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Negotiating last-minute concerns in closing Korean medical encounters: The use of gaze, body and talk

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ABSTRACT

Although patients may raise new concerns during any time of the medical visit, the closing phase of the consultation is a critical locus for the negotiation of the topicalization of additional concerns. Using conversation analysis as the primary method of analysis, this study provides an analysis of the structure of consultation "closings" in Korean primary-care encounters and the way in which the organization of closings in this context discourages patients' presentation of additional concerns. Data are drawn from 60 videotaped primary-care encounters collected from Korea, between 2007 and 2008. The rare occasions in which last-minute concerns are raised are closely analyzed to reveal that the organization of gaze and body orientation play an important role in foreclosing the presentation of additional concerns. The results contribute to our understanding of closings in the primary-care interview by investigating a non-western setting that includes an investigation of an understudied subject – that of embodied resources – and shows how these closings serve the doctor's purpose of bringing closure in the face of last-minute concerns broached by the patient. The cultural meaning of gaze in the Korean medical care context is also discussed. The findings have implications for research on nonverbal communication, cultural differences, and interactions in medical care.

Introduction

When patients visit primary-care physicians, they frequently bring several concerns, which can include not only medical problems but also requests for non-diagnostic advice and information (Campion & Langdon, 2004; Heritage, Robinson, Elliott, Beckett, & Wilkes, 2007; Marvel, Epstein, Flowers, & Beckman, 1999; White, Levinson, & Roter, 1994; White, Rosson, Christensen, Hart, & Levinson, 1997). However, the opening questions of physicians, such as "How can I help you today" normally elicit single "current" concerns (Heath, 1986; Heritage & Robinson, 2006). In Korea, which provides the context for the current study, the most frequently employed question to open primary-care visits is *eti-ka aphase wass-eyo?*, meaning "Where does it hurt?" which is structurally (through its linguistic design) and pragmatically (through its sequential placement) designed to solicit the primary and single reason for the patients' visit (Park, 2009). In these contexts, patients' presentations of their first concerns are taken as cues to progress through the activities and stages of history-taking, physician examination, diagnosis and treatment (Beckman & Frankel, 1984; Greatbatch, 2006; Heritage & Maynard, 2006; Manning & Ray, 2009; Robinson, 2003). Because patients' primary concerns are solicited by physicians at the beginning of consultations and those concerns presented later in the encounter are more easily ignored (Beckman & Frankel, 1984), raising the additional concerns of patients as topics of discussion can be challenging.

Managing the full array of patient concerns is important because studies show that physicians' knowledge of the full spectrum of patients' concerns is vital to the accurate diagnosis and treatment of medical conditions and the delivery of comprehensive and high-quality health care (Bates, Bickley, & Hoekelman, 1995; Fisher, 1991; Lipkin, Frankel, Beckman, Charon, & Fein, 1995; Mishler, 1984). In a study of 48 American primary-care practices, Robinson (2001) found that the primary moment for physicians to topicalize additional concerns is during the transition into closing activity, particularly, through questions such as "anything else?" When physicians do not solicit additional concerns from patients during these moments, patients may actively seek opportunities to state their concerns (Campion & Langdon, 2004; White et al., 1994). These concerns lead to the classic "by-the-way" syndrome (Byrne & Long, 1976) or what Campion and Langdon (2004) described as "in-situ announcements" through which patients try to introduce

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previously unmentioned difficulties and engender further discussion about their problems. Although patients may raise new topics or concerns during any time of the medical visit (Campion & Langdon, 2004), the closing phase of the consultation appears to be a critical locus for the negotiation of the topicalization of additional concerns (Heath, 1986). This paper explores the mechanisms by which physicians manage achieving visit closure in 60 Korean primary consultations and provides an analysis of how patients' efforts to bring up additional concerns during the closing sequence are discouraged in the context of a normative primary-care consultation oriented to a single, most "current" problem (Byrne & Long, 1976; Heritage & Robinson, 2006; Park, 2009).

The closing problem and soliciting patient's additional concerns

Studies have noted that participants face a fundamental challenge toward the end of the medical appointment in deciding how to coordinate their exit from the session (Robinson, 2001; West, 2006). This challenge, which Schegloff and Sacks (1973) refer to as "the closing problem" in ordinary conversation, is a general problem that participants have to solve whenever they plan to exit an encounter. Accordingly, the medical encounter cannot be terminated until participants display their mutual attendance to it as such. In the American primary-care context, the closing phases begin with the "arrangement-related" (West, 2006) or "final concern" business pre-closing sequence (Robinson, 2001), which discusses the action recommended by the physician after the current encounter is terminated (e.g., "I'll see you again in a couple of months") or involves the physician's solicitation of "last" or "final" concerns (e.g., "Any other problems?"). West (2006) found that re-invocations of arrangements that had already been made (e.g., "Let me see you back here on Thursday afternoon") occurred in 32 out of the 37 primary-care visits in which doctors initiated pre-closings. These pre-closing sequences in which arrangements are made deciding when the doctor will next see the patient generally lead to the actual closing activity, which is characterized by terminal exchanges (e.g., "bye") (Robinson, 2001; West, 2006; White et al., 1994).

White et al. (1994, 1997) examined audiotapes of American encounters to show how closings in medical encounters begin with a shift from a present to a future orientation (with sentences such as 'okay, well let's do some blood tests', 'see you in three to four months'). However, their study relied on audiotape data and coders' assessment of the talk; therefore, they did not have access to physicians' and patients' closing-relevant, embodied actions as evidence for what constituted transition-relevant places in the talk. Drawing on videotaped data from England, Heath (1986) analyzed the activity of closings as requiring tense negotiations between patients and physicians, indicating further that the last minutes of a visit are important for patients. While these studies have extended physician–patient interaction research by examining the communication practices employed in the closing phase of the encounter, they were primarily concerned with the organization of talk in the consultation and paid little attention to the ways in which physicians employ visual as well as spoken conduct. There also remains the task of establishing a framework for contextualizing such findings in a different cultural setting.

At least two of the contexts that characterize primary-care visits in Korea differ from those occurring in the United States. First, medical care in Korea is characterized by compulsory medical insurance with universal coverage, unlike current medical care in the US. Therefore, people in Korea freely choose among family physicians and the outpatient departments of hospitals rather than having a single family doctor or attending physician. Second, medical services are reimbursed on a fee-for-service basis (patients pay approximately 3 dollars out-of-pocket for each visit with a 74% imbursement rate) which explains the large number of patients (over seventy patients) that doctors see on a single day to remain profitable (Cho, Hong, & Park, 2004). This medical system may motivate the doctor to see as many patients as possible, which in turn may influence the interactional organization of closings between doctors and patients in primary-care consultations.

The aims for this study are, first, to describe the turn-by-turn organization of closings in the Korean primary-care context by investigating how physicians and patients collaboratively achieve visit closure, and second, to offer an analysis of the embodied practices that physicians use to negotiate a transition to the closing activity by exploring the rare exceptions (three out of 60 cases) when last-minute concerns arise. In particular, the position in which additional concerns are brought up will be analyzed to show how the patient's efforts at presenting new concerns are discouraged by the doctor. Because the data are collected in a non-Western context, the results add to the findings from previous studies on the organization of closings largely conducted in American and British medical care settings (Campion & Langdon, 2004; Heath, 1986; Heritage et al., 2007; Rhodes et al., 2008; Robinson, 2003; West, 2006; White et al., 1994, 1997). An example of a non-American/British study is that of Nishizaka (2010) who studied how pregnant women raise problems in Japanese regular prenatal checkups; however, the author did not address the closing problem, focusing instead on the mutual dependence between the position and construction of problem presentations. The current study thus contributes to our understanding of how unmet concerns are dealt with in a non-Western health care setting, where the interactional organization of closings is managed in a somewhat different way. Finally, this study adds to our understanding of the interdependence of talk and bodily conduct during the medical closing activity and to the cross-border or cross-system extension of existing knowledge.

Data and method

The current data are drawn from a body of 60 videotaped primary-care encounters collected from seven private clinics and hospitals in Seoul, Korea, between 2007 and 2008. The participants (physicians and their patients) were selected on the basis of their willingness to participate. All data collection was approved by a university human subject protection committee (#G07-06-021-01), and consent forms (including an agreement to be recorded and to allow the use of photographs in published manuscripts) were obtained from participants. The nursing staff at each health care facility identified potential participants and initially asked whether they would be interested in participating. If the patients gave permission, the researcher approached them in the waiting area, explained the goals of the study and obtained informed consent. Once the researcher had obtained consent from the patient, she would inform the nurse, who would then turn on the video camera before the patient entered the doctor's office. The filming continued until the visit was complete, at which point the nurse turned off the camera.

The physicians included four males and three females. Five of these physicians were currently professors at various universities in Seoul; only one of the seven physicians was a resident doctor in training. The mean age of the patients was 48 years. Sixty-seven percent of the encounters were with male physicians and 52% of the patients were women. Out of the 60 collected visits, 24 were for acute problems in which the patients visited the clinic with new concerns such as influenza, headache or cough. Seventeen visits were routine checkups to monitor the patient's glucose level or blood pressure, and the remaining 19 were follow-up visits for an earlier reported problem (e.g., a cold or back pain).

The videotaped data were transcribed using conversation analysis methodology, as applied to the study of institutional