Breaking the sequential mold: Answering 'more than the question' during comprehensive history taking*

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Abstract

This article uses conversation analysis focusing largely on a single unremarkable primary care doctor–patient encounter. In the relatively restrictive context of comprehensive medical history taking, this article investigates some of the ways in which a patient expands her answers—volunteering more information than was asked for. This article draws on previous work to establish that comprehensive history taking is designedly a restrictive environment for patients' responses, and is oriented to by patients as such. In this context, patient expansions are accountable in various ways, and are built to implement specific projects. We review a range of examples of these expansions, and examine their design and import for the interaction. The implication of this research is that while doctors may not routinely affiliate with patients' lifeworld narratives as interactants in ordinary conversation might, these narratives can nonetheless be treated as resources for learning more about patients and ultimately facilitating their care and education.

Keywords: *doctor–patient communication; conversation analysis; question-response sequences; patient participation; narrative.*

This article is a case study investigation of the ways in which a patient expands her answers—volunteering more information than was asked for—in the restrictive context of comprehensive medical history taking. In what follows, we draw on previous work to establish that comprehensive history taking is designedly a restrictive environment for patients' responses, and is oriented to by patients as such. In this context, patient expansions are accountable in various ways, and are built to implement specific projects. We review a range of examples of these expansions, and examine their design and import for the interaction.

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Whether as part of a first visit, an annual check-up, or another less routine type of visit, physicians regularly ask questions addressing patients' past medical conditions, the health status of parents and siblings, and psychosocial and lifestyle aspects of the patient's circumstances. These questions ordinarily emerge in a series, making up an identifiable activity within the consultation which, following Bates, Bickley, and Hoekelman (1995), we will term the comprehensive medical history.

Consider the following series of questions addressing a patient's past and current medical conditions:

(1)	Torn Roto Cuff		
1	DOC:		Okay_ How old are you sir?
2	PAT:		I'm thirty eight.
3			(2.5)
4	DOC:	→	An' do you have any other medical problems?
5	PAT:		Uh: no.
6			(7.0)
7	DOC:	→	No heart disease,
8	PAT:		#Hah:. # ((cough))
9	PAT:		No.
10			(1.3)
11	DOC:	→	Any lung disease as far as you know:,
12	PAT:		No.
13			(.)
14	PAT:		Not that I know of.
15			(.)
16	DOC:	→	Any diabetes,
17	PAT:		No.
18	DOC:	→	Have you ever had (uh) surgery?
19			(0.5)
20	PAT:		I've had four surgeries on my left knee:.

This series of questions begins with 'Okay_' which projects the beginning of a new activity (Beach 1993, 1995)—in this case a shift from dealing with the patient's presenting complaint (data not shown) to the comprehensive history. The five arrowed questions are designedly brief and are plainly presented as part of a concerted series. This is mainly achieved by a form of sequential parasitism (cf. Frankel 1990) in which, after the second question (line 4), the next several are managed through phrasal increments that offer some specifications of the 'other medical problems' identified at line 4.[1] Moreover, each question is a *yes*/*no*-question designed, through polarity markers (Horn 1989), to prefer

a ‘no problem’ response from the patient (Heritage and Sorjonen 1994; Boyd and Heritage, to appear).[2]

With the exception of the last question, the patient’s responses confirm or align with the ‘no problem’ state of affairs that the questions prefer, and do so immediately and minimally. After the patient responds to each question, the doctor proceeds to the next, treating the preceding minimal answer as sufficient. The minimality of the patient’s responses exhibit his understanding of the ‘checklist’ status of the questions and his preparedness to comply with that understanding. In this sense, doctor and patient progressively co-construct and realize this series of questions as embodying a ‘checklist’ dealing with background health information. Notably, the final nonaligned response to the last question is produced in delayed fashion, exhibiting a departure not only from the ‘no’ preference of the question, but also from the routine series of ‘no problem’ answers which had become the established *modus operandi* of the series.

Finally, while the physician’s questions are in search of background information that might inform his management of the patient’s medical condition(s), their optimization (Boyd and Heritage, to appear; Heritage, to appear b), for ‘no problem’ responses is designed to discourage movement beyond the immediate agenda set by each question. In this way, they facilitate movement through the list of questions, and achieve the activity of comprehensive history taking as a course of action having continuity and cohesion across the series as a whole. Insofar as this form of questioning is typical of the comprehensive history taking, it is clear that it is designed to be a relatively restricted context for patient-initiated actions (Waitzkin 1991).[3]

Minimal answers in comprehensive history taking are not restricted to *yes/no*-question designs. In the following case, in which an initial response to a *yes/no*-question triggers two contingent *wh*- inquiries, the patient’s responses are still relatively unelaborated, offering just the information that was requested:

(2)
1 DOC: Tlk = .hh hIs your father alive?
2 PAT: 1→ (.hh) No.
3 DOC: How old was he when he died.
4 PAT: 2→ .hh hhohh sixty three I think. = hh
5 DOC: What did he die from. = hh
6 (0.5)
7 PAT: 3→ He had: = uhm:: He had high blood pressure,
8 (.)
9 PAT: 3→ An:d he = (uh)/(’ad–) uh: heart attack.

10		(4.0)
11	DOC:	Is your mother alive

Here the patient's second response is elaborated only by epistemic markings ('hhohh' and 'I think') that identify her response as slightly uncertain, and the third offers an initial response to the question 'What did he die from' with an etiological statement (high blood pressure). This statement is concluded with a little nod, and is thus observably complete. However, it is subsequently continued with an addition that more exactly addresses the father's cause of death (a heart attack). These responses answer just the question as put, and embody the patient's understanding that the question invites a response simply in terms of unelaborated fact. As was true of example (1), in each case the response is produced as complete by the patient, who does not elaborate further, and treated as complete by the doctor, who, in a place where he might request elaboration, goes on to a next question (line 11) in an agenda-organized series (Heritage and Sorjonen 1994). By this means, once again, physician and patient collaborate in the co-construction of comprehensive history taking as a recognizable and concerted undertaking.

In this article, we will examine instances in which a patient departs from this general pattern of minimal responses by expanding some of her responses to comprehensive history taking questions. These expansions can be divided into two broad types. The first and most common type of expansion, which we will term 'expanded answers', involves some response to the question and a brief elaboration.[4] A hallmark of these expansions is that they are designed to address potentially problematic features of the patients responses. The most common of these expansions cluster into three main classes that:

i. address the patient's difficulties in giving definite answers to some questions;
ii. support answers by adding details; or
iii. preempt negative inferences which might otherwise arise from unelaborated answers.

In each of these circumstances, the patient's response includes both a component that addresses the question as put, and an expansion addressing a possibly problematic feature of the response. We will suggest that these expansions can be arrayed along a continuum in terms of the extent to which their provision departs from the agenda of the question, and contrast them with examples of a second, more extensive, type of departure which we will term 'narrative expansions'. We will

propose that the narrative expansions enable the patient in our data to build a progressive movement away from the agenda of the physician's question. They are thus resources for more extensive departures through which the patient can introduce her own agenda of concerns.

In all of these expansions, whether intentionally or not, the patient provides the physician with some degree of access to her life circumstances (Mishler 1984). However, our final example of a full blown narrative expansion is the most substantial departure. Both by the magnitude and the 'self-motivated' manner of its departure from the agenda of comprehensive history taking, it can be heard to raise matters that are 'on her mind' independent of the immediate issues made relevant in the preceding question(s), and thus to offer a more substantial window onto her concerns and preoccupations.

Data

This article is centered on an unremarkable primary care doctor–patient consultation that occurred in 1989 in a Midwestern city in the United States. The physician specializes in internal medicine at a university teaching hospital. The patient is an observably overweight, middle-aged woman who is the owner/manager of a small restaurant in a rural township. She is divorced, and has a twenty-nine-year-old daughter. This visit is for the routine monitoring of her high blood pressure, for which she has been prescribed dyazide. She missed her last appointment with the doctor two months previously, and is several years delinquent with basic cancer-screening procedures such as mammograms and pap smears. Although she has seen this physician on at least one prior occasion some four months prior to this visit, it is on this visit that the doctor engages in a full-scale interview including a comprehensive medical history.[5]

Three contexts for expanded answers

1. *Addressing difficulties in responding*

One circumstance in which the patient provides elaborated responses is when her responses embody uncertainty about information to which she could be expected to have privileged access. In this context, she recurrently treats epistemically downgraded responses, indexed by turn-initial 'I don't know' or 'I think', as accountable (Beach and Metzger 1997). For instance, in example (3), both the doctor and the patient treat the patient's statement 'I don' know_' (line 2) in response to a question about her working hours, as incomplete. First, the patient does not

produce the utterance as complete, and the doctor does not acknowledge it as such (line 3). Second, the patient, after 1.5 seconds of silence (line 3) provides an account for her initial response:

(3)

1	DOC:	.hh How many hours uh week do you work,
2	PAT:	.hhh Uh:: = hhh I don' know_
3		(1.5)
4	PAT:	I'm there uh lot_ (.) an' I'm not actually working
5		uh lot. but (0.3)/(.hh) yeah. I would say prob'ly
6		(1.8) thuh last: –couple months prob'ly about:
7		<sixty,>
8	DOC:	[( )
9	PAT:	[<I– I don't know.

Here the patient's response to the doctor's question is designed from the outset as a dispreferred action (Pomerantz 1984; Sacks 1987): it is delayed by an initial inbreath, a stretched 'Uh::' and a sighing outbreath (line 2). Subsequently, her 'I don' know_' invokes a difficulty in answering the question as put. On one level, the patient offers a classic 'inability' account in response to this question, and inability accounts are themselves routinely accountable (Heritage 1988). Thus the patient's inability account for information to which she has privileged access clearly projects subsequent elaboration. On a second level, 'I don' know_' is hearable, particularly with its level intonation, as projecting a subsequent estimation. The patient's expansion (lines 4 and 5) draws a distinction between the time she spends 'at work' and the time she spends 'actually working', thus developing an account for her difficulty in answering the question directly. Subsequently, she offers a highly circumscribed estimate of the hours she works (lines 5 to 7), an estimate that was projected at line 2. Finally, the patient concludes her turn by returning to the terms of her initial response 'I don't know' (line 9). While the patient's account deals with the difficulty she has in addressing the question, it also conveys a glimpse into her life circumstances. Insofar as the patient is 'actually working' for sixty hours a week, and spends more time at her restaurant not working, her response indicates that her work absorbs the majority of her time.

In example (4), the physician's question concerns the general health of the patient's six siblings. In this case, the patient's initial response 'Yeah', although conforming to the terms of the question, is delayed.[6] Additionally, it is qualified with 'I think so:' (line 3). These elements in combination project elaboration and, immediately thereafter, she elaborates with an explanation of her family circumstances, thus expanding

on and accounting for her uncertainty:

(4)

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 1   DOC:  Are they in good health? er hh
 2         (0.5)
 3   PAT:  Tlk = Yeah I think so: = They're really strung ou:t.
 4         y[a know they're over uh long period uh time. but–
 5   DOC:   [Mm hm,
 6   PAT:  .hh Yieah: (,)
```

Here the patient's account (lines 3 and 4) invokes the age range of her siblings as the basis for her difficulty in providing a generalized response to the question. The account perhaps alludes to other difficulties too: that 'good health' may need to be construed relative to their ages, and that she may not be in close contact with them.

In the previous two cases, it was the patient who volunteered an account. However, the doctor also treats difficulties in responding as requiring expansion. In example (5), for instance, following another delayed and qualified response (line 7), it is the physician who solicits expansion (line 8). In response to the affirmatively polarized question 'You have your gall bladder?' (line 5), the patient responds with delay (line 6) and some uncertainty. Her 'I think so' incorporates some stress on the epistemically downgraded 'think', and the little laugh that follows expresses some discomfort with the nature of her response (Haakana, this issue):

(5)

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 1   DOC:  Tlk Any ulcers?
 2         (0.5)
 3   PAT:  (Mh) no,
 4         (2.5)
 5   DOC:  Tl You have your gall bladder?
 6         (2.0)
 7   PAT:  I think so. uh huh = hh
 8   DOC:  £Nobody took it out [that you know (of er hhh)
 9   PAT:                      [.hh hah hah hah
10   PAT:  .hhh
11         (0.2)
12   PAT:  Well I had uh tubular pregnancy (once,) .hh
13   DOC:  Kay. =
14   PAT:  = An' I was too afraid tuh even ask 'em anything about
15         it. an' so (.) I don't know what they did.
```

The doctor's pursuit (line 8) quite exactly matches the tenor of the patient's response. It is produced in 'smile voice' (indicated by the use

of the £ sign) which is affectively aligned to the laughter at the end of the patient's prior turn. Additionally, its polarity is matched to the affirmative form of the patient's previous response. Finally, it topicalizes the only likely grounds—a prior surgical procedure—on which a person could be uncertain as to their possession of a gall bladder. This pursuit provides an opportunity in which the patient can appropriately talk about her previous experience with surgery. Her ensuing description of surgery for a tubular pregnancy accounts for her reported uncertainty at line 7 by describing how she did not ask about the procedure involved. In this way, she invokes the (unlikely) possibility that her gall bladder might also have been removed without her being informed. By the use of this response, she also conveys that she fears surgical procedures and avoids discussing them.

These expansions of patient responses to questions index, and are pursued as indexing, some concern with the patient's uncertainty with respect to matters which are primarily and properly known to her. They are treated as appropriate in this environment and, when they are not provided by the patient they can be accountably sought by the doctor (as in example [5]). Across the cases in examples (3) to (5), the participants are concerned to explain why the patient is unexpectedly having difficulty in providing a definite answer to a question, while simultaneously seeking to elaborate and specify the nature of the difficulty itself. Finally, each expansion leaks some additional information about the patient's 'lifeworld' and psychosocial orientations into the interaction in a way that an unexpanded response would not.

2. *Supporting responses by adding details*

In addition to dealing with difficulties in answering, expanded answers may also add supporting details to the patient's answer. This type of expansion is often used to offer documentation for responses to questions in which the patient gives some estimation or judgment, as in the following:

(6)

1	DOC:	(.hhhh hhhh) Tlk = Headaches very often?
2	PAT:	Mm mm.
3		(0.8)
4	PAT:	Hardly ever take aspirin, = h

Here, the patient offers a minimal (negative) response to the question at line 2. After 0.8 seconds of silence during which the physician enters information into the patient's chart, she expands her answer with an

additional statement 'Hardly ever take aspirin, =h'. The information provided in this turn is strictly 'volunteered'. It does not account for difficulty in responding, nor is it solicited by the physician who is, at this point, disengaged from the patient, and writing in her chart. Instead, the patient's turn elaborates her previous response with a report of a tangible, objective index—aspirin use—which supports her initial negative response (line 2). That this elaboration is designed to address the doctor's question in line 1 is clear from the parallelism between the turn designs used by the doctor and patient. Specifically, the patient's 'Hardly ever take aspirin' (line 4) is compressed: the subject of the sentence is deleted in a fashion that matches the design of the doctor's subjectless question 'Headaches very often?'. Moreover, the patient's adverbial phrase 'Hardly ever' is directly matched to the doctor's temporal reference in 'very often'. In this way, the patient adds documentation in externally measurable form to her subjective estimate at line 2, and does so through the use of an expansion whose design specifically ties it back to doctor's question.[7]

In example (7), the patient is also asked to perform an act of judgment, in this case in response to a question about the adequacy of her glasses (line 4). Her initial response ('Yiea::h') at line 6 is affirmative and yet, through its delay (as in examples [4] and [5]) and prosody, is managed so as to convey a reservation. This reservation is then elaborated:

(7) [simplified]

1	DOC:	Do you wear glasses er contacts?
2		...
3		...
4	DOC:	Are they adequate?
5		(1.8)
6	PAT:	Yiea::h I finally got back for an examination. (s:)
7		(0.2) two yea:rs, =h
8		(.)
9	PAT:	They're– They– didn't change much but I do– (0.5)
10		hafta have 'em changed.

As the patient subsequently details, the reservation she conveys in her initial response is not based in a subjective judgment, but rather on an external expert opinion. As she reports it, her eyes 'didn't change much' and in this sense her glasses have indeed been 'adequate'. However, as she also reports it, 'I do– (0.5) hafta have 'em changed' and in this sense, they are not. It is this duality, indexed in her reservation-laden 'Yiea::h', that is unpacked in her subsequent elaboration. Here then the patient's expansion documents an answer about the adequacy of her glasses by

reference to the outcome of objective tests, but does so in a way that is congruent with the fundamental history activity 'in play'.

In examples (6) and (7), the patient supplied additional details that specified her response in ways that enhanced their objectivity and credibility. But this too is an environment that the doctor orients to as requiring expansion. Thus in example (8), which parallels example (5), it is the physician who pursues expansion of the patient's answer—in this case, an estimate of her alcohol consumption:

(8)

1	DOC:	Alcohol use?
2		(1.0)
3	PAT:	Mm:: moderate I'd say.
4		(0.2)
5	DOC:	Can you define that, hhhehh ((laughing outbreath))
6	PAT:	Uh huh hah .hh I don't get off my – (0.2) outa
7		thuh restaurant very much but [(awh:)
8	DOC:	[Daily do you use
9		alcohol or: = h
10	PAT:	Pardon?
11	DOC:	Daily? or[:
12	PAT:	[Oh: huh uh. .hh No: uhm (3.0) probably::
13		I usually go out like once uh week.
14		(1.0)
15	DOC:	°Kay.°

In response to the doctor's question 'Alcohol use?' at line 1, the patient provides what is clearly an estimate, 'moderate'. The estimate is delayed with a one-second silence and further with a turn initial 'Mm::'. The latter hearably embodies a process of consideration, and this is strongly reinforced by the patient's post-positioned 'I'd say' which explicitly formulates the answer as a judgment. As it stands, the patient's judgment lacks an underlying measurement framework that would make it interpretable, and it is just this issue that the doctors question at line 5 pursues. The patient's subsequent elaboration (lines 6 and 7) in terms of not getting 'outa thuh restaurant very much' documents her earlier use of 'moderate' in terms that suggest that she does not consume alcohol on a regular basis, but only on social occasions. However, the doctor's next question, 'Daily do you use alcohol or: = h', does not treat this as sufficient: it pursues a measurement framework in terms of a periodic metric (e.g., daily, weekly) which is exemplified by the selection of 'Daily'.[8] After a repair sequence (lines 10 to 12) the patient arrives at a specification of her alcohol use in terms of such a metric 'once uh week'.

These expansions of patient responses to questions index, and are pursued as indexing, a concern with the witnessability, measurability, and in the last analysis, the objectivity of the patient's judgment. As these examples show, these concerns can emerge at the initiative of the patient or the doctor. But in either case, they are resolved through a form of supportive detailing in which the patient's private judgment is objectified by recourse to an external reference point involving actual or potential measurement. As was the case with examples (3) to (5), here too the patient's expanded answers (as in example [8]) can offer a degree of insight into her life circumstances.

3. *Pre-empting negative inferences*

A third context in which the patient provides expanded answers involves situations in which the patient's initial response may be indicative of what might be termed 'medico-moral' deficiencies or derelictions. These tend to cluster around issues of preventative health care. These responses, by overtly acknowledging some deficiency in her prior conduct, work towards preempting a negative evaluation by the physician. For instance, in example (9) the patient acknowledges a failure to perform simple self-examinations which are important for breast cancer prevention:

(9)

1	DOC:	Tl = D'you have any breast lumps that = yer aware of?,
2		(0.8)
3	PAT:	I don't check_
4		(4.0)
5	PAT:	I should.

In this case, the patient's 'I don't check_' (line 3) indicates her awareness that self-examination is a prerequisite for answering the question, and treats the question as holding her accountable for performing this action. Her subsequent addition of 'I should' (line 5) appears designed to preempt criticism by explicitly treating herself as having failed in this basic obligation of self-care. In expanding on her answer in this way, the patient displays a dual concern with the general management of her health care. On the one hand, she conveys that she has insight into the nature of her health problems and knowledge of what should be done to address them. On the other hand, given the conversational preference to avoid telling persons what they already know (Terasaki, to appear [1976]), she can attempt to circumvent any sustained topicalization of this issue including, in particular, explicit counseling. In this process the patient

brings an explicitly moral stance towards her failure of self care to the surface of the interaction, and this may play a role in preempting further discussion.

The patient deploys a very similar maneuver in example (10). Here, the third of the patient's responses (line 10) departs from the 'no problem' answer which the doctor's questions are designed to prefer:

(10)

1	DOC:	Tlk You don't have as:thma do you,
2		(.)
3	PAT:	Hm mm.
4		(1.1)
5	DOC:	(hhh) .hh Any chest (type–) pain?,
6	PAT:	Mm mm.
7		(3.4)
8	DOC:	Shortness of brea:th,
9		(1.0)
10	PAT:	Some: but that's: cuz I should lose weight (I know that,)
11		(.) I thin'. =<Not much.
12	DOC:	When do you get short of breath_

The patient responds promptly and briefly to the first two of these questions (lines 1 and 5) with responses aligned to the preference structure of each (lines 3 and 6). The third question, though devoid of any explicit polarity marking, is clearly designed to 'borrow' the negative polarity established in the previous one.[9] However, in this case, the patient's response, which departs from the 'no problem' preference, is noticeably delayed (line 9) and is expanded with an account (lines 10 to 11). The account is developed as a grammatical continuation of 'Some:' using 'but' as a connective. Its import is to offer a candidate explanation (Gill 1998) for the medical problem she has just acknowledged. In offering this explanation, however, the patient also works to minimize her shortness of breath as a specifically medical problem. Instead, with the morally formulated 'that's: cuz I should lose weight', she treats it not only as something which she understands, but also as something which she can and should control. Her post-positioned remark ('I know that') further underscores that she is aware of the link between breathlessness and being overweight, and thus discourages the physician's pursuit of this topic.[10] Overall, this account appears designed to minimize the extent to which her initial response 'Some:' should be pursued as a medically problematic state of affairs. And indeed, after this account, she revises that response to 'Not much' (line 11). Once again, the moral formulation of her account is accomplice to an effort to preempt an extended

focus on her problem, although in this case it is unsuccessful: the doctor does go on to pursue the matter (line 12 and beyond [data not shown]).

In contrast to the previous two cases where the patient volunteered an elaboration of a medico-morally problematic response, in example (11) the elaboration is produced in response to the doctor's pursuit (line 4). This case is complicated, however, by the fact that the manner of the patient's response appears to motivate the doctor's pursuit. Here the negatively polarized design of the doctor's question about exercise (with the use of 'at all?') is entrained by an immediately preceding sequence shown in example (3), in which the patient indicated that she works at least sixty hours per week and, more distally, by the earlier discovery that she had gained eleven pounds since her last visit four months previously—neither fact being consistent with regular exercise:

(11) [Immediately following Extract 3]
1 DOC: Tlk Do you exercise at all?
2 (2.5)
3 PAT: N::o, uh huh huh huh
(.hh–[.hh) huh [huh (.hh huh huh)
4 DOC: [Hm [£Not your thing [ah:, £]
5 PAT: [.hh]
6 PAT: £Would you believe me if I sai [(h)d y(h)e(h)s, =
7 DOC: [.hhh hhh
8 PAT: .hh [h I– I– (do –) thee idea's good. [Thee idea's good.
9 DOC: [< N::o: I think– > [I (could've–)
10 PAT: [(I) huh .hh huh
11 DOC: [I think I knew thee answer to that question when I
12 ask' it.
13 PAT: .hhh
14 DOC: hhh ((laughing))
15 (1.5)
16 PAT: I'm going to. It's on one uh those (0.5) pretty soon.
17 DOC: Great.

In this case, while the patient's response (line 3) is aligned to the polarity of the question, it is notably delayed (line 2). The articulation 'N::o', with its extended stretch on the 'n' sound before release into a comparatively short 'o' is almost coy and indeed is immediately followed by laughter. The net effect of this response is to playfully suggest the unwilling disclosure of a 'guilty secret'. It is just this import that the doctor addresses with his pursuit in smile voice '£Not your thing ah:, £' (line 4). This response jokingly accounts for her prior

answer in nonevaluative terms—as simply a matter of personal preference. Together with its tag ('ah:' line 4), this turn creates a context in which the patient can progressively take a position which recognizes the desirability of exercise. She initially exploits this with a turn—'£Would you believe me if I sai(h)d y(h)e(h)s, = '—that underscores the predictability of her response at line 3. This turn is done as a joking counterfactual, and is designed for a 'no' response.[11]

In the context of her evident weight gain, the patient accomplishes self-deprecation in this turn by representing herself as someone who could not credibly claim to be exercising. Subsequently, she responds more directly to the doctor's account '£Not your thing' by acknowledging that exercise is a good idea (line 8), and later adding (line 16) a vaguely formulated undertaking to begin exercising. In these ways, as in the previous two cases, she takes an evaluative position on her failure to exercise. Significantly, although this position displaces the doctor's earlier treatment of her failure to exercise as a matter of personal preference, as in examples (9) and (10) it appears designed to preempt overt criticism or counseling on the issue.

In contrast to the previous two sets of cases in which the patient accounted for difficulties in responding or sought to add supporting details to subjective estimates, these expanded answers address what she treats as the moral implications of her failure to take action in various aspects of self-care. In these cases—checking for breast lumps, medical symptoms which the patient associates with excess weight, and exercise—the patient works to demonstrate her knowledge of the appropriate course of action while still not proposing any change in her future behavior. These expansions are evidently defensive and designed to preemptively block any attempt by the doctor to advise or critique the patient's inaction. It is notable that none of these sequences eventuates in any advice or evaluation by the doctor, and neither does the patient ultimately propose to modify her behavior in any concrete ways.

Narrative expansions

A pre-emptive telling

In the previous section we examined cases in which the patient's expanded responses were addressed to their potentially problematic features. In some of these cases, the patient volunteered these expansions while in others the doctor solicited them. In all cases, however, these expanded answers were delivered as part of a response, and thus their provision

and content was largely shaped by the terms of the questions to which they were addressed.

In what follows we will examine two rather different expansions—a smaller scale telling and a full-blown narrative. In each of these cases, the information the patient volunteers is neither licensed by a question nor does it expand on an answer. Instead, the expansions exploit the local environment to raise a matter that is apparently 'on the patient's mind'. In these cases also, we will argue, the patient's talk is designedly preemptive—aimed at conveying her awareness that she should regularly seek preventive medical care and that she should not 'put things off'.

The first case—a preemptive telling—occurs at the beginning of the consultation as the physician is reviewing the patient's chart. The doctor's remark at line 3 'I saw you in Ma̲rch', delivered while gazing at the chart, states the last time he saw the patient in a prosody which does not overtly solicit a response. While this remark, and its supplement at line 5, appear to be primarily concerned with documenting the patient's most recent visit, the patient treats it as a 'my side telling' that, by asserting 'limited access' to her circumstances (Pomerantz 1980), is in search of an account for an unexpected four-month time gap between the previous and the current visit. In response, she refers to a canceled appointment (lines 6 and 7).[12] Subsequent to the doctor's acknowledgment of this account (line 8), the patient further expands her account by referring to her daughter's reaction to her failure to keep scheduled medical appointments. While this case is clearly not a full-blown narrative, it embodies an incremental step away from the more basic form of expanded answer, in the direction of a spontaneously produced telling.

(12)

```
 1  DOC:      °('kay)° let's se̲e:::=hh
 2            (3.0)
 3  DOC:      I saw you in Ma̲rch,
 4            (.)
 5  DOC:      ([First week er)
 6  PAT:  →    [Tlk Yeah:. .hh I had an appointment uh couple mo̲nths
 7        →   ago an' then I: had tuh cancel tha̲t one.
 8  DOC:      'kay,
 9  PAT:  →   But my daughter woulda ki̲lled me if (I'd uh cancelled)
10        →   thi̲s one s[o.
11  DOC:                [Really?
12  PAT:      (Nyoh yeah.)
```

```
13   DOC:    She's on your ca̲se
             [(huh,)
14   PAT:    [Oh: yeah. = hh[h
15   DOC:                   [How[old is your da̲ughter?, =
16   PAT:                       [An–
17   PAT:    = Mm:: she's twenty (eigh–) twenty ni̲ne.
18   DOC:    (Okay_) hh
19           (0.2)
20   PAT:    (h)I: = uh uh huh huh .hh
21   DOC:    What's she on your ca̲:se about.
22           (0.8)
23   PAT:    O[h:::
24   DOC:     [What concerns he̲r mostly about you:,
25   PAT:    Ke̲epin' thee appointments.
26           (1.0)
27   PAT:    Cuz she knows I: have uh tendency tuh put– uh lo̲tta
28           things (off.)
```

In lines 9 and 10 the patient describes her daughter's attitude in an increment to her earlier report of having missed an appointment (lines 6 to 7). The connective *but* builds this unit as incremental to, but contrastive with, the prior one, the relevant point of contrast being the cancellation of the previous appointment and the keeping of the present one. The contrast is buttressed by the lexical reuse of cancel and contrastive stress on 'tha̲t one' versus 'thi̲s one'. In this way, the patient indicates that both she and her daughter are aware of the issue of missed appointments as a problem. The daughter's concern is pursued by the doctor (lines 13, 21, and 24), eventuating in the patient's explicit acknowledgment that she has 'uh tendency tuh put– uh lo̲tta things (off.)' (lines 27 and 28).

This sequence embodies a number of features of the preemptive expansions we have already examined, but in more elaborate form. First, the patient's admission of a canceled appointment two months previously preempts the possibility that the doctor would raise the matter on his own as part of his review of her records. Second, by invoking a close relative's involvement, the patient documents that her concern with keeping scheduled medical appointments is an objective one. Third, in lines 27 and 28, the patient's explicit acknowledgment of procrastination as a 'tendency' that she has is akin to her earlier acknowledgments that she 'should' check for breast lumps (example [9]), 'should' lose weight (example [10]), and that the idea of exercise is 'good' (example [11]). However, finally, with the additional invocation of her daughter's

concern, the doctor's engagement with the issue is more completely preempted. Just as in the previous cases where the patient's acknowledgment of her derelictions effectively preempted their thematization by the physician, here too there is no further elaboration of the topic: the physician opts to continue with his review of her chart. Unlike the previous cases, however, this telling is not responsive to the terms of a prior question. Though triggered by the doctor's observation at line 3, it is much closer to a pure case of volunteering information about a concern which, by this action, she independently treats as a problem to be acknowledged.

A narrative response

Narrative expansions to questions represent a different order of expansion from the expanded answers considered so far for three reasons. First, narratives embody a shift in the interactional organization of history taking, from one in which patients respond to physician questions to one in which physicians are unambiguously placed in the role of a story recipient. In this role, physicians are unassured of a next slot in which to resume history taking and, in this sense, lose part of the interactional initiative associated with history taking as an activity. Second, narrative structures build an 'internal' context within which material that departs from the agenda of a prior question can be accountably placed. Narratives are thus resources for the introduction of material in pursuit of objectives that cannot otherwise be introduced with any assurance in the context of a question–answer series (Zimmerman 1992; Atkinson and Heritage 1985; Heritage, to appear; Halkowski, to appear). Third, whereas in expanded answers patients' 'lifeworld' concerns tend, at best, to be leaked into the talk in ways that are subordinated to the agenda of the question, narrative expansions involve a volunteering of information that more overtly attends to the patient's agenda of concerns. For these reasons, narrative expansions to comprehensive history questions are of particular interest. In this final section we will analyze an extensive narrative offered as an expansion to a history taking question. We will go on to discuss the physician's response to the narrative, and to expansions more generally.

The narrative which we will discuss in this section is preceded by a stretch of talk that involves an incremental step away from the agenda of the question to which it responds. From this point in the interaction through the narrative we subsequently examine, we can trace the patient's progressive movement from a history-taking interactional framework into one which more closely resembles ordinary conversation.

This movement begins when, following a series of three questions about her father's death (lines 1 to 9), the patient is presented with what she anticipates is the first in a similar series of questions regarding her mother (line 11). Her response is structured to contain responses to the three questions that were asked about her father and presented in an order that parallels the order of those questions.

(13)

1	DOC:	Tlk = .hh hIs your father alive?
2	PAT:	(.hh) No.
3	DOC:	How old was he when he died.
4	PAT:	.hh hhohh sixty three I think. = hh
5	DOC:	What did he die from. = hh
6		(0.5)
7	PAT:	He had: = uhm:: He had high blood pressure,
8		(.)
9	PAT:	An:d he = (uh)/('ad–) uh: heart attack.
10		(4.0)
11	DOC:	Is your mother alive,
12	PAT:	No:.
13		(1.0)
14	PAT:	No: she died– in her: like late (.) fifties: or:
15		I'm not sure.
16		(.)
17	PAT:	Late fifties or early s– early sixties. .hhh
18		A:n:d she had cancer. = hh ('n) that was–
19		That was also in about ninetee:n: sixty-one:,
20		I think er sixty:: lemme think sixty-four.
21	DOC:	Mm hm.
22		(0.5)
23	DOC:	Whe[re was her cancer
24	PAT:	[#°about.°#

Unlike her minimal responses in lines 2 to 9 (examined in example [2]), the patient's turn in lines 12 to 20 contains several components which do not respond to the *yes/no*-question in line 11 and instead volunteer additional information about her mother's death. The second unit of the patient's turn (lines 14 and 15) incorporates answers to the first two questions asked by the physician about her father, while a further turn constructional unit, joined to the prior with a connective *and* (line 18), works to address the third of the questions earlier asked about the patient's father. Additionally, the patient's turn is produced through

a series of components in which the repetition of the previous response component is used to launch the next, thus incrementally advancing her response in a stepwise fashion. In line 14, for example, the re-use of 'No:' renews her earlier response (line 12) as the basis for an expansion, thus tying the two elements of her expanded response together. In line 17, the re-use of 'late fifties' (from line 14) provides for the subsequent modification of her earlier response 'or early s– early sixties'. This facilitates the subsequent expansion of her turn to describe the cause of her mother's death and its approximate time frame (lines 18 to 20). Two points can be made about this example. First, this response is produced in the service of the agenda set by the physician's first three questions about the patient's father. It moves only slightly outside of that agenda with the turn-final component (lines 19 and 20), which volunteers an estimate of the year in which the patient's mother died. This also makes available to the physician that both of her parents died within a short space of time, indexed primarily by her use of 'also' (line 19) and, more indirectly, the relative ages at which both parents died. Second, however, the patient clearly departs from the 'standard' pattern of history taking interaction in the way that she anticipates the physician's line of questioning, rather than waiting for it to unfold. The patient's excursion into a telling role is briefly conversational, and sets the scene for the narrative which follows immediately.

This narrative is produced in response to a question—'Where was her cancer'—which calls for a single turn constructional unit response identifying a bodily location. It could hardly be less promising as the basis for a narrative. The patient's response, however, establishes the background for a story with two turn constructional units that describe where her mother lived—'.hhh Well:–she lived in Arizona'—and establish the initial problem that will drive the narrative—'she:: wouldn't go to = uh doctor much. She only went to uh chiropractor'. This story beginning is established in a position where a response to the doctor's question would have been due and displaces that response. The patient manages the dual task of appearing responsive to the question and launching her own narrative project by exploiting the basic terms of the doctor's 'where' question which seeks a location formulation. Her response, however, which incorporates the geographical location 'Arizona', is transparently exploitative of the terms of the question, and provides only the thinnest veneer of a response that conforms to the terms of the question:

(14)
1 DOC: Whe[re was her cancer.
2 PAT: [#°about.°#

```
 3  PAT:   .hhh Well:– she lived in Arizona an:’ – she::
 4         wouldn’t go to=uh doctor much. She only went
 5         to uh chiropractor. (h[u–)
 6  DOC:                         [Mm [hm,
 7  PAT:                             [An:d she had (’t)
 8         like– in her stomach somewhere I guess but (.)
 9         thuh– even– that guy had told her tuh go (into)
10         uh medical doctor.
11  DOC:   [Mm hm,
12  PAT:   [.hhh An:’ she had– years before her– (.) m– uh
13         hh mother in law: had died from: waitin’ too–
14         or whatever ya know (on–) in surgery, .hh an’
15         she said well I’ll never have an operation.
16  PAT:   .h[h An’ so she put it off an’ put it off an’=
17  DOC:     [Mm hm.
18  PAT:   =by thuh time she did go: (0.2) uh: she never
19         –came back outa thuh hospital,=
20  DOC:   =Ok[ay.
21  PAT:      [<They:– .hh ya know she was only like–
22         seven weeks: (.) in there,
23         (.)
24  PAT:   an’ it was uh (0.5) pretty fast but she=uhm
25         (1.5) I– I always thought if she’d uh went maybe
26         sooner (.) maybe.
27  DOC:   Mm hm,
28  PAT:   They could’ve helped her. (°[I don’t know.°)
29  DOC:                               [Tlk=.hh
30  DOC:   Do you have brothers ’n sisters?
```

At this point the stage is set for a substantial volunteered departure from the terms of the doctor’s question. However, an answer to the doctor’s previous question is still due and the patient briefly curtails the story’s progression to produce it (lines 7 and 8), but only after her initial narrative segment has been acknowledged as such by the doctor’s ‘Mm hm’ (line 6), and thus the doctor has displayed a willingness to adopt the role of a story recipient.

In abandoning the main storyline to respond to the physician’s question about the location of the cancer (lines 7 and 8), it is noticeable that the patient goes to substantial lengths to embed this answer within her ongoing narrative, and thereby to undercut its status as a free-standing second-pair part that would otherwise complete the sequence. Specifically, the beginning of her answer to the question is attached to the

narrative with the connective *and*, while the resumption of her narrative is conjoined to the conclusion of her answer without a break and with the connective *but*. Moreover, by comparison with the clarity and definiteness of her story initiation (lines 3 to 5), her answer to the doctor's question 'An:d she had ('t) like– in her stomach somewhere I guess' is approximate and hedged. Both 'like–' and 'somewhere' equivocate on the specific location, and 'I guess' hedges still further on this approximation. In these ways she downgrades the significance of the answer relative to her narrative, while also subordinating it grammatically as an embedded interpolation. Finally, she resumes the narrative with a finely pointed renewal of its problematic context. The statement 'but (.) thuh– even– that guy had told her tuh go (into) uh medical doctor.' underscores her mother's general unwillingness to seek mainstream medical care. In particular, her use of 'even–' and her stress on 'that guy' suggests competitiveness between chiropractors and medical doctors to dramatically highlight the disinterestedness of the chiropractor's advice. Her mother's failure to seek medical care is thus rendered as highly resistant, withstanding all advice to the contrary.

The doctor's contribution to the narrative in progress is relatively minimal. He gazes steadfastly at the patient from line 1 through to the word *but* on line 8, after which he turns to the patient's chart and begins to write. Given the contiguity between the patient's answer to his question ('in her stomach somewhere I guess', line 8) and his turn to the chart, it is almost certain that he makes this move to record her response. The doctor's second continuer (line 11) is produced while looking away from the patient and actively writing in the chart (Figure 1). This permits the patient to continue even though the doctor is evidently not attending to her narrative in the same fashion as he was at line 6 or, for that matter, in the same way as an unencumbered story recipient would in ordinary conversation.

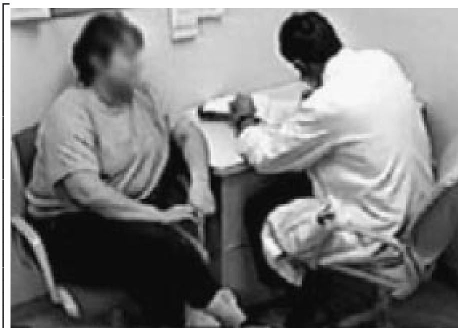

Figure 1. *11 Doc:* *Mm, hm,*

At line 12, the patient begins to complicate her description of her mother's resistance to medicine with a 'subnarrative' which describes how her mother's mother-in-law died during surgery. This provides an explanatory underpinning of the patient's mother's refusal to seek mainstream medical care, and its upshot for her attitude towards surgery, is represented by the mother's reported declaration 'well I'll never have an operation'. Following this, the patient describes the consequence of this declared attitude. Significantly, she describes this using the same form of words 'put it off' (line 16), emphatically reduplicated on this occasion, which she used earlier in the consultation to describe her own attitude (example [12], lines 27 and 28). In a further segment of this narration, the patient reports the outcome of her mother's conduct—'she never –came back outa thuh hospital' (lines 18 and 19).

Across this passage, the patient works to convey her belief that her mother's delay in dealing with her medical problems was a factor in her eventual death. This is accomplished first through the patient's conjoining of her mother's 'putting it off' with her refusal to have surgery. By using the connective 'An' so' she portrays her mother's delay in seeking medically necessary surgical treatment as a direct upshot of her earlier general decision against surgery. Second, the patient conjoins that delay with her mother's entry into the hospital with 'an' by thuh time she did go:' which, with its contrastive stress on did', portrays her arrival at the hospital as too late. This clause in turn is subordinated to the depiction of her mother's death, 'she never –came back outa thuh hospital', as resulting from delay in seeking medical care.

While the doctor's gaze alternates between the patient and the records during this section of the narrative, he broadly takes up a story recipient role vis-à-vis the patient. At lines 12 (on 'her–') and 14 (on '.hh an''), the doctor brings his gaze to the patient and nods, and at line 17—at the completion of the patient's climactic report of her mother's declaration against surgery—he offers a continuer. Each of these actions claims attentiveness without intervening in the story's progress. At the second of these points (line 14), the doctor moves to take up a focused, even 'rapt' position, placing his elbow on the desk and resting his chin in his cupped hand (Figure 2). He maintains this position until he says 'Okay' at line 20, during which he starts to return his gaze to the records, and to a writing posture. With this last action, he conveys his understanding that the story is complete, and projects a shift to new business (Beach 1993). However the patient's prior turn constructional unit was brought to completion with continuing intonation, thus projecting more to come.

The patient continues at line 21 with a turn beginning ('<They:–') that, with the institutional 'they', projects further talk about the hospital.

Figure 2. *15 PAT: she said well* [*I'll never have an operation.*

However, this is immediately abandoned in favor of a turn constructional unit that specifies the number of weeks that she was hospitalized. While it is likely that the content of the abandoned turn would have addressed the hospital's failed attempts at remediation, the revised continuation, rather than advancing the story in this direction, takes up and respecifies a previous story element 'she never –came back outa thuh hospital, = '. This apparently retrograde step is likely responsive to the doctor's shift-implicative 'Okay' which, accompanied by the withdrawal of gaze and return to the records, works to enforce his understanding that the story is complete. It is this understanding that the patient's revised turn constructional unit contests.

In this context, the patient's '.hh ya know she was only like– seven weeks: (.) in there' accomplishes a number of tasks. First, it moves the narrative back to deal with the period of time prior to her mother's death, reopening the story line, so as to re-attract the attention of the physician for the story's conclusion. Certainly some response from the doctor is due at line 23, and after the doctor's lack of uptake the patient continues with an assessment of the import of 'seven weeks:' in a way that visibly orients to the doctor's lack of responsiveness (i.e. she withdraws her gaze and focuses on her hands, see Figure 3).

Second, the continuation portrays her mother's stay in the hospital before dying as short ('only like– seven weeks:'). By implication, the patient conveys that her mother's procrastination had resulted in her not going to the hospital until her condition was quite deteriorated. Third, insofar as the patient had projected further talk about the hospital, probably about the hospital's inability to save her mother's life, the continuation tacitly accounts for that inability and thus reflexively indexes it. Moreover, in portraying her mother as having reached

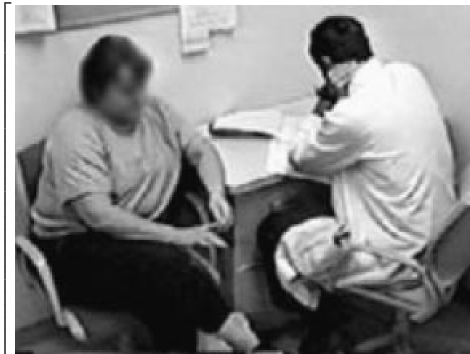

Figure 3.
24 PAT: an' it was uh (0.5) pretty fast ⌊*but she=uhm*

a terminal stage, the patient indicates that she does not blame the hospital for this outcome, and by implication, that she—unlike her mother—does not have a problem with the medical profession.

Following the silence at line 23, the patient continues her turn by assessing ('only like– seven weeks:' as 'pretty fast'. Perhaps to circumvent the doctor's lack of uptake (line 23)—in a position in which an assessment would surely be due in storytelling in ordinary conversation (Goodwin 1986; Goodwin and Goodwin 1992)—she prefaces this assessment with 'an'' rather than 'so' (line 24) which would have overtly marked her assessment 'pretty fast' as the upshot (Raymond 1997). In this way she avoids formulating that assessment as a version of one which was due from the doctor at line 23.

Finally, having rebuilt her narrative so as to create a new environment for a conclusion, the patient moves to its moral (lines 25 to 26, 28). The moral is introduced as an enduring point of view that the patient has held over a long period of time ('I– I always thought'). The moral is formulated using an *if … then* format. Such formats can be structured in one of two ways, *if X, then Y* and *Y, if X*, and it is instructive to look at the patient's formulation of her moral in this light. The conditional element of the patient's statement ('if she'd uh went maybe sooner (.)') is critical of her mother's actions, and by implication, her attitude that led to this inaction, while its sequentially implicative consequence ('They could've helped her') presents the hospital and hospital treatment in an affirmative light. If the ordering of these elements had been reversed, it would have been the mother's negatively evaluated actions that would have been the sequentially implicative item in this formulation. While the doctor might have been unlikely to address the patient's moral in this latter format, the format in which it is presented here is considerably more inviting, at least in its design.

Lerner (1996) has shown that, in ordinary conversation, compound utterances of this type routinely attract collaborative completions because of their projectability. In this case, the *if … then* structure is clearly projectable, while the likely content of the *then*-clause is also easily anticipated from the content of the patient's earlier talk. As the patient reaches the end of the *if*-clause she pauses briefly (line 26). This pause is understood by the doctor, who at the beginning of the clause was still oriented to the records, as inviting some display of recipiency. Such a display could take one of several forms:

i. turning to gaze at the patient,
ii. acknowledging the patient's turn at the mid-point of the compound unit with a continuer or other similar token, or
iii. providing a collaborative completion of the patient's utterance (Lerner 1996).

The doctor's actual response manifests the first two of these options. During the patient's 'maybe' (line 26), he brings his gaze to the patient and nods twice, and provides a continuer (line 27). During his production of the continuer ('Mm hm'), the patient nods reciprocally and smiles before proceeding to the then-clause ('They could've helped her', line 28). While the doctor does not venture as far as a collaborative completion, which would unambiguously display a shared understanding of the import of her story, his nods at line 27 suggest such an understanding. The patient's reciprocal nods and the accompanying smile, just after she has launched the *then*-clause with 'maybe' and deferred its continuation during his 'Mm hm', indicate a similar analysis. However, the doctor's continuer only acknowledges the patient's turn-so-far but declines to exhibit the understanding of her turn that can be clearly anticipated at this point, thus leaving it to the patient to articulate. At this point, then, there is a 'meeting of minds' but one that is brief, ephemeral, and minimally acknowledged.

At line 28, the patient concludes the moral of the story. The moral is somewhat hedged notably with the use of 'maybe' at lines 25 and 26 and the post-positioned '°I don't know°'; however, it clearly concludes the story and does so by taking a position against her mother's failure to seek medical care earlier than she did.

The doctor's response

In the context of ordinary conversation, any storytelling invites some form of response in the form of an assessment (Sacks 1974; Jefferson

1978; Mandelbaum 1987) or a second story (Sacks 1992; Ryave 1978). Moreover, a story conclusion in the form of a moral embodies the teller's evaluation of its import and thereby ordinarily invites agreement or disagreement from a recipient (Drew 1998). The doctor has two opportunities to respond to this narrative. In the first (line 20), which we discussed earlier as a shift implicative acknowledgment, he treats it as complete and thereby as something that he will not comment on further. His use of *okay* as a sequence closing third (Schegloff 1995), prototypical of 'segmented' question–answer sequences, treats the patient's extended response as an answer to a question rather than as a narrative that itself requires a response in its own right. In this treatment, the patient's story becomes merely an elaboration of an answer without any independent import or significance.

The second opportunity comes after the patient has drawn the moral of her narrative at line 28. Although in most interactional contexts a response would be due at this point, the doctor produces no acknowledgment of the moral payoff of the story developed between lines 21 and 28. Instead, as he had projected with 'Okay' (line 20), he initiates a return to comprehensive history taking with what is hearably the next in a series of 'health status' questions about the patient's family. In this way, he treats the patient's narrative as concluded, but without taking up any aspect of the story's telling.

In coming to terms with the doctor's conduct at this point, it does not seem profitable to treat it as an instance of a broader pattern of 'insensitive' behavior or of a generic resistance to the introduction of lifeworld topics by his patient. On various occasions, including some already shown as data in this article (example [12] for instance), he actively pursues lifeworld topics, and elsewhere his responses in pursuit of information about 'morally loaded' topics (as in examples [8] and [11]) embody significant elements of empathy and affiliation. Moreover, he later addresses some of the issues that are implicit to this narrative. Thus, in order to understand his conduct at this point, we need to consider the matters which the patient's narrative draws together, and the nature and appropriateness of possible responses to them.

As we have previously noted, this patient recurrently addresses difficult topics in ways that are designed to preempt doctor responses that would pursue the matter either through further questioning or in terms of advice or criticism. This practice was relatively transparent in relation to such topics as breast self-examination (example [9]), excess weight (example [10]), exercise (example [11]), and keeping appointments (example [12]). A key feature of the patient's preemptions is that they are designed to limit further responsive comment: they do so by indicating

that she has 'insight' into her medical problems and a grasp of what is required to remedy them. In this way they treat further comment by the doctor as redundant and, by implication, undesired. It is noticeable that the doctor does not pursue topics that the patient treats in this preemptive manner. The two topics which the patient treats most explicitly in this way are her recent weight gain and its consequences, and the difficulty she has in keeping appointments. In what follows, we suggest that the patient's narrative about her mother's death can be understood as dealing with the second of these topics, and more generally the matter of her various delinquencies in self-care that have associated health risks.

Viewed in these terms, this narrative has two kinds of contents. At the manifest level it describes the circumstances of her mother's death and its moral invites agreement or disagreement about whether she could have been helped if she had sought medical help sooner. At a second and more embedded level, her story can be understood as an allusion to her preoccupation and concerns with her own disposition to delay medically necessary procedures. The patient's talk provides some clues to this allusion. First, at the beginning of the appointment she acknowledges that she has difficulty keeping up with preventive health care procedures, and a tendency to delay medical appointments—a tendency which she describes as 'putting things off' (example [12], lines 27–28). It is noticeable that it is just this phrase which she reuses with respect to her mother's behavior in her narrative (example [14], line 16).[13] Second, in her account at the beginning of the appointment (example [12]) she portrays her daughter as being concerned with this disposition (lines 9 and 10) and as pushing her to 'keep the appointments' (line 25). Her later narrative, although constructed in retrospect, expresses similar concerns about her mother's attitude and consequent behavior. There is therefore a parallelism between the patient's report of her daughter's concerns about her delinquency and procrastination and her concerns about her own mother as expressed in the narrative. It is this parallelism which permits, or even invites, a hearing of the patient's story as, at least in part, self-referential.[14]

Each of these narrative contents creates difficulties for the construction of the doctor's response. Response at the manifest level would require that the doctor second guess the work of other medical practitioners, itself a speculative activity made more delicate by its emotional significance for the patient. Similarly, this particular speculation would require a judgment of medical practice a quarter century previously. To these disincentives can be added the embedded significance of the patient's narrative that becomes more salient as it progresses to its

conclusion. The presence of this embedded dimension may make response at the manifest level appear less than perceptive and thus reinforce the other disadvantages of response.

On the other hand, response at the embedded level would require the doctor to bring to the surface elements of the narrative which the patient had been at pains to leave implicit. Moreover, such a response would run counter to the preemptive nature of the patient's narrative project, with which she shows her awareness of the potentially life-threatening consequences of postponing medical treatment. Finally, electing to respond to the embedded import of the patient's story when its manifest content was available to be addressed is in its own way equally uninviting: to disembed these dimensions of her story for discussion, no matter how well intended, could seem a gratuitous exploitation of the details of her mother's death to make a point which the patient had already conveyed as something she had fully internalized.

Discussion

In the doctor–patient interaction literature, the patient is frequently portrayed as imprisoned within courses of action that are overwhelmingly undertaken at the doctor's initiative (Byrne and Long 1984; Waitzkin 1991; Mishler 1984; Fisher and Todd 1993, West 1984). This constraint is depicted as particularly marked in the context of history taking where, for example, Mishler (1984) has argued that the expression of patients' lifeworld concerns are discouraged by the design of physicians' questions. The prevalence of *yes/no*-questions, the selection of specifically medicalized topics of inquiry, and the determination of the scope of patient response through the provision of follow-up questions are commonly recognized to limit the exercise of patient initiative in the history-taking context (Mishler 1984; Roter and Hall 1992).

As discussed in relation to examples (1) and (2), it is clear that an activity such as comprehensive history taking, organized through a sequence of question–answer adjacency pairs, places substantial constraints on next actions (Schegloff 1972, 1995). As we suggested at the beginning of this article, by collaborating in these sequences through minimal answers, patients display an orientation to comprehensive history taking as a distinct activity within the medical consultation. Nonetheless, as the data presented in this article illustrate, patients' responses are not exclusively restricted to providing answers to doctor's questions. In each of the cases we have examined, the patient provided more than the question asked for. The additional material—whether addressing a difficulty in responding, adding supporting details, preempting negative

inferences, or a narrative departure—can be used to accomplish a range of ancillary tasks. Most significantly, they indicate features of the patient's lifeworld which are, for the patient, variously matters of significance, concern, or preoccupation. For instance, in example (5) as part of her response to a question about her gall bladder, the patient mentions a tubal ligation procedure and that she 'was too afraid tuh even ask 'em anything about it'. Here, besides addressing the doctor's question, the patient volunteers an account of an experience which evidently remains significant a number of years later. Similarly, in example (10) the patient clearly conveys her understanding of the connection between being overweight and her breathless condition, and in doing so as an 'nth' mention of her ongoing weight problem, displays her preoccupation with this issue. In the comprehensive history taking context, these expansions provide patients with a resource for providing insights into their life circumstances.

While all of the patient's expansions can be said to provide insight into the patient's lifeworld, expanded answers and narrative expansions operate somewhat differently. Expanded answers pursue projects which the patient encounters as made relevant, or even 'required', by the answer she has just provided. In these cases, the extra information the patient provides is deployed in a context or 'slot' that is legitimated by the prior question–answer sequence. These expansions are relatively common in our data and, as we have shown, either the patient or the physician may take the initiative in their development. The information the patient provides in these cases addresses perceived factual or moral deficiencies in the prior answer. Thus, in both their construction and their content, the expanded answers are organic to the sequence in progress, and their provision is made relevant by projects that are interactionally 'in play' in these sequences.

In the narrative expansions (examples [12] and [14]), by contrast, the patient actively initiates the offering of information that is neither part of answering a just prior question, nor part of clarifying a just provided response. The information offered here accomplishes a different sort of action and designedly so. In contrast to the expanded answers, which both the doctor and the patient oriented to as addressing potential problems in the prior response, the narrative expansions are geared to providing insight into what is 'on the patient's mind'. This is most clear in the extended narrative (example [14]). There, even though an answer to the just prior question is eventually given, it is embedded deep within the narrative. The patient's response is plainly focused on her own project—the narrative about her mother's attitude toward medicine and the consequences of that attitude.

These two sorts of expansions create different interactional contingencies for the physician. In ordinary conversation virtually any expansion, whether an expanded answer or a narrative, could serve as a launching pad for more talk. Comprehensive history taking, however, constitutes an environment in which this potential is most often curtailed. The need to progress the business of the interaction, and the primary mandate to orient to its medically relevant aspects, recurrently pose a dilemma for the doctor in responding to patient expansions. This dilemma is at its sharpest in the case of narrative expansions. In ordinary conversation, responses that take up answers-to-questions and invite their expansion, though common enough, are not specifically required.[15] Thus, in the expanded answers we have examined in this article, the doctor's failure to respond to expanded answers is not sequentially problematic, even though in ordinary conversation many of them might have been responded to. In ordinary conversation, by contrast, narratives are overwhelmingly responded to with assessments, appreciations, and second stories. Thus narratives in the history-taking context can pit the normative pressure for response against the demands of the task in a much sharper way.

In sum, there are two sources for the differential pressure exerted on the physician by our two types of expansions. The differential sequential pressures of the two expansions, imported from ordinary conversation, are reinforced by the different courses of action these expansions are used to implement. While the expanded answers are motivated, however loosely, by the original terms of the question, the narrative expansions we have examined implement projects that are independent of, and clearly exploit, the environments in which they occur. The patient's narrative, then, is more demanding of response both in terms of its sequential projection as a narrative, and in terms of the unlooked-for material contained in it which the patient evidently treats as significant.

Conclusion

It has long been recognized that ordinary conversation and doctor–patient interaction proceed under different constraints and sustain different affordances. A narrative of the kind shown here could readily be the object of expansive questioning and affiliation in ordinary conversation. In a medical consultation, while doctors do not affiliate with patients' lifeworld narratives, these narratives can nonetheless be treated as resources for learning more about patients and ultimately facilitating their care and education (Beach and Dixson, 2001).

In dealing with any lifeworld information however, the physician must always determine whether it represents an issue which should be

addressed at all, or simply 'filed away' as information. Additionally, even where the doctor feels that the issue should be addressed, there is still the question of whether the patient is the kind of person who would be receptive to such discussions. Further, if the information is to be addressed, then there must be a determination as to whether it should be addressed 'now' or 'later'. And if it is to be addressed in the here and now, how is that to be managed. Not every occasion of lifeworld disclosure is an occasion for the pursuit of that disclosure. For this reason, every such occasion involves a choice for the responding physician: a choice in which considerations of time, the personalities involved, and the relevance and significance of the matter under review will all play a role.

Although in the case of our narrative, the doctor did not choose to address either its manifest or its embedded content at the time it was delivered, he nonetheless clearly grasped its underlying significance. Following the patient's physical examination, during a discussion of future action, the physician says 'I don't want to lose track of you though 'cuz I don't want you out there with a diastolic pressure of a hundred and six, which is what it is today, for the next year without having it checked. So what I would like to do is let's have you come back in about six or eight weeks …'. In this turn the physician firmly instructs the patient to return to see him shortly and, with the phrase ''cuz I don't want you out there … for the next year without having it checked', he conveys his understanding that the patient—as she puts it—has 'uh tendency tuh put– uh lotta things (off)'. It is this, of course, that the patient's narrative embeddedly conveys, and which the physician earlier passed on the opportunity to address.

Notes

* We would like to thank Wayne Beach and Jeff Robinson for their comments on an earlier draft of this article.

1. The second question (line 4) is also managed as a concerted mamber of a series, though through a different procedure: the use of an *and*-preface (Heritage and Sorjonen 1994).
2. Comprehensive history taking can occur in the same consultation as history taking that is directed at diagnosing a specific problem and informed by principles of differential diagnosis. However the two types of questioning are clearly distinct in terms of their organization and design, and the types of response they mandate. By comparison with the question designs in comprehensive history taking, which are optimized for 'no problem' responses, differential diagnostic questioning commonly incorporates questions designed for the affirmative acknowledgement of problematic symptoms,

as in the following case:

(i) 206 (Viral Sore Throat)
1 DOC: → Okay:? .hhh Uh: = uhm Are you coughing?
2 (0.2)
3 PAT: Yeah:.
4 DOC: Mkay:,
5 (0.5)
6 DOC: → Uh runny nose?
7 (1.0)
8 PAT: #m# Like every once in uh while it'll start running.
9 (8.0)
10 DOC: O::kay.

While not all differential diagnoses are pursued in this 'problem-seeking' fashion, a significant proportion are, thus distinguishing differential diagnosis from comprehensive history taking (Stivers 2000).

3. This restrictive design that is broadly caught by Waitzkin when he remarks that this kind of questioning in 'systems review' (SR), a part of the comprehensive medical history, can be

> quite exhaustive, even more so if the patient happens to be a 'yea-sayer'. Then, doctor and patient enter potentially endless labyrinths of questions and answers. … Gradual recognition of these pitfalls during a medical career accounts for the exhaustive efforts that medical students devote to the SR, while their supervising physicians often truncate the SR to a very brief series of questions, for which they do not expect to hear 'yes' as an answer (Waitzkin 1991: 30).

4. With the term 'expanded answers', we mean to establish a contrast with the designedly minimal responses which are characteristic in comprehensive history taking. Accordingly we will use the term to embrace all turns in which the patient initiates a move away from this minimality—including internally expanded multi-unit patient responses, as well as responses that involve sequence post-expansion (Schegloff 1995; Robinson, this issue).
5. No history was apparently taken during the previous visit.
6. The term 'conforming' response is taken from Raymond (1999).
7. In this case, of course, the effectiveness of the patient's claim as an objective measurement relies on the associated implied claim, that she would normally treat her headaches with aspirin.
8. The physician's selection of the candidate answer 'Daily' as a possible response for the patient may appear surprising in light of the patient's previous talk. However, the selection may serve two functions in this context. First, it provides an example of a 'standard time' metric in terms of which the patient should ideally frame her response. Second, it offers the more face-threatening 'daily' (rather than 'weekly') metric, and in this way encourages a patient, who might be reticent, to acknowledge a possibly problematic drinking habit. It is noticeable, however, that this preference is retroactively softened with the addition of 'or' at the turn ending (Lindström 1997).
9. The process of 'borrowing' here may be assisted by the fact that chest pain and shortness of breath are related symptoms, and can be heard to collocate. Thus, the prefatory 'any' in 'Any chest (type–) pain?' may by this means be heard to also preface what can be heard to be a second item in the list 'Shortness of brea:th'.

10. This case, with its expression of certainty about the relationship between breathlessness and being overweight is an exception to the general pattern identified by Gill (1998) in which patients offer explanation in 'candidate' form for subsequent medical evaluation.
11. It is this feature of the patient's turn which is addressed by the doctor in his response at lines 9 and 11 to 12.
12. The date of the current visit is July—4 months from the previous appointment in March. The patient is scheduled to meet with the physician on a bi-monthly basis.
13. The patient invokes this same outlook when, after her suggestion to delay her scheduled mammogram is overruled by the doctor, she jokingly says 'y(h)ou– y(h)ou kn(h)ow I(h) w(h)on't b(h)e b(h)a(ck) .hhh huh', acknowledging her inertia in relation to preventative health care.
14. Elsewhere in this consultation, though after this narrative, the patient describes a fear of surgical procedures that may also parallel her mother's outlook—see example (5) lines 14 to 15.
15. Schegloff (1995) makes a definitive case for the two-part sequence as the basic sequence type in ordinary conversation, treating third-position objects (such as acknowledgments, assessments, etc.) as aspects of sequence expansion.

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