ELSEVIER

Social Science & Medicine 61 (2005) 481–493

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

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

Jeffrey D. Robinson[a,*], John Heritage[b]

[a]*Department of Communication, Rutgers University, New Brunswick, NJ 08901-1071, USA*
[b]*Department of Sociology, University of California, Los Angeles, CA 90095-1551, USA*

Available online 29 January 2005

Abstract

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

Keywords: Conversation analysis; Physician-patient communication; Problem-presentation; United States

Introduction

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

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

*Corresponding author.
E-mail address: jrob@scils.rutgers.edu (J.D. Robinson).

0277-9536/$ - see front matter
doi:10.1016/j.socscimed.2004.12.004

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

Problem presentation as a socially organized activity

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

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

The relevance of current symptoms

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

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