

**Seeking narrative coherence:  
Doctors' elicitations and patients' narratives in medical encounters**

**By**

**Susan Marie Barone**

**A Thesis  
submitted to the Victoria University of Wellington  
in fulfillment of the requirements for the degree of  
Doctor of Philosophy in Linguistics**

**Victoria University of Wellington**

**2012**



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## Acknowledgement

I acknowledge with much gratitude the following individuals for their support of this thesis:

I am particularly grateful to my primary supervisor, Janet Holmes, whose guidance directed me to think in new ways. It has been a privilege to have this opportunity to learn from you. My secondary supervisor, David Crabbe, for his thoughtful input throughout the process. The other staff and students at VUW School of Linguistics and Applied Language studies for their support and feedback, especially Meredith Marra, Deborah Laurs, Julia de Bres, and Bernadette Vine for assistance with transcription conventions. Maria Stubbe, a Research Associate of the Language in the Workplace Project, for helping me arrange my pilot study at the University of Otago, Wellington, School of Medicine and Health Sciences, and also all the doctors who participated in that study. The Thesis Group and the discourse analysts at VUW for their input and support and to VUW for the funding of research grants.

Dr. Rita Charon who, through introducing me to Narrative Medicine in 2006, altered the trajectory of my career. Dr. Mary Ann Cook, principal investigator of National Institute on Aging Project “Assessment of Doctor Elderly Patient Encounters” (Grant #R44 AG 15737) for granting access to the medical interactions corpus and the patients and doctors who participated in that study. The evaluating doctors for participating in my perceptions study. Tanya Stivers for initial topic direction and encouragement.

Carol Etherington, who encouraged me to “think big”; Dawn Turton for her support during my leaves of absence; Lisa Russell-Pinson, for her heartening words; friends in NZ who opened their lives to me, especially Desmond Cooper; and Mary Ellson and her wonderful family for their unconditional love.

My family and friends who shared their illness stories with me during this time. Their experiences shaped my thinking and motivated me to press on. Thank you, Noah, for rallying, “you gotta do what you gotta do”, which became my mantra.

My parents, Joseph and Assunta Barone, for their endless encouragement and my six brothers and sisters and their families. Thank you Layla, whose puppy kisses melted away stress and worries. Finally, I thank and dedicate this work to Sonya Barbour whose exceptional medical knowledge and compassion toward patients were driving forces for me to pursue meaningful study. You have been a constant, real-world voice, which informed my understanding of medical practice. Thank you for your love and for sharing your life with me. Shalwais.



**Abstract**

This thesis presents research on how doctors and patients negotiate meaning through interaction, focusing on the role of narrative in the medical encounter. Within sociolinguistics, most previous studies using discourse analysis to analyze patients' narratives have adopted the canonical (Labovian) framework. This thesis adds more recent approaches to narrative analysis, within an interactional sociolinguistics (IS) framework in order to examine the relationship between doctor elicitations and patient narratives. The analysis also explores the clinical approach of Narrative Medicine (NM), which offers patients "space" in which to construct their narratives, to create an interdisciplinary lens for exploring data.

The data comprised 69 videotaped medical interviews, amounting to 18 hours of naturally occurring medical interactions, plus evaluative feedback from questionnaires and interviews with 12 doctors. All interactions were initially analyzed for canonical narrative components. Twelve interactions were then selected for more detailed analysis on the basis of the frequency of doctors' elicitations, which represent medical interview approaches. The analysis of these interactions demonstrates how and to what extent participant roles and identities frame the co-construction of patient narratives. Evaluations of three of the interactions by 12 doctors provided information on how aspects of patient narratives are perceived by clinicians, particularly with respect to the types and amounts of patient information considered necessary for making diagnostic decisions.

Key findings demonstrate that both patients and doctors seek to construct narrative coherence. The analysis shows how the frame of developing narrative coherence offers insights on the interactional narratives as they are co-constructed by participants. Patients living with chronic illness may have difficulty constructing coherent narratives, and thus, strategies for developing narrative coherence are important for both patients and doctors when managing patients' chronic illnesses. Additionally, in constructing narrative coherence, patients present important aspects of their identities potentially offering important information related to their illness and intervention. Evaluating doctors' also engaged in using this frame which offers insight into one way

doctors develop their professional identities and perhaps indicates the strength of the role of narrative in our lives.

This research represents a first attempt to use both interactional sociolinguistics and NM to contribute to the understanding of doctor-patient interaction. Overall, the research indicates that narrative plays an important part in constructing relevant meanings in medical interactions between doctor and patient. Patients strive to create a coherent narrative as they present their medical problem to their doctor. Although this analysis provides further evidence of the relevance of the power asymmetry in medical interviews, it also suggests ways in which patients can shape their narratives to construct themselves as active agents to their benefit in medical interactions.

## **Chapter 1 Introduction: Doctors' elicitations and patient narratives as means for constructing narrative coherence and identity**

### **1.1 Introduction**

The role of narrative in workplace settings is only beginning to be analyzed and better understood, notably in the areas of relationship development and identity construction (Holmes & Marra, 2011). One workplace setting which is becoming of increasing interest to sociolinguists is the medical clinic. How co-constructed narratives in this setting impacts the development of patient narratives is important to understanding what is taking place in these interactions, where patients' health and how they maneuver through illness is at stake. This thesis demonstrates how patients use narrative to present themselves as active agents as they negotiate narrative coherence with their doctors. It also shows how both participants use narrative to accomplish transactional work as well as to develop relationships and identities in interaction with each other.

An applied linguistics approach provides a means of identifying problematic areas in society that have a communication dimension. This approach attempts to represent problems through critical interpretation (Bygate, 2004). Generic and specific communication barriers in health care have been explored through various frameworks. The thesis draws from sociolinguistic frameworks as well as the "Voice of Medicine" (Mishler, 1984) using the frame of Narrative Medicine (NM) (Charon, 2006) to explore communication issues associated with the interactional construction of narratives within the health care domain.

This study explores one aspect of communication within medical interactions, focusing on how patients employ linguistic processes which display agency as they manage their health conditions. The research aims to understand the relationship between doctors' elicitations and patients' narratives as a way to contribute to knowledge of communicative events in clinical settings for the purpose of exploring how discourse analysis might be used in applied linguistics research focusing on medical discourse. In addition, by gathering feedback from practicing doctors, this project extends the sources of data for applied linguistics in regards to how doctors draw out patients' narratives and

aspects of their identities in medical interactions. The research also offers doctors a resource for better understanding how their elicitations might impact patients' responses and the development of their narratives. In sum, drawing on both sociolinguistics and NM, the study extends applied linguistics research, offering an informed and novel approach to understanding medical interactions, both when they work well and when communication breakdowns occur.

Previous research suggests that more complete narratives lead to greater patient satisfaction and more accurate diagnosis. Gaining insight into aspects of narrative and identity within medical interactions is also important to understanding how to serve patient needs more effectively:

"Narrative is ever present in medicine and is an integral aspect of the doctor and patient relationship ... If the patient's narrative is not heard fully, the possibility of diagnostic and therapeutic error increases, the likelihood of personal connections resulting from a shared experience diminishes, empathic opportunities are missed, and patients may not feel understood or cared for." (Creswell, 2005, p.1637)

This is one key reason why I chose to explore the relationship between doctors' elicitations and patients' narratives from an applied linguistics perspective with the goal of improving approaches to the analysis of workplace discourse as well as improving medical practice aimed at better patient care.

## **1.2 The premise and rationale of the study**

### **1.2.1 The premise**

Situated within an emerging area of applied linguistics inquiry, the premise of this research is that there is a narrative either implicitly or explicitly presented by the patient in interaction with the doctor and that this narrative is, to varying degrees, prompted by the health care provider (Charon, 2006; Chatwin, 2006; Erwin-Trip & Küntayl, 2007; Heritage, 2002; Heritage & Robinson, 2006; Haakana, 1999; Heritage & Stivers, 1999; Peräkylä, 1998; West & Frankel, 1991). Narrative Medicine, the term referenced earlier, was introduced into the health care vernacular by Rita Charon in 1997. Narrative within



the NM context is defined as stories told in words, gestures, silences, tracings, images, and physical manifestations realizing that “any phenomenon has to be contextualized in order to be understood” (Charon, 2006, p. 26). The approach used in this research is based on the same premise; that is, that the patient has a narrative, and it is the responsibility of providers to offer the prompts, “space”, and empathetic ear necessary for the narrative to be told by the patients. This same assumption underlies Zola’s comments about, “the process by which an individual decides that a series of bodily discomforts he labels symptoms become worthy of professional attention” (1973, p. 677).

### **1.2.2 Rationale**

I became aware of NM and the role it plays in medical encounters in Spring 2004 after hearing Dr. Rita Charon of Columbia University speak at Vanderbilt University’s Ethics Grand Rounds about this clinical approach which Charon herself developed. She outlined how NM offers patients “space” in which to speak and encourages narrative competencies for clinicians. As an applied linguist at Vanderbilt University for 14 years at the time, I wanted to explore how a clinical approach such as NM influences the discourse of a doctor-patient interaction. Did it improve communication between doctors and patients by offering patients more space in which to speak as it intended, or did it impose new communication challenges? In light of this introduction to NM, the study grew out of the desire to gain insight into how narratives in the interactional language of medical encounters relate to clinicians’ elicitations.

I began from the working hypothesis that how well a patient’s narrative is presented directly corresponds to features (eg. type, frequency, distribution) of the prompts offered by the doctor (Boyd & Heritage, 2006; Cicourel, 1999; Heritage & Robinson, 2006, among others). The literature review will demonstrate support of the hypothesis that language is co-constructed so that any interlocutor’s input shapes the co-interlocutor’s output (Bochner & Ellis, 1995; Eggly, 2002; Jacoby, 1995; Jacoby & Ochs, 1995).

Approaches integrating concepts from applied linguistics and health care communication have gradually emerged over the last three decades (Candlin and Candlin 2003, Drew and Heritage 1992, Frankel 2001, Gill, Halkowski, and Roberts 2001, Hall

2001, Heath 1986, Jones 2001, Korsch, Putnam, Frankel, Robinson, and Roter 1995, Sarangi, 2006, Tannen and Waller 1993, and ten Have 2001). The interdisciplinary approach represented by these studies provided a useful model for the specific design of this study with the addition of the NM approach, in particular. Since this technique had been developed by clinicians, it was apparent that understanding patient narratives was considered important by a sector of practicing doctors who were also medical educators. In sum, the methodology integrates a sociolinguistic approach to analyzing spoken interaction with the clinical approach of NM, thus providing a new perspective on the topic.

I set out to address this topic by drawing on various more specific frameworks and research design models. The topic proved complex from the start when I recognized that I would need to include research from 1) sociolinguistics related to interactional language, narrative, and identity, 2) health care related to communication and interview approaches, and 3) NM as a clinical approach. Addressing the topic required orienting to medical interactions through in-depth, detailed analysis of video-recorded interactions and transcriptions in addition to review of literature. An existing corpus of 482 naturally occurring videotaped medical interactions, from clinics in the state of Missouri, which were collected for the U.S. National Institute on Aging Project “Assessment of Doctor Elderly Patient Encounters” (Grant #R44 AG 15737) and which are archived in the Health Sciences Center Library at Saint Louis University School of Medicine, provided a potential resource for this purpose. I supplemented the data set with feedback elicited from evaluating doctors<sup>1</sup> as a critical part of my contextual understanding of the topic. Methodological details are more comprehensively presented in Chapter 3.

The research draws from two areas of inquiry, applied linguistics and NM, in order to explore an area where they intersect. Combining these approaches strengthens the analysis of how illness narratives are shaped by doctors’ elicitations. Using discourse analysis, the project focuses on the impact of question design on doctor and patient performance as patient narratives are co-constructed. Just as interlocutors communicate

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<sup>1</sup> Evaluating doctors refers to the doctors who were recruited to participate in the study to offer feedback on the video-recorded interactions. These doctors are differentiated from the doctors whose interactions with patients are recorded.

in everyday life, patients and doctors use narrative as a way to make sense of life events as they relate to the patient's condition (Capps & Ochs, 1995; Ochs & Capps, 2001). Further, emphasis is placed on how participants' construction of narrative coherence, or a consistent sense of "what's going on" (Tannen & Wallat, 1993), influences interactional language and frames the manner in which patients present their identities. Narrative coherence is defined in more detail later in this chapter.

As noted, I employ an interactional sociolinguistics (IS) framework and methodology to accomplish this applied linguistics research, and I also use concepts from NM, a method developed for eliciting patient narratives, exploring how to use NM as an analytic frame in applied linguistics. To the best of my knowledge, this research represents the first attempt to merge these two frameworks, suggesting how sociolinguistic analysis might be enhanced as well as contributing to the area of health communication. Focusing on the narratives that patients construct in interaction with doctors, a range of approaches to doctor-patient interaction is reviewed. Information is presented on doctors' perceptions of the relative effectiveness of these different approaches of eliciting patient narratives. Although I set out to gain feedback from doctors about the elicitation approaches used in the selected medical interactions, I also found that the evaluating doctors utilized the frame of constructing narrative coherence even as they evaluated the interactions in the study. This finding may reflect the extent to which narrative is used in our lives. This frame of constructing narrative coherence is discussed in detail in chapters 4, 5, and 6.

Interactions from a video corpus of 69 naturally occurring medical interactions, (selected from the larger corpus mentioned above) are analyzed for elicitation type and narrative elements, followed by a more detailed discourse analysis of twelve of the interactions. Further in-depth analysis is undertaken on three interactions, which are used for eliciting evaluating doctors' perceptions and to contextualize doctors' elicitations and patients' narratives. The research explores how information gathered on effective ways of interacting with patients can be used to raise the awareness of doctors regarding the skills required in doctor-patient interaction and the complexities of communication in a medical setting.

This analysis comes at a critical time in medicine in the U.S. when applied linguists are drawn to researching medical interactions due to economic and technological circumstances that may impact communication between patients and doctors. One negative factor which might impede effective communication from taking place is the price of health care which may exceed what any individual can pay, and often times, even more than insurance companies are willing to pay. This in turn, restricts the amount of time doctors may spend with patients, which may in turn affect the quality of the decision-making in a medical visit (Gafni & Whelan, 1999). Thus, the health care “system” may be seen to a large extent as a constraint on the type of communication and interaction that takes place in the medical encounter. This analysis is also situated within a context where health care has become technology-centered rather than patient-centered as evidenced by the emergence of Electronic Medical Records (EMR’s), which have been designed to increase accuracy, decrease errors, and most importantly, to save time. Microsoft, a software company, recently released iPatient, which virtually constructs the patient as the sum of their lab tests and imaging in a web-based medical records application, which is an example of an EMR. As a result of having instant access to detailed patient records, specific information about the patient is consequently often expected to be fully absorbed by the doctor before the doctor actually meets the patient (Verghese, 2008). Verghese (2008) directs a spotlight on the “chart-as-surrogate-for-the-patient” approach to medical care, suggesting it should not take the place of skilled bedside manner and hands-on physical examination, although he acknowledges that future iterations of an EMR may eventually include the digitized input of a patient’s narrative as the patient speaks it. The analysis in this research focuses attention on the patient’s identity<sup>2</sup>, a different sort of I-Patient; the discourse analysis examines how this identity is co-constructed in the medical interaction through the patients’ narratives, as well as exploring how the process of co-construction is relevant to the medical encounter.

Drawing from both applied linguistics and health care communication, the analysis provides an interdisciplinary approach, to better understand how meaning is constructed in medical interactions through doctors’ elicitations and the co-construction of patients’ narratives and identities. It will become apparent that narrative is an

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<sup>2</sup> Identity is defined and more fully discussed in Chapter 5.

important discourse strategy in the participants' construction of relevant meaning in medical encounters.

### **1.3 Situating the topic**

Professional discourse, which explores the relationship between discourse and context (Gunnerson, 2009; Sarangi, 1999) in applied linguistics studies has been categorized in the following three groups: 1) the descriptive, genre-based studies focusing on specialized registers, 2) interpretive studies of talk and interaction in professional settings, and 3) problem-centered, interventionist studies, which include collaboration between discourse analysts and members of various professions (Sarangi, 2006, p. 209). This research draws from all three categories with emphasis on the second category, which assists in contextual understanding of medical interactions in professional settings.

Over thirty years ago, Kleinman, Eisenberg, and Good (1978) considered lessons from anthropological and cross-cultural research perspectives. At that time, the perception of the growing crisis in health care in the U.S. was already percolating, with identified causes including unacceptable and rising costs, difficulties in attaining medical care, and "dissatisfaction with the 'quality' of the medical encounter" (p. 251). Developing evidence was showing that "clinical reality is perceived in different ways by doctor and patient" (p. 255). Since then, time allotted for medical appointments has diminished significantly due to rising health care costs and budget restraints, and this trend has increased the pressure for more effective communication between doctor and patient (Whaley, 2000). While communication breakdowns clearly do not occur with every interaction, applied linguists, health care providers, and educators who train doctors have indicated a need for continued development of better communication with the patient in medical encounter (See Cordella, 2004a; Duffy et al, 2004; Epstein & Hundert, 2002; Hamilton, 2003; Hamilton & Woodward-Kron, 2010; Kim et al, 2004; Rowe et al, 2002; Sarangi, 2006). The communication problems which might be situated within the interaction between doctors and their elicitations and patient and their narratives may be improved upon by drawing from an inter-disciplinary approach such as the one used in this current study. This research focuses on representing the complexities of these

encounters in order to shed light on possible strategies for minimizing communication breakdowns.

According to Roter and Hall (1992), “The main ingredient in health care is talk” (p.3) and they suggest that it is the deficiencies in talk that prevent the medical encounter from achieving its therapeutic potential. When communication is ineffective, patients may be put at risk, diagnoses may be delayed, and there is potential for mistrust, non-adherence, and inadequate medical outcomes (Roter & Hall, 1992). Factors contributing to this may include the type of training health care providers receive as well as stress, time restraints, and barriers related to social interaction in these very personal experiences. Additionally, with the state-of-the-art medical technology used today, test results may supersede the patient’s narrative in the doctor’s decision-making process (Verghese, 2008). In response to this need for understanding patients and their conditions better, Charon (2006) offers NM, which contends that elicitations coupled with offering the patient “space” in which to present their narrative are important in medical communication.

The following statement describes very well the developing interdisciplinary approach to analyzing medical interactions. “When you step into an intersection of fields, disciplines, or cultures, you can combine existing concepts into a large number of extraordinary new ideas” (Johansson, 2004, p. 2). The research in this thesis builds on the growing body of work that involves the merging of fields of professional health care discourse and discourse analysis (Cordella 1999, 2004b, 2008; Sarangi, 2006 among others), which describes and analyzes the manner in which meaning and self are constructed in medical interactions.

As an applied linguist, I bring to the matter of analyzing communication in health care an understanding of the influential and respected position Evidenced-based Practice (EBP) holds in medicine (Greenhalgh, 1999; Grol, 2001) as well as with the knowledge that much of what happens in health care in many contexts is done well through various modes of communication. Rather than adopting a problem-oriented approach, I focus instead on analyzing what is accomplished in these interactions from a sociolinguistic perspective, highlighting themes and the effectiveness of approaches as they relate to the connection between doctors’ elicitations and patients’ narratives (Candlin & Sarangi,

2004; Chatwin, 2006; Heritage, 2002; Heritage & Robinson, 2006). Medicine is by nature a language-centered professional context (Gunnarsson, 2007) with its own set of measures for standard patient care and health outcomes, which need to be understood in order to interpret medical discourse. Using the EBP approach, health care professionals seek to use the best and most appropriate evidence available to them to make clinical decisions for patients (Brophy, 2009). I am also aware of the socialization process in which I have been immersed through examining medical interactions and interviewing doctors. This literacy was very important in the analysis of the data; understanding the medical profession's ways of performing and communicating is essential to the researcher's ability to negotiate guidelines and applications (Sarangi, 2006).

## **1.4 Relevant definitions**

### **1.4.1 “Patient” and “doctor” definitions and roles**

Understanding doctors' elicitations and patients' narratives begins with identifying the participants and their roles in the medical encounter. The following section provides working definitions and introduces these concepts, which are further discussed in subsequent chapters.

A “patient” is one who “receives or is registered to receive medical treatment” (Oxford Dictionary, 2010). Zola further hypothesized that “there is an accommodation physical, personal, and social to the symptoms and it is when this accommodation breaks down that the person seeks, or is forced to seek medical aid” (1973, p. 679). In other words, it is when this breakdown in accommodation occurs that one identifies as a patient and realizes that there is a story to tell. It is through the words of the illness story that patients transparently reflect their own “realities” (Summerson Carr, 2006, p. 636). Summerson Carr is here suggesting that in the Western world to be ‘healthy’ means using words to reflect this mental status; and correspondingly as one identifies as a patient, it is the words spoken which are indicators of one's health status. How these words are organized (Labov, 1972; Georgakopoulou, 2006) into the patient's narrative may also tell part of the patient's story and reveal their identity (De Fina, 2006; Holmes, 2005; Thornborrow & Coates, 2005; Schiffrin, 1996). Language is the main tool humans use to present the events in their lives, and they do this through storytelling, a universal genre

found in all cultures as a vehicle for socialization of values and world views and a powerful means to reflect on and present these “realities”. Silko (1986) very powerfully claims, “Stories are all we have. They are who we are, and all we have to fight off illness and death” (p. 2).

A “doctor<sup>3</sup>” is “a person who is qualified to treat people who are ill, who is qualified to practise medicine, especially one who specializes in diagnosis and medical treatment” (Oxford Dictionary, 2010). Foucault (1973) underscored the difficult task doctors have to “unravel the principle and cause of an illness through the confusion and obscurity of symptoms” (p. 88). This could be considered a strong argument for further attention to be given to analyzing the interaction between providers and patients and the often confusing development of the patients’ narrative. Health professionals are presented with the daunting task of unpacking the complexities related to patients’ health as communicated through patient narratives.

By the end of the 18th century, medical education had shifted from teaching and saying to a way of learning and seeing; in less than half a century, medicine transformed its perception of disease “from a classical notion that disease existed separate from the body, to the modern idea that disease arose within and could be mapped directly by its course through the human body” (Foucault, 1973). In the 1930’s, the discovery and use of both sulfa drugs and penicillin further solidified this notion; therefore, it is not surprising that medical education, at least in the U.S., has made operative use of patient interaction only from the early 1900’s and that it remains an arena which is not yet totally understood as it continues to transform (Pomerantz, 1995). In the last several decades the question-tree review-of-systems (see Appendix H) approach to the medical interview has become the standard technique in U.S. medical settings (Groopman, 2007). This approach is important to consider in the interpretation of medical interactions since doctors are trained to use this method to elicit patient information and it impacts the overall structure of the discourse.

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<sup>3</sup> Although both “doctor” and “physician” are commonly used in the U.S., the term “doctor” will mostly be used throughout the thesis. Similarly, “clinician” and “provider” are used to refer to medical diagnosticians.



Overall, the question-tree formulary has served clinicians' and patients' needs fairly well (Groopman, 2007). However, when considering how to enhance this very unique communication event, it is important to also consider Mishler's (1984) pertinent question, "How are the understandings related to differences in general perspectives, on the one hand, of doctors framing questions and making recommendations within the technical-scientific standpoint of the biomedical model, and on the other hand, of patients with orientations grounded in the concerns of daily life?" (p. 6). Mishler (1984) categorized this distinction by differentiating the Voice of Medicine, what "physicians attend to and ask about" from the Voice of Lifeworlds when "patient refer to the personal and social contexts of their problems" (p. 95). The frame of each of these two voice worlds will inform this study.

#### **1.4.2 "Elicitation", "narrative" and "narrative coherence" defined**

*Elicitations* are of particular importance to the analysis of institutional discourse (Cameron, 2000; Drew & Heritage, 1992; Freed & Ehrlich, 2010; Tsui, 1992; Weber, 1993), which includes medical interactions. Since elicitations are one of the main components analyzed in this study, it is important to clarify what constitutes an elicitation as used in this project. Elicitations are sanctioned by the occasion of the medical visit (Barton, 2000). The term "elicitation" is useful to describe the prompts that speakers offer responders because defining the term "question" is problematic (Freed, 1994; Freed & Ehrlich, 2010; Holmes & Chiles, 2007). The form and function of prompts often vary from the standard interrogative and may include declaratives or minimal feedback among other forms. However, studies such as that of Heritage and Robinson (2006) use the term "question". Both terms are used in this study, with "elicitation" used to encompass all prompts by a speaker, and the term "question" only when referencing other studies and comparing question type to Heritage and Robinson's (2006) data. Elicitations in this study include conventional question forms along with forms which offer the co-participant the floor or option to continue speaking. These may include discourse markers (*well, but*) (Schiffrin, 1994) and backchannels (*uh huh, mhm*) (Benkendorf, Prince, Rose, de Fina, Hamilton, 2001; Schiffrin, 1996). Although elicitations may include requests for confirmation, opinion, or evaluation, for the

purposes of this analysis, a working definition for elicitation is “request for information” based on the speakers’ intentions; that is, the speaker intends for the listener to understand that certain information is being sought (Searle, 1979). This is a widely accepted definition used in discourse analysis (Frankel, 1990, Stenström, 1984, West, 1984). According to Drew and Heritage (1992), “the institutional representative”, in this case the doctor, “is allowed to gain a measure of control over the introduction of topics and hence of the agenda for the occasion” (p. 42) through elicitations. This analysis explores the connection of these aspects of elicitations as they relate to prompting patients’ narratives. Further, the analysis shows how elicitations are used as a device for developing narrative coherence.

Definitions of *narrative* vary and are not widely agreed upon even within a single theoretical framework or discipline, including sociolinguistics. Therefore, it is important to define what is meant by narrative within the scope of this project. Generally speaking, narrative is used as a way to make sense of the world reflecting our experience as we navigate through our lives (Ochs & Capps, 2001) and involve ourselves with others through an account of an event (Holmes, 2003). Following Labov (1972), the narrative of personal experience is a report of a sequence of events that has entered into the biography of the speaker by a sequence of clauses that correspond to the order of the original events.. Within this framework, a narrative is “one method of recapitulating past experience by matching a verbal sequence of clauses to the sequence of events which (it is inferred) actually occurred” (pp. 359-60). Labov (1997) defines narrative more specifically as “the choice of a specific linguistic technique to report past events”, and a “minimal narrative” as a “sequence of two clauses which are temporally ordered” (1997: p. 360). In this study, and described more fully in Chapter 4, the Labovian framework is used to establish whether the patient renderings meet criteria for narrative, and the Ochs and Capps (2001) framework is used for exploring particular aspects of the patients’ narratives.

To expand the definition, a narrative may be viewed as 1) a form of communication for constructing realities and identities, as well as 2) the means to produce the final product of narrative (Georgakopoulou, 2007). Each approach also provides its own particular vocabulary for analysis and interpretive idiom (Bamberg

2004; Ochs & Capps, 2001). Narrative may be viewed as occurring in a discourse environment and may be not only embedded but also emergent (Georgakopoulou, 2007) and co-constructed (Helsig, 2010; Hydén, 2010; Hyvarinen, et al., 2010, Ochs & Capps, 2001; Rimmon-Kenan, 2006). The structure of narrative may also be viewed as dynamic and evolving within the interactional context of a medical encounter.

*Narrative coherence* can be defined as the rendering of a story which offers interactive participants a consistent sense of “what’s going on” (Tannen & Wallat, 1993). Linde (1993) describes coherence as a discursively constructed causal explanation of events. Kleinman (1988) suggests that patients develop narratives as a way to understand and show the relationship between their identity and their illness.

Developing these concepts, I suggest that both patients and doctors contribute to the patient’s narrative as they construct narrative coherence. As an approach, this provides one account of the relationship between doctors’ elicitations and patients’ narratives. Since the narratives analyzed in this study are interactionally co-constructed, as demonstrated through the analysis, I suggest that doctors use elicitations and patients use narrative as devices for co-constructing narrative coherence.

Narrative coherence is, in part, each participant’s attempt to answer the implicit questions “Why?” and “How?”. Kleinman (1988) considered the existential questions “Why? and How?” as found in the hypothetical patient question, *Why do I have this illness and how did it happen?* However, for the purposes of this study, these “Why? And How?” questions are more immediate to the specific task at hand of each medical encounter. Hypothetical questions related to the doctor may be, *Why is the patient’s condition currently this way given the information available?* Or in relation to one particular case study, *How is it possible for the patient’s condition to have developed in a certain way, if she is adhering to medical intervention, as she claims?* This analysis will show that this last question identifies one of the complications related to chronic illnesses in particular, where patients’ behaviors and adherence to intervention may be uncertain or difficult to check. Throughout the analysis narrative is viewed, not only as a product, but also, as a vehicle through which to construct narrative coherence.

### **1.5 What this thesis is and is not about**

Before moving to the research questions, organization and further explanation of this thesis, it is important to delineate what this thesis does and does not attempt to address. The thesis is an applied linguistics analysis of the manner in which doctors' elicitations and patients' narratives inter-relate. The discourse of doctor-patient interaction is analyzed and its contribution to the co-construction of patient narrative and identity is explored. While the analysis offers an account of the extent to which doctors' elicitations shape patient narratives and how the clinical approach may impact this relationship, it is not a comprehensive review of the NM approach nor its impact on patient outcomes. It is also not a critical account of evaluating doctors' approaches to the medical interview. The study takes into account preliminary quantitative data from a corpus of naturally occurring medical interactions in order to identify interactions for more in-depth, qualitative analysis. This approach is detailed in the Methodology described in Chapter 3.

### **1.6 Research questions**

The following research questions addressed in this thesis focus on applied linguistics frameworks associated with interactional language and co-construction of patient narratives and identities while drawing from an interdisciplinary approach to understanding aspects of medical interactions:

1. What is the relationship between doctor elicitations and the form of patients' accounts of their illnesses?

Research Question 1 relates to the descriptive aspect of the research and is addressed in Chapters 3 through 6. The analyses in Chapters 4 and 5 provide insights into the complexity of this question.

2. How do doctors evaluate the adequacy of patients' accounts of their illnesses during consultations for purposes of forming working diagnostic assessments and

treatment plans?

Research Question 2 corresponds with the evaluation portion of the research and is associated with the data collected from evaluating doctors and addressed in Chapter 6.

### **1.7 Organization of thesis**

Following this introductory chapter, Chapter 2 reviews the literature and establishes this research within the theoretical framework of sociolinguistics. It discusses a considered selection from the wide range of literature necessary to place this study at the intersection of applied linguistics and NM. It also introduces and establishes the clinical approach of NM as an analytic tool for understanding narrative within the medical encounter context.

Chapter 3 describes the methodology used to address the research questions of this study. Methodology for the phases of data analysis and collection is presented delineating the rationale for the selected methodological approaches, which includes the combination of demographic and narrative data necessary for the selection of narratives for discourse analysis. This chapter includes preliminary evaluation of the 69 medical interactions related to data pertaining to participant demographics, clinical contexts, and other relevant contextual data necessary for orienting the analysis in Chapters 4, 5, and 6. The demographic information regarding the patients and doctors is presented to introduce the group of participants before undertaking more detailed analysis of the individual interactions and participants' identities. This chapter describes the process used to select the interactions identified for in-depth analysis and for the Phase 2 study with evaluating doctors. This chapter also presents the methodological aspects of the analytical frameworks along with preliminary analysis of the data set. It provides a description and evaluation of the interactions in the video data, using Heritage and Robinson's (2006) question typology to analyze doctor's initial elicitation and Ochs and Capps' (2001) narrative dimensions to analyze the narrative elements. This preliminary analysis begins to establish important concepts related to this study including the role of doctors'

elicitation types within the context of medical interactions as well as the co-construction of patients' narratives. Three analytical chapters follow.

Chapter 4 focuses on narrative analysis which offers a deeper understanding of the relationship between doctor elicitation and patient narratives. Twelve of the 69 video recorded interactions have been selected, representing low, average, and high ranges of "space" offered to patients in which to speak, in order to demonstrate the complexities of this relationship by exemplifying co-construction, patient identity, and importantly, how the seeking of narrative coherence impacts doctors and patients in interaction. Three of the 12, which comprise the stimulus for Phase 1, are discussed in considerable depth. This approach analyzes patient narratives in context as a means to understanding how participants respond to each other interactionally as a way of constructing narrative coherence. Further, this chapter explores how NM as an analytic approach to narratives assists and broadens possibilities of analysis in understanding medical narratives and how they might be achieved, as well as their meaning.

Chapter 5 delves deeper into the analysis of the participants' complex identities as evidenced in the video-recorded medical interactions. An interactional sociolinguistic approach is used to explore how these participants present themselves, not only in their sanctioned roles of doctor and patient, but as individuals with extra-situational identities (Georgakopoulou, 2003, 2007) which flex and change based on the unique relationships between participants. The analysis in this chapter assists in understanding the extent to which doctors' elicitations and patients' narratives inter-relate and the extent to which this shapes how participants present their identities as they construct narrative coherence.

Chapter 6 presents data from the Phase 2 data collection focusing on evaluating doctors' perception of narrative elements in selected medical interactions. This second data set offers insights into the clinical perspective regarding what is perceived as effective elicitation approaches of patient information and narratives, as well as indicating how evaluating doctors perceive doctor and patient roles. It also reveals how evaluating doctors began to construct narrative coherence even as they evaluated existing medical interactions.

Chapter 7 pulls together the discussions from previous chapters detailing the contributions this study makes to applied linguistics. It considers possible conclusions

and implications for further discussion related to the topic of the relationship between doctor elicitation and patient narratives within medical encounters as viewed through sociolinguistic and NM approaches.

### **1.8 Summary**

In summary, this thesis explores the claim that patients attempt to create coherent narratives as they present medical issues to their doctors. The aims of the study are to examine the extent to which doctors' elicitation draw out, shape, and sometimes, constrain, patients' narratives. Additionally, the study aims to analyze the connection between this co-construction of patients' narratives with how they portray themselves as they construct identities in interaction with their doctors. The final aim of this study is to elicit feedback from practicing doctors to offer an insider perspective on the role of doctors' elicitation, patients' narratives, and the participants' roles in medical encounters. The analysis approaches narrative as an important aspect of how patients and doctors construct relevant meaning in medical encounters. The analysis also indicates how patients construct themselves as active agents within the asymmetrical power framework of the medical interaction.

In the next chapter, the literature review further situates and establishes how this research project contributes to existing knowledge in this research area.





## **Chapter 2 Literature review**

### **2.1 Introduction**

The literature focusing on language and communication in medical contexts is wide-ranging. As introduced in Chapter 1, the topic of this study intends to narrow the focus to the connection between doctors' elicitations and patients' narratives. This review will demonstrate that the selection of theoretical frameworks and methodological approaches in this current study make possible a unique exploration of communication in medical interactions. This review focuses on literature, which relates to analytic approaches associated with the investigation of narrative as a discourse strategy. Key terms were introduced in Chapter 1 while this chapter focuses on providing background and the explanation of key concepts associated with the analysis of medical discourse.

In the past few decades, linguistic research has reflected increased interest in analyzing interactional talk (Boxer, 2002; Georgakopoulou, 2007; Hymes, 2003; Tannen 1993; van Dijk, 1997), in work and institutional settings (Drew & Sorjonen, 1997; Duranti, 1992; Sarangi, 1999, 2001, 2006; Stubbe et al., 2003). The applied linguistics literature on health care communication includes the research of Candlin and Candlin (2003), Cordella (1999, 2004b, 2008), Drew and Heritage (1992), Frankel (2001), Gill, Haakana, (2002), Halkowski and Roberts (2001), Hall (2001), Hamilton (2003), Hamilton, Gordon, Nelson, Cotler, and Martin (2008), Heath (1986), Heritage and Robinson (2006), Holmes and Major (2003), Jones (2001), Korsch, Putnam, Frankel, Robinson, and Roter (1995), Stivers (2001), Tannen and Wallat (1987), ten Have (1991, 2001), and Waitzken (1984, 1990) among others. From this growing body of research, there is evidence that the focus is predominantly on the evolution of patient-centered communication as well as a concern with addressing issues of power and asymmetry (See Levenstien, et al., 1989; Maynard, 1991; Peräkylä, 2002; Robinson, 2001; Sarangi & Slembrouck, 1998; Ten Have, 2007).

This chapter reviews the current research within applied linguistics, situating the study as an empirical study of real-world communication and its implicit issues associated with healthcare interactions (Bygate, 2004; Candlin & Sarangi, 2004; Sarangi & Candlin, 2010). Particular emphasis is placed on interactional language, narrative, co-

construction of narratives and identity in the specific context of medical settings. This literature review encompasses a broad range of research from the fields of linguistics and medical discourse spanning the last several decades and provides the scaffolding upon which the present research is built. This broad approach is used in order to better understand the complexities of what takes place in a medical encounter; and thus, it is necessarily selective and organized thematically. The literature review is extended throughout the other chapters of this thesis as relevant to the chapter topic.

The review in this chapter includes key research from linguistic frameworks (largely applied linguistics and sociolinguistics) and from various discourse analytic (DA) approaches such as interactional sociolinguistics (IS) and conversation analysis (CA). The survey includes both qualitative and quantitative literature related to narrative, interactional language, identity, and Narrative Medicine (NM). As Menz (2011) notes, there is a “trend towards combining genuinely qualitative analysis with quantification of observations” (p. 339) (see also Haakana, 2001; Heritage & Robinson, 2006; Menz & Al-Roubaie, 2008; Stivers, 2001), giving studies in linguistics more prominence within medicine. It also includes research in health care communication related to interview approaches. The quantitative studies, which have targeted question-type in medical interactions, such as Heritage & Robinson’s (2006) typology used in this study, have helped develop conceptual models. The qualitative research has emphasized individual behavior, responsibility, and identity. These concept models guided the design and development of my research project. This review will also demonstrate how my research is situated within a number of relevant theoretical frameworks and contributes to existing knowledge in this area.

According to Menz (2011), linguistically oriented research on doctor-patient communication may be: 1) analyses of both conversation organization and interaction dynamics at a syntactic and semantic level, 2) investigations into the influence of macrostructural social dimensions, and 3) practically-oriented studies in the interest of applicability, (p. 330). Candlin and Candlin (2003), Sarangi and Candlin (2003), and more recently Sarangi, (2006) have focused the attention of applied linguists on the importance of drawing from various disciplines for data related to the language of medical encounters and identified existing gaps in the literature due to a lack of research

using an interdisciplinary approach. What seems to have been of most interest to applied linguists is the doctor-patient interaction in a clinical setting. One trend which has been identified in the discourse of healthcare is a focus on the professional communication of doctors and their actions as they invite, allow, or at times, discourage patients from telling their stories (ten Have, 2001). Other researchers, using various frameworks (including Drew & Heritage, 1992; Frankel, 1990, 2001; Gill, Halkowski & Roberts, 2001), identify and support the concept of the co-construction of the medical interaction. Yet, a focus on the co-construction of the medical interaction as narrative and the role of the provider in prompting patient narratives has not been fully explored. Using insights from this earlier research, my project examines the relationship between the type of elicitations used by doctors and the quality of the patients' narratives of illness as evidenced through co-constructed patient narratives. I will argue that although the relationship is multifaceted and complex on various analytical levels, there is evidence that one aspect of the relationship is driven by a desire for narrative coherence for both the doctor and the patient, which begins at the initial phase of the medical encounter.

Heath (1986) in particular analyzed opening sequences in general medical interactions in the U.K. over 20 years ago and demonstrated that they were orderly. Heath distinguished between new and returning appointments, the former being patient initiated, the latter being doctor initiated. Garfaranga and Britten (2003) established that there are selection rules that govern opening sequences<sup>4</sup> and analyzed how these rules were followed or broken which influenced the relationship to developing "mutuality between patients and doctors" (p. 243). They found evidence which, contrary to Heath (1986), established that who initiated the visit was of little importance; what was important, however, was that the actual nature of the consultation was being locally negotiated by the patients and doctors, rather than being externally decided before the interaction took place. They demonstrated that a selection rule works as a normative framework and does not mandate what the patient and doctor do in the interaction.

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<sup>4</sup> An example of a selection rule in an opening sequence is the selection between the Type-4 Question type, *How are you?*, more likely used in a follow-up medical visit, versus a Type-1 Question type, *What can I do for you today?*, which may be selected for new consultations (Garfaranga and Britten, 2003).

A patient's narrative is viewed as one means for understanding patients' health conditions (Capps & Ochs, 1995; Ochs & Capps, 2001). Patients' narratives are connected to doctors' elicitations in ways that are complex and which are only beginning to be understood. To date, research in the area of health care communication has identified relationships between various aspects of medical interactions, including how doctors' elicitations and patients' narratives inter-relate (Cordella 1999, 2004a; Heritage 2006; 2010; Heritage & Robinson, 2006), resulting in the current trends and frameworks presented in this review. The focus is on how elicitations are used to co-construct narratives. This chapter reviews research related to the topic of doctor elicitation and patient narratives in order to provide background to address the research question *What is the relationship between doctor prompts and the form of patients' accounts of their illnesses?*

Medical discourse has been a focus for analysis since the days of Hippocrates. From this vast analysis of medical discourse, it has been clear that medical training and communication parallel each other and that doctor-patient communication is critical for accurate diagnosis, intervention, and patient adherence to treatment plans (Brody, 1980; Schulman, 1979; Kaplan, Greenfield, & Ware, 1989; Vermeire, Hernshaw, Van Royen, & Denekens, 2001).

The development of methods for analyzing medical discourse and patient narratives as well as research on politeness, mundane talk, and institutional talk have all made great progress in the last 40 years (Candlin & Candlin, 2003). And yet, there remains minimal research which draws from multiple disciplines in order to fully understand the complex inter-play of language and behaviors in medical interactions. Further, prior to this current study, there is no known research that integrates approaches from applied linguistics and the relatively new clinical approach of NM.

In the past couple of decades, there has been an increase in discourse-based research in various professional settings (Georgakoupoulou, 1997; Holmes, 2005; Mullany, 2007; Sarangi, 1999). Not only have the studies varied in methods of analysis but also in the means of dissemination of results from analyzers to practitioners of the specific fields (Sarangi, 2001).

The next two sections focus on discourse-based research and narrative, highlighting significant work relevant to my thesis.

## **2.2 Narrative as a discourse strategy**

Section 2.2 reviews the literature associated with narrative used as a discourse strategy with the aim to help establish how narrative is viewed and analyzed in this study.

### **2.2.1 Discourse analysis (DA)**

Since narrative in this study is viewed as a discourse strategy, this section introduces DA, which is used to analyze narrative in interaction. Over the last several decades, DA has been developing and evolving as it gains disciplinary diversity. What DA means to scholars within this diversity varies. Within the scope of this study, I view DA as a term which encompasses the study of language “beyond the text” within specific instances of language use (Schiffrin, Tannen, & Hamilton, 2006). The relevant modes of analysis within DA, specifically IS and CA, are addressed later in this chapter. To analyze medical interactions, it is important to take into account general human interaction and sociological concerns (Parsons, 1951) and the foundational basis for research on medical interactions. Theories of human interaction and language are embedded in the analysis of medical discourse (Mishler, 1984). Looking back to early influences on social orders that people utilize to make sense of the world, ethnomethodology was developed as the study of how shared methods of knowledge are used to understand everyday life (Garfinkel, 1967). Within this theoretical framework, Garfinkel (1967) also established that human action and human institutions are based on the idea that humans make shared sense of their contexts and act accordingly. Social interaction is a type of social organization and has been referred to as the “interaction order” by Goffman (1983). Ethnomethodology and the study of the concept of self and how self is presented in everyday life (Goffman, 1959) prepared the groundwork for sociolinguistic analysis of spoken interaction. The sociolinguistic frameworks used in my study stem from these foundational concepts. The following section introduces the use of DA and the main analytic approach used in this study, IS.

DA examines the wider discourse context, “the web of social events” (Ainsworth-Vaughn, 2006), with emphasis on social features of interaction as well as occasion

(Fisher, 1993; Holmes, 2008; Schegloff, 1992; Schiffrin, 2006), which are relevant to the analysis of medical encounters. DA provides the means to “identify the norms of talk among different social ... groups in different conversational and institutional contexts, and to describe the discursive resources people use in constructing different social identities in interaction” (Holmes, 2008, p. 355). These studies assist the analysis of doctor-patient roles in interaction with each other. Further, they help to develop a means for analyzing how narrative might be used to construct identity in interaction (Georgakopoulou, 2011). This aspect is connected to this analysis, which explores the extent to which medical institutional settings and the sanctioned role of “doctor” (Barton, 2000) impact the doctor-patient interaction, and thus, the construction of patients’ narratives and their identities.

There are many varying descriptions of DA, but for the purposes of this study, I draw on Gumperz (1992). In using DA, we look to “a speaker – oriented perspective and ask what it is speakers and listeners must know or do in order to be able to take part in a conversation or to create and sustain conversational involvement” and focus on “the necessary goal-oriented interpretative processes that underlie their production” (Gumperz, 1992, p. 306).

The use of DA also emphasizes:

the linguistic analysis of naturally occurring connected speech or written discourse...to attempt to study the organization of language above the sentence...therefore to study larger linguistic units, such as conversational exchanges...It follows that discourse analysis is also concerned with language use in social contexts, and in particular with interaction or dialogue between speakers” (Stubbs, 1983, p.1).

Gumperz (1982) utilized an interdisciplinary approach (anthropology, linguistics, pragmatics, and CA) to analyze meaning in social interaction. Developed from the DA approach of ethnography of communication, this approach focuses on the contextualization cues (Gumperz, 1982, 1992, 1996) that interlocutors use to understand conversations in order to participate in them more fully (Holmes, 2008). Gumperz (1982) suggested that interactional experiences help interlocutors form expectations

regarding how they might utilize contextualization cues. Gumperz (1982) also focused on how interlocutors might contextualize cues differently based on cultural differences. Similarly, in institutional settings, the culture of the world of medicine might lead interlocutors to interpret contextualization cues differently from the lifeworld and vice versa (Gumperz, 1982; Mishler, 1984). Drawing from these studies, this analysis utilizes contextualization cues found within discourse in the medical institutional setting to help analyze how meaning is constructed between patients and their doctors in these encounters.

DA research makes use of both qualitative and quantitative research methods to assist in the interpretation of spoken and written texts. The approach provides a means of analyzing the organization of language in constructing realities and takes account of the relevance of factors such as gender, ethnicity, socioeconomic status, professions and institutions, and power with the caveat of “no a priori limit to the scope and level of what counts as being relevant context” (van Dijk, 1997, p. 14). Similarly, this study seeks to analyze the organization of constructing realities in medical settings, focusing particularly on roles and power in these asymmetrical encounters between doctors and patients.

DA encourages the researcher to ask why the speakers construct certain roles and/or tell a narrative. Further the approach explores how a speaker makes interactional decisions about sequential appropriateness (Heritage & Raymond 2007; Schiffrin, 1995). Some DA studies have shown how patients might exert power in the question and answer approach of the medical encounter (Gill, 1999; Halkowski, 1994; West, 1984) and focuses on the construction of identity in discourse.

Within the framework of sociolinguistics, a relational approach to identity has been proposed (Coupland, 2001; Fletcher, 1999; Georgakopoulou, 2011; Holmes, 2006). This approach focuses on how interlocutors use linguistic resources, which are made available from specific interactional contexts, to construct unexpected identities in practice (Bucholtz, 2003). For the purposes of this study, a contemporary view of identity is used which characterizes identity as flexible, variable, a social accomplishment, about self and other, and constructed through discourse. Identity is also viewed as emergent, positional at multiple social levels, indexical at multiple linguistic

levels, relational, and partial (Bulcholtz & Hall, 2005). Identity is discussed more fully in Chapter 5 where roles and power are elements instrumental in the analysis of the interactions. Although the focus of this study in regard to identity is on the patient, it is also important to consider how and to what extent doctors' professional identities (Holmes, 2006; Holmes & Marra, 2005; Holmes, Stubbe, & Vine, 1999; Roberts, 2007; Roberts, Campbell, & Robinson, 2008; Roberts & Sarangi, 2003; Sarangi, 2001, 2006) impact interactions (Georgakapoulou, 2007; Mullany, 2006). The professional identity of the doctor in the doctor-patient interaction is explored further in Chapter 6.

More recent research using DA has focused on understanding what takes place in medical settings (among others Cordella 1999, 2004a, 2008; Hamilton, 2003; Hamilton, Gordon, Nelson, Cotler, & Martin, 2008; Holmes & Major, 2003; Powers, 2001; Ramanathan, 1997) by understanding roles, expectations and other aspects of interactions. DA is used in this research to examine the contextualized meaning of the doctors' elicitations in medical interaction in order to consider their relative efficacy in eliciting patients' narratives. DA provides a means of exploring how patients' identities and agency emerge (Georgakoupoulou, 2006) as they interact with doctors, even as both interlocutors seek to construct narrative coherence within medical encounters (Hyvärinen, Hydén, Saarenheimo, & Tamboukou, 2010) an important point of analysis in this present study.

### **2.2.2 Interactional sociolinguistics (IS)**

The DA approach of interactional sociolinguistics (IS), derived from Gumperz' (1982) work, is commonly applied in the study of workplace discourse (among others Holmes, 2006; Stubbe et al., 2003) and is the approach used in this study. IS focuses on how people interact socially (Coupland & Jaworski, 2009) and examines how interlocutors use social processes to create meaning, establish and develop relationships, exert power, and construct identities in social interaction (Schiffrin, 1994; Tannen, 2005, 2006; Wodak, Johnstone, & Kerswill, 2011), and directs attention to how expectations and practices may or may not be shared (Tannen, 2005). Although in the past the approach has been used in the critical analysis of communication problems (Roberts, et al., 1992), it had not been extensively used for the analysis of medical interactions



(Aranguri, Davidson, & Ramirez, 2006) until more recently (Dew et al., 2008; Hamilton & Britten, 2006; Moss & Roberts, 2005). Research on medical interactions in the past has drawn from other approaches, such as Conversational Analysis (CA), which is described in the next section. IS uses recorded (audio and video) interactions as a way to capture the meaning-making process of talk within a given context, which is also the approach of this study.

Importantly, IS focuses on how that which is spoken and its meaning is situated within the context of the spoken act (Schiffrin, 1995). Thus, this approach focuses on using contextual cues to identify the intention of the participants (Gumperz, 2006; Holmes, 2008) and analyze their negotiation within an encounter (Roberts, et al., 1992). IS is used to analyze the “wider sociocultural context impacting on interactions” (Stubbe, et al., 2003) and “goal-oriented interpretive processes” (Gumperz, 1992). IS is used to explore the role contextual cues play in the understanding of medical interactions, focusing on interlocutors’ intention of elicitations and responses in their respective roles. In using this method, important questions to ask are “what aspects of background knowledge are relevant at any one time and is extracommunicative background knowledge enough?” (Gumperz, 2006, p. 217). IS may be used in conjunction with concepts from communities of practice, which assists the analysis of groups of people situated around a mutual endeavor (Eckert & McConnell-Ginet, 1992) within organizations. The IS method has also been useful in exploring identity in interaction and in narratives, an important aspect of understanding the nature of these interactionally, co-constructed narratives. The method is useful in describing and analyzing what does and does not seem to work well in medical communication.

Further, this study seeks to use the DA approach of IS within the combination of frameworks of sociolinguistics and NM. The literature review on IS is expanded in Chapters 4 and 5.

### **2.3 Narrative structure and co-construction**

Thus far, the survey has reviewed research focused on social interaction and the ways that linguists and others have addressed what takes place in an encounter. Since my research seeks to explore the connection between doctor elicitations and patient

narratives, understanding what constitutes a narrative and its elements and structure is another area of research which offers insight into how patient narratives emerge and are co-constructed in medical interactions.

Expanding on the definition of narrative in Chapter 1, narrative discourse utilizes varied linguistic structures to construct one's life story (Ervin-Tripp & Küntayl, 2007; Georgakopoulou, 2011; Labov, 1972, 1997, 2006, 2009; Labov & Waletzky, 1967; Ochs & Capps, 2001). Yet, researchers recognize that there is friction between the narrator's need to build a storyline that pulls together series of events in a smooth manner and the desire to capture a listener by including the complex layers of experiences which include vivid descriptions, moves of uncertainty, and conflicting feelings (Capps & Ochs, 1995). Much of what causes this friction in the medical encounter is related to both the patient and doctor's agenda and identity as expressed through narrative. This section of the literature review includes the body of research that analyzes narrative in both everyday conversation and in health care settings. It offers a review of the research, which analyzes not only the narrative but also the contributions of the narrator and narratee.

In order to understand narrative in the medical encounter, it is important to analyze what constitutes a narrative, the elements and structure of the narratives (Georgakopoulou, 2007; Holmes, 1998; Labov & Waletzky, 1967; Ochs & Capps, 1995, 2001) and how they are jointly constructed (Bamberg, 2004; Bell, 1988; Corston, 1993; Duranti, 1986; Goodwin, 1986; Riessman, 1993; Rymes, 1995) by patients and doctors. It is also important to recognize various analytic approaches to narratives as a means to explore and understand how patients present themselves and their health concerns to their doctors. Each framework yields varying degrees of understanding of the structure of these narratives.

### **2.3.1 Narrative approaches**

The prominent research by Labov & Waletzky (1967), which helped develop what has become known as the canonical approach to narrative analysis, offers an understanding of the internal structure of narrative, while the post-canonical narrative analysis approaches attempt to expand this understanding and go beyond the analysis of narrative structure. According to the canonical approach, the internal structure includes

an abstract (What happened?), orientation (Where? Who? Why? When?), complicating action (Then what happened?), evaluation (So what? What are the consequences of the event?), result/resolution (What finally happened?), and coda (Return to present or time of speaking). Labov and Waletzky's (1967) research in particular has influenced many studies in narrative analysis. In spite of its influence, this work has not gone uncriticized as narrative researchers have considered what takes place beyond what this framework reveals about narratives (Bamberg & Georgakopoulou, 2008; Georgakopoulou, 2006, 2007; 2011; Holmes, 1997; Hyvärinen, et al., 2010). The limitations of this framework to the analysis of the narratives in this study are further addressed in Chapter 4. I use Labov's (1972) approach as a first step to establish the selected patients' renderings as narratives before analyzing these interactions for particular elements and dimensions related to their co-construction and how narratives are used to construct meaning and identity. Post-canonical approaches focus on social interactional views of narrative (De Fina & Georgakopoulou, 2008; Georgakopoulou, 2011) which encompass this current study. This latter approach emphasizes the discourse environment important to the analysis of how doctors' elicitations are connected to patients' narratives and identity construction in interaction.

### **2.3.2 Narrative and identity**

Identities are constructed through the telling of narratives (Ayometzi, 2007; Georgakopoulou, 2011; Wagner & Wodak, 2006; Wodak & De Cillia, 2007). The important work by Ochs and Capps (2001) extends our understanding of narrative by offering insight into elements of narrative dimensions, focusing on the connection between the narrator's life experience and the narrative, and further, of the narrative to the specific context. This framework has been cited extensively and has been tested over time in studies focusing on narratives (notably Bamberg, 2004, 2010; Bamberg, de Fina, & Schiffrin, 2007; Bucholtz & Hall, 2005; Capps & Ochs, 1995; Georgakopoulou, 2006, 2007, 2011; Goodwin, 2008; Roberts, Campbell, & Robinson, 2008; Schiffrin, 2006 among others). Yet, the extent to which we may understand the interactional nature of narratives and the emergence of meaning (Georgakopoulou, 2011) created out of spontaneous interactions, such as the medical interview, is a limitation of this framework.

Ochs & Capps' (2001) Narrative Dimensions and Possibilities rubric is one of the tools used in this research for analyzing patient interactions for narrative elements and to explore the extent to which these elements have been prompted by doctors as an initial step to establishing the co-construction of patients' narratives.

The narrative dimensions, which are used in the analyses in Chapters 4 and 5, are tellership, tellability, embeddedness, linearity, and moral stance (Ochs & Capps, 2001). Tellership involves determining how high or low "the co-teller's involvement is in the development of the narrative constructed in interactions" (p. 26). Narratives are tellable "in the extent to which they convey a sequence of reportable events and make a point in a rhetorically effective manner" (p. 33). Narrative embeddedness refers to the degree to which a narrative "stands independent of the surrounding discourse" (p. 36). A relatively detached narrative is one where "the content is thematically unrelated to the focus of the current topic of discourse" (p. 37). Linearity refers to "the extent to which narratives...depict events as transpiring in a single, closed, temporal, and causal path" (p. 41). Moral stance is "the teller's recounting of self as virtuous" in the event rendered (p. 105).

These dimensions account for the ways in which narratives of personal experience are realized in everyday life, including experiences with illness, for which the Ochs & Capps (2001) rubric was developed. This rubric provides a framework by which to better analyze the internal structure of patient narratives, adding depth of understanding to who the teller is, the significance and believability of their story, and how it is structured and connected to the context. In the discussion in Chapter 4, I will demonstrate that although this post-canonical framework offers much to the analysis of patient narratives, it falls in line with more traditional notions of narrative coherence and thus does not offer the tools necessary to more fully comprehend those narratives which are less coherent.

Expanding our understanding of the narrator in relation to narratives, Georgakopoulou (2007) offers the concepts of situated and extra-situated identities within small stories (Bamberg, 2004, 2006; Bamberg & Georgakopoulou, 2008; Georgakopoulou, 2011) as an approach to analyzing participant identities and their contributions to the task at hand. Small stories are purposed as the non-canonical, shifting narrative fragments of the stories of life as they emerge in interaction

(Georgakopoulou, 2007, 2011; Banyham, 2010). The use of the small story frame may be viewed as problematic, in that, identifying a small story implies delineation from Labov's canonical definition of narrative. Yet, it is an attempt to focus upon and legitimize these other types of narratives, which occur in everyday life. Segments of narratives in interaction, such as those which occur within medical interactions, may fall into this category.

These approaches inform this analysis by suggesting how the identities of doctors and patients assist in structuring and developing patient narratives. The role of the participant positions each to seek narrative coherence from different perspectives. The doctor identifies as the individual who has power and knowledge. Doctors view their role as one that must gather the type of information deemed necessary to make diagnostic decisions. The patient identifies as an individual who must seek assistance for her health condition. In identifying as a patient, the patient must recall and present information and the story of what she believes is the reason for seeking medical attention, and thus, must make sense of her own narrative.

Narrative and identity are addressed in greater detail in Chapters 4 and 5.

### **2.3.3 Interactional narratives**

Earlier, I noted the interactional nature of human communication as the basis for analyzing medical interaction. Similarly, narratives which are produced in social interaction demonstrate the interactional nature of narratives as the basis for co-construction (Liebscher, 2007). The interactional nature of narrative permits experiences to be shaped and co-constructed by participants (Bakhtin, 1981; Cheepen, 1988; Georgakopoulou, 2007; Labov, 1997). Narrative in medical interactions is co-constructed as a "real-time interaction product" (Heritage & Maynard, 2006, p.1). The experience is given meaning through narrative with certain participants showing authority within the interaction (Ainsworth-Vaughn, 1994, 1998; Corston, 1993; Duranti, 1986; Goodwin, 1986; Rymes, 1995). It is also the context in which participants position and display agency (Davies & Harré, 1990), "a discursively mobilized capacity to act" (Miller, 2010) as a co-construction (Bucholtz & Hall 2005). This co-construction is part of the paradox found in sharing personal experience through narrative form, in that once

they are shared, they become de-personalized and exposed to scrutiny, making them open to the input of others and continued experiences (Ochs & Capps, 2001). The interactional nature of narrative is a basis of analysis in my research and offers added dimensions of insight into understanding the relationship between doctor elicitations and patient narratives and how one is shaped by the other. Specifically, I will demonstrate how each participant seeks coherence as they negotiate the meaning of the patients' narrative when in interaction with each other.

## **2.4 Narrative and medicine**

A key function of narrative is its use as a means of problem-solving by putting into words and making sense of life events (Capps & Ochs, 2001). Narrative in institutional talk is a "useful means of instantiating diverse aspects of a person's complex social and professional identity in the workplace" (Holmes, 2006, p. 24). Much of the literature looking at narrative and medicine (including Barton, 2000; Charon, 2006; Fisher, 1993; Frank, 1995; Greenhalgh, 1999; Hamilton, 2003; Hamilton, Gordon, Nelson, Cotler, & Martin, 2008; Holmes, 1997; Hydén, 1997; Schegloff, 1997) highlights the encouragement of storytelling and the sequencing of interaction. One can see evidence of how a complex narrative emerges out of the face-to-face encounter between doctor and patient. Within this framework the onus is clearly on the doctor to begin to understand and detect the worldview of the patient. This task requires eliciting pieces of the patient's narrative while "retrieving elements of the story setting and connecting them to subsequent emotions and actions" (Capps & Ochs, 1995, p. 12) and symptomologies. The analysis of the function of narrative in this particular type of interaction is especially relevant to the research as doctors and patients attempt to make sense of the patients' conditions.

In the last two decades there has been a trend in medical education toward the consideration of shared decision-making between doctors and patients (Gafni & Whelan, 1999). A basic premise of this approach is that before patients are able to share in decision-making for their health, they will need to be offered the opportunity to participate by the doctor. This decision-making opportunity is typically achieved by a verbal prompt. The probability of co-participation in the decision-making process is

believed by some to be greatly increased by co-participation in the development of the patient's narrative (Ong, De Haes, Hoos, & Lammes, 1995). According to Collins, Britten, Ruusuvuori, and Thompson (2007), there does not seem to be active use of these approaches in actual medical encounters in spite of attempts to alter medical education curricula. Further, it seems that patients do not "expect or wish for more than limited involvement" (p. 80). This research on co-participation and decision-making informs the analysis of this aspect of medical interaction.

#### **2.4.1 Narrative elements**

Literature on narrative has predominantly focused on the following elements: time and place of events, a plot line that shows a linear beginning, middle, and end, and the intended purpose and attention to audience and circumstance (Labov & Waletzky, 1967; Thornborrow & Coates, 2005). Each of these elements plays a role in how the standard narrative is structured, shaped, and co-constructed. In analyzing these elements, it is possible to explore what is behind the "key narrative function of making sense out of life events" (Ochs & Capps, 2001, p. 96).

In much of the research done on narratives in social interaction, the narratives have been prompted by an interviewer (Labov, 1972). However, more recent narrative research has focused on narratives which occur spontaneously in social interaction (Bamberg, 2004; Georgakoupoulou, 2007; Holmes, 2003; Ochs & Capps, 2001), with a focus on how one may display identity through narrative (Cordella, 2004a; De Fina, 2003; Georgakoupoulou, 2007; Holmes, 1998; Linde, 1993). This latter approach is fundamental to this current study where the analysis explores how one's identity and sanctioned roles forge his or her approach to seeking narrative coherence in the medical encounter.

With earlier studies, many researchers looked for whether or not a narrative existed in interactions based on established narrative criteria. When narratives were established, coherence was used as an indicator of a rich and more complete narrative. More recent studies have shown that narrative coherence may be influenced and limited by a variety of factors including illness (Hyvärinen, et al., 2010). My analysis aligns with this more recent research in that it also demonstrates how chronic illness challenges

the patients' ability to construct more coherent narratives, which is addressed more completely in Chapters 4 through 6.

### **2.4.2 Doctor and patient interaction**

The type and quality of doctor-patient interaction has been proven to have a direct positive effect on health care delivery and patient outcomes (Teutsch, 2003). Studies on doctor-patient interaction have been done using both CA and DA frameworks and methodologies. The doctor-patient interaction is a unique construct based on varied purposes: creating inter-personal relationships (Roter & Hall, 1992) in order to sustain mutual trust (Irwin, McClelland, & Love, 1989), exchanging information as a resource for informed decision-making (among others Inui & Carter, 1985; Roter, Hall, & Katz, 1988), and making diagnostic and treatment decisions (Cordella, 2004b; Ong et al., 1995) as a means for reconciling the two agendas presented by doctor and patient (Levenstein, et al., 1989). Qualitative analyses have focused on structure and phases of the medical encounter (ten Have, 1989), orientation of talk (Mishler, 1984), storytelling (Ainsworth-Vaughn, 1998; Hunter, 1991), delineating good and poor doctor-patient communication (Roberts & Sarangi, 2003), and turn-taking (Frankel, 1984; Tannen & Wallat, 1993). Much of this literature focuses on aspects of the interaction which relate to asking questions, offering information, counseling, patient education, diagnostics and treatment plans. Studies of medical discourse have focused on strategies that doctors and patients use to communicate with each other which are based on the relationship developed between doctor and patient and particular social variables such as sex, age, and social status (Blanchard, Labrecque & Ruckdeschel, 1988; Charon, Greene & Adelman, 1994; Fisher, 1993; Fisher & Todd, 1986; Frank & Bertakis, 2003; Irish & Hall, 1995; Sundquist, 1995; van Ryn & Burke, 2000; Willems, De Maesschaick, Deveugele, Derese, & De Masschaick, 2005). Over the past thirty years, doctors' information-seeking and giving have received more research attention than some other areas. This body of research shows disparity in data related to the extent to which information-seeking and giving are represented in medical interactions. The disparity seems to be dependent on specific medical interactional contexts (Heritage & Robinson, 2006; Robinson, 2006; Roter, 1988; Waitzkin, 1978). Some research on doctor-patient interactions emphasize



the power asymmetry and control doctors have over patients in their institutionally sanctioned roles (Burchard & Rowland-Morin, 1990; Stewart & Roter, 1989; Ten Have, 2007), and the impact this power has on medical outcomes related to chronic diseases (Kaplan, Greenfield, & Ware, 1989).

In contrast to this emphasis, with a trend toward shared decision-making and the influence of the consumer model of health care, there has been some research on the refocusing of the balance of power on the patient's rights as consumers and on doctors as service providers (Roter & Hall, 1992). Studies have documented the importance of doctor-patient communication and its impact on patient adherence to medical interventions (DiMatteo, Hays, & Prince, 1986; Hall, Roter, & Katz, 1988). These studies undergird my research, which focuses on aspects of how doctor question-types, doctor-patient roles, and institutional setting shape the interaction between doctor and patients. Most of the research on doctor-patient interactions has focused on the performance of the doctor whereas more recent studies (Cordella, 2004b), including my research, also focus on the discourse constructed by patients. Throughout these studies, there have been common threads related to how doctors and patients seek and offer information related to the patient's condition. Seeking narrative coherence on the part of both doctors and patients is an additional element I propose as essential to doctor-patient interaction and to the interpretation of the rebalancing of power.

## **2.5 Drawing from other approaches**

Section 2.5 focuses on two other approaches referenced in this study: CA and Narrative Medicine (NM). CA is reviewed to establish the contribution these types of studies have made to the analysis of medical interactions. Further, the CA review situates the Heritage and Robinson (2006) initial question typology in this present study, with a more detailed discussion of questions as elicitations addressed in Chapter 4. NM helps frame the unique approach of this project, as a first attempt to intersect the clinical approach of NM with sociolinguistics. NM attempts to place particular attention on the patient in the medical interaction with one aspect of this approach focusing on offering patients "space" in which to speak. Therefore, literature is included which focuses on the perceived connection between time and space within interactions.

### 2.5.1 Conversation Analysis (CA)

This study also draws from research using other approaches to discourse analysis including CA, which was founded by Harvey Sacks in conjunction with Emanuel Schegloff and Gail Jefferson. During the 1960's when this approach was being developed, the analysis did not focus on connecting interactional variables with medical decision-making (Heritage & Maynard, 2006) or the development of the microanalysis of discourse (Charon, Greene, & Adelman, 1994; Ten Have, 2007). CA developed as the study of talk-in-interaction, viewed as "the primordial site of human sociality" (Schegloff, 1992).

According to Heritage (2002), CA

embodies the core notions that 1) communicative meaning is inherently contextual in character, 2) social context is unavoidably dynamic and is managed through the participants' actions, 3) the specific contextual significance of actions is 'structurally' achieved by means of rules and practices of conduct which are systematically related and organized as systems, 4) the contextual significance of action also involves inference, and 5) all this is managed through the significance of talk (p. 916).

CA has been used to analyze the sequential context in the medical encounter (Heritage & Maynard, 2006; Heritage & Robinson 2006; Pilnick et al., 2010), looking at organization and turn design (Jefferson, 1983; Lerner, 1996; Pomerantz, 1984; Sacks, 1992; Schegloff, 2000), embodied action (Goodwin, 1986; Streeck & Hartge, 1992), interactional sequences (ten Have, 1999; Heritage, 1984; Schegloff, 1996), emergence of talk, structural phases in institutional interaction (Drew & Heritage, 1992), and the use of transcription and coding for analysis (Bales, 1950; Jefferson, 1985). An early problem found with coding was that although it offered information regarding specific elements, it intentionally distanced these elements from context (Schegloff & Sacks, 1973). Although distal context was deliberately excluded from analysis, the relevance of context has been constantly debated (Wetherell, 1997; Schegloff, 1999; Schegloff, Koshik, Jacoby, & Olsher, 2002), and some CA studies seem to consider context to a greater extent (Heritage, 2006; Stivers & Heritage, 2001). The quantitative data analyzed through CA are predominantly that of everyday conversation versus institutional talk, as Heritage (1984) has argued that institutional talk, including talk in medical settings, is based on "ordinary talk" (p. 239), although more recently there have been CA studies of

institutional talk specifically related to medical interactions (Drew & Heritage, 1992; Mangione-Smith et al, 1999, 2006; Stivers 2001).

CA has contributed to the investigation of doctor elicitations in connection with patient responses. In particular, Heritage and Robinson's (2006) work on a typology of initial provider question types used in interactions with patients in community-based clinics in metropolitan areas of the U.S. This typology is described in greater detail in Chapter 4. Expanding their research, this study also takes into account the relationship between question types, with their frequency and distribution, and the quality of patients' accounts as shaped and co-constructed by doctors' elicitations. Doctors' questions are structured not only to elicit information, but also to accomplish particular tasks within taking patient's history such as setting agendas, acknowledging preconceived ideas about patients and their health status, and eliciting preferred responses (Boyd & Heritage, 2006; Cicourel, 1999).

This typology provided a structured approach to analyzing the type of relationship, which existed between initial doctor elicitations and the structure and development of the patients' narratives. Expanding on this typology, Robinson (2006) identified three types of reasons why patients seek medical attention: 1) new concern, 2) follow-up concern, and 3) chronic-routine concerns, and doctors and patients orient themselves accordingly (p. 23). The third reason is indicative of the kinds of concerns represented by the vast majority of the patients in my research corpus. Understanding the type of questions in relation to the reasons why patients seek medical attention provides a framework for understanding how medical interactions are structured and for understanding the context for constructing their meaning. The use of these elicitations demonstrates the gate-keeping role doctors have and the implicit power designated to these roles to make decisions (Menz, 2011; Speer & Parsons, 2006).

More recently, Heritage (2010) focuses on how doctors orient their questions in relation to their patients, and in turn, how patients orient to the doctor's questions. Heritage's study offers support for the value of examining how the design of doctors' questions shapes the construction of patient narratives. Although this study offers support for doctor and patient orientation to elicitations and responses, it does not differentiate "well visits" from chronic illness re-checks as delineated by Robinson

(2006). This latter category is representative of the majority of the interactions in my corpus.

The main patient presentation of concern, which has been extensively studied (including Anspach, 2008; Brody, 1987; Heritage & Maynard, 2006; Stoeckle et al., 1963; Zola, 1973), is located in the initial phase of the medical encounter and is often produced in response to elicitation from either a nurse or doctor. Doctors use these reasons to determine how to begin the medical interaction with the patient. In addition to responding to the doctors' elicitations, patients are compelled to account for the medical visit to legitimize the doctorability of their concern and seek doctors' validation. Patients use these descriptive practices: 1) making diagnostic claims, 2) invoking third parties as part of decision-making process, and 3) making "troubles-resistant" claims, such as coping, etc. (Heritage & Robinson, 2006, p. 65). At times, patients use narrative for describing the discovery process of their symptoms and concerns by 1) announcing some pain, 2) using the phrase, "At first I thought", and then 3) giving reasons for why their theory was inaccurate (Halkowski, 2006, p. 87). In relationship building between the doctor and the patient, history-taking is an important phase in the interaction, where the patient includes the reason for the visit as well as any preexisting conditions, medications currently being taken, family history, and other social situations related to the condition of the patient. These studies support the notion that doctors and patients orient to the occasion of the clinic visit. This idea is the basis for my suggestion that participants negotiate meaning through interaction which is embedded in their orientation to the specific medical interaction.

Relevant to this research is the CA attention to interactional sequence based on the idea that "some current conversational action proposes a local, here-and-now 'definition of the situation' to which subsequent talk will be oriented" (Heritage, 1984, p. 245). There is an "interpretive corollary" where the initiator uses an action to presume what a next speaker will say. The speakers enter "an area of common understandings and assumptions just known and taken for granted" (p. 254). Typically, it is noted, "some analysis, understanding or appreciation of the prior turn will be displayed in the recipient's next turn at talk" (p. 255). According to Levinson (1983), the institutional context helps us to understand sequence in relation to questions and answers. Knowledge

of interactional sequencing informs how we understand doctors' prompts as they are presented throughout medical interactions. The role of sequence in institutional context is important to understanding how patient's narratives emerge and are constructed as they follow and constitute responses to doctors' elicitations. Yet, sequential analysis alone does not "account for situated interpretation" (Gumperz, 2006, p. 218).

Frame and how it relates to structures of expectation for co-participants (Coupland & Jaworski, 2009) is also considered in this analysis since "actions and meanings can be understood only in relation to the immediate context, including what preceded and may follow it" (Tannen & Wallat, 1993, p. 205). Kleinman (1980, 1988) and Mishler (1984) observed that there are variant knowledge schemas in medical encounters. This phenomenon is evident in medical encounters when it becomes apparent that clinicians are asking questions, a speech act seen as embodying power asymmetry (Ainsworth-Vaughn, 2006) from a particular knowledge paradigm unrecognizable by the patient, and vice versa. In the analysis in this thesis, this phenomenon is evident in how doctors and patients position themselves as they orient to each other and to each others' knowledge and information paradigm.

Although my research utilizes concepts and data related to doctor question types from CA, it does not focus on the social construction of the mechanisms which generate initial provider questions and patients' responses. Instead, it focuses on how the language that doctors and patients use is connected to the sociocultural context of the medical encounter. IS moves beyond the CA determination that speech acts are emergent and recognizes the illocutionary force behind a speech act as sequentially emergent (Georgakoupoulou, 2006). Importantly, CA research aims to explain the text, not what might be *behind the text*. Taking context into consideration is an important element in this research study and is discussed further in the next section.

### **2.5.2 Narrative Medicine (NM)**

As mentioned earlier, this research is a first attempt to integrate linguistics and NM. The most influential pioneering work related to NM has been done by Charon (1997) as she developed the concept and coined the term "Narrative Medicine". NM evolved out of the medical and comparative literature perspectives, and is thus, grounded

in sound narrative theory (Chatman, 1978; Genette, 1980; Rimmon-Kenan, 2005). NM assumes that following evidence-based medicine (EBM) alone cannot assist patients in dealing with the full extent of illness and finding meaning in their health conditions (Charon, 2006). In this sense, the NM approach attempts to treat the whole person instead of solely focusing on symptoms and disease processes. To this end, the approach requires clinicians to develop narrative competencies and how to read the patient's story as text. NM also strives to nurture empathy among clinicians for their patients. The NM approach attempts to modify the medical interview approach commonly referenced in the U.S., which follows a question-tree formulary and review of systems model. This model focuses on the clinician gathering data, developing rapport, and educating and motivating the patient (Cole & Bird, 2005). However, this and other patient-centered models have not been effectively demonstrated in medical encounters (Collins, Britten, Ruusuvuori, & Thompson, 2007). Although this traditional approach is not conducive to pedagogical adaptation, it attempts to describe the *interaction* in a patient-centered approach, while Byrne and Long's (1976) seminal work focuses on doctors talking *to* patients as the title implies.

Neither the question-tree formulary nor the Byrne and Long models offer characteristics of a "successful" doctor-patient encounter. These models seem to focus on the behavior of the doctors more so than on the patient and patient's participation, which at best seems to be implied. Whereas the question-tree formulary focuses on patients by aligning questions to the patients' main concerns, NM attempts to enhance this approach to the medical encounter by recognizing both the patient and the doctor in the midst of the clinical setting and institutional demands. Studies on patient-centered communication have focused on rapport building (Campbell, 2005), the training of the clinical approach of patient-centered care (Dahm, 2011; Martin, 2003; Stewart, 2001; Stewart et al. 2003), the impact on adherence (Hahn et al., 2010), and particular disease processes (Hamilton, 1994). This current study focuses on the approach of NM as a patient-centered model of communication.

The NM approach emphasizes the interaction between doctor and patient in eliciting patient narrative through "space" offered to the patient to speak and "connotes a practiced medicine with narrative competence and is marked with an understanding of the

highly complex narrative situations among doctors, patients, colleagues, and the public” (Charon, 1997, para. 7), with focus on the patient’s narrative. This narrative competence is challenged by the nature of illness narratives in relation to linearity and coherence.

The concept of offering patients “space” in which to render their narratives follows Mishler’s (1986) notion that narratives occur during medical interviews if those being interviewed are “given room to speak” (Cheshire & Ziebland, 2005, p. 18). If given the opportunity, “patients offer themselves to physicians as text” (Wood, 2005, p. 286). The concept of “space” in the medical encounter is difficult to fully describe and observe. In attempting to identify an observable behavior in the medical encounter which may demonstrate NM, and thus, operationalize “space”, doctor-elicitation frequency for the medical interaction emerged as a variable that could imply that the patient is given more time and perceived “space” in which to speak. Chapter 1 introduced what constitutes an *elicitation* in this study focusing attention on its role as “prompt”. According to mental space theory (Fauconnier, 1994, 1997) *time* relates to the concept of *space* and may be applied to discourse analysis (Oakley & Hougaard, 2008). “Space”, as an embodied concept, alludes to the idea that the perception of “space” is connected to time, and “influences how we talk and think about temporal relations” (Kranjec & McDonough, 2011). Further, the “transfer between space and time is... open to...conscious reflection” (Tenbrink, 2010). This research explores the connection between doctors’ elicitations as prompts, which offer patients varying degrees of perceived space in which to speak. In relation to the interactions in this study, when patients are offered “space” they may perceive it as the time allocated for them to speak about their condition. In speaking about their health, they are given the opportunity to utilize narrative to make sense of illness in their lives. This concept is more fully addressed in subsequent chapters, particularly in Chapter 4. There is sociolinguist interest in the affordance of this approach and the “space” offered to patients in relation to patient agency and empowerment. Although this study is similar to the work others have done in relation to medical narratives (Capps & Ochs, 1995; Ochs & Capps, 2001; Cordella, 2004b), using NM creates a unique approach to addressing the complexity of what takes place in the medical encounter. It must be noted that the NM approach is also not without criticism. Although Charon presents NM as an approach to give voice to

patients and their experiences, her presentation of patients' actual stories in their own voices is limited. The patients' stories Charon presents are filtered through the doctor's understanding of these stories in what she calls parallel charts, non-medical records charts that doctors create to sort through patient narratives. My research extensively exemplifies the importance of hearing patients' voices through their stories, in their own words, in order to learn about these individuals and their health conditions. Also, the approach of offering patients "space" in which to speak is cause for problems related to patients' abilities to construct coherent narratives, which are addressed in Chapters 4 and 5.

Similar to the other approaches presented in this review, NM focuses on interaction between doctor and patient with emphasis upon the relationship between doctors' elicitations and patients' stories. Implicit to the framework is the notion that doctors' elicitations, particularly those which offer patients "space" in which to speak, co-construct patient's narratives. This aspect of the approach differentiates it from the other analytic frameworks. Further, NM is a clinical approach that is being explored as an analytic framework in this study. The impact NM as a clinical and analytic approach has on patients' narratives is discussed in Chapters 4, 5, 6.

## **2.6 Narrative coherence**

Noted above, a shift in paradigm has been emerging concerning how to view, analyze, and understand all types of narratives, including those which may be found to be less coherent. Most of the patient narratives in this study, created out of spontaneous interactions with doctors, pertained to chronic illness. Since some were viewed as less coherent, exploring other frameworks for narrative analysis was important to more fully understand patients' narratives in this context. Traditionally, and when using canonical approaches to narrative analysis, narrative coherence has been viewed as a way of determining one's ability to use language and emotional and mental capacity (Chafe, 1990; Labov, 1982; Peterson & McCabe, 1983). Although the area of childhood development has focused on narrative coherence more extensively than many other areas (Oppenheim, Nir, Warren, & Emde, 1997), some research has looked to narrative coherence as marking diagnoses and advancement of certain mental disorders (e.g.



schizophrenia) and disease processes (e.g. Alzheimer's ) (Gubrium, & Holstein, 1998). Narrative coherence has also been used to determine whether a speaker's moral stance is substantiated by the narrative rendered (Ochs & Capps, 2001).

More recently, there has been some research focus on narratives which lack narrative coherence, particularly in the cases of trauma and certain medical conditions (Freeman, 2010; Hydén, 2010; Hyvärinen, et al. 2010). According to Hydén & Brockmeier (2008), illness narratives are described as “undecided, fragmented, and broken” (p. 2). Within the context of illness narratives, analyzing linearity is reconsidered (Hyvärinen, et al, 2010). These new approaches move toward a wider understanding of narratives, and importantly, how the patients themselves are viewed. Therefore, there has been more recent consideration of analytic tools for understanding the full range of narratives found in life circumstances. Although the canonical approaches offer much insight into the construction and co-construction of narratives, my research demonstrates how these approaches do not fully explore the range of coherence often found in medical encounters. My research also adds the dimension of NM to this exploration of narrative coherence and how the performance of seeking narrative coherence shapes the interaction between doctor and patient. Findings in my study demonstrate that the range of coherence in medical encounters may also include less severe, chronic cases of illness, where the lack of coherence itself may tell part of the patient's story. This discussion in this thesis shows that NM seems to be a clinical approach which not only allows for, but encourages, the full range of narrative coherence. It also focuses on narrative competencies which doctors may develop in order to “read” these complex, and often times, less coherent patient narratives. The literature reviewed in this chapter situates the study and identifies specific areas of exploration in order to address the research question *What is the relationship between doctor prompts and the form of patients' accounts of their illnesses?*

## 2.7 Conclusion

In summary, studies from varied theoretical frameworks have demonstrated that the medical encounter is a multifaceted interaction which warrants analysis to shed light on the complex interplay between doctors' elicitations and patient narratives. This

literature review situates my research questions within the frameworks of sociolinguistics and NM, using a IS approach. The review has surveyed the existing body of research related to prompts and to narratives, predominantly analyzed as discrete elements, each within the context of the medical encounter.

The review also highlights what has not yet been undertaken prior to my research, which is an exploration of the relationship between the doctors' elicitations and the quality of the patient's narrative in relation to the NM framework. This study makes a contribution to the understanding of patient narratives by focusing on how doctor and patients seek narrative coherence in medical encounters. The process of seeking narrative coherence as presented in participants' voices is evidenced by its impact on the emerging interactional patient narrative and offers an important context to explore patient agency. There has also not been any prior research on how doctors rate the efficacy of different prompts or techniques in eliciting adequate patient narratives in relation to the NM framework. When focusing on context, identity, and expectations, the IS and narrative analytic frameworks dovetail and may be used jointly to help provide a deeper understanding of what is actually taking place in a medical encounter. Chapter 3 will describe the methodological details of this research.

## **Chapter 3 Methodology: Data collection**

### **3.1 Introduction**

Chapter 2 reviewed the literature as a basis for situating the present research study, establishing that although medical interactions have been analyzed for a wide range of purposes, no prior studies have related sociolinguistics to NM. Chapter 3 presents the methodological approaches and preliminary data analysis for this study. This chapter describes and justifies the methodological approaches and research design used to address the research questions. The first section focuses on the preparation of the data for evaluation from a corpus of 69 medical interactions. The second section describes the frameworks used for analysis and provides some preliminary information about these interactions as contextual background for the narrative and IS analyses in Chapters 4 and 5. The evaluation and preliminary analysis in Chapter 3 also contextualize the feedback received from evaluating doctors in Phase 2 data collection addressed in Chapter 6.

#### **3.1.1 Method design**

In this study, I utilized both qualitative and quantitative data and approaches. The main analysis of this study is qualitative, focusing on the discourse of the medical interactions represented in this study. The quantitative data was drawn upon to provide context for this qualitative analysis.

This cross-sectional study uses qualitative discourse analysis (Cheek, 2004; Gee, 1999) as well as quantitative data analysis based on Heritage and Robinson (2006). As indicated in Chapter 2, the multi-layered topic of this study benefits from an approach making use of multiple frameworks, and thus, I used a multi-method research design to collect empirical data in order to address the research questions. Using mixed research methods provides complementary strengths and non-overlapping weaknesses. This chapter provides an overview of the research design and describes the main methods employed, which include my implementation of 1) observations and discourse analysis of medical interactions from videotaped medical encounters, 2) semi-structured interviews with evaluating doctors, and 3) questionnaire surveys completed by evaluating doctors. I

used the discourse analysis approach of IS to analyze doctor-patient interaction transcriptions. In this chapter, I present specific processes used for data collection, the approaches used for data analysis, and the procedure for ethics approval. The chapter concludes with a summary of the methodology presented in the chapter.

I first begin with the description of the quantitative data, which were drawn from to help establish the context for the discourse analysis. One of the strengths of quantitative data is that its methods produce quantifiable, reliable data typically generalizable to larger populations (Creswell, 2009); a weakness is the decontextualization of the data (Johnson & Christenson, 2004). This research used quantifiable data specifically for presenting 1) demographic information, 2) discrete elements associated with the relationship between doctor elicitation and patient narratives and 3) doctors' evaluative feedback on selected interactions. The approach provides a more generalized understanding of patient-doctor interactions, while at the same time offering quantifiable variables, defined later in this chapter, as a basis for categorizing and selecting interactions for qualitative analysis. The qualitative approach offers a unique point of view from both patients and doctors as to how the individuals are situated in specific contexts, and they present who they are in their own voices, and what they are trying to accomplish.

Combining both methodological approaches strengthens the theoretical implications of the data collected and analyzed (Creswell, 2009). As described in the Literature Review, much preceding research in the areas of health care communication comprised quantitative studies, which provided variables and categorizations of specific aspects of medical interactions such as Heritage and Robinson's (2006) question typology. The research related to medical interactions has provided important bases allowing for researchers to not only describe medical interactions but to also consider why and how the interactions are constructed within particular contexts. DA studies have also offered much insight into how identities are constructed within specific contexts. Using the NM approach as a method of analysis in addition to DA offers a novel approach to analyzing medical interactions. How the NM concept of "space" is operationalized in this study was presented in Chapter 2 and describes the manner in which the elicitation frequency was conceived along with its practical application for use

in this study. Using this clinical approach as an analytic tool is further described in Chapters 4 and 6. Drawing from and utilizing both approaches offers a richer and more complete understanding of participant narrative and identity and what may be taking place in medical interactions.

Since I am using 1) two data sources, 2) dual data collection processes over a period of time, and 3) multiple data analysis tools, the triangulation of data, theory, method, and time are involved (Creswell, 2009; Johnson & Christenson, 2004). This approach allows for an analysis of the topic from varied perspectives, avoids the weaknesses of any particular method, and strengthens the findings of the data analysis; it therefore, improves reliability of methods and validity of findings (Fowler, 2009).

Two data samples were used, which were addressed in two phases. The first data set comprises naturally occurring videotaped medical interactions, a standard kind of data set for analysis within IS approach, selected on the basis of an analysis of the data collected from a Midwestern clinic in the state of Missouri, in the U.S. This selection process encouraged identifying recordings which reflect representative sets of interactions (Gumperz, 2006). Secondly, questionnaires and interviews were completed by evaluating doctors recruited from a university-based medical center and community clinics in the Southeastern region of the U.S. Phase 1 involved analyzing the interactions in order to categorize and select appropriate interactions for discourse analysis from the corpus of 69 interactions. This phase introduces the patients and their doctors as participants and their interactions for review. Phase 2 involved collecting feedback from 12 evaluating doctors on the approaches doctors use in the selected interactions for eliciting patient narratives. The characteristics of the evaluating doctors are presented later in this chapter and in greater detail in Chapter 6. This phase introduces the evaluating doctors and the context in which to situate their feedback. The research presents an innovative combination of discourse analysis and survey data related to evaluating doctors' perceptions of patient narratives.

### **3.1.2 Procuring and preparing the videotapes of medical interactions**

#### **3.1.2.1 Ethics approval**

Before permission to access the existing video corpus could be requested, ethics approval for the study was necessary. Ethics approval from the Standing Committee of the Human Ethics Committee of Victoria University of Wellington was granted in March, 2007, for use of the videotaped interactions of doctors and patients and to recruit evaluating doctors to review medical interactions, answer questionnaires, and be interviewed. Characteristics of the evaluating doctor are presented later in section 3.2.1.2. The application for ethics approval included a sample questionnaire and interview questions. After receiving ethics approval, permission was sought and granted to review the videotapes for the purposes of this study in April, 2007. Evaluating doctors in the study provided informed written consent before completing questionnaires and participating in interviews.

#### **3.1.2.2 The medical interactions corpus**

Through other sociolinguists, I learned of an existing corpus. As introduced in Chapter 1, the corpus was comprised of 482 medical interactions which at been collected between August 1998 and July 2000. Participants were recruited from three sites: an academic medical center, an inner city private clinic, and a managed care clinic. All participants were informed that the aim of the study was to examine doctor-patient interactions. Each videotaped recording represents a single clinic visit by a patient. Dr. Mary Ann Cook, principal investigator of the study, oversees the maintenance of the archive and serves as the granter of permission to access the interactions<sup>5</sup>.

Although there are some weaknesses associated with using secondary sources (Johnson & Christenson, 2004), such as the previously recorded videotapes referenced in the previous paragraph, the strengths outweigh the weaknesses for the purposes of this research. Noted weaknesses in using this type of data include the possibility that the content may not fully meet the requirements of the study and the quality of the

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<sup>5</sup> Article detailing methods and demographical particulars of study: Teresi, J., M. Ramirez, M., Oceppek-Welikson, K., & Cook, M. The development and psychometric analyses of ADEPT: An instrument for assessing the interactions between doctors and their elderly patients, *Annals of Behavioral Medicine*, 30 (December 2005), 225–242.

videotaping (including audio) may make the material difficult to use. In this case, the data from these videotaped medical interactions, which included doctors' elicitations and evidence of patients' narratives, were directly linked to the research questions, and thus, minimized the potential weakness of the approach. One negative aspect to using an existing corpus is that there was no control over how the interactions were recorded. For this originating study, the recordings were done for audio purposes, so the sound production quality was quite good for the vast majority of the videotapes received. However, since audio was the primary focus of the recordings, the physical set up of the video recorder was randomly placed in each clinic room. This means the video recordings did not permit a consistent analysis of body language; however, this aspect was not a focal point in the discourse analysis.

Additionally, patient privacy restrictions in the U.S.<sup>6</sup> have made it extremely difficult to gain ethics approval to videotape medical interactions as was made evident from other researchers in my university setting. These privacy restrictions have been noted to have a negative impact on biomedical research (American Association of Health Centers, 2008). Therefore, being able to gain access to an existing corpus of medical interactions, which met the research criteria, was instrumental to the success of my research design. Another issue with requesting access to an existing corpus created for another study was that I was at the mercy of the availability of the videotapes from the archive.<sup>7</sup> Groupings of videotapes were received in stages throughout a period of one year as they became available. Once received, I digitized the videotapes, and compressed and archived them on a local, video-streaming server.

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<sup>6</sup> The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is enforced by the Office of Civil Rights of the U.S. government. The Act ensures federal protections for personal health information which is held by covered entities, but allows for disclosure of personal health information for patient care (<http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>).

<sup>7</sup> The archive, surprisingly, did not have multiple copies of the videotapes. Only one circulating copy was available at any given time. When the archive manager discovered I was digitizing the videotapes before returning them, which I had been approved to do by Dr. Cook, he began digitizing the videotapes for future users.

In addition to its availability to me, the corpus was particularly appealing because it was large enough to set criteria pertinent to what I was trying to achieve in my study and yield a reasonable sample size. These criteria are indicated later in this chapter. It also offered interactions recorded from from different clinical settings, which added to generalizability.

I transcribed selected interactions according to the transcription conventions used by the Wellington Language in the Workplace Project and found in the *Wellington Archive of New Zealand English Transcriber's Manual* (2002). This is an adapted version of the conventions originally developed to transcribe the Wellington Corpus of Spoken New Zealand English and the New Zealand component of the International Corpus of English. As indicated in the manual, these conventions are based on Gail Jefferson's CA conventions among others (e.g. Brown, Currie & Kenworthy, 1980; Crystal & Davy, 1975).

### **3.1.2.3 Narrowing the corpus: selecting interactions for deeper analysis**

In order to accomplish both phases of my study, the following describes how a more manageable corpus size was necessary, particularly for Phase 2. As a language program director, I often adopt the "backward design" (Wiggins & McTighe, 2005) model which encourages instructors and researchers to design the study based on intended outcomes. Similarly, I followed this model in the design of my study. Starting with Phase 2, where I would elicit input from extremely busy evaluating doctors, I had to consider what was an appropriate number of interactions to present for thoughtful feedback. This was particularly important to me as I had hope for the evaluating doctors to engage in the feedback process as much as possible given their time constraints. As a non-medical clinician, I perceived their insider perspective as critical to my deeper understanding of the context in order for me to make a more meaningful analysis (Sarangi, 2001). Below I describe the process of narrowing down the number of interactions in a systematic way.

The participants of the originating study met the requirements of being between the ages of 65 and 77 and of having previously seen the doctors in the study as their primary doctor, although the length of their relationship was not indicated by the original



study data. I selected additional patient social criteria which reduced the corpus size. These criteria related to patient ethnicity and first language since I was attempting to focus as closely as possible upon the connection between the doctors' elicitations and the patients' narrative and not the impact of these two variables upon that relationship. The number of interactions which met my criteria and which contained an audible initial doctor question was 69 out of 75. In total for my study, the videotaped interactions included 69 patients meeting with 22 doctors. The recordings included 16 hours and 40 minutes of video. These 69 interactions were evaluated in detail in Phase 1 for numerous elements, including demographic information of patients and doctors, the clinical setting, narrative elements, and other relevant contextual data. These data are described later in this chapter.

From these data, the doctor elicitation frequency, which was used as one way to operationalize the NM concept of "space", as described in Chapter 2, was used to further select interactions for detailed analysis. On the basis of well established research, the "distribution of silence" (Sacks, Schegloff, & Jefferson, 1974, p. 697) and the "highest priority decision" (Zimmerman & West, 1975, p. 109) of a current speaker's selection of a next speaker assisted in the development of utilizing the NM approach of offering patients "space" as an analytic frame. In these interactions, the doctors selected the patient as next speaker and offered the floor for varied periods of time as elicitation approaches. The lower the doctor elicitation frequency the more time and perceived "space" patients were given to speak, while higher doctor elicitation frequency provided less time and perceived "space" for patients to speak. Using this variable, 12 interactions were selected for further analysis: the four interactions with the lowest question frequency, the four at the average number of elicitations, and the four with the highest number of elicitations. Since the increments of frequency were along a continuum, it was important to not extend beyond groupings of elicitation frequencies which might be considered demonstrative of a given approach. Again focusing on a backward design and what was reasonable to present to evaluating doctors as stimulus, three interactions were selected based on having the lowest, the average, and the highest elicitations, and these are used as the core anchoring interactions for in-depth analysis in Chapters 4 and 5. This selection of three interactions was helpful in more fully contextualizing the utterances in

the discourse analysis and assists the reader in engaging with the stories of these particular interactants. This decision afforded me the opportunity to see the extent to which the contextualization cues throughout these interactions, in developing communicative ecology, “work reflexively to build and change the interaction” (Auer & Roberts, 2011, p. 389). It was intended to further connect the interactions with the evaluating doctors’ responses. It was also done to demonstrate how constructing narrative coherence and presenting one’s identity is consistently developed throughout interactions. The remaining nine interactions were used to provide further support for the discourse analysis. The selection process, based on the elicitation frequency and analysis of these twelve interactions, ensured that the selected interactions were representative and not atypical medical interactions. This process offered the opportunity of a qualitative form of generalizability demonstrating “how a phenomenon can be seen or interpreted” (Talja, 1999).

#### **3.1.2.4 Variables evaluated**

The following variables are considered in this study:

- Presenting concern: Acute condition vs. chronic condition
- Presence or absence of patient companion
- Gender of provider
- Question type
  - General Inquiry
  - Gloss Confirmation
  - Symptoms Confirmation
  - How are you?
  - History Taking
- Number of doctor elicitations
- Length of visit
- Presence or absence of pain
- Narrative Dimensions
  - Tellership
  - Tellability
  - Embeddedness
  - Linearity
  - Moral Stance

Shared features of doctor-patient interactions:

- Return visit with primary doctor
- Gender of patient

- Ethnicity of doctor
- Ethnicity of patient
- L1 of provider
- L1 of patient

These variables were selected based on the intended focus of the research topic (Creswell, 2009): the doctors' elicitations and the patients' narratives. Limiting visit-type to return visits with primary doctors eliminated the differential between the type of introductory communication between a doctor and a new patient and one where a relationship is already established. Gender was controlled since there is some evidence in other contexts that the manner in which men and women construct narratives is different (Coates, 1996; Holmes & Meyerhoff, 2003; Johnstone, 1997). Gender was controlled by selecting interactions with only female patients. Ethnicity and whether each participant was a native English speaker was controlled in order to focus on native English speaking communication and avoid features which might stem from a different cultural orientation. These variables were controlled by selecting interactions with Caucasian American patients and doctors who were native English speakers.

### **3.2 Data set composition (from Phase 1)**

#### **3.2.1 Demographics**

The next two sections introduce the patients and doctors who participated in the original study. A description of social features of patients provides useful background information for better understanding the medical interactions in which they participated.

##### **3.2.1.1 The patients**

The 69 patients were Caucasian females and native speakers of English. They were between the ages of 65-77, as presented in Table 3.1 below. These were controlled variables since the study was attempting to explore the relationship between doctors' elicitations and patients' narratives and not necessarily any disparities associated with patient gender, ethnicity, or language.

Table 3.1 <i>Patient Age Distribution n=69</i>	
<b>Age</b>	<b>Number of Patients</b>
65	8
66	5
67	5
68	4
69	4
70	8
71	6
72	4
73	1
74	4
75	2
77	1
*	17
<b>Total</b>	<b>69</b>
* Precise age not available, but between the ages of 65 and 77.	

Most of the participants whose precise age was known (65%) were between the ages of 65 and 70, and represented the younger half of the distribution from the originating study. This may account for the fact that patients were physically active and that the majority of them were able to attend the clinic visit alone without a caregiver. Consequently, they were self-reliant in describing their current medical condition. This information impacted the analysis of the patients' narratives in the study in relation to tellership and co-construction.

### 3.2.1.2 The doctors

The 22 doctors in the videotaped medical interactions were Caucasian and native speakers of English. The doctors' years of experience and years working in the clinic represented in the interactions were not offered in the original study data set. Table 3.2 shows the gender distribution among doctors in the study.

Table 3.2 <i>Doctor Gender n=22</i>			
<b>Gender</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
<b>Number</b>	14	8	22
<b>Percentage</b>	63%	37%	100%

Male doctors represented 63% of the total giving a 2-to-1 ratio. This distribution is also represented in the three core interactions: two visits were with male doctors, and one with a female doctor. It is notable that the percentage of female doctors in this corpus, 37%, is higher than recent data on doctor gender distribution provided by Women Physician Congress (2008) showing female doctors to be 27% of all practicing doctors.

### **3.2.2 Contextual material**

#### **3.2.2.1 The clinical setting**

As mentioned earlier in the chapter, the medical interactions used in Phase 1 were extracted from an existing corpus of 482 videotapes which had been created for an aging study. The medical practices involved in the original study included a salaried medical practice, which was part of an academic medical center in the Southwestern part of the U.S; a managed care practice in a Midwestern suburb; and individual fee-for-service practices in a Midwestern inner city. Each room contained an examination bed, at least one chair, and a countertop. In some cases, a second chair was available, which was used by the patient during some point in the encounter.

#### **3.2.2.2 Other relevant contextual data**

Additional data were collected to provide some relevant contextual information about the medical encounters. This proved particularly helpful for those interactions selected for deeper analysis. Also, some of the following variables are presented in order to provide further contextual information for the reader, who does not have the benefit of having viewed all 69 of the videotapes or who may not have background knowledge of medical contexts in the U.S. This offers the opportunity for them to more fully

understand the contextual cues in this particular setting. Not all of these data were directly used in the analysis.

One variable for consideration was the type of concern presented by the patient. This variable was selected in order to gauge whether there was a connection between the patients' presenting concern and the doctors' elicitation types. A pattern that emerged was that the majority of the patients' presentations of concern were predominately chronic as opposed to acute as Table 3.3 depicts.

Table 3.3 <i>Presentation of Concern: Chronic or Acute n=69</i>		
	<b>Chronic</b>	<b>Acute</b>
<b>Number of Interactions</b>	67	2

The type of presenting concern seemed to greatly shape the interactional language of the encounters as well as the doctor's approach to the interview (Heritage & Robinson, 2006). Depending on the type of concern, the doctor will shift to a particular question-tree formulary-review-of systems approach<sup>8</sup>. This type of approach is commonly taught in medical schools in the U.S. in order to narrow down the diagnosis and intervention. The approach is particularly apparent when a patient presents an acute concern. This variable is an important aspect of the analyses in Chapters 4 and 5.

Another variable considered was the physical position of the patient in the room and in relation to the doctor in order to consider roles and power. Table 3.4 represents the physical position of the patient in the clinic room.

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<sup>8</sup>The question-tree formulary review-of-systems is explained more fully in Chapter 6. See Appendix H Question-tree Formulary for sample.

Table 3.4 <i>Physical Position of Patient n=69</i>	
Physical Position of Patient	Number
Seated on Chair	17
Seated on Table	41
Moving from Chair to Table	6
Table to Chair	4
Chair to Table to Chair	1

The vast majority of the patients were seated on the exam table when the doctor entered the room and began the interaction. This physical posturing may be an indicator the role of patient and may assist in the structuring the discourse – where the doctor has authority and power and asks the first question to begin the interaction.

The physical position of the doctor in relation to the clinic room and patient was examined as well and is indicated in Table 3.5.

Table 3.5 <i>Physical Position of Doctor n=69</i>	
Physical Position of Doctor	Number
Seated	31
Seated to Standing	23
Standing	10
Standing to Seated	4
Seated on Patient Table	1

Table 3.5 shows that most of the doctors began the interactions in a seated position. Perhaps this demonstrates the attempt of the doctors to be in the same physical position as the patient during the interviews although there was no evidence of this from the data, or it could be representative of the long working days of the doctor and the need to sit whenever opportunity becomes available.

The variable of a white coat became a consideration upon viewing the video-recordings of the interactions as an apparent physical difference among doctors' attire.

Whether or not a doctor wore a white coat was considered in that this symbol is an indicator of the local institutional culture, which may impact the communication between doctor and patient and was the reason why this variable was selected. The white coat for doctors is often considered a symbol of honor, authority and hierarchy. From a medical anthropology perspective, where “Western” or “biomedicine” is examined as a system, doctors are historically viewed as treating themselves as an elite group with self-imposed roles (Hahn & Kleinman, 1983). This may determine when a white coat is presented to the doctor, and in some cases, the length of the white coat depending on rank. In recent years, some clinics and/or individual doctors within clinics have chosen not to use the white coat, which has been viewed as a distancing device between doctor and patient. Data showing the representation of a white coat in the medical interactions are represented in Table 3.6.

Table 3.6 <i>Presence or Absence of Doctor's White Coat n = 69</i>		
	<b>Presence of White Coat</b>	<b>Absence of White Coat</b>
<b>Number of Interactions</b>	38	31

Table 3.6 shows the number of doctors who wore a white coat while interacting with patients, which was 38 (53%) while 31 (45%) did not. Of the three doctors in the selected interactions, only one doctor wore a white coat. Interestingly, this particular doctor was the one who offered the patient the most “space” in which to speak.

These additional data offer support for our understanding of the context and participants in this study.



### 3.2.3 Selected interactions summary

Table 3.7 summarizes the data which has been presented for the three core interactions.

Table 3.7 <i>Summary Data of Three Selected Interactions for Analysis</i>									
Interaction	Patient Gender	Doctor Gender	Patient Age	Doctor Age	Position of Patient	Position of Doctor	Doctors' White Coat Yes/No	Acute or Chronic Condition	Question Frequency to nr qtr min
A1	Female	Male	72	35	Seated On Table	Seated then Standing	No	Acute	1 question every .25 min (28 q's/8:16)
C1	Female	Male	71	48	Seated On Chair	Seated	No	Chronic	1 question every 1.5 min (17q's/24:25)
C2	Female	Female	72	37	Seated on Chair	Seated then Standing	Yes	Chronic	1 question every 5 min (7q's/27:13)

As previously indicated, three interactions were selected based on the doctor elicitation frequency, for qualitative discourse analysis. These interactions are referred to as A1 (Acute 1), C1 (chronic 1), and C2 (Chronic 2). Acute cases are those in which the patient's presenting concern is more immediate, such as having a fever or having fallen. Chronic cases are those in which the concern is related to longer-term illness, such as high blood pressure or diabetes. The order of these interactions is from lowest amount of space offered to the patient (A1), to the average (C1), to the highest (C2). Interaction A1 is the one that has the highest frequency of questions in relation to the time allotted for the interaction. In this interaction, the doctor is male, not wearing a white coat, and is seated until he performs the physical. Interaction C1 has the question frequency at the mean. In this interaction, the doctor is male, not wearing a white coat, and seated throughout the interaction. Interaction C2 is the interaction with the lowest elicitation frequency and reflects "space" as described in NM (Charon, 2006) for the patient to

speak. In this interaction, the doctor is a woman, wearing a white coat, and seated until she performs a brief exam.

### **3.3 Phase 2 evaluating doctors' perceptions**

Phase 2 concentrated on the evaluation of selected interactions by 12 doctors, gauging whether they perceive narrative elements in the interactions as well as whether they perceive them as useful and sufficient in the decision-making process of forming a working diagnostic assessment and treatment plan. Doctors provided ratings of the relative adequacy of the interactions for diagnosis and intervention.

#### **3.3.1 The instruments**

Phase 2 of the data collection process involved collecting feedback from evaluating doctors on the approaches the videotaped doctors in the selected interactions used for eliciting patient narratives. The data collection procedure and the instrument in the perceptions study were designed with the 12 participant doctors' time constraints in mind, as all participants were doctors working in clinical and research settings.

The instruments used were

- a stimulus of three abridged patient narratives selected from the three core interactions (combined with questionnaire -approximate time: 15 minutes). (See Appendix F Stimulus)
- a questionnaire with six questions. (See Appendix G Stimulus Feedback Form)
- an interview comprising six questions (approximate time 15 minutes). (See Appendix G Stimulus Feedback Form)

Making the decision regarding the form of the narratives that the evaluating doctors would view required several considerations. The first option considered was to show the three videos in their entirety to each of the doctors. With a total of over 70 minutes of video and an additional 20-30 minute interview per interaction, the time required of each doctor was not feasible. Another possibility was to use an approach where each doctor would watch a single interaction and respond to the corresponding

survey. Using inter-rater reliability, I would determine how much homogeneity was achieved by the ratings. However, for the longest of the three, which was 27 minutes long, this constituted too long a period of time to ask of the doctors. Again, I was working on the assumption that these doctors' time was a valuable commodity.

Another possibility was to edit the videos, reducing them to critical segments that included the doctors' elicitations and the essential aspects of the patients' narratives. Due to the editing process, there was the issue of selectivity of segments and the lack of fluidity of each edited video. I also considered the issue that one of the doctors' physical movement in the recording was a serious distraction from what was being said.

A final consideration for video was to have the transcriptions acted out and videotaped, but there was concern that the authenticity of the interactions would be lost and time for the participating doctors to view the videos was still too great. Using audio only was also considered, but the issue of piecing segments together in a way that would not be too distracting to the participants of the study ruled out this option.

I concluded that I would use the authentic material of the transcriptions. However, once again, these were all too long to be read in their entirety. Therefore, I used the approach considered for editing the video and created abridged, written interactions, which included the doctors' elicitations as they connected with the patients' narrative. These interactions were limited to two pages each. The core elements of narrative as defined by Labov (1972) were included. Using this approach, it was estimated that each interview session would last approximately 30 minutes, a time requirement much more manageable for doctors on busy schedules.

A questionnaire (See Appendix F Questionnaire) was used to collect data related to evaluating doctors' perceptions of selected medical interactions. The focus of this questionnaire is on the evaluating doctors' perceptions of the connection between the approaches doctors in the medical interactions used with the corresponding patients' narratives. The design of the questionnaire was based on the intention to collect both quantitative information, in order to test the specific hypothesis and qualitative information for the purposes of better understanding the hypotheses (Fowler, 2009; Johnson & Christenson, 2004; Oppenheim, 1992). The 12 evaluating doctors were asked to fill out a paper-and-pencil questionnaire in my presence. As indicated earlier, I had

communicated to the participants that the questionnaire would be completed in conjunction with the interview. Since the evaluating doctors were not rating themselves or close colleagues, it was considered unproblematic for me to be present during this task (Fowler, 2009; Johnson & Christenson, 2004).

In constructing the questionnaire, I considered several general principles in the design of the questions (Cheek, 2004; Creswell, 2009; Fowler, 2009; Johnson & Christenson, 2004; Oppenheim, 1992). Firstly, I considered how closely each question connected to my research questions. Secondly, I considered the participants and the knowledge they might have about various aspects of my topic. Related to this consideration, I tried to exclude terms that could be misinterpreted, or that were considered jargon (Creswell, 2009), such as “narrative”, “narrative medicine”, etc. I attempted to use natural and familiar language that would be understood by non-linguists and/or non-narratologists. Questions were kept as clear, precise, and relatively short as possible in order to offer participants the best possibility of understanding and answering each item more easily and within the expected length of time designated for this part of the data collection. This approach allowed participants to focus on content versus the language or structure of the question. I was careful not to use leading or loaded questions (Johnson & Christenson, 2004; Fowler, 2009). Finally, the instructions for how participants would complete the questionnaire used simple and direct language. Since I was present and available when each questionnaire was distributed, I was able to ask each participant if the directions were clear and if they knew how to proceed.

The questionnaire asked two questions for each of the three interactions (i.e. 6 questions in all):

- 1) To what extent does the type of information given by the patient lead to forming a working diagnostic assessment and treatment plan (including tests/referrals)? and
- 2) To what extent were doctor interaction technique(s) useful in eliciting patient information?

A five-point Likert response scale was used for the summation of feedback responses by doctors to the two questions listed above. On the scale, two points were anchored: 1 was the lowest response and 5 was the highest response a participant could use to rate each item.

Although there are some weaknesses to using questionnaires, such as non-response to selective items, most weaknesses are offset by face-to-face delivery of the questionnaire with support for clarification of questions (Fowler, 2009; Johnson & Christenson, 2004). Additionally, I informed the participants at the beginning of the session that the subsequent interview would be based on the stimulus and their responses to the questionnaire, which seemed to encourage thoughtful completion of all items.

Data gathered from interviews supplemented the data from the questionnaires. The interview consisted of the following questions for each of the interactions:

- 1) What additional question(s) could be asked to elicit more useful information for diagnosis and intervention? and
- 2) Why these questions?

Doctors were also asked to rate on a scale of 1-5 to what extent they considered that the patient was sufficiently “heard” in each interaction. The rapport setting established through the initial recruitment process assisted in the use of probing questions related to these interview items (Johnson & Christenson, 2004), such as *Is there anything else you would like to add? Any other reason for your response(s)?* or *What do you mean?*

Although the same questions and information were provided to all participants, a practice more common in quantitative interviews, these interview questions were designed to elicit responses more suited to qualitative analysis. The interviews were semi-structured using an interview guide approach and following an interview frame (Crewswell, 2009; Johnson & Christenson, 2004). This means the interview questions were structured, but I ordered them differently as appropriate to the flow of the interview. The effect was a less formally structured interview which encouraged thoughtful, yet

candid, responses by participants. The uniformity of the responses indicates that the approach did not have a negative impact on the data collection process.

### **3.3.2 Pilot study**

During my time in residency at Victoria University of Wellington, I ran a pilot study, through the auspices of a Research Associate of the Language in the Workplace Project at the University of Otago, Wellington, School of Medicine and Health Sciences. Running a pilot study offers opportunity to alter the instrument based on feedback from participants (Creswell, 2009) before initiating the study with the main participants. The pilot study included interviewing doctors using the instrument described above. With the assistance of my advisors, I decided to interview three doctors in this pilot phase. These doctors were able to offer input into the design of the data collection process and specific feedback on the questionnaire and interview. This feedback assisted in assessing the quality of the data collection instrument.

The pilot study took place in a New Zealand medical setting, which was considered comparable to the U.S., where the main would take place. New Zealand and the U.S. have similar general approaches to medicine and similar use of knowledge and technologies. Therefore, for the most part, the instruments used for the stimulus, questionnaire, and interviews transitioned seamlessly from one cultural medical setting to the other. There were no apparent differences based on the instruments themselves.

The response to the instrument and the procedure was positive overall. The design approach worked well in offering the participants the essential aspects of the interactions upon which to base their ratings. The interview questions worked well in eliciting the information I was seeking in order to better understand the interactions and to gain insight from the doctors of what was taking place in the interactions. Also, the format of the interview offered the participants an opportunity to speak freely about their perceptions and opinions of the interactions. Feedback from the participants in the pilot indicated that switching the position of the two questions on the questionnaire and moving the fill-in response question to the interview allowed for better logical flow. These changes were made following the pilot study.

### 3.3.3 Summary of Phase 2 study

Participant recruitment began in the U.S., where the data were collected. Delineating the details of this recruitment process is important in understanding how it might impact the data and the interpretation of the data (Ainsworth-Vaughn, 1998; Creswell, 2009). Arranging appointments and meeting with doctors in fast-paced medical settings provides its own set of challenges. Eliciting participants who were willing to put aside heaps of paperwork that must be done when they are not seeing patients was the first hurdle. Being a member of a university community where medical clinics exist, I was able to network through medical educators and clinicians. These connections made this task accomplishable within a reasonable timeframe (Koester, 2006; Sarangi, 1999).

After discussions with my advisors, it was decided that 12 doctors would be sufficient for the qualitative data I was seeking. We also concluded that data collection for Phase 2 of the study should take place in a U.S. medical setting in order for the perceptions of the evaluating doctors to align with U.S. contexts of the videotaped medical interactions. The interview settings varied from individual office space to private conference rooms, depending on availability and the location of the doctor at the time of our meeting. The evaluating doctors' years of experience varied, from post medical school fellowships to 25 years of practice, as did their specialty areas, which include infectious diseases, cardiology, oncology, epidemiology, and pediatrics. Indicative of the health care system in the U.S., these doctors were often harried, exhausted, and had to contend with emergency situations. Such last-minute emergencies were the cause for four re-scheduled interview appointments.

I used email messages to establish the relationship with participants during the recruitment process. Information regarding my connection with my university of employment, university of study, and any common party between us assisted in establishing trust and rapport. This trust encouraged individuals receiving the recruiting message to enlist in the study as participants and assisted in the interview as mutual relationships were often conversation starters upon meeting.

Over a period of six weeks in January and February of 2009, I subsequently arranged to meet with 12 medical doctors in their clinics to administer the questionnaire

and conduct the interviews. In the email messages sent out, I had indicated the particulars of the study and the role of the participants. Therefore, upon arrival at each clinic site, it typically took very little time for the evaluating doctors to become reacquainted with the purpose of the study and their role in it. The first task I asked of them was to read the Informed Consent form and sign it if they agreed to continue in the research as participants. Next, I asked them to review and respond to the questionnaire. Once this was accomplished, I explained that I would then ask them a few questions related to the interactions they evaluated for the questionnaire. I also asked permission to digitally record each interview so that I would have recordings to review for further understanding of the responses. All participants completed the questionnaire, gave permission to be recorded, and answered the interview questions and were given opportunity to ask questions or further elaborate on responses in their own words.

Although in-person interviewing is time-consuming and means anonymity is impossible (Johnson & Christenson, 2004), the strengths of the approach outweigh the weaknesses as it helped to gain insight into the attitudes and perceptions (Key, 1997) of the evaluating doctors. The expandability of questions and use of probing questions informed me of aspects of medical interactions I would not have thought to question in a more structured list of interview questions (Key, 1997). This exploratory aspect of the interview approach highlighted health care procedures and clinical protocols that impact how evaluating doctors responded to the interactions and the interview questions. I transcribed the evaluating doctors' responses to assist in identifying patterns of responses. These responses are discussed in Chapter 6.

In spite of the heavy scheduling demands on the evaluating doctors, I found that they were focused and appeared genuinely interested in my research, often asking numerous questions and making additional comments, which made the interviews much longer than anticipated. Several of the university-based doctors are also researchers, and others, medical educators. The interview data were analyzed in order to uncover evaluating doctors' perceptions of the medical interactions and not to rely solely on the analysis of a non-medical researcher and the process and procedures described thus far proved useful toward this goal. The data analysis for Phase 2 is described later in this chapter and further discussed and demonstrated in Chapter 6.



### **3.4 Summary**

In this part of the chapter, I have described and provided reasons for the methodological approaches and research design used in this study. The methods of data collection have also been described. I have also presented the rationale for the multi-method approach as a means of addressing the complexities of understanding what is actually taking place in medical interactions.

The next section of this chapter further describes the analytic approaches introduced in Chapter 2 as they relate to the Phase 2 of the study and presents the results of a preliminary analysis of the complete data set as context for the subsequent qualitative analysis.

### **3.5 Analytic approaches and contextual information for analysis**

#### **3.5.1 Analytic frameworks**

As indicated in Chapter 2, the analysis of the initial doctor elicitations begins by evaluating question types using Heritage and Robinson's (2006) typology which is detailed later in this chapter. I then began the analysis of the medical interactions for narrative dimensions as described by Ochs and Capps (2001), while other frameworks include Labov (1972) and NM (Charon, 2006) for the narrative analysis.

As discussed in Chapter 2, IS provides the main sociolinguistic framework and methodological tools of analysis in order to more fully address the research questions proposed for this study. In using this qualitative approach of analysis, I viewed the text as data and understood my role to analyze the extent to which the participants in these interactions share communicative resources (Gumperz, 1982; 1999). I also interpret the text in order to explain how certain utterances might come to be said and what was enabled or constrained within the interactions. I recognized the "tension...between the text and the context in which that text is situated" (Cheek, 2004, p. 1146). In order to answer my research question, my main interest was in exploring how interlocutors engage in "an ongoing process of negotiation, both to infer what others intend to convey and to monitor how one's own contributions are received" (Gumperz, 2006, p. 218). Special attention was then placed on how doctors designed elicitations with their specific agenda of gathering information they perceived as important. Also noted was how this impacted patients' responses in the form of narrative. I used IS as a way to investigate

how participants use talk to achieve their communicative goals focusing the meaning-making strategies employed and on power relations within interaction. In applying the procedures of IS, I utilized Phase 1 to provide insight into the “local communicative ecology”, the analysis to discover “recurrent encounter types relevant to the research problem”, and the interviews of Phase 2 to see how “local actors handle the [communicative] problems” (p. 223) in medical encounters.

The analytical frameworks associated with doctors’ elicitations and narrative dimensions are outlined in this chapter and are further developed and their application demonstrated in Chapters 4 and 5. The following sections focus on the data from the 69 medical interactions. They describe the length of the interactions, the initial doctor elicitations, and narrative elements.

### **3.5.2 Interaction data**

#### **3.5.2.1 Interaction length**

Tai-Seal, McGuire, and Zhang (2007) found in their data that the interaction length varied little even when the presenting concern varied. In contrast, my data showed that there was length variation. In operationalizing “space” in the medical interactions, the length of the interactions is one component of the answer to the main research question, *What is the relationship between doctor prompts and the form of patients’ accounts of their illnesses?* Information on the length of the medical visits demonstrates how these particular medical interactions compared and contrasted with other types of medical interactions in the U.S. in relation to the total amount of time given to each patient. The length of the medical visits in this corpus influenced the doctor question-frequency index since I was factoring the length of the visit with the number of elicitations.

Figure 3.1 represents the length of each medical visit in minutes. Medical session length commenced at initial greeting and continued until the point the interaction ceased and the doctor left the room.

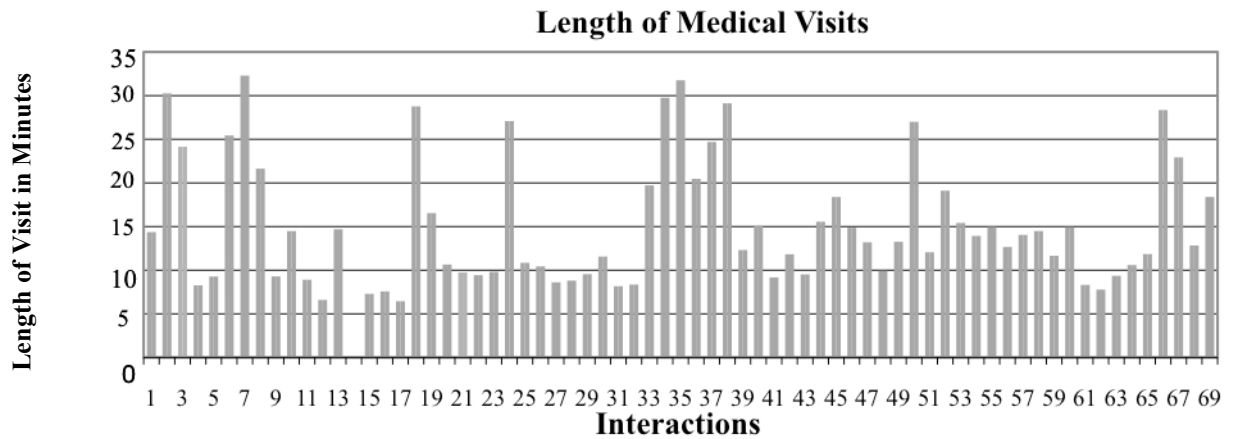
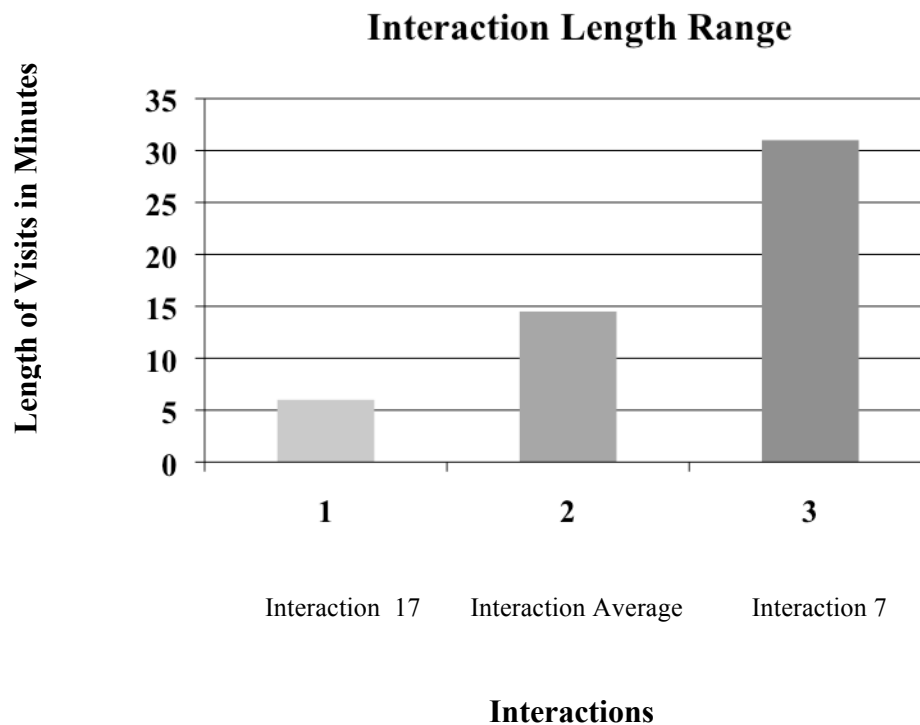
*Figure 3.1*

Figure 3.1 shows that the length of the visits is widely variable. The length of interactions ranged from 6 minutes, 11 seconds to 31 minutes with an average length of 14 minutes, 30 seconds.

Figure 3.2 illustrates how the shortest and longest interactions from this current study compare with the medical interaction average.

*Figure 3.2*

The average length of a medical visit in this study was 14.5 minutes. This average closely matches the average length of a medical visit in the U.S., which is 15 minutes as approximated by the American Association of Family Practitioners (2010).

### **3.5.2.2 Elicitations**

#### **Chronic illness and question design**

Research on question design in medical settings has tended to focus on question types and their functions in acute and “well visits” (Heritage & Robinson, 2006; Heritage, 2010); by contrast, questions related to routine recheck visits for chronic illnesses (Robinson, 2006) have not been extensively explored. This type of visit is unique in that it entails information-gathering without involving the pursuit of a differential diagnosis while monitoring for the emergence of comorbid (presence of more than one) conditions. At the same time, the purpose of the encounter is not a routine overview of the patient’s health status. The question design is forged by the combination of routine checklists as well as special attention to any changes to patient health factors since their previous clinic visit. These factors may be related to the chronic illness, the chronic use of medications for the illness, and secondary symptomology, or the possibility of an additional disease process. Since the majority of the interactions in this study represent recheck visits related to chronic illness, the question design and responding patient narrative are constructed accordingly.

#### **Elicitation frequency**

Figure 3.3 details the number of elicitations asked by each doctor in the medical interactions. “Elicitations” were considered the prompts offered to patients for responses. This term is further defined and explored in Chapter 4.

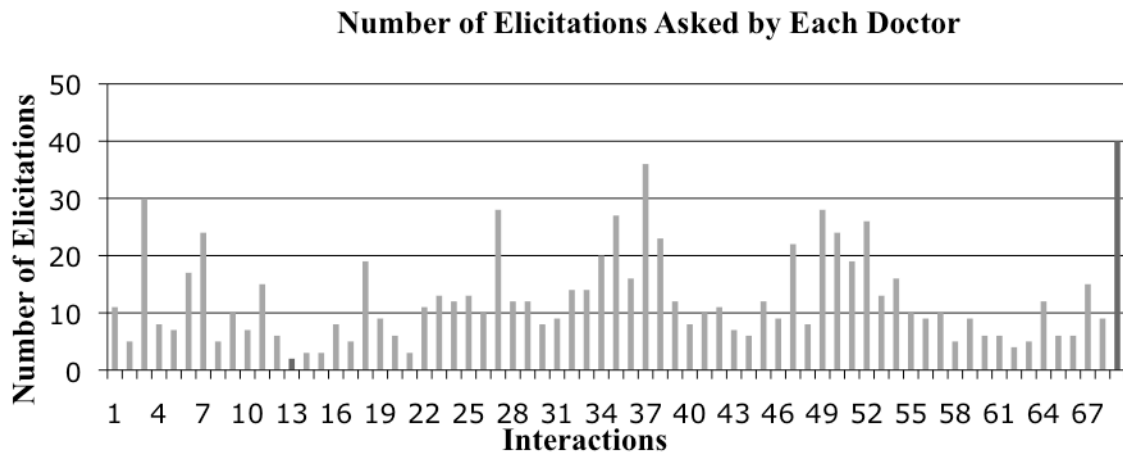
*Figure 3.3*

Figure 3.3 shows that the number of questions range from 2 to 40, with an average of 12.5 questions per visit. This figure demonstrates the wide variability in the number of questions asked by doctors. According to Davies (2007) data on questions asked in medical interactions varies greatly. Variability is due cultural context, medical specialty, specific institutional setting and purpose of presenting concern. Comparable data on the number of questions doctors ask within a context similar to the one represented by this study (chronic, return visits within aging study) have not been previously reported.

Data recorded in figures 3.1 and 3.3 were used to create the initial doctor-elicitation frequency index which is used throughout the study as the indicator for the amount of “space” available to the patient, operationalizing the NM approach. Figure 3.4 represents the frequency of elicitations index, which was calculated by dividing the total amount of time for each interaction by the total number of elicitations asked by the doctor. The elicitation frequency is one aspect of the co-construction since these prompts were used to elicit and shape the structure of patient narratives. Chapters 4, 5, and 6 explore the extent to which elicitations co-construct patient narratives.

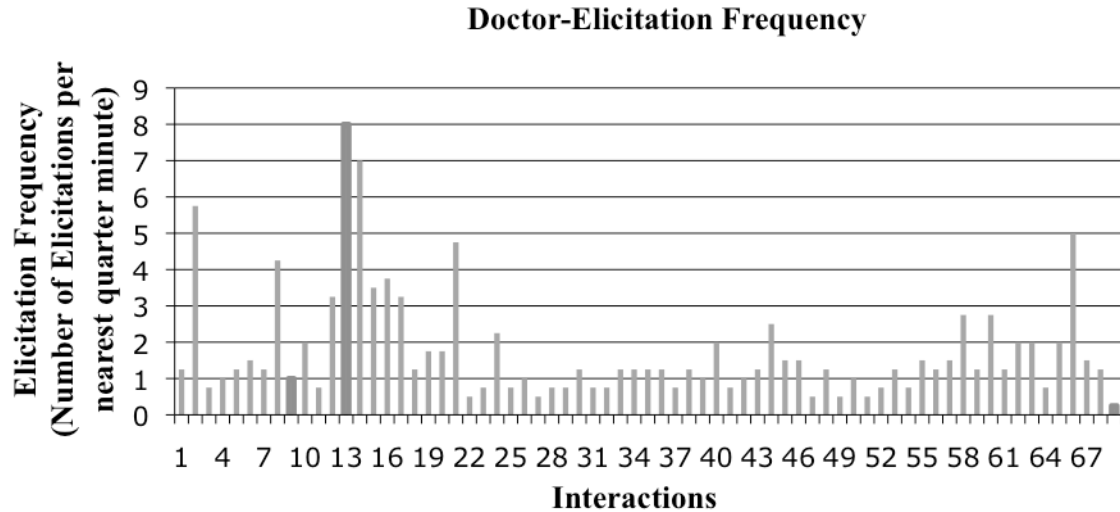
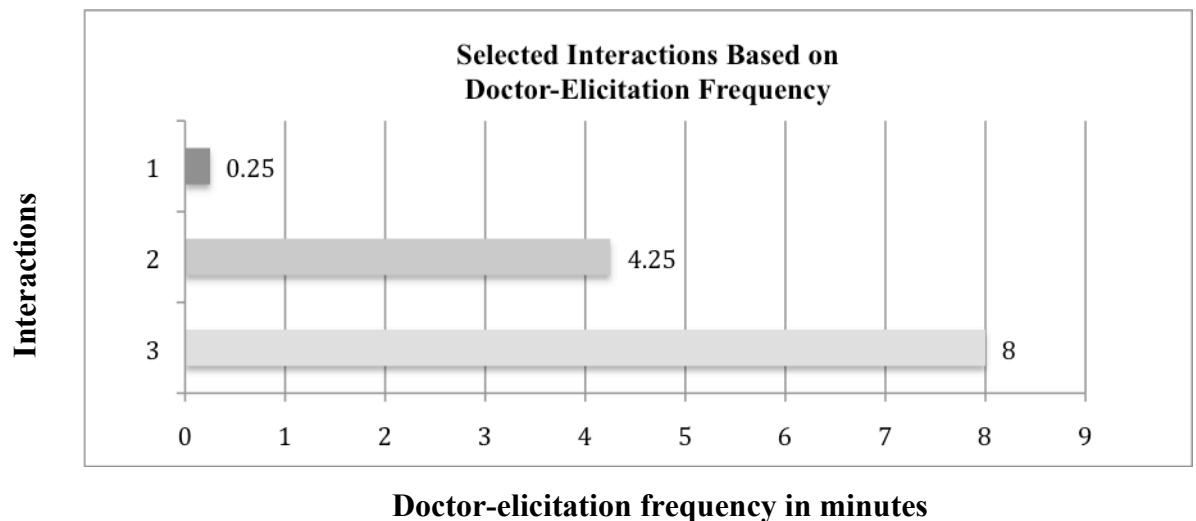
*Figure 3.4*

Figure 3.4 shows the number of questions asked by each doctor in relation to the time allotted for the interactions, providing a frequency index. The darker shaded interactions are the three selected for Phase 2. Figure 3.5 shows the doctor-elicitation frequency of these three interactions.

*Figure 3.5*

To interpret Figure 3.5, in interaction 1, which is referred to subsequently as interaction A1, the doctor asked the most questions for the time allotted, thus indicating that the patient had less “space” available in which to speak. In interaction 3, referred to

subsequently as C2, the doctor uses the fewest elicitations, thus offering the patient more “space” in which to speak.

### **Heritage and Robinsons’ (2006) question typology**

Since the focus of this study is to analyze the relationship between doctors’ elicitations and patients’ narratives, analytical tools for each of these elements are described in the following sections.

An important element in this study was the initial doctor question. As introduced in the Literature Review, the seminal work of Heritage and Robinson (2006), in which a typology of initial provider question types was created, was used as a way to categorize question prompts, when they occurred, in the discourse analysis of naturally occurring medical interactions.

The typology includes the following question types and is discussed in greater detail in the Chapters 4 through 6.

Type- 1 General inquiry (What can I do for you today?)

Type- 2 Gloss-for-confirmation (You’re having problems with your...knee...)

Type- 3 Symptom(s)-for-confirmation (So, you have a headache, sore throat...)

Type- 4 How are you?

Type- 5 History-taking (Have you any fever?)

Based on these descriptors, identifying the initial question type used in the interactions was rather straightforward with minor variations of these question types represented in the corpus. Following is further explanation of each type and examples from the interactions.

Type – 1 General Inquiry questions have three main features. They “1) invite immediate presentation, 2) are ‘general’ in that they take agnostic stance about precise nature of patient’s concern, and 3) offer patients opportunity to present concerns in their own words” (Heritage & Robinson, 2006, p. 11). A variation from the corpus of this type of question is from interaction C11, *What can I do for you today?* This type of question implies a ‘service’ relationship between doctor and patient (Heritage & Robinson, 2006).

Type – 2 Gloss-for-confirmation questions are used as an interactional practice focusing on ‘degree of resolution’ (Shegloff, 2000) marking the degree of the doctors’

prior knowledge of the patients' concern and, in their specificity, inviting an expansion of details from the patient (Heritage & Robinson, 2006) in spite of their form as yes/no questions. An example of this type of question from the corpus is from interaction C12 *So you have a cold?*

Type – 3 Symptom(s)-for-confirmation type questions are similar to Type – 2 questions in that they are structured to make (dis)confirmation the next action, but differ in that the request seeks concrete symptoms (Heritage & Robinson, 2006). An example from the corpus is from interaction C13 *Your ear's been aching?*

Type – 4 How are you? question types solicit general evaluations as a response rather than a problem presentation (Heritage & Robinson, 2006; Robinson, 1999). One way to differentiate this type of question from a greeting is the position of the question following the greeting phase of the interaction (Robinson, 1999). An example of this type of question comes from interaction C5 *How are ya?* In this interaction, this question is used after the initial greeting and is responded to with an evaluation by the patient: *like I say, like an old Timex I just keep tickin'.*

Type – 5 History-taking questions bypass problem presentation with the agenda of seeking relevant information gathering. Taking the form of yes/no, fill-in-the-blank, and multiple choice, these questions constrain the patient's response patient (Heritage & Robinson, 2006). An example of a Type-5 question from the corpus is from interaction C5 *Have your neurosurgery consult?*

Exploring the extent to which the type of initial question prompts and shapes patient narratives was the main use of this typology in conjunction with IS analysis. The following section presents data, which provide contextual background, on the type of initial doctor elicitation used in each of the 69 interactions.

Table 3.8 compares the initial question frequency by type found in Heritage and Robinson's (2006) study with the data collected from this current research.



Table 3.8		
<i>Question Type Distribution Comparing Heritage &amp; Robinson (2006) and Current Study</i>		
	<b>Heritage &amp; Robinson</b>	<b>Current Study</b>
Question Type	Frequency	Frequency
<b>1 General inquiry (What can I do for you today?)</b>	<b>61.92%</b>	11.59%
2 Gloss-for-confirmation (You're having problems with your....knee...)	10.93%	2.89%
3 Symptom(s)-for-confirmation (So, you have a headache, ...)	15.89%	5.79%
<b>4 How are you?</b>	5.30%	<b>60.86%</b>
5 History-taking (Have you any fever?)	5.96%	18.87%
	100.00%	100.00%
Heritage & Robinson <i>n</i> =302 Current study <i>n</i> =69		

According to Table 3.8, Type 4 Questions, such as *How are you?* were most commonly used, followed by Type 5 Questions, *History taking*. Possible reasons for the different distribution are discussed below.

Table 3.9 represents the question type as it relates to the question frequency distribution in this study.

Table 3.9	
<i>Question Type in Relation to Question Frequency Distribution (Mean) n=19</i>	
Question Type	Question Frequency at or above Mean 1.73 (1 question every 1.73 minutes)
1 General inquiry (What can I do for you today?)	5
2 Gloss-for-confirmation (You're having problems with your knee)	0
3 Symptom(s)-for-confirmation (So, you have a headache)	1
<b>4 How are you?</b>	<b>8</b>
5 History-taking (Have you any fever?)	5

From the data in Table 3.9, it can be calculated that 19 of the 69 (28%) interactions had question frequencies at or above the mean frequency of rate of 1.73. Of the 19, 8 (42%) of them used question type 4, the most frequently used question type overall.

The data in these two tables indicate that this study provides examples of each of Heritage and Robinson's (2006) typology of questions; however the distribution in this study is different. The differences in question-type distribution may be due to the fact that the interactions in this study were mostly of chronic conditions, whereas Heritage and Robinson's study represented acute interactions. Acute conditions typically lead to the use of particular initial questions related to the specific health concern presented on that occasion whereas chronic conditions tend to generate more routine initial questions, such as *How are you?* in order to gain a general sense of how the patient is managing with a chronic illness (Heritage & Robinson, 2006). Based on the patients' responses, it is possible that the use of *How are you?* in this current corpus may have been interpreted by the patients as an attempt by their doctors to gauge their overall well being as they manage their chronic illness.

### **3.5.3 Preliminary narrative analysis of dataset**

#### **3.5.3.1 Narrative dimensions**

This section focuses on Ochs and Capps' (2001) Narrative Dimensions and Possibilities (see Table 3.10 below) providing background for the more detailed narrative analysis in Chapters 4 and 5. These narrative dimensions are employed to describe tendencies in narrative dimensions within patient accounts. Although Ochs and Capps used these dimensions discretely for analysis purposes, they identified a global tendency among the dimensions found in narratives used in everyday life. This general tendency found that most narratives have one teller, high tellability, and are causally linear. They also hold to a certain, high moral stance, and importantly, are embedded within the interaction. This general tendency falls along the left side of the second column of the table.

Table 3.10 <i>Ochs &amp; Capps' Narrative Dimensions and Possibilities</i>			
Dimensions	Possibilities		
Tellership	One active teller	< ..... >	Multiple active tellers
Tellability	High	< ..... >	Low
Embeddedness	Detached	< ..... >	Embedded
Linearity	Closed temporal and causal order	< ..... >	Open Temporal and causal order
Moral stance	Certain, constant	< ..... >	Uncertain, fluid
From Ochs and Capps, 2001, p. 20			

This rubric offered a basis for evaluating discrete aspects of the patients' narratives in this study. However, the difficulty in using this rubric is that it is based along a continuum scale, which is a subjective, qualitative measure. Analyzing for narrative dimensions proved challenging since the dimensions fall along a continuum but lend themselves to being interpreted in a binary fashion. For example, can we consistently interpret that someone either is or is not morally virtuous in her portrayal of her moral stance or might she fall somewhere less distinctive along the continuum? Therefore, for the purposes of this study, the evaluation using this scale for the 69 interactions interpreted each dimension as either high or low and not at points along the scale, as is congruent with application of the rubric (Ochs & Capps, 2001).

My interpretation of and norming to these dimensions and how they might be applied was informed by the detailed account presented by Capps and Ochs (1995) of a patient with agoraphobia. In this account, the patient's discourse was analyzed for how she constructed panic in various scenarios and proved an excellent context in which to explore the varying degrees in which each dimension might be interpreted. Chapter 4

describes and demonstrates in greater detail how the analysis of narrative dimensions was conducted using this rubric.

In the next section, I establish how the narratives in my study are similar to and different from what Ochs and Capps refer to as “default” narratives found in everyday interactions. This is useful background information for the analysis in Chapter 4.

As illustrated in Table 3.10, Ochs and Capps (2001) indicated tendencies for narrative dimensions in “default” everyday narratives as: *an* (my italics) active teller, a highly tellable account, *relative detachment from surrounding talk and activity* (my italics), linear temporality and causal organization, and a certain, constant moral stance, as opposed to a more indeterminate or fluid one (Ochs & Capps, 2001). In Table 3.11, the narratives in this study conformed to this tendency with the exception of the dimension of embeddedness, and to some extent tellership. This shift in tendency for these two dimensions is likely to be due to the nature of medical encounters and what they are designed to accomplish and/or the doctors’ participation, particularly in eliciting patient narratives.

Table 3.11 Narrative Dimensions Represented in Current Study n=69		
Dimension	Range of Possibilities	Number of interactions
<b><i>Tellership</i></b>	<i>One active teller</i>	62*
	<i>Multiple active tellers</i>	7
<b><i>Tellability</i></b>	<i>High</i>	66
	<i>Low</i>	3
<b><i>Embeddedness</i></b>	<i>Detached</i>	0
	<i>Embedded</i>	69
<b><i>Linearity</i></b>	<i>Closed temporal and causal order</i>	69
	<i>Open temporal and causal order</i>	0
<b><i>Moral stance</i></b>	<i>Certain, constant</i>	62
	<i>Uncertain, fluid</i>	7
*Unless doctor is considered co-teller of narrative, in which case all 69 would have multiple tellers.		

The narrative dimensions tendencies in this study were similar to those Ochs and Capps (2001) found for tellability, linearity, and moral stance. These interactions were rendered in a manner where the patients used a linear structure to represent causation between actions. As the data show, the patients told their stories in a manner which helped them construct themselves as moral and adhering to advice offered in prior medical interventions. The patients' moral stance is further addressed in Chapters 4 and 5.

There were also some ways in which the narratives in this study differ from those of Ochs and Capps (2001). As indicated earlier, Ochs and Capps (2001) note that previous analysis of canonical stories has tended to identify single tellers versus co-constructed stories with multiple tellers. In the medical encounters, the main teller or author of the patients' narratives may be viewed as the patients themselves. However, tellership in medical encounters may be open to interpretation. When patient narratives are co-constructed with the doctor, with further support in some cases from a patient's companion accompanying them on the visit, then the tellership may be interpreted as multiple active tellers. In this case, using this rubric for determining tellership would yield a markedly different result from that which is indicated in Table 3.11, and the table would indicate a strong tendency toward multiple tellership (as indicated by the asterisked note in the table). This is one way that the evaluation of the 69 interactions may use narrative dimensions to demonstrate that patients' narratives in medical encounters are co-constructed by multiple tellers. Similarly, the dimension of embeddedness demonstrates how patients' narratives are constructed as part of the medical interactions. What this means is that the patients' narratives were embedded in the institutionally structured discourse of the medical interactions. Clearly the two features of tellership and embeddedness do not conform to the Ochs and Capps' (2001) "default" tendency of everyday narratives. This framework thus offers a way of describing narratives in a medical encounter, which differentiate them from the conversational narratives found in everyday interactions with friends and family.

### **3.5.3.2 NM**

NM was introduced in the Literature Review and is further addressed in Chapters 4 through 6. NM is discussed here for the purposes of describing its role in methodology. From the onset of designing this study, there was tension between understanding NM as a clinical approach, as it was originally intended, and devising a way to operationalize NM in order to use it as an analytic frame.

In reviewing the medical interactions, a pressing question presented itself: How might NM be characterized? Relevant observable behavior in the medical encounters based on the guidelines proposed by NM could comprise the types of doctors' questions, the frequency of doctors' elicitations, the tone in which the questions were asked, the amount of space and attentive feedback offered by the doctors, and the patients' responses to these elicitations as they render their narratives. What is not observable, of course, is what the doctor is thinking in each interaction. We cannot know if the doctors are being attentive to what the patient is saying when the patient is offered "space" and given the floor to speak for lengthier periods of time, or if the doctors are simply letting the patients speak for the sake of the patient perceptions of "being heard". Conversely, when the patient is not offered "space" in which to speak, is it possible that the doctor was simply focusing on using the question-tree formulary, learned in their training. The impossibility of answering such questions encourages analysis of more observable features of interaction as a means of operationalizing NM.

In the light of such considerations, I elected to focus on the function and frequency of doctors' elicitations to explore the concept of offering patients "space" in which to speak, and as one way to operationalize NM for the purposes of this study.

### **3.5.3.3 Perceptions study**

Phase 2 elicited feedback from evaluating doctors regarding their perceptions of the medical interactions, which represented three clinical approaches to gathering information. The design and data collection process of this phase was introduced earlier in this chapter. This section describes the approach to analysis that is further addressed and demonstrated in Chapter 6.

My approach to analyzing the data in Phase 2 was focused on qualitative analysis of quantifiable data. The questionnaire described earlier first elicited evaluating doctors' feedback on a Likert scale before prompting them to offer more descriptive, self-constructed responses. Although the countable data were helpful in capturing the development of tendencies for each item, my interest was more focused on *how* and *why* the evaluating doctors responded to questions as they did. For example, I was very interested in discovering not only if evaluating doctors wanted to ask additional questions, but if so, what these additional questions might be as well as the rationale for asking these particular types of questions. With this qualitative approach, I was able to analyze a corpus of the evaluating doctors' responses and found informative tendencies, which are described in detail in Chapter 6.

### **3.6 Conclusion**

This chapter has presented the rationale for the methodological approaches, research design, and analytic frameworks. It provided some preliminary analysis related to doctors' elicitations and patients' narratives as background to the more detailed analysis provided in Chapters 4 through 6. The preliminary analysis of narrative dimensions suggests that patients' narratives may be usefully analyzed as co-constructions with doctors' participation as co-tellers appearing to be very relevant.

The next chapter focuses more fully on the connection between doctors' elicitations and patients' narratives.





## **Chapter 4: “Tell me what that means...” Constructing narrative coherence through doctors’ elicitations and patients’ narratives**

### **4.1 Introduction**

Chapter 3 presented the methodology related to the analytic approaches and preliminary review of the data set from the corpus of naturally occurring medical interactions. These data introduced the medical contexts and participants in the interactions and established how the use of elicitations and the quality of the narratives in this study are similar to and different from those found in previous research. In this chapter, narrative analysis is used as a framework to address the research question, *What is the relationship between doctor prompts and the form of patients’ accounts of their illnesses?* Since there is no prior research which intersects the study of doctors’ elicitations and patients’ narratives with the clinical approach of NM, this analysis is an initial contribution to understanding the relationship of these elements through these combined frameworks. The analysis focuses on the key finding of the “constructing narrative coherence” frame by demonstrating how doctors’ elicitations and patients’ narratives contribute to the construction of narrative coherence and offering insight into “how sociocultural knowledge enters into the ongoing negotiation of meaning between speakers” (Auer & Roberts 2011).

This portion of the analysis focuses on the three core interactions, which were identified through the data analysis in Phase 1, using the frequency of doctor elicitations as the basis for selection. As summarized in the previous chapter, these interactions fit the criteria established for operationalizing the NM approach of offering patients “space” in which to speak. Doctor question frequency evokes the concept of “space” offered to patients to speak and each range of frequency represents an approach to eliciting patient information. Not only did selecting three interactions provide a realistic way in which to gain feedback from the evaluating doctors in Phase 2, but it also allows for a more in-depth discourse analysis. These anchoring interactions demonstrate how participants consistently construct narrative coherence throughout the interactions. The analysis of these core interactions is supported by extracts from nine additional interactions, which meet similar criteria based on doctor question frequency, and thus, represent the varying

elicitation approaches. Although power seems to remain with the doctor, who directs interactions through elicitations (Heritage & Robinson, 2006), the discussion explores how power shifts from one participant to the other as each contributes to the shared goal of making sense of the patient's medical condition. This underlying goal is evident through the interaction narrative as it is formed, and is a common frame in the process of constructing narrative coherence.

Moving into the analysis, Labov's (1972) framework is first used to establish the core patient renderings as narratives. Next, Ochs and Capps' (2001) post-canonical framework helps to identify narrative dimensions, which offer further insight into the interactional nature and co-construction of the narratives. The clinical approach of NM is then utilized as a basis for analyzing patient narratives. Throughout the analysis, doctors' elicitations are linked to patients' narratives with particular attention to how participants construct narrative coherence in the medical context.

In the next section I briefly address the use of transcriptions for narrative analysis before moving toward the first step of the analysis which relates to the canonical approach.

#### **4.1.1 Using transcriptions for narrative analysis**

To analyze the narratives, full transcriptions were made of the three interactions identified through Phase 1 data analysis. In order to better support the discourse analysis and show how narratives and identities are constructed consistently throughout a range of interactions, transcriptions were then made of nine additional interactions extracts using the same criteria for selecting the three core interactions. Transcripts from recordings are valuable resources that allow the analysis of patterns and sequences of communicative acts (Frankel, 1990; Linnel, Gustavsson, & Juvonen, 1988; Roter & Hall, 1992; Waitzkin, 1985) and the emergence of ideas as they develop presenting the "choreography of story construction" (Capps & Ochs, 1995, p. 28). The transcripts demonstrate how the teller constructs a story systematically even when the narrative is rendered implicitly. It also shows how meaning in emerging interactions may be conveyed by how something is uttered as much as the semantic content. The false starts, pauses, overlaps, interruptions,

repetition, tone, intonation demonstrate different components of meaning and construct aspects of the teller's identity.

## **4.2 Narrative analysis frameworks**

Two well established narrative frameworks within this area of inquiry, Labov (1972) and Ochs and Capps (2001), yield varying degrees of understanding of the structure of narratives. Narrative coherence is demonstrated to a greater extent in using some frameworks rather than others. Labov (1972) provides a means of identifying the main components and internal structure of the narratives. This framework is used to establish the core interactions as narratives. After acknowledging what can be learned from the Labovian approach, I use the Ochs and Capps (2001) narrative dimensions for analyzing particular aspects of the patient narratives providing a means of analyzing the storyteller role (tellership), which is instrumental in exploring the connection of the narrative to the context. This post-canonical approach expands upon the Labovian framework to provide a means of interpreting the role of the narrative in the particular circumstance of the medical encounter.

Although various phases of the narratives are considered in this analysis, the opening phases of the medical interactions are a particular focus of analysis in order to explore the extent to which the initial elicitations impacted the emerging structure of the discourse. Specific attention is given to initial doctor elicitations, and the analysis examines how by engaging with each other, the participants collaborate and negotiate their way into medical encounters (Coupland, Robinson, & Coupland, 1994).

### **4.2.1 Establishing renderings as narrative using Labov's narrative framework**

As a way into the analysis, the Labovian framework is used to identify the basic structure of the narratives, establishing the core interactions (A1, C1, C2) as narratives. The analysis begins to describe the relationship between doctors' elicitations and patients' narrative. It also indicates that the structure of the narrative is shaped to a great extent by whether a patient's presenting concern is related to an acute case versus a chronic condition.

Each interaction is analyzed based on the following Labovian (Labov, 1972) components and descriptions, which would indicate a fully formed narrative. Not all components may be present in each interaction.

**Abstract** (What happened?)

**Orientation** (Where? Who? Why? When?)

**Complicating action** (Then what happened?)

**Evaluation** (So what? What are the consequences of the event?)

**Result/Resolution** (What finally happened?)

**Coda** (Return to present/time of speaking.)

According to Labov (1972), only the complicating action is necessary to identify a narrative, and the other elements answer the questions that point to the purpose of the narrative. To illustrate this narrative framework and to demonstrate the extent to which it assists in interpreting medical interactions, the three core interactions used in Phase 2 are analyzed in the following sections.

#### **4.2.1.1 Analysis of A1: An explicitly rendered acute case**

This first example is taken from interaction A1 (Appendix B: Transcription A1), the interaction which had the most doctor elicitation. The interaction involves the story of a female patient who had fallen three weeks before the clinic visit and follows a common narrative structure; it has a beginning, middle, and end format<sup>9</sup> as though the patient had asked herself – Where shall I begin? (Labov, 2009). In response to the doctor's prompt, *what brings ya in today?* (line 1) the patient begins the reconstruction of this narrative with *well i was walkin*. According to Labov (2006), prior to when a speaker develops a narrative of personal experience, the speaker constructs the narrative by a cognitive process. At the beginning of this process is a decision that an event is reportable, and in this case, that the patient's illness is doctorable and reportable to

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<sup>9</sup> Aristotle established that a story has a beginning, middle, and end (In Norton Anthology, 2001). Additionally, Euro and Anglo organization is typically episodic around units of three. (Capps & Ochs, 1995, p. 171).

someone who can remedy the problem. A description of the event in interaction A1 in Labovian terms follows.

### Example 1

*Context:* Excerpt from interaction A1. Patient A, Ann, a 72 year-old woman, presents to her primary care provider with shoulder pain following an accident.

[A1-6-25]<sup>10</sup> lines 6-9, 11-14, 16-20, 24-25

- 1 D:           okay what brings ya in today?  
 2 Ann:       well i was walkin  
 3           and i went to cross the street at the curb<sup>11</sup>  
 4           and my foot musta got caught in the curb  
 \*...  
 5           there was a metal strip there  
 6           i went later to look  
 7           and i kind of flew out in the street  
 8           and i put my two arms out to protect my body  
 ...  
 9           and um hurt this arm really bad  
 10          i knew when i got up it was just killing  
 11          and should have gone to the er  
 12          by the time i got home  
 13          i thought well it's probably bruised bad ya know  
 ...  
 14 D:       and which arm is it that's hurting  
 15 Ann:      this one, mainly

---

<sup>10</sup> Excerpt convention: Example: [A1-5-10]

The excerpt is from interaction A1

The original lines in the original transcript are 5-10

\* "... " indicates omitted line(s)

<sup>11</sup> American English spelling for *kerb*

In this patient rendering, the abstract encapsulates the point of the story: the patient was walking across the street, her foot must have got caught on something causing her to fall and hurt her arm (lines 2, 3, 9). The orientation, which is placed at the beginning of the narrative (line 2), uses a past progressive clause, *i was walkin*, which indicates the time, person, and what was going on before the first event of the narrative. The complicating actions (lines 5, 7, 8) tell some of the details of the event, answering the question, *What happened next?* The evaluating clauses (lines 10, 11, 13) indicate that the patient was attempting to signal to the doctor why she was at the clinic. They also show how the patient attempts to make sense of what had taken place and how she made the decision to become a patient. The coda (line 15) is co-constructed by the doctor asking *and which arm is it that's hurting*, and the patient responding, *this one, mainly*. This coda brings both participants from the time of the event back to the present.

Due to the tellability of this explicitly rendered narrative, it can be readily identified as a fully formed narrative and described in Labovian terms. Evidence of this is that the main clauses of the narrative are easily identifiable and are in close proximity to one another in sequence. This sequencing may be due to the nature of this interaction as an acute case. In an acute case, the retelling may be more straightforward since the event causing the condition happened close to the time it was recounted and also because there is such an identifiable, reportable, or tellable event.

Even though the narrative is extracted and decontextualized from the rest of interaction, this analysis demonstrates that the narrative is coherently rendered. The main elements of the narrative are explicit and succinct, and the rendering tells what appears to be a complete story. It also shows how the patient seeks to make sense of what happened and why it happened: *my foot musta got caught on in the curb* (line 4).

Using this framework, however, limits our understanding of how the doctor, as interviewer and co-constructer of the patient's narrative, perceives the level of coherence of the narrative. Further, the analytic framework does not reveal how the doctor contributes to the patient's narrative by his own construction of narrative coherence of the patient's story, which is discussed later in this chapter.

Next is an analysis of interaction C2 (See Appendix D: Transcription C2), where the patient's narrative is also explicitly rendered, but the presentation of concern is related to chronic illness.

#### 4.2.1.2 Analysis of C2: An explicitly rendered chronic case

This next extract is from interaction C2.

##### Example 2

*Context:* Routine medical visit. Patient C, Cara, a 72-year-old woman presents to her primary care provider with fatigue and continued pain.

[C2-5-50] lines 5-9, 11-12, 20-25, 37-38, 42-47, 49-50

- 1 D: um what can i do for you today  
2 Cara: well, i did have a rough several months  
3 i feel better than i was when i was here  
4 y'know, the fatigue stills exists  
5 i ended up having to have the surgery done  
...  
6 well i had one tooth er root canal  
7 and then uh the sack was not healing  
...  
8 it's not been real tender  
9 it's just really flared up my pollen  
10 my allergies are just something fierce  
11 and uh so i'm //i'm feeling\  
12 D: what have you been doing with the prednisone idea  
13 Cara: i'm still on the two presnisone  
...  
14 about the past three weeks  
15 i just don't think the trazodone is holding anymore

...  
 16 i'm waking up at night sometimes  
 17 uh my arms have been  
 18 the other night i just woke up i was numb all the way down  
 19 and i was on my back and it wasn't that i was  
 20 and i'm waking up at least two or three times during the night and  
 21 sometimes trying to get comfortable going to bed once i can go to sleep  
 ...  
 22 and i really don't think it's the pain  
 23 as much as that i'm not getting enough sleep

In this analysis, the abstract (lines 5-8) attempts to encapsulate the point of the story; the patient has been fatigued and has had continued pain. The orientation, which is placed both at the beginning (line 2) of the narrative and then midway (line 14), references that the past few months have been rough, with possibly a more difficult time during the last three weeks. The complicating actions (lines 7, 16, 18) tell some of the details of the event, such as the sack not healing from the root canal, she is not sleeping well, and at times, she wakes up with her arm numb. The evaluating clauses in this narrative are integrated throughout: at the beginning (line 3), toward the middle (line 15), and at the end (lines 22 and 23). The patient seems to use these evaluative clauses to construct meaning related to why she is visiting the clinic (ie. she is fatigued possibly due to suffering from pain at night which prevents her from sleeping well).

Perhaps due to the fact that the patients' presenting concern is related to a chronic condition versus a single, more tellable event, the extract suggests how the patient attempts to construct why she is a patient through a less coherently rendered narrative than one structured around an acute situation. Patients dealing with chronic illness seem to struggle with coherence when attempting to organize numerous factors they believe might be salient to their current health status (Hyvärinen, Hydén, Saarenheimo, & Tamboukou, 2010). Evidence of this is that the main clauses of the narrative are not as easily identified and are distributed throughout the rendering. This example shows how a case where a chronic health condition exists may be described in the canonical Labovian



framework as a classic narrative, with some evidence that it is relatively loosely structured. However, this lack of narrative coherence is made more apparent when reviewing the entire narrative (see Appendix D: Transcription C2).

The narrative is organized in a less coherent manner than A1. However, similar to A1, the analysis demonstrates that the patient is trying to make sense of her condition, as revealed throughout but particularly in line 15 *i don't think the trazodone is holding*. This evaluative clause suggests that the patient is attempting to identify perhaps one reason why she is not feeling well and is no longer able to accommodate her condition.

Narratives of chronic illness may also be more implicitly presented, as seen in the following example.

#### 4.2.1.3 Analysis of C1: An implicitly rendered chronic case

The next example, interaction C1<sup>12</sup> (Appendix C: Transcription C1) represents an implicitly rendered chronic case.

##### Example 3

*Context:* Routine medical visit. Patient B, Bess, a 73-year-old woman presents to her primary care provider with high blood pressure.

[C1-2-99] lines 2-3, 24-25, 27, 30, 71, 89-91, 22-23, 99

- 1 D: ya see that blood pressure
- 2 Bess: it's always high
- ...
- 3 D: ++can't figure out why it would be on medicine
- 4 D: why it would be elevated here and you
- ...
- 5 Bess: because i suffer from uh anxiety about going to the doctor
- ...

---

<sup>12</sup> Interactions C1 and C2 were named based on the order they were presented in Phase 1, and the identifiers have remained for consistency.

- 6 D: we actually sent did get home home blood pressure monitoring didn't we  
...
- 7 Bess: because it's been a long time since i've had anything done  
...
- 8 D: and when i last saw you in november uh
- 9 D: uh we talked a little bit about diabetes
- 10 Bess: [takes deep breath] i'm always hurting with that and i have lost weight  
...
- 11 Bess: i don't want to think i have high blood pressure [laughs] either
- 12 Bess: but i really don't think i do but i do take medication  
...
- 13 Bess: however i will agree for you to do a glycohemoglobin again um

Using Labov's framework to analyze this chronic case interaction is challenged by two main points: 1) some of the narrative components are implicitly rendered, and 2) the more complete narrative is only possible to extract by incorporating some of the doctor's elicitations and statements (i.e. this exposes some of the problems with using Labov's framework for less standard types of narrative). These challenges are discussed further in the following analysis.

Analyzing the implicitly rendered patient narrative, an abstract that encapsulates the story seems to be that the patient does indeed have high blood pressure (line 2) because she has anxiety about going to the doctor (line 5). The orientation (lines 7, 8) related to long period of time from the previous November, when there was the perceived need to send the patient home with a blood pressure monitor. The complicating actions (lines 3, 4) seem to be associated with the overarching point of the story – the patient says she takes medication, yet her blood pressure remains elevated. In this case, the doctor contributes the complicating actions. The evaluating clauses (lines 10-12) indicate that the patient was attempting to signal to the doctor that although she has high blood pressure in the clinic she does not believe she normally has high blood pressure. Yet, she insists that she takes medication for high blood pressure. The coda (line 13) is indicated by the patient agreeing to have a test performed related to diabetes moving from narrative

to action (Beach, 2009).

In this interaction where the patient is dealing with a chronic illness, it seems difficult for her to determine what is a single, tellable event. The implicitly rendered, less coherent manner in which this narrative has been presented (Bamberg 1999, 2004; Holmes, 1997; Hyvärinen, et al., 2010) challenges the Labovian framework. However, there is evidence that the patient's account contains the essential components and thus meets the criteria for narrative.

The entire patient narrative in this case is prompted by the doctor's elicitation *ya see that blood pressure?* The narrative appears in response to what this elicitation implies, which is that the doctor cannot understand why the patient's blood pressure continues to be high if she, as she states, is adhering to the medicinal intervention. It also seems the main point of this narrative is implicitly conveyed through the doctor's comments, which indicate he believes that the patient has high blood pressure and is pre-diabetic. The fact that the narrative is implicitly rendered forces the hearer/analyzer to re-construct the narrative in order to understand and describe it within this framework. The patient appears to be positioning herself as though she feels accused of not adhering to her medication regimen. It seems that because of this, she becomes nervous and perhaps unable to explicitly render a comprehensive, more concise and coherent narrative detailing her situation leading to this follow-up visit. The patient appears uncomfortable during the medical visit and this discomfort seems to over-ride the actual health condition in importance during the telling of her narrative. In the process of trying to narrativize her experience in order to make meaning of it, the patient seems to be confronted with the doctor's suspicion, which may in turn prevent her from ordering and structuring her experience through a more coherent, explicitly rendered narrative. However, it may be that the patient's implicit rendering of her narrative is her usual manner of storytelling or that it "may reflect the closeness of the relationship between the conversationalists" (Holmes, 2003), which is unknown and not apparent from the interaction.

This example demonstrates how a chronic case that is implicitly told may only be described by stretching the understanding of the canonical Labovian framework to include interactional aspects of the narrative (ie. doctor's elicitations). Similar to interaction C2, the narrative rendered in this interaction is less coherent than the narrative

in A1. As another chronic case, this interaction encourages consideration of the role chronic conditions play in narrative coherence.

#### **4.2.1.4 Impact of chronic illness on patient response**

Patients dealing with chronic illness are forced to reconcile multiple facets of disease, which is evident in the medical interaction as patients seek to make sense of their health condition through their narrative. Chronic illness, coherence, and completion of patient narratives are factors which require consideration when analyzing these types of narratives. Even though these interactions represent patients' narratives of chronic conditions which extend beyond the timeframe of the medical interaction, there seems to be evidence that these patients' stories include endings as evidenced in the Labovian analysis. This phenomenon may be due to what is known about the act of storytelling, which is that the act typically takes place "after the end of the story sets the end in place" (Wood, 2005, p. 289). The patient as story-teller seems to find it necessary to tell a "completed" story even when the end of the larger illness narrative has not yet transpired. It may be that the end of the narrative in these chronic-illness-related interactions is the end of the story as known to the patient thus far, as the end of an episode, or small story (Bamberg & Georgakopoulou, 2008; Georgakopoulou, 2006, 2007, 2011) in the longer story associated with chronic illness. The end of a narrative may be "its re-beginning, as the life concludes in a desire for the life story" (Wood, 2005, p. 290). It may be that in the North American context, one feels compelled to complete a story or part of a larger story rather than feeling free to leave it unfinished or open-ended as has been reported for other cultural groups (Holmes, 2003).

#### **4.2.1.5 Limitations of Labovian framework**

For the purpose of establishing these core interactions as narratives, the Labovian framework has served well. The narrative components are useful in identifying narratives within interactions even when the narratives are implicitly and less coherently constructed. However, as mentioned in the Literature Review, the Labovian framework has certain limitations for analyzing narratives.

Although it is clear that Labov (2006, 2009) has since expanded the analytic framework for narratives, these further developments do not address the issue of the co-constructive qualities of narratives created in interaction, and nor do they relate to aspects of patients' identity. This canonical framework does not fully explore the interactional, conversational narrative which is not limited to a "reporting of sequences of actions" (Fludernik, 2009, p. 59) since aspects of the interactional nature of patient narratives are apparent when doctors prompt, and at times utter, portions of the patients' narratives. Importantly, unless this analytic tool is extended to include more context, which includes the doctors' elicitations and comments, the analysis does not offer much insight into how doctors and patients attempt to make sense of patients' conditions.

Applying the Labovian framework to these interactional narratives does not readily enable the analysis to differentiate between acute and chronic health condition narratives, whether the narratives are explicitly or implicitly rendered, or their degree of coherence and seems to be limited in its ability to reveal aspects of narrative coherence.

In summary, the canonical Labovian framework provides a means of identifying the internal structure of the narrative. However, gaps remain in fully interpreting the meaning conveyed by these patients' narratives. The structural development of the narrative may also depend on the context and the cooperation of the participants to a greater extent than this type of analysis affords (Holmes, 1997). Within this framework, there is no analysis of how and why these interactions are taking place (Bamberg 1999; 2004; Hyvärinen, et al, 2010). Without consideration of these two important factors, it is difficult to understand how doctors and patients construct narrative coherence which, as the following analysis illustrates, is evident in their interactions.

In the next section, I explore a post-canonical perspective.

#### **4.2.2 Post-canonical narrative frameworks**

The canonical first wave of narrative analysis focused on text, structure, and tellability. The post-canonical second wave tends to focus more on narrative as situated in interaction where narrative is viewed as emergent and dynamic and context is viewed as the surrounding frame (Georgakoupoulou, 2007). In this interactional paradigm, the narrative is prompted in the ongoing course of an interaction. Prompting has been

viewed canonically as the elicitations of the research interviewer (Labov & Waletzky, 1967). For purposes of this research, prompting is viewed as elicitations made by doctors of patients in the specific occasion of the medical encounter. Since elicitations are fundamental to this analysis, the following section examines the role of the doctor as elicitor before moving to the analysis.

#### **4.2.2.1 Interviewer as elicitor of the narrative**

The research interview may be regarded as a type of narrative if the prototypical interviewer is positioned as elicitor of the narrative (Georgakoupoulou, 2007) and “an emerging consensus among qualitative methodologies is that an interview is a joint accomplishment of the interviewer and the interviewee” (Fontana & Prokopiou, 2007). Although the elicitation approach may vary, what is meant when an elicitor is requesting what has happened is culturally understood (Ervin-Tripp & Küntay, 2007). It is elicited stories that “best demonstrate that the structure of stories is strongly related to the circumstances of their telling” (p. 207). In interpreting this concept within the medical encounter, this translates to the role of the doctor as interviewer. Although the concept of “patient as expert<sup>13</sup>” is considered, the analysis demonstrates that the doctor’s primary role is that of “expert” whose expertise is being sought for a condition the patient cannot remedy herself. “Expert” in the medical encounter implies the individual holding the knowledge, experience, and access to resources necessary to make sense of a patient’s condition. If the primary role of the doctor is that of expert, then the secondary role is that of elicitor of the patient’s narrative. As expert-elicitor, the doctor uses elicitations as a tool to draw out the information the patient provides as expert of her illness experience in order to create a working diagnosis and intervention. Ultimately, the purpose is to gain

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<sup>13</sup> The “patient as expert” is a controversial concept, particularly in the U.K. where government-sponsored health care system has constructed from this concept the “expert patient”. In essence the driving force behind the concept is to view the patient as informed and an active participant in the medical interaction. This concept implies at least two main points: 1) the patient is to be viewed as the expert of their illness experience and 2) the patient is to be informed of their illness from medical professionals so that they may continue to cultivate “expertise” of their illness. (Association of the British Pharmaceutical Industry, 2011).

information through the patient's narrative. Gathering information through elicited patient narrative is an important vehicle for doctors to construct narrative coherence.

The role of the prototypical interviewer is to prompt the interviewee and avoid interrupting the speaker (Georgakoupoulou, 2007) while also recognizing that some standard initial phrases may inhibit patient participation (Diaz, 2000; Menz, 2010). In contrast, doctors are trained to ask questions through a question-tree formulary review of systems in order to receive important patient information. In this case, the doctor may be viewed as an atypical interviewer. Although the floor is typically held by a single teller during the rendering of the narrative (Coates, 1996; Labov, 1972), the listener may also participate in a more active role (Corston, 1993; Duranti, 1986; Goodwin, 1986; Rymes, 1995). As an atypical interviewer, the doctor as expert and elicitor seems to elicit specific types of information from the patient, and concurrently, influence the direction in which the interaction develops. This is, in part, what makes the medical interview an example of a co-constructed interactional narrative. In this interview model, where narratives are prompted by an interviewer (the doctor), the roles of the participants as the teller (patient), who has a right to hold the floor, and a receiver (doctor) of this information may not be as clearly delineated as in the prototypical interview (Georgakopoulou, 2007).

Ascribing the role of prototypical interviewer to the doctor as the receiver of information, the doctor might be expected to offer few elicitations throughout the interview, which would align with NM framework. The doctor in interaction C2 (see Appendix D: Transcription C2) offers the patient the floor for lengthy periods of time. This allows the patient the opportunity to tell her story and the doctor listens and receives the patient's account as seen throughout the discourse of the interaction. Most interactions in this study, however, do not appear to demonstrate this aspect of the NM approach. (See Figure 3.4: Doctor-Elicitation Frequency, Chapter 3). Instead, what is evident in most interactions is a doctor actively asking numerous questions with the expectation that the patient should answer them without elaborating or redirecting the interactions. This active eliciting of information can be interpreted as evidence of the doctors constructing narrative coherence as they try to gather information to make sense of the patients' conditions.

#### **4.2.2.2 Ochs and Capps narrative framework analysis**

The following sections focus on the post-canonical framework established by Ochs and Capps (2001), which expands on the canonical narrative analysis by recognizing the relationship between the patient's experience and the manner in which she renders her narrative (Andrews, Squire, & Tamboukou, 2008; Squire, 2008). This approach acknowledges the healing power of narrativization of experiences as the patients present their identities in these medical circumstances. The Ochs and Capps framework expands the Labovian narrative analysis from a focus on text, structure, and tellability to a focus on more dynamic narrative dimensions, which further shed light on 1) tellership, 2) the narrative as situated in the context of time and place, and 3) construction of narrative and identity as emergent and interactional (Bamberg, 2006, 2010; Bucholtz, 2009; Georgakoupoulou, 2007; Ochs & Capps, 2001). From this perspective, narrative is a knowledge sharing and discursively complex genre (Ochs & Capps 2001). As introduced in Chapter 2, a set of narrative dimensions was proposed: tellership, tellability, embeddedness, moral stance, and linearity. Although these dimensions were developed precisely for analyzing narratives in medicine, they are also common in general narrative research. These dimensions are repeated from Chapter 3 for the reader's convenience in Table 4.1.



Table 4.1

*Ochs & Capps' Narrative Dimensions and Possibilities*

Dimensions	Possibilities		
Tellership	One active teller	← ..... →	Multiple active tellers
Tellability	High	← ..... →	Low
Embeddedness	Detached	← ..... →	Embedded
Linearity	Closed temporal and causal order	← ..... →	Open Temporal and causal order
Moral stance	Certain, constant	← ..... →	Uncertain, fluid

From Ochs and Capps, 2001, p. 20

#### 4.2.2.3 Post-canonical analysis of constructing narrative coherence

This section of the chapter analyzes examples from the medical interactions corpus which demonstrate how doctors and patients orient to the purpose of the interaction as they construct narrative coherence, and in doing so, show one aspect of the relationship between doctors' elicitations and patients' narratives. Using a number of case studies from the interactions corpus, I focus on doctors' elicitations and patients' narratives as discrete elements before exploring how these two elements inter-relate.

The key function of the classical narrative has been viewed as the construction of coherence (Ochs & Capps, 2001). More recent research of naturally occurring narratives has suggested the need for a shift in paradigm (Hyvärinen, et al, 2010) related to how narrative coherence may be perceived and analyzed. This shift suggests that less-coherent narratives be given greater consideration as acceptable narratives worthy of analysis. These narratives, often rendered by marginalized narrators in settings such as medical contexts, do not lend themselves to conventional narrative construction and are often perceived as fragmented and disorganized (Hyvärinen, et al, 2010) as is demonstrated throughout the rest of this chapter.

Data from this study suggest that the interaction between doctor and patient is influenced and shaped by each participant's development of narrative coherence. Doctors interacting with patients, especially patients with chronic illnesses, design elicitations in order to make sense of the patient's illness story. Accordingly, patients respond to these uniquely designed elicitations in a manner, which attempts to offer greater narrative coherence. Patients may use narrative to respond to doctors' elicitations as they struggle to understand and make sense of their own health conditions and illness experience. At the same time, doctors' elicitations may not explicitly draw out patients' coherency making. They may be implicit even as doctors themselves are attempting to make sense of the patient's condition as they design particular elicitations.

The following sections focus on the connection of doctors' elicitation design and patient narratives as responses exploring how these speakers share communicative resources (Gumperz, 1982, 1999) as the work toward a common goal. Heritage (2010) established that doctor question design is embedded in both the purpose of the medical context and the particular health concern presented by the patient and affects patient responses. Gafaranga and Britten (2003) suggest that question selection is based on whether an initial or follow-up visit is taking place. I propose that fundamental to question design is the doctors' desire to achieve narrative coherence. The analysis suggests that doctors' construction of narrative coherence seems to be evidenced by the types of elicitations doctors use in order to retrieve patient information and to understand the patient's health-related story. As doctors follow the question-tree-review-of-systems formulary, they alter the direction of the interaction as they orient to patients' responses. As is the case with participants in other interactional occasions, doctors attempt to organize the interaction, and thus the patient's narrative, in a neatly structured and more coherent manner for their intended purposes (Hyvärinen, et al., 2010). The traditional question-tree-review-of-systems formulary can be seen as de-contextualizing patients' narratives by focusing on certain aspects of and types of patient information. This means patients and doctors must continuously orient to the isolated elicitations that doctors are trained to use to gather information. Doctors must also orient to the patients' responses in order to identify the next most appropriate elicitation. In this sense, elicitations are viewed as a resource for doctors and patients as a way to attempt to construct narrative

coherence. The following analysis focuses on this important aspect of the interactional dynamic (Liebscher, 2007) found in medical encounters as revealed through doctors' elicitations used in the co-construction of patients' narratives (Heritage & Maynard, 2006).

### *Prompting concerns*

First, the analysis focuses on how a doctor's elicitation may be designed to prompt a patient's concern. The examples will demonstrate that the attempt to do so may or may not achieve the doctors' intended goal.

Example 4, taken from interaction A2, shows how the doctor's prompt achieves the goal of eliciting the patient's concern.

### Example 4

*Context:* Patient D, Debra, a 71 year-old woman, presents to her primary care provider with concern over specific symptoms.

[A2-1-5]

- 1 D: how are you
- 2 Debra: well this is i probably maybe didn't even have to come in
- 3 but i pulled two ticks off myself in the last week and a //half\
- 4 and i wouldn't even have thought about it but yesterday
- 5 man i felt like a truck ran over me

In this example, the doctor's Type-4 *How are you?* question form, typically found in a follow-up visit (Gafaranga & Britten, 2003), offers the patient the opportunity to present the condition which has prompted her to visit her doctor: feeling like a truck ran over her (line 5). This exaggerated description of how the patient feels satisfies the doctor's goal of eliciting the patient's concern.

The following example, taken from interaction C8, also demonstrates how a doctor's elicitation may help to achieve the goal of drawing out a patient's concern.

## Example 5

*Context:* Routine medical visit. Patient J, Jill, presents to her primary care provider for a routine visit.

[C8-3-16]

- 1 D: we are re-checking your blood pressure today because we made a change  
2 in your blood pressure medication //last time\  
3 Jill: /right\  
4 D: uh eventually we increased your ( ) + uh that didn't seem to work moved  
5 the ( ) back to twenty five milligrams per week and we added ( ) thirty  
6 milligrams once a 1//day\1 any problems with that 2//medication\2 as far  
7 as you can tell  
8 Jill: 1/right\1  
9 2/no\2  
10 D: okay any other problems  
11 Jill: not that i know of  
12 D: okay  
13 Jill: last week i had a scratchy throat now it's hoarse  
14 D: uh huh

In this example, the doctor's elicitation in line 10, *any other problems*, has been preempted by what has already taken place in the interaction, which is a reiteration of the purpose of the appointment to recheck the patient's blood pressure. This elicitation is attempting to offer the patient a chance to present other health issues. The patient's initial response is negative, *not that i know of*. However, after the doctor acknowledges this response, the patient presents a concern *last week i had a scratchy throat now it's hoarse* (line 13). The doctor's elicitation achieved his goal of eliciting a concern although not in the patient's initial response. It is possible that given more time to consider the prompt, the patient is able to recall a concern to present.

In contrast, the doctor's elicitation may not draw out a concern, particularly in the case of a routine medical visit as seen in the following examples taken from interactions C5 and C10.

#### Example 6

*Context:* Routine medical visit. Patient, G, Gail, presents to her primary care provider for a routine medical visit.

[C5-13-15]

- 1 D: no problem with medication as you can tell
- 2 Gail: no problems period
- 3 D: no problems period man this is perfect

In this example, the patient emphatically indicates that there are no problems with her medications. The doctor accepts the patient's response by repeating it, *no problems period* (line 3), and does not pursue further inquiries related to medication.

#### Example 7

*Context:* Routine medical visit. Patient L, Louise, a 73-year-old patient, presents to her primary care provider for a routine visit.

[C10-9-10]

- 1 D: is it (dealing with the death of spouse) becoming a problem for you
- 2 Loise: [patient shakes head side to side]

In Example 7, the doctor offers a prompt eliciting whether the death of the patient's spouse is becoming a problem. The patient responds with shaking her head

from side to side indicating that she is not having a problem dealing with her spouse's death that may be related to a health issue. This inquiry is not further pursued.

The following example, taken from Example 1 and repeated for the reader's convenience, shows how a doctor's elicitation (indicated in bold) may be oriented to prompting the patient's presentation of concern and demonstrates how the concern may be presented throughout the course of an interaction and not always in a single, concise response. This excerpt is analyzed in further detail to help contextualize the prompt as situated in one of the core interactions, which will be reviewed by evaluating doctors in Phase 2. Interaction A1 illustrates how the doctor's use of an elicitation *okay what brings ya in today* (line 1) opens the interaction with the patient.

#### Example 8

*Context:* Routine medical visit. Patient A, Ann, a 72 year-old woman, presents to her primary care provider with shoulder pain following an accident.

[A1-6-16]

- 1 D:           **okay what brings ya in today**
- 2 Ann:       well i was walkin'
- 3               and i went to cross the street at the curb
- 4               and my foot musta got caught in the curb
- 5 D:           okay
- 6 Ann:       there was a metal strip there
- 7               i went later to look
- 8               and i kind of flew out in the street
- 9               and i put my two arms out to protect my body
- 10 D:         uh huh
- 11 Ann:       and um hurt this arm really bad#

In his sanctioned role, the doctor demonstrates authority in the encounter as the one who begins the interaction. The elicitation, another Type-1 *How are you?* formed

question, demonstrates this power as its open-ended design not only invites, but also, could be interpreted as a demand for a response from the patient. The occasion of the medical visit positions the doctor to design questions to seek information in order to make sense of the patient's condition. This elicitation could be interpreted as the doctors' initial attempt to construct narrative coherence.

The patient's narrative begins in line 2 in response to the doctor's elicitation in line 1. In telling the event, the patient links the details in a sequence which not only indicates the order of the events but also the cause of her condition and is important for the doctor to understand the patient's condition more completely.

Since many events are not known to doctors before a particular encounter, and narratives, as Burke (1962, p. 498) has indicated, may be "selections rather than reflections of reality", the manner in which patients tell their narratives may influence doctors' decisions about what to explore further.

### *Seeking additional details*

When the patient's narrative is presented in a way that does not offer the doctor the level of detailed information perceived as necessary to make a diagnostic decision (Cordella, 2004b; Inui & Carter, 1985; Ong, et al., 1995; Roter, Hall, & Katz, 1988), a finding from Phase 2 indicates that doctors require more elicitations.

The following examples, taken from interactions C9 and C6, demonstrate how doctors attempt to elicit more details from the patients.

### Example 9

*Context:* Routine medical visit. Kate, a 66 year-old woman, presents to her primary care provider for a follow-up visit. The doctor is discussing the patient's weight gain.

[C9-6-9]

- 1 D:           how have you been doing with your diet
- 2 Kate:       i don't eat meat but i have been going out more and I try+

3                   but that's why I gain weight, it just, eh

In this example, the doctor's general inquiry related to the patient's weight loss diet yields more specific details about the patient's actual food type intake (no meat, line 2) and general recent eating practice (going to restaurants more, line 2)

However, there are instances from the corpus when the doctor's attempt for more details is truncated by the patient's response as seen in the following example.

#### Example 10

*Context:* Routine medical visit. Patient, H, Helen, presents to her primary care provider for a routine visit.

[C6-11, 19]

- 1 D:           now how did you feel uh with the physical therapy+did it help  
2 Helen:       i just hurt so bad i didn't think it did anything

In response to the doctor's elicitation, the patient's more specific information indicates that she did not find the previous physical therapy to be helpful to her chronic condition and continues to present with pain at the current clinical appointment. This response truncates the doctor's pursuit of more specific details related to the patient's physical therapy intervention.

#### Example 11

*Context:* Routine medical visit. Patient, F, Flo, presents to her primary care provider for a routine visit. She discusses why she is not taking pain medication for her back pain.

[C4-29-32]

- 1 D:           pain medicine puts you to sleep  
2 Flo:         yeah i have to be alert because i can't let him fall again



- 3                    he had a bad fall two weeks ago  
 4                    leg was swollen and he's diabetic

In Example 11, the doctor's elicitation is oriented toward more detailed information related to why the patient refuses to take pain medication. This prompt not only elicits more detailed information but also offers the patient the opportunity to connect a reason to her behavior. Since causation is one aspect of narrative which contributes toward coherence, the doctor's elicitation helps the patient co-construct a more coherent part of her narrative. This function of co-construction is further exemplified in the following examples.

#### Example 12

*Context:* Excerpt from interaction A1. Patient A, Ann, a 72 year-old woman, presents to her primary care provider with shoulder pain following an accident.

[A1-46-63]

- 1    D:            **has it uh been swollen at all any place**  
 2    Ann:        i can't tell that i'm so //heavy\ in that area that i can't //tell\ that  
 ...  
 3    D:            2/it's hard to tell\2 um **do you think it's any better now**  
 4                   **than when you first did it or is it about the same or is it worse**  
 5    Ann:        i think it's better it just is aggravating to me  
 6    D:            okay  
 ...  
 7    D:            **regardless of which way you lift it it hurts**  
 8    Ann:        yeah  
 9    D:            **okay does it hurt down into the arm or into //the\ fingers**  
 10 Ann:        [mumbles] /yeah it hurts to the elbow\  
 ...  
 11 D:            /okay\ **have you ever injured that shoulder before**

12 Ann: no

In example 12, the doctor's elicitations are oriented to the tellability of this patient's acute health concern, the event's structured linearity, and the causation linking the event to the patient's main concern contribute to narrative coherence. The patient's narrative is both constructed and perceived as coherent; this is indexed not only by her linear, highly tellable presentation but also by the doctor's display of understanding and use of elicitations.

### Example 13

*Context:* Excerpt from interaction C7. Routine medical visit. Patient I, Iris, 70 year-old woman, presents with not feeling well and having no energy.

[C7-1-7]

- 1 D: how have you been feeling
- 2 Iris: i have not been feeling well at all
- 3 D: **tell me what that means**
- 4 Iris: that means i'm just very very tired i have to push myself
- 5 i still have like no energy
- 6 D: okay
- 7 Iris: and i can hardly get through my housework

In Example 13, a chronic case, the doctor elicits the patient's narrative by asking her to explain what the utterance "*not feeling well*" (line 2) means. This elicitation *tell me what that means* (line 3) engages the patient to describe what this phrase means to the patient specifically as it relates to this particular medical concern. The way this elicitation links to the patient's narrative demonstrates how the doctor and patient work toward the shared goal of constructing narrative coherence. By engaging the patient in this way, the doctor is assisting in creating "affiliation and camaraderie" (Cordella, 1996; Schiffrin, 1984) with the patient, who is given the opportunity to offer specific descriptors of her condition as seen in lines 4, 5, and 7.

The following examples show how some patients' concerns and presentation of details, when associated with chronic health conditions, vary in their contribution toward narrative coherence sometimes in spite of doctors' and patients' efforts to make sense of patients' chronic health narratives. Example 14 demonstrates the doctor's attempt to use a prompt to gather information which might make the patient's narrative more coherent.

#### Example 14

*Context:* Patient L, Louise, a 73 year-old patient, presents to her primary care provider for a routine visit.

[C10-17-23]

- 1 D:           there was some strife about it (brother's drama)
- 2 Louise:     [patient shakes head no]
- 3 D:           no
- 4 daughter:   no about me
- 5 D:           [to daughter] about you you're causing problems
- 6 daughter:   yes i'm causing problems
- 7 Louise:     [to daughter] no you aren't

In example 14, the doctor attempts to gather more specific details associated with the patient's home life to make more coherent sense of the patient's story by using prompts which hypothesize (line 1) and ask for clarification (line 5). In these instances, the doctor's hypothesis is not confirmed by the patient (line 2) while his gloss-for-confirmation is confirmed by the daughter (line 6) yet disconfirmed by the patient (line 7) leading to less coherence of the patient's story. In this case, the doctor's attempts to utilize elicitations in order to gather more specific details to gain greater understanding of the patient's narrative are not fully productive. At the same time, it could also be interpreted that the lack of coherence in spite of his efforts may indicate the extent to which this family situation is possibly compromising the patient's health.

At the same time, when the interaction is viewed in its entirety, this particular patient's narrative does show some coherence which is directly elicited by the doctor later in the interaction as seen in Example 15.

#### Example 15

*Context:* Routine medical visit. Patient, L, Louise is meeting with her primary care physician.

[C10-44-51]

- 1 D: do you have things to keep you busy
- 2 Louise: i try to stay busy
- ...
- 3 i love to read
- ...
- 4 D: okay so you've been doing that
- 5 Louise: yes a lot of that

In Example 15, we see that the patient more directly responds to the doctor's prompt which elicits detailed information related to the patient's behavior that might offer insight into her well-being.

In the following example from the core interaction, C1, the doctor uses an atypical elicitation to begin the interaction. The excerpt is an expanded version of Example 3. This expanded version is used to display the doctor's utterances and prompts in context, which demonstrates his attempt to consistently construct narrative coherence throughout the interaction.

#### Example 16

*Context:* Routine medical visit. Bess, a 73-year-old woman, presents to her primary care provider for a blood pressure monitoring follow-up.

[C1-2-32]

- 1 D: **ya see that blood pressure**
- 2 Bess: it's always high //( )-\
- 3 D: **/i can't** that's right\\ that's right we
- 4 uh what is it we do uh
- ...
- 5 Bess: you monitored me
- 6 D: we monitored yeah
- ...
- 7 i don't want to think i have high blood pressure [laughs] either
- 8 but i really don't think i do
- 9 but i do take medication
- 10 D: **++ can't figure out why it would be on medicine**
- 11 why it would be elevated here and you
- 12 let me check your let me review my notes
- 13 Bess: because i suffer from uh anxiety about going to the //doctor\
- 14 D: /to the doctor\\
- 15 Bess: i think
- 16 D: we actually sent did get you the home blood pressure monitoring didn't we

Through his sanctioned role, the doctor displays power by taking control of the medical interaction with an initial elicitation *ya see that blood pressure* (line 1). Within this context, this question may be interpreted in multiple ways. One interpretation is that the doctor is confronting the patient about her high blood pressure, and in support of this interpretation it can be argued that the patient seems to respond appropriately with a coherent comment. However, the doctor's elicitation might also be interpreted as displaying his desire for understanding the patient's current health status that up to this point does not make coherent sense. Examining lines 1, 3, and 10, the doctor's complete expression seems to be, *I can't figure out why on medicine your blood pressure is still high*. When interpreted through the frame of constructing narrative coherence, this seems to be the doctor's attempt to understand the patient's condition given the inconsistency of

her blood pressure and her insistence that she does, indeed, adhere to taking her blood pressure medication.

Similarly, the overlap (lines 13-14) of the doctor completing the patient's statement *because i suffer from uh anxiety about going to the //doctor\* may have multiple interpretations, especially when analyzed through the frame of constructing narrative coherence. In past research using discourse analysis, an overlap, or interruption has been interpreted as both a indication of control used by the participate of perceived power (Zimmerman & West, 1983) or an attempt to demonstrate solidarity (James & Clarke, 1993; Tannen, 1984, 2009). With this potential "ambiguity of power and solidarity" (Tannen, 2009, p. 177), the analysis requires looking to other aspects of the interaction to assist in the interpretation. Earlier in the interaction, the doctor is in agreement as indicated by his use of *yeah, yeah* (lines 9-10) and uses *we* (lines 13, 22) as a term of solidarity. Sometimes, when an overlap is used by a participant and is interpreted as a form of control over the interaction, the co-participate may stop speaking (p. 177). However, the patient in this interaction does not stop speaking due to the overlap and responds with the phrase *i think* (line 21) which seems to complete her full phrase from line 19 and also confirms her hypothesis. When an overlap is used to control the interaction, the participant may use this device repeatedly or to change the topic. However, in this interaction the doctor does not overlap repeatedly. Also, following the overlap in lines 19 and 20, he does not use the device to start a new topic but instead reconfirms that the patient had been sent home with a monitor (line 20). With both the patient's response and the doctor's move back to the issue of the monitor, the overlap may be viewed as solidarity versus power. Within the frame of constructing narrative coherence, this particular overlap might be interpreted as an attempt by the doctor to "talk along with another" (p. 177) in the co-construction of the patient's narrative.

When the interaction is reviewed in its entirety, the lack of explicit statements contributes toward an understanding that the narrative is implicitly rendered. This excerpt provides evidence of the patient's less structured story as she struggles to respond (lines 5 and 6) to the doctor's elicitation and attempts to "set the story straight" as she develops narrative coherence. It is possible that the doctor's question is designed to simply direct the patient to her high blood pressure. As a straight interrogative, this

question seems to be grammatically designed to favor a “yes” response and the content of the question seems to index an expected outcome (Heritage, 2010). The design of the question could also be interpreted as a way for the doctor to understand and make sense of the patient’s illness story. The question indicates that the doctor has prior knowledge (Robinson, 2006) of the patient’s health condition. Evidence of this prior knowledge might be the direct approach of the doctor, demonstrating familiarity with the patient. This prior knowledge seems to contribute to the lack of clarity related to why the patient’s blood pressure remains high if she is indeed taking her blood pressure medication. Prior knowledge could also include information which would indicate that the patient is not taking her blood pressure medication. This particular initial elicitation seems to be asking for and seeking an explanation that might assist the doctor in making sense of the medical variable of high blood pressure given his knowledge of and prior experiences with the patient. The doctor may be using this elicitation to assist in aligning the patient’s high blood pressure with her narrative.

The initial elicitation design is one where the doctor and the co-participant-patient are prompting an exchange of information (Cassell, 1985) in order to make sense of why the patient’s blood pressure is elevated if the patient is adhering to medication which lowers blood pressure. This elicitation is agenda setting (Clayman & Heritage, 2002; Heritage, 2002; Mishler, 1984) in the sense that the doctor prioritizes an aspect of the patient’s health information, her blood pressure, and is intending to elicit information and content which may assist the doctor in understanding the patient’s story as a more coherent narrative. The elicitation could be interpreted as implying that the doctor does not believe the patient is adhering to her medical intervention; otherwise, her blood pressure would possibly be better maintained. Interestingly, this interpretation is further supported by the doctor’s comment in line 23 which is an explicit linguistic display acknowledging that, based on the information he currently has about the patient’s condition, he cannot make sense of why her blood pressure remains high.

The agenda-setting purpose of the doctor’s elicitation shapes not only the patient’s response but also the decision-making course the doctor is attempting to set and maintain. The doctor seems to present an agenda, which seeks to make sense of the factors related to the patient’s condition. The one variable of high blood pressure does

not align with the patient's claim that she is taking her blood pressure medication and does not create a story which allows the doctor to make a diagnostic decision. Observing how this doctor uses an elicitation to set an agenda and how the patient responds to it offers insight into one way doctors and patients orient and cooperate with each other as they seek narrative coherence in order to make sense of "what matters" (Heritage, 2010) in this medical interaction.

The next two examples contrast two scenarios. Although the doctor offers a similar service-oriented Type-1 initial elicitation in both, the responses differ in their level of narrative coherences.

#### Example 17

*Context:* Excerpt from interaction A2. Patient D, Debra, a 72 year-old woman, presents to her primary care provider with concern over symptoms possibly related to tick bites.

[A1-7-23]

- 1 D:           how are you  
...  
2 Debra:       and according to articles i've saved over the years  
3               that's one of the symptoms  
4               so i thought maybe i oughtta be safe than //sorry\1 well or it  
5               could be rocky mountain spider fever  
6               even with that you get a rash on your wrists and your ankles  
7               and i don't have that  
8               i don't have the typical bulleyes //thing\2  
9               the one tick i pulled was on my scalp  
10              and i mean the whole side of my head's swollen  
11              and the site where i took the tick out was  
12              about like that [indicating size with her left hand]  
13              about that big around and that high  
14              and are there some lymph nodes right about below that



- 15           [turning her head to the right and indicating location with her left hand]  
 16           well that was all bumpy and really sore yeah  
 17           and the other tick i pulled off [stands and turns back of leg toward doctor]  
 18           is down right here

In this example, we see the patient render a fairly coherent part of her narrative (lines 2-18), which relates to symptoms possibly from a tick bite. This rendering is in contrast to Example 18 taken from core interaction C2, the second chronic case introduced earlier. In this next situation the doctor uses service-oriented initial elicitation, similar to A1 above, *um what can i do for you today?* and offering the patient “space” in which to speak. In response to this open-ended question, coupled with being given the floor for lengthy periods of time, the patient offers a great deal of information and seems to lose track of the story she attempts to develop. As illustrated in Example 18, the patient is unable to create links between events: taking the medication amitriptyline, (line 2), using a tapping technique (line 8), having an asthma attack (line 14), and returning to medicine for pain (line 16).

#### Example 18

*Context:* Routine medical visit. Patient C, Cara, a 72-year-old woman presents to her primary care provider with continued pain in her neck and shoulder.

[C2-1,87-102]

- 1 D:           um what can i do for you today?  
 ...  
 2 Cara:       and **i don't wanna go to that amitriptyline**  
 3 D:           yeah, no  
 4 Cara:       //is there anything\  
 5 D:           /there are side effects with that\<\  
 6 Cara:       oh gosh yes is there anything cause it's not the  
 7           i don't think it's paying for medicine because when i'm feeling that way

8           **i'm doing my tapping or the thought field technique**  
9           which maybe takes two and a half to three minutes  
10          and you can repeat it and repeat it done  
11          you know it's not dangerous to the body or anything  
12          and what it is doing the polarity so it's it's helping me  
13          and i can i can just tell it's like when someone is tryin' to breathe  
14          **and feel an asthma attack coming on and maybe they open the**  
              **window**  
15          or get a breath of air your body senses it immediately  
16          **so i know that it's bad and and i don't want any medicine for pain**  
17          it's not i don't think it would it would would be effective

The patient in this interaction seems to have difficulty organizing her ideas. This may be due to the challenge she has of making sense of her chronic condition and that for her meaning might “emerge from individual interpretation and re-articulation of the relationships among countless seemingly unconnected experiences” (Harter, Japp, & Beck, 2005, p. 33). She is apparently unaware her narrative may be perceived as less coherent due to the way she presents material. Although tellers “respond to a lack of attention by repeating, rephrasing, ... and the like” (Capps & Ochs, 1995, p. 278), there does not seem to be evidence which would indicate that inattentiveness by the doctor is driving this particular patient to present her narrative in this manner. Reviewing the video of this interaction does not offer any additional evidence related to the doctor's attentiveness as the doctor's face is not fully visible. What is not clear is if the patient perceives the doctor to be inattentive or uninterested since the doctor offers so little feedback, comments, or redirection (Edelsky, 1981; Tannen 1991, 1994; Zimmerman & West, 1975) thus explaining why the patient continues in this manner. Moreover, the patient may not understand that the disjunctive components of her narrative may lead to a listener questioning her moral stance.

These two examples show the contrast between the organization of patients' narrative details from an acute versus chronic case in spite of the use of similar

elicitations. These examples begin to extend the focus from the doctors' elicitations to the patients' responses which is the focus of the next section.

### **Patients constructing narrative coherence through question response**

Patients managing chronic illness may have a difficult time determining what from their experience is relevant information to their doctors (Hyvärinen, et al., 2010). This phenomenon may be present in health-related narratives in general and especially in chronic cases as patients attempt to make sense of multiple factors related to medications and secondary medical concerns. The lack of coherence itself may very well be telling this part of their story as demonstrated in the following examples.

As mentioned in the previous section, doctors' elicitations invite, and at times, demand patients' responses. The previous examples focused on the doctors' elicitations as both prompts and as displays of seeking narrative coherence. The following examples focus more closely on the patients' responses to their doctors' elicitations. These examples display the patients' construction of narrative coherence with particular attention on narratives related to chronic conditions.

Example 19, taken from interaction C9, a chronic case, demonstrates how a patient's narrative might directly and concisely offer a response to her doctor's elicitations.

#### **Example 19**

*Context:* Routine medical visit. Kate, a 66 year-old woman, presents to her primary care provider for a followup- visit. The doctor is discussing the patient's elevated blood pressure and weight gain.

[C9-2-5]

- 1 D: oh, blood pressure's up a bit, now
- 2 Kate: yeah, i had been walking again
- 3 D: what happened that you got off your schedule
- 4 Kate: well, the weather and company

In this example, we see how the patient attempts to offer reasons for why her blood pressure may be elevated by stating that although she had been walking (line 2), her routine had been disrupted by the weather and visitors (line 4). By responding to the elicitation in this way, the patient is attempting to link the lack of a certain behavior, walking, directly to her higher blood pressure as a way to construct narrative coherence.

Similarly, in Example 20, which is from core interaction C1, the patient attempts to use her responses to her doctor's elicitation to make sense of her health status. The selected patient responses are in bold text. The patient's response, starting in line 2 *it's always high* and continuing throughout the exchange seems to launch a narrative explaining why her blood pressure may be high. This is seen in line 26 *because i suffer from uh anxiety about going to the //doctor\* as she explains that her blood pressure is high only when she visits the doctor. She seems to have difficulty framing her response as seen in lines 5 – 7, with the additional challenges imposed by the doctors' interjections and interruptions (lines 8-10, 12).

#### Example 20

*Context:* Routine medical visit. Bess, a 73-year-old woman, presents to her primary care provider for a blood pressure monitoring follow-up.

[C1-2-28]

- 1 D: ya see that blood pressure
- 2 Bess: **it's always high** //( )-\
- 3 D: /i can't that's right\\ that's right we
- 4 uh what is it we do uh
- 5 Bess: **that uh this is my this week's blood** 1//pressure\1
- 6 **there are a whole bunch of other months blood** 2//pressure\2
- 7 **and it it seems to be around in the one thirty to seventy**
- 8 D: 1/yeah\\1
- 9 D: 2/yeah\\2

- 10 D: that's right i it's  
 11 Bess: all the time  
 12 D: *we uh we actually uh*  
 13 Bess: **you monitored me**  
 14 D: we monitored yeah  
 15 Bess: **with an electronic monitor when was it last summer spring**  
 16 D: yeah i remember now i'm sorry  
 17 Bess: **it's all right i'm sorry you don't believe me [laughs]**  
 18 D: well  
 19 Bess: **i know [laughs]**  
 20 **i don't want to think i have high blood pressure [laughs] either**  
 21 **but i really don't think i do**  
 22 **but i do take medication**  
 23 D: ++ can't figure out why it would be on medicine  
 24 why it would be elevated here and you  
 25 let me check your let me review my notes  
 26 Bess: **because i suffer from uh anxiety about going to the //doctor\**  
 27 D: /to the doctor\\  
 28 Bess: i think

Instead of agreeing to the doctor's initial elicitation, the patient's response seems to contest the doctor's elicitation in that she offers an explanation (Heritage, 2010), which continues to position her as a patient adhering to her medical intervention. In lines 5-7 the patient offers what she believes is evidence of lower blood pressure readings at home, perhaps not fully realizing that the readings she offers are still considered rather high<sup>14</sup>. Even though she further reminds the doctor that *you monitored me* (line 13) *with an electronic monitor when was it last summer spring* (line 15), the doctor apparently does not have immediate access to her records. The patient seems to take the doctor's lack of

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<sup>14</sup> Normal (systolic) blood pressure range is less than 120 according to the American Heart Association <http://www.americanheart.org>.

access to her records as an opportunity to imply that her blood pressure was not high during the period it was monitored, *it's all right i'm sorry you don't believe me [laughs]* (line 17). The first part of the patient's response, *it's all right* seems to be acknowledgement and understanding that they are both trying to make sense of the patient's condition.

What immediately follows the elicitation is the patient positioning herself as one who apparently perceives the need to defend her moral stance (Ochs & Capps, 2001) *it's always high* (line 2), an extreme case formulation to legitimize her claim (Pomerantz, 2007), *because i suffer from uh anxiety about going to the //doctor\* (line 26) as she seeks to make sense of why her blood pressure reading is elevated when she is in the clinic since she does indeed adhere to taking her medication (line 22).

From this discourse interplay, it becomes increasingly apparent that the doctor and patient are seeking to make sense of why the patient's blood pressure reading at the clinic is high. Evidence of this is found in the doctor's elicitations in lines 3 and 23, as discussed earlier, and in the patient's response in line 26 as she indicates that one reason for her high blood pressure reading at the clinic is her anxiety about going to the doctor. There seems to be differences and interplay between the two discourses as each participant seeks different narrative coherence goals and varied approaches as to how to achieve them. Simultaneously, these two participants work together toward achieving the shared goal of improving the patient's health status (Cordella, 2004b) in spite of challenges made by each participant.

As each participant moves through the interaction, they are working against, with, and orienting to this disconnect of discourse interplay (See model below in Figure 4.2). Although they each attempt to achieve narrative coherence, the narrative coherence they seek seems to be unique and different from the other, even as they move toward a common goal. The participants co-construct the patient's as they move to achieve their interactional goals (Georgakoupoulou, 2006; Helsig, 2010; Phoenix, 2008; Riessman, 1993, 2008; Squire, 2008). Each participant constructs coherence in different ways and in response to different prompts: patients in response to doctors' elicitations and doctors in response to the type of information they receive from patients.

The following figure illustrates one way the medical discourse interplay may be understood in medical interactions by using the patient information from interaction C1. The figure offers insight into the complexity associated with understanding how narrative coherence and the discursive display of constructing narrative coherence may emerge from the participants in the medical interaction as they co-construct the patient's narrative.

**Figure 4.2: Medical Discourse Interplay  
in the Co-construction of Narrative Coherence**

**DOCTOR**

**PATIENT**

**WHO**

Doctor's perception of patient -  
One who has high blood pressure  
One who is not adhering to intervention

Who the patient says she is –  
One who has high blood pressure  
One who is adhering to intervention

**WHAT**

Patient has high blood pressure reading  
A patterned concern

Patient has high blood pressure reading  
An isolated event restricted to clinic

**WHY**

Reason unreconciled with patient's  
claim to adherence –  
*Prompts doctor to  
construct narrative coherence*

Isolated event due to fear of being at clinic  
*Prompts patient to  
construct narrative coherence*

**JOINTLY CONSTRUCTED  
NARRATIVE COHERENCE**

The following examples illustrate an added layer of complexity to this interplay with focus on the tension between doctors' and patients' agendas. These examples demonstrate occasions where patients' agendas are prioritized by the patients' initiation of the interactions. These are rare examples from the corpus (only two of the 69 interactions) of a patient leading the interaction. In some cases, where patients may be seeking a specific outcome associated with a prescription, the manner in which the patient may attempt to achieve this goal may lead to a more or less coherent narrative.

In Example 21, the patient initiates the interaction as a first step toward constructing narrative coherence.

#### Example 21

Context: Routine medical visit. Patient, H, Helen, presents to her primary care provider for a routine visit.

[C6-1-3]

- 1 Helen:       there are some things i wanted to ask you
- 2 D:           yeah
- 3 Helen:       did you really confirm what you thought i had fi//fibro\
- 4 D:           /fibromyalgia\\ right um++

In this example, the patient very directly indicates that she has questions to ask her doctor (line 1), and once confirmed by the doctor to proceed (line 2), the patient asks a very specific question of confirmation related to a potential diagnosis (line 3). This initial posturing of the patient indicates that her question is a priority and that she is attempting to construct coherence of her condition.

Similarly, in Example 22, taken from core interaction C3, the patient initiates the interaction. In this case, the patient uses the marker *first off* (line 1) in order to pursue one of her goals for the interaction, which is obtaining a prescription to refill her medication. This discourse marker indicates that the item that follows, ordering a three-months' supply of prescriptions, is from her perspective to be presented as the first order



of business for the encounter. This marker embodies her “pre-emptive self-identification” (Schiffrin, 2006, p. 237) versus waiting for the doctor to know her (Schegloff, 1979) through a presentation of her self as elicited by the doctor. It may be seen as a way to prioritize or do “urgency”. In using this marker, the patient indicates to the doctor that she plans to continue to speak and foreshadows the telling of the issue and its importance to her (Schiffrin, 2006).

## Example 22

*Context:* Excerpt from interaction C3. Routine medical visit. Patient E, Ella, a 74-year-old woman presents to her primary care provider with desire to alter ordering of prescription supply.

[C3-1-5]

- 1 Ella: *first off*
- 2 D: first off
- 3 Ella: **i'd like to mention ( ) ordered a three months supply of prescriptions**
- 4 **get for the same price as for one month**
- 5 D: okay

In Example 22, the patient exerts control over the usual questions and answers approach (Gill, 1999; Halkowski, 1994; West, 1984) of the typical medical interaction. She takes control of the topic and its development (Paget, 1993) through the sequencing of information (Fisher, 1993; Schiffrin, 2006) and through the opening of the interaction structure with greater control over this portion of her narrative (Byrne & Long, 1976; ten Have, 1989) to move toward achieving her goal. Although the doctor does not elicit this opening of the patient's narrative, it is sanctioned by the occasion of the medical visit and seems to be ratified by the doctor's *okay* response in line 5 (Barton, 2000). This further exemplifies the medical consultation as “a goal-seeking activity in which, while each party has goals, the goals of one party may or may not be clear to the other party” (Byrne & Long, 1976, p. 31). Since the patient's request is associated with an existing

prescription and is understood by both parties as a legitimate prescription to continue, the patient's agenda-setting and directness appear acceptable. Given the appropriateness of her request, this portion of her narrative is clear, concise, and coherent and appears to be perceived as such by her doctor, who agrees to her request.

In other cases, the patient's request for a prescription may be less direct. This may be for several reasons including 1) the patient may not want to directly tell the doctor how to perform her job and 2) depending on the type of prescription, the patient may not want to be perceived as drug-seeking. The following excerpts from interaction C2 illustrates one of the goals that the patient is attempting to achieve.

### Example 23

*Context:* Routine medical visit. Patient C, Cara, a 72-year-old woman presents to her primary care provider with continued pain in her neck and shoulder.

[C2-37-39]

- 1 Cara: about the past three weeks
- 2 **i just don't think the trazodone is holding anymore**
- 3 **and i don't think i need to go up on it**

[C2-307-308]

- 1 Cara: **so i would be very open to y'know stay on the trazodone**
- 2 **but take something //like that\ flexeril**

Toward the beginning of the interaction in excerpt [C2-37-39], the patient states that the sedative she has been taking, Trazadone, has been losing its effectiveness, but she does not want to increase the dose. Toward the end of the interaction in excerpt [C2-307-308], she agrees to continuing with the Trazodone and adding a muscle relaxant, Flexeril. It is unclear whether or not this was her goal from the onset. We cannot be sure; but if

this is the case, it may be one of the reasons why her narrative is less coherent since directly asking for this type of medication has negative connotations.

These examples demonstrate that chronic patient concerns seem to have a direct impact on the level of narrative coherence found within medical interactions. This may be due to the difficulty patients have in managing chronic illness and understanding its impact on their lives (Hyvärinen, et al., 2010).

The next section focuses on NM as an analytic approach.

#### **4.2.3 NM as analytic approach**

As mentioned previously, NM is an important frame for the analysis of elicitations and narratives in this research. Within this framework, narratives are the form in which patients experience ill health, encourage empathy and promote understanding between doctor and patient, assist in the construction of meaning (Riessman, 2008), and may supply useful analytical clues and categories (Greenhalgh & Hurwiz, 1999). As indicated throughout this thesis, the approach introduces the concept of offering patients “space” in which to speak (Charon, 2006) and the analysis so far has established that the “space” offered may be particularly challenging to patients when they are experiencing chronic health conditions. This finding aligns with previous research which establishes that individuals with certain chronic health conditions tend to construct less coherent narratives (Freeman, 2010; Hydén, 2010; Hydén & Brockmeier, 2008; Hyvärinen, 2010). It may be difficult for them to construct narratives without the guidance of doctors’ elicitations. The analysis has also suggested that offering patients more “space” can challenge doctors in constructing narrative coherence and determining what is salient to patients’ conditions. Therefore, within this framework, narrative competencies are required of the doctor. This analysis further expands the scope of narrative analysis with a focus on the narrative competency of the doctor as well as on participants beyond the immediate interaction.

##### **4.2.3.1 Narrative competency in medical interactions**

This section expands the Literature Review focusing on narrative competency. As indicated in Chapter 2, the main rationale for NM is to use narrative as a device by

which to better understand patients through their narratives. The purpose of the approach is to more effectively diagnose patients and provide medical interventions. The NM approach focuses on the doctors' narrative competencies, their abilities to "read" patient narratives. In doing so, they develop skills in "listening in new and creative ways" (Hyvärinen, et al., 2010) and understand the patient's story with greater empathy for singular knowledge of the patient in order to, not only approach and engage in patient narratives but also, gain co-ownership of them (Charon, 2006). In using this approach, the doctor may be better able to determine 1) how a patient's concern is situated in the medical encounter, 2) what is salient to the patient's condition, 3) how various factors may have contributed to the event, such as family members, etc., and 4) how the health concerns may impact the way the patients view their identity.

In addition to vast medical knowledge, constraints and demands from the health care system, and the particular demands and goals of the patient, the doctor in the NM framework is also asked to develop narrative competency. In doing so, the doctors' identity in the interaction as doctor may be merged with the Fellow Human (FH) voice (Cordella, 2004a). Considering the FH voice within the NM approach seems to focus as much on the identity of the doctor as the identity of the patient. The doctor's history and experiences brought to the encounter seem to be as important to consider as what the patient's history and experiences brings to the encounter. The power asymmetry (Maynard, 1991; Peräkylä, 2002; Robinson, 2001; Sarangi & Slembrouck, 1998; ten Have, 2007) still exists as sanctioned by the institutional and societal role given to doctor (Barton, 2000). However, the NM approach attempts to peel away the outer, institutional facets of this role to reveal the FH voice of the doctor and to see what the FH voice of the doctor brings to the medical encounter and elicits from the patient.

Narrative competency within the NM approach is intended to develop a higher level of doctor empathy toward the patient. Karl Phillip Moritz referred to the concept of empathy as *erfahrungsseelenkunde* (Oster, 2005), which might be translated, "experience the notion of the soul/mind of the customer". Situated in experiential psychology, a psychology that is based on one's own experiences, this term refers to how one can understand others by using one's life experiences in a narrative format. In this sense, empathy through the NM approach seems to bring a greater "genuineness" on the part of

the doctor in order to assist the patient in revealing their very personal illness narrative (Oster, 2005). This empathy is developed as doctors reflect on their own experiences with life, illness, and other patients' illnesses. With narrative competency, the doctor may then better ascertain what is salient to an illness and what is not (Charon, 2006). The patient's narrative is critical to the doctor's ability to grasp how each medical event is situated in a patient's life. Implicit to this narrative competency within this framework is the self-awareness of the doctors to acknowledge their own experiences and history that they bring to the present interaction.

### **Sideshadowing and narrative competency**

According to the NM approach, doctors welcome and encourage open-ended narratives since this is a natural element of conversation, which is the most likely means for expressing unresolved and problematic life events (Charon, 2006). In telling narratives, patients may use sideshadowing, "the process of making the past present and establishing that something else might have taken place" (Ochs & Capps, 2001, p. 5). In narrative analysis, identifying sideshadowing is either excluded by traditionalists or accepted only by acknowledging that "1) the boundaries of narrative are fuzzy and 2) the narrative allows authors to imagine possibilities, with alternatives, shift mindsets, and act without knowing what is likely in the future" (p. 6). This second point is especially true for doctors as they co-construct patient narratives. Therefore, within the medical encounter, doctors may need to orient to the open-endedness of patients' narratives as patients articulate and try to construct meaning of their unresolved health conditions even without understanding what has actually happened and why.

The following example is taken from interaction A1, repeated for the reader's convenience, and offers an example of how doctors and patients appear to maneuver through a narrative even when the story may not be fully resolved. In Example 24, the doctor's feedback, *okay*, in line 5, seems to indicate that he accepts what the patient has presented thus far and is anticipating the next part of the patient's story. In this same excerpt, the patient expresses a lack of understanding of what actually caused her to fall by hypothesizing that her *foot musta got caught in the curb* (line 4).

## Example 24

*Context:* Patient A, Ann, a 72-year-old woman, presents to her primary care provider with shoulder pain following an accident.

[A1-6-16]

- 1 D:           okay what brings ya in today
- 2 Ann:       well i was walkin'
- 3           and i went to cross the street at the curb
- 4           and **my foot musta got caught in the curb**
- 5 D:           okay
- 6 Ann:       there was a metal strip there
- 7           i went later to look
- 8           and i kind of flew out in the street
- 9           and i put my two arms out to protect my body
- 10 D:       uh huh
- 11 Ann:      and um hurt this arm really bad#

Although this patient's narrative is not completely resolved in regard to why the event she describes has taken place, it can be differentiated from interaction C2, where the patient's narrative seems to leave much of the meaning of the events without resolve. As seen in the following three excerpts from C2, the patient in her rather contradictory comments presents an open-ended story.

## Example 25

*Context:* Routine medical visit. Patient C, Cara, a 72-year-old woman, presents to her primary care provider with continued pain in her neck and shoulder.

[C2-37-39]

- 1 Cara: about the past three weeks  
 2 i just don't think the trazodone is holding anymore  
 3 and i don't think i need to go up on it

[C2-47-50]

- 1 Cara: and sometimes trying to get comfortable going to bed  
 2 once i can go to sleep  
 3 and i really don't think it's the pain  
 4 as much as that i'm not getting enough 1//sleep\2

[C2-307-308]

- 1 Cara: so i would be very open to y'know stay on the trazodone  
 2 but take something //like that\ flexeril

This example in particular demonstrates the type of open-endedness the doctor might experience in offering the patient “space” in which to speak without offering elicitation to lead to a more completed narrative. By offering the patient “space” without the guidance of more frequent elicitation, the patient may or may not be able to present a concise, more complete narrative. Further, dealing with chronic illness, the patient's narratives may remain open-ended as they move through the disease process and the future of the illness and the extent to which they can successfully manage the condition is unknown.

### **Additional participants as resources**

The NM approach brings to the analysis the inclusion of medical colleagues and their impact on the immediate medical interaction. Although the Ochs and Capps (2001) approach may allow for other participants to be considered in the construction of a narrative, this approach deliberately includes individuals beyond the interaction. Considering other medical colleagues encourages analysis beyond the immediate interaction and to other factors, which may impact what takes place between doctor and patient. Interaction C1 illustrates this additional layer of participation. Example 14

shows that the doctor references associates in the medical profession when referring to *there's staff there* (line 1). This explicit reference to staff plays a fairly important role in this section of the interaction in that the staff is being held responsible for why the doctor does not have the patient's chart made available to him. As Ehrlich (2007) states, "participants who are not directly and actively involved in an interaction can nonetheless influence the meanings and understandings that are assigned to that interaction" (p. 196).

#### Example 26

*Context:* Routine medical visit. Patient B, Bess, a 73-year-old woman, presents to her primary care provider with high blood pressure.

[C1-64-70]

- 1 D: /i mean\\ there's staff there and i i go out and i
- 2 Bess: you always go out there and look
- 3 D: and i say i say i know i keep an up to date record
- 4 why is it that i can't get a
- 5 actually most of the time i do get it
- 6 but when i don't get it it's still very disconcerting
- 7 Bess: because it's been a long time [laughs] since i've had anything done

The importance of these additional staff members in this part of the interaction is that since they had not provided patient information, the patient is asked to supply information about her medical history (line 7). This aspect is important to the analysis of this particular narrative because as noted earlier, the patient seems to capitalize on the fact that the doctor does not have her record readily available. Even though these additional staff are not contributing to the interaction through words, their role and responsibility for patient charting contributes to the development of the patient's narrative. Further, the omission of the patient records force both participants to construct narrative coherence from information available only from what they can and cannot recall, a missing artifact of a medical record making the narrative less coherent.



#### 4.2.3.2 NM and doctor elicitation and feedback

The NM approach may also be used to focus more explicitly on doctors' elicitations since the frequency of the elicitations in a medical encounter seems to be an indicator of the basic aspect of the approach. As noted earlier, in the acute case interaction A1 (See Appendix B: Transcription A1), the doctor begins the interaction with the open-ended question, *okay, what brings ya in today* [A1-6]. Within the medical setting, this question obviously assumes that there is a health-related reason which has brought the patient to the clinic. This type of question seems to align with the NM framework in that it offers the patient the floor in order for her to present her narrative of why she is at the clinic on this day. The open-ended question used in this interaction seems to offer a service orientation. It also implies that there is a problem which the patient cannot remedy herself and thus has come to the doctor to be solved (Robinson, 2003). At the same time, interaction A1 has the highest question frequency rate, so the patient has been given less time to respond to the doctor's elicitations. The doctor seems to use questions as a way to keep his line of thinking "on track" (Holmes & Chiles, 2007). The patient, perhaps well socialized in the U.S. healthcare system, seems to have organized her narrative and presents it in a very concise manner: she fell three weeks earlier, she had thought about going to the emergency room but decided against it, and is now accommodating limited range of motion and pain associated with having fallen on her arm.

As noted above, the patient's narrative seems to be complete in the Labovian sense of "recapitulating past experience by matching a verbal sequence of clauses to the sequence of events which (it is inferred) actually occurred" (Labov, 1972, p. 359-60). Yet, the doctor responds to the patient's narrative with a question-tree-review-of-systems formulary that is designed to give him more details or perhaps a fuller narrative, necessary to make a decision for this patient. In this section of the interaction, the doctor elicits an expanded rendering of the account. After this expanded rendering of the narrative is complete, the doctor asks no more questions.

A possible interpretation is that the patient was given sufficient space in which to speak, and her narrative of her acute event is complete. From her perspective, there

might be no other relevant information to offer and no other unspoken narrative. There is no compelling discursive evidence to assist here.

This example challenges the offering of “space” aspect of the NM approach to the extent that the patient’s narrative is rendered fairly completely in spite of the high question frequency and the limited amount of “space” in which the patient was offered to speak relative to the length of the medical visit. This might mean that there are other approaches which might elicit a more complete patient narrative, given the particular condition of a patient. It may also mean that in acute cases, the NM may not be deemed the most essential approach to assist patients in telling their stories.

In the chronic case in interaction C2 (see Appendix D: Transcription C2), the doctor begins the interaction with an open-ended question, *what can i do for you today* [C2-5]? This question is also service-oriented and is similar to the initial question in A1, offering the patient the floor and the space in order for her to present her narrative. As discussed earlier in this chapter, this particular patient offers much information about her health status and who she is as she negotiates through the telling of various medical concerns. It has also been noted how the chronic nature of her conditions seems to make it difficult for her to concisely and coherently render her narrative. However, we have also considered that perhaps the patient’s narrative may be considered not only complete but also rendered in the manner which was most suitable for the patient. In this case, the burden is on the doctor to listen to the patient’s narrative and identify what is salient to the patient’s health condition.

What is manifested in this interaction through the framework of NM is the doctor offering the patient space through elicitations and feedback which seem to indicate that the doctor is available to listen to the patient and to be of service. In summary, the doctor is challenged to construct narrative coherence from the wealth of information the patient offers in a less-than-coherent manner. This summary seems to reveal the paradox potentially created by the NM approach, that is, that the more “space” in which to speak places the patient in the challenging position of creating a coherent narrative (Hyvärinen, et al., 2010). When this is not achieved, the doctor must attempt to make sense of a less coherent patient narrative in order to determine what is relevant to the patient’s health condition.

#### 4.2.3.3 The parallel medical narrative

NM introduces the concept of a parallel charting as a way for doctors to present their non-medical emotional response to patients' conditions (Charon, 2006). There is a "parallel medical narrative", which is the narrative doctors construct in order to interpret and distill patient information, medical and personal, to make working diagnoses and interventions. Through the parallel narrative the doctor empathetically engages in the patient's narrative via the lenses of their own memories and experiences through which they are "able to encounter the patient's story" (Wood, 2005, p. 285). These parallel medical narratives shape what doctors 1) say in interaction with patients, 2) write and do not write in medical records, and 3) share with other doctors. Although the doctor may attempt to recall and render a patient's story as presented by the patient, which may have been rendered in a particular sequence, the parallel narrative plot may be reinterpreted as the doctor creates a logical-temporal arrangement of events to link to causality (p. 292).

Additional caveats of such narrative re-construction include the personal and medical experiences the doctor has had as well as "filling in" of information. This "filling in" of information is similar to what is seen in music theory that the human brain fills in what is missing in the resolve of a section of music when the composer and/or musician has not offered it<sup>15</sup> (Garfinkel, 1964; Gumperz, 1976; Ochs & Capps, 2001; Sacks, 2007). The phenomenon of "filling in" missing information in conversations is one that participants rely on each other as a way of "sharing responsibility for information" (Ochs & Capps, 2001, p. 29) and is documented across cultures. I suggest that the patient narratives that doctors create include the information that doctors add to patients' narratives drawing upon their own life experiences and those of their former

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<sup>15</sup> This phenomenon, referred to as the "White Christmas Approach", has been studied since the 1960's. Using this popular song, listeners of portions of the song "completed" the song in their mind, claiming to be able to "hear" the song in their heads. This phenomenon was more recently studied by Kelley, et al. at Dartmouth using functional MRI to scan the auditory cortex of the brain. They found that participants in the study had much more activity in this area of the brain with known songs than with unknown songs (Sacks, 2007).

patients<sup>16</sup> as they empathize with the patient, for “stories influence one another” (Charon, 2006, p. 110).

Ultimately, through this narrative analysis and certainly through the approach of NM, we can begin to see how doctors might rely more heavily on “the person before them” (Groopman, 2007). The following quote from a medical doctor, is apropos:

“as we bustle from one well-documented chart to the next, no one is counting whether we are still paying attention to the human beings. No one is counting whether we admit that the best source of information, the best protection from medical error, the best opportunity to make a difference — that all of these things have been here all along.

The answers are with the patients, and we must remember the unquantifiable value of asking the right questions.” (Rifkin, 2009)

*Dr. Dena Rifkin is a physician at the University of California, San Diego.*

Although it is unlikely that there are “right questions” for any given medical encounter as the patient and doctor identities, knowledge, and experiences are unique, there seems to be a deliberate movement toward focusing on the patient and realizing that the patient has a story to tell when given the “space” and attention by the doctor to do so. Dr. Rita Charon, as she considers the approach of NM in her medical practice, begins each medical interaction with a question similar to “What do you think I need to know about you and your health condition in order for me to address your medical concern?” This open-ended question differs in structure and specificity from the other open-ended questions used by doctors in this corpus and seems to imply that the patient’s story and what they view as relevant to their health is important and the focus of the medical encounter. The NM approach seems to allow for narratives which are more or less coherent by offering patients “space” in which to speak with minimal feedback and interruption from the doctor.

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<sup>16</sup> This version of “parallel story” can be differentiated from what Ochs and Capps (2001) call “parallel story episode”, which is when a co-teller tells a similar story to the one presented by another narrator.

### 4.3 Conclusion

This chapter examined how elicitation and narrative are connected to narrative coherence as a starting point for analyzing how doctors' elicitations and patients' narratives inter-relate. Examining interactions from the corpus using both canonical and post-canonical narrative analytic approaches, I have also explored how narrative analysis can contribute to understanding how narratives in medical interaction may be elicited, and how they may be viewed as emergent, and as co-constructed. The analysis indicates the value of viewing elicitations and narratives as devices used for developing narrative coherence. The analysis has also indicated how each narrative framework furthers our understanding of who patients are in interaction with doctors in medical interactions and what participants are trying to accomplish. It has emerged that a common goal for both participants is making sense of the patient's medical condition. The analysis has demonstrated how participants construct narrative coherence as one means to achieve this common goal.

It is the culturally and institutionally agreed upon understanding that medical doctors are available as resources to treat patients' varied health conditions. When patients present with non-acute, difficult-to-manage chronic illnesses, such as those found in interactions C1 and C2, much of what occurs in the medical encounter is a negotiation between the patient and doctor to determine appropriate medical intervention. In these two interactions, the participants' sense-making of the patients' condition helps them move toward an agreed upon intervention. If this consensus does not take place, the patient may or may not adhere to the intervention. A consensus is not possible without sufficient understanding of the patient's condition. Therefore, it is important to consider how doctors and patients' construction of narrative coherence contributes to consensus-making and, possibly, to better treatment and health outcomes for the patient (Mansfield, McLean, & Lilgendahl, 2010). In understanding this phenomenon, we can begin to see how this negotiation to consensus may transpire to accomplish the participants' shared medical goal.

In addressing the research question, *How do doctors' prompts inter-relate with patients' accounts of their illnesses?*, this chapter has illustrated the complexity of a response to this question. Much of what is at play are the goals the participants attempt

to achieve. Although power asymmetry still characterises in the doctor and patient encounter, both participants attempt to make sense of the patient's narrative and work toward narrative coherence even if it is not fully achieved. These factors impact the elicitation doctors used to draw out patient narratives which shape patient accounts of their illnesses. This analysis of power asymmetry in connection with the construction of narrative coherence also makes a contribution to better understanding how power is realised in discourse.

Although patients' narratives are influenced by doctors' elicitation and the type of presenting concern (acute or chronic), they are also influenced by many factors beyond the scope of the medical setting, doctor's elicitation, and test results. These complexities impact and shape the development of patient narratives, which often lack typical, explicitly rendered narrative structure and coherence, despite efforts by both participants. Coherent or not, patient's narratives do tell their stories and illuminate dimensions of their identity that they may or may not want presented, offering insight into the extent to which illness is integrated into their lives. The actual rendering of their narratives is also a potential resource for patients in dealing with their condition as they seek to give meaning to their lives in relation to their illness. As Doloughan (2006, p. 134) says, "how [narratives] are framed and the contexts in which they are presented become as meaningful as the stories themselves". In sum, patients' narratives are embedded in the complexity of the medical encounter, and when their narratives are less coherent, this in itself may very well be a key element in the story of their current health status.

The next chapter focuses on how patients construct identities as they construct narrative coherence.

## **Chapter 5 Identity and constructing narrative coherence in medical encounters**

### **5.1 Introduction**

Chapter 4 established that constructing narrative coherence is one way to illustrate how doctors' elicitations and patients' narrative inter-relate. The chapter focused on how this is particularly the case when patients have chronic illnesses and may have difficulty developing coherent narratives (Hyvärinen, Hydén, Saarenheimo, & Tamboukou, 2010). As the main goal of Chapter 5, I extend this argument by focusing on the strategies participants use to construct identity as they develop narrative coherence. In doing so, this analysis further helps to address the research question: *what is the relationship between doctor prompts and the form of patients' accounts of their illnesses?* I accomplish this by first presenting a working understanding of the concept of identity and explaining how identity is situated in social context. Next, I further describe how the method of analysis, IS, is used for exploring identity construction, and how the selected interactions are analyzed. Then I illustrate how individuals identify as patients and how doctors' elicitations contribute to the manner in which patients construct their identities through narrative. Throughout the chapter, I demonstrate how the construction of identity is impacted as each participant attempts to develop narrative coherence.

The analysis demonstrates the dynamic relationship between the construction of narrative coherence and identity construction, showing that participants' attempts to make sense of the patients' conditions contribute to understanding themselves in the situated interaction. While Chapter 4 focused on both doctors and patients, this chapter focuses more closely on the construction of patient identity, connecting their identities to their interactionally co-constructed narratives.

In the next section, I introduce aspects of the concept of identity and describe how identity is situated in context.

#### **5.1.1 Concepts of identity in medical narrative**

As introduced in the Literature Review in Chapter 2, concepts from a relational approach to identity (Coupland, 2001; Holmes, 2006) are used to focus on how identity is constructed by participants, drawing from linguistic resources made available in specific interactional contexts (Ayometzi, 2007; Bamberg, DeFina, & Schiffrin, 2007; Bucholtz,

2003). In order to understand identity in interaction, it is important to establish the surrounding context. The analysis below explores how the language in medical interactions is situated in the particular context of an institutional health clinic, as “an individual’s contribution to an interaction at a particular point must also be interpreted in the light of the social and personal identity they are constructing through discourse” (Holmes, Stubbe, & Vine, 1999, p. 352). The analysis will also show how identity is fluid and dynamic and changes over time (Brockmeier & Harré, 2001; Bucholtz, 2009; McLean & Mansfield, 2010), “continually shaped and reshaped through interactions with others and involvement in social and cultural activities” (Wetherell & Maybin, 1996, p. 220).

### **5.1.2 Analytic tools for identity analysis**

Analyzing identity in the specific circumstance of the medical encounter requires a methodological approach which takes account of context. Using IS affords this consideration. Expanding on the Literature Review, this sociolinguistic approach provides a framework in which the speakers’ utterances are analyzed for social and linguistic meanings as they are produced and situated in each interaction in order to answer the question, “What is going on here?” (Cicourel, 2007; Goffman, 1959). In using this approach, the markers of social, cultural, and personal meaning of the speakers are analyzed as they relate to surrounding utterances, or local context, as well as to the more global institutional setting of the medical encounter. This analysis focuses primarily on how participants construct identities as they develop narrative coherence in the particular institutional setting of a medical clinic, since “social identity is locally situated: who we are is a product of where we are and who we are with” (Schiffrin, 1996, p. 198). The two assumptions made by Holmes, Stubbe, and Vine (1991) related to workplace interactions hold true in this analysis as well: firstly, the global context is critical to the understanding of the discourse as well as for defining social identity in a specific interaction; and secondly, “interaction and identity construction are dynamic and interactional processes” (p. 351). Further, one of the functions of workplace talk is “maintaining professional and social relationships” (Holmes, 2006, p. 167). Speakers’



utterances, then, are viewed as both contextualized and contextualizing for the construction and co-construction of meaning of the patients' narratives (Schiffrin, 1994).

Since discourse analysis offers a wide repertoire of tools with which to analyze text, the following describes the discourse analytic tools used in this analysis. In addition to the dimensions offered by Ochs and Capps (2001), a sociolinguistic approach to understanding identity in narrative, the following analytic tools are used in this analysis: authorial role, alignment, position, and stance. These concepts are used to illustrate aspects of the patients' identity as they develop narrative coherence. This approach was selected as a way to understand the connection between the doctors' initial elicitations and patients' response throughout the interactions as patients developed their narratives. The doctors in their authorial role initiated the interactions and the patients aligned with their doctors to varying degrees as they positioned themselves within the encounters.

The authorial role may be described in relation to Goffman's (1974) concept of *footing*. In this framework, footing refers to an approach which considers that the "participant's alignment, or stance, or posture, or projected self is somehow at issue" (p. 496), and the self is viewed as the original author of the narrative. There is also the animator or "other", who may perform or paraphrase the narrative and may be the possible contributor to of the structure of the narrative. Finally, there is the principal, who is the author of the meaning of the narrative (Goffman, 1970, 1974). It could be argued that although the patients may be viewed as the author (selects sentiments expressed) and principal (whose position is established by the words spoken) of their narratives, the analysis will also show that doctors, through elicitations and feedback, are co-authors of the structure of patients' narratives (1974).

*Alignment* is another important analytic tool which demonstrates the relationship between participants and focuses on identity as related to social roles. Alignment is a device participants use to synchronize with others whether they agree fully with them, or not (Goffman, 1970). Examining participant alignment in interaction is another way to understand the context of who is speaking and displaying identity (Schiffrin, 1996).

*Position* focuses on contextualization cues (Gumperz, 1989) and how participants continuously seek to position themselves through the form and context of their utterances. The participants position themselves as to how their content and utterances

relate to the social and cultural identities within the immediate context (Jaffe, 2009). Position indicates the shifting of alignment and/or identity from moment to moment in discourse (DuBois, 2007).

*Stance* reflects the personal orientation a participant shifts toward in discourse in relation to other participants (Goffman, 1974) as “they simultaneously respond to and construct linguistically” (Jaffe, 2009, p. 4). As a participant orients to a role and identity within an interaction, that participant assumes certain rights, agenda, and obligations as they relate to the matter at hand. The participant’s stance may change from moment to moment as the interaction unfolds (Coupland & Coupland, 2009). “Stance is a public act by a social actor, achieved dialogically through overt communicative means, of simultaneously evaluating objects, positioning subjects (self and others), and aligning with other subjects, with respect to any salient dimension of the sociocultural field” (Du Bois, 2007, p. 169). Speakers in defined roles may be associated with particular stances, which is the case in the medical encounter involving doctors and patients. Stance may be seen as the interactional positioning of self and other and is a device for constructing more long-lasting forms of identity (Bucholtz & Hall, 2005).

Following is an example used to illustrate these devices. The excerpt is taken from a familiar interaction from Chapter 4.

#### Example 1

*Context:* Excerpts from interaction C1. Routine medical visit. Patient B, Bess, a 73-year-old woman, presents to her primary care provider with high blood pressure.

[C1-2-4]

- 1 D:           ya see that blood pressure
- 2 Bess:       it’s always high //( )-\
- 3 D:           /i can’t that’s right\\ that’s right we

In this excerpt, the doctor offers the elicitation, *ya see that blood pressure* (line 1). The patient’s response, *it’s always high* (line 2), is a demonstration of the patient’s

footing as she attempts to position her stance in response to the doctor's elicitation. The defensive tone of the patient's response suggests that her moral stance, or defending her "self as virtuous" (Ochs & Capps, 2001, p. 105) in her role, or position, as "patient" is challenged as possibly one who is not adhering to medical intervention. She seems to begin to develop this stance as she moves toward re-establishing the role (Jaffe, 2009; Schiffrin, 1996) of a patient who is adherent. The doctor first interrupts the patient with the statement, *i can't* (line 3). This interruption from the doctor suggests that he was attempting to establish his position and stance as an individual in the role of "doctor" (Bucholtz & Hall, 2005; Jaffe, 2009; Schiffrin, 1996) who is trying to understand the patient's condition. The doctor then seems to align, or agree with, the patient by repeating the phrase, *that's right that's right we* (line 3) (Du Bois, 2007).

As in Chapter 4, excerpts from the core interactions are used in this chapter to further contextualize the utterances used throughout the analysis and to demonstrate how identity is consistently constructed through interactions. Examples from a number of additional interactions are used to illustrate important points of discussion and to show that the aspects discussed related to the development of identity in medical interactions are consistent among other participants managing both acute and chronic conditions.

## **5.2 Identifying as "patient" and having "space" in which to speak**

### **5.2.1 Identifying as patient**

With the analytic approach and associated concepts introduced, I turn to the analysis of patients' identity in selected medical interactions.

Before any medical encounter, an individual must first identify as a patient and consider what they will report as 'doctorable' (Zola, 1973). Zola (1973) detailed "the process by which an individual decides that a series of bodily discomforts he labels symptoms become worthy of professional attention" (p. 677), and further hypothesized that "there is an accommodation physical, personal, and social to the symptoms and it is when this accommodation breaks down that the person seeks, or is forced to seek, medical aid" (p. 679). It is when this breakdown in accommodation occurs that one identifies as a patient and realizes that there is a story to tell (Zola, 1973).

Making the decision to identify as a patient is important to the next step toward participation in a medical encounter. The evaluation component in Example 2 below recounts the decision-making process a patient went through before initiating an appointment for a medical visit.

### Example 2

*Context:* Excerpt from interaction A1. Patient A, Ann, a 72 year-old woman, presents to her primary care provider with shoulder pain following an accident.

[A1-6-17]

- 1 D:           okay what brings ya in today
- 2 Ann:       well i was walkin'
- 3           and i went to cross the street at the curb
- 4           and my foot musta got caught in the curb
- 5 D:           okay
- 6 Ann:       there was a metal strip there i went later to look
- 7           and i kind of flew out in the street
- 8           and i put my two arms out to protect my body
- 9 D:           uh huh
- 10 Ann:      and um hurt this arm really bad#
- 11           i knew when i got up it was just killing me
- 12           **i should've gone to the er**
- 13           and then by the time i got home
- 14           i thought well it's probably bruised bad //ya know\
- 15 D:        /mm hmm\\

In line 1, the doctor's initial elicitation asks the patient to explain why she is at the clinic. The patient then proceeds to tell the narrative account of having fallen and hurting her arm (lines 2-10). The patient reflects on a decision she seems to regret, which is one of not having gone to the emergency room after her fall, *i should've gone to the er* (line

12). In telling the doctor this regret, the patient is providing her rationale for why she is at the doctor's office. The patient may believe that presenting the regret of not taking a past action further justifies her concern as doctorable.

In contrast to this narrative evaluation is one found in another medical interaction in Example 3, where the patient remains hesitant, even while at the clinic, about her decision for visiting the doctor for her concern of symptoms related to tick bites even though she has taken the action of making an appointment with her doctor for this concern.

### Example 3

*Context:* Excerpt from interaction A2. Patient D, Debra, a 72 year-old woman, presents to her primary care provider with concern over symptoms possibly related to tick bites.

[A2-1-6]

- 1 D: how are you
- 2 Debra: **well this is i probably maybe didn't even have to come in**
- 3 but i pulled two ticks off myself in the last week and a //half\
- 4 and I wouldn't even have thought about it but yesterday
- 5 man i felt like a truck ran over me
- 6 D: /okay\\ oh really

In this excerpt, the patient says, *well this is i probably maybe didn't even have to come in* (line 2), seems to show her hesitancy with the words “*well*”, “*probably maybe*”, and the altered grammatical structure “*this is...i*”. The patient presents a health concern she apparently believes to be doctorable in that she made the decision to make the medical appointment, but is seemingly not confident about this decision or that the doctor will agree with her decision. It is also possible that the individual is normally reluctant to be a patient. In both examples, the patient finds it necessary to justify being in the role of patient to their doctors.

These examples demonstrate one means by which an individual may identify as a patient. Sometimes this identity remains ambivalent to the patient even as she presents to her doctor, and at other times, the patient seems to find it necessary to justify taking on this role to her doctor. An individual identifying as a patient implies that the individual will assume a role as they communicate with the doctor (Jaffe, 2009; Schiffrin, 1996). Certain expectations for each role control and constrain what each participant deems appropriate to say and do in this context. Important to the discussion of this chapter, identifying as patient may be viewed as an individual's initial step toward developing narrative coherence and for constructing their identity as patient.

### **5.2.2 Offering “the floor” and authorial role**

Another important aspect related to a patient's identity within a medical encounter is the concept of being offered the floor to speak and the patient's authorial role in rendering her narrative. Within the frameworks used in this analysis, narratives are viewed as being comprised of multiple utterances which require tellers-patients to be offered permission to maintain the floor for extended interactional discourse (Capps & Ochs, 1995). The NM concept of offering patients “space” in which to speak is consistent with this theory. This “space”, or time (Fauconnier, 1994; 1997), is offered to the patient in which to render her narrative (Kranjec & McDoough, 2011) and present her identity (Oakley & Hourgarrd, 2008). In previous chapters, this NM concept has been described and illustrated in relation to how the approach impacts patient narratives. In this chapter, “space” is used to illustrate one way patients are offered the floor to author their narratives and construct their identity within the interaction. Since the institutionally sanctioned role of doctor implies that the patient must be offered space (Barton, 2000), the following examples illustrate the extent to which offering the floor is accomplished by doctors. Further, part of the analysis focuses on how a patient might negotiate to take the floor, exhibiting control over how she constructs her narrative and identity.

Example 4 is from interaction A1, which is an expansion of the excerpt in Example 2, providing more context. In this example, the offering of the floor seems to be

indicated by the doctor's greeting<sup>17</sup> *how ya doin'* (line 1) and initial elicitation *okay what brings ya in today* (line 3). According to Heritage and Robinson's (2006) typology discussed in Chapter 3, the question is a Type 1, general inquiry. Implicit to this type of open-ended elicitation is the offering of the floor to the patient.

#### Example 4

*Context:* Patient A, Ann, a 72 year-old woman, presents to her primary care provider with shoulder pain following an accident.

[A1-4-26]

- 1 D:            **how ya doin'**
- 2 Ann:        fine
- 3 D:            **okay what brings ya in today**
- 4 Ann:        well i was **walkin'**
- 5               and i went to cross the street at the curb
- 6               and my foot **musta** got caught in the curb
- 7 D:            okay
- 8 Ann:        there was a metal strip there
- 9               i went later to look
- 10              and i kind of flew out in the street
- 11              and i put my two arms out to protect my body
- 12 D:            uh huh
- 13 Ann:        and um hurt this arm really bad#
- 14               i knew when i got up it was just killing me
- 15               i should've gone to the er
- 16               and then by the time i got home
- 17               i thought well it's probably bruised bad //ya know\

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<sup>17</sup> According to Duranti (2007), "there is to date no generalizable definition of greetings and therefore no systematic way for deciding what qualifies as 'greetings' in a particular speech community" (p. 126).

- 18 D: /mm hmm\\
- 19 D: **so you actually went down?**
- 20 Ann: oh yeah
- 21 D: and and which arm is it that's hurting
- 22 Ann: this one mainly
- 23 D: okay

In addition to the question type, another factor that may indicate the degree to which the doctor is encouraging the patient to speak is his alignment with the patient through the phonological and morphological variation. In the greeting and initial elicitation, the doctor uses the informal variant, *ya*, for “you” as well as the reduced form, *doin*, for “doing”. This may be the doctor’s attempt to reduce the asymmetry of power (Maynard, 1991; Peräkylä, 2002; Robinson, 2001; Sarangi & Slembrouck, 1998; ten Have, 2007) between doctor and patient by presenting himself as approachable. These linguistic variants appear to invite the patient to speak, and she responds accordingly by telling her account. Perhaps in an attempt to align with the doctor, the patient responds using the informal variant, *walkin*, for “walking” and, *musta*, for “must have”.

The combination of offering the patient the floor, “space” in which to speak, and using the alignment devices may illustrate how the doctor offers the patient the opportunity to develop narrative coherence. As seen through the extended excerpt, the patient is given the floor and allowed to render her account without interruption until she is at the end of her account and offers an evaluation, *i thought well it's probably bruised bad* (line 17).

After offering minimal feedback in lines 7, 12, and 18, the doctor asks a clarification question, *so you actually went down* (line 19) providing an opportunity for the patient to further develop a coherent narrative. Up to this point, there is evidence that the “space” offered to the patient is useful to her in the construction of her narrative and identity.

The patient uses another discourse device as she describes what took place during the event of her fall. The amplification of “fell” is represented by the phrase *flew out*, a metaphor. The phrase is selected by the patient to replace a literal, non-idiomatic form,



“fell”, to assist her development of the reportable event (Drew & Holt, 2007; Menz, 2011). The patient may use this metaphor to amplify the action in the event in order to maintain the doctor’s attention, which is one function of amplification (Ochs & Capps, 2001), or it may be used to present the event as more believable, albeit this may seem counter-intuitive. It is also possible that the metaphor functions to support her implicit claim that her injury is doctorable and views it as her right to describe it in her own terms (Heritage & Raymond, 2007).

The authorial role of the patient in telling her narrative appears to be challenged when the doctor introduces different terms to represent the patient’s figure of speech (Menz, 2011; Schiffrin, 2006). In the excerpt below, the doctor introduces the phrase *went down* (line 1) and the word *fall* (line 2), to describe the action that the patient had described as *flew out* in Example 4.

#### Example 5

Context: Later in the same interaction above.

[A1-69-77]

- 1 D:           really okay did ya are you aware which way you **went down** on it
- 2               did you //**fall**// down on it this way or
- 3 Ann:       /i// i no this way i went on this arm mainly
- 4 D:           so you
- 5 Ann:       i hit both arms
- 6 D:           so you went right down on that //shoulder\
- 7 Ann:       /i// think right here [motions to left shoulder]
- 8 D:           okay
- 9 Ann:       i **went down** on

Another possible interpretation is that the doctor rephrases the action as “fall” to show that he understands what the patient meant by “flew out”, but elicits from the patient more information regarding the nature of this fall as a way of further developing

narrative coherence. In line 9, the patient mirrors the doctor's language by using the phrase he introduced, *went down*.

This infusion of the doctor's terminology is evidence of the co-construction of the patient's narrative (Bamberg, 2004; Young, 2009) and shapes the patient's authorial role. The fact that the patient adopts the doctor's words to replace her own may be significant. The patient seems willing to forego her own terminology and collaboratively align with the doctor's terms to construct narrative coherence and her identity. This may also be evidence that the doctor is explicitly demonstrating comprehension by using non-metaphorical terms.

Up to this point of the interaction, the patient has been offered the floor and has taken the opportunity to present herself as one who is competent to construct a concise, coherent narrative (Hydén, 2010; Hyvärinen, et al, 2010; Ochs & Capps, 2001). Yet, as Example 6 shows, the doctor seeks more information asking the patient to expand her narrative. The doctor achieves this expanded narrative by offering numerous elicitations, as expected from a doctor using the question-tree formulary review of systems.

#### Example 6

*Context:* Later in the same interaction referenced above.

[A1-46-66]

- 1 D:           **has it uh been swollen at all any place**
- 2 Ann:        i can't tell that i'm so //heavy\ in that area that i can't //tell\ that
- 3 D:           1/okay\1
- 4 D:           2/it's hard to tell\2 um
- 5               **do you think it's any better now**
- 6               **than when you first did it**
- 7               **or is it about the same or is it worse**
- 8 Ann:        i think it's better it just is aggravating to me
- 9 D:           okay
- 10 Ann:       because i have pain every time i do

- 11 D: mm hmm
- 12 Ann: even to fold clothes
- 13 D: **regardless of which way you lift it it hurts**
- 14 Ann: yeah
- 15 D: okay **does it hurt down into the arm or into //the\ fingers**
- 16 Ann: [mumbles] /yeah it hurts to the elbow\\
- 17 to the elbow
- 18 D: to the elbow
- 19 Ann: //right\
- 20 D: /okay\\ have you ever injured that shoulder before
- 21 Ann: no

The doctor uses the elicitations in lines 1, 5, 6, 7, 13, 15 to invite elaboration from the patient, which contributes to his development of narrative coherence. The doctor may find it necessary to challenge the patient's authorial role in order to obtain the information that he deems necessary as the expert and within the time constraints imposed upon him.

In requesting more specific details about the patient, the doctor gives her additional opportunity to expand her narrative and present aspects of her identity in spite of the constraints of frequent elicitations. The elicitations in lines 5, 6, and 7 ask the patient to describe if the condition is better or worse now than it was before. These elicitations offer the patient the opportunity to indicate that although her shoulder is better than before, it is still aggravating (line 8) and prevents her from folding clothes (lines 10 and 12). This behavior of folding clothes contributes an aspect of her identity (Holmes, 2006; Tannen, 1994; West & Zimmerman, 1987) that had not been previously presented, and it could be argued, would not have been presented had the doctor not prompted the patient for more information. Although the approach of offering more elicitations controls and shapes the manner in which the patient presents her narrative, it also offers the patient additional opportunities in which to express more of her identity.

Later in interaction A1, the patient appears passive as she responds to the frequent elicitations from her doctor. Through the use of her doctor's elicitations, the patient may

perceive that her story and reason for her visit have been ratified by the doctor, and the doctor is responding to her concern in a manner that meets her expectations. The patient may not view these elicitations as disruptions (Coates, 1996), and thus, they may not be interpreted as challenging the patient's authorial role. Evidence of this possible interpretation is that the absence of the patient's attempt to gain permission to hold the floor and to defend herself and/or reason for being at the clinic. Much later in this same interaction, the doctor ratifies the patient's condition by acknowledging the lengthy period of time the patient has been accommodating her painful injury.

### Example 7

*Context:* Later in the same interaction referenced above.

[A1-198-200]

- 1 D:               three weeks is a long time and you'd expect it to be better by now
- 2                   why don't we have you see an orthopedic //doctor\
- 3 Ann:            /okay\\

Perhaps in her *okay* (line 3) response to this acknowledgement by the doctor, the patient positions herself as one who is seeking and expecting medical intervention to remedy the situation as she can no longer accommodate it on her own. The patient may concede to the approach the doctor uses to help remedy her situation.

This interaction illustrates how a doctor may offer the patient the floor. In doing so, the doctor elicits information necessary to construct narrative coherence and offers the patient "space" in which to develop coherence for herself. It also demonstrates that the elicitation approach may vary even within a given interaction. Although more elicitations may be viewed as challenging the patient's authorial role, they may also offer her opportunities to express aspects of her narrative and identity that would not have been drawn out otherwise.

### 5.2.3 Patient power and taking the floor

The previous section presented the approach of giving the patient “space” in which to speak by offering her the floor through elicitations. There were examples from the corpus which demonstrate the patient’s initiative to taking the floor either in the course of the interaction or at the initial phase.

An example of the patient taking the floor and transitioning the interaction toward a topic selected by the patient is found in interaction C8 below.

#### Example 8

Context: Routine medical visit. Patient J, Jill, presents to her primary care provider for a routine visit.

[C8-51-55]

- 1 Jill: oh yeah they’re god’s /creatures\\ we take and we feed them
- 2 D: //that’s right\\
- 3 Jill: in fact in our bird bath we put a ( ) ++
- 4 i wanted to tell ya too i’ve gone back to my daily walking
- 5 D: uh huh

In Example 8, the interaction had been focused on wild animals that were in and around the patient’s home. This “small talk” had been initiated by the doctor as he began the physical exam. In line 54, the patient redirects the interaction toward a positive behavior *daily walking* that she wants the doctor to know she has been doing. In taking the initiative in this way, she takes control of the construction of this part of her health narrative in the interaction.

As indicated in Chapter 3, there were two of the 69 interactions which demonstrate the patient’s initiative in taking the floor and initiating the interaction. The following examples offer an opportunity to consider how the patient’s presentation of self in narrative may not always hinge on the initial elicitations from doctors. In the

following interaction, C3 (Appendix E: Additional Transcriptions), the patient takes the floor and controls and directs the beginning of the interaction.

### Example 9

*Context:* Routine medical visit. Patient E, Ella, a 74-year-old woman presents to her primary care provider with desire to alter ordering of prescription supply.

[C3-1-6]

- 1 Ann:       **first off**
- 2 D:         first off
- 3 Ann:       i'd like to mention ( ) ordered a three months supply of prescriptions
- 4             get for the same price as for one month
- 5 D:         okay
- 6 Ann:       so why can't we order three months at a time

This move by the patient may be interpreted in a number of different ways. One interpretation is that her socio-economic status may prompt her to begin the interaction with an inquiry regarding a way to save money by asking the doctor about ordering three months' prescription at one time, which would require a single co-payment from the patient (Starfield, 2000). It may also simply demonstrate her recent awareness of such a payment option, which would be preferable to an individual of any socio-economic status. Regardless of the motivation, the patient displays a desire to be viewed as one who is willing to negotiate for control of the floor in order to introduce an important issue to her. This display may be representative of her extra situational identity (Georgakoupoulou, 2006) or the importance of this topic to her.

In this interaction, the patient not only assumes that the doctor's prescription for a refill of her medication will be given following the visit, but places her request for her prescription refill at the beginning of the encounter. This could indicate that she is nervous that her special request for a three-month supply is likely to be refused, or that it may be overlooked as an important topic if the encounter is led by the doctor. There are

some encounters in the corpus in which the doctor leads with questions in regard to the need for refills but again this is typically a doctor-led discussion. This patient clearly considered her request important enough to bring it to the forefront of the office visit.

A patient takes the lead in another interaction, C6 (Appendix E: Additional Transcriptions). She says, *there are some things i wanted to ask you*.

#### Example 10

*Context:* Routine medical visit. Patient, H, Helen, presents to her primary care provider for a routine visit.

[C6-1-5]

- 1 Helen:       there are some things i wanted to ask you
- 2 D:           yeah
- 3 Helen:       did you really confirm what you thought i had fi //fibro\
- 4 D:           /fibromyalgia\\ right um ++

In this example, the patient's initial move may be an indication of the level of her concern about the diagnosis of fibromyalgia, prompting her to begin the interaction with an inquiry of confirmation or that she is negotiating control of the interaction. Since a diagnosis may help the patient identify what ails her, starting with this inquiry is important to the construction of the next part of the interaction. If the diagnosis is confirmed, the discussion might be directed to education about the disease. If the diagnosis is not confirmed, the interaction may continue to include discussion about what might be cause for the patient's continued symptomology. In either case, the patient initiates the interaction as a discourse strategy to assist her in negotiating for control over the floor, and to create agency for herself in this encounter.

Perhaps in the examples, the patients, based on their previous experiences, understand the roles they have in the medical encounter and may anticipate a possible doctor's agenda; therefore, they realize that they must become active agents by gaining the floor from the beginning of the interaction to express their own agenda before the flow of the interaction becomes directed by doctor elicitation. The concept of the

predominance of the doctors' agenda is supported by my analysis of the 67 other interactions and the feedback from evaluating doctors, which is presented in Chapter 6.

### **5.3 Constructing identity through interactional narratives**

The analysis thus far has established that in normatively constructed medical interactions an individual must first identify as a patient and the doctor must offer the patient "space" in which to present her narrative and her identity. It has also shown that there may be institutionally sanctioned circumstances that require the doctor to develop the patient's authorial role, particularly when the doctor is attempting to construct narrative coherence by eliciting patient information. The analysis has begun to demonstrate how doctors' elicitations and patients' narratives are used to develop narrative coherence and assist in constructing patients' identity.

Example 6 from interaction A1 shows how the doctor and patient are explicit in trying to accomplish their goals. This is demonstrated through direct and frequent elicitations from the doctor and direct responses from the patient presented in a coherently constructed narrative. The patient's interactionally constructed narrative was the means through which she was able to present aspects of her identity, especially those aspects which directly related to her concern.

#### **5.3.1 Constructing identity in relation to doctor's elicitation**

Some interactions in the corpus demonstrate explicit connections between the doctor's elicitation and the construction of patient's identity. The following example taken from interaction C7 illustrates this point.

#### **Example 11**

*Context:* Routine medical visit. Patient, I, Iris, presents to her primary care provider for a routine visit.

[C7-1-7]

1 D:           how have you been feeling



- 2 Iris: i have not been feeling well at all  
3 D: tell me what that means  
4 Iris: that means i'm just very very tired i have to push myself  
5 i still have like no energy  
6 D: okay  
7 Iris: and i can hardly get through my housework

In this example, the doctor's initial elicitation, *how have you been feeling* (line 1) prompts the patient to indicate that she is not feeling well (line 2). When the doctor asks the patient to elaborate on the meaning of what *not been feeling well at all* means, the patient begins to describe not only how she is feeling such as *very very tired* (line 4), but also activity such as *getting through my housework* (line 7). By using this description, the patient identifies as someone who does housework herself revealing both social-economic status, and given her age group, her gender as women of her generation were typically the ones who did housework.

The following example from interaction C1 provides a contrast to this explicit approach to developing narrative coherence and identity. The analysis suggests that the patient's authorial role is challenged throughout the interaction as she interprets her doctor's elicitations, some of which seem to challenge her moral stance. The focus is on how the patient constructs her identity as she attempts to simultaneously respond to her doctor's elicitations and make sense of the factors surrounding her condition.

Since the next example is a relatively long excerpt from a lengthy interaction, one of the IS approaches of beginning the analysis with a single utterance is helpful as a way into the analysis (Schiffrin, 1994). Using a single utterance is a starting point toward a deeper understanding of the patient's identity as presented in narrative and the surrounding context. Using this approach to achieve a more in-depth analysis, an utterance that encapsulates how a patient may present her identity in the interaction is selected and then situated within the context by illustrating how this utterance relates to other utterances within the interaction. The analysis begins with an utterance from the patient in C1 and is used to show how this utterance inter-relates with the doctor's elicitation. Additional utterances within the same interaction are used to situate the

utterance in order to gain a deeper, contextualized, understanding of it. As the utterance becomes better understood within its local context, excerpts from the other interactions are used to help support concepts related to identity in the medical encounter. Utterances from other interactions in the corpus are also used to compare and contrast how the language devices used in the main interaction are used and are illustrative of how patients construct identity as they develop narrative coherence. This approach shows how aspects of identity are consistently presented throughout interactions.

Up to this point the analysis has shown how the participants have constructed their identity in relation to the context of the medical encounter and to each other. The following analysis focuses on the relationship of the doctor's initial elicitation to the patient's utterances and how this might present an aspect of the patient's identity. As previously indicated, the following utterance, *i don't want to think i have high blood pressure [laughs] either* (line 20), can be interpreted as providing valuable information about the way the patient constructs her identity as she develops narrative coherence in response to her doctor's elicitation.

#### Example 12

*Context:* Routine medical visit. Patient B, Bess, a 73-year-old woman presents to her primary care provider with high blood pressure.

[C1-2-28]

- 1 D:       **ya see that blood pressure**
- 2 Bess:    it's always high //( )-\
- 3 D:       /i can't that's right\\ that's right we
- 4           uh what is it we do uh
- 5 Bess:    that uh this is my this week's blood 1//pressure\1
- 6           there are a whole bunch of other months blood 2//pressure\2
- 7           and it it seems to be around in the one thirty to seventy
- 8 D:       1/yeah\\1
- 9 D:       2/yeah\\2

- 10 D: that's right i it's  
11 Bess: all the time  
12 D: we uh we actually uh  
13 Bess: you monitored me  
14 D: we monitored yeah  
15 Bess: with an electronic monitor when was it last summer spring  
16 D: yeah i remember now i'm sorry  
17 Bess: it's all right i'm sorry you don't believe me [laughs]  
18 D: well  
19 Bess: i know [laughs]  
20 **i don't want to think i have high blood pressure [laughs] either**  
21 but i really don't think i do  
22 but i do take medication  
23 D: ++ can't figure out why it would be on medicine  
24 why it would be elevated here and you  
25 let me check your let me review my notes  
26 Bess: because i suffer from uh anxiety about going to the //doctor\  
27 D: /to the doctor\  
28 Bess: i think

The following analysis of this example shows how the patient uses position and stance in response to the doctor's initial elicitation as she constructs aspects of her identity and indicates what she believes about herself and her illness. This approach not only connects the elicitation to the utterance (line 20), but further contextualizes it, illustrating how the doctor's development of narrative coherence contributes to how the patient constructs her identity.

In order to analyze this utterance (line 20), it is important to consider how it is situated in the interaction and relates to the doctor's initial elicitation. Assuming that this contribution to the interaction "both responds to what precedes it, and affects what follows" (Holmes, Stubbe, & Vine, 1999), examining the placement of this utterance within this frame assists in understanding the circumstance.

The patient's utterance is situated in an atypical question-response sequence and within a medical interaction. The doctor begins the elicitation with *ya*, a variant of "you". As previously discussed, this informal variant of "you" may represent an attempt to align with the patient. However, the patient's immediate response suggests that she interprets the elicitation as an accusation. The patient begins to respond to the doctor's initial question with the statement, *it's always high* (line 2). This appears to indicate that the patient agrees with the doctor that her blood pressure is indeed always high. However, as indicated in Chapter 4, subsequent utterances, and particularly, *because i suffer from uh anxiety about going to the doctor* (line 26), indicate that a very plausible interpretation is that the complete response could be *it's always high* (line 2) *because i suffer from uh anxiety about going to the doctor* (line 26). This hypothetical rendering (Ochs & Capps, 2001) combines the utterances and offers a different understanding of what the utterance *it's always high* might mean. It may be interpreted to mean that it is only when the patient anticipates going to and is situated in the doctor's office that she becomes anxious and her blood pressure is elevated<sup>18</sup>. This portrayal of her identity as one who adheres to medical intervention but has anxiety about going to the doctor, defends her moral stance. However, as indicated in the surrounding interaction (lines 13-15), it becomes apparent that the patient's blood pressure is elevated not only when she is in the clinic but also when she has been monitored at home, a point which weakens the patient's claim, and consequently, her self-construction.

The following utterance in the sequence comes from the doctor, *i can't that's right that's right we* (line 1). As discussed in the previous chapter, the first part of this utterance, *i can't*, appears to be a construction which is interrupted by the patient.

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<sup>18</sup> It could be argued that the patient's elevated blood pressure may be attributed to the phenomenon known as "white coat hypertension" (Pickering, et al. 1988). However, although this phenomenon is more commonly found in women, they tend to be younger women than those in this study. Additionally, the phenomenon is typically identified when the doctor checks the patient's blood pressure, which was not the case in this medical interaction where a nurse has performed this act.

## Example 13

*Context:* Same interaction referenced above.

[C1- 4-24]

- 1 D: /i can't that's right\\ that's right we  
 ...  
 2 D: ++ can't figure out why it would be on medicine  
 3 why it would be elevated here and you

The complete construction could thus plausibly be *i can't figure out why it would be that if she is on medicine it (patient's blood pressure) would be elevated here* (lines 1-3). Viewed this way, the hypothetical complete utterance indicates that the doctor cannot understand why the patient's blood pressure is elevated if she is adhering to her medication regimen. This utterance illustrates how the doctor attempts to develop narrative coherence as he struggles with figuring out why the patient might have high blood pressure if she is adhering to her medical intervention. His attempt to do so frames the patient's construction of her identity as she tries to make sense of her condition. Interrupting the doctor as an active agent is one way the patient is able to respond to the doctor's initial elicitation more completely (Corston, 1993; Duranti, 1986; Goodwin, 1986; Rymes, 1995). In doing so, the patient presents herself as one who is willing to defend herself as one who is adhering to medical intervention.

Restructuring the doctor's elicitations and patient's utterances may further illustrate how both patient and doctor work to hold their position and stance throughout an expansion of the sequence. This demonstrates how doctors and patients continuously attempt to develop narrative coherence, which directly impacts the consistent manner in which the patient presents herself as one who is adhering to medical treatment.

### 5.3.2 Patient as expert of illness experience

There were examples in the corpus which demonstrate when patients are portrayed as experts of their illness experience. The following interaction is a rare

example from the corpus of a doctor delineating who is expert of different aspects of the patient's illness experience.

#### Example 14

*Context:* Routine medical visit. Patient C, Cara, a 72-year-old woman presents to her primary care provider with fatigue and continued pain.

[C2-201-204]

- 1 D:           now we got several different choices  
2           and what i know as medicine is a little bit better  
3           you have more experience with some of the //energy fields\ and tapping  
4 Cara:       //right, right\

In this example, the doctor is very explicit in identifying what areas of the patient's treatment she is more expert *what i know as medicine is a little bit better* (line 2) while establishing the patient as expert of what might be considered alternative medical treatment *some of the //energy fields\ and tapping* (line 3). In line 4, the patient agrees with this delineation.

In Example 15, the interaction focuses on the patient offering specific details about her blood pressure readings over a longer period of time thus portraying herself as expert of her experience with a chronic health condition (Association of British Pharmaceutical Industry, 2011). This is possibly an attempt to support her argument that she does not always have high blood pressure. In defending her moral stance, the patient continues to portray herself as one who adheres to medical intervention. The doctor unsuccessfully recalls what had taken place previously to monitor her condition, and the patient reminds him that they had monitored her at home.

#### Example 15

*Context:* Later in same interaction referenced above.

[C1-5-16]

- 1 D: uh what is it we do uh
- 2 Bess: that uh this is my this week's blood 1//pressure\1
- 3 there are a whole bunch of other months blood 2//pressure\2
- 4 and it it seems to be around in the one thirty to seventy
- 5 D: 1/yeah\\1
- 6 D: 2/yeah\\2
- 7 D: that's right i it's
- 8 Bess: all the time
- 9 D: **we** uh we actually uh
- 10 Bess: **you** monitored me
- 11 D: **we** monitored yeah
- 12 Bess: with an electronic monitor when was it last summer spring

During this part of the exchange, the doctor uses the pronoun “*we*” (lines 9 and 11) which aligns him with the patient and suggests a shared effort of managing the patient’s chronic condition. This may be an acknowledgement by the doctor of the patient as expert on her condition, or an attempt to make the interaction more patient-centered. However, the patient does not align with the doctor and instead uses the pronoun “*you*” (line 10), possibly demonstrating her expectation of the doctor’s responsibility in this matter versus her own (Heritage & Clayman, 2010).

The patient’s utterance, *it’s all right, i’m sorry you don’t believe me [laughs]* (line 2 below), is particularly interesting in that it could be interpreted as an attempt to align with the doctor or alternatively to distance herself from him.

#### Example 16

Context: Later in same interaction referenced above.

[C1-17-22]

- 1 D: yeah i remember now i’m sorry
- 2 Bess: it’s all right **i’m sorry you don’t believe me** [laughs]

- 3 D: well
- 4 Bess: i know [laughs]
- 5 **i don't want to think i have high blood pressure [laughs] either**
- 6 but i really don't think i do but i do take medication

In line 1, the doctor apologizes for not remembering what they had done previously. This response could be interpreted as a politeness strategy, explicitly acknowledging personal responsibility (Brown & Levinson, 1987). The patient acknowledges the doctor's apology with the response, *it's all right* (line 2). The patient's next statement, *i'm sorry you don't believe me [laughs]* (line 2), taking account of the tone with which it is spoken and the patient's laughter following the statement, functions as and continues to develop the patient's defense of her moral stance. The patient, aware of her role within this institutional setting, may be attempting to hedge with the statement, *you don't believe me* (line 2). The patient speaks for<sup>19</sup> the doctor in this utterance in that the doctor has not explicitly said that he does not believe her. In doing so, the patient attempts to show "sequential coherence" (Schiffrin, 1994) as she constructs narrative coherence. At the same time, the doctor also does not explicitly deny this claim in his response, *well* (line 3). This "speaking for" the doctor portrays the patient as one who is attempting to maintain the floor and to claim power. The patient follows this unclear response from the doctor by attempting to align with him, *i know [laughs]* (line 4). By responding in this manner, the patient seems to direct the meaning of the doctor's *well* response. The patient may have interpreted the doctor's response as one where he did not believe her. Regardless, if this is how the patient interprets the doctor's response, she utters the alignment phrase *i know* and follows it with the statement, *i don't want to believe i have high blood pressure [laughs] either* (line 5). Redirecting the interaction in this way can be interpreted as a demonstration of the patient's attempt to take control and give her a sense of power.

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<sup>19</sup> Schiffrin (1994) considers speaking for another as "an act in which one person *takes the role of another* and taking the role of another is itself a way of *showing sequential coherence*" (p. 128), "drawing upon the other as a resource for a next utterance" (p. 130). Further she contends, "speaking for another can be seen as the linguistic submersion of the self in the interactive process itself" (p. 131).



### 5.3.3 Laughter as device for alignment and constructing patient identity

The utterance from C1 *i know [laughs] i don't want to think i have high blood pressure [laughs] either*, may be further contextualized and understood by exploring how laughter, a device commonly used for alignment purposes (Capps & Ochs, 1995) and to “reduce the face threat of speech acts such as directives and criticism (Homes, 2007) is used by the patient. Laughter is an interactional device more commonly used by patients than doctors and typically used when the doctor’s advice is perceived as delicate (Haakana, 2001), as is the case in this interaction. The patient’s laughter is noted numerous times throughout this interaction, without any reciprocity by the doctor.

In the patient’s statement, she defends her moral stance, which she attempted to construct earlier in the interaction, but states more explicitly here. This utterance is also used as a face-saving device whereby the patient emphatically claims to not have high blood pressure, the condition which is of concern to the doctor. The patient positions herself as someone who is attempting to align with the doctor and may also be acknowledging that the doctor is indeed concerned, beyond what may be expected of the role of “doctor”. Immediately following this utterance, the patient reinforces her statement by saying, *but i really don't think i do* (line 6), yet seems to admit to the condition by stating, *but i do take medication* (line 7). This possible admission of adherence to the medical intervention of medicine for high blood pressure seems to substantiate the patient’s admission to having this condition more than supporting her argument that she does not. The difficulty the patient has in expressing herself in this part of the interaction leads to a less coherently structured narrative. What is unclear is the extent to which this less coherently structured narrative helps her self-construction as one who is mitigating responsibilities for her health condition. It also is an indication of the resistance to the anticipated implications of having high blood pressure, which given the context, may be an indicator of the diagnosis of diabetes. This struggle may very well represent her lack of control over her health condition, which she may perceive as rendering her powerless.

Communication between doctor and patient seems to be impacted by the patients’ ability to negotiate the tension of resisting, and then potentially accepting, the realities of certain diagnoses related to chronic diseases (Hyvärinen, et al, 2010; Ochs & Capps,

2001). A patient confronted with the reality of facing a diagnosis is forced to re-construct her identity based on this diagnosis. Although a condition such as hypertension may be related to patient behaviors, it appears more difficult for a patient to accept becoming a diabetic, a new aspect to her identity. In interaction C1, it becomes apparent how the patient, in her resistance against the diagnosis of diabetes, maneuvers her interaction with the doctor using certain devices such as laughter to manage this delicate topic. In this analysis, there is some evidence that the doctor's discourse choices are related to question design (Heritage & Robinson, 2006) and are grounded in his desire for narrative coherence (Hyvärinen, et al., 2010), and these choices seem to impact the patient's development of her own identity in response to the doctor's elicitations.

The following example is an exchange found later within this interaction, which demonstrates how this same patient consistently constructs herself as one who is adhering to her medical intervention.

#### Example 17

*Context:* Later in the same interaction referenced above.

[C1-88-95]

- 1 D: and when i last saw you in november
- 2 uh we talked a little bit about diabetes
- 3 Bess: **i'm always hurting with that**
- 4 **and i have lost weight** your scales don't [laughs]
- 5 i weighed myself this morning
- 6 i weighed a lot less than than your scales say
- 7 but i know i've lost weight
- 8 uh i've been very trying to be very careful with my diet
- 9 i do have one of those //accu-
- 10 D: check\

In this excerpt the patient seems to defend her moral stance in response to the doctor recalling an earlier discussion about her weight, which connects both the patient's current blood pressure levels and weight to the disease of diabetes. This exchange illustrates how the patient develops her identity as one who is struggling with the diagnosis of diabetes. Although this may truly be a difficult adjustment for the patient, she seems to present her struggle as a way to gain empathy from the doctor as a strategy to portray herself as one who is trying to adhere to medical intervention. It also indicates her desire to make sense of the long-term story (Bamberg, 2010) of her overall health condition. The patient's statement, *i'm always hurting with that* (line 3), appears to be a defense against the doctor's elicitation. The response begins with the level of anguish she has over the possibility that she may have diabetes. The patient then continues to defend her attempt to lose weight and argues that the scale at the doctor's office does not match her scale at home, and that she has, indeed, lost weight. The patient also tries to gain empathy by showing compliance: *i've been trying to be very careful with my diet* and *i do have one of those accu(check)* (lines 8-10). The patient may also be indirectly saying that she is prepared to take care of herself if she does indeed have diabetes. This may be viewed as her way of drawing together unconnected patches or aspects of her illness in order to make more coherent sense of it (Bamberg, 2010). It is as though she is poised for illness and is attempting to relate to the identity of being a diabetic versus someone who is merely managing a symptom such as hypertension.

Both examples show how the same patient uses different devices throughout the interaction to construct her identity. What remains constant is her self-construction as one who is doing her best to take care of herself which is evidenced in the previous examples (cf. Brockmeier & Harré, 2001; Bucholtz, 2009; McLean & Mansfield, 2010).

The identity this patient attempts to construct in defending her moral stance contrasts with that of another patient illustrated in the Example 18 from interaction C9.

#### Example 18

*Context:* Routine medical visit. Patient, K, Kate, a 66-year-old woman, present to her primary care provider for a follow-up visit.

[C9-9-11]

- 1 D: have you gained weight+ //a few pounds\  
 2 Kate: /oh yeah\\ then again, **i got boots on too**  
 3 **but i have to admit they're light boots + so**

In this example, the doctor first elicits whether the patient has gained weight but then indicates that she has gained *a few pounds* (line 1). The patient attempts to argue against this slight weight gain with the statement, *then again, i got boots on too*, while admitting that she has indeed gained weight, *oh yeah* (line 2). In the end, the patient concedes that her objection is not a strong one *but i have to admit they're light boots so* (lines 2 and 3). The patient's struggle with the doctor's elicitation illustrates the extent to which she is identifying as one who is challenged by managing her weight. The patient uses this part of her narrative to construct meaning and the aspect of her identity related to her weight gain.

In both examples, the construction of narrative coherence is a vehicle through which at least one aspect of the patients' identity is presented - that they are individuals who claim they are adhering to the intervention of maintaining their weight. This aspect of a patient's identity is important to consider in a medical interaction as weight gain may be associated with numerous health issues and, as seen in interaction C1, may be one step toward having to accept the identity associated with a given diagnosis, such as diabetes.

### 5.3.4 Speaking for the patient as resource for constructing patient identity

Part of the analysis of C1 thus far has focused on how the patient constructs her narrative and identity through the development of narrative coherence, which is co-constructed through her doctor's elicitations. As referenced earlier, the use of elicitations in this interaction is not extensive as this interaction had the average number of doctor elicitations. What seems important here is the type of elicitations offered by the doctor. In contrast to Example 16, where the patient spoke for the doctor, Example 19 is an instance of when the doctor speaks for patient as a type of elicitation.

## Example 19

*Context:* Excerpt from interaction C1. Routine medical visit. Patient B, Bess, a 73-year-old woman presents to her primary care provider with high blood pressure.

[C1-110-116]

- 1 Bess: if the hemoglobin the glycohemoglobin shows that i need to do it
- 2 i will and and i have been trying to be careful about diet
- 3 D: /okay\\
- 4 D: **i'm sorry bess if the glycohemoglobin is a little bit elevated you're**
- 5 **saying that then you'll check your-**
- 6 Bess: i'll i'll go and get the strips

The doctor's speaking for the patient seems to elicit clarification from the patient as the doctor continues to develop narrative coherence. In this example, the doctor tries to synthesize and/or clarify the conditions and terms that would prompt the patient to use the diagnostic tool to check her blood sugar levels. In this case, "speaking for another" could be viewed as an attempt to align with the patient (Schiffrin, 1994). In aligning with the patient, he is assisting in constructing face-saving aspects of her identity. He is trying to explicitly say what, up to this point in the interaction, the patient has been unable to say for herself – that she will test her glucose levels in spite of the fact that the outcome may indeed mean that she will have to identify with the diagnosis of diabetes. This assistance from the doctor seems to lead the patient to say *i'll i'll go and get the strips* (line 6); however, she appears to do so reluctantly as indicated by the repetition of the phrase *i'll*. This exchange, through the doctor's speaking for the patient, seems to be another attempt by the doctor to include the patient in his own construction of narrative coherence and in the decision-making process related her chronic health condition.

Example 20 explores another reason for when someone may speak for the patient, be it doctor or other. There were a few such circumstances in the 69 medical interactions where a patient's family member spoke for the patient during the exchange with the doctor. In two of the interactions, the daughter spoke for the mother. In certain medical

situations, it may be perceived as necessary for a third party to speak for the patient. This is particularly the case as patients age and have multiple chronic conditions with numerous medications to keep track of during the medical visit. It is also a period of time when, as illustrated in the following example, patients are particularly vulnerable due to the possible loss of their lifelong partner. The perceived need to speak for the patient, even for seemingly legitimate reasons, adds another dimension to how the patient's identity is constructed in the medical encounter.

Example 20 shows the patient's daughter speaking for the patient by saying, *she's blaming herself about dad too* (line 1) as an evaluation of her mother's emotional state after the death of the patient's partner.

#### Example 20

*Context:* Routine medical visit. Patient L, Louise, a 73-year-old patient, presents to her primary care provider for a routine visit.

[C10-54-55]

1 **daughter: she's blaming herself about dad too**

2 D: //oh\

The incident spoken of by the patient's daughter appears significant to the patient's identity, which appears to have been shaken by the death of her partner. Whereas in the previous interaction example from C1 where the patient appears to be in a position to defend her moral stance, the patient's daughter in Example 20 deems it necessary to account for her mother's emotional condition. In both examples, aspects of the two patients' identities are presented which maintain their moral stance before their respective doctors. In both interactions, there seems to be the perceived need to defend the actions of the patient to the doctor either by the patient herself or by a third party. This defense of moral stance constructs the patient as one who is justified for her actions and behaviors.

In interaction C5, the daughter helps the mother keep track of what needs to be mentioned to the doctor. The doctor elicits how the patient is doing and if there have been any problems with medications since the patient's last visit. The patient responds with the emphatic statement, *no problems period* (line 2). The daughter does not seem to agree with her mother's evaluation and interjects *you want to mention your eyes* (line 4).

#### Example 21

*Context:* Routine medical visit. Patient, G, Gail, presents to her primary care provider for a routine medical visit.

[C5-13-17]

- 1 D: no problem with medication as you can tell
- 2 Gail: **no problems period**
- 3 D: no problems period man this is perfect
- 4 daughter: **you want to mention your eyes**
- 5 D: what about your eyes

For the rest of the interaction related to the patient's eyes, the doctor and daughter interact with each other without any input from the patient. During this part of the interaction, the patient only looks at the doctor and does not speak until the topic shifts and the patient becomes interactive again. Throughout the rest of interaction, the patient seems to offer her opinion when she deems necessary, so it appears that she agrees with the information that her daughter is offering about the condition of her eyes as silence may be interpreted as consent (Cunningham & McElhinny, 1995; Eades, 2008; Roberts, Sarangi, Southgate, & Wakeford, 2000).

To further explore the patient's silence in this interaction, it is not known if the patient typically omits information about her health when speaking to her doctor. The omission of information about her eyes may be indicative of a common phenomenon for this patient and may be the reason the patient's daughter accompanies her on this visit. From the evidence provided by from the video recording of the interaction, the patient

physically moves around on her own quite well and seems to be able to speak for herself in a coherent manner. What is also clear from viewing the video is that the patient says very little and the daughter fills in information in response to elicitations about the patient's husband, who is in poor health.<sup>20</sup> This immobilized response may be yet another reason why the patient has a companion accompany her to this visit and why the daughter warrants speaking for the patient even in instances when the patient's direct medical condition is not being addressed. In sum, the patient's daughter may consider it necessary to speak for the patient when the patient has omitted medical history information and when the patient is asked to speak about a difficult topic such as the condition of her husband. Speaking for the patient seems to present aspects of the patient's identity that may be too painful for the patient to speak for herself (Schiffrin, 2006), or perhaps, because a companion is available, the patient defers to this third party to provide this difficult information. This contribution from the patient's daughter adds to the complexity of patient and doctor developing narrative coherence of the patient's condition as now an additional speaker is participating in the co-construction of the patient's narrative and identity.

### **5.3.5 Using others' circumstance to construct identity**

In the last section of the analysis, the focus was on speaking for the patient as a way of considering the patient's authorial role in the construction of narrative coherence and patient identity. In some cases, this activity of speaking for the patient was perceived as necessary in order to present an aspect of the patient's identity, which they had been unable or unwilling to present themselves. The following examples illustrate the introduction of challenging family circumstances, which the patients contribute perhaps to portray themselves as people trying their best to manage chronic health conditions.

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<sup>20</sup> According to Bakhtin, "ideas and words from an individual who is not present may influence a teller" (Ochs & Capps, 2001, p. 24). It is possible to extrapolate from this claim that the idea and memories of another individual not currently present in an interaction may also influence the teller. In this example, it may be what silences the mother/patient.



In Example 22, the patient introduces a family circumstance, which seems to appear from “nowhere” and is not connected to prior and following utterances: *kind of a hectic family affair right now* (line 3).

#### Example 22

*Context:* Excerpts from interaction C1. Routine medical visit. Patient B, Bess, a 73-year-old woman presents to her primary care provider with high blood pressure.

[C1-106-112]

- 1 Bess: it belonged to my daughter
- 2 and i have to get new strips for it
- 3 and **we’ve had kind of a hectic family affair right now**
- 4 so i haven’t really //got\ gotten around to doing it
- 5 but if you if the hemoglobin the glycohemoglobin
- 6 shows that i need to do it i will
- 7 and and i have been trying to be careful about diet
- 8 D: /okay\\

This utterance seems to be an attempt by the patient to justify why she may not have been complying with the medical intervention. Previously in the interaction, the patient defended herself and her actions. In line 1, the patient indicates that she has access to her daughter’s glucose testing device, referred to as “it”. Then she transitions with the introduction of a family circumstance in line 3. With this statement, she contributes personal information, perhaps in an attempt to make her stance more believable by the doctor.

This utterance is alluding to another, perhaps implied, part of her narrative that is not further exploited by the doctor. A possible embedded narrative (Ochs & Capps, 2001) is one that might present more of her identity than she is either willing or is invited to offer. This embedded narrative could also be another possible argument for the defense and position the patient is constructing in response to the doctor’s initial

question: she's been through challenging family situation recently and does not want to be challenged by the doctor about how she perceives her condition or about the degree to which she is adhering to medical intervention. Portraying herself as a family member who is going through a "hectic family affair right now" may be all that she is willing to present about this aspect of her identity even if the circumstance would help justify why her blood pressure may be high even while adhering to medical intervention.

The extent to which the doctor acknowledges the patient's introduction of this family circumstance into the interaction is unclear. The doctor's *okay* (line 8) feedback sounds affirming based on tone and falling intonation. However, it is not clear if he is responding to other statements, acknowledging the circumstance, or simply using this pivotal, transitional utterance to acknowledge that the patient has spoken. The patient makes no further attempt to pursue this point. What seems perplexing is why the doctor does not use this patient interjection as a resource for pursuing narrative coherence. What the patient may have been attempting to present about her identity remains unclear. The storyline is truncated by the doctor, and a potentially important aspect of the patient's identity is not presented any further.

In contrast to the former interaction, C4 presents a patient who is very willing to introduce personal family situations as reasons for not taking medication for her back pain. In this situation, the patient introduces two family situations, which have had an impact on her decision. In the following patient statement, *i've had so much pain and i can't take any medication because of paul my husband* (lines 2-3), the patient introduces one of the reasons – a situation with her husband. In spite of this reason, the patient is presenting back pain as a concern. Her agenda for doing so and her expectation for what the doctor can do about this concern are unclear. The patient continues to explain that the pain medication makes her sleep and thus unable to take care of her husband who cannot take care of himself.

### Example 23

*Context:* Routine medical visit. Patient, F, Flo, presents to her primary care provider for a routine visit. She discusses why she is not taking pain medication for her back pain.

[C4-1-28]

- 1 D: have your neurosurgery consult  
 ...  
 2 Flo: **i've had so much pain and i can't take any medication**  
 3 **because of paul my husband**  
 4 D: why  
 5 Flo: you don't know oh god  
 6 D: well i know that he's very sick and in and out of the hospital  
 7 and i know you've moved out of town  
 8 Flo: now it looks like he's going into alzheimer's  
 9 D: why can't you take medicine  
 10 Flo: i can't take pain medicine because it puts me to sleep +  
 11 and i have to be alert

In line 1, the doctor's elicitation, *have your neurosurgery consult*, seems to prompt not only the patient's narrative but also construction of one aspect of her identity. In this context, the doctor is likely to have made a recommendation to the patient and a referral to the neurosurgeon in order to comply with insurance protocol. However, in lines 2 and 3, the patient's response suggests a causal link between her husband's condition and her not taking medication. Since the doctor does not repeat this elicitation after the patient's reply, it seems he recognizes the patient's avoidance response as a potential answer to his elicitation. It is possible to interpret her response as indicating that she did not go to the neurosurgeon nor has she been taking pain medication due to her husband's condition. This patient's response thus begins to construct her identity as one who is a victim of her circumstance; i.e. she is unable to properly take care of herself because she must take care of her husband.

Later in this interaction, as seen in Example 24, the patient brings in a second family situation: her daughter's addiction to drugs. This topic seems to be prompted by the doctor's elicitation *ya know it's too much on you all the time to never have a break* (line 1).

## Example 24

*Context:* Routine medical visit. Later in the same interaction referenced above. Patient talks about daughter with drug addiction.

[C4-33-49]

- 1 D: ya know **it's too much on you all the time to never have a break**
- 2 Flo: i know and you know **i still got my daughter**
- 3 D: you still have that daughter that **wonderful daughter**
- 4 that you always talk about
- 5 Flo: i kicked her out
- 6 D: you kicked her out she was doing drugs again
- 7 Flo: oh yeah ++ three weeks ago ( )
- 8 and the ambulance came and took her
- 9 i said please god take her
- 10 D: that's the overdose you told me about
- 11 Flo: yep
- 12 D: yeah you told me about that i think
- 13 Flo: yeah
- 14 D: she took handfuls of a bunch of different stuff
- 15 Flo: no this this was a shot
- 16 D: oh
- 17 Flo: she's a shooter +++this was only three weeks ago ( )

The second family situation is introduced into the interaction with the patient's statement, *you know i still got my daughter* (line 2), spoken in a tone which seems to imply that the patient's daughter is another responsibility and concern for her, and further, another reason why does not take medicine for her back pain. During this introduction to the family situation, the patient disengages her gaze from the doctor and looks off into the distance, possibly as a way of marking the situation as significant or stressful.

Immediately following this utterance, the doctor makes the statement, *you still have that daughter that **wonderful** daughter* (line 3). The tone of the word *wonderful* appears sarcastic, possibly used as an interactional resource (Local & Walker, 2008) alluding to shared knowledge of the daughter as a continued concern as indicated in the statement, *that you always talk about* (line 4). The patient confirms in line 7, *oh yeah*, the doctor's statement about the daughter's drug use: *she was doing drugs **again*** (line 6). The use of the word *again* provides further evidence that the doctor has prior knowledge of the daughter's drug use, and yet, he still seems confused over the details of the overdose. First, the doctor sounds hesitant: *yeah you told me about that **i think*** (line 12). The doctor then goes on to describe the drug overdose attempt he recalls: *she took handfuls of a bunch of different stuff* (line 14). The patient rejects the doctor's incorrect recall and responds, *no*, and then corrects the doctor with the statement, *this was a shot* (line 15).

Although the patient does not directly connect her daughter's addiction with why she does not take medication, it is possible that she is indicating that she does not want to be identified as a drug user herself. Another possible interpretation is that the patient herself does not want to connect her own use of pain medicine with her daughter's drug use. She may be afraid of addiction herself, and is she reminded of her daughter's plight every time she thinks about using medication. Any of these interpretations might lead the patient to the same decision to not take pain medication in spite of the fact that she is presenting with the concern of back pain. In acknowledging the patient's statement, the doctor may be accepting the patient's home situation as a reason for why she is not adhering to medical intervention, or he may offering recognition of their shared understanding. The patient utilizes these family situations as a way to consistently construct her identity as she constructs narrative coherence throughout this interaction.

In comparing the two interactions, it should be noted that the doctor in Example 19 does not seem to have any prior knowledge of the *kind of a hectic family affair right now* (line 3) the patient interjects and does not exploit this interjection further. However, in Example 21 there seems to be shared knowledge about both the husband's physical condition and the daughter's drug use. Perhaps introducing a new very personal family situation is more challenging than discussing one that is already known by the patient's

doctor. In the first interaction, the patient is hesitant about using her family circumstance to help construct meaning, while in this second interaction the patient feels that it is necessary that her identity in relation to her family be understood and heard.

### 5.3.6 Other's identity as resource for constructing identity

Another resource interlocutors have to assist in constructing identity is the identity of others as constructed in the interaction (Charon, 2006; Georgakoupoulou, 2006). The following example from interaction C1 shows one way the doctor's construction of his identity is used as a resource for understanding the patient's identity.

#### Example 25

*Context:* Routine medical visit. Patient B, Bess, a 73-year-old woman presents to her primary care provider with high blood pressure.

[C1-116-131]

- 1 Bess: i'll i'll go and get the strips  
**they cost forty dollars a bottle** [laughs]
- 2 D: oh do they
- 3 Bess: yes [laughs]
- 4 D: ++ that's a lot
- 5 Bess: it is a lot and i don't think anybody pays for it [laughs] so
- 6 D: well
- 7 Bess: i don't mind **i can afford it** y'know i just
- 8 D: well **forty bucks is forty bucks i mean**
- 9 **i'd think twice about forty /bucks \**
- 10 Bess: /[laughs]\
- 11 D: and i'm not retired yet
- 12 Bess: right [laughs]
- 13 D: (4) [flips through file] you you are just being carried by medicare
- 14 is that right

15 Bess:       that's //right\

In this example, the patient agrees to buy the hemoglobin testing strips. The doctor attempts to align with the patient by agreeing that the \$40 for testing strips is *a lot* (line 4) and that *forty bucks is forty bucks i mean i'd think twice about forty /bucks\* (lines 8 and 9), and that he has *not retired yet* (line 11). In an attempt to align with the patient, the doctor seems to present himself as someone who is trying to understand the patient's situation and the possible reason for her condition and suspected non-adherence. In categorizing himself as *not retired yet*, he implies that the patient is a retired person and also assumes the patient is being covered by Medicare (line 13), a government-funded insurance for retirees.

This example shows how the doctor, as he presents an aspect of his own identity as a non-retiree sympathetic to the patient's circumstance, attempts to align with the patient, and in doing so further constructs the patient's identity in this interaction.

#### 5.4 Conclusion

This chapter first described the analytical tools and concepts used throughout the analysis and then illustrated how individuals identify as patients. As a novel approach to understanding identity as situated in a specific context, this analysis considers how patient identities are presented as they are offered "space" in which to speak and in response to doctors' elicitations. I demonstrated how participants construct their identities from contextual resources found within interactions as they use the frame of developing narrative coherence, a finding original to this study. Importantly, I illustrated how patients construct their identities in connection to their doctors' elicitations showing one way doctors' elicitations and patients' narrative inter-relate.

The patients' responses to the doctor's elicitations place them in the local here-and-now of the medical clinic as their responses correspond to their current health condition. At times, patients seem to present their identities in response to doctor elicitations, and at other times, perhaps in spite of particular doctor elicitations.

The patients define themselves as individuals who believe that Western medicine can heal their concerns (Davies & Harré, 1990) by the very fact that they have elected to

go to a clinic where this approach is used. The patients tend to portray themselves throughout the interactions as adherent to the recommendations and interventions offered through this system of health care. The way that patients present their identities in medical interactions is influenced by a variety of factors: the reason for the visit, whether the concern is acute or chronic, a pressing issue the patient would like to raise that is not necessarily the reason for the visit, and doctor elicitation as they themselves develop narrative coherence.

Presenting one's identity through narrative is a vehicle by which to achieve an understanding of self as it is derived from actions and experiences (Schiffrin, 1996). Doctors and patients construct themselves as relatively accepting or critical of each other, and there is a regular movement of aligning and distancing throughout the interactions. They each present themselves epistemically as they state their beliefs: the patients and their moral stance; the doctors and their belief in what the diagnostic tools offer them to believe about patients. They present their agentive selves as they move toward intended goals: e.g. the patient toward convincing her doctor that she is adhering to medical intervention; the doctor as he attempt to gain an understanding of why the patient's blood pressure remains high in spite of the fact she is telling him that she is adhering to medical intervention. Both have the shared goal of making sense of the patient's condition.

The analysis shows that using NM, an approach where the doctor makes attempts to elicit information by giving the patient ample use of the floor, may or may not prepare the patient to present their narrative. Other factors may take precedence in the patient's lives including their personal experiences and family situations. Additionally, there may be times, especially in relation to chronic conditions, when patients may not be prepared to present their narrative, regardless of the elicitation offered by the doctor. An example of this comes from Rita Charon's experience with one of her patients, an 89-year-old African-American woman, with chronic hypertension, insomnia, and uncontrollable anxiety among other physical health conditions. Charon had been perplexed by her condition for years until one day, 20 years in practice with this patient, the patient provides information on an event which Charon believes to be at the core of her illness: being raped at age 12 by a Caucasian boy. The implications here were that not only had she been raped, but she had been rendered unable to speak of the traumatic event since



her African-American father would probably have taken matters in his own hands and would likely have died due to this action. According to Charon, harboring this event all those years had “disfigured her heart with wrath and fear” (p. 65). Charon concluded that it had taken the patient 20 years to trust her doctor and recount this very personal, heart-wrenching narrative of her life. Once the patient was able to speak her narrative, her health improved. Thus, we can see how medical interactions remain complex in nature and not necessarily predictable. Patients can only present their identities as they understand themselves at a particular moment in time.

The discourse analyses in Chapters 4 and 5, focusing on the connection between doctors’ elicitations and patients’ narrative and identity construction informs the analysis found in Chapter 6, which focuses on the feedback received in Phase 2 from evaluating doctors in relation to the elicitation approaches used in interactions A1, C1 and C2.



## Chapter 6 Doctors' perceptions and narrative coherence

### 6.1 Introduction

Chapter 3 described the social characteristics of the doctors and patients in the database of videotaped medical interactions selected in Phase 1. The data from Phase 1 provided contextual background information for the analyses in Chapters 4 and 5 identifying characteristics of the doctors' elicitations, patients' narratives, and the participants. These data and discourse analyses inform the analysis of Phase 2 data which is presented in this chapter. Chapter 6 presents the results of the data collected by questionnaire and interviews in Phase 2 which examine how evaluating doctors measure the effectiveness of elicitation approaches in the three core medical interactions, strengthening the findings of the discourse analysis. Focus on the content of the evaluating doctors' feedback triangulates the topic from the medical perspective, which strengthens the analysis (Fowler, 2009; Johnson & Christenson, 2004). This information adds support to the overall argument of the thesis, which is that participants in medical encounters seek narrative coherence and in doing so shape the construction of patients' illness stories. The feedback provides valuable insight into the relationship between the doctors' elicitations and patients' narratives, the main research question addressed in this study. The evaluating doctors' responses further illustrate how doctors, through their elicitations, and patients, through their own narratives, develop narrative coherence as they co-construct patient narratives through interaction.

This chapter addresses the research question, *How do doctors evaluate the adequacy of patients' accounts of their illnesses during consultations for purposes of forming working diagnostic assessments and treatment plans?* In addition, what techniques do doctors perceive as useful in eliciting patient information in the video-recorded data? From a doctor's viewpoint, what additional strategies could be used to elicit a more useful account/narrative? These questions focus on the clinical perspective of the data so as not to rely solely on the analysis of a non-clinician. The answers to these questions provide data on 1) how evaluating doctors perceive the effectiveness of techniques doctors use to elicit patient information, 2) additional strategies doctors perceive as potentially useful to eliciting patient accounts, 3) the extent to which

evaluating doctors perceive patients are being heard by their doctors, and ultimately 4) a unique clinician perspective of how doctors' elicitation and patient narratives inter-relate, which is the main purpose of this study.

The main findings presented here include observations that 1) the evaluating doctors required more questions eliciting more detailed information in spite of the frequency of questions represented in the interactions; 2) the perceived expected role of doctors is to demonstrate control of medical interactions; 3) the close similarity of doctors' responses indicate the extent to which training and socialization impact on doctors' interactions with patients, with particular attention to NM; 4) the institutional setting plays a role in the interactional language between doctors and patients; and 5) the extent to which patients were perceived as "being heard" was not connected to the amount of space patients were offered by their doctors. In the discussion, I describe the importance of each finding and how it makes a unique contribution given the novel approach to this study. In addition, although I set out to gain evaluations from doctors about the elicitation approaches used in the selected medical interactions, I found that the evaluating doctors slipped into the role of constructing narrative coherence themselves, even as they evaluated the interactions in the study. These evaluating doctors naturally engaged as 'doctors' and began developing narrative coherence as they measured the impact of the elicitation approaches in the encounters. This response demonstrates the extent to which this frame of constructing narrative coherence is important to understanding what takes place in medical encounters as well as the analysis of the interactions in this context.

## **6.2 Phase 2 overview**

As described in the methodology chapter, the data collected in Phase 2 are feedback from evaluating doctors on the approaches doctors use in medical interactions to elicit patient narratives. The evaluating doctors reviewed the three selected medical interactions identified by Phase 1 data, which had the lowest, average, and highest question frequencies. These interactions represented three styles doctors use in eliciting patient narratives with regard to the amount of "space" offered to patients to render their

narratives. Evaluating doctors from medical clinics located in the Southeastern part of the U.S. were asked to offer feedback on their perceptions of 1) the clinical approaches for eliciting patient narratives, 2) the patients' narratives, and 3) the extent to which they thought the patients were being sufficiently heard. These data were collected by questionnaire and interview and were sought to provide a medical perspective on the doctor-patient interactions under analysis. These instruments, how they were used, and how the data were analyzed are described in the methodology chapter. The evaluating doctors responded to:

- A) survey question 1 - To what extent does the type of information given by the patient lead to forming a working diagnostic assessment and treatment plan (including tests/referrals)?
- B) survey question 2 - To what extent were doctor interaction technique(s) useful in eliciting patient information?
- C) the interview question - What additional questions could be asked, if any, to elicit more useful information for diagnosis and intervention? and
- D) the prompt - Please offer reasons for why you would ask additional questions.

These questions were designed to elicit feedback on the techniques which were used by the doctors in the medical interactions in drawing out patient information. The main focus was on the medical perspective related to the usefulness of the various elicitation approaches in gathering patient information related to diagnosis and intervention. Evaluating doctors were not asked to offer feedback on whether they thought the doctors in the interactions were considered "good" doctors; instead, they were asked to focus their feedback on the elicitation techniques. These data were analyzed qualitatively in order to explore evaluating doctors' perceptions of particular aspects of the medical interactions.

The following section of the chapter presents the substantive findings of this phase of the study.

### 6.2.1. Substantive findings

This section provides the specific data collected through the survey and interviews, which support each of these findings. The data are arranged according to the substantive findings related to the survey and interview questions. For each finding, I first present the data from the survey in medical terms, drawing on the evaluating doctors' actual words in order to triangulate the data. Drawing from the medical perspective, I then add support from the medical interactions and use IS to analyze the examples extracted from the interactions the evaluating doctors reviewed.

#### 6.2.1.1 Substantive finding 1

**Substantive finding 1: Evaluating doctors desired *additional questions*, which would elicit *more detailed patient information* for each interaction regardless of the existing question frequency.**

The first finding is that the evaluating doctors perceived that they would require *more questions* be asked of patients regardless of the elicitation frequency and the acute or chronic nature of the patients' presenting concerns. Further, there seems to be consensus among the evaluating doctors that additional questions were desired for the purposes of obtaining more *detailed information* from the patients regarding their presenting concern. What is important here are the type and quality of the information the evaluating doctors perceived as necessary. This feedback may allude to the importance of shared experience and knowledge between the patient and her doctor. In other words, if given the opportunity to be in similar patient-doctor encounters, these evaluating doctors may not require these additional types of elicitations due to their experience with and knowledge of their own patients. This information is what the evaluating doctors perceived as necessary for making sense of the patients' narratives and is evidence of the evaluating doctors engaging in the clinical interactions as doctors.

### Support from responses to survey question 1

As indicated in Chapter 3, the survey and interview questions were designed to collect feedback used to test the hypothesis (Fowler, 2009; Johnson & Christenson, 2004; Oppenheim, 1992). Support for this finding begins by looking at the evaluating doctors' responses in Table 6.1 to Survey Question 1: *To what extent does the type of information given by the patient lead to forming a working diagnostic assessment and treatment plan (including tests/referrals)?* This question focuses on the extent to which the information patients offered in each interaction assisted the doctor in understanding the patients' narratives and making diagnostic decisions. All questions were based on a five-point scale, 5 being the highest.

Table 6.1 <i>Evaluating Doctors' Feedback on Survey Question 1: To what extent does the type of information given by the patient lead to forming a working diagnostic assessment and treatment plan (including tests/referrals)?</i>	
Interaction	Feedback Rating Average
Interaction 1 (A1)	4,4,4,3,3,4,4,4,2,4,3,2 Range: 2-4 Range NM: 3-4 Median: 4
Interaction 2 (C1)	2,4,4,2,3,1.5,3,3,3,1,1,2 Range: 1-4 Range NM: 3-4 Median: 2
Interaction 3 (C2)	2,4,2,1,2,1.5,3,5,4,5,3,1 Range: 1-5 Range NM: 2-4 Median: 2
n=12	NM=Narrative Medicine exposure <b>BOLD</b> =ratings by doctors with exposure to NM

For interaction 1 (A1), the response range was 2-4 with a median rating of 4. The range is narrow for this item and the median of 4 is at the higher end of the range. In contrast, the evaluating doctors who had been exposed to NM, through either formal training through university training (undergraduate or medical school) or through continuing education, rated this item between 3-4. Given the small number of

respondents, we can tentatively say that this feedback may indicate that the doctors who had previous exposure to NM, through either coursework in the medical curricula or through continuing education, viewed the “space” offered to the patient as slightly more sufficient than those who had no prior NM experience. The role of NM training on the feedback is addressed further in Section 6.2.2.1. What is important to note in these responses is that these particular doctors evaluated the interaction more similarly. With an overall median response of 4, it seems that the evaluating doctors found the information offered by the patient to be helpful to the doctor in making a working diagnosis for the patient. This response does not, of course, measure whether or not the patient’s narrative was actually more helpful in patient care.

There are several possible reasons for why the evaluating doctors may have rated the item on the higher end of the scale. Interaction 1 (A1) was an acute case where the presentation of concern clearly marks the main reason for why the patient is at the clinic. The doctor’s response to this concern was a series of question-tree-review-of-systems elicitations, which helped the doctor narrow down what may have happened to the patient, create a diagnosis, and make a medical decision. The patient seemed to respond to the doctor’s elicitations without resistance as evidenced by her consistent following of the doctor’s direction, responding to each doctor elicitation accordingly. Although there are many possible reasons for this, a rationale may be that the patient’s expectations of the doctor were being met and that her goals matched those of the doctor’s (Cicourel, 2007). The evaluating doctors may have viewed this interaction as one that was sufficiently addressing the medical situation while perceiving the participation from the patient as appropriate to the situation and in correspondence with the doctor’s participation. However, the patient may have believed that it was her role as patient to simply follow in the manner the doctor was directing the interaction. The reason for the patient’s level of participation is not always clearly marked. Overall, the evaluating doctors perceived the information offered by the patient in this interaction useful for the doctor to make sense of the patient’s narrative to the extent that the doctor could make diagnostic decisions.

The responses to Survey Question 1 for interactions 2 (C1) and 3 (C2) indicate that the response range is slightly wider with ratings of 2-5 and 1-4 respectively, with a



median of 2 for each item. Interactions 2 (C1) and 3 (C2) represent chronic illness cases, which may account for the slightly wider range of responses when compared to interaction 1 (A1). It may be that the patient narratives, when used to communicate conditions related to chronic illness, are not always explicitly and coherently rendered and may be more challenging to the doctors to identify and follow in spite of the participants' interactional history, in which case, it would be particularly challenging to evaluating doctors who do not have a shared history with the participants. Although there has been a developing shift in medicine in the U.S., from a focus on acute care to the management of chronic illnesses (McEwan, Davison, Forester, Pearson, & Stirling, 1990; Holman & Lorig, 2000), communication models in medicine which better address complex continuous care are yet in their infancy. Perhaps when the patients are allowed to speak for longer periods of time and with less coherence as seen in interactions C1 and C2, it is more challenging for evaluating doctors to determine the particular issues that patients are trying to present. Overall, the evaluating doctors found the extent to which the type of information given by the patient was perceived more useful in interaction 1(A1), the acute case, than in interactions 2(C1) and 3(C2), the chronic cases. The reason may be that more information is perceived as necessary by both doctor and patient in acute cases where not as much background knowledge related to the event is shared.

### **Support from evaluating doctors' suggested additional questions**

The evaluating doctors indicated that they required not only additional questions but also more detailed patient information for each interaction, to which the doctors in the interaction had access.

Evaluating doctors offered responses to the interview question: *What additional questions could be asked, if any, to elicit more useful information for diagnosis and intervention?* The responses are listed in Table 6.2 detailing the questions evaluating doctors thought necessary to obtain the type of information required to make a working diagnosis for the patients.

<p>Table 6.2</p> <p><i>Evaluating Doctors' Responses Related to Patient Information to Interview Question: What additional questions could be asked, if any, to elicit more useful information for diagnosis and intervention?</i></p>	
Interaction	Feedback Questions/Comments
Interaction 1 (A1)	<ul style="list-style-type: none"> <li>• <i>Had the patient had other falls recently? Was this an isolated event or is there some other underlying issue?</i></li> <li>• <i>Did you feel you injured anything else? Did you feel a pop or crack?</i></li> <li>• <i>More open-ended questions.</i></li> <li>• <i>Had you passed out earlier?</i></li> <li>• <i>Questions about details</i></li> <li>• <i>A lot more specific questions. More questions regarding whether pain was worse or better. Elicitations do not fully exploit medical case.</i></li> <li>• <i>Doctor's questions could be more direct.</i></li> <li>• <i>Specifics on where pain was exactly.</i></li> <li>• <i>Other joint symptoms before? Injuries before to joints? Duration alone has brought patient in? What movements are more painful? Progressed? Why such a low dose of NSAID? Is this really what happened? Concerns with somatic symptoms, more details.</i></li> </ul> <p><i>9 of 12 evaluating doctors offered more questions</i></p>
Interaction 2 (C1)	<ul style="list-style-type: none"> <li>• <i>Delve further.</i></li> <li>• <i>How was the patient feeling? What meds were taken daily?</i></li> <li>• <i>How do you feel? What symptoms are you having?</i></li> <li>• <i>More open-ended questions.</i></li> <li>• <i>Doctor's questions could be more direct.</i></li> <li>• <i>Questions not detailed enough: what was her blood sugar/blood pressure exactly?</i></li> <li>• <i>What is the social/family situation? Diet specifics, pertinent to weight/BP/cholesterol; Changes in diet?; Quality of life? To what extent is medical condition limiting lifestyle/daily routines? How do all medical conditions tie together?</i></li> </ul> <p><i>7 of 12 evaluating doctors offered more questions</i></p>
Interaction 3 (C2)	<ul style="list-style-type: none"> <li>• <i>What meds were taken and when? How often were meds missed? Was there mental illness? Substance abuse?</i></li> <li>• <i>Tell me about the root canal. Tell me about the neck pain. What are you still taking at this point?</i></li> <li>• <i>More open-ended questions.</i></li> <li>• <i>Where to start? So many more questions. The patient offers a lot of information but not much that will assist the doctor in making a diagnosis.</i></li> <li>• <i>Doctor's questions could be more direct.</i></li> <li>• <i>needs to have asked detailed questions about pain and sleep; differentiate symptoms and sources of pain.</i></li> <li>• <i>Quality/location of pain/discomfort; Did increase in prednisone interfere with sleep?; Clarify why she is there – what needs to be addressing – sleep?</i></li> </ul> <p><i>7 of 12 evaluating doctors offered more questions</i></p>

These findings seem to indicate that most of the evaluating doctors (7-9 of 12) responded by indicating that they would need more elicitations, which would have prompted more specific details. Although it is true that the evaluating doctors were reviewing reduced versions of the interactions, it is important to note that for interaction 1 (A1), most of the evaluating doctors (9 of 12) desired more information in spite of its existing high question frequency in order to make sense of the patient's story and the fact that they rated it more highly. This supports the idea that the perceived narrative coherence in a patient's story is dependent on what the doctor as listener or "reader" brings to the patient's narrative. This will include multiple resources such as background knowledge, visual appearance of patient, and the co-construction (Phoenix, 2008) of the interactional patient narrative developed through elicitations and responses. Doctors' experience with and knowledge of their patients' overarching illness narrative may implicitly play a role in how they understand their patients' stories within a specific encounter. For example, in the feedback from interaction 3 (C2) in Table 6.2, *How often were meds missed?*, might not be considered an important question to ask if the patient is known to the doctor as one who is usually fully adherent to her medical regimen.

Table 6.3 categorizes the responses from Table 6.2. Table 6.3 focuses on the types of additional elicitations the evaluating doctors suggested.

<b>Table 6.3</b> <i>Categorizations of Evaluating Doctors' Responses to Question:  What additional questions could be asked, if any, to elicit more useful information for  diagnosis and intervention?</i>				
<b>Related to:</b>	<b>Interaction 1</b>	<b>Interaction 2</b>	<b>Interaction 3</b>	<b>Total</b>
<b>Questions: type and frequency</b>	1 more open-ended 1 more direct 1 eliciting more details <hr/> 3	1 more open-ended 2 more direct 1 delve further 1 regarding family <hr/> 5	1 more open-ended 3 more direct <hr/> 4	12
<b>Patient History</b>	3 prior history 4 symptomology <hr/> 7	1 medications 2 symptomology <hr/> 3	3 medications 2 symptomology <hr/> 5	15
<b>Negative Evaluative Comments</b>	1 not patient-centered <hr/> 1	1 not patient-centered 2 not organized/effective 1 did not delve deeper <hr/> 4	1 not patient-centered 2 not organized/effective 2 doctor was passive <hr/> 5	10
<b>Positive Evaluative Comments</b>	0	0	1 allowed patient to speak <hr/> 1	1
<b>Other</b>	1 listen more 1 questions patient's moral stance <hr/> 2	1 more diabetes education <hr/> 1	0	3
<b>Total</b>	13	12	15	40

From Table 6.3, the number of additional questions and comments made by evaluating doctors were fairly evenly distributed among the interactions. Interestingly, the number of questions related to patient history was highest for interaction 1 (A1). This interaction had the highest doctor-question frequency, and the questions were predominantly related to the patient falling on her arm. What might account for this response was the acute nature of the presentation of concern, since most of the suggested questions relate to symptomology. Another factor to consider is that the evaluating doctors viewed this interaction without a complete history of the patient, which may account for the three general history questions. This latter idea underscores the implicit, shared knowledge that may exist between the participants in a medical interaction when they have an established relationship (Ainsworth-Vaughn, 1994; Duff, 2008; Goodwin, 1990; Hymes, 2003; Roberts, Sarangi, Southgate, & Wakeford, 2000). Importantly, this

shared knowledge assists the doctor in understanding the patient's narrative as it is being rendered since there is background knowledge of the patient's long-term health narrative.

A more anticipated outcome was that interaction 3 (C2), the interaction with the lowest question frequency, where the patient was given more "space", received the most negative evaluative comments. The reason I anticipated this response was that the discourse analysis in Section 4.2.2.2 had indicated that patients may have difficulty organizing a more coherent narrative when not guided by at least some feedback from their doctor. It seemed reasonable to anticipate the evaluating doctors difficulty in "reading" this patient's less coherent narrative. The evaluating doctors' comments related to 1) the interaction not being patient-centered enough, 2) the interaction not being organized or effective, and 3) the doctor being passive. These negative comments may have been made because the development of this interaction was perceived as disorganized. At the same time, this interaction received the only positive evaluative comment: The doctor "allowed the patient to speak". The patient was offered more space, but with that opportunity the patient's narrative appeared less coherent and difficult for evaluating doctors to follow.

### **Support from reasons offered by evaluating doctors**

If evaluating doctors suggested additional questions, they were given the opportunity to offer reasons for why they would ask these particular questions. Following is the feedback received, organized thematically.

#### *Perceived type versus amount of patient information*

Even when patients provided a lot of information, the type of the information was more important to the evaluating doctors than the amount, a natural perception arising from clinical training. (Hamilton & Woodward-Kron, 2010; Janicik et al, 2007).

The comments below underline the importance of the clinical usefulness of information elicited.

- Doctor 3: *Although **a lot of words were heard**, I'm **not sure the problem was heard**.*
- Doctor 4: *Sometimes a bit of redirecting of the patient to **get at the information you need**.*

- Doctor 6: *It's a fine balance that I think few of us can find between allowing the patient to express what they want to say but also **getting the information you need** as a physician.*
- Doctor 9: *I prefer more open-ended questions and from the information and guide it to more specific question **gather more information and distill it down to what I need to know.***

Note: Not all doctors offered responses to each of the questions.

The evaluating doctors' judgments are consistent with a need to reach a satisfactory elimination of possibilities offered by the patient.

#### *More specific, detailed information*

Evaluating doctors stated that more specific, detailed information was needed from the patients.

- Doctor 1: *2<sup>nd</sup> interaction, doctor did not **delve on further** as to why the patient was having trouble with taking medications, blood pressure, and diet – all aspects that would influence their hypertension and diabetes.*
- Doctor 4: *I would want **a little more information** about the fall. More questions regarding ... symptoms and how are you feeling.*
- Doctor 6: *but if you want the physician to help with the problem it helps to be **more specific or detailed.***
- Doctor 7: *The last patient generates a lot of information but she's chatty it's not what the physician is doing (laughs). Very few times where doctor acknowledges confirms what patient is saying to **delve deeper** into the symptomology or concerns of the patient. As soon as they get a small snippet sort of move on to the next question the next thing on their agenda.*
- Doctor 10: *Were there...also in kinda **eliciting what kind of treatments** she had been having it probably may be a minor point useful to find out why she was on such a low dosage of anti inflammatories to see if a higher dose had been tried at any point during the 3-week trial.*

This feedback related to patient information is an insight into the heavy reliance by doctors on specific and detailed information to more fully understand the patients'

conditions. This was the case in both the acute (interaction 1, A1) and chronic (interactions 2, C1 and interaction 3, C2) cases, regardless of the question frequency. The prevailing view from the evaluating doctors was that the type of information necessary for a more coherent patient narrative should be elicited by the doctors. This is a strongly established role of the doctor, reinforced by training in ways of eliciting patient information (Groopman, 2007), framing the evaluating doctor's measure of the extent to which an elicitation approach might be viewed as satisfactory.

### *Tangential information*

Some patient information seemed to be perceived as tangential or not useful to understanding the patients' conditions. The feedback from evaluating doctors' does not seem to indicate that there is an awareness of what doctors might be missing from their patients by letting their patients speak freely about their health concerns.

Tangential information may be viewed as narrative digression. Digression in narrative analysis may be seen as the equivalent of syntactical embeddedness, not only as a way of adding information but of restructuring the information in a manner to "help define the position of the speaker" as it "articulates the narrative voice" (Stewart, 1993). However, the doctors in this study seemed to view tangential information as information they did not necessarily need or find useful. Instead, as illustrated in the examples below, two of the evaluating doctors viewed tangential information as a negative.

- Doctor 5: *it just seems like what that patient was saying she seemed to **get off on a tangent**.*
- Doctor 6: 3<sup>rd</sup> *one doctor is allowing patient to be **more tangential** (conveyed by negative tone)*

Theoretically, some doctors may tolerate more tangential information and perhaps see the potential of its usefulness in yielding important information to the diagnosis of the patient. One aspect addressed by the NM approach may be that narrative competency may assist the doctor in "reading" and understanding patient narratives (Charon, 2006),

which are viewed as less coherent due to tangential information (Hyvärinen, Hydén, Saarenheimo, & Tamboukou, 2010).

### Support from examples from medical interactions

The drive for more specific information that emerged in the evaluating doctors' responses was certainly evident when returning to the original interactions. In interaction 1 (A1), the doctor elicited more information regarding the patient's fall and trauma to her shoulder than the patient initially offered.

#### Example 1

*Context:* Excerpt from interaction A1. Patient A, Ann, a 72 year-old woman, presents to her primary care provider with shoulder pain following an accident.

[A1-46-63]

- 1 D:           **has it uh been swollen at all any place**
- 2 Ann:        i can't tell that i'm so //heavy\ in that area that i can't //tell\ that
- ...
- 3 D:           /it's hard to tell\ um **do you think it's any better now**
- 4               **than when you first did it or is it about the same or is it worse**
- 5 Ann:        i think it's better it just is aggravating to me
- ...
- 6 Ann:        because i have pain every time i do
- ...
- 7 Ann:        even to fold clothes
- 8 D:           **regardless of which way you lift it it hurts**
- 9 Ann:        yeah
- 10 D:          **okay does it hurt down into the arm or into //the\ fingers**
- 11 Ann:        [mumbles] /yeah it hurts to the elbow\\
- ...
- 12 D:          /okay\\ **have you ever injured that shoulder before**



13 Ann: no

In this example, it seemed more information was elicited by the doctor related to the nature of how the fall impacted the patient's current condition rather than the nature of the fall. The patient's doctor asked these additional elicitations in order to gather more specific information about the extent of the patient's symptoms related to whether it was *swollen* (line 1), *better now* (line 3) or *worse* (line 4) and if it hurts to *lift it* (line 8). It could have been that the shared history and knowledge of the patient did not require the doctor to ask additional questions related to the nature of the fall which might have focused on whether she simply tripped or if there was another issue (physical abuse, health condition, medication side effects) that may have caused the fall. The evaluating doctors, not personally knowing the patient, desired responses to additional questions which focused on the actual fall to more fully satisfy their understanding of the patient's history in relation to the current symptomology. The doctor in the interaction may also have felt that the information was sufficient to order tests and refer the patient to a specialist for the immediate concern. In particular, when the doctor asks the patient whether *it's any better now than when you first did it* (line 3), the patient indicates that it is still limiting her ability to do everyday tasks, *even to fold clothes* (line 7). How much information is sufficient to make these types of decisions may also be dependent, to a certain extent, on how each doctor practices medicine. Additionally, in this interaction, there was no apparent evidence of the patient attempting to offer tangential information and so no "redirecting" strategies were necessary for the doctor to use.

In interaction 2 (C1), where the patient's main concern was her blood pressure, the patient offered responses which seem to be directly related to the doctor's elicitations. The section of the interaction, as seen in Example 2, where the doctor and patient begin to talk about health care systems could be considered tangential.

## Example 2

*Context:* Routine medical visit. Patient B, Bess, a 73-year-old woman presents to her primary care provider with high blood pressure.

[C1-485-489]

- 1 D:                yeah +++ most civilized countries provide adequate health insurance
- 2 Bess:            oh i know they do
- 3 D:                y'know 1//in europe\\1 2/they're always worried about\\2
- 4                    the universal coverage
- 5 Bess:            1/i know they do\\1

Stating that *most civilized countries provide adequate health insurance* (line1), although related to health care in general and health insurance more specifically does not directly pertain to the patient's health condition or her health care benefits, and thus, is considered tangential. This part of the interaction was peripherally related to the medical interaction in that the doctor originally inquired about the patient's history by asking about the patient's mother and her final days in a nursing home under government health care coverage. Given the fact that the doctor initiated this part of the interaction with a patient history-seeking elicitation, it seems the doctor was initially using transactional talk (Geyer, 2008) which may have evolved into relational talk (Holmes, 2006; Holmes & Marra, 2004; Koester, 2006; Mullany, 2006). The doctor's utterance in line 1, starting with a term of agreement, *yeah*, and followed by the patient's repeated statement of agreement, *i know they do* (lines 2 and 5), demonstrate alignment and continued development of comradery (Cordella, 1996; Schiffrin, 1984) between patient and doctor and supports the consideration of this section of the interaction as relational talk emerging from transactional talk.

In this chronic case, the doctor was unable to answer the question of "why?". Why is the patient still experiencing high blood pressure when she insists that she is taking medication: [C1-24] *can't figure out why it would be on medicine why it would be elevated here*. As was discussed in Chapters 4 and 5, this comment by the doctor can be considered an attempt to construct narrative coherence. Even though the doctor indicated that he needed to understand "why" in order to make sense of the patient's condition, he was unable to obtain sufficient information from the patient to assist him. It seems to be the perception of the evaluating doctors that this question remains unanswered.

In interaction 3 (C2), the patient offered a good deal of information, but evaluating doctors did not seem to perceive it as the type of information that can assist the doctor in making a diagnostic decision. There seemed to be so much information that the important data may have been said by the patient but not heard by the doctor. This may have occurred because it is difficult to process large amounts of information on the spot, the doctor's attention may have waned, and/or the information was perceived as not relevant. It is also possible that the doctor in this interaction knows the patient well enough to understand that she simply needed to speak (Roter, 2002) and that the doctor's decision for what to do next had already been established early in the interaction. Therefore, this shared knowledge may not be observable or linguistically indexed (Goodwin, 1990; Liebscher, 2007), but may play a role in how the interaction is shaped, how well the doctor understands the patient's narrative, and how the narrative may be perceived as less coherent by evaluating doctors.

The evaluating doctors seemed to perceive that interaction 3 (C2) had the most tangential information. The actual topics the patient discusses seem to speak to either her condition or what she has done via Western and alternative medicines to remedy her symptoms. However, her level of detail for each, such as the details related to the "*tapping technique*" [C2-67], used for her fear of snakes, seems to make it appear as tangential and contributes to the entire narrative as being perceived as less coherent. It is not apparent whether the doctor in the interaction finds the additional level of detail informative. In response to the *tapping technique*, the doctor delineates what is within her realm of expertise as a way to redirect the discussion, as illustrated in Example 1.

### Example 3

*Context:* Routine medical visit. Patient C, Cara, a 72-year-old woman presents to her primary care provider with continued pain in her neck and shoulder.

[C2-201-205]

- 1 D: now we got several different choices
- 2 and what i know as medicine is a little bit better

- 3           you have more experience with some of the //energy fields\ and tapping  
 4   Cara:    //right, right\  
 5   D:        //and so\ i can't help you out on that

In this excerpt, the doctor seems attentive to some of the details the patient provides by delineating the type of service she is able to provide as a doctor as seen in line 2, *and what i know as medicine is a little bit better*. At the same time, the doctor displays understanding of the patient's narrative to the extent that she responds according to the topics presented by the patient, reiterated by the doctor in line 3, *you have more experience with some of the //energy fields\ and tapping*.

## Discussion

Using the question-frequency as a way to determine if the technique used by the doctor resembles aspects of the NM approach, interaction 3 (C2) seems most representative of the approach. Within the NM frame, the patient may provide much information, which may be tangentially presented. This offering of tangential information is a process typical of stories told of past events (Georgakoupoulou, 2007). These less coherent narratives may lead to challenges for the doctor to determine what is salient to the patient's condition. Therefore, using this approach without adequate narrative proficiency may lead to a surplus of unprocessed information for the doctor who has yet to develop clinical intuition (Groopman, 2007) and narrative competency (Charon, 2006). The doctors' competencies in NM, "reading" the patients' narratives and making sense of their illness stories, are critical to the success of the approach, and importantly, to patient assistance.

The results of the perceptions study indicate that only a minority (3 of 12) of evaluating doctors viewed interaction 3 (C2) as a good example of the doctor hearing the patient's account. These doctors were the ones who had been exposed to NM prior to the study. The majority of doctors perceived this interaction to be "inefficient" and wondered if the doctor in the interaction was paying attention to the patient since she offered little feedback and minimal elicitations.

It appears that particularly in the nature of chronic illness cases there are patient concerns that evaluating doctors may not perceive as related to the patient's actual

diagnosis or medication. There was some evidence that the evaluating doctors thought it was important for the doctors to hear what the patients had determined they needed to say. In these cases, the doctors would need to ascertain if indeed there were connections with this information and the patients' conditions. The doctors' active listening may constitute a therapeutic intervention on its own merit (Beach, 1995; Sechtem, Scherz, & Di Lollo, 2009).

It is notable that the range for the doctors who have been exposed to NM remains constant for these two questions with responses of 2 - 3 for interaction 2 (C1) and 3 - 4 for interaction 3 (C2), which may be a result of exposure to the NM approach.

These findings lead to the conclusion that the approach and logical development for each doctor is unique even as they employ common diagnostic tools such as the question-tree formulary and review of systems. Although these tools are fairly standardized, the uniqueness of the individual doctor and their relationship and understanding of the patient also contribute to what does and does not take place in the medical encounter. The evaluating doctors did not have the benefit of knowing these patients over time and were not aware of known patterns established by the patients' histories. Further, these findings seem to indicate that the manner in which doctors' elicitations and patient narratives inter-relate is complex in ways that extend beyond question types, and "space" offered to patients. The development and level of coherence of the patients' narratives seem to be important to the extent that they provide doctors what is perceived as necessary for making sense of patients' narratives.

#### **6.2.1.2 Substantive finding 2**

**Substantive finding 2: The evaluating doctors consistently indicated their expectation that the doctor should demonstrate control of the medical encounter.**

An important element in the evaluating doctors' feedback is the perception that doctors are the participants who are in control, setting agendas (cf. Holmes, Stubbe, & Vine, 1999) and directing the patient and the path of the medical interaction as they strive to make sense of patients' conditions.

Table 6.4 represents the responses evaluating doctors offered when asked: *To what extent were doctor interaction technique(s) useful in eliciting patient information?*

Table 6.4 <i>Doctors' Feedback on Question 2: To what extent were doctor interaction technique(s) useful in eliciting patient information?</i>	
<b>Interaction</b>	<b>Feedback Rating</b>
Interaction 1 (A1)	3, <b>2</b> ,2,1, <b>3</b> ,4, <b>3</b> ,4,2,3,4,2 Range: 1-4 Range NM: 2-3 Median: 3
Interaction 2 (C1)	1, <b>3</b> ,2,1, <b>2</b> ,3, <b>2</b> ,2,2,3,3,3 Range: 1-3 Range NM: 2-3 Median: 2
Interaction 3 (C2)	2, <b>4</b> ,1,1, <b>2</b> ,1.5, <b>3</b> ,4,2,2,2,2 Range: 1-4 Range NM: 2-4 Median: 2
<i>n</i> =12	NM=Narrative Medicine exposure <b>BOLD</b> =ratings by doctors with exposure to NM

Table 6.4 illustrates the extent to which doctors' techniques in interactions 2 and 3 were perceived as useful was less when compared to interaction 1 (A1). This finding is important in that it indicates that the evaluating doctors viewed giving the patients "more space" as less useful.

### **Support from reasons offered by evaluating doctors**

#### *Doctor role is "organizer" of the interaction*

Evaluating doctors seemed to have perceived that interactions 2 (C1) and 3 (C2) were "disorganized", and that there was not enough control by the doctor. This may imply that doctors perceive it to be their responsibility to organize the interaction (Heritage & Clayman, 2010). In this case, the expectation is for the doctor to control the interaction and the patient's "access" (Van Dijk, 1996) to participation in order to organize the interaction.

- Doctor 4:
  - 3<sup>rd</sup> *If I hadn't read the chief complaint, I wouldn't have known what it was about.*
  - *Sometimes a bit of **redirection** of the patient to get at the information you need.*
- Doctor 5:
  - 2<sup>nd</sup> *struck by – seemed **disorganized**.*
  - *It would have been more helpful I think if the doctor could have **redirected** her.*
- Doctor 8:
  - 2<sup>nd</sup> *so, uh holy cow. 1<sup>st</sup> at least went somewhere this is just **all over the map**.  
This is a doctor who asks questions, doesn't get an answer. Very inefficient a lot of back and forth some of it is idle chatter friendly but it doesn't get you anywhere. The doctor goes in **different directions**.*
- Doctor 10:
  - *because even issues she did bring up **all over the place**.*
  - *But at some point you do need to **direct** the conversation.*

These comments are in contrast with the one presented for the acute illness interaction A1 regarding being “on track”:

- Doctor 4:
  - 1<sup>st</sup> *doc was **on track***

*Doctor role offers patient “permission” to speak*

The evaluating doctors used the term ‘allow’ or ‘let’ in several instances. To “let her (patient) go on and on” was viewed as negative doctor interviewing behavior.

- Doctor 2:
  - *One of the doctors **allowed** the patient to talk #3 and evaluated what needed to be done for the patient*
- Doctor 6:
  - 3<sup>rd</sup> *one doctor is **allowing** patient to be more tangential*
  - *It's almost **allowing** the patients to run the conversation which is fine if you have 3 hours*

- *3<sup>rd</sup> patient talked a lot. Doctor didn't interrupt **allowed** patient to be able to talk about multiple different things*
- *Very fine balance between **letting** them be themselves and say what they want to say and trying to guide them to what you need to hear in order to appropriated diagnose and treat.*
- Doctor 7:
  - *They didn't get too much of a plan so maybe there should be some agenda setting by the doctor.*
- Doctor 10:
  - *He says nothing basically and just **lets** the lady talk around in circles and it's not as if you want to cut the patients off but as some point you do need to direct the conversation and find out exactly why they're here and what they need.*

In these observations, the discourse used by the evaluating doctors clearly constructs the patient as unequal. In reference to co-construction, we also need to consider how the doctor, as the expert and the powerful participant who has the authority, “allows” the patient, as expert of her condition, to tell her story. The doctor also has the power to impose a determinant path on the patient’s story through the selection of elicitations.

It is important to note that the doctor’s autonomy is also limited and challenged by the health care system. The amount of time, the need to determine a diagnosis code, and the demand to create an intervention acceptable to the insurance business all impose their control and power on the doctor and, to varying degrees, direct their elicitation approach. Although this analysis could focus on power asymmetry (Maynard, 1991; Peräkylä, 2002; Robinson, 2001; Sarangi & Slembrouck, 1998; ten Have, 2007), we can also recognize that the inequality may be tacitly accepted by both parties, in part, due to the enormous responsibility the doctor has to the patient and the recognition of the control the health care system has upon the doctor (Groopman, 2007; Heritage & Clayman, 2010; Inglehart, 1992).

*Doctor role is to “fix” health concern*



The perception of evaluating doctors seems to be that patients want doctors to “fix” their concern by the end of the visit and that this is the reason they are seeking medical attention; therefore, evaluating doctors seem to view it as doctors’ active role to guide and redirect patients.

- Doctor 1:
  - *3<sup>rd</sup> Doctor was very **passive**... be more active in the encounter.*
- Doctor 4:
  - ***why they’re coming in***
- Doctor 6:
  - *especially in the 3<sup>rd</sup> one – what is bothering you the most today. If there’s one thing we can **fix** today – what would that be*
  - *3<sup>rd</sup> patient talked a lot doctor didn’t interrupt allowed patient to be able to talk about multiple different things but if that’s going to be **beneficial to the patient’s health in the end**, I don’t think so.*
  - *Because at the end of the experience at the doctor’s office, they’re going to want something **fixed** or a medication*
- Doctor 7:
  - ***patient** sometimes comes in with their **agenda**.*
- Doctor 8:
  - *3<sup>rd</sup> Doctor was exceedingly **passive***
- Doctor 10:
  - ***why she was even here***
  - ***why they’re here and what they need***

In these observations, there is a focus on the need for action and for a diagnosis and intervention in order to “fix” or remedy the patients’ concerns, or why they are seeking medical attention. This is the patient’s agenda: to have their concern remedied. Patients may have a secondary agenda related to *how* they expect doctors to “fix” their concern. Important in this finding is the focus on the culturally agreed upon purpose of a medical visit along with the expectant role of the doctor. Patients expect their doctors to not only remedy their physical health issue but also satisfy their affective needs (Sechtem, Scherz & DiLollo, 2009).

### Support from medical interactions

The doctor-in-charge expectation can be seen in returning to the medical interaction data. In interaction 1 (A1), although the patient does not explicitly say, “I fell and hurt my shoulder and need you to assess it and make it better”, her expectations for her doctor is illustrated in Example 4.

#### Example 4

*Context:* Excerpt from interaction A1. Patient A, Ann, a 72 year-old woman, presents to her primary care provider with shoulder pain following an accident.

[A1-40-45]

- 1 Ann: and uh ibuprofen i took two hundred milligrams maybe twice a day
- ...
- 2 Ann: it [sigh] gave me a little relief
- 3       it didn't cure it but it gave me a little relief

In line 3, by indicating that *it* (ibuprofen) *didn't cure it but gave me a little relief* indicates that the patient is still in pain and is seeking medical assistance from her doctor. This more explicit presentation of concern is in contrast with in interactions 2 (C1) and 3 (C2), where determining how the doctors can understand their patients' narrative in order to “fix” the medical concern is complicated by how each narrative is rendered; neither is concise and interaction 2 (C1) is implicitly rendered. Embedded in the narrative of interaction 2 (C1) is an unclear reason for why the patient is at the clinic. If the medical reason is not made explicit, it is challenging to the doctor to determine, as stated in the evaluating doctors' words: “why they're [the patients] here” and “what they need” [Doctor 10] in order to see “if there's one thing we can fix today – what would it be” [Doctor 6]. Interaction 2 (C1) represents a routine visit, which the patient willingly arranged and attended; yet, the patient is seemingly unwilling to accept that the doctor thinks she still has high blood pressure and may be pre-diabetic as illustrated in Example 5.

## Example 5

*Context:* Routine medical visit. Patient B, Bess, a 73-year-old woman presents to her primary care provider with high blood pressure.

[C1-20-22]

- 1 Bess:           i know [laughs]  
2                   i don't want to think i have high blood pressure laughs either  
3                   but i really don't think i do but i do take medication

There may be other reasons why the patient arranged for the office visit. One reason is in order to receive a prescription to refill her blood pressure medicine, as an office visit is often required for regular medication refills. She may also want to maintain good standing with her primary care doctor so as not to be discharged from the practice for being non-adherent. These reasons are important to consider since they may contribute to the fact that the patient needs to be at the appointment, and therefore must maneuver through the doctor's indirect accusation that she may not be taking her blood pressure medication.

In interaction C2, the patient made clear from the beginning her concerns and why she was at this medical visit, which is to ask the doctor to remedy her medical condition by stating that she *did have a rough several months* (line1) and *the fatigue still exists* (line3) as seen in Example 6.

## Example 6

*Context:* Routine medical visit. Patient C, Cara, a 72-year-old woman, presents to her primary care provider with continued pain in her neck and shoulder.

[C2-6-8]

- 1 Cara:           well i did have a rough several months  
2                   i feel better than i was when i was in here

3 y'know with the fatigue still exists

Interestingly, in interactions 1 (A1) and 3 (C2), the patients were asked general, open-ended service-related questions, *what brings ya in today* [A1-6] and *what can I do for you today* [C2-5], which may have elicited the presentation of concern from the patient at the very beginning. In interaction 2 (C1), the doctor leads with: *ya see that blood pressure* [C1-2], and as addressed in Chapters 4 and 5, the initial elicitation may have positioned the patient in such a way that her presentation of concern is not explicitly provided. What is evidenced in all three of these interactions is the shared understanding of how the medical encounter, a meeting as activity type (Angouri & Marra, 2010; Culpeper, Crawshaw, & Harrison, 2008; Levinson, 1992 [1979]; Sarangi, 2000), should operate, with each participant orienting accordingly. Within this understanding, the doctors in their sanctioned roles (Barton, 2000), lead or direct the medical encounter in order to “fix” the patient’s health concern, and in doing so, expect responses to their elicitations (Heritage & Robinson, 2006), which help to construct the patients’ narratives. In light of this shared understanding, the patient in C2 must orient to the doctor’s unorthodox initial elicitation and understands that a response is expected regardless of the challenge to respond to such an accusatory elicitation, which may account for the less coherent manner in which it is rendered.

These data suggest that the evaluating doctors have a strong sense of the doctor’s role to redirect, guide, and set agendas as necessary to elicit information they think they need to make sense of the patient’s emerging narrative. This focus on the doctor as the manager of the interaction’s organization seemed more important than the relational talk (Fletcher, 1999), alluded to by one doctor as “idle chatter”, which was viewed as “friendly, but it doesn’t get you anywhere”.

## Discussion

These observations help us begin to consider the tension which exists between narrative theory, including NM, and the more pragmatic interactional approach to analysis (Schiffrin, 2006). The tension appears to lie between concepts of narrative and how medical doctors are trained to gather patient information. It seems that doctors are

trained in various ways to organize the medical interaction through the question-tree-review-of-systems approach. More recently, with the advent of Electronic Medical Records, patient templates further organize the medical encounter serving to structure clinical information to ensure patient data are not overlooked. In interaction 1 (A1), the doctor tries to gain a better understanding of the patient's current condition as a result of her fall three weeks earlier. He does this by asking a series of questions related to the nature of the fall and the nature of the pain she is still experiencing. The organization of interaction 1 (A1) appears to be acceptable to the evaluating doctors since none of them commented negatively. As illustrated in evaluating Doctor 4's comment above, the doctor in this interaction was perceived to be "on track". However, in interactions 2 (C1) and 3 (C2), the encounters were perceived as disorganized by some of the doctors surveyed. Interaction 2 (C1) appears *disorganized* (Doctor 5) and *all over the map* (Doctor 8), while C2 was *all over the place* (Doctor 10). Doctor 4 comments on C2: *If I hadn't read the chief complaint, I wouldn't have known what it was about*. These latter two interactions, which more closely resemble the NM approach, seem to be perceived as less organized than interaction 1 (A1), where more doctor control through elicitations takes place.

In interaction 1 (A1), although it is not known for certain that the patient agrees with the approach the doctor is following, there is no evidence of the patient challenging or attempting to redirect the encounter in a way that might better meet her expectations. The direction and guidance the doctor provides seems to satisfy the patient. The doctor seems to follow the patient who interjects a wide range of information as she tries to offer what she has and has not done as a way to explain her current condition. He may be exercising strategies characteristic of the NM approach in that he waits to hear what the patient has to say and then uses his expertise to determine what to explore further. In interaction 3 (C2), where the lowest question frequency exists, there is very little direction from the doctor. It is possible that this doctor is also exercising strategies consistent with the NM approach, or that he is simply letting the patient speak because in knowing the patient, the doctor is aware that it is important for the patient to feel that she has been sufficiently heard. This observation is important because it suggests that some situations in the medical setting may actually warrant less coherently rendered patient

narratives in order to satisfy the patient's emotional needs and the interpersonal relationship between doctor and patient.

### **Role expectation summary**

The role expectations imposed upon the doctor in a medical setting stems from Hippocrates<sup>21</sup> who established that the doctor was an authority figure and that the medical encounter was “an inherently unequal exchange” (Cordella, 2004b, p. 5). Even with a more contemporary understanding of the medical encounter, where patients are armed with information from the Internet (Eysenbach, 2000) and pharmaceutical company advertisements, and where a commercial model of medicine is used which views patients as customers, this unequal exchange still exists (Drew & Heritage, 1992; Koester, 2010). This asymmetry may be due to the fact that a doctor is viewed as someone who has the knowledge base necessary to remedy the patient's health concern. As illustrated in the evaluating doctors' responses, a doctor's “duty” may be one where they redirect, guide, and set agendas in order to serve the patient with a remedy since a patient presents as someone who cannot remedy their own health concern. This institutional ‘goal orientation’ (Drew & Heritage, 1992, p. 22) marks the doctor's control, in spite of the limitations presented earlier, and creates asymmetry. Although this asymmetry exists, a common aspect in the interaction is that doctors and patients both try to make sense of the patients' conditions. For the patients, it may be that this is achieved in response to, and sometimes, in spite of the doctors' elicitations. As presented in Chapters 4 and 5, this idea is important in that it attempts to equalize the participants to the degree that they are both seeking narrative coherence in order for the patients' concerns to be addressed.

This section has presented the substantive findings of Phase 2. Additional findings from the data are addressed below.

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<sup>21</sup> “But whoever does not reach the capacity of the illiterate vulgar and fails to make them listen to him, misses his mark” (Hippocrates, *On Ancient Medicine*, tr. F. Adams).

## 6.2.2 Additional findings

### 6.2.2.1 Additional finding 1

**Additional finding 1: The impact of the NM approach on evaluating doctors who had had exposure to the NM approach is apparent as they offer feedback on doctors' techniques.**

The numerical responses from evaluating doctors who had been exposed to the NM approach clustered more closely (1.7 range variation) than the responses of doctors who had not been exposed to the NM framework (2.7 range variation). The feedback responses for the questions ranged from 1 to 5 among interactions and questions, as illustrated in Table 6.5, which represents doctors' overall feedback response range.

### Support from responses to questions 1 and 2

Table 6.5 <i>Evaluating Doctors' Feedback Response Range to Questions 1 and 2</i>					
	All doctors in Perception Study			Evaluating Doctors with prior exposure to NM	
Interaction	Overall	Question 1	Question 2	Question 1	Question 2
Interaction 1 (A1)	1-4	2-4	1-4	3-4*	2-3*
Interaction 2 (C1)	1-5	1-4	1-3	3-4*	2-3*
Interaction 3 (C2)	1-4	1-5	1-4	2-4**	2-4**

\*The range for the doctors who had been exposed to NM (3 of the 12) prior to this study was almost always within one point ranging from either 2-3 or 3-4.

\*\*The only exception to this one-point range variation was the response to questions 1 and 2 for the third interaction, where the patient's narrative is mostly implicitly rendered and perceived as more difficult to identify and follow.

The doctors who had been exposed to NM prior to this study once again responded to the questions within a single rating point except for in interaction 3 (C2); this may begin to suggest that a background in NM may provide a more consistent frame by which to evaluate patients' narratives, although we might also attribute this finding to interpersonal style. Even though these doctors may each understand the value of hearing a patient's narrative, one doctor seemed to have a difficult time determining if the doctor in the interaction had used an elicitation technique that would gather the type of information perceived as necessary from the patient and rated the item as 2. This particular evaluating doctor questioned whether the doctor in the interaction was actually hearing the problem since the patient provided a lot of information as indicated in the response below.

- Doctor 3:
  - *Although a lot of words were heard, I'm not sure the problem was heard.*

This is an important observation in that it cautions us when identifying ways to measure features of NM in practice. Observing a doctor appearing to be listening to a patient is possibly a superficial demonstration of what is actually taking place (Ochs & Capps, 2001). However, in relation to interaction 3 (C2), this evaluating doctor's observation may be unfounded. In the earlier observations related to interaction C3 (eg. that the patient might know more about alternative medicine than the doctor: *you have more experience with some of the energy fields and tapping* [C2-203]), this particular doctor seems to be responding to the patient's comments appropriately, an indication that she was listening to the patient.

The clustering of evaluating doctors' responses may indicate that exposure to NM had given the three evaluating doctors a similar perspective on how to view narrative within medical interactions.

#### **6.2.2.2 Additional finding 2**

**Additional finding 2: The impact of the role of the institutional setting on medical interactions is considerable.**



The survey questions did not ask evaluating doctors for feedback relating to the role of the institutional setting and its potential impact on the medical interactions. In spite of this, when evaluating doctors were given the opportunity to explain why they suggested specific additional questions, some of their responses related to ways the institutional setting controls doctors' interaction with patients. This feedback connected doctors' elicitation type (open- or closed-ended in particular) to time constraints imposed by the medical setting, indicating the importance of the institutional context as a factor in the analysis of the discourse (Drew, 1992; Goodwin, 1990; Heritage, 2005).

### **Support from reasons offered by evaluating doctors**

#### *Doctors' elicitations are controlled by time constraints*

The perception among evaluating doctors was that time constraints control doctors' behaviors in relation to the types of elicitations they may use with patients, perhaps in contrast to what doctors were taught in medical school (to ask open-ended questions – see Doctor 5 feedback below) (Groopman, 2007; Roter, Cole, Kern, & Barker, 1990). Asking open-ended questions is perceived as too time consuming even though doctors indicated they would like to be able to use them. Therefore, doctors often rely on leading the patient through elicitations in order to access information they deem critical to understanding the patient's narrative and making a diagnosis.

- Doctor 5:
  - *3<sup>rd</sup> left the biggest impression on me I've been in situations like that where unfortunately the doctors are **pressed for time** sometimes and it just seems like what that patient was saying she seemed to get off on a tangent.*
  - *I think most doctors wish they could spend more time with patients than they're allowed to. (This interaction was 29.5 minutes) We're taught in medical school to **ask open-ended questions** say tell me about that is kind what we're supposed to say what makes it worse but I find myself finishing patient questions or sentences or asking them leading questions because of the pressure time pressure it's easy to slip into it's a struggle.*
- Doctor 6:

- *we don't want to interrupt we don't want to influence patients in what they're going to say but we know we **have limited time** I think we know **you have to be more direct** and cut them off so if it's say let's talk about 3 things especially in the 3<sup>rd</sup> one – what is bother you the most today. If there's one thing we can fix today – what would that be. If time left over – to address other things.*
- Doctor 9:
  - *You have days where you're willing to allow yourself to get more involved in patient narratives than others. **Time constraint** – or part a difficult patient remains on your mind.*

### Support from medical interactions

One example from interaction C1 shows the explicit connection between time and the medical appointment.

#### Example 7

*Context:* Routine medical visit. Patient B, Bess, a 73-year-old woman presents to her primary care provider with high blood pressure.

[C1-310-311]

- 1 D:           well we have an unusual little bit unusual for me situation  
2               where we have a little extra time to talk

In this example, the doctor indicates that there is *a little extra time to talk* (line 2) and initiates a discussion related to the patient's end-of-life wishes. It is not clear if there was indeed "extra" time or if discussing this topic was part of the doctor's agenda.

### Discussion

A leading healthcare communication researcher, Debra Roter, in conversation with Dr. Jerome Groopman, states, "If you know where you are going, then close-ended questions are the most efficient. But if you are unsure of the diagnosis, then a close-ended question serves you ill because it immediately, perhaps irrevocably, moves you

along the wrong track” (Groopman, 2007, p. 18). As helpful as this suggestion may be for many common cases, the problem with this advice is that the doctor’s level of certainty for asking closed-ended questions may be variable based on experience; this may lead to an incorrect diagnosis based on limited information, possibly related to time constraints. However, if in most cases this is sound advice, it supports the notion that the type of elicitation and the space provided patients not only shape patients narratives but, importantly, may also prevent the delay of chronic illness diagnoses (Creswell, 2005). In the three interactions presented to evaluating doctors, one had an apparent diagnosis related to a fall while the other two had known chronic illness diagnoses. Yet, interactions 1 (A1) and 3 (C2) were initiated with open-ended questions, while interaction 2 (C1) with a gloss-for-confirmation type question. The question type selection does not seem to be determined by whether the patient’s health concern was acute or chronic nor by the amount of time allotted for each interaction.

Nonetheless, a health care system is likely to have an impact on other aspects of the medical encounter. The length of appointment sessions is based on the presentation of concern typically made over the telephone and has been preset by what insurance companies will pay for the appointment (Groopman, 2007; Inglehart, 1992). This constraint restricts the amount of time doctors typically have to ask open-ended questions and offer patients more time to speak. There is also the added pressure from the health care system to create a working diagnosis with a diagnosis code to post to the patient’s record as well as a plan of action that will likely be covered by insurance; therefore, charting is critical. Doctors enter narrative information by selecting existing diagnosis codes and list more subjective information in a condensed, medically determined shorthand. Charting a patient’s narrative may be much more difficult and require more time and space on patient record forms than what the current standards allow. Also, clinicians are required to document the time spent to justify a billing code.

These observations demonstrate that the evaluating doctors are readily aware of the extent to which the institutional setting impacts what takes place in the medical interaction. The main constraint mentioned was related to time, which in turn, influenced their responses to the types of questions doctors ask or should ask patients in order to understand patients’ narratives.

### 6.2.2.3 Additional finding 3

**Additional finding 3: The extent to which patients were perceived to have been heard by evaluating doctors was not necessarily connected to the amount of “space” patients were offered by their doctors.**

The evaluating doctors were asked to rate the extent to which the patient was sufficiently heard in the interactions. The following chart represents the doctors’ responses.

#### Support from responses to interview question

Table 6.6 <i>Response to Question:</i> <i>On a scale of 1-5, 5 being the highest, to what extent was the patient sufficiently heard in the interactions?</i>	
Interaction	Feedback Rating
Interaction 1 (A1)	4,2,2,3.5,3,3.5,3,4,3,4,1,3 Range: 1-4 Range NM: 2-3 Median: 3
Interaction 2 (C1)	2,3,3,2,2,2.5,2,3,2,4,4,3 Range: 2-4 Range NM: 2-3 Median: 2.5
Interaction 3 (C2)	2,4,2,1,2,1.5,3,5,4,5,3,1 Range: 1-5 Range NM: 2-4 Median: 2

Table 6.6 shows that the evaluating doctors responses indicated that the patient in interaction 1 (A1) was perceived as being more sufficiently heard than the patients in the other two interactions. This high rating occurred in spite of the fact that the doctor had asked the most questions for the time allotted. Thus, the patient was given less “space” in which to render her narrative than the patients in interactions 2 and 3.

## Discussion

This finding is interesting in that the evaluating doctors' responses, which gave interaction 1(A1) the highest rating for the patient being sufficiently heard, suggest that their perceptions are impacted by how coherent they found the patient's narrative. Since the patient's concern was acute, and a more complete patient narrative is rendered in relation to the patient's presenting concern, it could be that the evaluating doctors concluded that the patient had been sufficiently heard. In contrast, in interactions 2 (C1) and 3 (C2) the narratives are less complete and coherent, leaving an observer with a sense that something is missing. Since the picture of what is taking place with the patient is not complete, the evaluating doctors may have perceived that the patients had not been as sufficiently heard as the patient in interaction 1 (A1). Also, in spite of the fact that in these two chronic case interactions the patients are given substantially more time in which to speak and render their narratives, the evaluating doctors rated the patients as having been less sufficiently heard. This may be another example of how relational talk (Fletcher, 1999) may not be viewed as important to the evaluating doctors as a way to elicit patient narratives.

## 6.3 Conclusion

This chapter presented the results of the data collected in Phase 2, which included feedback from evaluating doctors on the elicitation techniques used by doctors in the medical interviews for prompting patient narratives as they try to make sense of patients' conditions. Feedback from evaluating doctors helped answer the research question, *How do doctors evaluate the adequacy of patients' accounts of their illnesses for purposes of forming working diagnostic assessments and treatment plans?*

The substantive findings show that there is similarity in evaluating doctors' feedback specifically related to 1) the frequency and type of elicitations as doctors desired additional questions to obtain detailed patient information, and 2) the expected role of doctors, which should demonstrate control of medical interactions. Additional findings included the apparent impact of exposure to NM on evaluating doctors' feedback, the role the medical context has on interactions, and the extent to which patients were perceived as being heard by their doctors. These are some of the reasons,

which encourage or inhibit eliciting and hearing patient narratives in spite of whether they are rendered coherently or not. Importantly, the results also show how the evaluating doctors themselves engaged in constructing narrative coherence as they measured the adequacy of the approaches used in the interactions, even when challenged by less coherently rendered patient narratives. Perhaps this indicates the strength of the role of narrative in our lives.

Focusing on the doctors' techniques points to the fact that unpacking the complexities of medical interactions is an arduous task. NM as one type of clinical approach is hard to define and measure and has elusive, subjective qualities. When analyzing doctors' techniques, it is important to be able to identify elements that are observable and measurable. Since doctors' motivations and thoughts are not observable, we have to observe behaviors and interpret them in the light of what is known about available approaches. Regardless of the type of training the three doctors in the interactions being analyzed received, which may or may not have included NM, they each presented a different type of technique with their own individual qualities. The doctors, asking varying number of questions, may simply have developed these approaches based on their understanding of their role as doctor, their individual communication styles, and the constraints made by the institutional setting. They may have developed the narrative competencies necessary to evaluate the patients' narratives and to be able to make sense of less coherent narratives. These competencies coupled with the benefit of prior and shared knowledge of the patients' conditions may have afforded a higher level of success in assisting the patient than what is observable to the evaluating doctors. The important point here is that these doctors used the types of elicitations that they thought important to make sense of patients' narratives as they sought to care for the patient.

Although none of the evaluating doctors suggested that more space be offered to patients, they all indicated how important it is for doctors to listen to patients and to develop a strategy for listening to patients' stories (Charon, 2006; Roter, 2002).

Chapter 7 draws together the conclusion of this thesis.

## **Chapter 7: Conclusion**

### **“I can’t figure out why...” Constructing narrative coherence in medical encounters.**

#### **7.1 Introduction**

Chapter 7 presents a summary of this thesis, which considers the relationship between doctor elicitations and patient narratives. The chapter summarizes the key findings of the study as they relate to the research questions presented in the introduction. The chapter also describes how the findings contribute to professional discourse and medical communication, and presents considerations and implications for applied linguistics and health care communication. The final section suggests directions for future research.

Health care in the U.S. is pressurized by institutional and cultural expectations, constraining communication in medical interactions. The intention of this study was to explore the extent to which doctors’ elicitations and patients’ narrative inter-relate, drawing from applied linguistics and health care communication frameworks and research. When doctors and patients interact, the complexity of the interaction may prevent each participant from fully understanding the meaning of the patient’s narrative and how this story impacts the patient’s condition. Although there has been inquiry in this area, there is no previous research that analyses medical interactions through the interdisciplinary lens of sociolinguistics combined with NM. This emerging approach builds on research by Candlin and Candlin (2003), Drew and Heritage (1992), Frankel (2001), Gill, Halkowski, and Roberts (2001), Hall (2001), Heath (1986), Jones (2001), Korsch, Putnam, Frankel, Robinson, and Roter (1995), Sarangi, (2006), Tannen and Wallat (1987), and ten Have (2001). This research utilized these frameworks to offer a new perspective, which provides a window into understanding one aspect of the complexities of how participants present their stories and their identities in medical interactions through the construction of narrative coherence.

The research for Phase 1 was carried out in a Midwestern clinic in the U.S. Phase 2 research was carried out at a university-based medical center and a local clinic in the Southeastern region of the U.S. A number of theoretically compatible analytical approaches were used: 1) analysis of an existing corpus of medical interactions to

identify elicitation types and narrative elements, 2) discourse analysis of the interactions to identify ways in which identity construction and the role of narrative offer insight into medical interactions, 3) qualitative analysis of a questionnaire completed by evaluating doctors and 4) qualitative analysis of interviews with evaluating doctors.

A preliminary analysis identified particular interactional elements related to doctor elicitations and patient narratives. The purpose was to guide the selection of interactions based on data related to doctor-question frequency, used to help operationalize the “space” offered to patients when administering the clinical approach of NM. An important finding emerged from the discourse analysis and Phase 2 data: patients through narrative, and doctors through elicitations, develop narrative coherence as a means for understanding patients’ conditions and presenting aspects of their identity.

Although this analysis provides further support for the relevance of the power asymmetry in medical encounters, it also suggests ways in which patients can develop their narratives to construct themselves as active agents to their health benefit. It also offers a new perspective on how power might be interpreted within interactions.

## **7.2 Summary of key findings**

This section presents a summary of findings as they relate to the research questions, which framed the focus of the investigation on how patients employ linguistic processes to perform as active agents as they manage their health conditions. These questions are reproduced here for the reader’s convenience:

1. What is the relationship between doctor elicitations and the form of patients’ accounts of their illnesses?
2. How do doctors evaluate the adequacy of patients’ accounts of their illnesses during consultations for purposes of forming working diagnostic assessments and treatment plans?
3. What is the relationship between the features of the medical interactions (elicited by corpus analysis in Phase 1) and the doctors’ evaluations of the interactions (elicited by feedback analysis in Phase 2)?



With the primary objective of investigating the relationship between doctor elicitation and patient narrative, discourse analysis in Chapters 4 and 5 suggested that:

- patients and doctors seek to construct narrative coherence. The analysis of the discourse demonstrates how the frame of developing narrative coherence provides valuable insights on the interactional narratives as they are co-constructed by participants.
- patients dealing with chronic illness may have difficulty constructing coherent narratives; therefore, strategies for developing narrative coherence are important for both the patient and doctor when managing patients' chronic illnesses.
- in constructing narrative coherence, patients present important aspects of their identities as active agents in their health conditions. Through this performance, we see how patients position themselves, at times aligning with their doctors, and at other times distancing themselves from them as they negotiate an understanding of their illness and their identities in relation to it.

In support of this goal, Phase 2 of the data collection was used to gain insight from currently practicing doctors which revealed important aspects of how doctors, through constructing narrative coherence, develop their professional identity.

In what follows, I expand upon these findings as I present what was addressed in each chapter of the thesis.

Chapter 1 introduced the topic and provided the rationale for undertaking this study, focusing on the important role narrative and identity construction play in the medical encounter as a means for understanding patients' conditions. The intention of the research was to add to the sociolinguistic understanding of how patients tell their illness stories as they negotiate meaning and construct their identity as well as to improve medical practice. It was apparent from the onset of this study that a careful selection of theoretical and methodological frameworks was necessary to understand the complexity of the communication found in the occasion of medical encounters. The participants'

identities, the context of the institutional setting, the patients' health condition, and participants' prior experiences with illness and with each other contribute to this complexity. In consideration of these factors, interactional sociolinguistics and NM were identified as the most useful and relevant theoretical and methodological frameworks for this study. Chapter 1 introduced the research questions. Addressing these research questions helps to fill a research gap which intersects aspects of interactional language, the NM concept of "space", and doctors' professional identities. The knowledge gap exists due to the fact that both patients' and doctors' perspectives had not been previously researched utilizing the sociolinguistic and NM frameworks. Indeed, few sociolinguistic studies have made use of a medical framework, such as NM, or have considered evaluating doctors' perspectives. Additionally, NM is a relatively new clinical approach which has not been extensively explored.

The Literature Review in Chapter 2 described the varied approaches previously used from a wide range of research perspectives. This body of research, which draws on the areas of linguistics, sociology, and health care communication, has contributed to more recent understanding of the medical interaction as patient-centered. The review noted the lack of interdisciplinary studies used to understand medical interactions. The interdisciplinary and multi-model design of the current study was described, establishing it as a first attempt in analyzing doctors' elicitations and patient narratives through the frameworks of sociolinguistics and the clinical approach of NM, with inclusion of a clinical perspective from evaluating doctors. The outcome was an innovative approach in which the analysis was strengthened through the varied frameworks and triangulation of perspectives.

Chapter 3 presented the methodology for Phase 1, which was used to develop the context for the discourse analyses in Chapters 4 and 5. Chapter 3 introduced the participants and relevant aspects of the clinical settings and helped identify the initial doctor question types based on Heritage and Robinson's (2006) typology. The chapter established how "space" was operationalized by using doctor-question frequency, which was also instrumental in selecting interactions for Phase 2. The qualitative approaches were described for both the discourse analysis and the feedback from evaluating doctors.

This preliminary analysis helped to prepare the data for narrative analysis in Chapters 4 and 5.

Through the detailed analyses in Chapters 4 and 5, I identified and described an important aspect of the communication found in medical encounters, that both doctors and patients seek to develop narrative coherence, and in doing so co-construct patients' narratives and identity. This finding maintains that "we become who we are through discourse and social interaction (Scollon & Scollon, 2006) and offers a new frame by which interactions between patients and their doctors may be analyzed and better understood, contributing to both sociolinguistic analysis and health care communication. This analysis also helped determine "where" the narrative was being constructed. This "where" is not referring to the location of the participants, although the clinical setting certainly impacted the development of the narratives. "Where" the narrative is constructed refers to the multiple narratives being developed in a medical encounter. One narrative is constructed by the patient, another by the doctor, and a third narrative is co-constructed between the participants through their discourse. This third narrative is what is negotiated and co-constructed between participants, an important distinction for discourse analysts.

The discourse analysis using IS also showed that patient's narrative and identity are ephemeral in nature and are dynamic and continuously changing, even as core components may emerge as stable and constant over time (Eckert, 2008; Bucholtz, 2009). Constructing narrative coherence is a tool patients use to better understand themselves in relation to their health condition, which is particularly important when they are trying to understand what is occurring throughout the processes of chronic illness. With chronic illness, what is happening to patients is evolving moment to moment and they are challenged with the task of understanding their changing story and to describe it to others. Perhaps it is when dealing with the non-ordinary events related to illness, and particularly chronic illness, that we can more clearly identify this need to construct narrative coherence and its impact on telling our stories and presenting our identities. The expression, "*I can't figure out why*", uttered by the doctor in interaction C1 analyzed in Chapters 4 and 5, sheds light on one aspect of doctors' professional identity as one who constructs his or her task as attempting to understand patients more fully. It also aptly

encapsulates the challenge doctors face in making sense of what is going on with patients – when parts of stories do not align with prior knowledge of the patients’ condition and/or medical measurements such as blood pressure rating – in order to determine what is salient to patients’ conditions. This indicates the difficulty doctors have in helping patients manage their chronic illness as the condition constantly changes. Understanding all of these multi-layered aspects of medical encounters enhances the discourse analysis of interactions within this institutional context.

Analysis of these naturally occurring interactions demonstrated the complexity of interaction: that is, that health care related communication is sometimes seemingly “messy”. This was illustrated by the analysis of interactions C1 and C2. These interactions comprised less coherently structured patient narratives as evidenced by digressions and seemingly randomly organized patient information, which may not contain apparent cause and effect relationships to observers. The analysis suggested that although these narratives could be described as less coherent, they accurately captured how the patients maneuver through illness. Indeed, their lack of coherence could be seen as a way of indicating the challenge of living with chronic illness and how one’s identity is transformed by illness. Thus, these less coherent narratives may tell the part of the patient’s story which is so difficult to construct, that is, that living with chronic illness may be confusing and challenging to describe and that relating cause and effect is not always clear. This is also an important aspect of patient narratives to be considered by narrative and discourse analysts in that 1) less coherently structured, and at times, implicitly rendered narratives are worthy of analysis and 2) these types of narratives offer possibilities to understanding patients’ identity construction as they manage chronic illness.

The discourse analysis in Chapter 4 yielded the key finding of the “constructing narrative coherence” frame by demonstrating how doctors’ elicitations and patients’ narratives contribute to the construction of narrative coherence, offering insight into “how sociocultural knowledge enters into the ongoing negotiation of meaning between speakers” (Auer & Roberts 2011). This finding encourages a re-consideration of how discourse analysts might view power in the medical encounter.

In Chapter 5, the analysis focused on the strategies participants use to construct identity as they develop narrative coherence in interaction with each other. Important to this finding is the use of the constructing narrative coherence frame by the doctors in the interactions to develop their professional identities. In doing so, they also contributed to patients' construction of their identities through these co-constructed narratives.

While the discourse analyses in Chapters 4 and 5 were helpful in identifying the development of narrative coherence among the participants in the medical interactions, receiving feedback from practicing doctors added the "insider" medical perspective to better understanding these interactions. This feedback provided an additional layer of support for the analysis. Chapter 6 discussed how the evaluating doctors, using their medical frames of evaluation, measured the usefulness of elicitation approaches in gathering necessary patient information in the recorded interactions.

The first substantive finding in Phase 2 was that the evaluating doctors required additional questions eliciting more detailed information in spite of the sometimes high-question frequency represented in the interactions. This was an important finding especially in relation to the main purpose of the study, which was to intersect sociolinguistics and NM, with particular focus on the operationalization of "space". This approach offered a new perspective and contributes to the previous understanding of how elicitations and perceptions of "space" impact interactional language. Going into the study, I would have predicted that offering the patient more space would provide a context allowing patients to render more complete narratives satisfying their doctors' desire to understand their health condition. To the contrary, in spite of the varying amount of space, the evaluating doctors still sought more elicitations, indicating at least two important points: 1) the perception of the type and level of detail of patients' response is particular to individual doctors with their varied experiences and approaches to patient care and 2) shared knowledge between doctors and their patients may lead to the need for fewer elicitations than the evaluating doctors required.

Another finding is that the perceived expected role of doctors is to demonstrate control of medical interactions. The evaluating doctors' feedback included their perceptions of what they believed the role of doctors should be as well as their understanding of the patients' expectations of the doctor's role. This is an important

finding in relation to NM particularly when doctors might perceive that patients want them to “fix” the health problem. Offering elicitations might be one way that patients perceive doctors fulfill their role even as doctors attempt to ensure that their patients feel they have been sufficiently heard.

A third finding was the close similarity of doctors’ responses which seems to indicate the extent to which training and socialization impact doctors’ interactions with patients, with particular attention to NM. In general, there were similarities among the evaluating doctors in how they described aspects of the interactions such as in the doctors’ role as one who controls the interaction, allows the patient to speak, and “fixes” the patients’ problems. Their responses demonstrated a similar manner in which to express the relationship between doctors’ elicitations and patients’ narratives. This was particularly the case with their descriptions related to explaining doctor-patient roles, expectations for the medical encounter, and the type of information they perceived they needed in order to assist patients. Although the number of evaluating doctors with some level of previous exposure to NM was small, there seems to be a tendency indicating that NM training shapes the way doctors perceive patient and doctor roles and the importance of patients being heard.

The fourth finding was the extent to which the institutional setting plays a role in the interactional language between doctors and patients. The training and socialization of doctors through medical education and the specific requirements of medical settings impacts the communication doctors have with patients. The data from this study suggest that roles expectations, time allocation, insurance requirements, and record-keeping shape the approach doctors use to elicit patient narratives. Some of these aspects of patient care seem incongruent with the NM approach of viewing the patient’s narrative as critical to understanding who the patient is and what his or his health condition might be.

An interesting finding was the extent to which patients were perceived as “being heard” which was not connected to the amount of space patients were offered by their doctors. The evaluating doctors did not perceive that the patients were being heard to a greater extent simply because they had been given more space in which to speak. This suggests that being heard is more than being allowed to speak. Doctors’ feedback and acknowledgement of what the patient is saying and a connection to subsequent turns of

talk may be better indicators that a patient is being heard as their responses shape the interaction.

In addition, although I set out to gain evaluations from doctors about the elicitation approaches used in the selected medical interactions, I found that the evaluating doctors utilized the frame of constructing narrative coherence themselves, even as they evaluated the interactions in the study. This finding demonstrates the important role narrative plays in our lives in both daily and professional contexts.

The results from Phase 2 confirmed the findings from the discourse analysis: 1) that doctors utilize the types of elicitations they have been trained to use to gather necessary patient information, 2) that patients' narratives and identities are co-constructed through doctors' elicitations and patients responses, 3) that patients and doctors use the frame of constructing narrative coherence to make sense of patients' health conditions, and 4) that patients dealing with chronic illness may produce narrative which are less coherently constructed. Unless evaluating doctors had prior experience in NM, they proved not as likely to appreciate what the patient's narrative might offer and tended to view less structured patient narratives as less useful to patient care. Although doctors' training in the question-tree formulary and review of systems, used as a strategy for understanding patients' conditions, is necessary for the purposes of the institutional setting, it does not necessarily encourage the types of elicitations that allow patients "space" in which to speak. The approach also limits patient opportunity to offer information that may supplement the path of the standard question-tree formulary. The results suggest that doctors accustomed to this standardized approach may not be aware of information that might be left unspoken which could possibly be vital to the patient's condition. For those who have been trained in NM, the results explain why the approach might be useful as it relates to "reading" patients narratives with varied levels of coherence.

Stemming from the unique design of the study, the findings in this thesis contribute to the importance of interdisciplinary approaches, the reconsideration of how power is interpreted by discourse analysts, how interactional elements might be better understood by drawing from evaluating doctors' perspectives, and importantly, how patients' voices might be heard not only by their doctors, but also by informed discourse

analysts who seek to understand how patients' narratives and identities are constructed.

### **7.3 Implications and applications for DA and health care communication**

One central goal of this research was to explore the relationship between doctors' elicitations and patients' narratives for the purposes of enhancing sociolinguists' understanding of communication in medical encounters. The goal was to describe this relationship to discourse analysts and medical clinicians and identify particular aspects of the role that elicitations play in the construction of patient narratives and identity. The analysis demonstrated how participants develop narrative coherence from the initial phase of medical interactions and consistently continued throughout the encounter. Elicitations such as, *what brings ya in today* (interaction A1, line 1), which helps the individual identify herself as a patient through her presenting concern, and *tell me what that means* (interaction C7, line 3), which assists both patient and doctor negotiate meaning within the interaction, demonstrate the important role constructing narrative coherence plays to draw out dynamic patient narratives and identity through the entirety of these interactions. This is an aspect that might be recognized as important to discourse analysts and clinicians. The next section discusses the implications for discourse analysts, doctors, patients, and clinical practice.

#### **7.3.1 Discourse analysis**

This study offers a way for linguistic concepts to be interpreted and applied differently by merging the clinical approach of NM and sociolinguistics as a way to enhance discourse analysis of medical interactions. Further, accessing evaluating doctors' perceptions related to approaches for gathering patient information through the NM approach added a dimension of understanding medical interactions also not referenced in earlier studies.

The discourse analysis explored the ways patients and doctors express their desire to understand the patient's health condition. At times, this display of developing narrative coherence was explicit, as found in the example from interaction C7 in Chapter 4, "*Tell me what that means*". However, in many of the occurrences, the display was more implicit and required consideration of the context as resource for identifying the



construction of narrative coherence.

This analysis presented a richer picture of how participants' development of narrative coherence illustrated aspects of their roles, expectations, and identities. For doctors, more cooperation with the patient may be vital to their understanding of the interaction and how patients may respond to doctor elicitations. Patients use narrative to connect their illness experience with their understanding of self.

The analysis provides further evidence of how the power asymmetry between doctors and patients is instantiated and negotiated in medical interactions, an asymmetry which has been well documented (West, 1984; Mishler, 1984; Roberts, 1999). However, as doctors in their sanctioned roles exert control in the medical encounter, the evidence presented illustrates that doctors also seek to develop narrative coherence. This encourages a re-consideration of how this power differential is negotiated and interpreted by discourse analysts. Doctors' frequent elicitations may be as much a display of "humane medicine" (Charon, 1993; Kleinman, 1988; Mishler, 1984) as the approach of offering patients "space" in which to speak. This might be especially true if each doctor attempts to construct narrative coherence through elicitations in order to improve patient care.

Using different approaches to analyze the data has enhanced understanding of the interactions. IS brought to the analysis established methodology and concepts related to interactional language and identity; NM contributed a clinical perspective related to the exchange between doctor and patient. Feedback from evaluating doctors offered insight not possible from a linguist as analyst. Drawing from all three, I have presented a rich data set and an informed, interdisciplinary lens of analysis. Using this approach, the sociolinguistic concepts of narrative and constructing narrative coherence have been expanded. Although the multi-method approach is unique in this research context, I have presented a model of data collection and analysis that is also replicable for future studies.

### **7.3.2 Doctors and patients and clinical practice**

The analyses in this study support the claim that the frame of constructing narrative coherence may be useful to clinicians in 1) understanding how to approach patients for health related information, 2) describing to patients the purpose behind the

elicitation approach, and 3) understanding how patients are also attempting to develop narrative coherence as they respond to their doctors' elicitations.

The results of this study demonstrate that in order for doctors to make accurate diagnostic decisions while pursuing an understanding of the patient's story, they seek certain types of information, which are displayed through their construction of narrative coherence. The usefulness of elicitation approaches may be unclear to the patient. Doctors may enhance their interactions with patients by explicitly explaining the motivation behind elicitation approaches (Groopman, 2007). In doing so, patients may be persuaded to view the elicitations as efforts at guidance rather than interruptions and unwelcome displays of control over the interaction. This approach may further encourage patients to be more active participants in medical encounters.

Doctors may also gain additional insight into the concept of offering patients "space" in which to speak. This approach not only affords patients the opportunity to share important, relevant medical information about their conditions, but also allows them to develop narrative coherence. In doing so, doctors might understand that patients use narrative as a way to reconstruct their identities as they come to terms with illness, particularly chronic conditions.

This analysis has also shown the extent to which doctors may be patient-centered, viewing patients as shared decision-makers and experts of how they perceive their health conditions. As seen in an example from the study (from interaction C1), a patient on the verge of being diagnosed with diabetes may resist not only the diagnosis but also the identity of "a diabetic", which may have negative behavioral connotations. The impact of such a diagnosis on a patient's concept of identity may cause resistance and delay intervention. Describing this impact to doctors may offer them insight into how to further engage the patients in information-sharing and decision-making aspects of their illnesses. The clinician may do this by accommodating the patient to a certain extent when the diagnosis is first made, realizing that the patient is confronted with not only a diagnosis but also a marked transition in their identity construction when managing a chronic condition.

The analysis from this study also illustrated the paradox of utilizing the NM approach: offering patients more "space" in which to speak, especially when talking

about their chronic illnesses, may result in less coherently rendered patient narratives. This might mean that doctors who offer patients with chronic illnesses more time to speak need to develop narrative competencies in listening to less coherent structured patient narratives in order to determine what is salient to patients' conditions. The approach impacts the co-construction of the patient's narrative for both the patient and doctor.

This study has also shown that clinical practice may be adapted to better suit the type of communication necessary with patients who have chronic illnesses. As stated previously, the data analysis indicated that evaluating doctors who had previous training in NM responded to the interaction stimuli in a more consistent manner than those who had not been exposed to this clinical approach. The challenge to medical educators is to contextualize the NM approach and the concept of constructing narrative coherence into health care communication training. This may prove difficult given the constraints of the institutional clinical setting fixed by external expectations, norms, and requirements of the medical profession. The important focus would be on how to integrate such an approach in order to achieve better patient outcomes.

#### **7.4 Implications for future research**

While the main approach adopted in this study involved discourse analysis, the study also demonstrated the importance of taking an interdisciplinary approach in order to more comprehensively analyze medical interactions (Sarangi, 2006). In spite of the complications of such a research design, no single approach offers the scope necessary to understand the complexity of medical encounters. The outcome is a fuller understanding of what is taking place between doctors and patients in a clinical setting. An interdisciplinary approach also requires the analyst to orient to the world of medicine, challenging one's presuppositions about the role of medical personnel, institutional norms, insurance requirements, as well as one's own personal experience with illness and the world of medicine. Without consideration of such concepts, the analysis cannot show how the full context of the medical encounter may be used as a resource for analysis. Future researchers in this area may consider these factors and their importance to discourse analysis in order for the applications to be legitimized by the world of medicine

as well as sociolinguistics (Sarangi, 2006). Recognizing this, the following are suggestions for future research topics.

Gaining insight from the clinical perspective informs the discourse analysis with a perspective that cannot otherwise be gained as non-clinical discourse analysts. Further exploration of how to incorporate varied perspectives to more fully understand medical interactions would prove useful for real-world application of the DA findings. This approach would not only enhance DA but also clinical practice.

DA of how patient identities are co-constructed through the frame of constructing narrative coherence would further test the approach and its usefulness to discourse analysts. A focus could be on the way this frame forces a re-consideration of how we understand power asymmetry in order to apply it to discourse analysis. Although this study supports the argument that power asymmetry exists between doctors and patients, this frame may encourage another way to analyze this relationship in medical interactions.

This study captured a single episode of each of the 69 patients' long-term negotiation of chronic illness. Longitudinal studies would provide data on how patients' narratives may develop and be reshaped over time as they deal with chronic illness. Utilizing the NM approach for this type of study would offer a wealth of data and potential insight into how patients might develop strategies for constructing narrative coherence and making sense of not only their illness but also their identities as they cope with illness.

The current study used an existing typology of doctors' elicitations (Heritage & Robinson, 2006) and a well-established framework of narrative dimensions (Ochs & Capps, 2001). Studies encouraging the development of coding for the NM approach as well as for linguistic construction of narrative coherence would prove useful for future analysis of medical interactions that might focus on the connection of doctors' elicitations and patients' narratives and the NM approach.

A suggestion emerges from Phase 2 of the data collection, which indicated that evaluating doctors were trying to construct narrative coherence as they offered feedback. In doing so, they also demonstrated shared language to describe the relationship between doctors' elicitations and patients' narratives, particularly among those doctors familiar

with NM. Features of these descriptions included explaining doctor-patient roles, expectations for the medical encounter, and the type of information they perceive as necessary.

With any research study, larger samples and more comprehensive analysis are always more desirable. A limitation of this research is the relatively small sample size for Phase 2 data collection of 12 evaluating doctors. Although the number of participating evaluating doctors in Phase 2 assisted in addressing the research questions, it was too small to justify generalizations.

The research was also limited by the stimulus instrument used in Phase 2 of the study. Using abridged versions of interactions seemed the only reasonable way to present stimuli to evaluating doctors, given the time constraints on medical doctors. Obviously, presenting full medical interactions for evaluation is more desirable if it can be achieved.

The results of this study suggest that constructing narrative coherence in medical encounters is a useful paradigm for doctors and patients in interaction with each other. The study identifies ways each participant utilized this device as a resource for making sense of the patients' conditions. Identifying this aspect of the relationship between doctors' elicitations and patients' narratives will assist in future analysis of medical interactions as they relate to the clinical approach of NM. Research focusing on a more complete understanding of this relationship as it connects with NM will contribute to a useful inter-disciplinary approach, recognizing the significance developing narrative coherence may have on knowledge about medical interactions. Future research is necessary to help translate these findings into medical practice, medical training, and more informed discourse analyses (as suggested by Cordella, 2004b; Sarangi, 2006 among others).

Factors associated with constructing narrative coherence may become increasingly important in cultures where chronic illnesses are more prevalent. This has not been fully explored in the present study. Therefore, focusing research on chronic medical conditions with consideration to the NM approach offers many opportunities for future study. Further, focusing on specific chronic illnesses that are becoming more epidemic, such as such as diabetes or hypertension, would prove useful to patients and doctors alike.

Since the beginning of this project four years ago, more medical schools in the U.S. have incorporated curricula in NM (including Sarah Lawrence University and Vanderbilt University). The exact data on the number of programs is inconclusive as some NM courses are embedded in curricula while others have bonafide programs and degrees. This increase in the presence of NM in curricula has exposed doctors-in-training to the approach and the concept of constructing narrative competencies. This development provides more opportunities for understanding how the NM approach might impact the medical interaction from a sociolinguistic point of view.

The feedback offered by NZ doctors during the pilot study contrasted with that of the U.S. doctors to the stimulus (i.e. medical interactions conducted in the U.S.). The feedback seemed to relate to the interactional language in the encounters and involved the decision-making protocol, which is different in NZ. The U.S. protocol seems to be based more on insurance requirements. For example, one NZ doctor asked why the doctor in interaction A1, the acute case, had requested an x-ray of the patient's shoulder. The U.S. doctor in the interaction had discussed with the patient the arrangement for the x-ray and then later discussed the results. The NZ doctor went on to explain that there was no need for an x-ray for the likely outcome of the intervention. However, in the U.S. the procedure was considered necessary in order for the doctor to offer a definitive diagnosis code that would be indicated in the patient's chart. Without this diagnosis code, the recommended intervention of physical therapy may not be approved by an insurance company. This protocol is not necessary in NZ where the doctor could have called for physical therapy without the x-ray. This is just one example of how the language and functions of the medical interaction are shaped by culturally-specific, institutionally mandated procedures. Further, given the issue of liability, the doctor and the physical therapist in the U.S. often must have an x-ray result in order to start. This study was unable to capitalize on this cross-cultural difference in medical approaches related to culturally-specific, institutional policy, but the comments of the NZ doctors in the pilot study suggest this is a potential area for future cross-cultural research.

This study focused on native-English speaker to native-English speaker communication. How someone might tell their illness story with limited proficiency in the language of the physician and a low level of understanding of medical procedures

may be considered. In cases where clinicians are predominantly English speaking and the patient's native language cannot be used in the medical encounter, it is unclear how effective doctors' elicitations are in drawing out patient information and offering patients the opportunity to tell their stories. How might an understanding of the discourse of a co-constructed, interactionally-created narrative and the NM approach empower such patients? (See Eades, 2000 for a study on silencing Aboriginals in courts in Australia). Studies exploring the relationship between doctors' elicitations and patients' narratives in community and global health settings, where differing languages are used by doctor and patient, would prove beneficial for improving medical care in those contexts.

### **7.5 Conclusion**

The primary purpose of this study was to gain a greater understanding of the relationship between doctors' elicitations and patients' narratives in relation to the clinical approach of NM, which proposes offering patients "space" in which to speak. The secondary goal was to solicit feedback from evaluating doctors to add insider insight to the analysis.

The most useful finding from this study was evidence that doctors and patients appear to consistently seek to construct narrative coherence throughout medical interactions. This finding provides a discourse analytic frame from which to gain insight into how these participants co-construct patient narratives and identities, particularly in interactions pertaining to chronic illnesses. This finding makes an important contribution to the area of discourse analysis of medical interactions by creating this framework for analysis, which enhances our understanding of how patients' narratives and identities are co-constructed. The study provided insight into how through this process, doctors and patients present important aspects of their identities as participants situated in medical encounters.

It is important to keep in mind that breakdowns do not occur with every interaction. Effective interactions are generally not considered reportable, while stories of poor health care communication and litigious outcomes attract a great deal of attention, although they constitute only a minority of interactions. Health care communication is in a constant state of change due to new technologies and protocols and is being regularly

analyzed. As a result of such scrutiny, strategies for improvement are regularly suggested and reviewed. This thesis makes a contribution here. The analysis of the interactions indicates that the extent to which doctors and patients negotiate meaning, or construct narrative coherence, is an important aspect of the medical interaction. Using this frame, both doctors and patients are viewed as individuals in dynamic interaction with each other with the shared goal of understanding the patients' condition in order to remedy it. Although power asymmetry exists in medical interactions, patients can present their narratives to construct themselves as active agents. The clinical approaches described around the NM concept of offering patients "space" in which to speak highlights the importance of viewing these interactions as very personal, and sometimes, life-changing experiences. These personal interactions offer doctors and patients the opportunity to both learn from and inform each other. In doing so, each is offered the opportunity to construct meaning and understanding about themselves and the other.



## Appendices

### Appendix A: Transcription conventions

The transcription conventions for the transcriptions of interactions in this study are based on the conventions used in the New Zealand Language in the Workplace Occasional Papers 5 with minor alterations (noted in italics) as particular to this study. The following conventions are used.

#### Identifiers of Interactants

Patient	Pseudonym
Doctor	D

#### Times

The time the extract begins is noted at the beginning of the body of the transcript. Subsequent minutes are noted in whole minutes. The time the extract ends is noted at the end of the transcript.

#### Standard character set

a b c d e f g h i j k l m n o p q r s t u v w x y z

( ) [ ] : - + / \ ' ?

Alphabet Roman characters are used in lexical transcription and editorial comments. The hyphen indicates incomplete words and cut off phrases/clauses (although words are complete). Non-alphabetic characters are used to mark discourse features, editorial comments and their scope, e.g. [pause while writing] and [laughs].

#### Comprehension problems and/or transcriber doubts

Parentheses ( ) enclose doubtful transcription: untranscribable or incomprehensible speech.

The question mark (?) is used only to signal “question” where it is ambiguous on paper.

The hash/pound key (#) is used to signal the end of a “sentence” where it is ambiguous on paper.

#### Pauses

The plus sign represents a pause of one second. Four or more seconds is noted within parentheses.

### Noises

er, uh, um	represent hesitations
mm hmm	yes
uh huh	yes
uh uh	no
oof	reference to pain

### Non-standard Speech and Variations

okay	standard spelling (not ok or OK); <i>variation mmkay</i>
yeah	yes
yep	yes
ya	reduction of you
y'know	reduced contraction you know
oh	
gonna	pronunciation of going to
wanna	want to
musta	pronunciation of must have
'bout, 'em	reduced forms of about and them

### Simultaneous or Overlapping Speech

The slash is used to show simultaneous or overlapping speech:

// indicates start of simultaneous or overlapping speech in utterance of “current speaker”.

\ indicates end of simultaneous or overlapping speech in utterance of “current speaker”.

/ indicates start of simultaneous or overlapping speech in utterance of “incoming speaker”.

\\ indicates end of simultaneous or overlapping speech in utterance of “incoming speaker”.

Numbering is added where a speaker is overlapped more than once within a turn.

### Punctuation

No punctuation is used except for apostrophes. Apostrophes are used for contractions e.g. it's, *and* for syllable reduction in words e.g. 'bout reachin' for about reaching; 'em for them, etc.

### Numbers and Abbreviations

Numbers and forms that are usually abbreviated are written out in full

e.g. “seventy five” for 75

“saint” for St.

“missus” for Mrs.

**Appendix B: A1 Transcript**

1 :17 seconds Coding: A=Acute, 1= first acute, beginning-ending line #: [A1-2-276]  
2 Doctor: good morning  
3 Patient/ANN: hi  
4 D: how ya doin'  
5 ANN fine  
6 D: okay what brings ya in today  
7 ANN: well i was walkin'  
8 and i went to cross the street at the curb  
9 and my foot musta got caught in the curb  
10 D: okay  
11 ANN: there was a metal strip there  
12 i went later to look  
13 and i kind of flew out in the street  
14 and i put my two arms out to protect my body  
15 D: uh huh  
16 ANN: and um hurt this arm really bad#  
17 i knew when i got up it was just killing me  
18 i should've gone to the er  
19 and then by the time i got home  
20 i thought well it's probably bruised bad //ya know\  
21 D: /mm hmm\  
22 D: so you actually went down?  
23 ANN: oh yeah  
24 D: and and which arm is it that's hurting  
25 ANN: this one mainly  
26 D: okay  
27 1:00  
28 ANN: i hurt this a little bit but this one's pretty good  
29 it's this one //that\  
30 D: /okay\  
31 ANN: uh and how long ago was that missus s//  
32 D: three weeks  
33 ANN: yeah  
34 D: so what have you been doing to it in the //meantime\  
35 ANN: /i've\  
36 D: mm hmm  
37 ANN: rubbing that on it  
38 and that seemed to aggravate it more  
39 D: [laughs]  
40 ANN: and uh ibuprofen i took two hundred milligrams maybe twice a day  
41 D: twice a day  
42 ANN: //[mumbles]  
43 D: /you think\  
44 ANN: it [sigh] gave me a little relief

45 it didn't cure it but it gave me a little relief  
46 D: has it uh been swollen at all any place  
47 ANN: i can't tell that i'm so //heavy\ in that area that i can't //tell\ that  
48 D: 1/okay\1  
49 D: 2/it's hard to tell\2 um  
50 do you think it's any better now  
51 than when you first did it  
52 or is it about the same or is it worse  
53 ANN: i think it's better it just is aggravating to me  
54 D: okay  
55 ANN: because i have pain every time i do  
56 D: mm hmm  
57 ANN: even to fold clothes  
58 D: regardless of which way you lift it it hurts  
59 ANN: yeah  
60 D: okay does it hurt down into the arm or into //the\ fingers  
61 ANN: [mumbles] /yeah it hurts to the elbow\\  
62 ANN: to the elbow  
63 D: to the elbow  
64 ANN: 2:00 //right\  
65 D: /okay\\ have you ever injured that shoulder before  
66 ANN: no  
67 D: okay //uh\  
68 ANN: /you know\\ where it hurts too that i can't get over is across my shoulders  
69 D: //okay\  
70 ANN: /it's\\ almost like a whiplash  
71 D: really okay did ya are you aware which way you went down on it  
72 did you //fall\\ down on it this way or  
73 ANN: /i\\ i no this way i went on this arm mainly  
74 D: so you  
75 ANN: i hit both arms  
76 D: so you went right down on that //shoulder\  
77 ANN: /i\\ think right here [motions to left shoulder]  
78 D: okay  
79 ANN: i went down on  
80 D: all right uh can you lift your arm up above your head  
81 ANN: i can now but it hurts to do that  
82 D: okay when how long has it been uh since you've been able to do that  
83 i mean //is it\  
84 ANN: /about\\ a week [mumbles] i couldn't even wash under my arm it hurt that bad  
85 i couldn't lift it  
86 D: how about turning your arm over //does that\  
87 ANN: /i can\\ do that  
88 D: //that doesn't hurt\  
89 ANN: /my hand\\ my hand i can  
90 D: but but to try to //move\

91 ANN: / [sound of pain] \ that hurts  
92 D: okay all right so no old injuries to the shoulder that you know of  
93 ANN: no  
94 D: has the shoulder ever been x-rayed before  
95 ANN: no  
96 D: okay (4) [pause while writing] all right um and the ibuprofen helped a little bit  
97 but it's it's still not right  
98 3:00  
99 ANN: well i didn't know what to take  
100 D: no, it's a good //choice\  
101 ANN: /my son \ suggested //that\  
102 D: /that's\  
103 ANN: but it was only two hundred //milligrams\  
104 D: /yeah \ that's that's a good choice  
105 ANN: okay  
106 D: okay well um i think certainly today we're gonna wanna do an x-ray  
107 and check it out for ya and then decide if more ibuprofen  
108 or if something else needs //to be \ done  
109 ANN: /right\  
110 D: okay?  
111 ANN: okay  
112 D: um show me what you can do just lifting it on your own  
113 how high up can you go  
114 ANN: i can lift it but  
115 D: //not much higher than\  
116 ANN: /it hurts to do that\  
117 D: how about straight out ++ can you hold it out there + don't let me push it down  
118 ANN: [in pain]  
119 D: oof + that's real sore  
120 ANN: [mumbles]  
121 D: how 'bout reachin' behind your back //can you do\  
122 ANN: /that's hard \ to do i can do it i can make myself do it  
123 D: okay how 'bout the other hand can you do that  
124 ANN: yes i can  
125 D: that one's easy  
126 D: okay  
127 ANN: yeah  
128 D: now with your left arm just reach across the front ++ any pain when you do that  
129 ANN: //yeah\  
130 D: /where \ [patient begins to answer but doctor talks over her]  
131 now is this mostly up in the top here  
132 4:00  
133 ANN: it's really like here too  
134 D: and it's //right over\  
135 ANN: /uh huh\  
136 D: the side too okay how 'bout in here is that tender

137 ANN: yeah  
138 D: that's //sore\  
139 ANN: /here\\ it hurts in here  
140 D: right across the front  
141 ANN: yeah  
142 D: okay + it's sore in there  
143 ANN: mm hmm  
144 D: sorry + anything up in the muscle here  
145 ANN: yeah  
146 D: that's //a little\ sore too  
147 ANN: /a little\\ not bad but yeah when i lay  
148 D: okay  
149 ANN: the back and the  
150 D: tender back //here\  
151 ANN: /no\  
152 D: over the shoulder blade not bad  
153 ANN: no  
154 D: okay ++ back here?  
155 D: //no\  
156 ANN: /no\\  
157 D: how 'bout on the outside here is that sore  
158 ANN: a little  
159 D: and there?  
160 ANN: mm hmm  
161 D: a little bit okay  
162 ANN: right there  
163 D: right in there it's real bad okay+  
164 now i want you to try to reach across your is that sore  
165 ANN: [in pain] oh  
166 D: i'm sorry that's a real bad spot there //okay\  
167 ANN: /yeah\\  
168 D: all right# squeeze my fingers + hard as you can good okay  
169 can you put your arms up like this + can you push me away? ++  
170 okay this really hurts  
171 5:00  
172 ANN: mm hmm  
173 D: okay all right well let's do an x-ray  
174 and uh after the x-ray we'll decide if uh you just need more medicine  
175 maybe physical therapy could be helpful uh to help you exercise it uh  
176 maybe we need to have you see an orthopedic doctor  
177 we'll we'll just see what it looks like okay  
178 ANN: okay  
179 D: all right wait right here and rhonda will come get ya  
180 and then i'll be back in after your x-ray  
181 ANN: okay  
182 D: okay +++ [looks at patient's file] okay great

183 ANN: thank you  
184 D: be right back [leaves room]  
185 ANN: okay [waits, is in pain]  
186 [after x-ray has been taken]  
187 D: the separation here  
188 ANN: mm  
189 6:00  
190 D: at the uh at the collarbone where the collarbone meets the shoulder  
191 ANN: uh huh  
192 D: there's a little abnormality there now#  
193 we were trying to angle the the x-ray for a certain angle  
194 and we just couldn't get it quite right um  
195 but there looks like there's some, some separation# [drawls]  
196 um what i would suggest since it's been so long  
197 ANN: //right\  
198 D: /you know\\ three weeks is a long time and you'd expect it to be better by now  
199 why don't we have you see an orthopedic //doctor\  
200 ANN: /okay\  
201 D: and we'll set up an appointment for you over there at saint johns  
202 and um and they'll probably do er a different type of x-ray  
203 to see the the treatment options probably are just going to be  
204 to splint the arm for a little while //to hold\  
205 ANN: /that's fine\  
206 D: to sling it and and then have you do some physical therapy  
207 well they'll have you do that uh exercises and things like that + /um\  
208 ANN: //so\  
209 D: ibuprofen's a good choice and i'd i'd probably have you stay on that  
210 //and\\ just take a tad bit more  
211 ANN: /oh\\ okay  
212 D: what i'd have you do is take two of 'em three times a day  
213 ANN: okay  
214 7:00  
215 D: so four hundred milligrams three times a day  
216 ANN: //oh\  
217 D: /okay\\ that's that's that's kind of getting into the prescription strength  
218 ANN: //yeah okay\  
219 D: /uh\\ but you could just use the over the counter //kind\  
220 ANN: /i do\\  
221 D: just take two tablets three times a day  
222 ANN: okay  
223 D: so take six a day  
224 ANN: right  
225 D: um have you ever seen an orthopedic doctor over at saint johns  
226 ANN: uh uh  
227 D: okay well we'll uh we'll get ya an appointment and uh when you check out

228                   and get you over to see somebody by the end of the week  
229                   so they can kinda  
230 ANN:           okay  
231 D:              take a look at it and //decide\  
232 ANN:           /should\\ i have somebody drive me over there  
233 D:              you know how'd ya do comin' over here today  
234 ANN:           well it hurts when i drive but i can manage  
235 D:              well if you can get a ride that's fine but if you can manage i think that's  
236                   //fine too\  
237 ANN:           /okay\\ but i mean i won't be unable to drive home y'know  
238 D:              oh, with a sling  
239 ANN:           //yeah\  
240 D:              /that's\\ a good thought um ya know it's possible  
241                   so depending on what they wanna do to ya  
242                   so why don't you go ahead and get a driver  
243 ANN:           okay  
244 D:              uh we'll try to get ya in tomorrow or friday  
245                   and uh and then in the meantime just do the ibuprofen  
246 ANN:           okay  
247 D:              and kinda keep your arm down uh so it doesn't hurt too much  
248 8:00  
249 ANN:           you know i thought heat would help that but heat didn't help //that\ at all  
250 D:              /yeah and you\  
251 ANN:           it aggravated it  
252 D:              yeah right  
253 ANN:           and i get a burning sensation  
254 D:              well the ( ) you thought would help too and that was a good thought  
255                   //but it\ it didn't help at all  
256 ANN:           /that didn't help either\  
257 D:              yeah so let's see them and see what their thoughts are  
258 ANN:           //okay\  
259 D:              /and\\ and uh we'll get ya an appointment  
260                   uh i'll go make some phone calls for ya  
261                   and uh call me in the meantime if anything gets worse  
262                   but we'll get ya in there right away  
263 ANN:           okay  
264 D:              okay?  
265 ANN:           okay  
266 D:              sorry about all the x-rays today  
267 ANN:           no that's okay thank you  
268 D:              all right you bet# nice to see ya  
269 ANN:           same here  
270 D:              okay  
271                   [both leave room]  
272 D:              give you this to take up front  
273 ANN:           okay



274 D: ++ you're uh is it medicare and blue cross blue shield  
275 ANN: blue cross blue shield  
276 D: okay

**Appendix C: C1 Transcript**

1 :27 seconds Coding: C=Chronic, 1= first chronic, beginning-ending line #: [C1-2-555]  
2 Doctor: ya see that blood pressure  
3 Patient/BESS: it's always high //( )-\  
4 D: /i can't that's right\\ that's right we  
5 uh what is it we do uh  
6 BESS: that uh this is my this week's blood 1//pressure\1  
7 there are a whole bunch of other months blood 2//pressure\2  
8 and it it seems to be around in the one thirty to seventy  
9 D: 1/yeah\\1  
10 D: 2/yeah\\2  
11 D: that's right i it's  
12 BESS: all the time  
13 D: we uh we actually uh  
14 BESS: you monitored me  
15 D: we monitored yeah  
16 BESS: with a electronic monitor when was it last summer spring  
17 D: 1:00 yeah i remember now i'm sorry  
18 BESS: it's all right i'm sorry you don't believe me [laughs]  
19 D: well  
20 BESS: i know [laughs]  
21 i don't want to think i have high blood pressure [laughs] either  
22 but i really don't think i do but i do take medication  
23 D: ++ can't figure out why it would be on medicine  
24 why it would be elevated here and you  
25 let me check your let me review my notes  
26 BESS: because i suffer from uh anxiety about going to the //doctor\  
27 D: /to the doctor\\  
28 BESS: i think  
29 D: we actually sent did get you the home blood pressure monitoring didn't we  
30 BESS: sure i went over to the //main\  
31 D: /that's right\\  
32 D: that's right  
33 BESS: to the //main\  
34 D: /yep yep\\  
35 BESS: office there  
36 D: yep yep  
37 BESS: and i wore it for twenty four hours and  
38 D: end of problem  
39 BESS: okay let's hope [laughs]  
40 D: well um i'm not sure why you didn't get your chart here  
41 um it's always disconcerting for me  
42 because i always like to go over //things\ mammograms  
43 BESS: /why\\

44 BESS: why aren't the charts here when you see the patient  
45 that's one thing //i've always\  
46 D: /that's an excellent question\  
47 2:00  
48 BESS: i've always wondered about that [laughs]  
49 D: why is it that uh we can't get a chart system that works well  
50 a hundred percent of the time  
51 that's a question i put to the powers that be all the time  
52 BESS: really  
53 D: yep  
54 BESS: uh //you always-\  
55 D: /your chart\  
but what i need is see i keep fairly meticulous records  
56 and i have a little summary sheet  
57 that tells me when i ordered a mammogram and + then i think  
58 BESS: well then //who puts\ who puts the uh stuff in the chart  
59 you know i you know who is responsible  
60 for putting the the tests and all the results in there  
61 D: /i don't see it\  
62 honestly i don't know  
63 BESS: //yeah\  
64 D: /i mean\  
there's stuff there and i i go out and i  
65 BESS: you always go out there and look  
66 D: and i say i say i know i keep an up to date records  
67 why is it that i can't get a  
68 actually most of the time i do get it  
69 but when i don't get it it's still very disconcerting  
70 BESS: because it's been a long time [laughs] since i've had anything done  
71 3:00  
72 D: well tell me do you remember when your last mammogram was  
73 BESS: sure uh last spring or early summer i can't //remem-\  
74 D: /okay\  
75 BESS: and it was negative  
76 D: well i remember that  
77 BESS: and i had my eyes examined three days after christmas  
78 december twenty eight and uh they were very normal  
79 in fact the doctor said they were very [laughs] healthy looking uh that was  
80 D: good  
81 BESS: and uh [sighs] i have to get new sunglasses  
82 which i haven't gotten the prescription filled for  
83 but that's all i really needed to do  
84 D: good i noticed that i did a sigmoidoscopy  
85 BESS: and that was //normal\ that was normal  
86 D: /recently\  
that was normal  
87 D: good we have your heart records at least +  
88 and when i last saw you in november  
89 uh we talked a little bit about diabetes

90 BESS: [takes deep breath] i'm always hurting with that and i have lost weight  
91 your scales don't [laughs] i weighed myself this morning  
92 i weighed a lot less than than your scales say but i know i've lost weight  
93 uh i've been very trying to be very careful with my diet  
94 4:00 i do have one of those accu-  
95 D: check  
96 BESS: yeah but i hadn't i haven't done it over christmas  
97 i have i had to go out and buy strips and i haven't done it  
98 however i will agree for you to do a glycohemoglobin again um  
99 D: okay let's see  
100 BESS: you've been doing those and  
101 D: i know some of that it's just um [reading from chart]  
102 we gave her a script for an active and have her bring 'em in two months  
103 you didn't do that  
104 BESS: i didn't do that but i have a //machine\  
105 D: /i see that\  
106 BESS: it belonged to my daughter and i have to get new strips for it  
107 and we've had kind of a hectic family affair right now  
108 so I haven't really //got\ gotten around to doing it  
109 but if you  
110 if the hemoglobin the glycohemoglobin shows that i need to do it i will  
111 and and i have been trying to be careful about diet  
112 D: /okay\  
113 D: i'm sorry bess if the glycohemoglobin is a little bit elevated you're saying  
114 that then you'll check your-  
115 5:00  
116 BESS: i'll i'll go and get the strips  
117 they cost forty dollars a bottle [laughs]  
118 D: oh do they  
119 BESS: yes [laughs]  
120 D: ++ that's a lot  
121 BESS: it is a lot and i don't think anybody pays for it [laughs] so  
122 D: well  
123 BESS: i don't mind i can afford it y'know i just  
124 D: well forty bucks is forty bucks  
125 i mean i'd think twice about forty /bucks\  
126 BESS: /[laughs]\  
127 D: and i'm not retired yet  
128 BESS: right [laughs]  
129 D: (4) [flips through file] you you are just being carried by medicare  
130 is that right  
131 BESS: that's //right\  
132 D: /so you\ so you pay for it  
133 BESS: i do pay for it and i can afford to pay for //it\  
134 D: /well, I know you can\  
135 BESS: i'm willing to //do that\

136 D: /yeah\\ forty bucks is forty bucks  
137 actually the curious thing is medicare now pays for it  
138 BESS: the strips the machine the machine my doctor er my daughter used  
139 when she she had a baby four years ago  
140 and she was having to watch her sugar  
141 1//and uh\1 her insurance paid for it 2//but uh\2  
142 and and i borrowed it from her and i did use it when i saw dr ( )  
143 after the first time i came here i was using it  
144 D: 1/let me\\1  
145 D: 2/um okay\\2  
146 6:00  
147 D: we're going to make this very simple  
148 BESS: mm hmm  
149 D: you drive  
150 BESS: sure  
151 D: let's have you come in fast each morning  
152 BESS: you want to do that okay  
153 D: yeah i i'm not going to spend your forty dollars when we  
154 when it would be easy for me to send you out and have all that stuff done  
155 but what i really need to do is do a glycohemoglobin which i'll do  
156 when i bring you back for your fast and you'll come in nothing by mouth  
157 after midnight and i want to know what your fasting blood sugar is  
158 BESS: okay  
159 D: because if it's normal i may still tell ya to watch your diet  
160 but i'll be able to reassure you that  
161 by the current criteria you don't have diabetes  
162 BESS: i don't think i do but i i mean i know i'm borderline  
163 and it seems to be related to my gaining weight //uh\ and losing weight  
164 and i was on diabea when i saw another doctor before i came here  
165 D: /of course\\  
166 7:00  
167 D: yeah i remember but you got your blood sugars would get really low  
168 BESS: //and i would have a lot of\  
169 and i would have a lot of blood sugar blood sugar reactions  
170 D: /even on a low dose\\  
171 D: all right  
172 BESS: and uh but you want now when do i come in  
173 D: whenever you want  
174 BESS: but i'd have to be early [laughs] //to be\  
175 D: /eight thirty\\ i mean i think that we draw after eight thirty  
176 BESS: okay  
177 D: but if you don't mind //nothing by mouth\  
178 BESS: /i don't mind\\ doing any of that  
179 i don't even //mind\ buying the the test strips  
180 D: /don't\\  
181 don't save your money for something else

182 BESS: all right okay you're gonna do the fasting and the glycohemoglobin  
183 at the same //time\  
184 D: right  
185 BESS: you're gonna draw the blood for that  
186 D: they're not gonna stick you twice  
187 BESS: well i don't mind being stuck [laughs] either  
188 uh now what's my cholesterol and vitamin  
189 y'know i think you checked it in the beginning uh i just wondered  
190 D: let me pull it up on the machine because again  
191 if normally i run it on my own records but i don't have my own records  
192 BESS: i think it was two thirty two when they did it when i first //came\  
193 or something like that  
194 D: /yeah\  
195 8:00  
196 D: let me see let me see if i can pull it up on the computer  
197 BESS: the reason i ask is we are on a big cholesterol thing in our family  
198 my husband had a triple bypass  
199 D: //recently\  
200 BESS: /seven\\ years ago and his doctor has now got him on lipitor  
201 and he's been on mevacor and his  
202 and we're very careful about diet i am  
203 D: good  
204 BESS: and uh his his is within normal range  
205 D: hold on for a second let me see should be tests done (4) [flips through file]  
206 bess why did why did your daughter um have to-  
207 BESS: because they were they were concerned  
208 that uh her her blood sugar was going up  
209 D: so they want you to-  
210 BESS: it never went uh to the state with them  
211 it was always sorta within high normal range  
212 9:00  
213 D: mmkay well let me see what i can pull up on the computer  
214 if not what we'll do since you're coming in fasting  
215 we'll just recheck it then  
216 BESS: fine if you're gonna draw blood from my vein  
217 D: let me see if i can pull it up i'll be right back  
218 BESS: sure i think it was 1//i don't\1 two thirty 2//something like that\2  
219 D: 1/well\\1  
220 D: 2/okay\\2  
221 D: let me see  
222 BESS: mmkay  
223 10:00 [doctor leaves room patient waits 9:20-10:15]  
224 D: it must have been checked before the computer i saw had the records  
225 because i i just went back let's just do a fasting a fasting  
226 BESS: //( )\  
227 D: /well i mean when you\\

228 BESS: the cholesterol too yeah  
229 D: yeah  
230 BESS: okay all right i'm not concerned about it  
231 but it seems to be a big interest now in everybody's //lives\  
232 D: /well\\ it's been a big interest for //um\ at least five  
233 or well at least ten ten years um [sighs] (4) you are seventy four is it  
234 BESS: //a long time\  
235 BESS: mm hmm i'll be //seventy four\ in may  
236 D: /seventy four\  
237 D: uh i think that when a person has high blood pressure  
238 we pay a little bit more attention to their //cholesterol\  
239 BESS: /yes i know you do\  
240 D: if they've had a heart attack we really //pay\ attention  
241 11:00  
242 BESS: /oh yeah\\ that's what my husband has  
243 D: uh to it um and as a seventy four year old woman who's just fine  
244 and whose cholesterol is two thirty to two forty [sighs]  
245 well is really a tossup as what 1//to do\1 but let's do the test  
246 //and then\ decide what we need to do  
247 BESS: 1/mm hmm\\1  
248 BESS: 2/see how it goes\\2  
249 BESS: okay i notice when my husband's lab tests come back  
250 they now have lowered the normal level  
251 from a hundred forty to a hundred ninety nine  
252 and i can remember when it used to be  
253 1//uh three\1 yeah they they list the normals you know what his are  
254 and what the range of 2//normal\2 desired normal yeah total  
255 hundred and forty to a hundred and ninety nine  
256 is supposed to be the normal range  
257 D: 1/when your husband's cholesterol level comes back\\1  
258 D: 2/the desired or the\\  
259 D: what's his now  
260 BESS: well his is a hundred and ninety seven [laughs] the last one  
261 but they do them every since he's on lipitor  
262 they do 'em every uh two months i guess  
263 12:00  
264 D: in someone like your husband we we really look closely at the so called ldl  
265 /and that should be less\\ and that should be less than a hundred  
266 the ldl not the total cholesterol  
267 BESS: //i know and the triglyc-\  
268 BESS: that's okay his is i forget what his ldl is  
269 so triglycerides are also important aren't they in making  
270 in contributing to the ldl i've read  
271 D: that is correct  
272 BESS: mm hmm

273 D: so if someone has very high //triglycerides\ [sighs]  
274 well it it makes it difficult to measure the ldls i think  
275 BESS: /then they worry about the ldl\  
276 BESS: if if the triglycerides //are\  
277 D: /are\ very high like six or seven hundred  
278 BESS: no his are not ya'know everything's within normal  
279 but it seems to me you can't get low enough [laughs]  
280 to make everybody happy  
281 D: well someone with an 1//established\1 coronary disease  
282 you want the ldls to be less than a hundred  
283 and in someone like you  
284 we like them to be less than a 2//hundred and forty\2  
285 certainly less than a hundred and sixty  
286 BESS: 1/oh yeah\1  
287 13:00  
288 BESS: 2/mm hmm\2  
289 BESS: i don't remember when you did a complete when you did it  
290 D: well i just don't have it here  
291 BESS: okay  
292 D: it's embarrassing for me but i just don't have everything  
293 BESS: well we'll do it and //we'll see\ then i can worry about that [laughs]  
294 D: /um\  
295 D: (4) [flips through file] it it behooves us to redo 'em  
296 BESS: okay  
297 D: well how are things otherwise  
298 BESS: i'm fine really i feel fine i have no real  
299 i have arthritis and i got stiff fingers and my knees hurt but //i don't\  
300 D: /is it\ serious enough to interfere with your activities  
301 that you decided to do  
302 BESS: no i do everything uh i walk i do all my housework i do all my gardening  
303 y'know i just am slower and  
304 and uh not as anxious to to uh take on tough things but i do it ++  
305 and i take um really just tylenol for arthritis pain  
306 and i get loosened y'know i loosen up after i get up in the morning  
307 14:00 and i only take one tylenol extra strength tylenol in the morning  
308 and it goes away usually  
309 D: well we have an unusual little bit unusual for me situation  
310 where we have a little extra time to talk  
311 and i wanted to bring up something i just again i wish i had my own notes  
312 cause i they are generally pretty good  
313 do you have a living will  
314 BESS: yes i do  
315 D: have you have you given me a copy of it  
316 BESS: well our lawyer drew it up for us and we had those papers uh  
317 D: bring it in sometime maybe for me  
318 BESS: okay sure



319 D: and your wish is pretty clear  
320 BESS: i think so i think we've taken care of y'know all those important things  
321 D: i'm not asking you this because i expect you to keel over dead  
322 BESS: no i [laughs] it's just a good idea to have it  
323 we we we did make a will a couple years ago  
324 and all those things are taken care of  
325 you want a copy huh  
326 15:00  
327 D: now this is not your i'm talking 'bout a living will  
328 a sort of advanced we call it advanced directives  
329 where if you were to have for example  
330 uh a diag let's say god forbid a diagnosis of cancer  
331 and it spread to your brain and you went into a coma  
332 //what\ would you want your husband  
333 BESS: /yeah it takes\<\  
334 it mentions all those things  
335 D: right that's good  
336 BESS: okay we had ours already drawn up i know  
337 D: yeah it would help me to know it it happens  
338 especially as you get on in years  
339 when people come in and and uh things happen  
340 and then it always //helps me\  
341 because the person on call calls me and says well what does mrs jones  
342 what would she want  
343 well i talked with her  
344 and she said if she had a an illness  
345 from which there was no reasonable hope for recovery  
346 to a full independent life  
347 then she wouldn't want heroic measures  
348 BESS: /to know what to do\<\  
349 i that's exactly the way we //feel\  
350 D: /it helps\<\  
351 BESS: /sure\<\  
352 and that sometimes can happen uh  
353 nobody wants to to be kept a vegetable [laughs] for any length of time  
354 16:00 + uh i just don't yeah it's nothing to look forward to  
355 D: + you mind if i get a little specific cause it does it does help me  
356 i'm asking this again not because i'm terribly worried //today\  
357 but just because [looks at watch] we've taken care of some business  
358 and can get on to some of the more general aspects of care  
359 what's an unacceptable what would an unacceptable life be for you  
360 BESS: /[laughs]\<\  
361 BESS: well it would have to be kept on machines to have lost my mind y'know  
362 i have no hopes of uh + of being a y'know a functioning rational person  
363 y'know dependent y'know bedridden any of that

364 would would be unacceptable with no hope y'know  
365 when you know there you have something that you can't recover from  
366 D: how 'bout a devastating stroke 1//in which you were-1  
367 2//you couldn't speak\2 or 3//couldn't feed yourself\3  
368 17:00  
369 BESS: 1/that's another one\\1  
370 BESS: 2/that's a\\2  
371 BESS: 3/that's another one\\3  
372 D: maybe you're aware of what's going on  
373 BESS: i still wouldn't want to be kept alive  
374 and neither would my husband  
375 and neither would my kids really i think //it's all\  
376 D: /no\\ these are appropriate responses you're giving me  
377 that's what people often say  
378 BESS: yeah now sometimes i don't think i'd change my mind [laughs]  
379 if it //happened\  
380 D: /people\ do you know  
381 BESS: i know they do and  
382 //chil-\ and children do y'know children don't wanna see their parents die  
383 but y'know they we're all gonna die sometime  
384 and there's a such a thing as a quality of life  
385 D: /( )\\  
386 D: i agree ++ if if if you had a stroke in which you were awake  
387 but you couldn't 1//communicate\1 and but you couldn't feed yourself  
388 would you want a 2//feeding tube\2 put into your stomach 3//if\3  
389 if that were the only way to 4//really nourish you\4  
390 BESS: 1/that's another bad one\\1  
391 BESS: 2/no\\2  
392 BESS: 3/no\\3  
393 BESS: 4//no + not that\4  
394 D: these are the specifics bess that sometimes people never go into  
395 18:00  
396 BESS: mm hmm well if you don't  
397 well nobody wants to think that they're gonna die [laughs]  
398 but they are [laughs] and we all have to  
399 D: very perceptive  
400 BESS: [laughs]  
401 D: it's true ( )  
402 BESS: and it's easy to say it when you don't  
403 when you aren't expecting to be dying soon but you never know y'know  
404 you got an accident you could be in an accident ++  
405 D: that's true  
406 BESS: mm  
407 D: okay well that helps me i mean y'know ya you can be specific  
408 but up to a point only and then and then you have to get sort of a sense

409 that's most important to communicate to your husband  
 410 and to your kids the gist of //what-\  
 411 BESS: /i know they know\\ we talk about it  
 412 D: have you have you had that conversation  
 413 i can't tell you the number of times  
 414 that it's just made the family the children and the husband or the wife feel  
 415 so much more relaxed about saying no  
 416 y'know my mother lived a long full life  
 417 and she never would want to spend the rest of her life in a //nursing home\  
 418 and um so let's not put in a feeding tube  
 419 and it's a it's a nice step in that sense without a lot of anguish  
 420 i mean there's sadness but there's no anguish about what you do  
 421 19:00  
 422 BESS: /no no no\\  
 423 BESS: and i think doctors maybe in past years used to be feel obligated  
 424 to keep people alive when uh  
 425 because they're supposed to be keeping people [laughs] healthy and alive  
 426 but it's it's a waste of money and it's a waste of all kinds of //things\  
 427 D: /you're on\\ very dangerous territory  
 428 BESS: [laughs]  
 429 D: when you start talking about a waste of money uh  
 430 BESS: i know  
 431 D: i mean that's precisely what a lot of older people are concerned about  
 432 when people start asking well what you do want done  
 433 what they're really //saying\ is  
 434 we want to save medicare ten thousand dollars  
 435 BESS: /now\\  
 436 BESS: no in fact i think i think a lot of people are on medicare  
 437 20:00 who can't afford to be paying for their own uh health problems  
 438 D: what do ya mean  
 439 BESS: well y'know people  
 440 i don't know that everybody who's in a higher income bracket  
 441 shouldn't be paying more  
 442 D: oh i see what you're saying you mean that's  
 443 that's what they're talking about 1//doing is\1  
 444 is 2//having\2 the upper middle class the middleclass 3//[mumbles]\3  
 445 BESS: 1/i know\\1  
 446 BESS: 2/and\\2  
 447 BESS: i don't think there's anything wrong with that  
 448 BESS: 3/i don't think\\3  
 449 BESS: i don't think that's anything wrong with that uh  
 450 D: [tapping writing instrument on table] + up to a //point\ up to a point  
 451 BESS: /sure\\  
 452 BESS: but medicine has changed so much y'know i can remember  
 453 when health insurance [laughs] first 1//came in\1

454 2//blue cross and blue shield\2  
 455 and i'm not sure that the insurance hasn't changed things  
 456 sometimes for the worse [laughs]  
 457 D: 1/i know\\1  
 458 D: 2/i know\\2  
 459 D: in what sense  
 460 BESS: oh i think the cost the medical costs have gone up because of it  
 461 //and uh\ and people expect to be reimbursed for things  
 462 21:00 they might have not have taken care of [laughs] on their own  
 463 D: /that is true\\  
 464 D: well when did your parents die  
 465 BESS: my father was dead at sixty five  
 466 and he had hodgkin's disease uh  
 467 and he my sister's an rn  
 468 and for the most part when we realized that nothing was going to help  
 469 y'know uh she decided we'd keep him at home and he died at home  
 470 D: well i ask that because there was a time before medicare  
 471 when older people +++would be financially devastated by 1//health bills\1  
 472 so i think medicare as an insurance  
 473 2//has been a\2 a wonderful 3//uh program\3  
 474 BESS: 1/oh sure and they were\\1  
 475 BESS: 2/oh it's it's\\2  
 476 BESS: 3/it's sure and i\\3 [laughs]  
 477 22:00  
 478 BESS: that's what we use to but i don't mind paying more for things  
 479 [doctor drops writing instrument] that medicare doesn't cover  
 480 uh my mother did have to go to a nursing home  
 481 my mother lived to be eighty two  
 482 and she was in a coma the last couple years of her life and had bedsores  
 483 and y'know and didn't know anybody  
 484 and it was uh not any kind of a life  
 485 D: yeah +++ most civilized countries provide adequate health insurance  
 486 BESS: oh i know they do  
 487 D: y'know 1//in europe\\1 2/they're always worried about\2  
 488 the universal coverage  
 489 BESS: 1/i know they do\\1  
 490 BESS: 2/i\\2  
 491 BESS: i know  
 492 D: now i think they don't do as much  
 493 they don't they don't put all these people in the intensive care units  
 494 in europe that we do we americans and this is changing //( )\  
 495 BESS: /i think\\ a lot of people expect it yeah  
 496 D: keep people alive 1//uh\1 despite themselves 2//but\2  
 497 but they have a pretty good system of health care for everybody in europe  
 498 and it costs money and people pay expect to pay a lot in taxes  
 499 BESS: 1/yeah\\1

500 BESS: 2/sure\\2  
 501 23:00  
 502 BESS: sure and they do in england and //scandinavia\  
 503 D: /france germany\\  
 504 BESS: yes they do but they do have good coverage i guess  
 505 D: they have very good coverage and they are appalled at  
 506 as they contemplate what happens in the united states  
 507 BESS: i know they are [laughs]  
 508 D: the problem here in the united states is people don't wanna pay more taxes  
 509 they're used to relatively 1//low taxes\\1  
 510 2//can't have it both ways\\2  
 511 BESS: 1//i guess\\1 uh we have friends who are  
 512 BESS: 2//i know you can't\\2  
 513 we have friends who are canadians and of course  
 514 they have very good national health 1//insurance\\1  
 515 and they're never they never complain y'know they they give us  
 516 they pay high taxes on things like 2//alcohol\\2 [laughs] and cigarettes  
 517 D: 1/( )\\1  
 518 D: 2/do they\\2  
 519 BESS: very high  
 520 D: so they're paying five dollars a pack  
 521 BESS: a lot and alcohol is very expensive but anyway they think it's worth it  
 522 and they really think they get and these are people we know are wealthy  
 523 y'know they're well to do they have good jobs and 1//good incomes\\1  
 524 they support 2//the national\\2 health care  
 525 and they love to bash up here [laughs] this country a lot of times yeah  
 526 24:00  
 527 D: 1/but they very much\\1  
 528 D: 2/support the\\2  
 529 D: anyway let's go ahead i'm gonna what i'm gonna do is write  
 530 um for the blood test which means that when you come in  
 531 you can be able to say  
 532 well peter uh wrote down the tests that he wants ordered  
 533 they'll pull your chart [laughs]  
 534 you'll say well how will they have done it um they don't  
 535 you can page me um  
 536 and then i'd like to see you back after the tests have been done  
 537 and let's just go over them  
 538 BESS: okay and i can do this anytime  
 539 D: anytime ah eight thirty after eight thirty in the morning  
 540 BESS: okay  
 541 D: nothing by mouth after midnight i suppose you can have coffee  
 542 but don't put //sugar\\ or cream in it or anything  
 543 BESS: /i've\\  
 544 BESS: i've done the fasting //stuff\\ a lot of times [laughs] so i can do it  
 545 D: /all right\\

546 D: i'll put your chart in when you go out there  
547 BESS: okay  
548 D: i'm sorry they don't have your records it's always embarrassing  
549 BESS: that's all right that's all right  
550 D: you know i'm used to it  
551 BESS: yes i think that's part of the system here [laughs]  
552 D: right have a seat out there i'll get them  
553 BESS: yeah okay  
554 25:00  
555 [doctor and patient leave the room]

**Appendix D: C2 Transcript**

1     2:10            Coding: C=Chronic, 2= second chronic, beginning-ending line #s: [C2-2-611]  
2     Patient/CARA: michelle we gonna be on candid camera  
3     Doctor:        i think it's more looking at me than at you so that's the purpose of it  
4     CARA:          well  
5     D:              um what can i do for you today  
6     CARA:          well i did have a rough several months  
7                      i feel better than i was when i was in here  
8                      y'know with the fatigue still exists  
9                      i ended up having to have the surgery done  
10    D:              uh huh  
11    CARA:          well i had one tooth er root canal  
12                      and then uh the sack was not healing  
13                      and that's what was happening  
14                      so the end of august i think it was the thirtieth of august  
15                      he did um he cut up in here  
16                      and cleaned it the nerve and everything  
17                      and i purposely waited to make an appointment with you  
18                      because i knew my body needed so it's needing  
19                      within the maybe like about the past week  
20                      it's not been real tender but my y'know  
21    3:00              it's just really flared up my pollen  
22                      my allergies are just something fierce  
23                      and uh so i'm i'm //feeling\  
24    D:              /what have\\ you been doing with the prednisone idea  
25    CARA:          i'm i'm i'm still on the two prednisone  
26                      and i i know i'm gonna have to have to be on that  
27                      y'know i was able to go on back down to the one y'know you said like three  
28                      whatever it was and and  
29    D:              //but you decreased it for a couple of weeks\  
30    CARA:          /right\  
31    D:              and it seemed like things //were\  
32    CARA:          /and um\\ i don't think i can do without the prednisone  
33                      even though it's two milligrams i know that  
34                      but increasing the prednisone is not the answer and  
35                      and it did need i did need  
36    CARA:          1//that\\1 boost me over the the infection  
37                      about the past three weeks  
38                      i just don't think the trazodone is holding anymore  
39                      and i don't think i need to go up on it  
40                      is there a substitute because i've been on it since november  
41                      and it's it's done well but i have had rectal symptoms  
42    4:00              i'm waking up at night sometimes  
43                      uh my arms have been  
44                      the other night i just woke up i was numb all the way down

45 and i was on my back and it wasn't that i was  
 46 and i'm waking up at least two or three times during the night and  
 47 and sometimes trying to get comfortable going to bed  
 48 once i can go to sleep  
 49 and i really don't think it's the pain  
 50 as much as that i'm not getting enough 1//sleep\2  
 51 D: 1/mm hmm\\1  
 52 D: 2mm hmm\\2  
 53 CARA: so that's that's one thing i have been  
 54 have you ever heard of a doctor righteous callahan  
 55 in eighty five he came out with a technique  
 56 that cures phobias  
 57 were you ever aware that thought field therapy  
 58 D: i mean i've heard //but\ i wouldn't know this particular person //or\  
 59 CARA: /okay all right\  
 60 CARA: /right\  
 61 CARA: but he he discovered he's a psychologist  
 62 in eighty five he came out with the the technique  
 63 and anything that i can do holistically in the energy fields you know  
 64 i i work on  
 65 so about um it was the end of august um  
 66 i took a little y'know course  
 67 5:00 and it's it's a tapping technique but what i found  
 68 it does help with  
 69 it does help with the phobia cause i got rid of my abnormal fear of snakes  
 70 so that was you know [laughs] that was something  
 71 but it's the technique it's a tapping  
 72 and it does something with the with the uh meridians mkay  
 73 and so i said if i can do anything just to help relax me  
 74 and get rid of help my my pain and i realized with the polarity uh  
 75 there's a certain part you will tap and for some people who are sick  
 76 their polarity is quote backwards  
 77 D: uh huh  
 78 CARA: and i have found when i'm just feeling real awful and i'm take my ( )  
 79 and check my energy fields and my ( ) is blocked  
 80 i'll do the tapping  
 81 and all of a sudden i i can just feel a shift in my body  
 82 so i have been doing that quite a bit  
 83 D: mm hmm  
 84 CARA: so i i i know it's with the energy field and new medicine ( )  
 85 6:00 so i feel like if y'know if i can just sleep at night stay on the prednisone  
 86 and and get get something i i don't think the trazodone is gonna ( ) me  
 87 and i don't wanna go to that amitriptyline  
 88 D: yeah, no  
 89 CARA: //is there anything\  
 90 D: /there are side effects with that\\



- 91 CARA: oh gosh yes is there anything cause it's not the  
92 i don't think it's paying for medicine because when i'm feeling that way  
93 i'm doing my tapping or the thought field technique  
94 which maybe takes two and a half to three minutes  
95 and you can repeat it and repeat it done  
96 you know it's not dangerous to the body or anything  
97 and what it is doing the polarity so it's it's helping me  
98 and i can i can just tell it's like when someone is tryin' to breathe  
99 and feel an asthma attack coming on and maybe they open the window  
100 or get a breath of air your body senses it immediately  
101 so i know that it's bad and and i don't want any medicine for pain  
102 it's not i don't think it would it would would be effective
- 103 7:00  
104 D: as far as at night  
105 do you have a pretty typical routine that you go through  
106 i mean there are some folks that are helped just by  
107 y'know kind of a //routine ( )\  
108 CARA: /oh yes\\ what i do in the evening um i'll either listen to to uh lot of times  
109 i don't even fiddle with the news anymore cause to me it's just so y'know  
110 i mean the cardinals are playin' i'll listen but anyway i i uh  
111 i am quieter in the evenings like from y'know nine thirty to ten o'clock  
112 and then or sometimes i'll may be reading or put the the radio on  
113 but if it's disturbing that i don't do that  
114 i try to be quiet y'know to go on off to sleep  
115 i don't go to sleep right away but that's okay  
116 i'll set in my chair sometimes and rest or do something like that  
117 and then go on to bed  
118 but i take the trazodone maybe thirty thirty five minutes  
119 it depends you know i feel tired i go to bed uh  
120 and i try to get to bed the same time every night  
121 D: mm hmm
- 122 8:00  
123 CARA: um ten thirty or somethin' like that  
124 regardless of what time i go to bed at night  
125 the next morning at six twenty five that alarm goes off  
126 whether i feel like it or not i get up i mean cause i'm not  
127 cause i can fiddle around and then stay up real real late  
128 and then when and so i don't wanna get my sleep pattern off  
129 um a lot of times sometimes my shoulders have been uncomfortable  
130 and i energize it's a therapeutic touch get me energized  
131 that current course and i put over to here cause my muscles  
132 i mean it's from here the base of my neck in here  
133 that's where i have always had the pain and it hurts [laughs] y'know  
134 it's it's but i if i can get comfortable i drop on off to sleep  
135 when i wake up um y'know i'm aware of it and i finally go on off to sleep

136 but i feel therapy technique the tapping technique has has helped that  
 137 and i i just don't take anything for pain i mean i i don't need it  
 138 9:00 so it's this it's and the fatigue still uh it's nothing like it was [laughs]  
 139 when i came in in july and i'm sure it was the infection then  
 140 and the two um i just i just i still get out and get tired  
 141 but i also know once i do the tapping on the the side here um  
 142 it'll switch and i can just feel like [snaps fingers with both hands] y'know  
 143 i can tell it immediately i still have to pace so much if if  
 144 and i'm not frustrated anymore i to me if i'm gonna live and go  
 145 and do my stuff if it takes me longer that's okay i mean that's  
 146 i have made that that that choice so i don't feel um  
 147 well i feel a little bit frustrated once in a while  
 148 but i don't feel any any mild depression or or sadness or anything like that  
 149 i think i've dealt with that and and y'know this is this is it the [sighs]  
 150 this past week my stomach began settling down some uh  
 151 and i know it was all the ( ) i'm on  
 152 and i'm just taking the the um crystallized ginger the ginger snaps  
 153 10:00 just y'know were not effective and i i'm taking the crystallized ginger  
 154 and y'know it helps so that's i //have been\  
 155 D: /did he put you on any antibiotics\\ during the time //of-\  
 156 CARA: /no\\ what he did was put on y'know when you applied it locally and  
 157 and he was doin' all that cleaning no um since it was  
 158 it didn't seem like to be systemic and so forth  
 159 i mean when he worked on it cleaning but he didn't y'know  
 160 order any and uh i'm not //one\\ to take [laughs]  
 161 D: /yeah no\\ that's okay  
 162 CARA: and he he certainly y'know didn't seem like it was indicated so no  
 163 D: okay  
 164 CARA: the other thing that i found is um is the the thousand milligrams of the um  
 165 vitamin c has made a difference in clearing and keeping this  
 166 this uh area cleared and um i would need a prescription for that  
 167 and that's an over the counter drug i know  
 168 but in my community gets gets reimbursed by a local  
 169 by our uh um regional office  
 170 11:00 and i really i have felt since i started it i have been on it y'know  
 171 about a month and a half at least or somethin' like that  
 172 and it has really made a difference  
 173 so my sinus is better than it's ever been  
 174 and um i really think i need to stay on on the um  
 175 well i was on the thousand milligrams and i just take the one tablet  
 176 in the morning and that and that seems to have worked um  
 177 that's about it as far as  
 178 D: now are you still takin' the trazodone  
 179 CARA: yes cause i [laughs] need uh y'know i wasn't 'bout ready to do anything  
 180 and it's been like like i said i just noticed the past three weeks  
 181 and i've done everything else and i don't take caffeinated stuff at night

182 anything like it anything and i try to quiet down um um  
 183 anything that's real violent on tv i just don't watch it  
 184 because i wanna keep y'know not be so stimulated so  
 185 12:00 it is the trazodone did work //and i\ am so grateful for it cause i started out  
 186 in like mid november or something like that  
 187 so i just feel like probably my body is just not responding to it anymore  
 188 D: /mm hmm\\  
 189 D: um got a couple of suggestions  
 190 CARA: okay  
 191 D: um and what we may wanna do is keep the trazodone going  
 192 CARA: okay  
 193 D: cause even though it's not working as 1//well\1 it definitely 2//works\2  
 194 CARA: 1/it does\\1  
 195 CARA: 2/right\\2  
 196 D: and it still helps so if and if we're gonna add or try somethin' different  
 197 y'know i don't like to change //five\ different things  
 198 CARA: /yeah\\ right no that seems okay  
 199 D: and so kinda keeping that going  
 200 CARA: mm hmm  
 201 D: now we got several different choices  
 202 and what i know as medicine is a little bit better  
 203 you have more experience with some of the //energy fields\ and tapping  
 204 CARA: //right, right\  
 205 D: //and so\ i can't help you out on that  
 206 CARA: /yeah\\ no no and i and i it's working for me i just felt like y'know  
 207 i needed to share with you what i'm i'm doing and  
 208 anything you've ever asked me y'know i've tried tried to do so  
 209 and you're the y'know that's why i'm talking to you  
 210 13:00 cause you're the medical [laughs] expert  
 211 D: yeah well [sighs] so as far as y'know kinda the medicine sides of things  
 212 not pain medications but some some suggestions  
 213 we might want to consider 1//trying\1 at different times is um  
 214 there's like a mild muscle relaxant 2//that\2  
 215 CARA: 1/mm hmm\\1  
 216 CARA: okay  
 217 CARA: 2/see\\2  
 218 CARA: there that might be cause doctor this is where um this is pretty much  
 219 1//consistent\1 [points to shoulder area] from here on up to here  
 220 in the base of my neck  
 221 i don't mean that i don't have some stiffness  
 222 in the it's really 2//not joints\2 it's the muscle  
 223 but this is sort of like a a dull  
 224 it's /3muscle\\3 y'know so that might uh  
 225 and it is pretty much continuing 4//um\4  
 226 D: 1/mm hmm\\1  
 227 D: 2/uh huh\\2

228 D: 3/mm hmm\\3  
229 D: 4/yeah\\4  
230 CARA: i'm rarely not aware of it but it's mild enough i think i'll have  
231 D: and go on back to your daily business but that might be something that uh  
232 at night before you go to bed this is during the day you're doin' okay  
233 14:00  
234 CARA: well it's it's hurting but if i got a good night's sleep but  
235 but this is where both sides but if i do my arm up like that  
236 or anything like that y'know from here up  
237 i i just can't do anything so i just i don't y'know  
238 D: well we also want to make sure that you do periodically do that  
239 cause we don't //want-\  
240 CARA: //oh no\  
241 CARA: i'm not no but i'm talkin' about i don't lift uh no  
242 i try to do range of /motion\\ and things like that  
243 but when i do it it's it's pulling in here and it hurts  
244 oh no i definitely make sure cause i don't want a frozen joint or  
245 or just not a proper exercise no  
246 D: //motion\  
247 D: anytime something hurts the muscle around it tries to protect it  
248 CARA: mm hmm  
249 D: //it's a response\  
250 CARA: /so you're like that and\\ you just keep on and on //right\  
251 D: /the way it tries to protect\  
252 CARA: mm hmm  
253 D: is by contracting it so if we could get it to relax  
254 that may help a lot with the discomfort  
255 and particularly your sleeping at //night\  
256 CARA: /that\\ definitely yeah  
257 D: there's um one that  
258 CARA: if there's a mild one [laughs]  
259 D: there is um [laughs]  
260 15:00  
261 CARA: because you know um i don't wanna have to be able to  
262 not be able to //drive\\ and things like that  
263 D: /right\\  
264 D: um now the the one i'm thinkin' about is called robaxin  
265 or the generic name of it is methocarbamol  
266 so you might see that it's um something that's very short acting  
267 so you could take two tablets four times a day  
268 and still be in a normal dose range //for it\\ um  
269 CARA: /do you\\  
270 CARA: i i she put me on something before i could get in to see doctor doctor  
271 it was it was october  
272 D: last year

273 CARA: uh year before last and it just knocked the livin' daylights out of me  
274 but i was hurtin' so bad i i just had severe spasms  
275 D: [looking through patient's file] mm  
276 CARA: doctor uh donnie was takin' call that weekend  
277 D: okay now there is some muscle relaxants one called flexeril  
278 that's used a lot and it will knock people out  
279 CARA: it was flexeril i it's that y'know be careful operating machinery  
280 and i said i can hardly operate the elevator goin' //down\  
281 16:00  
282 D: /yeah\  
283 CARA: i mean maybe it was //flexeril\  
284 D: /i've\ i've seen folks just be knocked out for three days  
285 CARA: i mean i y'know i i the maybe it was flexeril i just have //not\  
286 D: [consulting file] yup flexeril  
287 CARA: okay  
288 D: three milligrams and this was in october of ( )  
289 CARA: that was it okay as long as i i mean because it took  
290 i was in such severe spasm and any of it i was just //zombielike\  
291 D: /that was it\  
292 CARA: okay  
293 D: i have seen //people\  
294 CARA: /that\ was it i couldn't remember what it was but i mean to tell ya  
295 i really was //feeling no pain\  
296 D: /i've seen people\ take like a quarter of a tablet but [laughs]  
297 and still be //( )\  
298 CARA: no //that's\  
299 D: /well\ i don't like to use it very much unless we really have //to\  
300 CARA: /well\ it was marvelous that weekend before i could get in to see her  
301 y'know that monday or tuesday whenever it was when it was flexeril okay  
302 i would be very open cause the the thing is is this is so uncomfortable  
303 and i try to keep it warm and y'know somethin' like that  
304 but it is it is just it's the muscle that that aches  
305 17:00  
306 D: right  
307 CARA: so i would be very open to y'know stay on the trazodone  
308 but take something //like that\ flexeril  
309 D: /and it\ would be okay to add 'em together  
310 and this one isn't a narcotic that's addicting like //that so\  
311 CARA: /would i\ if i'm really uncomfortable be able to take a tablet  
312 in the daytime too //of that\  
313 D: /you could\  
314 CARA: okay if if it if i need it  
315 D: everybody responds a little bit differently  
316 so it has a potential that it could make you drowsy  
317 so i always recommend the first time you take it  
318 the first time take it a little while before you're planning on going to bed

319 CARA: mm hmm  
320 D: not right before you go to bed //just to see\ how you respond to it  
321 CARA: /just to see\\ how my body is reacting  
322 D: and if ya take one and you're goin' okay i can feel it not too bad  
323 you might even be okay with taking two  
324 but if you take one it's a ( ) 1//make\1 out  
325 then you know that just one is all that you're gonna need  
326 and taking that at night  
327 so get an idea of how your system responds to it um  
328 and so if you more likely if you're real uncomfortable during the day  
329 you're probably not gonna be going a lot of places  
330 and doin' a lot of 2//things\2  
331 CARA: 1/oh then\\1  
332 CARA: 2/no\\2  
333 CARA: i have to rest [laughs] rest and then i go do  
334 i just pace myself through the day  
335 18:00  
336 D: mm  
337 CARA: and  
338 D: and this is fairly short acting  
339 it's designed to be a four times a day medicine  
340 CARA: mm hmm  
341 D: and so it would be okay to take it //( ) a day\  
342 CARA: /if i need to repeat it\  
343 D: if you need it um and y'know even if you needed it at night  
344 you can take a couple of 'em but i would say just start out with one  
345 CARA: yeah  
346 D: and it's okay to just take it as you need it  
347 CARA: //yeah i'm i would be open\  
348 D: /so it's not something\ you have to take all the time to make a difference  
349 y'know trazodone works a little bit better if you take it regularly  
350 to kinda help with the sleep pattern where with a robaxin y'know  
351 if you're having problems you can take it then  
352 if you're not having problems you don't have to take it  
353 CARA: //that's good\  
354 D: /um\\ and i would say let's let's try that  
355 CARA: mm okay  
356 D: another option that we have  
357 and i'm not um as interested in this one at this point  
358 but we could get ya a fairly short acting sleeping medication that's y'know  
359 that if you //just\ really couldn't get to sleep  
360 CARA: /right\  
361 CARA: i think it's the pain that is [laughs] is //keeping me\ awake  
362 D: /yeah\  
363 CARA: and if i could settle down and  
364 sometimes it's hard for me to turn on one side or the other

365 19:00 because of it's the muscle pain and and y'know something like  
366 D: the the muscle relaxant  
367 CARA: what'd you say  
368 D: robaxin  
369 CARA: robaxin  
370 D: mm hmm  
371 CARA: you know that would be y'know what i think i i need  
372 D: that's kinda my thought //too\  
373 CARA: /so\  
374 D: i mean we've got y'know some other options //but i think\  
375 CARA: /no\  
376 CARA: and only thing i think trazodone has done so well for me  
377 when i was on the fifty it was really [laughs]  
378 D: too much  
379 CARA: too much and uh but i need it  
380 and i've accepted the fact i'm gonna need it for a period of time  
381 and and i take day by day  
382 i don't look in the future cause i y'know we don't have a future anyway  
383 so uh that and that seems so good to have something for muscle pain  
384 cause i just am so uncomfortable so  
385 D: so let's try that  
386 CARA: okay  
387 D: other questions concerns that you have  
388 CARA: um i got my okay i need some scripts filled  
389 but but uh my mammogram needs to be reordered  
390 20:00  
391 D: //okay\  
392 CARA: /cause\\ i my last one was the thirty first so uh  
393 D: ++ september of ( ) all right //and\  
394 CARA: /yeah\  
395 D: now we did a breast exam this year in february  
396 CARA: yeah and i've been uh i still take my pelvic here  
397 but i do the breast exam manually uh y'know //once a month\  
398 D: /self breast exam right\  
399 CARA: right right  
400 D: mm hmm  
401 CARA: and um i just need the the prempo refill the prednisone refill the vitamin c  
402 and then the trazodone //prescription\  
403 D: /and so\  
404 CARA: so that's what  
405 D: prednisone and what was the other //thing\\ vitamin c  
406 CARA: /vitamin c\\ okay and i have enough of the um what do you call synthroid  
407 i have sufficient on the on the synthroid  
408 D: okay  
409 CARA: and i think that's all i'm on course the vitamin but that's  
410 21:00

411 D: okay //um\  
412 CARA: /oh\\ and i'll need the trazodone refill because i don't have any more  
413 uh refill i have maybe like four or five more tablets  
414 D: okay  
415 CARA: um well half you know  
416 D: yeah um so you've been getting the fifty and cutting them in half  
417 CARA: fifty and cutting them cutting them in half  
418 yeah i don't think they come in twenty five  
419 D: they do um so let me give you //the\ prescription for the twenty five  
420 i think i'd given you the fifty  
421 cause we thought we were gonna go with a higher dose  
422 CARA: right but they but what happened oh  
423 CARA: /would you\  
424 D: well some //insurance\ will pay for fifty  
425 and some will pay for twenty five without a copay more than others  
426 CARA: /insurance\  
427 CARA: yeah  
428 D: and stuff //so\  
429 CARA: /well\\ if i can get the twenty five well  
430 i think you wrote the twenty five last time  
431 and they might in the pharmacy not have the fifty  
432 and they gave me the fifty and put you know  
433 be sure to cut in and so i just go to the third floor  
434 and use their their pill cutter  
435 D: yeah  
436 CARA: but but it's but it's it's uh easier if you have the //twenty five\ milligrams  
437 D: /the twenty five\  
438 22:00  
439 CARA: //but-\  
440 whatever\  
441 D: /let me see\\ um i mean again i may have written for the fifty  
442 because we thought that you might need the fifty  
443 CARA: mm hmm  
444 D: um but i can definitely write for the twenty five  
445 and we'll see what //happens\  
446 CARA: /okay\  
447 D: um yeah cause here it had been written for the fifty previously  
448 CARA: okay yeah  
449 D: so that's why you got fifty uh so let me just write for //twenty five\  
450 CARA: /twenty five\\ times how many  
451 D: yeah  
452 CARA: uh uh the day now and i'm not opposed to taking the the trazodone  
453 i mean like i said when something gets [laughs]  
454 D: [laughs]  
455 CARA: works you don't wanna change it  
456 and i really like the idea of the the uh muscle relaxant



457 cause i think that might be the the answer um  
 458 + to work with y'know  
 459 D: uh huh  
 460 CARA: to work with the trazodone  
 461 D: just real quick here is there [stands to perform exam]  
 462 CARA: sure  
 463 D: any particular one spot that's more uncomfortable than the other  
 464 like as i press along here is there-  
 465 23:00  
 466 CARA: this is where this is where i'm i'm continually feeling the that and  
 467 and all across my my my back and i mean that's tender  
 468 i'm not i'm not popping off the the table when you're doing that  
 469 but but what i consistently feel and see down that part y'know  
 470 i don't mean to i'm not sore  
 471 but it is just like you put a band right across there  
 472 but this arm especially y'know this is such a y'know  
 473 a a tender and i y'know and i still move it around and everything  
 474 D: so your able //to-\  
 475 CARA: /yeah\\ and i i can go on and  
 476 and like i use the curling brush on my hair something like that  
 477 but i can't i mean maybe thirty seconds it //bothers me\  
 478 D: /you can't hold it up\\ for very long  
 479 CARA: right so i just use the other arm [laughs]  
 480 D: [laughs]  
 481 CARA: you know //the left arm is not as tender\  
 482 D: /okay up in front this way\  
 483 CARA: see i can come up  
 484 D: okay  
 485 CARA: oh yeah i can do that i can put my bra on and so forth  
 486 24:00 it's just that y'know if it hurts too much i just don't  
 487 and it sometimes it's more sensitive than others  
 488 so but i i've been always able to y'know move  
 489 it's hard when i with the windshield wipers something like that  
 490 so i mean i kind of just so i just don't do it if i don't feel like it  
 491 but i really feel like that sometimes if it's so tender  
 492 maybe the muscle relaxant will would uh  
 493 would help to take the edge of the the discomfort off  
 494 D: yeah and again it's not something you need to use all the time  
 495 and so you have it y'know if you need it  
 496 CARA: right prn +++ and i think if i could just get some rest  
 497 because i have noticed y'know a good three weeks  
 498 and i should be feeling a lot better because y'know otherwise i'm //doing\  
 499 D: /and i think\\ you should /have a ( )\  
 500 CARA: /right\\ right and i think my stomach is finally settling  
 501 about the past four days it's better  
 502 D: mm hmm

503 CARA: and with the polymyalgia  
504 do you do you end up with do you have stomach symptoms with that  
505 or was that not also dyspepsia that i  
506 25:00  
507 D: probably more the dyspepsia  
508 CARA: okay  
509 D: and also just when you //have a lot of drainage\  
510 CARA: /oh post nasal drip right\  
511 D: that drainage can be real irritating as well  
512 and that would be more likely than because of //the-\  
513 CARA: /the\  
514 D: mm hmm  
515 CARA: well and like i said it's improved since i took the uh the uh vitamin c  
516 D: okay  
517 CARA: and one other question  
518 does would would the uh prednisone  
519 cause I've been on it so long  
520 would the prednisone in the beginning  
521 would that have helped irritate the stomach  
522 or was it also caused from the advil  
523 D: um  
524 CARA: or a //combination\  
525 D: /both\  
526 CARA: okay well that's what i i thought when i skimmed something  
527 with the the prednisone it didn't say anything about stomach irritation  
528 but i man i wasn't doing y'know but a few days the pain was taken care of  
529 but i began feeling it immediately and i knew that with the advil too  
530 D: you particularly see it in folks like in a hospital on high dose steroids  
531 people that have lung //problems\ or something else  
532 26:00  
533 CARA: /mm hmm\  
534 D: and they need to be on really high //steroids\  
535 CARA: /yeah\  
536 D: right but it's still y'know so we know it irritates people at high doses  
537 and y'know so the same theory would go along  
538 it has a potential of irritating hopefully not as bad //in low doses\  
539 CARA: /yeah\  
540 D: but it's still there  
541 um so yeah robaxin the trazodone vitamin c (4) [writes]  
542 CARA: and i just get that up at tom's  
543 i just need to have that as a so as to get //reimbursed\  
544 D: /does it come\  
545 CARA: + i think it's ninety  
546 D: ninety okay  
547 CARA: yeah if you could just put like for re yeah and just put refill  
548 D: [laughs] okay

549 CARA: [laughs] as necessary right it's yeah it's it's ninety  
550 D: okay  
551 CARA: tabs (4)  
552 D: [writes]  
553 CARA: i think it's a bufferin one but anyway whatever it is just //divide them\  
554 D: /yeah\  
555 CARA: until you get uh  
556 D: that's your twenty milligrams of prednisone  
557 27:00  
558 CARA: what you have done was you put the hundred milligrams  
559 and i think what we did was uh one milligram times a hundred and twenty  
560 because we //could use it\  
561 D: /so then we could\\ //change it if we needed\  
562 CARA: /one\\ to two to three right but  
563 but the thing is uh one milligram times a hundred and twenty  
564 D: [writes] (26)  
565 D: [mumbles]  
566 CARA: yeah thanks think there are twenty eight to that thing  
567 D: [doctor writes] (19)  
568 28:00  
569 CARA: the the mammogram  
570 D: yeah something we may wanna try to do to see  
571 if we can get the breast exam and mammogram kinda hooked together  
572 ideally it's nice to have the breast exam right before the mammogram  
573 so if there's something that we find on the breast exam  
574 we can say to the //radiologist  
575 please pay attention to the right\ breast like this  
576 CARA: /be alert for something like that\  
577 D: or something //like that\  
578 CARA: /is see\\ and i don't remember when we had when we did the last //exam\  
579 D: /why\\ don't we go ahead and we'll turn off the camera  
580 CARA: yeah  
581 D: and do a breast exam //today\  
582 CARA: /okay\\ that's fine  
583 D: and then get ya set up for the mammogram  
584 CARA: okay  
585 D: +++ [writes]  
586 D: okay i think i got all of these let me grab  
587 29:00  
588 CARA: because it is so cool [laughs]  
589 would it be possible if i could just throw some keep something on  
590 y'know like [laughs] um  
591 D: why don't you just leave your shirt on  
592 CARA: that's fine //i can remove my bra\  
593 D: /and just unhook your bra\  
594 CARA: okay because

595 D: i mean there's also a gown if you want to put that //over you\ as well but  
596 CARA: /no this is\\ //i'm warm in here\  
597 D: /just unbutton your shirt\  
598 CARA: because those things are not especially in the back i  
599 f you don't mind  
600 D: no problem so um let me figure out +++ um let me grab her real quick  
601 CARA: okay  
602 D: so don't do anything  
603 CARA: all right i'll be here  
604 [doctor leaves room patient waits doctor comes back] (8)  
605 D: she said the red button  
606 CARA: she's a great //doctor\  
607 D: /oh this one\  
608 CARA: but she doesn't know ( )  
609 D: right there?  
610 29:50  
611 [end of interaction]  
612

612

**Appendix E: Additional transcripts****A2                    A2-1-22            Patient D**

*Context:* Excerpt from interaction A2. Patient D, Debra, a 72 year-old woman, presents to her primary care provider with concern over symptoms possibly related to tick bites.

:42                    Coding: A=Acute, 2= second acute, beginning-ending line #: [A2-1-32]  
 1 D:                    how are you  
 2 DEBRA:            well this is i probably maybe didn't even have to come in  
 3                    but i pulled two ticks off myself in the last week and a //half\  
 4                    and i wouldn't even have thought about it but yesterday  
 5                    man i felt like a truck ran over me  
 6 D:                    /okay\\ oh really  
 7 DEBRA:            and according to articles i've saved over the years  
 8                    that's one of the symptoms  
 9                    so i thought maybe i oughtta be safe than //sorry\1 well or it  
 10                    could be rocky mountain spider fever  
 11                    even with that you get a rash on your wrists and your ankles  
 12                    and i don't have that  
 13                    i don't have the typical bulleyes //thing\2  
 14                    the one tick i pulled was on my scalp  
 15                    and i mean the whole side of my head's swollen  
 16                    and the site where i took the tick out was  
 17                    about like that [indicating size with her left hand]  
 18                    about that big around and that high  
 19                    and are there some lymph nodes right about below that  
 20                    [turning her head to the right and indicating location with her left hand]  
 21                    well that was all bumpy and really sore yeah  
 22                    and the other tick i pulled off [stands and turns back of leg toward doctor]  
 23                    is down right here  
 24 D:                    /lymes disease right\\1 /true\\2  
 25 D:                    oh i see that that is swollen  
 26 2:02                    is that sore  
 27 D                    [examines area]  
 28 DEBRA:            the other tick i pulled off i've been putting caladryl  
 29                    not caladryl cortisone stuff  
 30                    and so i just thought maybe i'd better come in  
 31 D:                    sure sure  
 32 DEBRA:            articles i've read say you can have heart problems you can have arthritis  
 2:36

**CHRONIC****C3            C3-1-40            Patient E**

*Context:* Excerpt from interaction C3. Routine medical visit. Patient E, Ella, a 74-year-old woman, presents to her primary care provider with desire to alter ordering of prescription supply.

:36

- 1 ELLA: first off  
2 D: first off  
3 ELLA: i'd like to mention ( ) ordered a three months supply of prescriptions  
4 get for the same price as for one month  
5 D: okay  
6 ELLA: so why can't we order three months at a time  
7 D: where do you get your prescriptions  
8 ELLA: right over here [pointing in direction] at the pharmacy  
9 D: //oh\  
10 ELLA: /i found that out\\ about it found that out with doctor ( )  
11 D: you can only do that on certain medications  
12 ELLA: yeah  
13 D: the long term chronic disease type of medications  
14 are the ones they'll let you //do\  
15 ELLA: /well\\  
16 D: so you have one copay for the three months supply as to one a month  
17 ELLA: uh huh  
18 D: yeah  
19 ELLA: it's the same price for thirty as it is for //ninety\  
20 D: /so\\ we want to do that on the lisinopril and the pepsid  
21 ELLA: and we can also do on the ( )  
22 D: there's another one you're using for your blood pressure  
23 ELLA: yeah and we can do it on the otc  
24 D: yeah ( )  
25 ELLA: and the there's quite a few of these we can use  
26 D: okay that's fine with me no problem at all  
27 now you have prescriptions  
28 i don't know if they'll let you do this  
29 since you already have prescriptions that have  
30 we wrote you a prescription in february for a six months supply  
31 ELLA: i probably won't be able to do it for those  
32 i forgot the little booklet  
33 i forgot the little booklet that i've got with it in it  
34 D: okay well we can call them  
35 are you ready to pick up any prescriptions  
36 ELLA: no i just got it today

- 37 D: so what we should do is next time  
 38 when you're ready for your refills we'll try to order a three months supply  
 39 ELLA: uh huh  
 40 D: okay because that will be the best ( )  
 41 because they won't give us any more than that if you just got ( )  
 42 ELLA: i just thought it was something we should do  
 43 D: oh yeah absolutely

#### **C4 C4-1-61 Patient F**

*Context:* Routine medical visit. Patient, F, Flo, presents to her primary care provider for a routine visit. She discusses why she is not taking pain medication for her back pain.

:19

- 1 D: have your neurosurgery consult  
 2 FLO: yeah  
 3 D: and what'd they say  
 4 FLO: got scheduled another mri  
 5 D: another mri  
 6 FLO: yes  
 7 D: uh uh what and when  
 8 FLO: ( )  
 9 D: i thought we did that already  
 10 FLO: we did he wants another one  
 11 D: okay what'd they say about what'd they thought was wrong  
 12 when they examined you  
 13 FLO: they didn't really examine me they just talked with me  
 14 and i was really angry because i didn't really like him  
 15 i didn't like his attitude  
 16 D: who was it that you saw  
 17 FLO: ( ) he was very condescending  
 18 he acted like i was an idiot  
 19 i couldn't talk to him  
 20 i mean i can talk with you we have a rapport  
 21 but i i couldn't talk to him and you know doctor  
 22 i've had so much pain and i can't take any medication  
 23 because of paul my husband  
 24 D: why  
 25 FLO: you don't know oh god  
 26 D: well i know that he's very sick and in and out of the hospital  
 24 and i know you've moved out of town  
 25 FLO: now it looks like he's going into alzheimer's  
 26 D: why can't you take medicine  
 27 FLO: i can't take pain medicine because it puts me to sleep +  
 28 and i have to be alert  
 29 D: pain medicine puts you to sleep  
 30 FLO: yeah i have to be alert because i can't let him fall again

31 he had a bad fall two weeks ago  
 32 leg was swollen and he's diabetic  
 2:16  
 ...  
 9:25  
 33 D: ya know it's too much on you all the time to never have a break  
 34 FLO: i know and you know i still got my daughter  
 35 D: you still have that daughter that wonderful [sarcastic] daughter  
 36 that you always talk about  
 37 FLO: i kicked her out  
 38 D: you kicked her out she was doing drugs again  
 39 FLO: oh yeah ++ three weeks ago ( )  
 40 and the ambulance came and took her  
 41 i said please god take her  
 42 D: that's the overdose you told me about  
 43 FLO: yep  
 44 D: yeah you told me about that i think  
 45 FLO: yeah  
 46 D: she took handfuls of a bunch of different stuff  
 47 FLO: no this this was a shot  
 48 D: oh  
 49 FLO: she's a shooter +++this was only three weeks ago ( )  
 50 D: she's okay now  
 51 FLO: at the moment  
 52 D: she living with you  
 53 FLO: no + she can't live with us  
 54 D: why //just won't work\  
 55 FLO: /i won't allow it\\ i kicked her out  
 56 D: cause of the drugs  
 57 FLO: ( ) i said you got two choices clean up your room or go through the door  
 58 D: she chose the door  
 59 FLO: she chose the door she was told +don't+ come+ back  
 60 D: so does she call you when she gets in trouble now  
 61 FLO: no  
 11:01

**C5 C5-1-94 Patient G, Gail**

*Context:* Routine medical visit. Patient, G, Gail, presents to her primary care provider for a routine medical visit. The patient indicates that there are no problems with her medications, nor any other problems. Her companion, her daughter, indicates otherwise.

:01

1 D: how are ya  
 2 GAIL: like i say like an old timex i just keep ticken'  
 3 D: your blood pressure looks wonderful huh



4 GAIL: better than it was  
5 D: wasn't your thyroid out of whack  
6 Daughter: yeah, it'll be a year in two weeks for another blood draw  
7 D: did i increase it  
8 Daughter: no  
9 D: i just wanted to make sure we did that  
10 Daughter: yeah we did  
11 D: you getting out walking you exercising  
12 GAIL: oh yeah, i exercise  
13 D: no problem with medication as you can tell  
14 GAIL: no problems period  
15 D: no problems period man this is perfect  
16 Daughter: you want to mention your eyes  
17 D: what about your eyes  
18 daughter: ( ) wide angle low pressure glaucoma  
19 D: who did she see  
20 Daughter: ( )  
21 D: and what does he want her to do  
22 Daughter: he's got her on medication it's well controlled  
23 D: good well that's why you go see the ophthalmologist  
24 get ahead of the game +  
25 what about a mammogram  
26 Daughter: same thing she told you last year [laughs]  
27 D: gotta ask+  
28 GAIL: i got nothing to worry about the only time i get boobs is when i get a chill  
29 D: what you'd tell me about flu shot  
30 GAIL: i get those once a year  
31 [doctor begins physical exam]  
32 D: one out of two's not bad  
33 Daughter: all three of us got flu shots last year  
34 D: i got all three of you in for a flu shot last year  
35 Daughter: yeah all three of us at the same time  
36 and i had to admit it was good  
37 i i had less of everything over the winter than  
38 D: well what convinced me about the whole thing was  
39 people i didn't see in the office  
40 were getting flu shots ++  
41 so i started taking it myself  
42 GAIL: once you start getting to that age  
43 D: be careful i've got to stick something in your ear here  
44 GAIL: [holding finger up by opposite ear doctor is examining]  
45 how many fingers do i have up  
46 D: [communication with office about seeing another person in a second]  
47 GAIL: you see anything crawling in there let me know  
48 D: ( ) potatoes  
49 GAIL: that's //right\

50 D: /open up\\ [louder] open up  
51 GAIL: [makes loud noise as she sticks out tongue]  
52 D: how are the grandkids  
53 GAIL: big getting bigger  
54 D: are they doing okay  
55 GAIL: i've got ( ) great grandchildren  
56 Daughter: she's watching three of her great grandchildren five days a week  
57 D: that is something  
58 GAIL: so i get good exercise  
59 Daughter: ( ) they're eighteen months to five years  
60 D: not too rough  
61 hold your breath ++ breathe  
62 GAIL: [as doctor check patient's lungs]  
63 oh this is the most a man's done to me in a long time  
64 D: [laughs] she's a ham bone  
65 Daughter: always has been  
66 D: breath in +++  
67 don't want you to pass out  
68 D: are you guys going out for lunch or anything  
69 Daughter: nah we have people comin' to the house in an hour and a half  
70 to draw blood for dad  
71 D: oh really how's he doing about the same no good  
72 GAIL/Daughter: ( )  
73 D: [to daughter] is he happy  
74 Daughter: i don't know that he's one way or the other  
75 GAIL: he's never been the type of person to express himself  
76 Daughter: first he's quiet i don't think he's one way or the other  
77 i think he's existing at this point  
78 D: yeah +++ it's tough+++ but you know you can't+  
79 GAIL: [during abdominal exam] now watch that  
80 don't disturb nothing down there  
81 D: just don't let it get away from ya  
82 GAIL: my handlebars  
83 Daughter: that's gramma padding  
84 D: just means you're a good cook  
85 GAIL: i don't eat my cooking  
86 D: [listening to heart] +++couldn't be better ++  
87 you're good for another twenty thousand miles  
88 GAIL: when i get to nineteen thousand i'm gonna slow down  
89 Daughter: getchu an oil and lube job you're set  
90 GAIL: know anybody's got a good dipstick i can check my oil with  
91 D: i'm not going down that road  
92 there's no way i'm not going down that road  
93 + knew that was coming++  
94 get your flu shot  
95 i know you won't get a mammogram

96 D: [to daughter] does she need a refill  
97 Daughter: [shakes head no]  
98 D: and she's already drawn your blood and urinalysis was fine  
99 D: smartest thing is to stay on medication ok and keep her out of trouble  
100 GAIL: i have enough trouble keeping myself out  
101 D: all right i'll be right back  
102 you gonna be back in two weeks  
103 Daughter: two weeks  
104 D: all right don't run off  
6:26

**C6 C6-1-22 Patient H**

*Context:* Routine medical visit. Patient, H, Helen, presents to her primary care provider for a routine visit.

:26  
1 HELEN: there are some things i wanted to ask you  
2 D: yeah  
3 HELEN: did you really confirm what you thought i had fi //fibro\  
4 D: /fibromyalgia\\ right um ++  
5 fibromyalgia is based upon a series of a bunch of complaints  
6 that we can't figure anything else out  
7 i'm not sure i have a specific test to run  
8 HELEN: you really don't for that do ya  
9 D: not to my knowledge  
10 HELEN: that's what i understood  
11 D: now how did you feel uh with the physical therapy+did it help  
12 HELEN: i've been only to two  
13 and then i'd been in dallas for almost two weeks  
14 and i have one next week  
15 D: did they help at all  
16 HELEN: i thought it did a little bit but in between that time i called you  
17 and you agreed to let me try celebrex  
18 D: how did that work  
19 HELEN: i just hurt so bad i didn't think it did anything  
20 D: how many did you use  
21 HELEN: i'd guess i used about twenty of them  
22 D: i mean i mean how many a day  
23 HELEN: one  
24 D: you can now increase it to two a day

**C7 C7-1-19 Patient I**

*Context:* Routine medical visit. Patient, I, Iris, presents to her primary care provider for a routine visit.

- 1 D: how have you been feeling
- 2 IRIS: i have not been feeling well at all
- 3 D: tell me what that means
- 4 IRIS: that means i'm just very very tired i have to push myself
- 5 i still have like no energy
- 6 D: okay
- 7 IRIS: and i can hardly get through my housework
- 8 D: what time do you get up in the morning
- 9 IRIS: anywhere from six to eight eight thirty based on what time i go to bed
- 10 i'm getting six and a half seven hours a night
- 11 D: how come so little
- 12 IRIS: sleep
- 13 D: yeah
- 14 IRIS: because when i wake up i just get up
- 15 D: okay um
- 16 IRIS: and i stay up quite late sometimes sometimes i don't
- 17 D: does it make a difference when you go to bed
- 18 IRIS: no it doesn't seem i go to bed sometimes and
- 19 it's half an hour before i go to bed

**C8 C8-1-65 Patient J**

*Context:* Routine medical visit. Patient J, Jill, presents to her primary care provider for a routine visit.

- : 15
- 1 D: how are you
  - 2 JILL: fine
  - 3 D: we are re-checking your blood pressure today because we made a change
  - 4 in your blood pressure medication //last time\
  - 5 JILL: /right\\
  - 6 D: uh eventually we increased your ( ) + uh that didn't seem to work moved
  - 7 the ( ) back to twenty five milligrams per week and we added ( ) thirty
  - 8 milligrams once a 1//day\1 any problems with that 2//medication\2 as far
  - 9 as you can tell
  - 10 JILL: 1/right\\1
  - 11 2/no\\2
  - 12 D: okay any other problems
  - 13 JILL: not that i know of
  - 14 D: okay
  - 15 JILL: last week i had a scratchy throat now it's hoarse

16 D: uh huh  
17 JILL: it's mostly cleared up yeah  
18 D: uh huh let's listen to your lungs here  
19 [examining patient] couple of deep breaths (13) let's check your pressure  
20 (40) ( ) over eighty now lie back for a minute any leg swelling  
21 JILL: no  
22 D: listen to your heart (24) and have you had any blood pressure readings any  
23 place else  
24 JILL: no i //haven't\  
25 D: /press on your side\\ okay go ahead and sit up check one more [gets blood  
26 pressure cuff off wall again] got any new critters at your house  
27 JILL: no got them pretty well gone now go ( ) rescues to the rescue center  
28 D: (26) got an equipment malfunction here sorry (19)  
29 found a dead screech owl in the road the other day //when\ i was out  
30 walking my dog  
31 JILL: /oh heaven's sakes\  
32 D: seen many of them around  
33 JILL: uh we have had them at our places in odd places going down our chimney  
34 one time they're a [indicates size with arms] a //big owl\  
35 D: /much bigger\  
36 JILL: yeah i don't know why unless they're chasing some smaller animal near  
38 the chimney and they fall down  
39 D: yeah uh huh  
40 JILL: we do get screech owls from time to time  
41 D: hear them in our //neighborhood\  
42 JILL: /oh yeah\\ you know you know we have a couple of squirrel boxes up in  
43 in our back yard and last week all of a sudden i saw something sitting up  
44 on top of it and when it ducked into the whole it was a flying squirrel  
45 D: really  
46 JILL: yeah  
47 D: oh yeah  
48 JILL: yeah it had that webbing like that it was real cute  
49 D: yeah + you got a squ the squirrels don't have enough homes out there  
50 you've got boxes  
51 JILL: oh yeah they're god's /creatures\\ we take and we feed them  
52 D: //that's right\  
53 JILL: in fact in our bird bath we put a ( ) ++ i wanted to tell ya too i've gone  
54 back to my daily walking  
55 D: uh huh  
56 JILL: i started just shortly after i was here the last time about a mile and a half a  
57 //day\  
58 D: /good\  
59 JILL: and there are two hills up and down and up and down so i'm going down a  
60 hill and up a hill  
61 D: ya feel good when you're walking  
62 JILL: i feel good and actually when i get back i feel invigorated i really feel

63 //good\  
 64 D: most people do it's really good for you  
 65 JILL: uh huh

5:39

**C9 C9-1-57 Patient K**

*Context:* Routine medical visit. Kate, a 66-year-old woman, present to her primary care provider for a follow-up visit. The doctor is discussing the patient's weight gain.

1 KATE: i didn't think i'd have 166 blood pressure  
 2 D: oh, blood pressure's up a bit, now  
 3 KATE: yeah, i had been walking again  
 4 D: what happened that you got off your schedule  
 5 well, the weather and company  
 2:15  
 6 D: how have you been doing with your diet  
 7 KATE: i don't eat meat but i have been going out more and i try +  
 8 but that's why i gain weight, it just, eh  
 9 D: have you gained weight+ //a few pounds\  
 10 KATE: /oh yeah\\ then again, i got boots on too  
 11 but i have to admit they're light boots + so  
 12 +++ i will just have to i've gotten into the snackwells and //things\  
 13 D: /hm hmm\\ leftovers from the holidays perhaps that's what i do you know  
 14 if i eat a whole bunch of snacks around the holidays i have to make a real  
 15 conscience effort after the holiday's over to maybe back off a little bit or  
 16 go for the healthier snack so when you're thinking snackwell, think  
 17 oranges try to think //grapes\ in stead of that-  
 18 KATE: /well\\ i do. i eat a lot of fruit now+++ including oranges and grapes  
 19 D: hm hmm  
 20 KATE: + i think probably i'm just eating too much  
 21 D: okay, i think you can change that  
 22 KATE: yeah, i think so too++ especially with the i need to increase the uh  
 23 activities++ physical //activity\  
 24 D: /physical stuff\  
 3:38  
 ...  
 10:42  
 25 D: sounds like what we need to concentrate on is getting you back to your  
 26 usual pattern of exercise things we know you can do  
 27 KATE: ( ) [laughter]  
 28 D: you've done it in the past we know you can do it  
 29 KATE: yeah  
 30 D: it's just a matter of being more consistent or persistent with it just not  
 31 getting off you know if you miss one or two days don't use that as a

32 reason to lose two or three more days just say hey i need to get and do  
 33 what know is good for me we see now the blood pressure is up a little bit  
 34 that's a sign that says there's other benefits to exercise besides i don't grit  
 35 my teeth and my blood pressure's lower and i just generally feel better and  
 36 your weight'll be down a little  
 37 KATE: yeah, i've got to get that weight down i know++ so that means my  
 38 cholesterol is gonna likely be higher too  
 39 D: well we don't know that we'll check and see  
 40 KATE: i don't eat meat but i do eat chicken i guess mainly it's when i go out it's  
 41 very hard  
 42 D: when you go out and eat you have to be careful and see what's on the  
 43 menu that might be better for you we have a tendency to eat what we like  
 44 to eat when we go out to eat  
 45 KATE: i try to stick with fish or but even then sometimes they serve it with /so\\  
 46 D: /sauces\\ i do the same thing so you just have to think about you know  
 47 while you're there about being on the right track  
 48 KATE: i'll say no dressing no dressing or dressing on the side  
 49 D: good  
 50 KATE: but it is hard  
 51 D: should we go ahead and check the cholesterol or would you rather wait  
 52 get back with your exercise and check it after you're back on track  
 53 KATE: ++ well, i think maybe we'd better what do you think  
 54 D: i would rather check it today and know what's happening with the  
 55 //medicine\  
 56 KATE: /right\\ i would too so let's do that  
 57 D: okay let's get it done  
 1:29

# **C10 C10-1-93 Patient L**

*Context:* Routine medical visit. Patient L, Louise, a 73-year-old patient, presents to her primary care provider for a routine visit.

3:30

1 D: how are ya doing  
 2 LOUISE: i'm doing ok  
 3 D: good++i know you lost your husband how's that going  
 4 LOUISE: okay  
 5 D: you doing all right with that  
 6 LOUISE: [patient is crying nods to doctor]  
 7 D: having any crying episodes or feeling down  
 8 LOUISE: //sometimes\  
 9 D: /sometimes\\ is it becoming a problem for you  
 10 LOUISE: [patient shakes head side to side]  
 11 D: no it's okay to cry+++  
 12 LOUISE: [patient motions to adult daughter in room to get her a tissue]  
 13 D: you want to talk about it you don't want to talk about it  
 14 LOUISE: [through tears] everything's okay

15 D: everything's okay now  
16 Daughter: she's also dealing with my brother's drama  
17 D: there was some strife about it  
18 LOUISE: [patient shakes head no]  
19 D: no  
20 Daughter: no about me  
21 D: [to daughter] about you you're causing problems  
22 Daughter: yeah i'm causing problems  
23 LOUISE: [to daughter] no you aren't  
24 Daughter: her heart's on like a platter being sliced up  
25 LOUISE: yeah  
26 D: people do strange things when people die you know  
27 even though he had been sick a long time, um  
28 LOUISE: you don't expect it to feel //this way\  
29 D: /right\\ right and everybody deals with death in different ways  
30 and unfortunately sometimes those aren't //the most-\  
31 LOUISE: /i don't\\ cry very much i really don't cry very much  
32 D: uh huh  
33 Daughter: you've been crying a whole lot since ( )  
34 LOUISE: that's a separate issue i'll deal with that  
35 D: +are you sleeping  
36 LOUISE: yeah there for a while i wasn't i lost my appetite for about three days  
37 but now i'm getting my appetite back //and\ i'm feeling better  
38 D: /okay\\ okay now some of this is to be expected  
39 even in the best of circumstances even if everybody was very supportive  
40 and looking out for your best interest some of this is to be expected  
41 cause you were together for a very long time and you took care of him  
42 //while he was sick\  
43 LOUISE: /a long time\\  
44 D: do you have things to keep you busy  
45 LOUISE: i try to stay //busy\  
46 D: uh huh  
47 LOUISE: i love to read  
48 D: you love to read  
49 LOUISE: love to read  
50 D: okay so you've been doing that  
51 LOUISE: yes a lot of that  
52 D: and do you get out with the family  
53 LOUISE: oh yeah yeah oh my they have been every day  
6:00  
7:02  
54 Daughter: she's blaming herself about dad too  
55 D: //oh\  
56 LOUISE: /well\\ i think i don't know if this is silly or not i think  
57 if i'd kept him home another 1//month\1 he'd have might've lived  
58 because i had gotten him through pneumonia just last 2//year\2



59           when i went up there and seen he had pneumonia i told them you know  
60           he's got pneumonia they didn't believe me 3//yeah\3  
61           but i figured if i had had him but my son said no mom  
62           dad would have lived forever and you wouldn't have been all right +  
63           it was really getting to me  
64 D:       1/uhhuh\1 2/uhhuh\2 3/uhhuh\3  
65 D:       yeah it's hard work taking total care of somebody  
66 LOUISE: yeah it's definitely hard work  
67 D:       and i'm sure that they took good care of him even though even though  
68           it wasn't as good as what you would have done at home you know  
69           it's never as good as you could do  
70 LOUISE: well my daughter and i went to see him on a friday he was sleeping  
71           we didn't want to wake him up he didn't know when we were there  
72           you 1//know\1 then we went to see him again on tuesday  
73           and in the afternoon said he was okay but he was breathing hard  
74           but then later in the evening i got a call from my son he said mom  
75           dad needs to be in the hospital i'll come down and get ya  
76           'bout two minutes he was in my driveway  
77           and i knew right when i walked into the room i said he's got pneumonia  
78           went to the nurses desk  
79           and that's when we insisted that he be put in the hospital  
80           but nothing showed up on the x-ray he had been 2//dehydrated\2  
81 D:       1/uh huh\1 2/oh\2  
82 D:       so he did go to the hospital  
83 LOUISE: yeah  
84 Daughter: but they didn't find anything until the morning after he passed away ( )  
85 D:       oh because he had been so dehydrated  
86 Daughter: i guess  
87 LOUISE: but at home he would have spells where he wouldn't want to eat  
88           and i'd and i'd say to him then i'm not either sit down here and eat  
89           and he said well god told me not to eat any hot food  
90           well then we're going to have to sit down here  
91           and have a conversation with god  
92           cause you need warm food in your stomach [laughs]  
93 D:       [laughs]

**Appendix F: Stimulus****Interaction 1 (A1)**

Ann, a 72 year-old woman, presents to her primary care provider shoulder pain following an accident. This doctor has seen this patient in the past.

Doctor: Okay what brings ya in today?  
Patient: Well I was walkin' and I went to cross the street at the curb and my foot musta got caught in the curb.  
Doctor: Okay.  
Patient: There was a metal strip there (I went later to look) and I kind of flew out in the street and I put my two arms out to protect my body.  
Doctor: Uh huh.  
Patient: And um hurt this arm really bad I knew when I got up it was just killing me I should've gone to the emergency room and then by the time I got home I thought well it's probably bruised bad, ya know?  
Doctor: Mm hmm. So you actually went down.  
Patient: Oh yeah.  
Doctor: Okay. And how long ago was that Mrs. S.?  
Patient: Three weeks.  
Doctor: Three weeks.  
Patient: Yeah.  
Doctor: So, what have you been doing to it in the meantime?  
Patient: Ibuprofen I took 200 milligrams maybe twice a day.  
Doctor: Twice a day.  
Patient: [mumbles]  
Doctor: You think that helped some?  
Patient: It [sigh] gave me a little relief. It didn't cure it, but it gave me a little relief.  
Doctor: Has it been swollen at all any place?  
Patient: I can't tell that. I'm so heavy in that area that I can't tell that.  
Doctor: Okay. It's hard to tell. Do you think it's any better now than when you first did it or is it about the same or is it worse?  
Patient: I think it's better. It just is aggravating to me.  
Doctor: Okay.  
Patient: Because I have pain every time. Even to fold clothes.  
Doctor: Regardless of which way you lift it, it hurts?  
Patient: Yeah.  
Doctor: Okay, does it hurt down into the arm or into the fingers?  
Patient: [mumbles] Yeah, it hurts to the elbow. Right.  
Doctor: Okay, have you ever injured that shoulder before?  
Patient: No.  
Doctor: Okay, uh...Are you aware which way you went down on it? Did you fall down on it this way or...  
Patient: I, I, no this way I went on this arm mainly.

Doctor: So you went right down on that shoulder  
Patient: I think right here [motions to left shoulder].  
Doctor: All right. Can you lift your arm up above head?  
Patient: I can now but it hurts to do that.  
Doctor: Okay. How long has it been, uh, since you've been able to do that? I mean is it...  
Patient: About a week [mumbles]. I couldn't even wash under my arm it hurt that bad I couldn't lift it.  
Doctor: How about turning your arm over, does that...  
Patient: I can do that.  
Doctor: That doesn't hurt.  
Patient: My hand, my hand I can...  
Doctor: But, but to try to move...  
Patient: [sound of pain] That hurts.  
Doctor: Okay, all right, so no old injuries to the shoulder that you know of  
Patient: No.  
Doctor: Has the shoulder ever been x-rayed before?  
Patient: No.  
Doctor: Okay, [pause while writing]. All right, and the Ibuprofen helped a little bit but it's still not right.  
Patient: Well, I didn't know what to take.  
Doctor: No, it's a good choice.  
Patient: My son suggested that.  
Doctor: That's...  
Patient: But it was only 200 milligrams.  
Doctor: Yeah, that's a good choice.  
Patient: Okay.  
Doctor: Okay, well, um. I think certainly today we're gonna wanna do an x-ray and check it out for ya and then decide if more Ibuprofen or if something else needs to be done.

**Interaction 2 (C1)**

Bess, a 73-year-old woman, presents to her primary care provider for a blood pressure monitoring follow-up. This doctor has seen this patient in the past.

- Doctor: Ya see that blood pressure? [sounding concerned, somewhat stern]  
Patient: It's always high...  
Doctor: I can't...that's right, that's right, we, uh, what is it we did?  
Patient: This week's blood pressure and other months are around 130-70 all the time.  
Doctor: Yeah, that's right, uh, we actually, uh...  
Patient: You monitored me with a monitor when was it last summer spring.  
Doctor: We monitored yeah, yeah I remember now I'm sorry.  
Patient: It's all right. I'm sorry you don't believe me [laughs].  
Doctor: Well.  
Patient: I know [laughs] I don't want to think I have high blood pressure [laughs] either but I really don't think I do, but I do take medication.  
Doctor: Can't figure out why on medicine it would be elevated here.  
Patient: Because I suffer from, uh, anxiety about going to the doctor.  
Doctor: To the doctor. We actually sent you home pressure monitoring, didn't we?  
Patient: Sure I went over to the main office there and wore it for 24 hours.  
Doctor: That's right, that's right. End of problem.  
Patient: Okay let's hope [laughs].  
Doctor: Well, I'm not sure why you didn't get your chart here. It's always disconcerting for me. I always like to go over things, mammograms.  
Patient: Why aren't the charts here when you see the patient that's one thing... because it's been a long time [laughs] since I've had anything done.  
Doctor: Well, tell me, do you remember when your last mammogram was?  
Patient: Sure, uh last spring or early summer I can't remember and it was negative.  
Doctor: Okay, well, I remember that.  
Patient: I had my eyes examined three days after Christmas, December 28 and they were very normal. The doctor said they were very [laughs] healthy looking. [Sighs] I have to get new sunglasses, which I haven't gotten the prescription filled for.  
Doctor: Good. We have your heart records at least and when I last saw you in November we talked a little bit about diabetes.  
Patient: [Takes deep breath] I'm always hurting with that and I have lost weight, your scales don't [laughs]- I weighed myself this morning. I weighed a lot less than your scales say but I know I've lost weight. I've been very careful and do have an Accu...  
Doctor: Check  
Patient: Yeah, but I hadn't I haven't done it over Christmas. I have to go out and buy strips and I haven't done it. But I will agree for you to do a glycohemoglobin.  
Doctor: Okay, let's see.  
Doctor: I'm sorry, Bess, if the glycohemoglobin is a little bit elevated you're saying that then you'll check your-  
Patient: I'll, I'll go and get the strips. They cost 40 dollars a bottle [laughs].

- I don't mind I can afford it, y'know, I just...
- Doctor: Well, 40 bucks is 40 bucks. I mean I'd think twice about 40 bucks.  
[flips through file] You are just being carried by Medicare, is that right?
- Patient: That's right.
- Doctor: So you, so you pay for it.
- Patient: I do pay for it and I can afford to pay for it.
- Doctor: Well, I know you can.
- Patient: I'm willing to do that.
- Doctor: Yeah, 40 bucks is 40 bucks actually the curious thing is Medicare now pays for it.  
We're going to make this very simple.
- Patient: Mm hmm.
- Doctor: Let's have you come in fasting each morning.
- Patient: You want to do that, okay.
- Doctor: Yeah, I'm not going to spend your 40 dollars when it would be easy for me to send you out and have all that stuff done. But what I really need to do is a glycohemoglobin, which I'll do when I bring you back for your fast.
- Patient: Okay.
- Doctor: If it's normal, I may still tell ya to watch your diet. But I'll be able to reassure you that by the current criteria you don't have diabetes.
- Patient: I don't think I do but I know I'm borderline and it seems to be related to my gaining and losing weight. I was on Diabeta when I saw another doctor before I came here.
- Doctor: I remember your blood sugars would get really low even on a low dose.
- Patient: I would have a lot of blood sugar reactions. All right, you're gonna do the fasting and the glycohemoglobin at the same time.
- Doctor: Right.
- Patient: You're gonna draw the blood for that.
- Doctor: They're not gonna stick you twice.
- Patient: Well, I don't mind being stuck [laughs] either. Uh, now what's my cholesterol and vitamin, y'know. I think you checked it in the beginning, uh, I just wondered. I think it was 232 when they did it when I first came, or something like that.
- Doctor: Yeah. Let me see let me see if I can pull it up on the computer.
- Patient: The reason I ask is we are on a big cholesterol thing in our family. My husband had a thyroid bypass seven years ago and his doctor has now got him on Lipitor and he's been on Mevacor, and we're very careful about diet. I am. And uh his is within normal range.
- Doctor: Okay. Let me see what I pull up. If not, since you're coming in fasting we'll just recheck it then. [doctor leaves room; patient waits ~1 minute]
- Doctor: Must have been checked before the computer had the records. Let's just do a fasting.
- Patient: All right, I'm not concerned, but it seems to be a big interest in everybody's lives.

- Doctor: I think when a person has high blood pressure, we pay a little bit more attention to their cholesterol. If they've had a heart attack we really pay attention.
- Patient: Yes, I know you do.
- Doctor: And as a 74-year-old woman who's just fine and whose cholesterol is 230 to 240 [sighs] it's really a tossup as what to do. But let's do the test and then decide.
- Well, how are things otherwise?
- Patient: I'm fine really. I feel fine. I have no real - I have arthritis, stiff fingers and my knees hurt, but I don't...
- Doctor: Is it serious enough to interfere with your activities that you decided to do?
- Patient: No, I do everything. I walk, do all my housework, my gardening. I just am slower and not as anxious to take on tough things. I take just Tylenol for arthritis pain and get loosened.
- [discussion on medical insurance and Medicare]
- Doctor: Well, when did your parents die?
- Patient: My father was dead at 65 and he had Hodgkin's disease, and my sister's an RN and she decided we'd keep him at home and he died at home.
- Doctor: Anyway let's go ahead. What I'm gonna do is write for the blood test which means that when you come in you can be able to say, well Peter wrote down the tests that he wants ordered. Then I'd like to see you back after the tests have been done and let's just go over them.
- Patient: Okay and I can do this anytime.
- Doctor: All right.

**Interaction 3 (C2)**

Cara, a 72-year-old woman, presents to her primary care provider continued pain in her neck and shoulder. This doctor has seen this patient in the past.

Doctor: What can I do for you today?

Patient: Well I did have a rough several months. I feel better than I was when I was in here, y'know, the fatigue still exists. I ended up having to have the surgery done.

Doctor: Uh, huh.

Patient: Well, I had one root canal and then the sack was not healing and that was happening the end of August I think it was the 30<sup>th</sup>. He cut up in here and cleaned it, the nerve, and I purposely waited to make an appointment with you because I knew my body needed...within the past week it's not been real tender but it's just really flared up my pollen my allergies are just something fierce and so I'm feeling...

Doctor: What have you been doing with the Prednisone idea?

Patient: I'm still on the 2 prednisone and I know I'm gonna have to have to be on that, y'know, I was able to go on back down to the one, y'know.

Doctor: But you decreased it for a couple of weeks and it seemed like things were...

Patient: Right. And um, I don't think I can do without the Prednisone, even though it's 2 milligrams. I know that, but increasing the Prednisone is not the answer, and I did need that boost me over the infection about the past three weeks. I just don't think the Trazodone is holding anymore and I don't think I need to go up on it. Is there a substitute because I've been on it since November and it's done well but I have had rectal symptoms. I'm waking up at night sometimes. The other night I just woke up I was numb all the way down and I was on my back, and I'm waking up at least 2 or 3 times during the night and sometimes trying to get comfortable going to bed once I can go to sleep, and I really don't think it's the pain as much as that I'm not getting enough sleep.

Doctor: Mm hmm.

Patient: So that's one thing I have been... Have you ever heard of a doctor Righteous Callahan? In '85 he came out with a technique that cures phobias. Were you ever aware of that thought field therapy?

Doctor: I mean I've heard but I wouldn't know this particular person or...

Patient: Right, but he discovered, he's a psychologist- and anything that I can do holistically in the energy fields, you know, I work on. So about the end of August, I took a little, y'know, course. It's a tapping technique, and I found it does help with the phobia, and it does something with the with the uh meridians, okay, and so I said if I can do anything just to help relax me and get rid of and help my pain. And I realized with the polarity, there's a certain part you will tap and for some people who are sick their polarity is quote backwards.

Doctor: Uh huh.

Patient: And I have found when I'm just feeling real awful and I check my energy fields and my ( ) is blocked I'll do the tapping and all of a sudden I can just feel a shift in my body, so I have been doing that quite a bit.

Doctor: Mm hmm.

- Patient: So I know it's with the energy field and new medicine, so I feel like if I can just sleep at night stay on the Prednisone and get something. I don't think the Trazodone is gonna help me and I don't wanna go to that Amitriptyline.
- Doctor: Yeah, no. There are side effects with that.
- Patient: Oh gosh, yes, if is there anything because when I'm feeling that way I'm doing my tapping or the thought field technique which maybe takes two and a half to three minutes and you can repeat it. It's not dangerous to the body or anything and so it's helping me, and I can just tell it's like when someone is tryin' to breathe and feel an asthma attack coming on and maybe they open the window or get a breath of air, your body senses it immediately, so I know that it's bad and I don't want any medicine for pain - I don't think it would it be effective.
- Doctor: As far as at night, do you have a pretty typical routine that you go through?
- Patient: Oh yes, what I do in the evening, lot of times I don't even fiddle with the news anymore cause to me it's just so, y'know. If the cardinals are playin', I'll listen but I am quieter in the evenings like from 9:30-10:00. Or sometimes I'll may be reading or put the radio on, but it's disturbing that I don't go to sleep right away. But that's okay. I'll set in my chair sometimes and rest or do something like that and then go on to bed. But I take the Trazodone maybe 30-35 minutes, it depends. If I feel tired I go to bed, and I try to get to bed the same time every night.
- Doctor: Mm hmm.
- Patient: 10:30 or somethin' like that. Regardless of what time I go to bed at night, the next morning at 6:25 that alarm goes off, whether I feel like it or not. I get up, I mean, cause I can fiddle around and stay up real late. And so, I don't wanna get my sleep pattern off. A lot of times, sometimes, my shoulders have been uncomfortable and I energize. It's a therapeutic touch gets me energized. It's from here the base of my neck in here that's where I have always had the pain and it hurts [laughs]. But if I can get comfortable, I drop on off to sleep. When I wake up, I'm aware of it, and I finally go on off to sleep, but I feel the tapping technique has helped and I just don't take anything for pain. I mean I don't need it so it's this and the fatigue. Still, it's nothing like it was [laughs] when I came in July. And I'm sure it was the infection then. And I still get out and get tired, but I also know once I do the tapping on the side here, it'll switch and I can just feel like [snaps fingers with both hands]. I can tell it immediately. I still have to pace so much and I'm not frustrated anymore. To me, if I'm gonna live and go and do my stuff, if it takes me longer, that's okay. I have made that choice, so I don't feel any mild depression or sadness or anything like that. I think I've dealt with that and, y'know, this is it. The [sighs] past week my stomach began settling down some. I'm just taking the crystallized ginger the ginger snaps just were not effective. I'm taking the crystallized ginger and it helps so I have been...
- Doctor: Did he put you on any antibiotics during the time of-
- Patient: No, what he did was applied it locally and he was doin' all that cleaning, no...
- Doctor: Yeah no, that's okay.



Patient: The other thing that I found is the 1000 milligrams of the Vitamin C has made a difference in clearing and keeping this area cleared and um I would need a prescription for that...my community gets reimbursed by a local regional office.

Doctor: Now are you still takin' the Trazodone?

Patient: Yes, cause I [laughs] I've done everything else, and I don't take caffeinated stuff at night and I try to quiet down...anything that's real violent on TV, I just don't watch it because I wanna not be so stimulated. So the Trazodone did work, and I am so grateful for it cause I started out in mid November, so I just feel like probably my body is just not responding to it anymore.

Doctor: Mm hmm, um, got a couple of suggestions.

Patient: Okay.

Doctor: What we may wanna do is keep the trazodone going. Now we got several different choices and what I know as medicine is a little bit better. You have more experience with some of the energy fields and tapping. There's like a mild muscle relaxant.

Patient: That's why I'm talking to you cause you're the medical [laughs] expert.

## Appendix G: Questionnaire/Interview questions

### Evaluation of Medical Interactions

*Please answer the following questions after reading the medical interaction excerpts. Rate each item on a scale of 1 to 5, 5 being the highest.*

#### Interaction 1

	Low					High				
To what extent did/was/were										
1. The type of information given by the patient lead to forming a working diagnostic assessment and treatment plan (including tests/referrals):	1	2	3	4	5					
2. Doctor interaction technique(s) useful in eliciting patient information:	1	2	3	4	5					

### Evaluation of Medical Interactions

*Please answer the following questions after reading the medical interaction excerpt.*

#### Interaction 2

	Low					High				
To what extent did/was/were										
1. The type of information given by the patient lead to forming a working diagnostic assessment and treatment plan (including tests/referrals):	1	2	3	4	5					
2. Doctor interaction technique(s) useful in eliciting patient information:	1	2	3	4	5					

### Evaluation of Medical Interactions

*Please answer the following questions after reading the medical interaction excerpt.*

#### Interaction 3

	Low					High				
To what extent did/was/were										
1. The type of information given by the patient lead to forming a working diagnostic assessment and treatment plan (including tests/referrals):	1	2	3	4	5					
2. Doctor interaction technique(s) useful in eliciting patient information:	1	2	3	4	5					

Interview

After written feedback from doctors, a brief interview will take place, asking doctors to respond to the question “What additional question could be asked to elicit more useful information for diagnosis and intervention?”

Interaction 1Interaction 2Interaction 3

Why these questions?

On a scale of 1 – 5, 5 being the highest, to what extent was the patient was sufficiently heard in the last interaction?

Interaction 1

Low

High

1      2      3      4      5

How does this compare with the extent to which the patients in the other two interactions were sufficiently heard?

Interaction 2

1      2      3      4      5

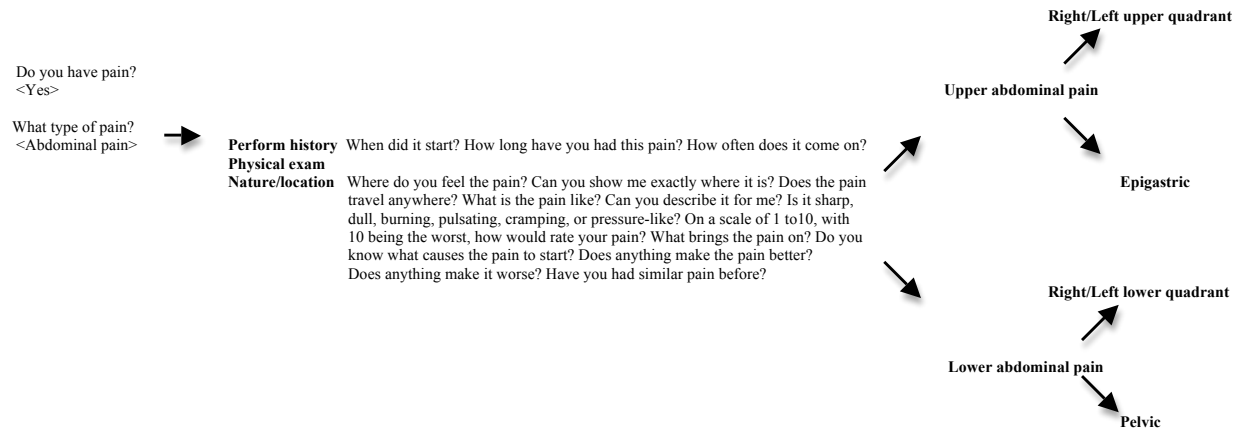
Interaction 3

1      2      3      4      5

## Appendix H: Question-tree formulary sample

The medical question-tree formulary as widely taught and used in U.S. clinical settings is derived from an algorithm approach. The following sample illustrates the logic of the algorithm approach and its impact on elicitation selection.

### Presenting concern: Abdominal pain



< > = Patient response    **Bold** = Algorithm

Adapted from

Common Medical Diagnoses: An Algorithmic Approach, 4<sup>th</sup> Edition (2006). P. Healey & E. Jacobson. Philadelphia: Elsevier Saunders Division.  
First Aid for the USMLE Step 2 Clinical Skills (2004). V. Bhushan, T. Le, F.A. Shahin, M. Sheikh-Ali, & L. D. Martin. NY: Elsevier Saunders Division.

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