

THE ROLE OF PATIENTS' QUESTIONS IN THE MEDICAL INTERVIEW¹

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Introduction

(The opening exchange in a doctor-patient encounter:)

Patient: You going to ask me a question, Doc?

Doctor: I have the results of your EMG test.

The striking nature of this opening exchange is apparent to anyone who is familiar with the rules of speaking in a medical interview. First, typically the doctor, not the patient, opens the conversation. Second, usually the doctor, not the patient, asks the questions. That this patient took the initiative in each case both by opening the conversation and by doing so with a question is marked. Ironically, however, embedded in the content of the patient's question is an acknowledgement that the power to ask questions resides with the doctor. And in the end the doctor confirms exactly that by disregarding the patient's opening utterance. This exchange exemplifies several issues of concern in studies of doctor-patient communication. How is authority manifested in the language of such institutional encounters? What can be learned from examining patterns of information exchange between participants of unequal status? What does the differential use of questions reveal about the rights and responsibilities of the participants in these interactions?

The organization of talk between doctors and patients has received considerable attention during the last two decades. In early studies investigators identified a number of cognitive, social and emotional factors associated with successful and unsuccessful doctor-patient communication and correlated them with varying levels of patient satisfaction and

compliance with treatment plans (Francis et al. 1969; Korsch et al. 1972). The more recent literature describes doctor patient encounters as asymmetrical interactions, in which communication is constrained by certain social, cultural, and situational variables. Among the issues which have been studied are: patterns of information seeking and control (Frankel and Beckman 1983; West 1983); the use of communication strategies to negotiate meaning and make decisions (Coulthard and Ashby 1973; Fisher 1982); the role of institutional authority and the distribution and sequencing of speech acts (Todd 1983); the role of status and gender (West, in press); and the occurrence of ambiguities, discontinuities and misunderstandings in doctor-patient talk (Paget 1983; West 1984).

The questioning behavior of doctors and patients during the medical interview has been a topic of serious investigation by Frankel and Beckman (1983). They found that doctors who overdirect the medical interview by asking a series of narrowly focused or "closed" questions can interfere with the patient's ability to identify his medical problem, thus resulting in miscommunication and possible misdiagnosis.

West (1983) also studied the questioning behavior of doctors and patients and found, predictably, that doctors ask far more questions than patients and (not so predictably) that doctors get a slightly higher rate of response to their questions than patients get to theirs. West's work and the work of other investigators concerned with the social organization of doctor-patient communication show that when interactions occur in institutional settings, the power differential is assured. Contact rarely occurs on a symmetrical basis.

The purpose of the present study was to investigate the interactional consequences of differential access to information during the medical interview through a focus on patients' questions and doctors' subsequent replies. In the study four questions were addressed:

1. What are the social and communicative functions performed by patients' questions?
2. What is the frequency and distribution of patients' questions?
3. What types of responses do patients' questions elicit from doctors?
4. What are the possible causes and consequences of doctors' failures to reply to patients' questions?

Setting

The setting for this study was an outpatient clinic of a large ambulatory care center in Philadelphia. This facility is a multi-service clinic which offers health care in general internal medicine as well as several specialties including cardiology, gynecology, psychiatry and orthopedics. The center has a diabetes clinic, a hypertension clinic and a nutrition clinic. An outpatient pharmacy and a prosthetics department are also located within this facility.

Patients waiting to see a physician sit in a centrally located waiting area in which chairs are placed classroom style facing a television set. As many as forty patients, all with appointments, may be in the waiting area at any given time. When the doctor is ready to see a patient, s/he goes into the reception area, picks up the patient's chart (if it is available), and calls the patient into his/her office. Each office serves as both an examining room and a consultation room and is equipped with an examining table, sink, cabinet, chairs and doctor's desk.

The setting was chosen for a number of reasons. The primary concern at this clinic is with the on-going care and follow-up treatment of patients with chronic health problems. As Frankel (1983) has pointed out, the bulk of medical care provided in this country on a daily basis is of this type, rather than in-patient, emergency or sub-specialty treatment. Therefore, descriptions of doctor-patient interactions in such a setting should contribute to our understanding of the routine elements of communication in typical medical encounters which are familiar to millions of people. Also, since many of the concerns and problems which arise in primary care encounters are handled at the level of discourse, an analysis of patients' questions and doctors' subsequent replies should provide insight into the ways in which patients gain access to important medical information.

Participants

The seven patients who participated in this study are all males, ranging in age from 37 to 68. Three are black and four are white; all are members of the working class. At the time of this study all of these patients had been receiving care for a chronic illness or disability. With one exception, all of the patients had had previous encounters with the physicians in the study.

The two physicians who participated in the study are white males in their mid- to late thirties. They were scheduled to see as many as 12 returning patients in each four-hour session, which allowed approximately 15 minutes per patient. A high no-show rate, however, enabled the doctors to spend considerably more time with each patient.

Method

The data for this investigation were collected through observing and audio-recording seven doctor-patient medical consultations. Each consultation lasted from 20 to 30 minutes. The researcher was present during the consultation and took field notes. Afterwards patients were interviewed briefly about the interaction with the doctor. Before the interaction written permission to observe and record was secured from each patient.

Each recording was then transcribed for analysis. Utterances were classified as questions according to formal linguistic criteria: statement word order with rising intonation; wh- prefacing; or subject-verb inversion.

Results

Functions of Patient Questions

Utterances realized in the interrogative form served several communicative functions in patients' speech: to elicit information, advice, opinion or reassurance; to register complaints; to request confirmation; to sustain the interaction through comprehension checks and clarification requests; to instantiate requests for action by the

doctor; to prefigure announcements; and to convey surprise, dismay, or fear. Table I displays the five communicative functions questions served, arranged from the most to the least frequent.

Informational functions

The questions in this category accounted for nearly half of the questions asked by patients in this study. They represented moves by patients either to acquire new information, advice, or opinion from the doctor, or to verify their understanding of a medical issue with the doctor. The kinds of information requested or checked included medical findings from previous laboratory tests, results of the physical exam, explanations for the cause of the health problem, the effects of medication, treatment alternatives and outcomes, and details about office procedures. In over half of the occurrences patients used information-seeking questions to initiate new topics.

In terms of surface structure the questions in this category were encoded as yes/no, information, tag, and alternative questions. Both syntactically well-formed questions and questions with disfluencies, ellipsis, and grammatical errors were found.

Information-seeking questions

Surprisingly, these questions constituted only 13% of the entire corpus of patient questions. Within the category of informational functions they represented only 26 percent. What, then, are information seeking questions, and what discourse functions do they serve in doctor-patient communication? Traditional grammars refer to them as wh-questions containing a presupposition in which a specific constituent in the sentence is being questioned (Celce-Murcia & Larsen-Freeman 1984). In conversations the speaker calls upon the hearer to fill an information gap in the sentence. Such questions can be well-focused and specific as the following example illustrates:

1. (re: nerves causing pain)
P: Which ones make me suffer, ya know?
(Presupposition: certain nerves are causing pain;
missing information: identity of the nerves.)

Information-confirming questions

These questions represented 29 percent of the questions in the corpus and 74 percent of the questions in the category of informational functions. Information confirming requests can be described as sentences which presuppose something and ask that the truth value or the accuracy of the presupposition be verified. In the doctor-patient interactions these question often served to initiate a topic, and, perhaps even more important, to provide opportunities for patients to display their own knowledge or opinions and then to invite comment by the doctor. Most of the confirmation-seeking questions were encoded as affirmative or negative tag questions. All but one of the tag questions ended with rising intonation, which, according to Huang (in Celce-Murcia et al. 1983) indicates a weak expectation on the part of the patient that the presupposition will be confirmed.

2. P: That fluid has something to do with my breathin' too, doesn't it?

Interactional strategies

Confirmation check

The second most frequent function served by patients' question was to sustain the interaction, facilitate comprehension and attempt to regulate participation. This was accomplished through interactional strategies such as comprehension checks and requests for clarification. When the patients wanted to make certain that the doctor attended to or understood their talk, they sometimes elicited feedback by using a comprehension check. This was encoded as a statement followed by an unanalyzed tag such as 'right?', 'follow me?', or 'OK?' as the following example illustrates.

3. P: Well, I can't give you a special xxx how they react, you follow me?

Clarification request

The other type of interactional strategy encoded as a question was the clarification request. This device signalled a communication failure and initiated an attempt to repair it.

In the data clarification requests occurred when the doctor failed to make himself clear, or the patient failed to understand the doctor's last utterance. Interestingly, not one request was a simple appeal for repetition or reformulation such as 'what?' or 'what do you mean?'. In each case the patient attempted to make sense of the doctor's previous utterance by offering in his own words a reformulation of the segment in question.

4. D: Ask him to unroof that.
P: To what to remove the scab?
D: mm hmm.

Expressives

This category constituted 9 percent of the total number of questions in the corpus. In such instances the question served as a stylistic device to express annoyance, surprise, or frustration, or to emphasize a troublesome aspect of the patient's health problem. The resulting structures were rhetorical or exclamatory questions, which did not necessarily require a reply to the surface content, but rather to the emotion underlying it.

5. D: So basically you're living on the service-connected disability.
P: No. My wi-. You kidding? Two hundred dollars?
D: Is that what it is, only two hundred bucks?

Pre-announcements

Pre-announcements, another type of question function in the data, constituted 9 percent of the total. These questions belong to a special class of structures known in the conversational analysis literature as pre-sequences (Levinson 1983). Basically, pre-announcements are offers to tell news, jokes or stories, the telling being contingent upon the news not already being known by the hearer. In order for the telling to occur, the bid must be ratified by the hearer.

Two types of pre-announcement (each with a different purpose) were found in the data. The purpose of one type was to request suspension of the normal turn-taking mechanism so that an extended turn could be granted to the patient who wanted to tell a

story. Typically pre-announcements of this type begin with references which orient the hearer to a past event as the following example illustrates:

6. P: Do you recall in July that little heat wave we had for a couple of weeks?

The second type of pre-announcement was not a request to extend turn length, but rather an attempt to check on the newsworthiness of a potential announcement. Two pre-announcements of this type were found in the data:

7. P: Did you hear any of those stories after "The Day After?"

If the news is known or not considered newsworthy by the hearer, the bid to tell is not ratified by the hearer, and the announcement sequence is aborted. Sacks (1974) has pointed out that pre-announcements are frequently used by speakers with restricted rights to speak.

Directives

The last category of functions performed by questions in the doctor-patient data was that of directives. In this study they accounted for 9 percent of the questions patients posed and nearly 100 percent of the directive types patients used. Question directives have been described extensively by Ervin-Tripp (1976) and are important here because of the social meaning attached to them. In the ordering of directive types according to the relative power of the speaker and the obviousness of the directive, question-directives are among the most indirect and deferential.

Because of their inherent ambiguity (are they questions or imperatives), the selection of this form gives the listener who does not want to comply the option of interpreting them as requests for information rather than as directives. Such forms are face-saving devices for patients who may be insecure about their right to request work of the doctor.

The structural features which identify question directives are that they do not specify the desired act and often omit the agent. Example 3 illustrates a question directive with its imperative gloss in parentheses:

8. P: I have shingles. Wanna see my favorite shingle?
(imperative: Look at my shingle!)

Distribution and Frequency of Patients' Questions

A total of fifty-four questions were asked by the seven patients in this study. As the data in Table II illustrate, however, there was considerable variation among patients in both the frequency and distribution of their questions. Two types of questioning styles seemed to emerge which will be called highly deferential and highly involved. The highly deferential patients asked five or fewer questions and limited themselves to asking the information-seeking or confirming type of question. Of these five patients, one asked no questions at all. When these patients were asked later if they felt they had ample opportunity to ask questions, they replied that they were satisfied with the interaction and that they did not want to bother the doctor with too many unimportant questions. On the other hand, the highly involved patients asked 20 or more questions. These questions showed greater variety in both form and function and were distributed across at least four of the five functional categories described earlier. Two of the patients in this study exhibited this style.

Did the difference in explicit attempts to elicit information from the doctor have any bearing on the total amount of information patients were given during the medical consultation? By analyzing both the solicited and unsolicited tokens of information given by the doctors, it was possible to determine that the information given to the patients whose style was one of high involvement differed from that offered to high deference patients both in quantity and quality. High involvement patients received from two to four times as much medical or procedural information. Information tokens were characterized by exemplification, illustration, definition and reformulation. In addition, high

involvement patients were able to influence the way in which treatment decisions were made.

Doctors' Replies

The next section will focus on the doctors' replies to the questions asked by the patients in this study. In total, doctors responded to patients' questions approximately 80 percent of the time. A token was coded as a reply if it met two criteria: if it came in the turn immediately following the question (maintaining adjacency requirements) and if it was on topic. The requirement of adjacency does not have to be strictly adhered to if conditionally relevant utterances (not replies) are inserted, temporarily interrupting the sequence. Insertion sequences, as these are called, are not failures to reply appropriately, but rather delays during which time the hearer gathers additional information needed in order to give an acceptable response (Levinson 1983). Such exceptions to the general rule of adjacency occurred once in this study:

9. P: How was the blood sugar? How was the the how um the last one?
D: Last blood sugar?
P: Yeah.
D: It was fine. About one twelve.

In analyzing the replies to information-seeking/confirming questions it became apparent that doctors' replies could be classified into two basic types: answers and cooperative responses. Answers consisted of minimal replies realized as single words or phrases, or sequences which more or less repeated the patient's question in statement word order. Examples 10 and 11 illustrate this:

10. P: They tell me if you take a little sugar it'll knock it down. Is that true?
D: No.
11. P: Do you think tension has anything to do with it, Doc?
D: Tension has something to do with it, Joe.

The other type of responses to question in this category were cooperative responses: these were answers that offered additional, unsolicited information above and beyond the minimum required. Some of these were simple expansions, as example 12 shows:

12. P: What is the low one, Doc?
D: One seventy over eighty, Joe. That's about right.

In this example the doctor gives the minimal response first: the patient's blood pressure reading. And then he gives his evaluation of it.

Other cooperative responses were far more elaborate, as example 13 illustrates:

13. P: Which ones make me suffer, ya know?
D: Well there's seven cervical vertebrae and between the 5th and the 6th there's interspaces. Between each vertebrae there's a hole where the nerve comes out of the spinal column and your nerves that come outta the spinal cord eventually join up in the arm and then form what is known as the median nerve, and the median nerve can cause these symptoms.

Some additional information about doctors' replies to patients' questions is found in Table III. This table summarizes the rate of doctors' replies according to the type of questions asked by patients. It is clear from this analysis that certain types of questions had a better chance of eliciting a reply from the doctor than did other types. Or perhaps stated another way, questions with certain functions seemed to be institutionally sanctioned while others were not. In particular, patients got replies to information seeking/confirming questions nearly 90 percent of the time, whereas their bids to tell news, stories or jokes were ratified only half of the time.

Another interesting pattern emerged when the variation in response to individual patients' questions was examined. As the data in Table IV illustrate, the patients who asked relatively few questions (the highly deferential patients) elicited responses to all of their questions. However, the two high-involvement patients who asked more than 20 questions elicited responses from their doctors only 70 percent of the time. Here again, the two

patterns converge. The questions asked by the deferential group were composed primarily of the institutionally sanctioned variety (informational and interactional questions). On the other hand, the questions asked by the high-involvement group contained the broadest variety of question functions, including questions whose appropriateness in this particular speech event was unclear (pre-announcements, directives).

Failures to Reply

As mentioned earlier, 20 percent of the questions patients posed did not elicit replies from doctors. A token was coded as a failure to reply if the doctor's turn following the patient's question consisted of a significant attributable silence, or if the doctor's response was not immediately relevant to the patient's question or expectable in terms of topic and content. One might regard such departures from the norm as failures on the part of the doctor to instantiate the functions represented by patients' questions. Such failures may have serious consequences for the patients and the interaction. Not providing patients with information they request or failing to advance topics patients select could potentially result in loss of face by the patient, disruption of the turn-taking mechanism, and further erosion of the patient's already limited opportunities to speak and become better informed. The following section will address several aspects of communication which seem to correlate with doctors' failures to respond to patients' questions.

Doctors' preference for not replying to certain questions seemed to be related to three separate aspects of communication: first, the sequencing of utterances within a turn; second, violations of the exchange of turns across speakers; and third, constraints on topics and speech acts as a function of "gatekeeping".²

The most prominent factor which appeared to correlate with doctors' failures to reply to patients' questions was the infelicitous positioning of the question within a patient's turn. These failures occurred after a patient's extended turn in which the patient's question appeared as the first utterance in the turn, immediately followed by

non-interrogative utterances within the same extended turn. In essence the patient first asked a question and then obviated the requirement to reply by refusing to relinquish the floor to the doctor. Nearly half of the doctors' failures to reply to patients questions occurred in this way.

The second group of failures to reply to patients' questions occurred when the patient's question was an interruption. Even when interruptions bear questions they may appear to violate the rules of speaking in this setting. Here an interesting complexity arises whereby two different kinds of conversational expectations work in opposing directions. One expectation is that questions command replies. The other expectation is that speakers have a right to complete their turns. If that right is violated conversationalists can negatively sanction the violation simply by disregarding it (Zimmerman and West 1975). Example 14 illustrates this unmarked alternative:

- 14: D: We can see how you do with that, we can give you an anti-inflammatory drug. I'll cut this dose back to a very small
// pill and see if that helps
P: // well what do you think
D: and see how you do and if it is really unbearable then the only recourse may be to try to operate.

In institutional settings where participants have unequal access to power and resources, those with the advantages of rank, status, age or gender may be able to affect the distribution of turns and consequently the allocation of resources in conversations, namely the control of topic and floor. This example shows how the doctor, who has the floor, asserts his right to fully utilize his turn to develop his topic and at the same time fails to acknowledge the patient's question.

In the previous discussion, it seems that doctors' failures to reply to patients' questions could be attributed to irregularities in the patients' questions or violations of the turn-taking system. In the following section, however, some examples will be examined that show doctors not replying to certain questions in order to exert control over the actions that some patients' questions perform and the topics that some questions introduce.

The most telling example of this form of gatekeeping was found in the category of pre-announcements. As stated earlier, questions in pre-announcements are bids to give a news item or tell a joke or story. In unmarked conversational interactions ratification of the bid is the preferred response unless the hearer already knows the news or the story. However, in the doctor-patient dialogues, one patient had considerable difficulty in getting his bids ratified so that the telling of the news could proceed. Note in the next example the doctor's reluctance to validate the newsworthiness of the item (as indicated by his silences) and the patient's persistent efforts to gain it.

15. P: Did you hear the stories about the movie, "The Day After"? (2.0)
Ya hear any of 'em? (2.0) You hear any a them Doc?
D: What.
P: The stories after "The Day After".
D: No. What.

This seems to be evidence that in institutional settings the rules of speaking which govern unmarked conversations between participants of equal status are suspended. A possible explanation for this phenomenon may be found by contrasting the above example with a different pre-announcement bid which was ratified by the doctor.

16. P: Do you recall in July that little heat wave we had for a couple of weeks?
D: Oh yes.
P: OK well I was out in it, And now everyone says that I shouldn't have been...(continues with the telling of the story)

In example 15 the prefiguring of the frame provided the doctor with a clue that what followed would be a joke or a story about a television movie. The doctor's refusal to ratify the bid to tell the joke or story indicated that in assessing the potential content of the bid he found it inappropriate within the context of the medical consultation and used his silence to discourage the patient from continuing.

In example 16, however, the patient's request for permission to tell a story was ratified without delay. Such a response is predictable given the characteristics of the bid: namely there was no indication that the story would be unrelated to the subject under

discussion- the patient's health. That in fact was the case. The patient then went on to describe how the heat and humidity had adversely affected his condition.

In a similar way, doctors can refuse to answer patients' questions in order to exert control over what a patient is allowed or not allowed to do in a medical interview. In the following exchange the patient tried to initiate the interview with a question:

17. P: You going to ask me a question, Doc?
D: I have the results of your EMG test.

Not only was the patient's question a rather bold attempt to manage the floor, but it also contained a directive. By ignoring the question the doctor reclaimed control of the floor and negatively sanctioned the patient's attempt to direct the conversation. In other examples it was found that doctors employ silence to discourage criticism and complaints.

The message communicated by such behavior is that it is within the doctor's provenance as gatekeeper of the interaction to assess the content of a topic, judge its acceptability within the medical setting and selectively validate the patient's right to pursue it.

Summary and Conclusions

An examination of the role of patients' questions in doctor-patient encounters offers insights into patterns of information seeking and control in the medical interview. Investigations of this kind also enrich our understanding of the nature of asymmetrical interactions in institutional settings in general. Based on the findings of this study several conclusions can be drawn.

First, it appears that patients' questions serve a variety of communicative and social functions but are primarily used to get information, to introduce topics that are of concern, and to sustain the interaction.

The results further indicate that doctors respond more often to informational types of questions and less often to questions which threaten their authority as gatekeeper. This may indicate that doctors are primarily concerned with maintaining control over the interaction and achieve this by restricting conversation to medical topics. It is also interesting to note that neither of the doctors ever explicitly invited questions from any of the patients.

There also seems to be a relationship between doctors' failures to reply and certain irregularities in patients' questions---namely questions posed at the beginning of a multi-utterance turn and those that violate the doctor's right to complete his turn.

Finally, we may conclude that patients vary widely in both the number and types of questions they ask and hence have very different questioning styles. These styles have consequences for the interaction. While patients who exhibited the deferential style succeeded in eliciting replies to specific questions 100 percent of the time, they were less successful in terms of the general quality and quantity of information presented by the doctor. On the other hand, patients whose questioning style was one of high involvement were less successful in eliciting a reply to each question; but on the whole, they got significantly more information from the doctor during the same amount of time.

Needless to say, to attribute all successes or failures in doctor-patient communication to the question/answer sequence would be extreme. Questioning is only one aspect of a complete interaction. However, if more equal access to information during the medical interview is a desired goal for both doctors and patients, both need to become aware of more effective ways to communicate.

¹ This paper was prepared for the "Language and Power" seminar taught by Dr. Nessa Wolfson and Mrs. Virginia Hymes.

² The concept of "gatekeeping" was described by Erickson (1975) in a study of interactions between school counselors and junior college students. "Gatekeeping" was the term used to describe the actions taken by individuals with institutional authority to block or facilitate access to control and decision making for individuals with lower rank or status.

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APPENDIX

TABLE I

Functions Represented By Patients' Questions

<u>Function</u>	<u>Frequency of Occurrence</u>
Information-seeking/confirming	44% (24)
Interactional strategy	28% (15)
Directive	9% (5)
Pre-announcement	9% (5)
	<hr style="width: 20%; margin-left: auto; margin-right: 0;"/> (54) Total

TABLE II

Patients' Questions During the Medical Interview

<u>Patient</u>	<u>Information</u>	<u>Interactional</u>	<u>Directive</u>	<u>Pre-ann.</u>	<u>Expressive</u>	<u>TOTAL</u>
EF	0	0	0	0	0	0
RK	2	0	0	0	0	2
LL	1	1	0	0	0	2
MW	0	1	0	0	1	2
RL	0	3	0	1	1	5
DS	11	7	1	0	1	20
JD	10	3	4	4	2	23

TABLE III

Doctors' Replies to Patients' Questions

<u>Question Function</u>	<u>Rate of Reply</u>
Information-seeking/confirming	87.5% (21)
Interactional strategy	87 % (13)
Directive	80 % (4)
Expressive	60 % (3)
Pre-announcement	40 % (2)

TABLE IV

Variation in Doctors' Replies to Individual Patients' Questions

<u>Patient</u>	<u>Number of Questions Asked</u>	<u>Rate of Reply</u>
EF	0	-
RM	2	100% (2)
LL	2	100% (2)
MW	2	100% (2)
RL	5	100% (5)
DS	20	70% (14)
JD	23	83% (19)