Explaining illness: patients’ proposals and physicians’ responses

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Introduction

Patients visit doctors for a variety of reasons, and a prominent one is to find out what is causing some health problem or symptom they are experiencing (Korsch et al. 1968; Novack 1995). However, during the course of medical interviews, patients often offer their own “lay” or “folk” explanations for what is causing their health difficulties. In the view of many researchers, doctors routinely ignore or dismiss patients’ theories (Cicourel 1983; Fisher and Groce 1990; Kleinman et al. 1978; Mehan 1990; Mishler 1984; Stoeckle and Barsky 1981; Waitzkin 1979, 1991). Doctors, because of their power and authority, are said to impose a biomedical perspective upon patients. They maintain an exclusive focus on only those symptoms and disease processes that are under the purview of the medical model, rather than considering or appreciating patients’ social experiences and perspectives regarding their illnesses. Thus, the “voice of medicine” regularly silences the “voice of the life world” (Fisher and Groce 1990; Mishler 1984).

Despite such pronouncements, investigators have not described or analyzed, in any detail, the interactional structure of patients’ explanations and doctors’ responses (explanation–response sequences) as they occur within the context of clinic visits. Nor has enough attention been given to how explanation–response sequences relate to ongoing courses of activity, such as the different

1 See the review and critique of literature on the “asymmetry” in doctor–patient interaction, in Maynard (1991c); Robinson (2001a).
phases of the medical interview. This chapter draws on audio- and videotaped data of patient visits to an outpatient medical clinic to examine the interactional strategies patients use to offer explanations for their medical problems and the methods doctors use to respond to these explanations. Our focus is how patients design and place their explanations in the phase of the medical interview where doctors are gathering information about symptoms.

What has been portrayed as a struggle between the doctor’s “biomedical” perspective and the patient’s “lifeworld” concerns can be recharacterized in terms of interactional dilemmas that doctors and patients face. These dilemmas involve sequential organization within two ordered phases of the medical interview: (1) the collection of medical data through verbal and physical examination or Byrne and Long’s (1976) phase III of the interview; and (2) the “consideration” or analysis of this data or Byrne and Long’s (1976) phase IV. During clinic visits, patients show that they face this dilemma: How, within a course of action that primarily involves collecting medical data (facts about the nature of patients’ symptoms and other aspects of their experiences) can patients offer their analyses of these facts (explanations) so that doctors may consider them, yet without requiring such consideration immediately, in the data-gathering context? That is, when the doctor is gathering facts about a particular symptom, it provides an opportunity for the patient to offer

2 Conversation-analytic and ethnographic researchers have considered patients’ or “lay” perspectives when investigating other topics in medical or clinical interactions (Drew 1991; Heath 1992; Heritage and Sefi 1992; Maynard 1991c, 1991d; Silverman 1987; Stivers 2002b; Strong 1979; ten Have 1991), but few have given primary attention to patients’ actual explanatory practices and doctors’ responses (see Gill 1995, 1998a, 1998b; Gill et al., 2001; Raavaara 1998).

3 Data were collected by the second author at an outpatient general internal medicine clinic associated with a teaching hospital in a medium-sized city in the Midwestern United States. The data corpus includes 15 audio- and videotapes of clinic visits (involving 15 patients and 5 physicians), and 2 audiotaped follow-up calls (involving 2 of the patients and 2 of the doctors).

4 A related dilemma is discussed in Gill (1998a): patients often have explanations for their illnesses, but treat as problematic any display of personal authority about these explanations. Patients handle the dilemma by displaying certainty about the explanations in contexts where they are not inviting doctors’ assessments. Conversely, patients downplay their certainty when their explanations solicit evaluation from doctors. Thus, patients do manage to insert their explanations into the medical interview yet refrain from requiring doctors to recognize them as authoritative sources of this type of knowledge. See also ten Have (1991), who argues that appearing “uncertain” is a way for patients to put explanations on the table yet maintain a subordinate role vis-à-vis the doctor.
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an explanation for this symptom. This will enable the physician to consider it as he or she generates and tests diagnostic hypotheses. If the patient does not take the opportunity then and there, it may not arise again, for the next phase of the interview involves the “flow of information from the physician to the patient” (Cohen-Cole and Bird 1991:28). Yet giving an explanation in the data-collection phase may be premature, since not all the facts are in. For their part, doctors show that their dilemma, in hearing a patient's explanation, is how to stay on course in the overall interview, rather than jumping the track and moving back and forth between data collection and data analysis, or prematurely moving to the phase wherein they educate the patient by delivering diagnostic or other information.

Patients handle their dilemma by constructing explanations that do not disrupt doctors' information-gathering activities. When patients present explanations, doctors address their own dilemma by strongly orienting to the canonical organization of the medical interview (where data collection precedes data analysis). Although in some cases doctors do evaluate patients' explanations immediately in information-gathering contexts, they typically stay on course when this option is provided and continue to collect data from patients without outwardly indicating that they heard patients insert their analyses into the conversation. Thus, as in previous research, we find that physicians may leave patients' explanations unassessed or even unacknowledged. However, this is at least partly due to both participants' orientation to the overall organization of the medical interview.

**Design of patients' explanations for health problems**

In this section, we outline three basic components of patients’ explanations as well as other dimensions of their design. To begin, we observe that, during clinic visits, patients regularly produce complaints. That is, they make reference to and describe the symptoms and health problems they are experiencing or have experienced. For example:

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5 See also Lazare et al. (1995) on the “three function” model of the medical interview.
In addition to producing complaints, a patient may overtly or tacitly propose that something is causing the symptom they are experiencing; that is, the patient proposes a diagnosis, etiology, or site of origin for the symptom. To make these connections, patients use linkage proposals. Linkage proposals range from attributive, wherein patients overtly propose a causal relationship, to non-attributive, where patients only tacitly suggest such a causal relationship.

### Overt explanations

When patients produce overt explanations, they explicitly mark that they are accounting for their symptoms, not just producing accounts of (i.e., descriptions of) their symptoms. Patients use attributive linkage proposals to produce overt explanations. For example, they may use the “because” form to causally connect a symptom to a reported fact, such as a life experience or circumstance. That reported fact then becomes a causal factor for the

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6 There are 63 overt and 22 tacit explanations in the data corpus, for a total of 85. We arrived at these figures by tallying participants’ activities rather than the content of these activities. For example, there are cases where a patient offers the same explanation for a symptom at three different points in time; this was counted as three explanations, in order to keep track of how patients design each one—the opportunities they provide for physicians to respond, the degree to which they invite a response, etc.—and how physicians actually respond at each available opportunity. If the explanations were counted by content (i.e., if several different explanations that cite the same causal factor were counted as one explanation), we would lose this detail. Similarly, if a patient offers three different explanations for the same health problem (i.e., proposed three different causes) and offers each only one time, this was counted as three explanations. In these cases we always note when the content changes (when patients propose different causes in successive explanations).

7 In conversation analysis, “accounting” is a broad category that encompasses activities such as “describing” as well as “explaining.” However, in doctor–patient interaction, describing a problem and providing an explanation for a problem are treated as two distinct activities; that is, there is a member-generated distinction between these types of accounts (Gill 1998b).
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symptom. In excerpt (2), Ms. O uses “because” to attribute her depression and upset feelings to lack of sleep.

(2) [2:104]
1 Ms. O: Well as I said I think I get: (. ) tah: (2.0) depressed and set because I can't (0.8) I'm not- getting sleep.

Patients also use forms of the indicative, such as “is” or “was,” as attributive linkage proposals. The causal factor in these cases is a hypothetical bodily condition. In excerpt (3) below, Ms. N uses “was” to question whether her rectal pain can be attributed to the condition, “hemorrhoids.”

(3) [10:594]
1 Ms. N: While we’re on my gut.
2 Dr. D: Yes.
3 Ms. N: A couple a weeks ago: hh u:m (0.6) I had (. ) tremendous amount of rectal pain?
4 Ms. N: No:w- whether it was hemorrhoids or not I'm not sur:e because there was a lot of (0.8) h pai:n when I tried (0.2) pressing.

Similarly, patients may propose that a hypothetical condition “brought on” the complaint. In excerpt (4), Ms. A and Dr. A are discussing the patient’s chest pain:

(4) [6:383]
1 Dr. A: An so: that (. ) came on with the exerci:se
2 Dr. A: An- with other activities that you’ve do[ne.
3 Ms. A: [M hm?
4 Dr. A: “Okay:”
5 Dr. A: hh (2.5) An in addi:ion sometimes you wake at nigh:[t wi]h that.
6 Ms. A: [M hm]
7 Dr. A: (3.5)
8 Ms. A: → An I was wondering if: “you know” stress could a (. ) brought that on too.

Patients may link a pain or other symptom to a specific site of origin, such as an organ in the body, by proposing that the symptom is “in” that organ. Below, Ms. B cites her “gall bladder”
and then her “kidney” as the cause of the abdominal tenderness she is experiencing:

(5) [7:365]

1 Ms. B: .hhh An: : :d then I get a lot of tenderness: in this area hh.
2 And again: , it’s probably: (1.0) [whether: it’s] in the =
3 Dr. A: [In the front]
4 Ms. B: → = gall bladder? Kidney?

Thus, patients’ overt explanations are based on a three-part turn structure, consisting of a complaint (reference to a symptom or other discomfiting health problem); an attributive linkage proposal; and a causal factor – a reported circumstance, hypothetical bodily condition, or site of origin. Patients put these elements together to account for the existence of their symptoms.

Tacit explanations

A patient can offer a tacit explanation by describing or referring to a symptom and then reporting a life circumstance or experience.⁸ The patient connects these elements with a non-attributive linkage proposal such as “and” or “but.”⁹ The patient invites the doctor

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⁸ Reporting is a generic strategy that speakers can use to accomplish various types of tacit or implicit activities in conversation. For example, a speaker can avoid taking an official position in relation to a proposal, such as an invitation, by producing a report of an activity or circumstance in response (Drew 1984:134):

I: How about the following weekend.

(0.8)

C: → .hh Dats the va vacation isn’t it?
I: .hhhh Oh: TRight so– no hassl, . . .

In this excerpt, I issues an invitation. C’s subsequent report (arrowed) provides I with “the materials from which she can see for herself that it will not be possible to go then” (Drew 1984:134). However, C leaves it to I to determine the implication of his report. I takes the report as a rejection of her proposal.

⁹ Whereas “and” projects that a forthcoming utterance is “additional” (in relation to a previous utterance) and thereby proposes a connection between the two, “but” can be used to propose a relationship between two utterances by setting off a forthcoming utterance against a prior utterance. A variation is for patients to use “since” to propose a temporal relationship between a symptom and another circumstance, and thus tacitly suggest a causal connection. See Drew and Heritage’s (1992:31–2) example, taken from Mishler (1984:165):

Dr: How long have you been drinking that heavily?
Pt: Since I’ve been married
Dr: How long is that?
Pt: (giggle) Four years
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to analyze the report’s relationship to the complaint, while stopping short of overtly proposing that those circumstances or experiences are causal factors. The patient merely implies or hints at such a relationship and provides the doctor with the opportunity to display recognition of the “upshot” and to officially make a causal connection between the patient’s report and the patient’s symptom (see Drew 1984; Gill 1995, 1998b; Strong 1979).

For example, in excerpt (6) Ms. B offers a tacit explanation. She complains of a symptom (line 1) and then reports that she has a new car (lines 1 and 3). The doctor does not immediately display recognition of an upshot. After two more reports related to the emergence of her symptom (line 6) and time spent sitting in the car (“=”shifts,” line 7), the patient herself goes on to propose (in a speculative manner) a causal connection between the car and the backache (line 9):

(6) [10:523]

1 Ms.B: .hhh I’ve been having this backache:KHH. .hhh A[n: nd we ] do =
2 Dr.A: [Do you:]
3 Ms. B: = have a new car:,
4 (1.0)
5 Ms.B: ‘M [hm’
6 Ms.B: [An:::d (:) it- (:) didn’t bother me the first two weeks.
7 But we did do: a couple of three hour:: shifts.
8 Dr.A: [Mm hm?]
9 Ms.B: Whether that’s it:th?h
10 (0.4) 

In contrast, in excerpt (7) the patient issues a tacit explanation and the doctor’s response does immediately display recognition of an upshot. That is, by proposing to look for “underlying causes” for the patient’s fatigue (lines 8 and 11), he also shows his understanding that in lines 3–5 the patient was offering an explanation for her fatigue, and that the real cause may be more serious than “burning the candle at both ends”:

(7) [16:1032]

1 Dr. C: You mention some easy bruising? An bleeding? Fatigue?
2 Ms.I: Uh. I- an the- an: Ut you know: has been (:) Ut recently
3 that I have the fatigue. But I guess: you know: you’re just
In other cases, neither the patient nor the doctor produces an upshot, and the complaint and report retain the ontological status of observations (i.e., accounts of facts and circumstances), never attaining the status of overt explanations. For example, in excerpt (8) Ms. B describes how often she experiences her symptom (lines 3–4), abdominal tenderness. She then reports monitoring her activities for “lifting something or doing something” (line 5), tacitly proposing that muscle strain from such activities could be a cause of the abdominal tenderness if, in fact, she were engaging in these activities. In a type of response that we will explore in detail later in the chapter, the doctor queries the patient about how long the tenderness lasts when she experiences it (line 7). The causal connection between lifting (or other physical activity) and the abdominal tenderness is never explicitly explored in this clinic visit.

(8) [7:365]

1 Ms. B: "h.lh Ptch [A::nd, hhhhh]
2 Dr. A: ['Bout how often does] that come.
3 Ms. B: Uh:: hhhhh (1.0) This cn: (1.5) m- be like at least once or
twice a week. And I've been trying to see if I've been:::
5 >you know,< lifting something or doing something. "h.lhhhh"

(1.5) (Dr. A gazes at patient, then turns to record))
6 Dr. A: How long does it last when you g[et it. ]
7 Ms. B: [Ah::m](. ) maybe a day or
two.

Thus, patients can offer tacit explanations a three-part turn structure, consisting of (1) a complaint (reference to a symptom or other discomfiting health problem); (2) a non-attributive linkage proposal; and (3) a reported circumstance. However, they require an additional turn, which either provides or shows recognition of an upshot,
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in order to turn the reported circumstance officially into a causal factor for the symptom.

The relevance of doctors’ confirming and disconfirming assessments

Explanation design and placement

Patients exhibit sensitivity to the activity context in which they are offering explanations. In the “investigative” phases of clinic visits where physicians are gathering empirical information (ten Have 1987, 1991; see also Byrne and Long 1976; Heath 1992; Waitzkin 1991), patients especially avoid compelling doctors to provide immediate confirming or disconfirming assessments. As Gill (1998a) shows, patients typically offer their explanations as “trial balloons” that suggest causal factors for doctors to investigate (or relevantly rule out), but which do not compel here-and-now assessments from doctors and thus do not propose to interfere with their collection of medical data. Patients design and place their explanations in ways that allow doctors to maintain a focus on fact-finding; i.e., to continue gathering information about patients’ symptoms or other medically relevant experiences. In designing explanations that can accommodate empirically focused queries, patients orient to the structure of a typical medical interview, where data collection precedes data analysis. Patients provide for the possibility that doctors will refrain from evaluating their explanations before all the “facts” are in (Gill 1998a). Accordingly, patients’ strategies at once make visible and deftly handle the dilemma of how to put explanations on the table so that doctors can take the suggested causal factors into consideration, yet avoid occasioning a situation where, if doctors choose to gather more information, patients’ theories would achieve the status of having been “ignored.”

In the following section, we briefly introduce the features of explanation design and placement which provide doctors with opportunities to focus on the activity of collecting data, rather than compelling them to evaluate their explanations. In the final section of the chapter, we show examples of doctors availing themselves of these features.
Explanations that do not strongly compel doctors’ confirming or disconfirming assessments

By design, a tacit explanation – complaining about a symptom and then reporting a fact or circumstance – puts very little pressure on the doctor to respond with a confirming or disconfirming evaluation, as in excerpts (6)–(8); that is, this set of actions does not firmly initiate an explanation–assessment sequence. The patient gives the doctor the option to display recognition of an upshot, but also gives the doctor the option to hear the report as simply that – a report of circumstances. The doctor may relevantly treat the report as “information” or “data” and proceed with information-gathering activities by simply nodding, or otherwise indicating receipt of the report. To say that the physician can relevantly take this option does not mean that this is the best option. It simply means that the patient does not put the doctor in a position where he or she must respond, or else appear to be ignoring an explanation that the patient put on the table. Officially, there is no explanation on the table for the doctor to evaluate.

Even though they officially propose causal connections, the design of some overt explanations can also put little pressure on doctors to produce an assessment. Patients often pose their overt explanations as speculations or out-loud musings,10 which not only display uncertainty, but are also relatively non-constraining in terms of the responses they require from doctors (Gill 1998a); see for example, excerpts (3) to (5) as well as line 9 in (6). Speculative explanation are not forthright questions, and therefore do not clearly constitute the first part of a question–answer adjacency pair. If such explanations did, then that would firmly establish the “conditional relevance” of a doctor’s confirming or disconfirming assessment, such that it would be “noticeably absent” were it missing (Schegloff 1972:76–77; Gill 1998a; ten Have 1991). Instead, speculative explanations provide for the relevance of an array of responses.

Similarly, overt explanations designed as qualified proposals, as in excerpt (2), are also relatively non-constraining for the doctor. Like a “first assessment” (Pomerantz 1984a:61), a qualified proposal makes a confirming or disconfirming assessment relevant as a next-turn activity, but does not require such a response. A distinctive

10 See Sacks (1992b:405) on “musing aloud.”
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feature of qualified proposals is that they display slightly more certainty than do speculative explanations (patients preface them with “I think” rather than “I’m wondering if” or “I don’t know if”), but, as we will show, patients offset this certainty by using qualified proposals in comparatively low-risk contexts, where agreeing assessments are likely – for example, when patients are proposing an explanation that is in line with the doctor’s own displayed view.

Patients’ **positioning** of overt explanations within turns can also lessen the degree to which they compel doctors’ assessments. Patients may place overt explanations within multiple-component turns that include both symptom-related and explanation-related components. This gives doctors the option to relevantly respond to either component (Gill 1998a). For example, a patient may construct a two-component turn – *reply + explanation* – wherein the patient replies to a doctor’s symptom-related question (regarding when a symptom occurs, how long it lasts, etc.) and then offers an overt explanation for the symptom. As Frankel (1990:237) notes, this type of turn design provides the doctor with “an option rather than an obligation” to respond to the second turn component (the explanation). This design is evident in excerpt (9) below. Dr. C seeks a confirmation of a problem Ms. I had mentioned earlier in her clinic visit, that she experiences pain with intercourse (lines 1–2). (Several years before, Ms. I had a surgery that included both a hysterectomy and bladder repair.)

(9) [19:1259]

1 Dr.C: .hh Kay. An then the other- the other thing you mentioned was (. ) you have (. ) pain with intercourse. Is that right?
2 Ms.I: Yeah. But that’s just since I’ve had that hysterectomy. An I don’t know if that bladder tie up? Was part of that?
3  (0.8)
4 Dr.C: For the last six or ten years. Ever since that [surgery. So]
5 Ms.I: [M hm? M]
6  [M hm? M]
7 Ms.I: [M hm? M]
8 hhm?

Ms. I replies (“Yeah,” line 3), clarifies the date of the onset of the pain (“since I’ve had that hysterectomy,” lines 3–4), which may also tacitly suggest that the surgery is the cause of the pain, and then she adds a more overt, speculative explanation concerning a “bladder tie up” (line 4). This turn design presents Dr. C with the option of
focusing on either the reported timing of the patient’s pain, or her explanation. He responds in terms of the timing of the pain (line 6) and goes on to query about its frequency (not in excerpt).

Patients may also add other turn components to overt explanations, so that the explanations themselves become less assessment-relevant. For example, patients may append turn components that return the talk to the activity of describing their symptoms. Then the doctor may attend to the descriptive portion of the patient’s turn. For example, in excerpt (10), Dr. B asks Ms. D whether she experiences shortness of breath (line 1). Ms. D replies to the query with “Some” (line 3), then produces her explanation (“that’s: ‘cuz I should lose weight.”). She adds a tag component: a downgraded description of how much shortness of breath she experiences (“NOT much,” line 6):

(10) [9:431]

1 Dr.B: Shortness of breath?
2 (1.0) —
3 Ms.D: Some: but that: ‘cuz I should lose weight. I know
4 that.
5 (.)
6 Ms.D: I think: NOT much.
7 Dr.B: When do you get short of breath.

Dr. B’s next query (line 7) is directed toward her temporal experience of the symptom, rather than her explanation.

Patients consistently use this turn design, which “envelops” the explanation within turn elements that describe a symptom or circumstance, when they offer unmitigated overt explanations, as in Ms. D’s line 3 utterance above (Gill 1998a). Accordingly, the explanations that patients deliver with the most certainty do not actively solicit assessment. We shall return to this matter later, when we explore other kinds of work that unmitigated overt explanations can do.

Explanations that strongly compel doctors’ confirming or disconfirming assessments

Patients may pose their overt explanations as frank questions that narrowly restrict doctors’ response options, such that doctors are
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compelled to provide “answers” by evaluating the explanations. However, out of 85 total explanations in the data corpus there are only 3 cases where patients embed their explanations within such questioning formats,\(^{11}\) and in these cases the patients place their explanations in locations in the medical interview where physicians are not engaged in gathering information (Gill 1998a). For example, in excerpt (11), Ms. N embeds an explanation in a frank question, soliciting Dr. D’s assessment at a juncture in the visit where he has paused to write her a prescription.

\[
(11) \quad \text{[11:716]}
\]

\((\text{Dr. is writing a prescription})\)

1 Ms.N: You know do you think I’m getting depressed at these times
2 because’v my period? A friend- er my health aide pointed
3 that out.
4 (1.0) (\text{(Dr. puts down his pen)})
5 (10 lines omitted where patient further describes her depression and not feeling well))
14 Dr.D: No Anna I’ve never had a very good- (1.2) feeling for what-
15 makes you go down in the dumps

The interrogative (questioning) format of Ms. N’s explanation (lines 1–2) does strongly establish the relevance of the doctor’s confirming or disconfirming assessment. As noted, however, this occurs at a place in the interview where the doctor is not gathering information. He listens to her description and then, at lines 14–15, rejects her explanation, claiming not to know what causes her depression.

Note also that Ms. N shifts “footing” (Goffman 1981) and attributes the explanation to her “health aide” (lines 2–3), thus proposing that her knowledge is “derivative” (Bergmann 1992:142) rather than hers alone. Third-party attributions occur in each of the three cases where patients embed their explanations within frank questions (see Gill 1998a). By using a third-party attribution the patient partially shifts to that third party the responsibility for asking

\(^{11}\) This is consistent with Frankel’s (1990) and West’s (1983, 1984) findings that patients’ questions are dispreferred in medical interviews. See also Pomerantz (1988) on embedding “candidate answers” within questions.
for an assessment, and marks this as a sensitive activity (Drew 1991; Pomerantz 1984b, 1988).

Explanations and their responses

We now turn to explanation-response sequences, focusing on cases where patients have offered overt explanations for their health problems. When a patient complains about a symptom and overtly proposes that a particular activity or condition is causing it, or that the problem may be emanating from a particular organ in the body, a physician may treat that explanation as a proposal for which a confirming or disconfirming assessment is a relevant response. That is to say, the doctor may handle the explanation as if it were the first part of an explanation-assessment “adjacency pair” (Schegloff and Sacks 1973) and respond accordingly. This pattern can be characterized as follows:

Response pattern 1

Turn 1: Patient's explanation

+ Turn 2: Doctor's confirming/disconfirming assessment

Although the assessment may be slightly delayed by tokens of hesitation, in this pattern the doctor orients relatively quickly to providing an assessment, rather than, for example, responding with a symptom-related query. Nevertheless, doctors’ immediate assessments as responses to patients’ explanations are relatively rare in our corpus. Out of 63 overt explanations, doctors disconfirm (5) or confirm (9) immediately in only 14 cases (or a little over 20 per cent of the time).

Explanation-assessment sequences

Doctors' immediate disconfirming assessments

In our five disconfirmation cases, the pattern is for doctors to respond in a cautious, disengaged manner. An example is shown below. Just prior to this excerpt, Ms. A reported having a problem with dry skin on her face, and Dr. A examined her face.
Ms. A speculates whether the hypothetical condition, “hormone deficiencies,” could cause dry skin (lines 1–4).

(12) [9:539]

1 Ms.A: The only thing I was wondering if dere is .hhhh you know
2 ah::n (2.0) ((doctor turns from desk to look at patient))
3 hormone deficiencies or something like this that it (0.6)
4 (> you know<) that dries your skin out too.
5 (0.5)
6 Dr.A: "Mm"
7 (0.5)
8 Dr.A: Tch .hhh ah:m
9 (0.8)
10 Ms.A: Or not too much
11 Dr.A: [tch There are some hormone problems like thyroid
12 p[roblems]=
13 Ms.A: ['Mm hm'] (nodding))
14 Dr.A: = which can do that. Um we’ve never found that (.) on you
15 before.
16 Ms.A: No = ((shakes head))
17 Dr.A: = (though) we could certainly think about- "about that."
18 Ms.A: An- how did my cholesterol test turn out.
19 ()
20 Ms.A: Blood tests I’m curious about that.

At lines 5–9, Dr. A delays answering and produces tokens that may portend disagreement, whereupon Ms. A revises her explanation in a way that anticipates a negative answer (line 10). In partial overlap with Ms. A’s revision, the doctor offers a disconfirming assessment (lines 11–12 and 14–15). She claims that, in Ms. A’s case, there is insufficient empirical evidence to support the explanation. Dr. A’s offering is cautious, in ways that “dispreferred” responses are canonically performed (Pomerantz 1984a). In addition to her initial delays (lines 5–9), she confirms the theoretical possibility of such an explanation (lines 11–12 and 14). But then she “cites the evidence” (Maynard 2004) in a way that could rule out these hormone problems in Ms. A’s case (lines 14–15). Note that by referring to evidence from previous lab tests (“Um we’ve never found that (.) on you before”), she displays still more caution in that she does not rule out the possibility that the patient may currently have such

12 Ms. A is revising in a way that observes the preference for agreement (Sacks 1987).
hormone problems. Ms. A shakes her head and says, “No,” displaying knowledge of these findings (line 16). Dr. A goes on to qualify her disconfirmation, portraying herself as still willing to consider the matter (line 17). However, Ms. A does not pursue it any further. She shifts the topic, inquiring about the results of her recent cholesterol and blood tests (lines 18 and 20).

**Doctors’ immediate confirming assessments**

While it is more common in these data for doctors to provide confirming than disconfirming assessments in response to patients’ explanations, confirming assessments also occur relatively infrequently. As mentioned, there are 9 cases out 63 overt explanations where, without first initiating an extended series of symptom-related queries and responses and/or a physical examination, doctors respond with confirming assessments after patients offer their overt explanations.

Not surprisingly, doctors tend to give confirming assessments in response to patients’ explanations that have *exhibited alignment with doctors’ displayed perspectives*. Even so, doctors’ confirmations are cautious rather than forthright. Excerpt (13) shows a doctor giving a qualified confirming assessment in response to a patient’s explanation. Mr. E has pain in his forearm that Dr. B has provisionally diagnosed as being caused by ulnar nerve entrapment syndrome (a pinched nerve in his elbow). This clinic visit is a follow-up visit; the doctor is evaluating the patient’s condition since he began using an elbow pad and an anti-inflammatory drug. Dr. B first examines Mr. E to determine whether he is developing muscle weakness in the affected arm. He explains that activities that involve vibration, gripping tight, and holding the arms bent for an extended period will be irritating (lines 1–2, 4–5, and 7).

(13) [5:258]

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1 Dr.B: It makes sense that things like mowin’ thuh lawn cuz ya know
2 you’re grippin’ tight an’ your arms are bent an’ you’re =
3 Mr.E: [ (that’s right) ]
4 Dr.B: holdin that position for uh long time ’n there’s vibration,
5 n’ that’s all [irritating. So it] makes sense that those
6 Mr.E: [ (That’s right) ]
7 Dr.B: kinds o’ things’re gonna bother it.
8 (. )
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9 Dr.B: .h|h
10 Mr.E: [.hh tch .h I think that >what it is < um- (. ) damaging
11 was:a- (. ) I- I do:n’t (. ) remember whether I mentioned to
12 you or not:as- was years ago; almost like a- (. ) bout six,
13 seven years ago. .hhh I work in a workshop in this machine
14 jis those:a- those gu::ns? Needle shape
15 Dr.B: Yeah =
16 Mr.E: = to- drill da h:ole ta-
17 Dr.B: Yea|h
18 Mr.E: [ta (glue).
19 Dr.B: Right.
20 Mr.E: And those one I probably work on em (. ) constantly work on
21 one time. If[for]got,
22 Dr.B: [Mhm ]
23 Mr.E: I didn’t (. ) [pay ] attention.
24 Dr.B: [Okay.]
25 Mr.E: And I continuously (0.5) shake it.
26 Dr.B: Right
27 Mr.E: [>I feel< that’s what’s the damaging
28 Dr.B: Yeah =
29 Mr.E: = ‘Ya’ [(cause for that)]
30 Dr.B: [It may have. ]
31 Dr.B: Yeah.

Mr. E agrees (line 6) and further responds (lines 10–14, 16, and 18) by offering a qualified explanation for what may have initially caused the damage to his arm: he worked at a machine that “continuously” shook his arm. Dr. B marks that he is following the patient’s narrative by offering continuers and other tokens of acknowledgment, including indications of agreement (lines 15, 17, 19, etc.), even as the narrative progresses (lines 20–21, 23, and 25). A summarizing turn (lines 27 and 29) refers back to the circumstances he reported in his story and the condition he experiences, more overtly proposing that the circumstances caused the damage. Dr. B offers an agreement token (line 28), and qualified confirming assessment, “It may have” (line 30). Thus, in a context where the doctor has already gathered information and made a candidate diagnosis (a pinched nerve), and where the patient’s explanation for what caused the problem (shaking the arm) is in line with this diagnosis and the doctor’s pronouncement of what could irritate the arm (vibration), the doctor produces guarded agreement. And Dr. B produces it quickly (line 28) – in the way that preferred responses are done – after Mr. E finishes his explanation.
Explanation–query sequences

In information-gathering phases of medical interviews, doctors also respond to patients’ explanations by attending to their symptoms. Specifically, doctors’ responses are often queries that ask patients to provide information about what they are physically experiencing – for example, the timing, location, or duration of the symptoms for which they are offering explanations (see Mishler 1984). This pattern is organized as follows:

Response pattern 2

Turn 1: Patient’s explanation

+ 

Turn 2: Doctor’s query

+ 

Turn 3: Patient’s reply to query

Doctors may also query patients about other components of their explanation turns. For example, doctors may direct their attention to the activities, experiences, or hypothetical conditions that patients cite as causal factors in their explanations. When doctors query patients about the existence of these factors, it provides patients with an opportunity to discuss them. Finally, doctors may direct their attention to evidence. That is, if after offering an explanation a patient reports evidence that either lends support to the explanation or implies it should be ruled out or otherwise excluded from consideration, the doctor may query the patient about this evidence rather than attending to the explanation itself.

An important feature of these types of queries, also observed by Mishler (1984), is that doctors typically do not mark whether or how the queries – and the responses they seek – are related to exploring patients’ explanations per se and determining whether they might be right. Doctors do not indicate whether or not these queries constitute “insertion sequences” (Schegloff 1972:78) that are being initiated in search of clarification or additional empirical information, which if provided would allow doctors eventually to confirm or disconfirm patients’ explanations. On the face of it, these queries solicit more data. In some cases, doctors’ queries represent the “end of the line” for patients’ explanations, in that these explanations are never confirmed nor disconfirmed during the clinic visit.
As we will show, however, there are instances where these queries do end up amounting to insertion sequences between patients’ explanations and doctors’ assessments; that is, in five cases in the data, doctors eventually do assess patients’ overt explanations after gathering additional symptom-related information through queries and physical examinations, and thus they retroactively display that this information-gathering was actually hypothesis testing (i.e., it was used either to rule out or confirm the patient’s explanation). This is consistent with Heath’s (1992) and ten Have’s (1991) findings that doctors may delay confirming or disconfirming responses until the completion of the physical examination or the medical interview. Such a pattern looks like this:

**Response pattern 3**

| Turn 1: Patient’s explanation | + |
| Turn 2: Doctor’s query | Insertion sequence |
| Turn 3: Patient’s reply to query | . |
| Turn n: Doctor’s confirming or disconfirming assessment of explanation |

Crucially, in the immediate sequential environment of the first two turns in Pattern 3, where patients offer their explanations and doctors respond with queries, it is not possible to distinguish this pattern from Pattern 2, where the patient’s explanation receives no eventual assessment. The two patterns begin identically and in neither case do doctors initially mark how and/or whether their queries are connected to exploring the patients’ explanations. As Mishler

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13 It is possible that there were actually more delayed confirming or disconfirming assessments than we have noted. In two of the interviews where patients offer overt explanations and receive no assessments, the recordings end just before the physical exams. In these two cases the doctors may have confirmed or disconfirmed the patients’ explanations during or after the exams.

14 In our data, these are all confirming assessments. However, in one case – see excerpt (17d) – the doctor’s assessment overtly confirms the patient’s first explanation (hemorrhoids) while also tacitly disconfirming her second explanation (obstruction).
Jeffrey Robinson (1984:120) has observed, doctors do not show the reasoning that underlies their queries.\footnote{Similarly, ten Have (1991:150) observes that in other positions (such as in the third turn position) physicians also “refrain from commentary, utterances displaying alignment, or any indication of their own information processing.”}

However, this focus on gathering empirical data is not a unilateral accomplishment, nor is it simply a matter of the biomedical model suppressing “lifeworld” concerns. Although Mishler (1984:115) contends that patients may be “confused by shifts in the content of the physician’s questions” and have “no clear idea of what [the physician] is trying to discover,” our data show a more bilateral orientation toward the activity that predominates in the information-gathering phases of the interview: gathering medical data. Even if patients are unfamiliar with the exact diagnostic agenda physicians may be working to establish through their queries, this should not imply either naivety or passive acceptance of the biomedical model. Instead, patients display an understanding of the interactional structure of the medical interview and the activities through which the biomedical model is realized.

When patients place their own analyses within the data-gathering phase of the medical interview, they design and position these explanations in ways that accommodate continued investigation or fact-finding. That is, as we observed earlier, where doctors are collecting data about patients’ physical states, patients’ explanations are not sequentially restrictive; they do not constrain doctors to produce confirming or disconfirming assessments then and there. Patients’ strategies for offering explanations thus adroitly handle the interactional dilemma noted in the introduction to this chapter: They allow patients to put explanations on the table for doctors’ consideration, without being seen to request an assessment “prematurely,” before all the facts are in. For their part, doctors capitalize upon the non-restrictive design and placement of patients’ explanations and respond in ways that focus on what patients are experiencing rather than on why they are experiencing it.

In addition, there are cases where patients’ explanations invite rather than merely allow responses that focus on what they are experiencing. For example, patients may use explanation formats as vehicles to introduce and draw doctors’ attention to additional concerns or complaints that may otherwise be difficult to put on
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the table. In the next section, we show extended explanation-query sequences, highlighting how doctors delay or avoid producing immediate confirming or disconfirming assessments in information-gathering phases of medical visits, while pursuing their information-gathering activities. First, we show how doctors’ focus on what is occurring (symptoms) rather than why it is occurring (explanations) leads to patients’ explanations being disattended for the entire interview. Subsequently, we examine how doctors may eventually confirm patients’ explanations, after extended insertion sequences that deal with the nature of the patients’ symptoms.

Query focuses on the patient’s symptom, no assessment occurs

In the next excerpt, a patient offers an explanation that never receives a confirming or disconfirming assessment from the doctor. Dr. B has been taking Ms. D’s health history. At this point in the interview, he is gathering information about a variety of matters such as her family members’ health, whether she smokes, and whether she experiences headaches or asthma. He then asks Ms. D if she experiences shortness of breath (line 1 below). She replies that she does have some shortness of breath, and then offers her weight as a cause for this condition (line 3). This reference ties back to the beginning of this medical visit, where they had discussed the fact that Ms. D had gained eleven pounds since her last appointment, despite the fact that she had said she was going to try to lose weight. In a laughing way, Ms. D displayed incredulity about this situation, and doctor and patient joked back and forth about what would have caused the weight gain. Her explanation at line 3 may be a way for her to display some authentic concern about this weight gain. However, Dr. B, at line 7, focuses away from the weight gain and on the shortness-of-breath symptom:

(14) [9.431]

1 Dr. B: Shortness of breath?
2 (1.0)
3 Ms. D: Some, but that’s cuz I should lose weight. I know that.

This interview, a portion of which is in excerpt (14), is explored in the chapter by Boyd and Heritage (this volume). Also see Gill’s (1998a) analysis of the patient’s portrayal of knowledge in this excerpt.
Ms. D: I think- NOT much.

Dr. B: When do you get short of breath.

(1.0)

Dr. B: Stairs? An: nat sort a thing? Er (1.0)

Ms. D: ...after about-< (. ) three flights or four.

HIH huh huh huh.

(1.5)

Ms. D: . h  ”Two.” H(h)o. Huh. .hhh

(1.5)

Ms. D: Really not- not much. Uh uh.

Dr. B: ”Okay.”

(7.0)

Dr. B: Are your bowel movements normal?

We noted earlier that Ms. D’s response (lines 3–4 and 6) allows the doctor to focus on gathering information rather than requiring him to assess immediately whether her explanation is correct. At line 6, “NOT much” seems to characterize her shortness of breath rather than the weight she needs to lose; i.e., it appears to be a downgraded recharacterization of her initial reply (“Somewhat,” line 3). Thus, her explanation by this point is effectively enveloped between two descriptions of her symptoms. Dr. B queries her about the shortness of breath, asking her to specify when she experiences this symptom (line 7). This query does not mark whether (or how) it is related to her explanation. After a silence (line 8), Dr. B produces a candidate answer (line 9) for the patient to confirm or disconfirm. Ms. D gives a characterization of how many flights of stairs it takes for her to become short of breath (lines 11–12), and appends a laugh. Next (line 14), she very softly upgrades this to “two” flights (i.e., she produces a characterization that displays the condition as more serious) and then quickly disclaims this upgrade (“N(h)o”), adding more laugh tokens and reasserting her line 6 recharacterization of her symptom: “Really not- not much. Uh uh” (line 16). As the laughter may be a display of “troubles resistance” (Jefferson 1984b:351), Dr. B (line 17) appears to accept it, and moves on (line 19) to another query related to Ms. D’s health history.

Thus, when Ms. D inserts her explanation into an information-gathering phase of the medical visit, she provides for the doctor to
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take other avenues besides responding to and assessing this explana-
tion. Not only does she use a turn design that envelops her explana-
tion between characterizations of how much she experiences
shortness of breath (thus allowing Dr. B to pursue additional infor-
mation about this symptom), she also minimizes the problem by
downgrading the extent to which she experiences the symptom,
and by displaying a light attitude toward it. While Dr. B never
does confirm or disconfirm Ms. D’s explanation for the shortness
of breath (being overweight), this reflects not just his unilateral
actions and imposition of the biomedical model, but actions on
his patient’s part allowing for pursuit of symptom-related infor-
mation during the information-gathering portion of the medical
interview.

Query focuses on the causal factor, no assessment occurs
Doctors may also query patients about whether the causal factors
they cited in their explanations do, in fact, exist. Such questioning
offers patients an opportunity to discuss the causal factors, which
suggests that when patients produce explanations they may be doing
additional work – explanations may be an oblique or delicate way
to get particular concerns on the floor when it might otherwise be
difficult to do so.

Put differently, patients may use physicians’ orientation to gath-
ering data and evidence as a resource for achieving their own ends.
When a doctor queries a patient about whether a causal factor exists
(sidestepping the issue of whether the causal factor in question actu-
ally causes a problem to occur), this topicalizes a possible problem
that the patient, by virtue of positioning it as ancillary to a more
primary complaint, has shown hesitance to bring up. For example,
in excerpt (15) Dr. A and Ms. A are discussing chest pain that Ms.
A has experienced during exercise. This is after Dr. A has given the
patient good news about her cardiology tests, which disconfirmed
“heart disease.” They are now discussing a “symptom residue,” the
pain that Ms. A had that was therefore not explained by any such
disease or condition.17

17 See discussion of this case and the problem of “symptom residue” in the Maynard
and Frankel chapter (this volume).
In the context of Dr. A gathering information about when the chest pain occurs (lines 1–8), Ms. A speculates about whether “stress” could cause the chest pain to occur (lines 11–12). Dr. A queries
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her about this possible causal factor; she asks the patient if she is experiencing stress (line 14).

Ms. A takes the doctor's query as an invitation to describe the problems she is having with her teenage son (lines 16–17). Dr. A displays familiarity with these problems (line 18), at least insofar as they have been “mentioned” before. However, her claim of prior knowledge does not invite explication of the trouble; that is, as Jefferson (1988:425) has argued, there are two types of responses to a troubles announcement:

one which marks arrival [at a troubles telling point] and elicits further talk on the matter but does not necessarily align recipient as a troubles-recipient . . . and one which, by displaying “empathy,” commits recipient as, now, a troubles recipient.

Ms. A treats Dr. A’s claim of prior knowledge as less than empathetic. In her “further talk on the matter,” Ms. A plays down the problem’s effect on her (line 19), shows a kind of resigned attitude (line 21), and claims that she has a remedy for the problem (lines 21–23 and 25). Ms. A thereby displays what Jefferson (1984b:351) calls “troubles resistance.” Still, after writing in the patient’s file (line 26), Dr. A re-topicalizes the problem by making a candidate assertion about where the son is living (line 27), which invites Ms. A to provide more information (line 28). Dr. A responds to the announcement that Ms. A’s son is “staying with his girlfriend” with a kind of news receipt (line 29) that again discourages troubles-talk development (Heritage 1984b; Jefferson 1981a; Maynard 1997). At line 30, Ms. A confirms that receipt and then (line 32) offers a further aspect of the trouble, after which there is nearly a half-minute silence during which Dr. A is writing in and examining the patient’s record. Subsequently, Dr. A invites Ms. A to bring up “other things” she may want to discuss (lines 34–36), whereupon Ms. A asks the doctor a question about her skin (lines 39–40), and they continue on that topic. The issue of whether stress could cause her chest pains does not get resolved here, nor later in the interview.

Turning to the issue of how Ms. A formulates her explanation in the first place, note that she offers “stress” as a causal factor

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18 There is no previous mention of the problems with her son in this interview and we take it that the physician is recalling something from a previous visit.
without also asserting that she is experiencing stress. This resembles a device Sacks ((1992b:405) has described, wherein a speaker “muses aloud” using an abstract reference to elicit interest in what he or she “meant by that.” By implying but not actually asserting that she is under stress, Ms. A may be inviting inquiry about whether she is, in fact, experiencing stress. As noted, the doctor’s empirically focused response (“◦ Are you feelin: stressed?◦”, line 14) gives her an opportunity to talk about the stress she is under.

While Ms. A appears to make attempts at troubles talk and to discuss what the medical literature calls psychosocial issues (Engel 1997; Stoeckle 1995; Frankel et al. 2003), Dr. A does not respond further in a way that encourages such talk. Nevertheless, we can see how a patient may use the doctor’s orientation toward gathering medical data to occasion the delivery of announcements about troubles, psychosocial issues, or other matters that would not otherwise easily fit within a context where the physician is gathering information about a particular symptom.

Query focuses on the patient’s symptom, assessment occurs after a delay

As noted, the non-constraining design of patients’ explanations allows doctors to focus away from the explanations and onto patients’ symptoms. Eventually, doctors may assess patients’ explanations. This happens in the following excerpts. After the patient offers an explanation for a symptom, in excerpt (16a), the doctor initiates an extended series of symptom-related queries and conducts a physical examination. She eventually confirms the patient’s explanation in excerpt (16b). Thus, the queries, replies, and examination become an extended insertion sequence between the patient’s explanation and the doctor’s eventual assessment.¹⁹

In excerpt (16a), Dr. A and Ms. B are in the phase of the medical interview before the physical exam where the patient is introducing her physical symptoms. She is holding a piece of paper, which she looks at as she reports experiencing tenderness in her abdominal area (line 1). As she raises this symptom, she also indicates its location with a gesture, motioning under her right rib. Then

¹⁹ Similarly, Whalen et al. (1988) discuss an “interrogative series” that operates like an insertion sequence between a caller’s request for help and a call taker’s announcement of dispatch in 911 calls.
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Ms. B appears to start a relatively firm explanation ("It's probably:", line 2), which she abandons in favor of a speculation as to "whether" the discomfort is "in the gall bladder?" (lines 2 and 4). Ms. B thus produces an explanation for the doctor's consideration, yet she does not expose herself to disaffiliative treatment by compelling the doctor's immediate assessment. The first part of this explanation overlaps the doctor's immediate pursuit of a candidate location for the discomfort: "In the front." (line 3). Ms. B then offers an alternate speculative explanation, "Kidney?" (line 4). Dr. A, in overlap with what appears to be the patient's continuation of her turn, asks again about the location of the pain (line 5), and points to her own right side. Now Ms. B confirms the location (line 6). In this segment, accordingly, the doctor strongly orients to gathering empirical information before engaging in analysis.

Furthermore, the doctor maintains her focus on the patient's experience of the tenderness, asking her how often it occurs (line 10). After Ms. B replies (lines 11–12), she reports monitoring her activities for another potentially related event (lines 12–13; see excerpt 8). There is a silence, where the doctor initially looks at

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20 This query (line 10) overlaps with the patient's line 9 utterance, where she again consults her slip of paper and projects the introduction of a complaint about another (different) symptom.
the patient and then turns her head to write in the patient’s medical record (line 14). While she is writing, she queries Ms. B about another aspect of her symptom experience – how long the tenderness lasts (line 15). This line of questioning continues after Ms. B’s answer at lines 16–17 (not shown on transcript), until the patient introduces a different complaint about feeling “sick” and a “sort of glad” feeling, to which the doctor directs her attention (see Gill 1998a).

Approximately seven minutes later, while examining the patient’s abdomen, the doctor demonstrates that she has not forgotten or otherwise permanently disattended the patient’s explanation for her abdominal tenderness. Continuing her examination of Ms. B, Dr. A asks her how long she has been experiencing the “sore times,” how often they occur, how suddenly they come on, and whether food ever brings them on. Then, in the excerpt shown below, she produces a response that invokes and tentatively confirms (via the stress on “could,” line 2) Ms. B’s original explanation:

(16b) [13:677]
1 Dr. A: .hh Thee um- (0.7) it- cuz the pain that yer telling me
2 about up in this: (.) area (1.2) you know could be::? (0.3)
3 from your gall bladder, an- what [we think] h
4 Ms. B: [[thats::: ]
5 Dr. A: = little stol:nes are let out. .hh periodically =
6 Ms. B: = Yeah =
7 Dr. A: = Us[ually in ] response to a meal,
8 Ms. B: = [An (that’s: ) ]
9 Dr. A: And that they may get caught? trangently? hh an it
10 causes this sudden pain.
11 (0.7)
12 Ms. B: That would make sense.

This confirmation (lines 1–3) recasts the doctor’s prior line of questioning as not just information-gathering per se, but as related to investigating Ms. B’s explanation that her gall bladder is the source of the pain. It thereby also (retroactively) recasts that explanation as the first component of an explanation–assessment sequence, whereas in its initial production it was merely marked as a speculation or “out-loud” musing which did not compel here-and-now assessment.
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In sum, patients and doctors both strongly orient to the overall organization of the medical interview. Patients’ explanations present doctors with options to relevantly go either one way or another (to focus on gathering information about symptoms or to focus on analyzing that information), and doctors consistently follow a particular course (gathering information). In sequential terms, because patients provide for confirming or disconfirming assessments to be relevant but not required in the next turn, those assessments cannot be said to be noticeably absent (Schegloff 1972:77) when not produced there. In other words, it is neither the case that patients naively set themselves up to be ignored, nor that doctors, because of their status-based authority, disregard patients’ opinions. The next-turn attention to symptomatology is collaboratively – rather than coercively and unilaterally – achieved.

Query focuses on evidence the patient provides, assessment occurs after a delay

Patients, as we have seen, may follow their explanations with tag components, reporting additional aspects of their experience (such as additional symptoms) that either lend support to their explanations or suggest that a particular cause should be ruled out. That is, patients may report evidence that bolsters explanations that they are apparently advancing, but they may also report evidence that would eliminate a particular explanation from consideration (as a preface to proposing a more serious explanation, for example). In either of these cases, doctors may focus on the tag component of the patient’s turn and topicalize the evidence itself, asking the patient for more information about it. The focus then stays on what the patient is experiencing and off the issue of whether the patient’s explanation is correct.

Excerpt (17a) occurs in the information-gathering phase of a medical interview, where the patient, Ms. N, is presenting various complaints. Ms. N reports experiencing a “tremendous amount” of rectal pain (lines 3–4). Then she offers an explanation for this pain—a speculation about “whether it was hemorrhoids or not”

21 See Pomerantz (1984b:624) on reporting the bases of assertions.
and she claims she is “not sure” in light of the following evidence: she experienced pain when she “tried (0.2) pressing” (lines 6–8). She thus suggests that the evidence points to a more serious problem than hemorrhoids. After a silence (line 9), she begins a repeat of what she “tried,” and during a hesitation in this utterance Dr. D seeks clarification by offering a candidate characterization, “pressing with your hand?” (line 11). Dr. D thus focuses on the evidence that the patient has reported.

In line 12, Ms. N corrects Dr. D’s candidate characterization by clarifying that “pressing” referred to her efforts to have a bowel movement. In overlap, Dr. D produces another clarification request (line 13). Ms. N confirms this (line 14). Accordingly, while Dr. D exhibits responsiveness to the evidence, this leads them away from assessment and keeps them in the mode of seeking and providing information. In line 16, after Dr. D has acknowledged (line 15) her confirmation of his candidate clarification (line 14), Ms. N returns to describing her symptom, now in terms of where the pain occurred.

In subsequent talk (seven lines of transcript not reproduced here), Ms. N describes applying a medication that took some of the “pain and itch” away. She then reintroduces her explanation (line 1 below), expressing a hope that “it was just hemorrhoids.”
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(17b) [10:613]

1 Ms. N: An I’m hoping it was just hemorrhoids
2 (0.4)
3 Ms. N: >because it really did ‘hurt a lot’
4 (0.7)
5 Ms. N: It’s not as bad now.

With this expression Ms. N implies its converse: that the problem may be more serious than hemorrhoids. Her next utterance, a reassertion of how painful the condition was (line 3), underscores her implied proposal. She then claims that the symptom has since abated (line 5). Then (not in excerpt here), Ms. N states that she bought a new medication (Anusol), and Dr. D queries further about the symptoms and their location. Reporting that the pain occurred not just externally but also “up some (0.7) in the rectum” (lines 1–3 below), Ms. N next proposes (in a qualified manner) that the pain could have been caused by an obstruction (lines 3–4). Again, Dr. D pursues more information about the location of the pain (line 7):

(17c) [10:630]

1 Ms. N: >I mean- there was some external (1.0) pain also but
2 there was a- it felt like it was up some (0.7) in the
3 rectum. Um (.) that it was hurting- Almost like it was
4 obstructed there somewhat.
5 (0.5)
6 Ms. N: "h."
7 Dr. D: [Could you touch] anything that was tender?

Many minutes later, during the physical exam, Dr. D assesses (line 1 below) Ms. N’s original explanation that the pain was caused by hemorrhoids:

(17d) [22:1435]

1 Dr. D: (You do) have a fresh hemorrhoid here An
2 Ms. N: [I do,
3 Dr. D: = over on the right side.
4 (0.5)
5 Dr. D: (They) also all around the anus it’s very re:d. = h
6 (0.4)
7 Ms. N: Well it has been sore th[e]re
8 Dr. D: [An I think that’s (probably from}
your diarrhea)

20 Dr. D: Alright well we'll jus' stop right there Anna cuz I think we know what's goin' on
21 Ms. N: What
22 Dr. D: You Have A: hemorrhoid [jis like you] said
23 Ms. N: [Oh “okay”]
24 Ms. N: I thought you were going to say something to “scare” me
25 Dr. D: “be” a good doctor Anna we’ll hire YA
26 Ms. N: ([laughs])

Note that Dr. D constructs this diagnosis as a confirming assessment (“You do have a fresh hemorrhoid”, line 1, and . . . “jis like you said,” line 23), suggesting that the patient’s explanation was correct. In this way, he pitches the diagnosis as responsive to that explanation and also as strongly affiliative. However, in light of Ms. N having designed her explanation in a way that suggested the pain was too severe to reflect hemorrhoids and may represent an obstruction, the doctor’s response is also an oblique disconfirmation of that alternate possibility. Ms. N’s response (line 24) exhibits a “change of state” in her understanding (Heritage 1984b). At line 25, she also displays an “At first I thought (X)” orientation, implying relief at this disconfirmation and the realization it entails, a less serious diagnosis (Sacks 1984:419; Halkowski this volume).

Conclusion

During the information-gathering phase of medical interviews, if the focus typically remains on patients’ symptoms and medically defined ways of exploring them, this is not wholly doctor-induced, nor a matter of doctors imposing a biomedical agenda upon patients who have little agency or understanding of medicine or the medical interview. Previous studies have failed to appreciate patients’ dilemma of needing to offer their explanations in a relevant sequential environment while not disrupting the information-gathering phase of the encounter. Nor has previous research appreciated the doctor’s dilemma of how to receive such explanations before gathering all the data necessary for analysis. Accordingly, the apparent struggle
Explaining illness between professional and lay orientations in medicine is at least partially a more local matter that is related to the overall organization of the medical interview and the conversational sequences through which participants assemble it.

In other words, a distinctive aspect of medical practice is that the “data” the “professionals” (doctors) are to analyze derive from “laypeople” (patients) who may have their own perspectives about what causes health problems. The question for patients is where to insert their own explanatory analyses, so that doctors may consider these explanations as they make determinations about what is going on medically. Patients appear sensitive to the pattern by which medical inquiry typically proceeds. They are wary of disrupting the gathering of information and avoid compelling an analysis (an official assessment) too soon, before all the data have been collected. However, if patients do not offer their explanations in the environment of data collection, the next phases of the interview may be even less propitious, for the immediate next activity, after verbal and physical examination, is the diagnostic informing when the doctor’s task is to deliver the news and the patient aligns to receive it.

Through the details by which they construct their turns at talk, patients address this dilemma by producing explanations during the collection of medical data and providing doctors with sequential options other than immediately producing confirming or disconfirming assessments. When doctors take the option to continue assembling data rather than engaging in analysis of it, they are, like patients, strongly orienting to the organization of the interview and to completion of its data-collection phase. Practices on the part of both patient and physician account for what comes off as a kind of tenuous introduction of, and minimalistic appreciation for, patients’ causal theories.

Our analysis suggests that there is the potential for conflict but that it does not derive from inherent tensions between physicians’ positioning within biomedicine and patients’ parallel embeddedness in the lifeworld. The conflict is between the local, sequential organization of talk and the organization of the medical interview. Even so, when patients offer overt explanations, in approximately 30 percent of these cases (19 out of 63), doctors do either assess them
immediately or respond to them in a delayed fashion. Also needing appreciation is the resourcefulness of both parties. Patients do have a device (the three-part turn structure) for introducing their explanations into medical interviews. Furthermore, they sometimes may have health worries about whose medical status they are not confident. This device for explaining their more clearly defined symptoms allows them to put these worries on the floor with minimal interactional risk. Given that the exploration of psychosocial factors is central to improved communication and medical care (Frankel et al. 2003), it is important for doctors to pay attention to patients’ explanations that introduce such factors.

More generally, our research has this implication: Doctors can increase their sensitivity to patients’ experiences by being aware of the patient’s and doctor’s dilemmas, and interactional resolutions thereof, that promote tenuousness and minimalistic talk directed toward patients’ own explanations for illness. For example, after hearing a patient’s explanation for a symptom, doctors can “signpost” that their subsequent queries about the symptom are related to exploring a variety of candidate explanations, including the patient’s. This strategy does not require the doctor to present a diagnosis prematurely (i.e., to immediately confirm or disconfirm the patient’s explanation); rather, it simply provides additional orientation about the direction of the doctor’s questions and may provide some reassurance to the patient that, indeed, the doctor has heard and is considering their explanation.

Another strategy doctors can use is to propose that they will consider the patient’s explanation later in the interview, during the physical exam. This occurs in the excerpt below, where (near the beginning of the medical interview) the patient and doctor are discussing the patient’s chest pain. The patient speculates whether the pain “could had (.) anything to do.” with the “breast” (lines 1–3). After a silence, she reformulates the causal factor in a progressively more specific way (lines 5–7), indicating what it is about her breast that could be causing the pain: “that (0.3) surgery”, and then having the “tumor removed.” The doctor initially queries the patient about the causal factor, asking whether she is experiencing tenderness in her breast (lines 9–10). After the patient confirms this, the doctor indicates that she will check the patient’s breast and “see” (line 13). Thus, the doctor exhibits responsiveness to the patient’s explanation
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by proposing to examine the breast later in the interview, during the physical exam. She then continues querying the patient about her chest pain; see excerpt (15).

(18) [5:271]

1 Ms. A: An’ the only other thing I was thinking of about da:: (.) da
2 pains is if- that could had (. ) anything to do: too is with
3 the breast.
4 (2.2)
5 Ms. A: When I had u::m (0.5) ’pt’ (0.8) that (0.3) surgery da
6 tumor removed. If dat could be anything (. ) connected with
7 that.
8 (1.2)
9 Dr. A: Pch .hh (.) ah:: >are you hav<ing:: (.) tenderness in in
10 your bre[ast it ]self?
11 Ms. A: [Mm hm?]
12 Ms. A: Mm hm =
13 Dr. A: = ‘You are.’ (. ) ‘I’ll check that breast again: an see.’

Finally, after collecting data in the medical interview and arriving at a diagnosis, doctors could attune themselves better to the patient’s dilemma by following up with a response to the patient’s explanation, such as a confirming or disconfirming assessment, as in excerpts (16b) and (17d).

Others have suggested strategies that enhance the patient’s participation in the interview.22 For example, Lipkin, Frankel, et al. (1995) recommend that the concluding tasks of the medical interview be reconceptualized so that, besides doctors delivering information to patients, patients themselves enter the analytic discussion with their perspectives and beliefs. Physicians should ask patients what they have understood about the physician has told them. Lipkin, Frankel, et al. (1995:79–80) write:

In the course of the patient’s exposition of what he or she has understood, the patient will reveal his/her explanatory model of the illness process – that is, to what the patient attributes the problem. These so-called attributions, the patient’s sense of the meaning or causality of the illness, must be acknowledged or some patients will reject the clinician’s approach as not appropriate.

22 See the discussion of cultural influences on patients’ “explanatory models” in Johnson et al. (1995).
We agree that physicians should encourage patients’ participation in medical interviews. Our analysis, however, shows that patients may reveal their explanatory theories well before the closing moments of these interviews. Patients orient to the process by which data is gathered and analyzed; in overt and tacit ways, they offer their explanations in information-gathering locations such that doctors can consider them as they generate diagnostic hypotheses. To suggest, as Lipkin, Frankel, et al. (1995) do, that doctors should elicit patients’ participation in the analytic discussion at the end of the visit, is to assume that patients will believe that doctors can take their theories into account as possible candidate diagnoses at this point, even though they have finished collecting data and have already delivered a diagnosis. It is perhaps more likely that patients may interpret the doctor’s efforts to give them (what Lipkin, Frankel, et al. [1995] call) a “final shot” at determining the agenda of the visit, as a move designed to make the doctor appear responsive. In addition, with this strategy doctors miss the opportunity to take patients’ explanations into account while considering and testing various diagnostic possibilities. We therefore suggest that if a patient does not volunteer a causal explanation within the data-collection phase of the medical interview, the doctor should solicit the patient’s explanation in that location, rather than wait until the end of the visit.