HHH but=uh did have blood transfusions when they
32        did thuh hysterectomy .hhh hh heh huh .h
33        [hh]
                                                    ↓(d)          ↓(e)
34  Dr:   [I ] think you were: am– among thuh ninety nine (.)
                                    ↓(f)
35        plu[s: percent that s::eems to have–                    ](.)
36  Pt:      [.hhh heh heh heh heh heh heh heh heh               ]
37  Dr:   [done alright.]
38  Pt:   [heh .huhh    ] Uh:: huh?
39  Dr:   Uh: [I see–
40  Pt:       [I think so.
                                          ↓(g)
41  Dr:   I see– you have– th:ree children? ((looking at
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42 patient's health history form))
43 Pt: Ye:s

The doctor restarts his turn in line 41, referencing, for her confirmation, the number of children she has, and pointing to the health history form at arrow (g). She confirms (line 43) and the doctor continues gathering information on additional aspects of her life circumstances and health history.

In summary, the patient has very delicately hinted at the possibility that she has a candidate health condition (AIDS) and that diagnostic testing may be warranted. Having tested the waters for the doctor's position, and obtaining evidence that he treats the situation lightly, she aligns with his stance. He treats her circumstances as requiring no further attention, but only reassurance that a miniscule number of people were actually infected by transfusions. However, the topic of AIDS re-emerges later in the clinic visit, when the patient reports experiencing a new, unaccountable symptom. The doctor then proposes a course of action that is primarily designed to investigate other symptoms she is experiencing, but which will additionally serve to 'reassure' him and the patient that she does not have AIDS.

Analysis: Part 2—Reporting a new, mysterious symptom

The next excerpt occurs later in the history-taking stage of the same medical interview. Just prior to this excerpt, the physician referred back to the patient's health history form, noting that she had mentioned feeling fatigued. The patient tacitly attributes the fatigue to 'burning the candle at both ends all the time', thereby displaying herself to be looking for a 'benign' explanation first (Halkowski, to appear; Sacks 1984). The physician exhibits troubles receptiveness, proposing to look for 'underlying causes' for her fatigue.

The patient takes this opportunity to report that she has been experiencing chest pains, and the physician begins a course of questioning about these pains.

(5) [Migraine trouble 20]
1 Dr: Any sweating or nausea °with that?°
2 Pt: No– not with tha:t,
3 Pt: Thee only (f) time I get sweating an °nau:sea° is
4 at– when I wake up at °night.°
5 (0.8)
6 Not nausea so much but all of uh sudden
7 I'll be just H:: (0.8) H::ot as h:ot can be.

Dr: >Mm hm<
(.)
Dr: Hm=
Pt: =An' then I'll get ↑real cold.
(.)
Dr: >Mm hm<
(0.2)
Pt: But I don't do that during thuh ↑day °at all.°
Dr: Hm.
Pt: ↑Never do that during thuh ↑day.
Dr: Okay when– when you ha:d >let's see–< didju ever
have any=uh hot f:lashes:[(around)] thuh menopause?
Pt: [>Nope<]
Pt: [>Nope<]
Dr: [(At all?)]
Dr: Nothing.
Pt: [Nothing.
Dr: [Wi– when did– when did [this–]=
Pt: [EVer.]
Dr: =when did these hot 'n co:ld spells seem tah
start for you.
Pt: OH::: about:=uh::w:: couple months ago.
(0.5)
Dr: Mm.
(0.8)
Dr: Uh– any– what– w– what ↑causes 'em.
Pt: I don't ↑know.=
Dr: =°Yeah.°
(0.2)
Pt: ↑Don't [know.]
Dr: [°Kay°]
Dr: Awri:ght=[we::ll?
Pt: [I just uncover for uh while? an' then
pretty soon I get cold an cover all up? an then
I'm fine an (n)=I never get 'em during thuh da:y,
I never get 'em any other time.
Dr: °Kay°
Dr: .hh In– in eva:lua[ting] you at this visit (.)
Pt: [So]
Dr: what we'll do: is check some: (.) blood tests.
S::ome >some< screening tests. N' they will inclu:de
things like your white blood count,

50 Dr: .hh ah:w I don't thin:k: (.) we need tuh worry about
51 AI:DS in fa[ct uh: .hh we'll uh when I check your =
52 Pt: [Huh huh huh huh huh .hh
53 Dr: =blood count yer some– (.) ah some uh thee: uh (.)
54 white blood count fractions that'll el– (.) I think
55 uh reassure me an: [yerself that that– =
56 Pt: [Heh heh heh .hh
57 Dr: that that's not uh problem.
58 Dr: .hh But we'll also look at some possible causes for
59 fati:gue, check your thyroi[d
60 Pt: [Mm hm?

A. *Putting the symptom on the table*

In the discussion of this data segment, we will focus on four activities that the parties are engaged in: (1) 'funneling the symptom'; (2) an attempted causal attribution and its blocking; (3) claimed causal agnosticism; and (4) treating the symptom as a 'delicate'. These four activities prepare the way for the physician to treat the patient as re-invoking the concern about AIDS (which she attributed to her children), and to address that concern in a particular manner.

1. *Funneling the symptom*

Through a series of moves, the patient progressively transforms the symptoms the physician mentioned (sweating and nausea) into a report of a very specific symptom: sweating at night. The transformation is accomplished as follows. The doctor asks her if she experiences 'sweating' and 'nausea' with the chest pains (line 1). The patient disavows experiencing any sweating or nausea with the chest pain (line 2), thus separating the symptoms from the chest pain. She then proceeds to connect the symptoms to one specific 'time' ('the only time I get sweating and nausea is at– when I wake up at night' (lines 3 to 4). Via her self-repair ('is at– when I wake up …'), the patient shifts from simply tying the symptom to a time and instead ties the symptom to a course of action. By doing this, the patient characterizes the symptom as more significant. It doesn't merely occur at night, it wakes her up.

In her next utterance she excludes the symptom of nausea (line 6), and through a course of action description characterizes her symptom as feeling very hot and then very cold (lines 6 to 7, and 11). She then emphasizes that this doesn't occur during the day 'at all' (lines 15), and then emphasizes this timing ('never', line 17).

Note that in this short spate of talk, the patient has disconnected the symptom from the original problem the doctor was investigating (chest pain), and connected it to a specific time of day and course of action. She has thus transformed what they were talking about from 'sweating or nausea with that [chest pain]', to sweating and nausea that only occur at night (never during the day), and wake her up.

2. *An attempted causal attribution and its blocking*

The doctor's question (lines 18 and 19), may anticipate the patient's resistance to a forthcoming causal theory. 'Okay when– when you ha:d' may be leading up to 'when you had hot flashes during menopause'. This question would allow him to tie the current symptom to that prior experience (e.g., 'When you had hot flashes during menopause did they sometimes wake you up at night?'). But the doctor self-repairs his question, 'let's see– didju ever have any=uh hot flashes' (lines 18 to 19). This reformulation of the question into a pre-sequence allows the doctor to inquire into the basis for the causal theory he is developing, before he explicitly proposes this theory.

But when the physician raises this candidate explanation by asking about her experience with 'hot flashes' during menopause, she emphatically disavows experiencing them; she utters '>Nope<' at the earliest turn completion point (following 'f:lashes:', line 19), thereby hearably 'heading off' this causal theory. She repeats this at line 21, immediately following the physician's turn, and overlapping his request for confirmation, confirms with 'Nothing' at line 24. Then, in interruptive overlap with the doctor's query in line 25, she underscores that hot flashes were something she *never* experienced ('EVer' line 26).

Thus, she takes the two candidate symptoms the physician mentioned (in the context of exploring the chest pains), and through a series of discards or exclusions 'funnels' them into this specific symptom: hot feelings that only occur at night, (never during the day), which cannot be accounted for by menopause.

3. *The patient's claimed causal agnosticism*

At line 33 the doctor asks a question which has some interesting formal similarities to his prior question about 'hot flashes'. The doctor asks 'Uh– any– what– w– what ↑causes 'em' (line 33). Note that the doctor starts the question with 'any' (presumably leading up to something like 'Any ideas about what causes them?'), but cuts off the 'any' and shifts to 'what'. Via this shift, the doctor displays himself as suspecting that the patient is holding a *particular* causal theory.

The patient responds by asserting an agnostic stance: 'I don't ↑know. … ↑Don't know' (lines 34 and 37). Beach and Metzger (1997) have discussed in detail the work that repeated 'I don't knows' can be used to do in ordinary conversation, and other realms of talk-in-interaction. Their analysis indicates that they can temporarily stall other-initiated sequences (see also Drew, to appear, and Sacks 1995, vol. 1:7). If the patient were to express a causal theory here, she would reasonably expect that the doctor would address that theory (i.e., agree with it, disagree with it, explain why it is unlikely, etc.). Her theory would become an explicit topic of their conversation. The patient's 'I don't knows' allow her to respond to the question without owning a particular causal theory (thereby preventing her theory from being commented on explicitly), yet allow her to add other observations that implicate a causal theory (Gill 1995).

At this point, the physician treats her as having completed her turn (lines 38 and 39), and starts to make pre-closing moves to end this topic ('kay alright = well') (Schegloff and Sacks 1973). But at just this point the patient presses forward another turn of talk, in overlap with the doctor's pre-closing moves (line 40). There are two significant aspects to this turn of talk (lines 40 to 43). First, the patient uses another course of action sequence to describe what she does when she experiences the symptom (lines 40 to 42). She reports taking a pragmatic approach of simply uncovering when she's hot, which results in her feeling 'fine'. Via this part of her turn, the patient portrays herself as one who attempts to simply cope with the problem, rather than immediately assume that it is a medically relevant problem. This is a way that patients demonstrate themselves to be competent perceivers (and reporters) of their bodily states and sensations (Halkowski, to appear; cf. Sacks 1984). Then the patient takes yet another opportunity to declare that she never gets the symptom 'during the day' or at 'any other time', thereby underscoring that this is sweating at *night*.

Thus, having just worked to display herself as one who attempts to cope with problems appropriately before bringing them to the doctor (i.e., a reasonable patient), she has an auspicious environment to strongly reassert that this symptom only occurs at night. This pairing of actions appears to be a systematic technique that patients have for cautiously raising particular health concerns with their doctor (cf. Halkowski, to appear).

4. *Treating the symptom as a 'delicate'*

Note the cautiousness with which both parties handle the naming of this symptom, as well as the work such talk is used to do. In line 3,

the patient used the term 'sweating' when it was in conjunction with 'nausea', but once she excludes nausea and says the symptom only occurs at night, she switches to a course of action description (line 6). Neither of them characterizes the symptom as 'sweats' or 'sweating' again.

In his question concerning the onset of the symptom (line 27), the physician transforms his description of the symptom to 'hot and cold spells'. This transformation is preceded by a series of disfluencies (line 25, 'Wi– when did– when did this– when did these hot n' co:ld spells …') which treat naming this problem as a delicate matter, now that the 'hot flashes' hypothesis has been rejected. From then on, both physician and patient refer to the symptom with a tying term, (line 33: 'What ↑causes em'; line 42: 'I never get 'em during thuh da:y'; line 43: 'I never get 'em any other time').

While the patient is emphatic about what the symptom is *not*, she does not name it (she only describes it), and she claims to be dumbfounded about what it *is*—what causes it. Again exhibiting disfluency in naming the symptom ('Uh– any what– w– what ↑causes 'em', line 33), the physician asks her for her own candidate explanation.

Through all of these namings and descriptions of the symptom, both parties are treating it as a 'delicate', that is, as a matter whose formulation will be implicative for them both. If the patient were to characterize the symptom as 'night sweats', she might be heard to be reaching for a much more serious diagnosis than her situation warrants. Other characterizations by her could minimize the problem such that the physician would not treat it as medically relevant and 'doctorable' (Halkowski, to appear).

Particular ways the doctor could characterize the symptom would make it harder to dismiss it as a benign, common occurrence, and might even compel him to investigate the problem further. Thus the sheer work of talking about this problem is a virtual minefield, where the very terms one is using may project and compel different trajectories (treat it as a non-medically relevant 'mundane' sensation, or as a medically relevant, doctorable problem).

B. *The physician's response*

The physician's response treats the patient as re-invoking the concern about AIDS (which she attributed to her children), addresses that concern, and does so in a cautious and minimalistic manner.

At line 45 the physician initiates a plan proposal. He proposes doing 'blood tests' and 'screening tests' (lines 45 to 48), and then projects a list

of specific investigations which 'will inclu:de things like your white blood count' (lines 48 to 49). This utterance ends in a continuing intonation. Then, in a move that he marks as parenthetical, he invokes AIDS (line 50 and 51). He lowers his pitch and proposes, 'I don't thin:k we need tuh worry about AI:DS'. This utterance ties back to the patient's earlier report of her children's 'worries' in Excerpt 4a.

By suggesting that he doesn't think 'we need tuh worry about AIDS', immediately on the heels of the discussion of 'sweating at night', the doctor accomplishes two tasks. First, he treats the prior symptom talk as a possible re-invocation of her kids' AIDS concern. Second, by using *we*, the doctor treats this concern as something that they are both oriented to. He thereby expansively transforms ownership of the concern from 'the patient's children', to now include the patient and doctor. This move makes the concern an explicitly legitimate matter for their discussion, here in this clinic visit.

Note that while the doctor is discounting our 'need to worry about AIDS' the patient produces a short series of laugh particles (line 52). Via her laughter at this precise point, where the doctor is 'formulating an understanding' of a less likely cause (Beach and Dixson, in press), the patient treats this formulation as a delicate (Jefferson 1984, 1988; Haakana, this issue). Note as well that the patient does not treat the doctor's relocation of the ownership of this 'concern' as an error that needs to be repaired. She lets it stand, thereby allowing the doctor to make it part of his plan for this problem.

He then proposes to piggyback an investigation of her HIV status onto the aforementioned blood tests ('when I check your blood count' lines 51 and 53), and suggests that the 'white blood count fractions' will 'I think uh reassure me an: yerself that that– that that's not uh problem'. By owning part of the concern himself, ('me an: yerself') the physician again portrays it as a legitimate concern and thus softens the relocation of his attribution.

Here, as earlier in this segment, the patient briefly laughs in overlap with the doctor's talk (line 56), just as the doctor says 'yerself'. The precision placement of her laughter, just at this point where the doctor is (again) including her in his transformative relocation of the AIDS concern (from the patient's kids to 'me and yerself'), treats his action as a delicate. But note again that the patient makes no move to correct or repair this relocation of the concern. Her laughter instead is hearable as a delicate acknowledgment of this concern (an acknowledgment because of its precise placement with respect to the doctor's talk, and delicate because laughter is a response that allows one to respond without taking an explicit pro or con position on the matter).

He closes the parentheses in line 58, with the contrast marker 'but' and continues the list he had projected. He proposes that through these blood tests he will 'also' look for causes of another of the patient's symptoms, fatigue (line 58 and 59). This plan proposal brings closure to what the physician clearly takes as her concern by promising at least a cursory investigation into her HIV status, and allows the history-taking phase of the interview to continue.

The proposal—to piggyback his investigation into the possibility of AIDS onto a test he was going to perform anyway—is a minimal way to treat the patient's symptom as medically actionable, and to address a concern that the patient has not explicitly owned. Thus, while the doctor proposes a medical intervention that is designed to provide reassurance about AIDS, in addressing the concern *en passant* he tunes his plan to the key in which the 'request' was made.

Discussion

Medical interactions are fraught with moments and activities that require delicate handling. In the case studied here, a patient brings up a possibly actionable matter through an organized series of reports, in a way that allows questions and concerns about the medical implications of her circumstances to be voiced by others. Her physician initially responds by citing evidence that undercuts the basis for concern; however, later in the visit, when the patient raises a mysterious symptom, the physician treats it as related to the aforementioned concerns and as warranting some action on his part—not for itself, but as part of another evaluation he was going to do anyway. In this single case analysis, we see how 'requesting' and 'responding' are oriented to as delicate matters. The patient puts a possible actionable collection of circumstances on the table, while never uttering an interrogatively formatted 'request' for an intervention (e.g., 'Doctor, may I have a(n) … ?'); the physician responds not by granting or denying a request, but by proposing an intervention that will allow—as an additional, incidental activity—an investigation of the concerns the patient raised.

These findings begin to answer a call for research that provides a more detailed understanding of the interactional dynamics between physicians and patients in those instances when patients request prescriptions and other medical interventions (Britten 1995; Friedler 1997; Gallagher et al. 1997). Friedler (1997: 485) advocates studying 'the negotiation process' that occurs during clinic visits when patients make requests, asking for studies to address the following kinds of questions: How are requests brought up? Are they broached specifically or through general questions?

Are physicians receptive to patients' requests for interventions? Are they cooperative or controling?

Our study thus has both substantive and methodological implications for future research on patients' requests. Whereas surveys can measure patients' and physicians' perceptions about what occurred, they cannot determine whether and how patients actually made requests and what physicians' responsiveness consists of as a set of conversational moves. Absent this information, there is nothing to connect to outcome variables (such as 'patient satisfaction'). Finding that eighty-five percent of the patients in Clinic A who felt their physicians were responsive are satisfied with their care, tells us nothing about how to reproduce that level of satisfaction in Clinic B. If the research on patients' participation in their health care and physicians' responsiveness to patient initiatives fails to take account of the various ways that they do this work, we lose an opportunity to improve the quality of medical education and practice.

The current study shows some of the complexity and subtlety with which patients and physicians accomplish the activities of requesting and responding. As medicine has become increasingly patient-centered, researchers have been eager to determine whether physicians exhibit responsiveness to patients' desires, concerns, and requests, and how this affects satisfaction with medical care; additionally, as medical costs spiral upward, increasing attention is being paid to physicians' recommendations for expensive medical interventions. Our analysis demonstrates that phenomena that get *treated as* requests in medical visits may well look nothing like requests. Furthermore, physicians can be responsive in ways that do not constitute wholesale granting of requests yet meet patients' medical needs as well as psychosocial needs for reassurance.

Notes

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1. Emerging evidence suggests, for example, that patients relinquish requests for treatment information that have been marked by the physician as 'out of order' and orient to the pursuit of an answer as an accountable action (Roberts 2000).
2. Sacks also takes up analysis of performatives, alloying his treatment of the verb *say* (as a weak pro-verb in place of stronger performatives such as *assert*) to Austin's philosophical perspective on the issue of accomplishing 'things' with words (Austin 1962). While speech act theory proposes to cover similar territory through the construct of 'indirect speech acts' it cannot provide a precise account of how—in actual practice, not in philosophical or psychological terms—participants arrive at some nonobvious upshot of prior talk. (Sacks 1995, vol. 1: 342–347).
3. We wish to extend our appreciation to Doug Maynard for sharing these data.

4. Halkowski (to appear) focuses on the way patients describe *discovering their symptoms* so as to show themselves to be oriented—at least initially—to mundane explanations for why the symptoms occur. In the present case, the patient shows this orientation away from hypervigilance, but in relation to *analyzing whether life events have put her at risk* for disease. She does not produce an explanation for a symptom she is experiencing; rather, she proposes the possibility of a candidate health problem (AIDS) on the basis of having had a medical procedure that put her at risk (a transfusion).
5. Because she is a new patient for this physician, the patient was asked to complete a health history form prior to her visit. This is a self administered questionnaire that includes questions about prior hospitalizations, medications the patient is currently taking, health habits (e.g., alcohol use, exercise), family and personal circumstances (e.g., occupation, number of children), specific health complaints the patient is currently experiencing, and emotional health (e.g., depression, anxiety). (See Heritage, to appear b, on another use of a health history form in a medical interview.)
6. The patient initially confirms this 1983 date, but later expresses indecision about when she actually had the surgery, and places it at 'somewhere between six and ten years ago', between 1979 and 1983.
7. This is the patient's second reference to losing contact with a physician. In the opening sequence, the patient accounts for why she is seeing this physician for the first time:

   [Migraine Trouble 1]
   28 Pt: I had Doctor L and she up and left [tow:n
   29 Dr: [up and left [eh eh
   30 Pt: [Yea::h
   31 Dr: An– an didn't even tell you?
   32 Pt: No::: isn't that ro:tten. uh huh huh huh

8. In this regard, the patient's use of 'also' in her report (line 20) casts it as 'yet another noticing to convey' regarding her hysterectomy, and underscores her engagement in the activity of collecting and chronicling facts and events rather than interpreting and spelling out the implications of those facts and events (Gill 1995, 1997).
9. This is because a question, as the first part of a question–answer adjacency pair, establishes the 'conditional relevance' of the second part, an answer (Schegloff 1972).
10. Certainly, the 'y(h)a kno:w', at line 29 invites him to hear those implications and gives him an opportunity space to respond.

References

Austin, J. L. (1962). *How To Do Things With Words*. Oxford: Clarendon Press.

Beach, W. (1995). Preserving and constraining options: 'Okays' and 'official' priorities in medical interviews. In *Talk of the Clinic*, G. H. Morris and R. Cheneil (eds.), 259–289. Hillsdale, NJ: Lawrence Erlbaum Associates.

—(1996). *Conversations About Illness: Family preoccupations with bulimia*. Mahwah, NJ: Lawrence Erlbaum Associates.

—(to appear). Inviting collaborations in stories about a woman. *Language in Society*.

Beach, W. and Dixson, C. (in press). Revealing moments: Formulating understandings of adverse experiences in a health appraisal interview. *Social Science and Medicine*.

Beach, W. and Metzger, T. (1997). Claiming insufficient knowledge. *Human Communication Research* 23: 562–588.

Beckman, H. and Frankel, R. (1984). The effect of physician behavior on the collection of data. *Annals of Internal Medicine* 101: 692–696.

Britten, N. (1995). Patients' demands for prescriptions in primary care: Patients cannot take all the blame for overprescribing. *British Medical Journal* 310: 1084.

Britten, N. and Okoumunne, O. (1997). The influence of patients' hopes of receiving a prescription on doctors' perceptions and the decision to prescribe: A questionnaire survey. *British Medical Journal* 315: 1506–1510.

Brody, D., Miller, S., Lerman, C., Smith, D., Lazaro, C., and Blum, M. (1989). The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. *Medical Care* 27: 1027–1035.

Butler, C., Rollnick, S., Pill, R., Maggs-Rapport, F., and Stott, N. (1998). Understanding the culture of prescribing: Qualitative study of general practitioners' and patients' perceptions of antibiotics for sore throats. *British Medical Journal* 317: 637–642.

Clayman, S. (1988). Displaying neutrality in television news interviews. *Social Problems* 35: 474–492.

—(1992). Footing in the achievement of neutrality: The case of news-interview discourse. In *Talk at Work: Interaction in Institutional Settings*, P. Drew and J. Heritage (eds.), 163–198. Cambridge: Cambridge University Press.

Cockborn, J. and Pitt, S. (1997). Prescribing behavior in clinical practice: Patients' expectations and doctors' perceptions of patients' expectations—A questionnaire study. *British Medical Journal* 315: 520–523.

Drew, P. (1984). Speakers' reportings in invitation sequences. In *Structures of Social Action: Studies in Conversation Analysis*, J. M. Atkinson and J. Heritage (eds.), 129–151. Cambridge: Cambridge University Press.

—(1991). Asymmetries of knowledge in conversational interactions. In *Asymmetries in Dialogue*, I. Markova and K. Foppa (eds.), 21–48. Hemel Hempstead: Harvester Wheatsheaf.

—(to appear). Misalignments between caller and doctor in 'Out-of-hours' telephone calls to a British GP's practice. In *Practicing Medicine: Structure and Process in Primary Care Consultations*, J. Heritage and D. Maynard (eds.). Cambridge: Cambridge University Press.

Eisenthal, S. and Lazare, A. (1976). Specificity of patients' requests in the initial interview. *Psychological Reports* 38: 739–748.

Eisenthal, S., Koopman, C., and Stoeckle, J. (1990). The nature of patients' requests for physicians' help. *Academic Medicine* 65: 401–405.

Friedler, E. (1997). The evolving doctor–patient to provider–consumer relationship. *Journal of Family Practice* 45: 485.

Froelich, G. and Welch, H. (1996). Meeting walk-in patients' expectations for testing: Effects on satisfaction. *Journal of General Internal Medicine* 11: 470–474.

Gallagher, T., Lo, B., Chesney, M., and Christensen, K. (1997). How do physicians respond to patients' requests for costly, unindicated services? *Journal of General Internal Medicine* 12: 663–668.

Gill, V. T. (1995). The organization of patients' explanations and doctors' responses in clinical interaction. Unpublished Ph.D. dissertation, University of Wisconsin, Madison.

—(1997). Facts and factors: Reporting as an accounting strategy in doctor–patient interaction. Paper presented at the annual meeting of the American Sociological Association, Toronto, Canada.

—(1998). Doing attributions in medical interaction: Patients' explanations for illness and doctors' responses. *Social Psychology Quarterly* 61: 342–360.

Gill, V. T. and Maynard, D. (to appear). Patients' explanations for health problems and physicians' responsiveness in the medical interview. In *Practicing Medicine: Structure and Process in Primary Care Consultations*, J. Heritage and D. Maynard (eds.). Cambridge: Cambridge University Press.

Goffman, E. (1981). *Forms of Talk*. Oxford: Blackwell.

Good, M., Good, B., and Nassi, A. (1983). Patient requests in primary health care settings: Development and validation of a research instrument. *Journal of Behavioral Medicine* 6: 151–168.

Haakana, M. (this issue). Laughter as a patient's resource: Dealing with delicate aspects of medical interaction. *TEXT* 21–1/2.

Halkowski, T. (to appear). Realizing the illness: Patients reports of symptom discovery in primary care visits. In *Practicing Medicine: Structure and Process in Primary Care Consultations*, J. Heritage and D. Maynard (eds.). Cambridge: Cambridge University Press.

Heath, C. (1992). The delivery and reception of diagnosis in the general-practice consultation. In *Talk at Work: Interaction in Institutional Settings*, P. Drew and J. Heritage (eds.), 235–267. Cambridge: Cambridge University Press.

Heritage, J. (1984). A change-of-state token and aspects of its sequential placement. In *Structures of Social Action: Studies in Conversation Analysis*, J. M. Atkinson and J. Heritage (eds.), 299–345. Cambridge: Cambridge University Press.

—(to appear a). Accounting for the visit: Patient's reasons for seeking medical care. In *Practicing Medicine: Structure and Process in Primary Care Consultations*, J. Heritage and D. Maynard (eds.). Cambridge: Cambridge University Press.

—(to appear b). Ad hoc inquiries: Two preferences in the design of 'routine' questions in an open context. In D. Maynard, H. Houtkoop-Steenstra, N. Schaefer and H. van der Zouwen (eds.) *Standardization and Tacit Knowledge: Interaction and Practice in the Survey Interview*. New York: Wiley Press.

Jefferson, G. (1974). Error correction as an interactional resource. *Language in Society* 2: 181–199.

—(1984). On the organization of laughter in talk about troubles. In *Structures of Social Action: Studies in Conversation Analysis*, J. M. Atkinson and J. Heritage (eds.), 346–369. Cambridge: Cambridge University Press.

—(1988). On the sequential organization of troubles talk in ordinary conversation. *Social Problems* 35: 418–441.

Joos, S., Hickham, D., and Borders, L. (1993). Patients' desires and satisfaction in general medicine clinics. *Public Health Reports* 108: 751–759.

Kravitz, R., Cope, D., Bhrany, V., and Leake, B. (1994). Internal medicine patients' expectations for care during office visits. *Journal of General Internal Medicine* 9: 75–81.

Like, R. and Zyzanski, S. (1987). Patient satisfaction with the clinical encounter: Social psychological determinants. *Social Science and Medicine* 24: 351–357.

Macfarlane, J., Holmes, W., Macfarlane, R., and Britten, N. (1997). Influence of patients' expectations on antibiotic management of acute lower respiratory tract illness in general practice: Questionnaire study. *British Medical Journal* 315: 1211–1214.

Mangione-Smith, R., McGlynn, E. A., Elliott, M. N., Krogstad P., and Brook R. H. (1999). The relationship between perceived parental expectations and pediatric antimicrobial prescribing behavior. *Pediatrics* 103: 711–718.

Peyrot, M., Alperstein, N., Van Doren, D., and Poli, L. (1998). Direct-to-consumer ads can influence behavior: Advertising increases consumer knowledge and prescription drug requests. *Marketing Health Services* Summer: 27–32.

Pomerantz, A. (1980). Telling my side: 'Limited access' as a 'fishing' device. *Sociological Inquiry* 50: 186–198.

—(1984a). Giving a source of basis: The practice in conversation of telling 'how I know'. *Journal of Pragmatics* 8: 607–625.

—(1984b). Agreeing and disagreeing with assessments: Some features of preferred/dispreferred turn shapes. In *Structures of Social Action: Studies in Conversation Analysis*, J. M. Atkinson and J. Heritage (eds.), 57–101. Cambridge: Cambridge University Press.

Roberts, F. (2000). The interactional construction of asymmetry: The medical agenda as a resource for delaying response to patient questions. *Sociological Quarterly* 41: 151–170.

Robinson, J. (1998). Getting down to business: Talk, gaze, and body orientation during openings of doctor–patient consultations. *Human Communication Research* 21 (1): 97–123.

—(1999). The organization of action and activity in primary-care, doctor–patient consultations. Unpublished Ph.D. dissertation, University of California, Los Angeles.

Sacks, H. (1984). On doing 'being ordinary'. In *Structures of Social Action*, J. M. Atkinson and J. Heritage (eds.), 413–429. Cambridge: Cambridge University Press.

—(1995). *Lectures on Conversation*, vols. 1 and 2, G. Jefferson (ed.). Cambridge, MA: Blackwell.

Schegloff, E. (1972). Notes on a conversational practice: Formulating place. In *Studies in Social Interaction*, David Sudnow (ed.), 75–119. New York: Free Press.

—(1987). Analyzing single episodes of interaction: An exercise in conversation analysis. *Social Psychology Quarterly* 50: 101–114.

—(1988). Presequences and indirection: Applying speech act theory to ordinary conversation. *Journal of Pragmatics* 12: 55–62.

Schegloff, E. and Sacks, H. (1973). Opening up closings. *Semiotica* 7: 289–327.

Stivers, T. (to appear). Negotiating antibiotic treatment in pediatric care: The communication of preferences in physician–parent interaction. Unpublished Ph.D. dissertation, Department of Applied Linguistics, University of California, Los Angeles.

ten Have, Paul (1991). Talk and institution: A reconsideration of the 'asymmetry' of doctor–patient interaction. In *Talk and Social Structure: Studies in Ethnomethodology and Conversation Analysis*. D. Boden and D. Zimmerman (eds.), 138–163. Cambridge: Polity Press.

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