

# The structure of patients' presenting concerns: the completion relevance of current symptoms

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## Abstract

This article uses conversation analysis to investigate the problem-presentation phase of 302 visits between primary-care physicians and patients with acute problems. It analyzes the social–interactional organization of problem presentation, focusing on how participants recognize and negotiate its completion. It argues that physicians and patients mutually orient to the presentation of current symptoms—that is, concrete symptoms presented as somehow being experienced in the here-and-now—as a locus of transition between the patient-controlled problem-presentation phase of the visit and the physician-controlled information-gathering phase. This is a resource for physicians to distinguish between complete and incomplete presentations, and for patients to manipulate this distinction.

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## Introduction

Patients visit primary-care physicians for a variety of different types of medical issues, including relatively new acute problems (e.g., injuries, infections, etc.), continuing chronic conditions (e.g., high blood pressure, depression, etc.), and general–physical examinations. At least in the United States and Britain, when patients with acute problems visit primary-care physicians, their communication tends to be organized into six phases: opening (e.g., greeting, sitting down, etc.), problem presentation, information gathering (i.e., history taking and physical examination), diagnosis, treatment, and closing (e.g., leave-taking) (for a review, see Robinson, 2003). This is the second of a series of articles dealing with acute *problem presentation* in US, primary-care visits (see Heritage & Robinson, in press b).

*Problem presentation* is typically initiated by physicians with questions, such as *What can I do for you today?*, and is the only phase in which patients are licensed to present their problems in their own ways and according to their own agendas. This phase is significant for a number of reasons. Apart from the sheer expressive value for patients of presenting medical concerns in their own terms (Roter & Hall, 1992), patients' expositions of symptoms are associated with improved systolic blood pressure (Orth, Stiles, Scherwitz, Hennrikus, & Vallbona, 1987) and increased visit satisfaction (Stiles, Putnam, Wolf, & James, 1979; cf. Putnam, Stiles, Jacob, & James, 1985). Furthermore, soliciting the full spectrum of patients' concerns in the early stages of visits can better prepare physicians for diagnosis and treatment (Arborelius, Bremberg, & Timpka, 1991; McWhinney, 1989; Mishler, 1984; Peppiatt, 1992). Despite these implications

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for patients' health outcomes, research suggests that patients frequently do not complete *problem presentation*; that physicians frequently interdict patients' presentations and 'prematurely' or 'interruptively' progress to the next phase of *information gathering* (Beckman & Frankel, 1984; Marvel, Epstein, Flowers, & Beckman, 1999). However, this research by medical scholars and educators has not been based on how physicians and patients show themselves to understand and organize the activity of presenting problems. This article addresses this gap by answering the questions: do physicians and patients mutually orient to a set of norms dealing with the 'completion' of *problem presentation* and, if so, what are they? Stated differently, does *problem presentation* have an internal social–interactional organization? This organization would be a resource for physicians—and thus for scholars and educators—to distinguish between complete and incomplete presentations, and for patients to manipulate this distinction toward a variety of socio-medical ends.

### *Problem presentation as a socially organized activity*

Previous research suggests that *problem presentation* is, in fact, socially organized at both the cultural and interactional level. Culturally, patients' understandings of their illness—which have been variously labeled patients' *illness attributions* (Stoeckle & Barsky, 1981), *explanatory models* (Kleinman, 1980), and *differential diagnoses* (Bergh, 1998)—partially overlap those of physicians (Bergh, 1998; Helman, 1978). This suggests that physicians and patients have similar ideas about what constitute 'doctorable' medical problems (Heritage & Robinson, in press a) and what it means to present them for investigation.

Interactionally, the activity of presenting acute problems is part of a medically institutionalized project of phased activities (i.e., *opening, problem presentation, information gathering, diagnosis, treatment, closing*), the ordering and functions of which are jointly and independently understood by physicians and patients (Robinson, 2003). Previous research has described: (1) the interactional organization of the phase that precedes *problem presentation* (i.e., *opening*; for review and analysis, see Robinson, 1998); (2) how physicians' questions can 'frame' and shape *problem presentation* (Robinson, in press; Heritage & Robinson, in press b); (3) how contingencies (e.g., legitimacy) associated with classes of acute problems (e.g., new, recurrent, unknown) can shape *problem presentation* (Heritage & Robinson, in press a); and (4) how the presentation of self diagnoses (vs. just symptoms) can shape physicians' expectations of patients' treatment objectives (Stivers, 2002). All of this research suggests that medical activities within acute visits have internal, social–interactional organizations. Missing from this research, however, is an account of the normative organization of *problem presentation as a socio-medical activity* that shapes participants' understandings of what is to be presented, how it is to be presented, and what constitutes a complete presentation. Such an account would provide an explanatory framework for the constitution and recognition of social action during *problem presentation*. Along these lines, Marvel et al. (1999) found a statistically insignificant, 3.9-s differential between presentations in which patients explicitly oriented to being complete (e.g., by saying *And that's why I'm here today*) and those in which physicians' merely assumed completion; in both cases, problem presentations ended when physicians began *information gathering* (e.g., history taking). This indicates that physicians are at least roughly accurate in predicting when patients are complete, which suggests that *problem presentation* may have a stable social organization.

### *The relevance of current symptoms*

Patients' *problem presentations* emerge with great variation in terms of content, cogency, affective expression, and organization. Physicians can be conceived as monitoring presentations not only for their content, but for their moment of completion. This moment potentially arises toward the end of each of the patients' sentences, including the very first one. As patients talk, physicians tend to show that they are attending with verbal and/or nonverbal behaviors (e.g., head nods, *Okay, Mm hm*), which display physicians' understandings of patients' talk and thus can encourage or discourage patients' continuance. Furthermore, physicians may take steps to curtail presentations that are too expansive or invite expansion of ones that are too terse.

This article contends that, independent from other factors that shape it—such as the design of physicians' opening questions (Heritage & Robinson, in press b)—*problem presentation* has its own social organization that shapes how physicians solicit problems and how patients present them. This organization facilitates physician–patient coordination in the ongoing management and completion of patients' presentations. Specifically, this article contends that physicians and patients mutually orient to *current symptoms*—that is, concrete symptoms presented as somehow being experienced in the here-and-now—as a locus of transition between *problem presentation* and *information gathering*. Analogous to the 'baton-passing' zone in a relay race, the presentation of current symptoms constitutes a place where patients indicate their willingness to relinquish the interactional floor and physicians tend to take it. This transfer is interactionally

negotiated and not always smooth. Physicians can interruptively take the baton too soon; patients can hold onto it too long; patients can offer it several times before it is accepted, and it can be fumbled. Thus, at every point in patients' presentations, dilemmas of co-construction and coordination can inhabit the interaction. In this context, our aim in describing the social organization of problem presentation is to establish a basis to provide analytically defensible claims of interactional missteps and meaningful characterizations of physician–patient negotiation and co-construction.

## Data and method

Data are 302 randomly selected, videotaped visits between patients with acute problems seeing primary-care physicians in community-based clinics in the United States. Data represent 77 physicians and 41 clinics. Visits did not include those in which patients described their problems by physically presenting/displaying them with minimal vocalization (e.g., *Look at this*); the 'showability' of problems affects their presentation, and this will be the subject of a separate article. In all, 191 visits were collected in urban Los Angeles and 111 were collected in rural Central Pennsylvania. All data collection was approved by University Human-Subjects Protection Committees. Data were transcribed by the authors, using the system developed by Gail Jefferson (in Atkinson & Heritage, 1984). The method used is conversation analysis (for a review, see Atkinson & Heritage, 1984), particularly as it is applied to the study of institutional interaction (for a review, see Drew & Heritage, 1992).

## Analysis

This article argues that *problem presentation* normatively requires the presentation of current symptoms. Seven forms of evidence are provided: (1) physicians' opening questions often make reference to current symptoms; (2) physicians and patients frequently treat responses that do not contain current symptoms as incomplete; (3) physicians can treat patients' arrivals at current symptoms as completing *problem presentation*; (4) patients may treat physicians' shifts into *information gathering* prior to the presentation of current symptoms as being premature/interruptive; (5) when physicians do not shift into *information gathering* after the presentation of current symptoms, patients frequently display their orientations to having completed *problem presentation*; (6) patients with more than one current symptom to present can be seen to prospectively orient to the possible-completion relevance of the first current symptom; and (7) distributional trends.

### *Evidence 1: Physicians' opening questions often make reference to current symptoms*

One form of evidence for at least physicians' orientations to the norm that *problem presentation* makes relevant current symptoms is found in physicians' opening questions. For instance, in 16% of the data (48 visits), physicians initiate problem presentation with requests for confirmation of concrete, current symptoms (see Heritage & Robinson, *in press b*). A frequent feature of such requests is the verbatim use of terms recorded by nurses in patients' records, which are often those of patients themselves. For example, see Extract 1, in which the physician reads from the records.

#### *Extract 1 [N:10:01]*

01 a-> DOC: .tch Alright. so having head:a:che, an' sore thro:at .hh  
 02 a-> and cough with phle:gm for five da:ys?  
 03 PAT: Mm hm:,

In these cases, physicians display their orientation to the relevance of current symptoms for the action of problem presentation.

In an additional 11% of the data (33 visits), physicians began with requests for confirmation of 'glosses' of concrete, current symptoms, which can be considered 'one step removed' from those represented in Extract 1 above (see Heritage & Robinson, *in press b*). For example, in Extract 2, "uncomfortable" (line 1) is a gloss for the patient's upper-respiratory symptoms (line 4).

#### *Extract 2 [P3:49]*

01 a-> DOC: Sounds like you're uncomfortable.  
 02 (.)  
 03 PAT: Yeah. my e:ar, = an' my- s- one side = of my throut hurt(s).

There is evidence that these gloss-for-confirmation questions are designed, and are heard by patients to be designed, to target concrete, current symptoms. One type of support for this claim is that patients' responses (e.g., line 3, "throat hurt(s)") display their understanding that such questions are glosses of concrete, current symptoms that invite 'unpacking'. Perhaps more compelling, though, is that physicians can be seen to repair gloss-for-confirmation questions to symptoms-for-confirmation questions. For example, in Extract 3, "botherin' ya," (line 1) is a gloss for the patient's leg pain.

*Extract 3 [N:19:05]*

01 a1> DOC: It's your left le:g, thet's [botherin' ya,]  
 02 PAT: [ ((2 nods)) ]  
 03 PAT: ((1 nod)) ((0.4))  
 04 a2> DOC: You were running, an' felt (a:/uh:) like=a ya got hit there,

In the face of the patient's extremely minimal confirmatory response (i.e., head nodding; lines 2–3), the physician pursues a more expanded answer with a request for confirmation of a concrete, current symptom (i.e., "felt (a:/uh:) like = a ya got hit") (Note that the physician is reading from the nurses' intake notes, to whom the patient reported: "I was running (.) faster than a guy my age is supposed to run, .hhh and I felt like I got hit right here."). By shifting to a concrete instantiation of his original gloss-for-confirmation question, the physician displays his orientation to the gloss-for-confirmation question as having been initially designed to index concrete, current symptoms.

*Evidence 2: Physicians and patients frequently treat responses that do not contain current symptoms as incomplete*

A second line of evidence is found in cases where physicians initiate problem presentation with questions that do not explicitly display their orientations to concrete, current symptoms (e.g., *What can I do for you today?*), and where patients' initial response units do not constitute the presentation of such symptoms. In these cases, such units are frequently produced and understood as incomplete. That is, patients continue to produce, and physicians wait for, more talk until patients present concrete, current symptoms. Due to space considerations, what follows is an illustrative list of four classes of this type of evidence.

*Class 1: Claims to not know.* A first class of incomplete response units are patients' claims to not know the nature of their problems. For example, see Extract 4.

*Extract 4: [P3:94]*

01 a-> DOC: What's happenin' to ya Clarise  
 02 b1> PAT: I don't know sir=if I knew that I wouldn't h [ave [(ta) ]  
 03 DOC: [You [wouldn't]  
 04 DOC: be here. [hu:h?]  
 05 b2> PAT: [Yeah.] this is true. .hh I- I asked Tommy. to:  
 06 b2> h=look at it for me. an' he says to me we'll, it's re:d, .h an'  
 07 b2> it's about this big.

The patient's initial response unit, "I don't know sir" (b1 >), is a possibly, grammatically complete response (Sacks, Schegloff, & Jefferson, 1974); the patient extends her turn with a second unit: "if I knew that I wouldn't have (ta)..." (b1 >). At lines 3–4, the physician aligns with the patient by collaboratively completing her second unit, "You wouldn't be here". (lines 3–4; see Lerner, 1996), to which the patient agrees: "Yeah. This is true." (line 5). Under ordinary circumstances, the patient's completion of "true" (line 5) would constitute a transition-relevance place (Sacks et al., 1974). However, this is altered by the social organization of *problem presentation*, which makes relevant the presentation of current symptoms, and thus embodies a context wherein the patient's "this is true" is pragmatically incomplete. This is supported by the fact that the patient immediately draws breath ".hh" (line 5), which projects more talk (Schegloff, 1996c), and continues to present concrete, current symptoms: "...it's re:d, .h an' it's about this big." (b2 >).

*Class 2: Requests for diagnostic or physical-examination procedures.* A second class of incomplete response units are requests for diagnostic or physical-examination procedures. For instance, see Extract 5.

*Extract 5 [P3:127:20]*

01 a-> DOC: How can I help ya toda:y.  
 02 b1> PAT: .tch=.hhh You c'n: (.) check my e:ars.  
 03 (.) ((doctor gazing at patient w/ hands at sides))

04 DOC: [(‘Kay./Yeh.)]  
 05 b2> PAT: [ It ap]pe:ars that I have (0.4) a couple weeks back I  
 06 noticed that (.) my ears were kinda plugged an’ they’re (.)  
 07 ki[nda have pressure in = around my ey:es, and face,  
 08 DOC: [(physician begins to raise patient’s chart))

As the physician produces his opening question (a->), he is standing in front of, and gazing at, the patient (who is sitting on the examination table); although the physician holds the patient’s medical chart in his left hand, it is ‘out of use’ as his arms are hanging vertically at his sides (cf. below). The patient’s initial response unit is a request for a physical examination, “You c’n: (.) check my e:ars.” (b1>). In the following micropause, the physician maintains his body and gaze orientation toward the patient, which treats this unit as incomplete. The patient treats himself as incomplete by continuing to present his problem, which quickly eventuates in current symptoms (i.e., “...they’re (.) have pressure in = around my ey:es, and face,” (lines 6–7). It may not be coincidental that the physician begins to access the patient’s chart (line 8) very shortly after the patient projects the presentation of current symptoms, that is after “they’re” (line 6; i.e., *My ears are...*).

*Class 3: Simple past tense formulations.* A third class of incomplete response units are descriptions of events (including concrete symptoms) that are described in the simple past tense. It is well documented that, especially in environments where one person is soliciting a ‘telling’ from another, beginning in the simple past tense is a practice for beginning a narrative, which projects that tellers will not be complete until they produce present-tense events (Labov & Waletzky, 1997). This practice is overtly oriented to by the patient in Extract 6.

*Extract 6 [P3:118]*

01 a-> DOC: What = in thuh world’s goin’ o:n.  
 02 (0.2)  
 03 b1> PAT: W’il (.)↑ · · ha:ve ↓(.) da- ta back up ta thuh very  
 04 b1> beginning. I think I had like an upper respiratory  
 05 b1> flu:.  
 06 DOC: Ri:[ght,] ((while nodding))  
 07 PAT: [ L:i]ke- (.) a week ago. I was running a fever...

In line with the present-progressive grammatical format of the physician’s question (i.e., “goin’ o:n”; a->), the patient begins to produce present-tense problems, “↑ · · ha:ve ↓” (b1>). However, she abandons this to begin in the simple past tense, “I had” (line 4), and accounts for her restart as ‘backing up to the very beginning’ (lines 3–4), which explicitly projects a multi-unit telling (see lines 4–7, which are in the simple past tense).

For an example of past-tense events being produced and understood as an incomplete response unit, see Extract 7:

*Extract 7 [P3:64]*

01 a-> DOC: An’ what can we do for ya today.  
 02 b1> PAT: .hh Well I was here on september = h <twenty third>  
 03 b1> because I had <bronchial> (.) >an’ I< was put on  
 04 b1> z:i]throma [x.  
 05 DOC: [Mm hm,  
 06 b2> PAT: .hh thuh following: tuesday wednesday I had such a  
 07 b2> sore throat I could hardly swallo [w.  
 08 DOC: [Mm [hm,]  
 09 PAT: [ .h ]h I came  
 10 i:n fo:r a culture an’ it was negative.

In her first response unit (b1>), the patient presents a diagnosis (e.g., “bronchial”) and a treatment (“z:i]thromax”) in the simple past tense (e.g., “had” and “put”, respectively). In her second response unit (b2>), she presents a concrete symptom (“sore throat”) in the simple past tense (“had”). In both cases, the physician treats the patient’s presentation as incomplete by responding with a continuer, “Mm hm,” (at lines 5 and 8; Schegloff, 1982). The patient treats her own presentation as incomplete by continuing to present her problem (at both lines 6 and 9). This is highlighted at line 9, where the patient begins in overlap with the physician’s continuer, and thus produces her continuation as being independent from the continuer.

*Class 4: Glosses of concrete symptoms.* A fourth class of incomplete response units are descriptions of problems (including current ones) that are formulated as ‘glosses’ of concrete symptoms. Patients can describe their medical problems in different ways. The interactional practice of describing is organized along a number of dimensions, one of them being *granularity*, or ‘degree of resolution’ (Schegloff, 2000). For example, in response to a child’s question, *What time is it?*, a parent can refer to the time as *Nine forty*, *Almost ten*, or *Bed time*. Different descriptions ‘zoom in on’ or ‘pan out from’ specificity or exactitude, include and exclude particular details (Jefferson, 1985), and are designed to accomplish different actions (Schegloff, 1996b). Problems can be described along varying levels of granularity. One level includes concrete symptoms, such as fever, cough, and pain. A relatively higher-grained level includes *glosses* of concrete symptoms, such as the descriptions *I have a problem*, *I have something wrong*, *I feel funny*, and *I’m falling apart*. In the context of acute care, the latter ‘gloss’ formulations are produced and understood as incomplete response units. For example, in Extract 8, the patient’s initial response unit is “my ear’s been acting up.” (line 3), where the gloss is “acting up”.

*Extract 8: [N:12:02]*

01 a-> DOC: What’s goin’ on.  
 02 (0.3)  
 03 b1> PAT: ‘ell my ear’s been acting up. hh [hh ]  
 04 DOC: [Uh huh]h?  
 05 (0.4) ((doctor gazing at patient))  
 06 b2> PAT: Thuh: >Friday< evening it started to: (.) to  
 07 b2> ring real loud,

Although the patient’s initial response unit (b1>) is syntactically and intonationally possibly complete (after “up.”), the physician orients to it as being incomplete by responding with a continuer, “Uh ↑huh?↓” (line 4; Schegloff, 1982). At line 5, the physician, who is gazing at the patient, waits for the patient to continue, which he does by presenting a concrete, current symptom constitutive of “acting up”: “it started to: (.) to ring real loud,” (b2>).

*Evidence 3: Physicians can treat patients’ arrivals at current symptoms as completing problem presentation*

Our third type of evidence is that response units (including initial ones) that embody concrete, current symptoms can be treated by physicians as possibly completing the action of *problem presentation*; physicians do this by shifting into *information gathering*. Although this is not evidence that patients are *actually* complete (e.g., there can be miscommunication, interruption, etc.), it is a physician practice for claiming a stance that patients are complete. For example, see Extract 9.

*Extract 9 [P3:101]*

01 a-> DOC: What, can = I do:, for you tonight. = hh  
 02 b1> PAT: We:ll = h I have = h (.) chest pains.  
 03 DOC: Hha: = hh = oka:y,  
 04 (0.2)  
 05 HX> DOC: How long have they been going on.

In response to the patient’s initial response unit, “I have = h (.) chest pains.” (b1>), which constitutes a concrete, current symptom, the physician initiates information gathering (HX>). Admittedly, the physician first produces *Okay* (line 3), which simultaneously registers and accepts the patient’s presentation and projects a possible shift to new matters (Beach, 1995), yet stands as a possibly complete unit that provides the patient with a turn-taking opportunity to produce more talk (see Extract 14, below, for a case in which this happens). However, despite this observation about *Okay*, which underscores the point that patients’ *actual* completion is an interactionally negotiated affair, the physician ultimately treats the presentation of concrete, current symptoms as constituting a *possibly* complete problem presentation.

This point is strengthened by the observation that *information gathering* can be positioned immediately after a current-symptom unit (i.e., without intermediate, acknowledging behaviors, such as *Okay*). For example, see Extract 10.

*Extract 10 [P3:126:20]*

01 a-> DOC: How >can I< help you today.

02 b1> PAT: Got = a #sore thro:at,# ((# = hoarse))  
 03 HX> DOC: .hhh How long [‘as it been the [re. ]  
 04 PAT: [ It’s kuh- [ .h]h #Since Monday. #

The patient is sitting on the examination table with both hands clasped in her lap. Her initial response unit presents a concrete, current symptom, “Got = a #sore thro:at,#” (b1>). As she begins this unit, she gestures toward her throat, and as she ends this unit, she returns her hand to her lap, once again clasped with her other hand. Immediately upon completion of this unit, the physician, who is gazing at the patient, begins to draw breath (line 3, “.hhh”), which projects, but does not officially begin, a turn of talk (Schegloff, 1996c). During the physician’s inbreath (0.3 s), the patient gazes at the physician, displaying an orientation to her own completion. As projected, the physician initiates information gathering (HX>), which displays his orientation to her completion, and thus to the possible sufficiency of a single, concrete, current symptom.

*Evidence 4: Physicians’ shifts into information gathering prior to current symptoms may be treated as premature*

If *problem presentation* is relevantly completed with current symptoms, then it not only obligates patients to (eventually) produce current symptoms, but also gives them the *right* to do so. Evidence for this is found in deviant cases (Silverman, 2001), where physicians come in ‘early;’ that is, prior to patients’ presentations of current symptoms. In these cases, it is not uncommon for patients to ‘fight’ for their right to present current symptoms. For example, see Extract 11, where the patient is visiting for an injured right foot. She is sitting on an examination table with her shoes off and both legs stretched out; the physician is sitting in front of the patient.

*Extract 11: FOOT PAIN [SG:8:4]*

01 a-> DOC: What = you up to:. = h  
 02 (.)  
 03 b1> PAT: I’ve gotta bad foot that I can’t- (.) get well.  
 04 (0.2) ((Doctor moves his chair close to foot))  
 05 HX> DOC: [Which part.  
 06 PAT: [((Patient begins to move foot back & away from physician))  
 07 b2> PAT: > Okay.< (0.2) about five weeks ago I went to Disneyland  
 08 b2> an’ I wore a pair = a sandals that weren’t very  
 09 b2> supportive.

The patient’s initial response unit, “I’ve gotta bad foot that I can’t- (.) get well.” (b1>), is merely a gloss (i.e., “bad foot”) for present-tense (“I’ve gotta”) symptoms, and thus incomplete. Nonetheless, the physician subsequently moves himself closer to the patient’s foot (line 4) and asks, “Which part.” (HX>). With this question, the physician proposes to shift out of *problem presentation* into *information gathering*. However, the patient resists this in two ways. First, after the physician moves closer, and simultaneous with the physician’s history-taking question, the patient begins to pull her foot away from the physician (line 6). Second, the patient initially ignores (i.e., does not answer) the physician’s history-taking question and instead initiates an illness narrative framed in the simple past tense, which projects more talk (b2>). If not for the patient’s persistence, the physician might have lost valuable diagnostic information. Indeed, in this case, in her subsequent problem presentation (data not shown), the patient goes on to inform the physician about the context of her problem, its current symptoms, her attempts at self-medication, and an underlying or ‘hidden’ concern (Barsky, 1981): “But what really made me come in here is that this morning (0.5) when I woke u:p (0.5) it was kind = of- reddish blue, right here?” (The patient is a diabetic and is concerned about the possibility of *phlebitis*).

For another example, see Extract 12.

*Extract 12 [N:25:08]*

01 a-> DOC: So:, tell me. what brings you in here today ( ).  
 02 b1> PAT: My back doc. I: uh (0.3)  
 03 HX> DOC: Back pa:in?  
 04 PAT: Yeah le’ = me tell you what ha:ppend.  
 05 DOC: Sure.  
 06 b2> PAT: I: uh (1.7) (have) one = a those little electric scooters? ...

The patient’s initial response unit, “My back doc.” (b1>), identifies the location of his problem, yet glosses its constitutive symptoms. The patient orients to his own lack of completion by continuing to present his problem, “I: uh”

(line 2). However, the patient is interrupted by the physician, who initiates *information gathering* by requesting confirmation of an as-of-yet undisclosed, concrete symptom, “Back pa:in?” (HX>). The patient orients to this specifically as an interruption by requesting permission to complete his telling: “le’ = me tell you what ha:ppend.” (line 4). Note that, after permission is granted (line 5), the patient re-begins with the same words, “I: uh” (b2>; cf. line 2), which is a practice for communicating that he is beginning the same action he started at line 2 (Schegloff, 1996a). The patient continues to present a concrete, current symptom (data not shown).

*Evidence 5: When physicians’ do not shift into information gathering after current symptoms, patients frequently indicate their completion*

If the presentation of current symptoms relevantly completes *problem presentation*, then upon their production, physicians should become increasingly accountable for shifting into *information gathering*. Another type of deviant case supporting our argument emerges when physicians do not initiate *information gathering* upon patients’ presentations of current symptoms. When physicians ‘fail’ to recognize that patients are actually complete—note that this is always a retrospective, and sometimes an unfairly pejorative/inaccurate analysis of a prospective process that is presumably motivated and accountable—patients frequently utilize practices for communicating their completion (as part of the process of negotiating actual completion). For example, see Extract 13.

*Extract 13: [P3:64:11]*

- 01 a-> DOC: An’ what can we do for ya today.  
 ((14 lines omitted; problem presentation))
- 16 CS> PAT: It gets really (f)sore in this side an’  
 17 CS> then its feels like its up in to my ear.  
 18 DOC: Okay, ((physician gazes at patient and nods))  
 19 (.) ((physician gazes at patient and nods))  
 20 \*-> PAT: [-h An’ that’s] why I’m here today. ‘Cause its been (.) long.  
 21 DOC: [Okay, ]  
 22 DOC: O:kay,  
 23 HX> DOC: >.hh< Well that sounds like a pretty good history  
 24 there, that’s pretty- pretty concise,

After the patient presents concrete, current symptoms (CS>), and while gazing at the patient, the physician nods and produces “Okay,” (line 18). In the subsequent micropause (line 19), the physician continues to gaze at the patient and nod, which displays his understanding that the patient is possibly incomplete (Schegloff, 1982). At this point, rather than producing another current-symptom unit (cf. Extract 14, below), the patient produces an ‘exit device’ that communicates her completion with *problem presentation*. The patient uses the indexical expression *that’s*, “An’ that’s why I’m here today.” (\*->), to encapsulate and reiterate her problem presentation, which she subsequently transforms into an account for visiting the physician: “‘Cause its been (.) long.” (\*->), both of which are akin to story-exit practices described by Jefferson (1978). Note also that she repeats the word “today” (line 6) used by the physician at line 1 (also in turn-final position), which is similar to what has been described as ‘returning to the beginning’ of extended tellings as a practice for exiting from such tellings (Jefferson, 1978). The physician orients to this as communicating completion by beginning information gathering (HX>).

For another example, see Extract 14.

*Extract 14 [P3:36]*

- 07 a-> DOC: What’s been goin’ o:n.  
 08 b1> PAT: Ba:d sinuses (0.4) achey. (0.2) cold an’ ho:t.  
 09 (0.6) ((physician gazes at patient and nods once))  
 10 DOC: °Okay.°  
 11 b2> PAT: Headaches.  
 12 (1.0) ((physician gazes at patient and nods twice))  
 13 \*-> PAT: °You know.° (.) your usual. =  
 14 HT> DOC: = When did they start. do you think.

The patient begins by producing a three-part list (Jefferson, 1990) of current symptoms (b1>), which possibly completes her problem presentation. In the silence at line 9, the physician gazes at the patient and nods, and then

subsequently produces “°Okay.°” (line 10), which registers and accepts the patient’s presentation and orients to its possible completion (Beach, 1995). However, the patient continues to produce another current-symptom unit, “Headaches.” (line 11), the completion of which marks another place of possible presentation completion. In the silence at line 12, the physician simply gazes at the patient and nods, which treats her presentation as possibly incomplete (Schegloff, 1982). Here, then, is an interactional location where the physician retrospectively ‘fails’ to recognize that the patient is actually complete, and this ‘failure’ is oriented to by the patient, who proceeds to utilize an ‘exit device.’ That is, she assesses and summarizes the upshot of her problem presentation, “°You know.° (.) your usual.” (line 13), which is a practice for communicating the ending of an extended telling (Jefferson, 1978). Immediately upon its completion, the physician initiates history taking, “When did they start.” (line 14), thus orienting to the patient’s exit device as communicating her completion with *problem presentation*.

*Evidence 6: Patients prospectively orient to the completion relevance of current symptoms*

If patients understand that presenting current symptoms possibly completes *problem presentation*, then, in cases where patients have more than one current symptom to present, and when this will require more than one unit of talk, we should find evidence of patients utilizing interactional practices for acquiring/producing more than one unit of talk, and of doing so prospectively (i.e., prior to physicians’ initiations of *information gathering*). For instance, see Extract 15. The patient begins her response with an illness narrative (lines 2–17), the entirety of which is not presented.

*Extract 15 [P3:117:19]*

- 01 a-> DOC: What’s goin’ o:n.  
 02 PAT: Well, (.) Saturday afternoon I started off like  
 03 aches an’ pa:ins, an’ I just kin(d)a laid aro:und,  
 04 an’ ‘hh same thing on Sunday and Monday = I f- didn’t  
 05 feel too bad so I went ta school.  
 06 DOC: Okay, ((begins taking/writing notes))  
 ((7 lines of patient narrative omitted))  
 14 PAT: I stayed home yesterda:y, = > ‘n < ‘hhh an’  
 15 really (intended of) going inda school > today  
 16 CS> [an’ I < jus’ > woke up < I just have s:o  
 17 [((begins gesture of left hand gripping throat))  
 18 CS> much congestion with = it >just-<  
 19 HX> DOC: Up [in here, ]  
 20 CS> PAT: [.hhhhh]hh Yeah when I co::ugh, or snee::ze or  
 21 CS> yaw::n my [ throat ] ju[st (.) a:] ches.  
 22 DOC: [((1 nod))] [((1 nod))]  
 23 DOC: = [°°Okay°°  
 24 DOC: = [((underscores notes twice with pen))]

At the beginning of line 16, the patient brings her left hand up to her throat in a mock grip (line 17); she maintains this gesture through line 21. When the patient produces “I just have s:o much congestion with = it” (lines 16–18), she presents her very first current-symptom unit; the “it” indexes her throat via her hand gesture.

Retrospectively, we can see that the patient has more than one current-symptom unit to present (see lines 20–21). As the patient produces her first current-symptom unit (lines 16–18), she prospectively orients to the possibility that it will be treated by the physician as possibly completing her problem presentation (which he, in fact, does by asking “Up in here,” at line 19). The patient does this by taking two measures to forestall the physician’s entry and project more talk. First, although “congestion” marks a place of possible syntactic completion (Sacks et al., 1974), it is produced with level (vs. rising or falling) intonation, which can be a practice for projecting a lack of turn completion (Ford & Thompson, 1996). Second, the patient speeds up her talk at “with” so that it ‘bleeds’ into “it” (symbolized by the equals sign), which is also produced with level intonation, and similarly produces “>just-<” with an increased pace (symbolized by inward-pointing carrots). In doing so, the patient *rushes through* (Schegloff, 1982) the turn-transition space of one unit of talk into another, which is a practice for securing an additional unit of talk when a recipient (e.g., the physician) might rightfully take a turn (see also Schegloff, 1996c). Note that the patient rushes through to her second current-symptom unit, which she reproduces in full as “when I co::ugh, or snee::ze or yaw::n my throat just (.) a:ches.”

(lines 20–21). The evidence that this was where the patient was going with “it >just-<” (line 18) is that she repeats “it” (line 18) in the form of “my throat” (line 21), as well as “>just-<” (line 18) in the form of “just” (line 21) (Schegloff, 1996a).

Immediately upon completion of this second unit, the physician whispers ““Okay”” (line 23), which acknowledges it and projects a possible shift to new matters (Beach, 1995), arguably history taking. Simultaneously, he uses his pen to twice underscore the notes he has been taking (line 24). This nonvocal gesture, which communicates his own completion taking notes, displays his understanding that the patient has (re)completed her problem presentation. This is supported by the fact that the physician subsequently places his hand in his lap (i.e., out of writing position) and shifts his gaze from the patient to the computer screen in preparation for asking another history taking question (data not shown).

#### *Evidence 7: Distributional trends*

All 302 problem presentations were coded for: (1) the number of current-symptom units presented; (2) where physicians initiated *information gathering* relative to current-symptom units; and (3) whether patients explicitly indicated their completion. Drawing on Marvel et al. (1999), we operationalized *problem presentation* as all patients’ talk following physicians’ opening questions until patients’ were subsequently ‘redirected’ by physicians’ questions. Current-symptom units were any turn-constructive units (Sacks et al., 1974) containing the presentation of concrete symptoms somehow framed as occurring in the here and now, including descriptions of biomedical and psychosocial problems (e.g., *I have a sharp pain in my right side, My wife and I have a hard time relating to each other*), their location (e.g., *It’s into the ears*), and their duration (e.g., *It’s been off an on for the last four days*). Drawing on Beckman and Frankel (1984), patients’ explicit indications of completion were either announcements of completion (e.g., *So that’s why I’m here*) or solicitations of information about their problem (e.g., *Do you have any idea?*), including *I don’t know if it’s ‘X’* formulations (e.g., *I don’t know if its bronchitis or what*), which have been shown to seek medical information (for review and analysis, see Robinson, 2003). Physicians’ redirections were coded as being adjacent to either a current-symptom unit or a non-current-symptom unit.

Three distributional trends support the argument that *problem presentation* is normatively completed with the presentation of current symptoms. First, 78% of the visits contained one or more current-symptom units. In three quarters of the remaining cases (16%,  $N = 48$ ), physicians initiated the phase of *information gathering* after patients merely confirmed (e.g., *Mm hm*) physicians’ descriptions of current symptoms (as in Extract 1, above). In the remaining quarter of the no-current-symptom cases (6%), physicians initiated *information gathering* after a non-current-symptom unit, such as in the middle of an illness narrative that had not progressed to the present tense. Of the 78% of visits that contained one or more current symptoms, 25% contained one current-symptom unit and 53% contained two or more such units. A *t-test* showed that patients’ presentations were significantly more likely to contain at least one current-symptom unit (vs. zero; mean = 0.78; SD = 0.42),  $p < 0.0001$ .

Second, in cases where patients presented at least one current-symptom unit ( $N = 238$ ), a *t-test* showed that physicians were significantly more likely to redirect into *information gathering* immediately adjacent to a current-symptom unit (vs. a non-current-symptom unit; mean = 0.68; SD = 0.47),  $p < 0.0001$ . And third, in cases where patients presented at least one current-symptom unit and where physicians redirected adjacent to a non-current-symptom unit ( $N = 75$ ), over half of the time (51%) this unit was an explicit indication of completion; these cases are similar to Extracts 13–14 (above), which were deviant cases that supported our argument. In sum, the distributional evidence strongly supports the conclusion that physicians initiate transitions into *information gathering* at, or very close to, patients’ first or  $N$ th articulation of current symptoms, and that patients tend to treat such initiations as being ‘legitimate.’

## **Discussion**

This article examined the activity, or phase, of *problem presentation* in US, primary-care, acute visits. It qualitatively and quantitatively demonstrated that physicians and patients mutually orient to a set of norms dealing with the ‘completion’ of *problem presentation*. Specifically, participants understand that *current symptoms*—that is, concrete symptoms presented as somehow being experienced in the here-and-now— are a required feature of *problem presentation* and are a locus of transition between it and the next phase of *information gathering*. This was supported distributionally in that a significant majority of *problem presentations* contained at least one current symptom. Additionally, physicians treated the presentation of current symptoms as being transition-relevant by predominately initiating the next phase of *information gathering* immediately adjacent to patients’ presentations of current symptoms.

Finally, when physicians ‘bypassed’ this transition point and initiated *information gathering* adjacent to the presentation of non-current-symptom units, a significant majority of such units were patients’ explicit indications of their completion, or ‘exit devices.’ Thus, patients also treated the presentation of current symptoms as being transition-relevant.

The social–interactional organization of *problem presentation* is a resource for physicians—and thus for scholars and educators—to distinguish between complete and incomplete presentations. Along these lines, our findings suggest that previous research (Beckman & Frankel, 1984) may have overestimated the frequency with which physicians ‘interrupt’ patients’ presentations. For instance, Marvel et al. (1999) found that only 28% of patients achieved completion; all others were ‘redirected’ by physicians, typically into *information gathering*. A key feature of prior operationalizations of completion (e.g., Beckman & Frankel, 1984) was patients’ talk that explicitly indexed completion (e.g., *And that’s why I’m here today*). We found that such units tend to be ‘exit devices’ that are employed after the presentation of current-symptoms; such exit devices are designed to communicate completion and to prompt transition into information gathering (see Jefferson, 1978, for a similar argument regarding the organization of stories). In our data, 25% of presentations contained one current symptom, and 53% contained two or more. Thus, viewed in terms of a normal locus of transition that physicians and patients recognize as a matter of empirical fact (rather than in terms of an ethical or medical ideal), as many as 78% of our patients achieved ‘completion’.

Of course, our data also suggest that more than one in five patients (22%) do not complete (or are not allowed to complete) their *problem presentation*. Part of the solution to this problem lies in an examination of the specific design of the questions that physicians use to initiate *problem presentation*. Importantly, the normative organization of *problem presentation* (revolving around current symptoms) exists independently of the design of physicians’ opening questions. This is precisely why, when patients (vs. physicians) initiate *problem presentation* (which is rare), they frequently do so by volunteering current symptoms (Heath, 1986). It is also why patients can understand physicians’ nominally social (i.e., non-medical) opening questions (e.g., *How are you?*) as, in fact, medical solicitations of current symptoms (Robinson, 1999). However, with the recognition that the normative constraints of question design and *problem presentation* are distinct comes the observation that these two sets of constraints can interfere with one another, with negative consequences for problem presentation and, potentially at least, patients’ health outcomes. For example, the conflict between the ‘social’ norms embodied in the question design *How are you?* (which require neutral social answers, such as *Okay* or *Fine*; Sacks, 1975) and the ‘medical’ norms of *problem presentation* (which require the presentation of current symptoms) complicates patients’ responses to such questions, and this complication can lead to a reduced number of current symptoms being presented (Heritage & Robinson, in press b). Similarly, opening questions whose designs strongly constrain patients’ immediate answers to something other than a presentation, *per se*—such as that in Extract 1, “so having heada:che, an’ sore thro:at .hh and cough with phle:gm for five da:ys?”, which constrains the patient’s immediate answer to a confirmation—also result in the presentation of significantly fewer current symptoms (Heritage & Robinson, in press b). In sum, part of the solution to patients having their problem presentations ‘interrupted’ lies in training physicians to use opening questions whose designs parallel the normative requirements of *problem presentation*, such as general-inquiry questions (e.g., *What can I do for you today?*, *How can I help?*, and *What’s goin on?*; see Heritage & Robinson, in press b).

Another obvious part of this solution is simply encouraging physicians to ‘wait’ until patients have presented current symptoms. Much more important, though, is the recognition that, even though patients may be *possibly* complete after the presentation of one current symptom, *they may still have more to present* (e.g., Extracts 14–15). Indeed, over half of our *problem presentations* (53%) contained two or more distinct current symptoms. The norms regarding the completion-relevance of current symptoms do not speak to whether or not patients are *actually* complete. Thus, upon completion of patients’ first current symptom, physicians might be trained to provide patients with structural opportunities to provide more symptoms rather than launching directly into *information gathering* (see Extract 15, line 19). The literature on medical interviewing has termed this ‘surveying patients’ concerns’ (e.g., Swartz, 1998), which includes asking questions such as *Are there other symptoms?* Regarding such procedural recommendations, however, extreme caution must be exercised—research based on actual practice does not yet fully understand their social or interactional implications.

The fact that the presentation of current symptoms is recognized as a recurrent locus of transition between *problem presentation* and *information gathering* makes it amenable to patient manipulation. For instance, the initial units of narratives are frequently simple-past-tense events (Labov & Waletzky, 1997) that ‘delay’ the presentation of current symptoms; they work to project and negotiate an extended turn space in which background information leads to current symptoms. More generally, deferring the presentation of current symptoms is a generic means through which patients can expand the problem presentation ‘slot.’ Conversely, beginning *problem presentation* with an enumeration of current symptoms may be a way of presenting a problem in a fashion that is ‘designedly brief,’ a presentational style that may be fitted to certain types of problems (e.g., extremely familiar ones, such as upper-respiratory illness).

Empirical analyses of the social organization of *problem presentation* provide a foundation for analytically sound evaluations of physicians' and patients' conduct. Given the importance of symptom disclosure for both medical care and health outcomes, the present findings can be used to design more valid and efficacious research interventions and medical-education programs.

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