Linguistic Analysis as Means of Soliciting Patients' Concerns

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Linguistics and Medicine

Structure of the Consultation

Increasing awareness of good communication in the doctor – patient relationship has promoted academic analysis in linguistics: the study of language. Such work has sought to clarify, quantify, and define some relatively intangible aspects of personal interactions, which are difficult to characterize and measure. Derived largely from academic study in psychology and psychiatric medicine, this discipline has developed a specific terminology. In particular, there has been study of clinicians' behavior during medical interviews. There is a growing body of evidence that suggests clinicians "use individual, distinctive, and describable types of behavior or interactional strategies" to conduct consultations and in particular four components of behavior have been identified (Frankel and Stein, 2001: 184-90).

These components are described as 'habits'. They comprise the opening strategy of the interview, the method of eliciting the patient's agenda, the demonstration of empathy, and some important elements of the final phase of the interview. These components bear a partially sequential relationship and are thus interdependent. They reflect and complement the structure of the consultation that is described below in four phases. They, thus, offer an efficient and practical framework for organizing the flow of medical visits and each component or phase families of interviewing skills. These aspects of conversation analysis may be concurrent or sequential. For example, empathy is as demonstrable in the early phase as in the concluding negotiation:

- First phase agenda
- In – depth discussion
- Formation of plan
- Final phase

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First phase of the medical interview (agenda):

Increasing importance is placed on the early phase of the medical interview especially in outpatient consultations. Determining the patient's major reasons for seeking care is of critical importance for a successful medical encounter.

Increasingly, emphasis is laid on the importance of establishing the patient's agenda and list of priorities.

It is necessary to use open – ended questions at the beginning of a consultation so as to allow the patient to describe the principal problems in his own terms. Open – ended questions initially allow one to gather some potentially rich data, help to develop rapport, and to identify the key areas of concern for the patient. Some examples of open-ended questions follow (Macdonald, 2004: 11-12):

"What would you like to discuss today?"

"What brings you to see me today?"

"What is it that's been bothering you?"

Some questions on the other hand can be so open as to be unhelpful, e.g. "Tell me about yourself".

Some very short open questions can sound accusatory in the wrong context; for example, if a patient describes something he has done or said and you respond "why?", this may sound antagonistic. It would be wiser to soften the inquiry with an expression such as,

"What was in your mind when you did (or said) that?"

Some further examples of open questions (ibid):

"Tell me, how can I help?"

"How are you feeling?"

"How do you feel about …?"

"Are you comfortable with…?'

"Can you tell me about your main problems /difficulties/ symptoms….?"

Too direct questions early in a consultation may make the patient passive and close off the disclosure of important information that could have assisted diagnosis and management decisions. Alternatively, if the patient is not encouraged to list all his concerns it may be only on conclusion of the interview, when the patient has his hand on the door – knob, that he raises a vital issue. This demonstrates an important matter which has neither been divulged by the patient, nor solicited by the doctor, earlier in the exchange.

This is unsatisfactory for the patient and doctor and faces the doctor with the difficult dilemma of pursuing this important issue and delaying other patients or postponing the investigation of this matter until future visit.

Asking about how patients feel in both physical and unemotional sense will help them open up. Confronting obvious emotional stress early is helpful (Ibid):

"Are you ok?"

"You seem very unhappy today. Can I help?"

This gives the patients the opportunity to be honest about what is really troubling them. With an anxious patient, deal with the anxiety first and try to get it out of the way, "You seem rather anxious today. Can you tell me why?". It may be that the concern is ill founded and can be cleared up quickly, "No, you will not need an operation for this problem". Legitimate concerns are immediately identified, "Well, yes, cancer is one possibility but there are others and that's what we are here to tend out" (Ibid).

Mention of cancer fear accidentally is very common and should be dealt with straight away. When any possibility exists that malignant disease is present, this fear should be acknowledged. False reassurance, later to be disproved, is destructive of trust. Other potential diagnoses (infection, gout, etc.) should be listed, and this is reassuring. The physician should affirm that his intention is to find out what is causing the problem and take action. Whenever reasonable logic affirms that this kind of cancer proves to be the problem, then there is plenty that can be done about it.

Physicians should choose a patient problem not merely to explore but rather to determine the patient's full spectrum of concerns (Marvel et al, 1999: 284).

Another interesting line of enquiry is to establish the predictive value of the presenting complaint, i.e. the first issue to be raised by the patient in a consultation.Burack and Carpenter (1983: 750) investigated the relationship between the presenting complaint and the main clinical problem identified during new patient visits in an academic primary care setting. They investigated the frequency with which patients start the consultation with their motivation in seeking care has not been illuminated. For reasons of lack of privacy or perceived uncertain confidentiality, the patient may have felt unable to talk freely and feel that the consultation has been 'wasted'. Active listening may help but just occasionally. There are people whose wishes can never be satisfied, who may know themselves what is really wrong, and can monopolize a doctor's time to no benefit to either party: "I can see we have not got to the bottom of things for you today. I'm afraid we must leave it there, but I will be happy to see you again on another day when you have had a chance to think about it a bit more".

Lastly, patients who initiate a visit but do not actually have any specific physical or psychological complaint may in fact be manifesting a

response to some stress in their life and demonstrating a cry for help in their inability to cope with personal problems: "you seem to be quite well in yourself really, but is there something else bothering you?" (ibid)

Second phase of the Consultation: in–depth discussion

The next phase of the interview requires the varied skills of facilitation. Some patients need to be prompted to continue by comments such as 'Mmm', 'I see', or 'go on'. These may be intent observations but are actually facilitating the confiding of all the patient's concerns. Alternatively take the direct approach:
"How did that make you feel?" (Macdonald, 2004: 14-15)

Further encouragement : repeating part of the patient's contribution ⟶ statements prove effective in prompting further disclosure and do encourage the same topic to be continued but on the other hand can restrict inclusion of the patient's other concerns and prevent the patient completing his whole agenda (Ibid) :

- Elaborative questions, e.g. 'tell me more about' encourage pursuit of a single topic in depth but can exclude others.
- Closed questions, limit responses and options much more tightly
- Non- question, e.g. 'that sounds serious' can encourage elaboration with further helpful information.

Third phase of the Consultation: the Management Plan

The third phase of a consultation is in effect the 'business' phase. Now there is an opportunity to complete closed questions of relevance concerning past history, family history, social enquiry, known allergies, etc. Physical examination will often throw important light on the complaint even when this seems from the history unlikely.

The next task is to work with the patient to generate a problem list and decide how best to proceed. A priority list is helpful: "What bothers you most?" The next step in the process should be organized. Appointments for specialist's opinion can at least be requested. Blood request forms can at least be selected. In this way, the patient has confidence that not only is there an agreed plan of action but that it is being taken seriously (Macdonald, 2004: 15-16).

Closing phase of the Consultation

Communication research has stressed the importance of the closing stages of the interview, both from the point of view of patient satisfaction and outcome effectiveness. This phase should provide a final opportunity for other concerns to be raised, should restate the management plan, and ensure that this is both agreed and fully understood.

Research shows that it usually the doctor who closes down the interview (White et al, 1994). However, only 75% of the doctors in his study clarified the future plan for care and only 25%asked the patients if they had more questions. Patients introduced new problems, not previously discussed, in 21% of the 'closure'. This is unsatisfactory and it is not surprising that these new problems tended to emerge following consultations that had been lacking in one or more important components such as attention to emotional or psychological issues and a failure to check on understanding. Satisfactory closure can often be assisted by giving the patient 'warning' that the consultation is nearing an end: "We have about five minutes left and I would suggest …. Is that alright?"

Such an intimation that time is nearing an end may participate the patient into mentioning something important that they would have regretted omitting. It the patient does not realize that the interview is nearly over, he may be left dissatisfied and angry when he does realize he has run out of time.

Occasionally patients may seek to prolong their interview by volunteering an important piece of information right at the end of a consultation. The doctor needs to be firm in response to this poly and ration his time fairly for the sake of his other patients: "I'm afraid we have, as I explained before, only twenty minutes today and we have taken up our time with your other concerns. Please make another appointment in the near future and I'll be happy to explore this matter then", (Ibid).

Data

The data includes audio and videotapes of actual, primary- care, physician- patient visits.

All of them are gathered from the internet. Names and identifying characteristics of the participants have been changed.

Analysis

- Question Formats Designed to Solicit New Concerns

New concern question formats can be either open or close ended. They are designed to communicate physicians understandings that patients are visiting to deal with new (viz follow up or routine) concerns. Some examples of open- ended formats are:

"What can I do for you today?"

"What brings you in to see me?"

"How can I help you today?"

These formats are designed to communicate that the concerns being solicited are unknown to physicians.

Thus, they communicate physicians` lack of knowledge of patients` concerns and thus, for physicians, the concerns are new (Heath, 1981: 80).

In the following extract, lines 1-13 have been left out because they are irrelevant to the topic:

Extract 1 : Ear Problem

14. Doc: Your ear's (`re) [pop] pin'. Huh?
15. Pat: Yeah
16. (0.7) seconds (pause)
17. Pat: Yeah it's like (either) / (maybe)
18. there's fluid er wax build up.
19. (0.2) seconds (pause)
20. Pat: But tuhday`s not as bad
21. (1.5) seconds (pause)
22. Pat: Actually it started like week – two weeks
23. ago uh week, h

(19 lines deleted)

43. Doc: Any drainage at all?
44. (0.3) second (pause)
45. Pat: only with cue tips
46. (0.2) second (pause)
47. Doc: What color is that stuff?
48. (1.7) second (pause)
49. Pat: hhh dark orange

The physician's question (line 14) is designed as what Labov and Fanshel (1977: 87) terms a b-event statement. This is a statement by one speaker (e.g. the physician) that includes events (e. g., medical concerns) that another speaker (e.g., the patient) has primary authority over, including access, knowledge, and so on. Physicians` b- event solicitations typically seek confirmation or disconfirmation by patients and thus communicate that, for physicians, the concern is new. This is supported by the fact that the physicians use the tag question "huh", (line 14) to pursue confirmation / disconfirmation, and that the patient produces a confirmation : "yeah" (line17). (Sacks, Schegloff, and Jefferson, 1974: 670). Besides, the physician proceeds to ask a series of questions about the problem (lines 43 and 47). So, for the physician the patient's concern is new. The patient understands that the physician's question solicits a new concern as follows: the former informs the latter when his problem began (lines 22-23). Terasaki (1976: 80) supports this: "the patient displays an orientation to both the recency of the problem and to the physician not already knowing about the problem.

Follow-up formats are designed to communicate physicians` understandings that patients` have follow-up (viz new or routine) concerns.

Question Formats Designed to Solicit Follow-up Concerns:

There are many question formats that solicit the patient's follow-up concern. First, Schegloff (1996: 480) maintains that the physician's question "How is it" solicits an update or evolution of a particular concern, which is referenced by "it". Extract 2 displays this point:

Extract 2 Sore arm

6. Doc: how is it?
7. (0.5) seconds (pause)
8. Pat: Its fine its (0.8) seconds (pause) still
9. a bit sore. But it's alright now.

By using the reference form 'it' – rather than others, such as "the arm" – the physician displays an assumption that his knowledge of the concern is shared by the patient.

In his response, the patient uses the word "still" (line 8) to describe his arm as continuing to be "a bit sore" relative to a prior point in time. The prior point in time is the patient's prior visit with the physician.

A less obvious question format is "How are you feeling". Frankel (1995: 235) includes this question format in the category of "How are you?" type questions, including "How are you?" and "How are you doing?".

Jefferson (1980: 180) observes that all these question formats contain lexical and grammatical similarities (e.g. they all begin with how are you), all can occur as solicitations of patients` presenting concerns, and all can relevantly be receipted with a range of identical evaluative responses (e.g., Great, Fine, and Terrible). Bates, Bicklely, and Hoekelman (1995 : 95) note that medical text books advise physicians to first "inquire how the patient is feeling" when beginning a medical interview in a hospital context and where patients have known about their concerns. Cohen-Cole (1991:56) cites one suggested solicitation: "Before I ask you about your illness itself, I want to check how you `re feeling right now?" In Extract 3, the patient is visiting the physician to follow up on a severe sinus infection:

Extract 3: Sinuses

1 Doc: Hi Mister Anderson. How are you
2 Pat: Hi

3 Pat: okay,
4 Doc: How are you feeling today?
5 Pat: hhh h better,
6 Doc: And your sinuses?
7 Pat: hh two sniffs
8 (pause)
9 Pat: Well they `re still they `re about
10 the same

At line 4, the physician asks "How are you feeling today?" "Today" invites the patient to evaluate the current state of his condition relative to its previous state. The response "Better" (line 5) reports improvement (positive evaluation) of the state of a particular ongoing health condition.

The physicians subsequent question: "And your sinuses?" (Line 6) supports this. Heritage and Sorjonen (1994: 20) note that in a preface of a question, the word "and" indicates a speaker's communication that it is a next question in a series of "agenda – related" questions. Thus, since this question requests an evaluation of a specific aspect (i.e. sinus vs. headaches) of the patient's general sinus – related condition, the physician displays that his "how are you feeling today?" is designed to solicit an evaluation of a particular, ongoing, physical health condition.

Question Formats Designed to Index Routine Visits

Patients, here, may either visit physicians on regular bases (e.g. monthly to monitor, e.g. blood pressure or diabetes; or they may possibly have new concerns. One question addressing both issues is "What's new?" (Button and Casey, 1985:45). "What's new?" – type question formats allow patients the opportunity to topicalize new medical concerns as first items of business and display physicians` orientations to new medical concerns as being immediately current, newsworthy events relative to routine concerns. As a result, "what's new?" – type question formats simultaneously communicate physicians understanding that : (1) patients have routine concerns ; (2) patients may have new concerns ; (3) there is a distinction between new and routine concerns ; and (4) both new and routine concerns are potentially relevant. Besides, this question format projects a structure for the ensuing visit by projecting at least two potential interactional trajectories (Ibid):

- If patients have new concerns and apt to present those concerns, then they will be dealt with first
- If patients do not have new concerns (or apt not to present new concerns), then the visit will proceed to dealing with routine concerns.

Let's deal with each in the following subsequent extracts; lines1-32 are not stated because they are irrelevant:

Extract 4 : Ear pain

33 Doc: hh ohm anything new?
34 (0.8seconds) pause
35 Pat: Nothing: really too new. But uh-
36 I don't know I've been having a
37 funny pain, (0.5second pause) and it swells upright in
38 here, (referring to her head)
(12 lines deleted)
51 Pat: hh and I never had that before of course
52 I've had trouble with this ear for quite a while (patient continues)
(144 lines deleted-history taking & physical exam)
198 Doc: uh m hh (3.9second pause) we'll just keep an eye
199 on things.
200 (0.1second pause)
201 Doc: Check again later.
202 (0.7second pause)
203 Doc : hum remind me next time.
204 (106) ((Doc prepares stethoscope for use))
205 Doc: huh uh hh that's fine. Just like
206 That's good
207 Pat: hhhhh hh hhh
208 Doc: Dee- deep breath,

Schegloff (1988: 495) notes that "anything new?" shapes the patient's response in two ways: first, the use of the negative-polarity item "anything" establishes a practice- based preference for a no-type response, or a report of new concerns. Second, it may embody a structure-based preference for a no-type response, i.e. patients who already have a series of ongoing concerns may not want to be seen as having new concerns. For example the patient's initial long pause (0.8 seconds at line 34) communicates she is about to produce a dispreferred response, that being a new concern. In line 35, the patient denies the presence of a completely new concern. Yet, in lines (36-38) the patient presents a new concern "a pain in the left side of her head." This new concern is emphasized in line (51) After 144 lines of talk, the physician is not able to diagnose the concern. So, at line 204, he begins to deal with the patient's routine concern: he begins to prepare his stethoscope for use. At lines 205-208, he begins checking the patient's lungs.

Extract 5: blood Pressure

3 Doc: Eh so what's new?
4 (0.2 second pause)
5 Pat: No I just came in to mmh blood pressure
6 recheck,
7 (0.1 second pause)
8 Doc: Mn hm
9 Pat: which I guess was high,

In contrast to the physician's "anything new?" "so what's new?" (line 3) is grammatically designed to state a report of new concerns (Schegolff, 1988; Ibid). The patient presents new concern in line (5). Thereafter, the patient proceeds to his/her routine concern (line 6).

Conclusion

This paper has attempted to demonstrate three things: First when a physician solicits patients` presenting concerns, subtle differences in how physicians design / format their questions subtly change the action that those questions perform. Second, physicians and patients orient to the existence of at least three different types of reasons for visiting physicians: dealing with new, follow-up, and routine- recheck concerns. Third, physicians format, are understood to format, and are held accountable for formatting their solicitations so as to be appropriately fitted to patients` type of concerns. These findings have implications for research and training. An examination of language in context proves to have consequences for medical care: how physicians solicit patients` concerns can have consequences for patients perceptions of physicians` competence and credibility, and thus for patient outcomes, such as satisfaction and adherence. Thus, this paper is addressed for physicians as well as patients. One possible suggestion for further study is the area where training can improve is how physicians solicit patients` presenting concerns.

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التحليل اللغوي كوسيلة للاستفسار عن شؤون المرضى

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المستخلص

درس العديد من الباحثين الاتصال الطبي عالميا من جانب تحليل نص الخطاب والمحاورة.يعتبر التفاعل بين الطبيب و المريض احد جوانب الاتصال الطبي الذي يتطلب عناية باحثي اللغة لأجل معرفة كيفية أن تكون اللغة احد جوانب السلوك الاجتماعي بالأخص في الجانب الطبي .خلال الاستهلال وقبل أن يستدعي الطبيب تسجيلات طبية للمريض تحدث أنواع أخرى من الأداء على الرغم من أن المرضى اهتمامات عدة إلا إن زياراتهم مع أطباء الرعاية الأولى تكون منظمة بصورة نموذجية حول أسباب معينة ترتبط بأهم شكاوي المرضى . بعد الاستهلال سيتفهم الأطباء عن شكاوي المرضى باستخدام أسئلة مثل:"ما الذي استطيع أن أقدمه لك اليوم؟" تعد مثل هذه الأسئلة مهمة في البحث لان الصيغ المختلفة للأسئلة تحدد وتكيف أجوبة المرضى:كيفية عرض أسلوب المرضى لمشاكلهم وهذه لها العديد من النتائج الطبية. ولأجل تطوير العناية الصحية،ينصح كلا من الباحثين والأطباء باستعمال الأسئلة المفتوحة.على أية حال يعد هذا الرأي عام لان قليل هو المعروف عن استفهامات الطبيب لمشاكل المرضى.يهدف البحث إلى:

١-إثبات إن الاختلافات الدقيقة لكيفية قولبة المرضى لأسئلتهم يمكن أن تغير الأداء الذي ينجزه الأسئلة.

٢-توضيح كيفية أن يؤقلم الأطباء والمرضى أنفسهم لثلاثة أنواع من أسباب زيارة المرضى:

أ-الاهتمامات الجديدة :أي تلك التي قدمت لأول مرة لطبيب معين أو لأول مرة منذ الزيارة السابقة .

ب-اهتمامات المعالجة :أي تلك التي أثيرت وقدمت منذ الزيارات السابقة والتي والتي يتم ألان متابعتها من خلال ملاحظة شفاء المريض .

ج- الاهتمامات الروتينية : أي تلك التي تكون بصورة عامة تحت السيطرة ٣-وصف صيغ الأسئلة التي تعنون المشاكل الجديدة أو مشاكل المعالجة أو مشاكل الروتينية للغرض من الزيارة ٤-مناقشة التضامين التي تكمن خلف صيغ الأطباء الاستفهامية للعناية الطبية.