

## 7 When patients present serious health conditions as unlikely: managing potentially conflicting issues and constraints

---

*Anita Pomerantz, Virginia Teas Gill and Paul Denvoir*

### **Introduction**

Patients not only describe their symptoms during medical visits, they frequently present possible explanations for those symptoms (Gill, 1995, 1998; Raevaara, 1998, 2000; Stivers, 2002; Gill et al., 2004; Gill and Maynard, 2006). Although patients often display uncertainty about their candidate explanations (Gill, 1998), they typically portray them as reasonable, and at least somewhat likely, possibilities. For this study, we analysed instances in which patients offered serious health conditions (a heart problem, appendicitis) as candidate explanations for symptoms and portrayed those candidate explanations as unlikely to be the case, as improbable, while also implicitly or explicitly directing the doctors to investigate and confirm that they were indeed improbable.

This study is part of a larger project of analysing the range of practices that patients use when they present medically serious conditions as candidate explanations. For this project, we examined a subset of those practices: those used on occasions in which a patient presented a serious health condition as an unlikely candidate explanation. We selected this phenomenon because we were intrigued by the following observations:

1. Patients did not simply raise the spectre of serious health conditions as candidate explanations; they spent considerable effort displaying sceptical stances toward those candidate explanations, often by presenting reports that served as evidence for the improbability of the candidate explanations. We wondered what potentially conflicting issues and constraints the displays of scepticism were designed to address and how the discourse was designed to deal with those issues and constraints.
2. In each of the instances, patients used rather elaborate packaging to raise the 'unlikely' serious health conditions. In two instances the

patients offered extended narratives, and in two instances the patients presented other less serious health conditions as additional candidate explanations. We wondered what issues and constraints the elaborate packaging was designed to address and how the discourse was designed to deal with those issues and constraints.

3. In each instance, the patient designed his/her presentation with either some ambiguity about, or minimisation of, how much concern he or she was experiencing. Additionally, patients sometimes shifted their stance with respect to how much concern they claimed or displayed. We wondered what interactional tasks were accomplished with the modulated claims and displays of emotion.
4. As mentioned in point 1, each patient spent considerable effort in portraying the candidate explanation as unlikely, or even quite unlikely. One inference that the doctor could have drawn was that a highly unlikely candidate explanation, one just about ruled out, would not warrant his or her attention. However, we observed that each patient succeeded, if not on the first try then on a second, to direct the doctor's attention to consider and/or address the candidate explanation. We wondered what strategies the patients used to direct the doctors' attention to the candidate explanations.

Our central claim is that the ways in which patients presented the 'unlikely' serious candidate explanations for confirmation were designed to deal with a number of potentially conflicting issues and constraints.<sup>1</sup>

The patients presented serious health conditions as unlikely candidate explanations by reporting that particular symptoms they experienced were atypical of the serious health condition and/or by reporting that symptoms associated with the serious health condition were absent. They incorporated their presentations in sequences and turns which were designed to address a number of potential conflicting issues and constraints that attend this type of activity:

1. Presenting the serious medical condition as a possibility *while also* presenting oneself as a sensible person who does not immediately embrace worst-case scenarios;<sup>2</sup>
2. Presenting oneself as able to make sense of one's symptoms and reason about the likelihood of possible explanations *while also* exhibiting an orientation toward patients' and doctors' differential rights to claim medical expertise;
3. Directing the doctor's attention to investigating and reporting on the serious medical condition *while also* portraying the candidate explanation as quite unlikely, which carries the implication that it need not be investigated.

## Data

We reviewed thirty-five videotaped medical consultations in two collections. The first collection contains consultations conducted in the early 1990s at an ambulatory clinic associated with a teaching hospital in a large city in the eastern United States. The second set contains consultations from the early 2000s in a Family Medicine practice associated with a medical centre in a mid-size city in the eastern United States. Among those thirty-five cases, seventeen patients raised at least one candidate explanation, explicitly and/or implicitly, about at least one of their medical complaints. Within these, we identified three clear instances in which a patient sought confirmation that some reported symptoms were not associated with a serious medical condition.

## Analysis

For each of the three consultations examined below, we first discuss the discursive practices that the patient used in presenting a serious medical condition as an unlikely candidate explanation. We then analyse how the practices represent at least partial solutions to conflicting issues and constraints operating in that local context.

### Consultation 1

The patient was an African American woman in her early fifties; the doctor was a young white male resident. Although the patient had a regular doctor at the medical centre, on this occasion she sought medical care from the same-day clinic at the medical centre. In response to the doctor's request for the reason for the visit, the patient described two complaints: pressure in her lower stomach and pains in her chest. After describing the symptoms associated with pressure in her lower stomach, she presented several candidate explanations, including appendicitis, which she framed as improbable. A bit later in the consultation, the patient raised appendicitis as a candidate explanation a second time.

#### *Patient's first presentation of appendicitis as a candidate explanation*

*How the patient created an opportunity to raise candidate explanations* The patient offered a series of candidate explanations in an early phase of the visit: in the slot provided by the doctor's soliciting her reason for the visit and after she presented the symptoms associated with her first complaint. In response to the doctor's solicitation

of the medical complaint (lines 1–2), the patient described a symptom, pressure in her lower stomach, which she claimed was severe enough to hinder normal walking (lines 3–7). She then offered another symptom, a little stinging when she urinated (lines 11–12), which is a symptom commonly associated with a bladder infection. In that interactional environment, the patient offered ‘bladder condition’ as a first of several candidate explanations (lines 14–15).

#### Consultation 1a

- 1 Doc: Uh why- wh:y are you um at the clinic today=what seems  
2 to be the [problem.]
- 3 Pt: [(W’ll) I ] ha- I have this pressure in my uh  
4 lowuh stomach,  
5 (1.0)
- 6 Pt: And uh: slightly (stiff) I cain’t (0.7) you know (.)  
7 (kinda) can’t hardly walk like I shou:ld.
- 8 Doc: Mm hmm,  
9 Pt: You know,  
10 (1.0)
- 11 Pt: When I go to ba:throom (um) uh (1.7) it’s u:h (1.5)  
12 (like/that) stings a little,  
13 Doc: °Mm [hmm° ]
- 14 Pt: [(And uh)] (1.0) it may be a bladder  
15 condition=I’ve had dat before,  
16 Doc: You’ve had that [bef- (tha)t’s)  
17 Pt: [An’ then ]  
18 (0.7)
- 19 Pt: I thought it was my appe:ndix=I (don’t/wouldn’t) know  
20 I d- guess (I) wouldna’ la:st this long=I woulda’ h-  
21 had (0.2) woulda’ had tuh be here before now.  
22 (0.2)
- 23 Pt: I don’ know=an’ den .hh I hadda’ lot of ga::s.  
24 Doc: °Mm [hmm° ]
- 25 Pt: [You] know but it’s (0.2) seem to be die:in’  
26 down >but I m-< I still have this pai:n inna lower  
27 s:tomach.  
28 Doc: Right.
- 29 Pt: An it’s severe, =you see how the walkin’  
30 Doc: Mm h[mm]  
31 Pt: [ H ]mm .hh  
32 (. )  
33 Pt: An’ u:m den I had uh pains in my chest

In partial overlap with the doctor’s acknowledgement of, and display of interest in, the patient’s report of the history of bladder condition (line 16), the patient presented a second candidate explanation, appendix, along with reports of circumstances that argued against its likelihood

(lines 17–21). The presentation of this candidate explanation is our focus here. In getting no audible response during a brief gap (0.2 seconds) in line 22, the patient commented on appendix as a candidate explanation ('I don' know' in line 23) and then implicitly presented a third candidate explanation, gas.

*How the patient raised the candidate explanation while orienting to potentially conflicting issues and constraints* Immediately following the description of her symptoms and before presenting appendicitis, the patient framed bladder condition as a likely possibility and one that was not particularly worrisome (lines 14–15).<sup>3</sup> The practice of presenting multiple candidate explanations, including at least one for non-serious medical conditions, can be seen as a solution to the potentially conflicting concerns of presenting a serious medical condition as a possibility *while also* presenting oneself as a sensible person who does not immediately embrace worst-case scenarios. Had the patient presented 'appendix' as her first or only candidate explanation, it might have been interpreted as her viewing appendicitis as a likely explanation. Hence she might have risked being seen as obsessed with a worst-case scenario (Halkowski, 2006). In this case, the patient presented herself as a person who was not obsessed with the worst-case scenario by raising the likely and less serious explanation of a bladder infection prior to presenting the possibility of appendicitis.

The patient displayed some scepticism about the candidate diagnosis, appendicitis. The patient distanced herself from appendicitis in several ways. First, she presented it as a past thought ('I thought it was my appendix' in line 19), and hence took a less committed stance than she would have had she reported it as a current thought. More importantly, she provided evidence that argued against the explanation. She reported two aspects of her experience with the symptom that provided grounds for its improbable status: the duration of the pain was longer than the duration expected for appendicitis ('wouldna' last this long' in line 20) and the level of pain was not as severe as would have been expected for appendicitis ('I woulda' h- had (0.2) woulda' had tuh be here before now' in lines 20–21). In producing these grounds for the improbable status, the patient displayed herself as somewhat knowledgeable about appendicitis, at least with respect to expected duration and severity of pain.

The patient presented herself as able to reason about the likelihood of appendicitis *while also* displaying an orientation to the parties' differential rights regarding medical expertise.<sup>4</sup> When the patient presented appendicitis, she offered it as a report of a 'thought' and followed that

with a claim of uncertainty, through which she positioned herself as less committed to it as a possibility: 'And then (0.7) I thought it was my appendix I don't know' (lines 17–19). When she offered a reason for the improbability of 'appendix,' she marked it as merely a guess: 'I d-guess it wouldna' last this long.' (lines 19–20). When she offered a further reason for the improbability, she again added a claim of uncertainty: 'woulda' had tuh be here before now. (0.2) I don' know.' (lines 20–23). By presenting the candidate explanations as a matter of uncertainty, the patient displayed her orientation both to the doctor's entitlement, and to her lack of entitlement, to claim medical expertise.<sup>5</sup>

Even though the patient portrayed the candidate explanation as unlikely, which might have implied that it need not be investigated, the patient directed the doctor's attention toward investigating it. The displayed uncertainty may be a way to prompt the doctor to attend to the likelihood of that candidate explanation in order to reduce the patient's uncertainty. In addition to possibly directing the doctor's attention through the use of uncertainty markers, the patient employed a second practice for directing his attention. She narrated a sequence of symptom experiences that implied that she considered *gas* as yet another candidate explanation that she then ruled out.<sup>6</sup> In ruling out this benign candidate explanation, the patient implicitly directed the doctor to consider explanations other than *gas* for her symptoms (Gill, et al., 2004).

*How the doctor responded to the patient's candidate explanation* The doctor responded to the patient's presentation of appendicitis in a noticeably different way than he responded to the patient's presentations of the other candidate explanations. While the patient was raising bladder condition as a candidate explanation and was reporting her history with the condition, the doctor engaged in large, slow nods. The nods seem to indicate that the doctor was considering, and perhaps supporting, a bladder problem as a possible cause. The doctor marked the patient's history with the condition as potentially significant by partially repeating it in line 16 ('You 've had that bef-'). When the patient raised appendicitis as a candidate explanation and presented evidence that implied it was unlikely, the doctor performed two sets of small, quick nods. These nods appear to be minimal acknowledgements, registering receipt of the patient's report and encouraging her to continue. When the patient raised *gas* as a candidate explanation and ruled it out, the doctor engaged in larger, slower nods and verbally acknowledged the patient's report with "Right" (line 28).

The patient could have read the doctor's differential employment of either large, slow nods accompanied by verbal acknowledgements or

small, quick nods with no verbal acknowledgements as revealing a different level of receptivity to the various candidate explanations she raised. By responding with large, slow nods and verbal acknowledgements to bladder condition as a likely cause and to gas as an unlikely cause, the doctor conveyed receptivity to the patient's presentations of those candidate explanations. In contrast, the doctor's small, quick nods were ambiguous or non-committal regarding the doctor's receptivity. Given the doctor's ambiguous or noncommittal reception to the patient's presentation of appendicitis as a candidate explanation, the patient might not have known whether or not the doctor would attend to appendicitis as a possible diagnosis as he gathered diagnostically relevant information.

*Patient's second presentation of appendicitis  
as a candidate explanation*

*How the patient created an opportunity to re-raise the candidate explanation* After the patient presented 'pressure in her lower stomach' and 'pains in her chest' as two problems for which she sought medical attention (Consultation 1a, lines 3–4, 33), the doctor set the agenda by proposing that they discuss each medical problem separately (not shown here). He began closed-ended symptom queries related to pressure in her lower stomach. In asking about symptoms related to urination (see below), the doctor seemed to have been investigating the possibility of a bladder infection, as urination problems are associated with bladder infections. In lines 82–4, it appeared that the doctor was moving to close the line of inquiry tied to a possible bladder infection. In the interactional environment of the doctor's apparently closing his inquiries associated with the pressure in her lower stomach and possibly moving to inquiries related to chest pain, the patient, with no gap, jumped in to again present appendicitis as a candidate explanation (line 85).

Consultation 1b

75 Doc: .hh U:h (0.2) any burning when you urinate?  
76 (1.0)  
77 Pt: M:aybe a little ( )  
78 (1.0)  
79 Pt: Maybe ( ) (0.2) I don' know.  
80 (0.5)  
81 Pt: until I (1.0) (s'posed to) u:rinate in a cup like  
81 [an' ] 'en they take the [uh]  
82 Doc: [Yeah] [Ye]ah I- I'll take a look at  
83 your urine i- in a little bit and we'll see if that's  
84 what's (.) what's goin' on=  
85 Pt: =I jus' hope it wasn't no appendix.

- 86 Doc: Okay.=  
 89 Pt: =Was what I was worried [about. ]  
 90 Doc: [Tha- th]at seems to be your  
 91 major concern whether (.) whether  
 92 it's [an appendix.]  
 93 Pt: [( ) ]  
 94 Doc: [°Yeah°]  
 95 Pt: [An' I ] had uh (0.2) cesarian (.) too=  
 96 Doc: =°Mm hmm°  
 97 Pt: With eight children  
 98 Doc: °Okay° (.) well we'll- we'll sort it out when I examine  
 you we'll see uh (.) u:h (0.5) i- if that's a  
 99 possibility

*How the patient re-raised the candidate explanation while orienting to potentially conflicting issues and constraints* While on the first occasion the patient framed appendicitis as 'improbable', on the second occasion she focused on expressing emotions of concern and worry, using a combination of past and present tense in describing the emotions. In reporting her worries and concerns ('I jus' hope it wasn't no appendix') to reintroduce appendicitis, she took advantage of her entitlement to know and report her own feelings while respecting the medical expertise and entitlement of the doctor to make diagnoses. Inasmuch as doctors direct their attention to stated concerns and worries of patients, the patient used her right to express her emotions and concerns to reintroduce appendicitis such that the doctor might conduct his medical investigation with that in mind and provide the confirmatory diagnostic assessment that the patient was seeking.<sup>7</sup>

## Consultation 2

Patient 2 was a white male in his late thirties or early forties; the doctor was a young white female resident. The patient reported that four or five weeks before the medical visit, he experienced symptoms, including cramping, tightness, burning, a 'gas bubble' sensation, and heartburn, in his chest and back. Through the way he presented his symptoms, he raised the possibility that some of them could portend heart trouble, but in each case he also implied that this was unlikely. Nevertheless, he sought the doctor's confirmation that the symptoms were not indicative of a heart problem.

*How the patient created an opportunity to describe a series of symptom incidents that implied candidate explanations* Patient 2 raised the spectre of a heart problem in a sequential place in the consultation that

was similar to the place that Patient 1 raised the possibility of appendicitis: in the slot provided by the doctor's soliciting the patient's medical business (Robinson 1998, 2006).

#### Consultation 2a

- 1 Doc: Suh c'n yih tell me=little bit about (.)  
 2 what- brings yih here t'day-  
 3 Pt: .hhh Oka:y ah:m tss- (0.3) °tsstory bee-  
 4 (.)>meen awy-< ih- th' story begins a while  
 5 ba:ck uh::m  
 6 (0.3)  
 7 Doc: °That's fine,°  
 8 (0.7)  
 9 Doc: °°(Yeh)°°  
 10 Pt: Started with::: (. ) uh:m (. )>I w'z drinkin'<  
 11 I drank one a' those power drinks?

Whereas the sequential environments were similar, each patient used the slot somewhat differently. Whereas Patient 1 used it as an opportunity to first describe her symptoms and then explicitly present her candidate explanations, among which was appendicitis, Patient 2 used the slot to indicate that he would answer the doctor's question by telling a story (lines 3–5). Once the doctor positioned herself as a recipient ('°That's fine°', line 7), the narrative format gave the patient the opportunity to describe his experiences and inferences over multiple turns without significant interference until he produced the upshot of the story. As we will see, this provided him with a way to introduce material that might otherwise have been difficult to introduce in a question-answer series (Stivers and Heritage 2001), such as his sense-making processes as he experienced and interpreted his various symptoms.

*How the patient raised the candidate explanation while orienting to potentially conflicting issues and constraints* The patient narrated three episodes of symptoms. In the first episode, he reported on symptoms that occurred four–five weeks before the consultation. In describing the episode, the patient employed symptom descriptions that implied digestive, muscular and heart problems, and further implied that the latter was unlikely.

#### Consultation 2b

- 10 Pt: Started with::: (. ) uh:m (. )>I w'z drinkin'<  
 11 I drank one a' those power drinks?  
 12 (0.6)  
 13 Pt: °Red Bull whatever they are now°  
 14 (0.3)

- 15 Doc: °Okay,°=  
 16 Pt: ah:m that evening (0.3) fih like (.) my:  
 17 lef' si[:de]  
 18 Doc: [u-How lon'=go w'z thi[s?  
 [[lines 19-28 deleted]]  
 29 Pt: Uhm I fel' like my lef' side of my (.)  
 30 chest like a- (.) mah had a k- cramp?  
 31 (1.0)  
 32 Pt: °Here,°  
 33 (0.4)  
 34 Pt: °'n tha' w'z fine it didn' la:st, ih w'z  
 35 very brief, .hhh Ahm ih >fel' like ih was<  
 36 (.) un- und- the muscle almos' >fel' like ths<  
 37 (0.2) ths right here.  
 38 (0.3)  
 39 Pt: °Thet the mu[scles (right) ]  
 40 Doc: [Tha' w'z right] after you had  
 41 the drink?  
 42 Pt: Thit- tha' w'z- later on in the evening

In linking his symptom temporally to his consumption of a beverage (a 'power drink', lines 10–11), the patient raised the possibility that the digestion of the drink might be at the root of his symptom. However, in identifying (both verbally and through gesture) the location of the symptom as occurring on the left side of his chest, he also raised the potential of heart trouble.<sup>8</sup> Additionally, the patient's characterisation that the symptom felt like a 'cramp' and his report 'It >fel' like ih was< ... the muscle almos' (lines 35–6) suggested overworked muscles in the chest area. Thus, three potential candidate explanations were implied by the patient's symptom descriptions.

The patient offered his assessment of the cramping episode as 'fine' (line 34) and provided evidence for not considering the symptoms worthy of concern: it 'didn' last' and it 'w'z very brief' (lines 34–5). Thus he used the *absence* of a symptom usually associated with a cardiac problem, persisting pain, to explain a lack of concern over that incident. In reporting that the cramp 'didn' last' and 'w'z very brief', he underscored the potential relevance of a cardiac problem while simultaneously portraying it as unlikely (see Stivers, 2002).<sup>9</sup>

In the second episode within the narrative, the patient reported symptoms in a way that re-raised the spectre of heart trouble (tightness in his chest) and digestive problems (burning on both sides).<sup>10</sup>

#### Consultation 2c

- 48 Doc: °°Okay°°  
 49 Pt: .hh Uh:m following that over the next (0.2)

50       uhw week er so (0.3) .hh there was a, a slight  
 51       tightness: (1.2) in the middle (0.3) my chest,  
 52       (0.8)  
 53 Pt: No pain, (0.3) nothing else  
 54       (.)  
 55 Pt: uh:m .hhh then I noticed on the right, en lef'  
 56       side right approximately right about here .p.hh  
 57       slight burning,  
 58       (0.9)  
 59 Pt: But again (.) no pain no pains in the arm no  
 60       shortness 'v breath

Again, the patient portrayed a heart problem as unlikely by reporting that symptoms typically associated with cardiac problems were absent ('No pain, (0.3) nothing else' in line 53 and 'But again (.) no pain no pains in the arm no shortness 'v breath' in lines 59–60).

After describing a third episode of symptoms,<sup>11</sup> the patient reported that he had engaged in extended and vigorous sports activities (lines 73–6) and did not feel any discomfort during it (line 78).

#### Consultation 2d

72 Pt: But .hh no other symptom' beyon' tha:t uh:m  
 73       (0.2) I've played, sports I play volley ball  
 74       (0.3)  
 75 Pt: eh: yesterday I played outside doubles fer (.)  
 76       .hh three hours,  
 77       (1.0)  
 78 Pt: Didn't fleny discomfort, (.) during tha:t,  
 79       (0.2)  
 80 Doc: Okay,

The patient provided further evidence against the likelihood of a heart problem by reporting the outcome of these activities, which he later characterised as a test: exercising strenuously did not cause any discomfort, as it would have had he had a heart problem (line 78).

Several practices incorporated as part of the patient's presentation may be seen as solutions to potentially conflicting issues and constraints. First, in describing the various episodes of symptoms that he experienced, the patient implied he had considered or was considering multiple candidate explanations, including relatively benign ones (digestive and muscular problems) in addition to a serious one (heart problem). In doing so, the patient managed to raise the possibility that his problem could be serious *while also* presenting himself as a reasonable person who does not immediately embrace worst-case scenarios (Halkowski, 2006).

Second, in each of his symptom presentations the patient presented evidence that argued for the improbability of a heart problem. In doing so,

he raised a serious medical condition as a candidate explanation *while also* positioning himself to be seen as sceptical of it and portraying himself as someone who knows what to look for and what to disregard vis-à-vis his symptoms and who can anticipate what might be relevant to the doctor.

Third, in describing the various symptom episodes, the patient implied the serious candidate explanation through reports of symptoms that he experienced (and did not experience), rather than explicitly offering the candidate explanation and/or asserting a causal link. In doing so, the patient presented himself as able to make sense of his symptoms and reason about the likelihood of possible explanations *while also* exhibiting an orientation toward patients' 'entitlement to knowledge in the realm of first-hand experience' and lack of entitlement to reason about the causes of the symptoms (Gill, 1998: 345).

*How the patient sought a confirmatory diagnostic assessment while managing potentially conflicting issues and constraints* While relating the episodes in his narrative, the patient did not actively seek, or specifically allow opportunities for, the doctor to offer her own view on the cause of his symptoms or indicate whether or not he was correctly interpreting them. However, after reporting his exercise 'test', he shaped his next contribution in a way that tentatively gave the doctor an opportunity to provide a diagnostic assessment. He reported that he had been eating spicy food and was experiencing heartburn that went untreated for lack of medication (lines 83–6). In speculating about a connection between this event and his symptoms ('en I wonder 'f (.) that's part 'v (it) er not' in line 88), he made relevant the doctor's confirmation/disconfirmation of the speculated gastro-intestinal cause of his symptoms; however, he did not require it such that it would be hearably absent if not provided (see Gill, 1998; Gill and Maynard, 2006).

#### Consultation 2e

- 82 Pt: en it- if it makes a difference (0.7) prior (.)  
 83 to: (.) even before that I w'z deet 'n lots 'v  
 84 uh:m (.) hot stuff (.) 'n getting s'm heartburn,  
 85 .hh didn' have in<sup>n</sup>ning take fer it so ah dis (.)  
 86 dealt with it.  
 87 (0.2)  
 88 Pt: En I wonder 'f (.) that's part 'v er not but  
 (2.1)  
 90 Pt: >So 'm 's curious w't-< (.) should I be concerned  
 91 uh more of a heart? (0.4) [issue? ]  
 92 Doc: [ih Su:re.]  
 93 (.)  
 94 Doc: [Sure I]

- 95 Pt: [Or is] it something e:lse,  
 96 (0.4)  
 97 Doc: °Sure wil° (.) Wi'll work through that.  
 98 Pt: O[kay]  
 99 Doc: [Uh:]:m (0.2) .k.hh °Uh:° number a' questions  
 100 about (0.2) about yer symptoms

The doctor did not respond to the patient's utterance in line 88 as a solicitation, she remained silent, sitting still and gazing at the patient. After a two-second silence, the patient more overtly solicited the doctor's assessment of heart trouble as a candidate explanation. Marking the query as the upshot of the narrative (via 'So', line 90), the patient named the candidate explanation for the first time, explicitly indicating the problem to which he had been obliquely referring throughout the narrative ('heart issue.').

While officially putting the candidate explanation on the table, he gave ambiguous signals regarding the degree of concern he had about the possibility of having experienced a heart problem. On the one hand, seeking the doctor's diagnostic assessment and using the formulation 'should I be *concerned* uh more of a heart (0.4) issue' (rather than 'Is it more likely to be a heart issue') could have been understood as reflecting a concern on his part about the potential of heart trouble. On the other hand, he managed to downplay his concern by (1) framing the question as motivated by curiosity ('>So 'm 's curious') and (2) by naming the condition in a general way (heart 'issue') without reference to a 'trouble' or 'problem'.

The patient's ambiguity regarding his level of concern may be seen as a solution to conflicting issues and constraints. Framing the serious health condition as a 'concern' solicited the doctor's attention to it; however given that the patient portrayed himself as someone who knew what to look for and what to disregard vis-à-vis his symptoms and hence as sceptical in this case, he needed to present himself as not *too* concerned about the serious health condition or he would undermine his stance of scepticism.

### Consultation 3

The patient was a white woman who appeared to be in her sixties and the doctor was a young white female resident. Although the patient had seen a number of doctors at the medical centre in the past, the patient had come to the same-day clinic at the medical centre. It is not clear whether the patient made this appointment to talk about any particular health problems; most of the consultation revolved around updating the

doctor about the status of the patient's existing health problems. At one point, she reported having experienced a pain on the right side of her chest and offered a heart problem as an improbable candidate explanation for this symptom.

*How the patient created an opportunity to tell about a symptom episode* The opening of this consultation did not follow the usual routine in which, after greetings and identifications, the doctor solicits the patient's reason for the visit (Robinson, 1998, 2006). In this visit, the patient burped upon entering the examination room, then remarked that she had been burping a lot lately and began to puzzle about why it had been happening. The doctor started exploring the patient's burping with a series of symptom queries, one of which inquired about chest pain: 'you having any chest pain with this burping?' (line 1). After the patient denied the symptom (line 3) and the doctor accepted the response (line 6), the doctor began what appeared to be the start of another symptom query, 'Have' (line 8). At this point, the patient came in with a latched utterance in which she sought permission to tell the doctor about an incident, 'You wanna' hear somethin'' (line 9).

#### Consultation 3a

- 1 Doc: °Okay° .h you having any chest pain with this burping?  
 2 (0.7)  
 3 Pt: Not usually.  
 4 Doc: N[o. ]  
 5 Pt: [ ( ) ] (Y'know)=  
 6 Doc: =°Okay°  
 7 Pt: ((hiccuping sound))  
 8 Doc: Have=  
 9 Pt: =You wanna' hear somethin'=  
 10 Doc: =Sure.

Essentially, the patient made a bid to interrupt what had been shaping up as a series of symptom queries about her burping to initiate talk about a matter of interest to her.

*How the patient prefaced and reported the symptom episode while orienting to potentially conflicting issues and constraints* After securing interactional space to tell about the symptom episode, the patient did not immediately talk about the episode. Rather, she provided two kinds of prefaces that displayed her orientation to potentially conflicting issues and constraints.

In the first preface, the patient claimed uncertainty about the correctness of her as yet unstated stance or views ('I- I don't know whether I'm wrong er what', line 12).

## Consultation 3b

9 Pt: =You wanna' hear somethin'=  
 10 Doc: =Sure.  
 11 (2.0)  
 12 Pt: I- I don't know whether I'm wrong er what. hh  
 Doc: Okay

By acknowledging to the doctor the potential incorrectness of the views she was about to put forward, the patient displayed an orientation to the patients' and doctors' differential rights to claim medical expertise. The patient implicitly positioned the doctor as the person who would rightly judge the status of her views on the symptom incident about which she would be reporting. In this way, she highlighted the disparity in their respective rights to make inferences or theorise about the cause of symptoms (Gill, 1998). In positioning the doctor as the medical expert and herself as uncertain, she also provided for the relevance of the doctor's assessment of her views after she completed the telling. Additionally, by claiming uncertainty about the correctness of her views, she positioned herself to be 'informed' by the doctor rather than disagreed with in the event that the doctor's views differed from hers.

In her second preface to describing the symptom incident (see below), the patient sought confirmation about the correctness of her knowledge about the warning signs of heart problems. The patient indicated her knowledge of heart symptoms by describing her different reactions to pains on her left side (lines 16–17 and 21) versus pains on her right side (line 23), and she sought the doctor's view as to whether her reactions were appropriate. The positioning and syntax of her solicitation ('I don't worry', line 23, 'Am I supposed to?', line 25) suggested that she was focused on confirming the correctness of her assumption that right-side chest pains generally were not regarded as symptoms of a heart problem. (As we will see shortly, it is with respect to that assumption that the patient cast her candidate explanation of symptoms as thoroughly unlikely.)

## Consultation 3c

12 Pt: I- I don't know whether I'm wrong er what =  
 13 Dr: =Okay  
 14 Pt: I have a heart problem [ okay ]  
 15 Dr: [Mm hmm] right  
 16 Pt: Now hhh usually (0.2) when I (0.2) feel a heart pain-  
 17 [er ch]est pain on this si[de] ((*points to chest, left*))  
 18 Dr: [**E**Mm hm**E**] [**E**Mm] **E**m**E**  
 19 Pt: .hh u::h  
 20 (1.0)  
 21 Pt: I worry.

- 22 Dr: **E**Mm hm**E**  
 23 Pt: On this side((*points to chest, right*)) I don't worry=  
 24 Dr: =Okay  
 25 Pt: Am I supposed to

In displaying her knowledge of typical warning signs of a heart problem, the patient presented herself as an informed and appropriately attentive heart patient who routinely made sensible inferences about different types of chest pains, including dismissing right-side chest pains as not heart-related. However, in seeking confirmation, she also displayed an orientation to the doctor as the expert who could officially assess the correctness of her typical reasoning.

In response to the patient's seeking confirmation of the correctness of her knowledge, the doctor started describing the usual symptoms that accompany a heart problem. Then, instead of positioning herself as a recipient of further information about typical warning signs, the patient manoeuvred to tell the doctor about the symptom episode. By asking the doctor if she knew her reason for asking ('Y'know why I'm askin', line 31), the patient implied that she had something more to tell and, in so doing, redirected the conversation to tell about the incident.

#### Consultation 3d

- 31 Pt: Y'know why I'm askin',  
 32 (0.2)  
 33 Pt: The other (n)day, (.) .hh (.) the other even[ing]  
 34 Doc: [°Mm ] hm°,  
 35 Pt: I was sittin' watchin' televi[sion an' I got such a  
 36 Doc: [°Mm hm°,  
 37 Pt: (.) .hh really (.) badpain [right here] ((right side))  
 38 Doc: [°Mm hm mm ] hm°  
 39 (.)  
 40 Pt: Y'know  
 41 (.)  
 42 Pt: h An' then h a pain shot down my arm.=  
 43 Doc: =Mm hm,  
 44 Pt: .hh An' I thought (0.2) if I didn't know any better  
 45 I'd swear somethin was goin' on with my heart [y'know]  
 46 Doc: [°Mm hm°]  
 47 Pt: .hh But (.) I didn't tend I didn't worry too much h  
 48 [like I say I on]ly worry (0.2) on this  
 49 Doc: [Cuz it was the right side.]  
 50 Pt: side.=  
 51 Doc: =°Right°

As in her preface, the patient's description of the symptom episode displayed her orientation to conflicting issues and constraints. The

patient described the pain as very similar to left-side heart pain – it was severe ('I got such a .hh really (.) bad pain', lines 35 and 37) and it shot down her arm; thus, in both its severity and its similarity to the typical warning signs of a heart problem, it warranted further attention. The patient then reported that, at the time she experienced the pain, she considered the possibility that her pains were heart-related but largely rejected that explanation: 'If I didn't know any better I'd swear something was goin' on with my heart', lines 44–5. By using a direct reported thought (Holt, 1996), she provided evidence with which the doctor could see for herself that even at the time of the pain the patient both had considered the candidate explanation of a heart problem and also was sceptical that it was the case. In making reference to 'knowing better', and by confirming that she worries when the pain is on the left side (lines 47–8 and 50), she suggested that, based on her knowledge, she largely dismissed the notion that she was experiencing a heart pain. She thus presented heart problem as a candidate explanation that was both worthy of consideration and highly unlikely, making the doctor's assessment relevant while showing that she does not embrace worst-case scenarios.

In short, the patient managed the conflicting issues and constraints of directing the doctor to consider the explanation while also establishing herself as a sensible person. She did this by taking a sceptical stance and portraying her reaction to this particular right-side chest pain as an exception to her usual way of reacting to right-side chest pains. This particularly severe right-side chest pain deviated from the typical right-side chest pains that she routinely dismissed to such an extent that she actually entertained the possibility that it was a heart pain. The severity of the pain, along with its similar characteristics to the warning signs of a heart problem, provided a warrant for raising the matter, even though she continued to treat it as improbable. Though the patient reported that she routinely dismissed right side chest pains, she treated this exceptional pain as an occasion for seeking special reassurance from the expert voice.

The tension between casting the serious health condition as a possibility warranting the doctor's attention while displaying oneself as a knowledgeable and sensible person also is evidenced in the patient's display of concern or anxiety. The patient reported her own reactions to the symptoms as 'I didn't worry too much' (line 47). While she downgraded the degree of worry with 'didn't worry *too much*', she also preserved some degree of worry in this formulation. She rode a fine line between preserving a measure of concern (and thus, medical relevance) and displaying the reasoning she had done to all but dismiss the concern.

### Discussion

In this chapter, we have examined some practices that patients used when they elected to present serious medical conditions as candidate explanations. Some practices that we identified are:

- Presenting the serious condition as one of several possible explanations and/or reporting evidence against the likelihood of the serious condition are solutions to the dilemma of how to raise a serious candidate explanation *while also* portraying oneself as a reasonable person who does not embrace worst-case scenarios.
- Reporting evidence against an explanation in the form of reports of the presence or absence of symptom experiences is a solution to the dilemma of how to present oneself as knowledgeable enough to make sense of one's own symptoms and to reason about one's health *while also* orienting to doctors' and patients' legitimate domains of expertise.
- Displaying some modulated degree of concern or worry is a solution to the dilemma of how to direct the doctor's attention to investigating the potential of a serious medical condition *while also* portraying the explanation as unlikely, which could imply that it need not be investigated.

In short, presenting the serious condition as one of several possibilities *and* displaying scepticism and uncertainty via experiential reports *and* modulating one's displayed degree of concern are solutions to the dilemmas of how to raise a serious candidate explanation *and* show that it warrants the doctor's attention *while also* portraying oneself as a reasonable patient who does not embrace worst-case scenarios *and* who respects the differential spheres of expertise between patients and doctors.

In the remainder of this section, we will address the relevance and potential use of this research. We believe that the primary audience that would benefit from our analysis is comprised of health-care providers. Patient-centred health-care providers are committed to listening to and understanding the theories, interpretations and concerns of their patients. However, this is not always an easy task, especially when patients present explanations that they then argue against, when they seem to be concerned about the possibility of having serious health conditions yet also present themselves as largely unconcerned about those possibilities, and when they hint about or allude to serious health conditions but do not explicitly state them (Lang et al., 2000). We think that our analysis can help health-care providers to disentangle fairly complex discourse, which on face value seems puzzling or contradictory, and make better sense of that discourse.

There are two implications of our research that we would like to offer to health-care providers. First, it is important to appreciate the complexities involved for patients in presenting serious candidate explanations. While it is inevitable to attempt to interpret the patients' state of mind from their discourse (Have they ruled out that candidate explanation? Are they concerned about this candidate explanation?), it would be a mistake to overlook the interactional issues and constraints that shape the discourse. When a patient portrays the serious candidate explanation as highly improbable, that may be as much, or more, a product of self-presentational issues than a reflection of the patient's views. The delicate and complicated ways in which patients present these serious candidate explanations create challenges in interpreting and hence responding to these types of presentations.

The second implication is that, if patients are to present serious health conditions as candidate explanations, they need sufficient interactional space to package the explanations in ways that allow them to deal with the multiple issues and constraints that emerge. These complex tasks seem to be nearly impossible to accomplish in an environment driven largely by queries from the healthcare provider. If patients are to present their serious candidate explanations, at least in the configurations we have examined here, they need to secure a certain amount of interactional 'space' to do this work. The interactional space is a joint accomplishment of both participants. The healthcare provider needs to allow the opportunity for the patient to present an extended version of events or narrative from the patient, and the patient needs to have the resources and feel they have the right to detail what needs to be told to have the picture understood as they wish.

It is our hope that through our identifying some of the practices that patients use, health-care professionals might be better sensitised to some of the issues and constraints that bear on patients' presentations of serious health conditions as candidate explanations and to recognise the complex work that patients perform to handle these constraints.

#### NOTES

1. This approach to discursive phenomena is similar to, and compatible with, the approach taken by Billig et al. (1988). In responding to patients' presenting serious health conditions as candidate explanations, doctors also display an orientation to conflicting constraints (Gill and Maynard, 2006).
2. This point particularly complements Halkowski's (2006) finding that patients present themselves in ways that would enable them to be seen as 'reasonable' patients. Halkowski found that patients can do this via narratives in which

they report that they first considered rather mundane possible causes for their symptoms ('at first I thought') before considering more serious possibilities.

3. The understanding of bladder condition as both likely and not particularly worrisome was achieved, in large part, in the patient's reporting that she had a history of the condition ('I've had that before'). In reporting the history, the patient provided grounds for its likelihood inasmuch as bladder infections recur and her prior experience might mean she would be more likely to be able to identify it again. In reporting the prior occurrences in a matter-of-fact manner, she implied that having a bladder condition was not a particularly newsworthy or serious event.
4. The patient displayed an orientation to differential expertise when presenting each candidate explanation. When presenting bladder condition, she incorporated an uncertainty marker 'may' ('It may be a bladder condition') and supported the likelihood of the candidate explanation by drawing on her experiences ('I've had dat before'), which is the kind of expertise that patients are entitled to claim (Drew, 1991; Heath, 1992; Gill, 1998). When presenting gas, she reported her symptom experience and relied on everyday logic for an understanding of the basis for ruling it out.
5. In presenting 'appendix' as a very tenuously held idea, the patient not only displayed deference to the doctor's expertise. She also maintained a stance that would not have to be strongly disagreed with if the doctor were to conclude that appendicitis was improbable.
6. The patient ruled out *gas* as a candidate explanation by describing a symptom history that argued against it as the cause. She reported that the gas was subsiding but the symptom remained ('I hadda lot of ga::s' 'You know but it's (0.2) seem to be dy::in' down but uh- I still have this pai:n inna lower s:tomach'). Understanding the candidate explanation as ruled out requires the use of everyday causal reasoning: the presence of a causal agent should produce the effect, and the absence of the causal agent should result in the absence of the effect.
7. In a later phase of the consultation, the doctor informed the patient of his diagnostic conclusions. He referred back to the patient's concern about appendicitis, gave multiple reasons for ruling it out, and reassured the patient not to worry. It is likely that the extent to which he reassured the patient was a response, at least in part, to the patient's invoking worry and concern to reintroduce appendix as a candidate explanation.
8. As Stivers (2002: 312) has argued, such specificity in symptom presentations can be 'diagnosis implicative'. For example, 'a parent can mention that their child has a "barky" cough to index croup, green nasal discharge to index sinusitis, or white or yellow spots on the child's throat to index strep throat'.
9. Stivers (2002: 321–2, lines 31–4) shows how a parent uses the same device to suggest that her child no longer has strep throat.
10. See Halkowski (2006) for a discussion of how the patient's formulation 'noticed' (line 55) works to counter undesirable inferences.
11. In the interest of space, we omit a discussion of lines 61–71, in which the patient moved the narrative to the present and reported that he sometimes experienced a gas bubble which was of short duration.