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"My Mom Had a Stroke": Understanding How Patients Raise and Providers Respond to Psychosocial Concerns

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In the following transcribed excerpts, drawn from a routine medical interview, a patient repeatedly discloses that "My mom had a stroke." On three different occasions, over the course of a single medical encounter, the patient invokes his mom's illness as a significant factor influencing key health behaviors that are eventually discussed: excessive drinking, inadequate exercise and diet, and sleeplessness. However, he does so in the midst of producing other actions: (a) explaining his drinking, (b) offering mild disagreement with the interviewer, a physician's assistant (PA), and (c) explaining why he does not exercise. In response, despite patient's repeatedly invoking the serious impact that his mother's stroke has had on his life and his health, interviewer does not take up these psychosocial matters, nor even minimally acknowledge them. Because the patient presents these serious lifeworld experiences three times, at times quite dramatically, it seems anomalous that the PA does not address them in some way.

This chapter focuses on how patients present and interviewers respond to psychosocial problems during medical encounters. We reveal how it comes about that the interviewer pursues a biomedical agenda

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in lieu of addressing patient's health-relevant issues (e.g., see Maynard, 1991; Beach, 2001; Beach, Good, Pigeron, & Easter, in press; Heritage & Maynard, in press; Roter & Hall, 1992; Stivers, 2002), actively drawing attention toward bodily symptoms-blood in his stools, a pancreas damaged by alcohol, high cholesterol, high blood pressure, and excess weight-and not taking up concerns that are made available, and could be heard as "root" (Barbour, 1995; Felitti et al, 1998) or psychosocial problems underlying the patient's symptoms: stress caused by being a caregiver for both his mother and father. Although the patient makes it clear that he takes these commitments seriously, he also frames his caregiving efforts as rational explanations contributing to his poor health habits.

More specifically, we examine how, in each instance, the patient raises "Mom's stroke" not as the focal, or main action of his turn, but rather as part of the implementing action, or vehicle for producing the focal or main action (i.e., the psychosocial impacts of caring for family members):

- In Excerpt 1, he introduces the matter of his mother's stroke as part of an account for, or justification of, his drinking:

- In Excerpt 2, he offers "Mom's stroke" in order to note the onset of his drinking, as a way of disagreeing with the PAs claim that his stomach ailments might be related to his pancreas;
- In the third occasion (Excerpt 3), patient invokes "Mom's stroke" to account for his failure to exercise.

In each case, the matter of his mother's stroke and the problematic implications her condition has for his life, are raised in the service of some other action-indirectly, not as something to be addressed in its own right. In the ways these matters are introduced and structured, then, the PA is not sequentially obligated to take up the patient's psychosocial, lifeworld issues. They are not announced as the "main business" of the turns in which they occur. Rather, their introduction is subordinate to, or a vehicle for, other primary and ongoing actions. For instance, they are not introduced as announcements of good or bad news, to which some sort of response to and eventual appreciation of the valence of the news delivery would be relevant (see Beach, 2002; Maynard, 1997, 2003). Nor does the patient initiate story prefaces seeking the interviewer's alignment before producing an extended telling (e.g., see Beach, 2001; Jefferson, 1978; Mandelbaum 1989; Sacks, 199).

For example, over 30 years ago, Terasaki (1976; also in press) observed how talk that may appear to do the work of "announcing" may

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not be treated by the next speakers as an "announcement." "It appears that features of the design and placement of the item in the overall structure of the conversation contribute as much to its recognition as do content considerations." (p. 3).¹ Kitzinger (2000)² also notes that a similar phenomenon can occur in utterances in which speakers "come out" as lesbians or as intersexual. Speakers may "embed" their coming out in a position that it is not presented as "announcing" news for appropriate acknowledgment, uptake, and assessment. Coming out, in these instances, is not the primary activity. Rather, it is embedded in other social actions, and it is these other activities that get taken up by next speaker: "*Not* presenting information about one's sexuality as news has decisive consequences for shaping the course of the talk's development. If it is not announced as news, recipients have to work hard to receive it as such." (Kitzinger, 2000, p. 185).

The interviewer in the case examined faces a similar predicament. Although psychosocial matters are raised, they are in each case embedded by the patient as accomplishing some other actions (i.e., accounting, disagreeing), and produced in such a way that it is these actions that are made relevant to be taken up by the PA. We now consider both how this embedding of psychosocial matters is recurrently achieved as well as the consequences of their embedding for interviewer's responses throughout this medical interview. In lieu of directness, scholars widely recognize the offering of cues or clues as common behaviors produced by patients during medical encounters (e.g., see Beach et al., in press; Gill, 1998; Gill, Halkowski, & Roberts, 2001)-resources for introducing psychosocial matters impacting emotional and physical health and thus, the quality of life. Because interviewers do not actively seek what patients only hint at, one consequence is that no "official" attention is provided for them to be addressed during interaction. However, as will be evident, patients' indirectness is not tantamount to the lack of significance for health and well-being. Thus, the findings of this study provide clear implications for both patients (in terms of how they present issues that have relevance to their health, but which interviewers may not ask about), and for interviewers (in terms of pursuing psychosocial matters that may have health relevance, even if they are raised only tangentially).

While attending to patients' concerns clearly does occur (e.g., see Beach & Dixson, 2001; Beach & LeBaron, 2002), recent research has consistently revealed a host of delicate moments arising from patients' attempts to describe and offer lay diagnoses of their condition (see Beach, 2001; Gill et al., 2001; Jones & Beach, in press; Perakyla, 2002; J. D. Robinson, 2001; Stivers & Heritage, 2001). One primary set of social activities involves moments where patients voluntarily elaborate about their lifeworld circumstances, raising matters that

could be heard to extend beyond what care providers were focusing on in prior questions. Within these elaborations, patients often disclose primary concerns, matters that may or may not be aligned with biomedical diagnoses but are nevertheless put forward as concerns. This chapter shows three environments in which this can occur, and explains how it is that a care provider could come to fail to take up a patient's psychosocial concerns. Our analysis addresses each of three instances involving "Mom's stroke" in the order in which they occurred. The contiguous nature of these social activities is thus preserved and used as a resource for this analysis. Observations can then be offered not only about each set of moments, but also their serial and cumulative organization over the course of a single medical encounter. Implications for communication and patient-centered care is raised and elaborated.

DATA AND METHOD

Interactional materials are drawn from a corpus of videorecorded and transcribed medical encounters within a large health maintenance organization (HMO) located in the southwest United States. All names and references to individual's identities have been removed to guarantee anonymity of speakers-PA and a 43-year-old male patient undergoing an annual health appraisal. The presenting problem nominated by the patient at the beginning of the interview is severe, persistent diarrhea.

Conversation analytic (CA) methods are employed (see Atkinson & Heritage, 1984; Drew & Heritage, 1992; Heritage & Maynard, in press; Pomerantz & Fehr, 1997; Sacks, 1992). This mode of analytic induction is anchored in repeated examination of recordings, in unison with systematic inspections of carefully produced transcriptions. Priority is given to locating and substantiating participants' methods for organizing and thus accomplishing social actions. It is an explicit and working assumption of this research method that participants continually and intrinsically achieve, through an array of interactional practices, displayed understandings of emergent interactional circumstances. The overriding goal, in examination of both ordinary/casual and institutional (e.g., medical) encounters, is to identify and describe patterns in interaction through which everyday life events are socially constructed.

DRINKING AS A DELICATE MATTER

Excerpt 1 begins with a series of progressive and increasingly specific questions by the PA about the frequency, quantity, and nature of patient's drinking behaviors (Appendix with transcription symbols):

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1. "Do you drink?": #2:3-4

INT: Do you drink?

PAT: Um hm.

INT: How often do you drink?

PAT: I usually have something 'everyday before >I go to bed<. INT: Okay and about how many drinks per day [do you drink]? PAT: [Maybe three].

INT: And what is it that you're drinking?

PAT: Usually vodka a:n: (0.2) °some kinda mixer Tdet (.) seven 1° [or something.]

INT: [°O k a y °..hh] Now. (.) drinks (0.2) in: the context of description uh usually has different meanings to different people? hh About what -quantity per drink would you say that you're having.

PAT: In terms of fingers or [\$uh heh heh heh huh\$].

INT: [Yeah. Are you- are yo]u having a shot? Are you having

a:=

PAT: = >Probably about a shot<. =

INT: =°I see.° hhh [And you

PAT: [>But that isn't- I mean that's just been in the la:st< (.)

our years or five years that I've been [°doing that °].

INT: [>But you've been doing that everyday<

(.) for the past four or five ye[ars?
 PAT: [TPrettymu:ch. (.) INT: °Okay.° (.)
 PAT: -4 My mom had a **stroke (.) five years ago and u:h I have to go every night after work and help (.) my dad out with her so: = hh when I come home just to unwind \$I have a few drinks\$ and then >go to bed<.**
 INT: -4 Have you ever noticed any **blo:od in your stools or bla:ck stools?**

Notice that once interviewer establishes patient's drinking, he next queries "How often do you drink?" Patient's response, "I usually have something (everyday) before >1 go to bed<." leaves unspecified both an *exactfrequency* and what he drinks. Yet, his drinking most "°everyday°" makes available a potential drinking problem for the interviewer to subsequently address, although it is not offered here as a problem. Note that the patient volunteers that he drinks prior to going to bed. Later in this excerpt, he makes clear that he seeks to unwind following a day of work and caring for his mom and dad.

PA next continues to gather information by addressing the quantity of patient's drinking. His "Okay" responds to patient's prior contribution by minimally acknowledging it before moving into a next question,

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"and about how many drinks per day do you drink?" (see Beach, 1993, 1995). This "Okay" action provides a brief glimpse into one resource employed for keeping the discussion focused and on track to accomplish an agenda interview is pursuing at any given point in time.

It is of some interest across the excerpts analyzed herein, then, that the initial attempt by the patient to volunteer even minimal information is met with some enforcement: Subtly but decidedly away from topics and issues indirectly raised by the patient, and thus not raised by the interviewer as he relies on "Okay" to move the medical encounter forward on his own terms.

It could be argued that, in providing the information regarding when he drinks ("before I go to bed"), the patient might be making available to the PA something that could be heard to be related to why he drinks. It is clearly not germane to how much he drinks, but locates it in the patient's day, and could be heard to be the beginnings of an account (explanation) for why he drinks (Buttny, 1993; Heritage, 1983; Scott & Lyman, 1968). Mentioning the timing of the drinking when it has not been actively solicited could be heard to be away of making available to the physician that there could be more to report regarding the drinking, such as the reason for it, that may be tied to when it occurs. This is not made actively relevant in any way, but the provision of a piece of unsolicited information could make available to the PA the opportunity to probe further in order seek a reason for its provision. The PA merely acknowledges the information and moves on to the next question regarding how much the patient drinks.

In overlap ([]) and response, patient's "Maybe three." suggests that an exact "metric" for assessing "how many" drinks is an ambiguous task (see Halkowski, 2000). So too is providing an exact answer to interviewer's next "And what is it that you're drinking?," as patient again qualifies that it is usually vodka and some kind of mixer. It is this interplay, between the interviewer's seeking specific answers and the patient's repeated offerings of hedging and inexact assessments, that his next question is designed to elicit a more specific quantification of how much the patient actually drinks:

2. "In terms of fingers": #2:3

PAT: Usually vodka a:n: (0.2) °some kinda mixer -(diet (.) seven p ° [or something.]

INT: [°O k a y °..hh I Now. (.) drinks (0.2) in: the context of description uh usually has different meanings to different people? hh About what quantity per drink would you say that you're having?

PAT: 1-4 In terms of fingers or [\$uh heh heh heh huh\$].

INT: [Yeah. Are you- are yo |u having a shot? Are you having a =
 PAT: =>Probably about a shot<.=
 INT: =°I see.° hhh [And you
 PAT: 2- [>But that isn't- I mean that's just been in the la:st< (.)
four years or five years that I've been [*doing that °].
 INT: 3-a [>But you've been doing that everyday<
 (.) for the past four or five years?
 PAT: [TPretty mu:ch. (.) INT: °Okay °

First, PAs "°Okay.°" acknowledges the patient's response of "-diet (.) seven up °[or something.]", closing this sequence. "Now" shows that he is moving on to something else that could be heard to have its basis in what precedes it. Because descriptions of quantity mean different things to different persons, the interviewer seeks a more specific "objective" measure from the patient. Patient offers a candidate metric: "In terms of fingers or [\$uh heh heh heh huh\$." As patient raises his left hand for interviewer's inspection, he forms different finger combinations (one to three) to symbolically portray possible measures for the amount of liquor in a glass. The fact that patient's verbal and visual depiction are followed by laughter (\$uh heh heh heh huh\$) may mark the somewhat awkward yet humorous and even delicate nature of his gesture and topic. Although the activity "at hand" (literally, in this instance) could simply be constructed by the patient as funny, the patient also exhibits awareness that the problem he addresses-quantity of alcohol consumed-is ultimately a serious matter requiring resolution. Discussing excessive drinking is delicate in almost any environment, particularly a medical one (see Haakana, 2001). Discussing such personal matters with a stranger also contributes to the delicacy of these moments.

In overlap, the interviewer translates the patient's "fingers" analogy and gesture into a more common metric-"a shot?"-which patient's "Probably about a shot." essentially confirms as a reasonable estimate and the interviewer quietly responds with °I see.°. It is here (2 -*), before the interviewer can complete what appears to be a next question ('And you-'), that the patient qualifies the amount of his drinking by stating that he's only been drinking like that "in the la:st < (.) four years or five years." This oblique reference to "the last four or five years" could make available to the PA that there is some circumstance that began 4 or 5 years ago that prompted the drinking. Similar to "before I go to bed," this information is not directly sought by the PA, and although

it is hearably relevant to the current project (providing an objective measure of how much the patient drinks) it offers another kind of objective measure of how long the drinking has been going on, and raises an unexplained question: Why 4 or 5 years? While this issue constitutes something the PA could take up, it is packaged in the service of minimizing the longevity of the drinking, and thus is, not officially proffered as that on which talk should now be focused: It is produced officially in the service of quantifying the drinking, rather than raising psychosocial matters that might have prompted the drinking.

The prior sequence is possibly complete at this point. Indeed, the PA has acknowledged the patient's response that he has "probably about a shot" with "I see," showing that this question has received its answer and that the sequence is closed. Thus, patient's attempt to minimize the extent of the drinking by limiting it to the past 4 or 5 years reopens it, providing for the possibility of further talk regarding this matter. Again, the PA is not put in the position where actively pursuing a psychosocial matter is made directly relevant, because it is raised officially in the service of quantifying the drinking. That he provides this attempt to delimit the extent of his drinking at this moment may also evidence his recognition that he could be found at fault for excessive drinking-and seeks to minimize possible blame associated with his actions (e.g., see Beach, 1996; Heritage, 1983). Thus, patient may be seeking to situate his drinking within significant (as yet unarticulated) lifeworld events.

In response (3-*), interviewer checks his understanding of patient's quantification of his drinking. The words the patient provided for characterizing the extent of the drinking are used by interviewer as a counter assertion (see Beach, 1996; M. H. Goodwin, 1990) for

characterizing the extent of the drinking. The patient then confirms this hearing, and PAs "Okay" shows that he takes it that this sequence is closed.

This action is, curiously, akin to how cross-examining attorneys do not simply query opposing/unfriendly witnesses but construct accusations shaped to attribute wrongdoing and even challenge the believability of witnesses' stories/testimony (see Atkinson & Drew, 1979; Drew, 1978, 1985, 1992; Metzger & Beach, 1996). Here, the interviewer is not taking up the patient's reference to "f:our or five years" bears resemblance to some modes of interrogation designed to restrict contributions from question recipient. On such occasions, it is not uncommon for those whose narratives (or potential narratives) have somehow been constrained or challenged- as with courtroom witnesses and even during news interviews (see Clayman & Heritage, 2002)-to continue by offering a fuller explanation substantiating their position, defending their argument, or even pleading for their

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innocence. The patient orients here to the problematic character of drinking to this extent, and seeks to provide some psychosocial information that explains and justifies this extensive drinking. Such an explanation is not actively sought by the PA-he has shown with his sequence closing turn, "Okay," that he takes this sequence to be officially closed. However, it may be generated by a possible hearing of the PAs understanding check, "But you've been doing that everyday (.) for the past four or five years?" as also embodying an accusation or critique of the patient.

The patient then uses this opportunity to provide an account of what happened 5 years ago that could be heard to at least explain what could have prompted this drinking:

3. "My mom had a stroke": #2:4

PAT: - My mom had a stroke (.) five years ago and u:h I have to go every night after work and helg (.) my dad out with her so: = hh when I come home just to unwind \$I have a few drinks\$ and then >go to bed<.

INT: -- Have you ever noticed any blo:od in your stools or bla:ck stools?

This excerpt begins with a report of his mother's stroke. As Kitzinger (2000) noted with regard to "coming out," his mother's illness is presented at a point in the utterance (here, in the beginning), such that it is not presented as an announcement to be responded to. Rather, it is followed by a report of his obligation: "I have to go every night after work and help (.) my da out with her." This volunteered information further legitimates the extremity of his situation (see Pomerantz, 1986)-a caregiving obligation from which there is little "time out'-efforts aiding both his ill mother and dad (presumably, mom's primary caregiver).

Importantly, however, he next formulates ("so:") that his drinking is a consequence of his caregiving efforts. In this way, he clearly accounts for having a few drinks. The report is produced quite overtly in the service of explaining how (and why) he comes to be drinking so much.

As patient volunteers "when I come home just to unwind \$I have a few drinks\$," additional and key information is disclosed: (a) A need to "unwind," which implies ongoing stress; (b) A delicate orientation to drinking, marked by laughter (\$\$) demonstrating patient's awareness that a discrepancy exists between his drinking and what good, appropriate patients might do to preserve their health (Haakana, 2001). As noted, such actions are routine during medical interviews, particularly when patients portray their behaviors as knowingly unfavorable and thus potentially unhealthy. Through

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these efforts, it is clear that the patient works to account for his drinking as a resource for coping with difficult family responsibilities. He also designs his account to better inform interviewer of the difficult life circumstances he is facing. Such an account could make relevant an offering of reassurance and compassion about his troubling situation (actions discussed in the conclusion of this chapter). However, because it is produced specifically as a postexpansion of a series of exchanges regarding the quantity of his drinking, the PA could

possibly hear it merely as accounting for these actions. Further, the mention of his mother's stroke is positioned at the beginning of this unit of talk, removing it as far as possible from the part of the turn designed to be responded to. That is, although the life circumstances the patient produces could be taken up here, they are produced at the beginning of the turn, not as an announcement for immediate response, but rather in service of another action: accounting for excessive drinking. They are not produced as an announcement in their own right. Their position in this part of the interaction—as the reopening of sequence (question by PA, answer by patient, acknowledgment by PA), providing a report of circumstances that can be heard to be accounting for the facts established in the immediately prior sequence—mean that the interviewer is not put in the position of "having" to respond to the psychosocial concerns that are the vehicle for the action of accounting for the quantity of drinking. Yet the patient raises serious life concerns, framing them as directly relevant to (that is to say, generative of) the health-related matter currently under discussion.

In the next turn, interviewer continues with, "Have you ever noticed any blood in your stools or bla:ck stools?" While bloody or black stools may be symptomatic of damage caused by excessive drinking, and thus are biomedically relevant, the interviewer can be seen here to be missing a prime opportunity to support and talk further about the serious, and clearly closely associated issue that the patient has depicted. As interviewer chooses not to deviate from "the biomedical agenda," a "window of opportunity" for being empathic and connecting with the patient has thus been passed by (see Bellet & Maloney, 1991; Branch & Malick, 1993; Lang, Floyd, & Beline, 2000; Spiegel, 1999; Suchman, Markakis, Beckman, & Frankel, 1997). His lack of uptake overlooks the patient's disclosure of directly relevant, personally private, and delicate information. Moreover, the significance of the patient's "lay diagnosis" (Beach, 2001) for treatment and possible referral is (at this moment) left hanging. Essentially, the interviewer chooses to sustain a focus on physiological matters in lieu of a practical description of his directly relevant daily lifeworld experiences.

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Summary

To briefly summarize Excerpts 1 through 3, patient's initial and tangential raising of the family context influencing his drinking were not pursued by the PA. The patient's subsequent and fuller depiction about "my mom had a stroke," produced to account for his heavy drinking, is not taken up. Instead, interviewer pursues his questions about physiological matters. Although the patient has progressively introduced details of his psychosocial situation, often as subordinate rather than focal matters, interviewer has chosen to focus exclusively on biomedical concerns. This option is in no small part made available by the way the patient raises these concerns (i.e., as an account rather than an announcement, and located in a part of the turn that removes it from that which is directly response relevant).

A DISMAYED RESPONSE

The patient's second reference to mom's stroke occurs approximately 9 minutes following Excerpts 1 through 3, soon after the completion of a physical examination, and thus during a phase of diagnosis and treatment (Byrne & Long, 1976). Interviewer begins with a projection of what he will do next (go over a list of items "quite uh germane to your health") that could be heard to indicate that the upcoming matter is delicate (Schegloff, 1980). He then proceeds to offer a recommendation, that he shows he is making with the support of his supervising physician, that relies on a possible diagnosis of pancreas trouble provoked by excessive drinking as the cause for the persistent diarrhea that the patient has come in with. The first issue addressed is drinking, an elaboration raising concerns about possible damage and "ill effects born by the uh alcohol":

4. "mom's had her stroke": #2:22-23

INT: Now um .h I wan to go over some thins which I uh (1.0) found and they're quite uh germane, to your #iealth. And one of those is the uh (0.3) drinking that you mentioned? PAT: Um hmm.

INT: You said that you're having (.) five <drinks a day> and there are con- some concerns. (.) Uh those concerns are number one, hh uh alcohol does effect your pi creas, hh an:d uh that may have some effect upon hh what's going on with

your diarrhea. =I've >had the opportunity to speak< with my mentoring physician. hh and uh he's recommended, that we do some additional tests on ya (.) pt.hh one of which is called a serum amylase.=That that'll give us an idea hh of

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how your pancreas is functioning. =What your pancreas does in your body is it produces various enzymes that aid in d g estion as well as producing insulin and glucogons, which is used in the regulation of your (.) blood sugars so we're going to test that. The other thing [we're].

PAT: [Blood] sugars were pretty low
f normal].

INT: [Yeah yeah y]ou're not a diabetic. =So_ (.) when we're checking your amylase hh we're not checking for diabetes, we're check ing to see if your pancreas hh is being damaged from the alcohol..hh The other, thing we want to look at is how your liver (.) is functioning hh and to see if there is any effects born by the uh alcohol so we're going to do some liver function test (.) as well.

PAT: 1-a Oh but the **daily you know the °drinking° everyday at night has been just since my mom's had her stroke the last four- four or five years. (.) >The diarrhea's been< since I really think ninteen years at least ((probably))].**

INT: [**Okay but J sometimes these things-**

PAT: 1--> >But I'll check it.< I don't **know, I \$hmp\$.**

INT: 2- NOW (.) we're also going uh to **send a referral to Doctor Dorsey who is yur designated primary care physician.**

PAT: He is?

INT: And [uh::-].

PAT: [°I've I never been there.°

The PA attributes to patient his reporting that he has "five < drinks a day> "--emphasized by being spoken slower (< >) than surrounding talk. (Patient actually reported having "Maybe three, "but does not correct PAs summary.) Informed that his pancreas may have been adversely affected by alcohol, which may explain patient's ongoing problems with diarrhea, interviewer's discussion with his mentoring physician (a common practice for PAs) has given rise to the prescription of additional tests (e.g., serum amylase). Next, interviewer explains this test and moves to describe for patient how the pancreas functions in the body. A query by patient seeks confirmation of low blood sugars, which interviewer apparently understands the patient as implying that this indicates that he may be diabetic. The PA rejects this concern by stating he [the patient] is not diabetic. He also again emphasizes the need to determine if the patient's pancreas has been damaged, and that the liver will also be tested.

The PAs lengthy overview is met with surprise by patient (I-+), indicated by a turn-initial "Oh." As Heritage (1984, 2001) has noted, "oh prefaces" routinely treat prior speaker's positions as "questioning the

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unquestionable" (2001, p. 4), actions which are misconstrued if not altogether inaccurate, inappropriate, or even inapposite (see also Beach, 1996). Such "oh prefaces" also project nonalignment as speakers move next to reassert contrary positions, as the patient's "but" indicates. He reemphasizes that his daily drinking, at night, "has been just since my mom's had her stroke the last four- four or five years." This declaration is followed by a reporting designed to clarify his problems and reveal an inconsistency in the interviewer's reasoning: Because he has experienced diarrhea for at least 19 years, how could this ailment be caused by drinking the last 4 to 5 years?

Essentially, the patient has challenged a portion of PAs diagnosis. We have shown that, when patients proffer their own and/or question an interviewer's diagnosis, such contributions are treated with hesitation and indirectness-as though patients are resisting adherence to a biomedical model in which physicians address diagnosis, and only subsequent to data gathering and physical examination, by displaying interactional resistance to distinct and mandated phases of clinical interviews, traditional and biomedical procedures are repeatedly challenged. In turn, physicians routinely resist opportunities to

expand on actions soliciting early requests for diagnostic information (Jones & Beach, in press).

Here the patient reports facts-the duration of his drinking, and the duration of the diarrhea-leaving the PA to formulate the upshot of the report (Drew, 1984). This technique of a "novice" reporting circumstances and leaving the "expert" to formulate its (disagreeing) "professional" implications has been noted in the library setting also (Mandelbaum, 1996). In the library, as is perhaps also the case here, such a technique may be used as a "delicate" method for disagreeing with a professional, because it provides resources for the professional to revise his professional opinion. Although, the patient is not soliciting an early request in the present case, he clearly offers an alternative analysis of relationships between his drinking and diarrhea, and in this way, makes available a possible disagreement with what the PA proposes doing. In response, with "Okay but sometimes these things-", The PA begins what could be heard to be a contesting patient's of the action. Patient then builds a contrast to his prior turn (indicated by "But") and offers uncertainty: (1->)-">(probably). But I'll check it. < I don't know I \$hmpH\$," thus altering his position. "But I'll check it" registers his concern, and the decision to comply regardless. Here, the patient displays recognition that, although his counter to the interviewer's position is potentially unfavorable, so too is he aware that his speculation about how long his diarrhea has occurred-initially marked with more fervor-is tenuous. Three specific actions are rele-

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vant here: (a) Patient states a need to "check" the claim he has advanced; (b) claims insufficient knowledge (Beach & Metzger, 1997) with "I don't know"; and (c) laughs with \$hmpH\$. Taken together, patient qualifies and backs off of the accuracy of his position, expressing some doubt and deference in the presence of a medical expert. Such actions are exceedingly common during medical interviews: "since patients are overwhelmingly tentative in their various solicitations, they reveal distinct orientations to their actions as delicate maneuvers while also legitimating physicians' authority and expert knowledge" (Jones & Beach, in press; see also Gill, 1998; Gill et al., 2001). This delicacy may be further indexed when the patient completes his utterance with laughter (\$hmpH\$).

In response, (2-) PAs "NOW" is a way of moving on to the next activity and is followed by the PA moving on to the next recommendation that he has for diagnostic testing. However, the patient's mentioning his mother's stroke serves as the method he uses to implement the primary action of this turn, questioning the PAs assumptions about the patient's pancreas. Further, it functions as an enforced attempt to draw attention away from patient's reported history and toward a referral to "our designated primary care physician." Doing so essentially curtails further elaboration of the patient's attempt to clarify interviewer's diagnosis. It also makes clear that although patient treats such matters as relevant to his medical history and thus diagnosis, they are best addressed (if at all) by another medical expert he will "send a referral to"-a relationship patient reports being unaware of because he has "never been there."°

Summary

In this instance also, the patient's mother's stroke is raised as part of the method for implementing another action. Here, he delicately provides the PA with reasoning, laying grounds for disagreeing with his diagnosis. When he mentions that "the daily you know the drinking everyday at night has been just since my mom's had her stroke the last four- four or five years," this is done as part of contesting the physician's claim that the diarrhea has been caused by heavy drinking. The case is completed by building the contrast that the diarrhea has "been since I really think nineteen years at least probably." He is building a contrast between the duration of the drinking (4 to 5 years, prompted by the Mom's stroke) and the duration of the diarrhea (roughly 19 years). The focal action here calls into question the diagnosis the PA has offered. Patient reports circumstances that put him in the position to infer that a pancreas damaged by heavy drinking is unlikely to be the

cause of the diarrhea, because the diarrhea is of much longer duration than the drinking.

Again, it would be possible for PA to take up the psychosocial matter of the mother's stroke and its impact on the patient, but this would involve beginning a quite different line of action than the one under way. Clearly, an important issue for care providers to consider is when and how to take up such matters, especially those that may underlie a set of potentially serious health problems (as appears to be the case here).

A SERIES OF OPPOSITIONAL COUNTERS

The third and final reference to mom's stroke occurs nearly 3 minutes following (Excerpt 4). Interviewer offers specific advice for patient's drinking, namely, to "cut down" to no more than two ounces (shots) a day and if that continues to be a problem, contact the chemical dependency program. Attention is then drawn to "the need to exercise," as interviewer queries "... are you exercising at all?"

Again, the matter of his mother's illness is subordinated to another principal activity-accounting for a failure to exercise:

5. "Not since my mom got sick": #2:25-26:

INT: Okay. pt hh Now in terms of um (.) your drinking, hh need I y (.) you certainly need to cut down. (.) Ideally no more than (.) two ounces a day. pt hh Um: If that might become a problem area for ya hh we do have a chemical dependency program.= I've circled the name and the phone number and you may call them at your leisure. PAT: °Okay °

INT: And I'd like to um (.) talk about some other things which are certainly, important. One of tho:se Is u::h (.) the need to exercise and I didn't ask ya are you exercisin at all?

PAT: 1-4 'Not since my mom got sick.° >I used to bike ride< three miles but I- I hadn't had time.

INT: 2- Well exercises (.) even if it's no more than just walking for thirty minutes non stop three to five days a week hh is a valuable tool. pt And uh it's certainly

PAT: 3- I- I don't have thirty minutes <either. \$heh\$ But what I do is like> when I came here (.) is I took the stairs instead of the elevator.

INT: [Uh hmm 1.

PAT: 3- [I always t)ry to take the stairs at work (.) rather than call somebody in the next office. INT: Uh hmm.

PAT: 3-4 >I'll walk over there so I tr to get as much exercise as I can that< way but setting time aside \$ I just don't\$ have it.

INT: 4-a Well- what I'd like to do though is just uh: (.) tell you that that (.) is something that you should consider doin in the future. And the reason why is it does help to raise your good cholesterol.

PAT: [Um hm].

INT: 4-, [It produces chemicals in your brain which helps to deal with anxiety and stress..hh It uh [helps].

PAT: [I to lye to exercise.=

INT: 4-, =Good. (.) Helps to lower your blood pressure, and it certainly helps you with weight. And >there's a little guide< to sort of help you with that..hh And > here's a little handout< I'd like to share with you.

Without hesitation, in response to PAs question about exercise, patient provides his mother's illness as an account for not exercising: "Not since my mom got sick." (1 -). The occurrence of mom's stroke is again invoked as an event of considerable magnitude in the patient's life: It is invoked as an account for his drinking and now for not exercising (e.g., not riding his bike 3 miles). The immediacy of patient's response also reveals mom's stroke as a benchmark date for assessing the time he has available to invest in health-promoting activity. This utterance marks

the third time that this particular psychosocial matter has been raised in direct connection with the patient's serious health problems (excessive drinking and failure to exercise). As we have observed, in each case, it has been raised as part of the implementation of some other action such as accounting for his unhealthy conduct, or making available evidence that could counter the PAs attempted diagnosis. Yet, it is nonetheless surprising that, given the clearly pressing and recurrent nature of the patient's concern, the PA continues to not take up his concerns.

Because "mom's stroke" is not presented as the patient's direct and only problem at any point in the interview, the PA does not exhibit being compelled to acknowledge or pursue these psychosocial matters. In the ensuing series of turns, as the interviewer continues to promote the value of exercise, patient continues to indicate his positive attitude toward exercise but his inability to make time for it. In (2-), by reasserting the importance of exercising, the PA treats the patient's prior turn (1-p) as his accounting for not exercising. Similarly in (3->), patient again accounts for his lack of exercise by reporting his lack of even 30 minutes and offering what he does instead (taking the stairs). In response, the interviewer minimally acknowledges, and the patient continues to give examples indicating his willingness to exercise. Yet, the

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patient does not state making exercise a priority over his other daily activities. Finally in (4->), the PA prefaces his report of another advantage of exercise with encouragement to the patient to "consider doing" it "in the future." This recommendation indicates that the PA still considers the patient to be in need of persuasion in the face of the patient being resistant to exercise regularly. The patient's "I love exercise" continues to positively assess the value of being physically active, yet leaves hanging an inability and/or unwillingness to enact an exercise plan because of the time constraints his mother's illness imposes.

This orientation by the interviewer is consequential for the unfolding of this interview, which resembles a series of reciprocal counters not unlike those noted earlier (see Excerpt 2). For example, just as the interviewer's (2-+) fails to pursue patient's problems, so too does patient

(3-*) immediately dismiss the interviewer's suggestion: "I- I don't have thirty minutes < either. \$ehh\$". Here, the patient treats as delicate his discounting and thus challenging of interviewer's proposed "walking" solution. Similarly, just as the patient produced an extended utterance establishing the relevance of his efforts to exercise (3-*), the interviewer also provides a series of reasons for compliance: Raising good cholesterol, reducing anxiety and stress, lowering blood pressure and weight. His reference to "anxiety and stress" is the closest he gets to addressing the concerns the patient has nominated throughout this entire medical interview. It is noteworthy, however, that "anxiety and stress" are raised here as part of a generic and itemized list (see Jefferson, 1990) for advancing health through exercise, not as tailored to the patient's unique circumstances. In the end, a compromise does not emerge where the patient might somehow increase his exercise in the midst of work and caregiving responsibilities.

Summary

For the third time, the patient uses his mother's health as an account for medical-related noncompliance. In turn, the PA does not utilize opportunities to address how the patient's mother's illness, and the caregiving responsibilities he takes on, reveal key health implications. However, it is once again clear that the particular ways the patient raises his mother's health situation remain embedded, that is, in a position in the ongoing turn where they are not made available as that which "should" or even "must" be responded to.

DISCUSSION

Close analysis of the social actions comprising this medical interview reveal that the patient's references to his mother's illness are not

straightforwardly produced, such as an announcement requiring response and assessment

by the PA. In sequential terms, the patient's accounting, disagreeing, and explaining of his daily circumstances provide resources for interviewer to not directly address and pursue mom's stroke-as consequential for the caregiving the patient provides, as impacting how the patient lives an unhealthy lifestyle, or as an ongoing and serious health matter requiring medical attention. These issues are not addressed in this interview, and we have advanced sequential, "structural" reasons for their not be taken up by PA: Local, embedded, and systematic explanations for why and how the patient's troubling life circumstances-not presented to be taken up, but in the service of explaining his drinking and life circumstances-do not get discussed. Technically, then, interviewer does not disattend concerns that patient did not make directly available as topics in their own right.

No claim is being made that the PA lacks concern for the patient's health condition. It is possible that the patient benefited, perhaps in significant ways, from participating in this medical interview. It is also possible, as with Excerpt 2, that the patient is anxious to connect his drinking firmly to his mother's illness, not just as an account for his behavior, but also to show that it is short-term conduct-at least in contrast with his long-term diarrhea-and may in fact not be as relevant as the PA is intimating. However, clearly, the interviewer did not seek elaboration on the patient's family dilemma, and thus further talk about the relevance of mom's stroke to the patient's health and lifestyle was constrained. Left unexplored, then, are potential "root issues" (see Barbour, 1995; Felitti et al., 1998) contributing to ongoing health problems and how such knowledge might shape not only diagnosis, treatment, and referral but, ultimately, mortality and morbidity. Thus, our findings should not be taken to imply that, by not further discussing patient's mom's stroke, better medical care was necessarily provided.

In writing this chapter we have had the opportunity to discuss these and a host of related and complex issues, which may be summarized as follows:

- What relationships exist between (a) a technical, sequential basis for interviewers not addressing concerns raised (but not raised to be directly addressed) by patient; and (b) acknowledging, reassuring, and offering support for patients' troubles even though they are not presented as primary topics for discussion?
- What windows of opportunity are passed by when not addressing "cues or clues" offered by patients about their condition, and what implications arise for the ongoing quality of care?

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- What interactional evidence can be provided about "compassionate" care in the midst of indirectly provided concerns by patients?

Indeed, the materials examined herein exemplify recurrent problems in not only providing medical care but also establishing sufficient interactional explanations for the organization of medical interviews. As noted, a long-standing and primary concern with understanding patient centered care involves the diverse ways patients offer "cues or clues" about their concerns, how (or if) these behaviors are addressed by providers, and overall impacts on healing outcomes (e.g., see Balint, 1957; Barbour, 1995; Beach & Dixon, 2001; Beach & LeBaron, 2002; Cassell, 1985; Engel, 1977; Frankel & Beckman, 1988; Gill, 1998; Gill et al., 2001; Heath, 1986, 1988, 2002; Jones & Beach, in press; Lang et al., 2000; Levinson, Gorawara-Bhat, & Lamb, 2000; Marvel, Epstein, Flowers, & Beckman, 1999; Mishler, 1984; Slivers & Heritage, 2001; Suchman et al., 1997; Waitzkin, 1991). However, how are "cues or clues" to be evidenced as interactional achievements, and in response, how do medical experts address (or not) patients' concerns (whether indirectly or directly raised)? The interactional moments examined in this chapter make clear that, over the course of a single medical interview, a distinction needs to be made between how a patient repeatedly verbalizes concerns about his mom's stroke, and how he does not actively invite pursuit of an obvious and important set of health-related topics (see Beach, 1996; Pomerantz, 1984). Similarly, other work is moving forward, such as ongoing examinations of how cancer patients' subtle and directly produced verbal and nonverbal expressions of "fear" get responded to by oncologists (Beach et al., in press).

It is important to emphasize that speakers' reportings about their worlds "are in fact extraordinarily complex speech events" (M. H. Goodwin, 1990, p. 230), progressively and collaboratively built in and through conjoint, moment-by-moment actions (see Beach, 2000; Mandelbaum 1989). Across a wide array of both ordinary conversations and institutional encounters (see Drew & Heritage, 1992), conceptions of "narratives" as uninterrupted monologues, produced by single speakers, are inadequate if and when the achieved character of human interactions remain the grist for the analytic mill. From the materials examined herein, it is possible to extract key moments of the patient's "narrative" and integrate his concerns into a coherent framework. The result would appear something like the following:

I usually have something ° everyday ° before >I go to bed< -* >But that isn't- I mean that's just been in the la:st< (.)Lour years or five years that

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I've been* doing that ° -a My mom had a stroke (.) five years ago and u: h I hay to gg every night after work and h p (.) my dad out with her so: = .hh when I come home just to unwind \$I have a few drinks\$ and then >go to bed< 4 Oh but the daily you know the ° drinking ° everyday at night has been just since my mom's had her stroke the last four- four or five years. (.) >The diarrhea's been < since I really think nineteen years at least (probably) >But I'll check it.< I don't know I \$hmph\$. °4 Not since my mom got sick.* > I used to bike ride < three miles but I_- I hadn't had time. -* I- I don't have thirty minutes <either. \$heh\$ But what I do is like > when I came here (.) is I took the stairs instead of the elevator -* I always try to take the stairs at work (.) rather than call somebody in the next office -> > I'll walk over there so I trig to get as much exercise as I can that < way but setting time aside \$ I jn t don't\$ have it.

From this extracted "narrative," a claim could be advanced that the patient repeatedly attempts to raise that and how his mom's stroke continues to influence his life. Yet to whom does he raise the fact and with what interactional consequences? Viewing the patient's "narrative" as solely produced does provide a user-friendly opportunity to comprehend the basic gist, or plotline, of the drama he is portraying. What is inevitably lost, of course, are the interactional contingencies co-produced by the interviewer and the patient animating this encounter: As we have shown, each utterance is designed as responsive to not just any but specific social actions, and in turn, makes available to the next speaker particular and relevant understandings of evolving courses of meaningful conduct behaviors that, by definition, could not and would not be produced by individuals apart from this embedded context (Goodwin, 2003). Inherently, social phenomena—such as extended answers to prior questions, delicately produced laughter, raising concerns indirectly, or not addressing topics related to mom's stroke—would therefore not be available for examination. The lack of embedded contexts would be a great loss if what we seek to understand is how communication shapes, and is shaped by, illness and wellness. Nor would a much wider range of social activities be available as a resource for better understanding the interactional organization of medical interviews—for their own sake as interesting forms of institutional involvements, and/or to improve communication between providers and patients.

These are critical issues as medical care systems seek innovative ways to preserve wellness, medically and morally (Bergmann, 1992). The consequences of artificially separating body, mind, and spirit are nontrivial for the human condition. When patients' basic needs and concerns are unmet—even as a result of their inability to raise them directly—patients seek return visitations, including ERs, because their

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stated problems were not heard and attended to in prior encounters. Satisfaction, loyalty, and compliance is compromised in ways severely impacting healing outcomes. Despite increasing technological sophistication, malpractice suits escalate as basic communication problems between patients and providers drive the machinery of litigation (see Levinson et al., 2000). Resolving these disjunctures begins with giving

priority to basic social actions: How the patients construct and the providers respond to lifeworld experiences throughout history taking, physical examination, and diagnostic and treatment discussions. Any prescriptions we offer about how to improve these critical moments must remain sensitive to actual practices employed by lay and medical experts (Heath, 1986), accessible only through close examination of recorded and transcribed encounters. The alternative is to propose vague solutions for nonexistent interactional problems, or perhaps worse yet, specific but misdirected remedies further restricting patients' disclosures.

NOTES

1. For example, consider the following excerpt and discussion by Terasaka (1976):

(3) [NB:-21

1 B: So, Elizabeth'n Will were s'poze tuh come down las'night 2 but [there was death 'n the fam'ly] so they couldn'

3 come so Guy's asked Dan tuh play with the comp'ny deal,

4 so I guess he c'n play with'im. So, 5 A: Oh good.

In this example, the news of the death (indicated by brackets) is not remarked on, whereas the news that the golf game will take place is received as assessable news. Our suggestion is that a major factor in the recognition of announcements by speakers is to some degree independent of the content of the events they report and resides, instead, in the organization of their presentation in the talk.

Thus, announcements should be differentiated from talk about occurrences that might otherwise appear to be announceable but can be shown to have been "buried" in their presentation. There are additionally instances of talk in which a recipient treats some talk as news to them, which were not marked by the deliverer as announcements.

2. We are grateful to Gene Lerner for pointing out the relevance of this article.

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BEACH AND MANDELBAIM APPENDIX: TRANSCRIPTION SYMBOLS

In data headings, "SDCr stands for "San Diego Conversation Library,"

a collection of recordings and transcriptions of naturally occurring interactions; "OC" represents "Oncology" followed by vernacular ex

tracts drawn from the video-excerpts being analyzed (e.g., "feeling (. lately"). The transcription notation system employed for data segments

is an adaptation of Gail Jefferson's work (see Atkinson & Heritage, 1984, pp. ix-xvi). The symbols may be described as follows:

Colon(s): Extended or stretched sound, syllable, or word. _ Underlining: Vocalic

emphasis. (.) Micropause: Brief pause of less than (0.2).

(1.2) Timed Pause: Intervals occurring within and between same or different speaker's utterance.

(()) Double Parentheses: Scenic details.

() Single Parentheses: Transcriptionist doubt. Period: Falling vocal pitch.

?Question Marks: Rising vocal pitch.

T 1((Arrows: Pitch resets; marked rising and falling shifts in intonation.

° ° Degree Signs: A passage of talk noticeably softer than surrounding talk.

= Equal Signs: Latching of contiguous utterances, with no interval or overlap.

(| Brackets: Speech overlap.

((Double Brackets: Simultaneous speech orientations to prior turn. ! Exclamation Points:

Animated speech tone. Hyphens: Halting, abrupt cut off of sound or word.

> < Less Than/Greater Than Signs: Portions of an utterance delivered at a pace noticeably quicker than surrounding talk.

OKAY CAPS: Extreme loudness compared with surrounding talk.

hhh hhh 1-1's: Audible outbreaths, possibly laughter. The more 1's, the longer the aspiration. Aspirations with periods indicate audible inbreaths (e.g., .hhh). H's within (e.g., ye(hh)s) parentheses mark withinspeech aspirations, possible laughter.

pt Lip Smack: Often preceding an inbreath.

hah Laugh Syllable: Relative closed or open position of laughter

heh hoh

\$ Smile Voice: Words marked by chuckles and/or phrases hearable as laughed-through.